The experiences of mental health nurses who have been assaulted by patients in medium secure mental health settings

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ABSTRACT

Background: The prevalence of assaults on mental health nurses in inpatient settings is high and research has identified negative outcomes including depression and anxiety, PTSD, burnout and intention to leave. Quantitative approaches to researching this subject have dominated, with there being very few studies exploring mental health nurses' personal experiences of being assaulted by patients, and none focussing on secure settings. **Aim:** The aim of this exploratory study was to develop understanding of the experiences of mental health nurses who are assaulted by patients in secure settings. **Methods:** Sixteen registered mental health nurses working in secure services across the UK were interviewed, and the data were analysed using Reflexive Thematic Analysis. Ethical approval for the study was granted by Oxford Brookes University Research Ethics Committee. **Results:** Three themes were generated: 'We know the risks, but being assaulted is not 'normal''; 'Keep emotions under wraps and crack on' and 'The response to assault can make or break'. The themes each speak to the enduring narrative that assaults on mental health nurses are normal. Whilst nurses explicitly rejected this narrative, its impact was evident in both their own responses to being assaulted, and the responses they received, particularly from their managers and the police. In order to protect themselves from the shame of being exposed as weak and a failure, they suppressed their emotional responses to being assaulted. The expectations on nurses to "crack on" was frequently reinforced by the responses they received from others both within and beyond their organisations. **Conclusions:** The normalisation of assaults on mental health nurses is understood with reference to the Fricker's (2007) concept of epistemic injustice, influenced by mental health nursing's history, associative stigma, and the narrative of nurses as 'angels and heroes'. Recommendations for education, practice and further research are made, focussing on challenging the cultural, organisational, and systemic factors that serve to perpetuate the damaging normalisation of assaults on mental health nurses.

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LIST OF ABBREVIATIONS / GLOSSARY

Assault:	'Assault' is not defined in this thesis, rather the ways in which participants conceptualised and defined their experiences to the sense they made of them. This is discussed further in chapter three.
Mental disorders:	Term used in this thesis to describe mental illnesses and mental disorders as described in the Mental Health Act 1983 (amended 2007).
Patient:	Where this term is used, it describes individuals receiving care and treatment in secure hospitals. The choice of term stems from my clinical experience, and many conversations with such individuals who considered the term 'patient' best represented their status as people detained in hospital. It is recognised that there are different perspectives on this issue.
Secure mental health services:	Also known as 'forensic' services, secure mental health services are organised in to high, medium and low secure hospitals. They provide care and treatment for individuals, often who are or have been involved with the criminal justice system, who require enhanced levels of security in order to maintain their own safety and the safety of others.
CINAHL	Citation Index for Nursing and Allied Health Literature
JBI	Joanna Briggs Institute
NHS	National Health Service
NMC	Nursing and Midwifery Council
NICE	National Institute for Health and Care Excellence
NIOSH	National Institute for Occupational Safety and Health
RN	Registered Nurse
TA	Thematic Analysis
RTA	Reflexive Thematic Analysis
UK	United Kingdom
US	United States
WHO	World Health Organisation
WPV	Workplace Violence

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CHAPTER 1: INTRODUCTION

1.0 Introduction

This chapter provides the context and rationale for this research study. The first section presents the background to the research from the perspective of what is currently known about violence against healthcare professionals. After identifying mental health nurses as being among those most likely to face violence and aggression, a broad overview of the literature on this topic is given. The second section of this introduction gives the background to the research from a practice perspective, with the study being situated as practice-based research, undertaken by a practitioner and insider researcher. The research study is then described with its aims and objectives outlined.

Terminology relating to violence towards mental health nurses - and healthcare workers more generally - varies, and this is discussed at several points in this thesis. For this background, the language used reflects this variation in the literature.

1.1 Background to the study

Workplace violence (WPV), defined by the National Institute for Occupational Safety and Health as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty" (NIOSH, 2002), is recognised as a significant global problem for healthcare workers. In 2002, the World Health Organisation reported that WPV in the healthcare sector accounted for nearly a quarter of all such violence (WHO, 2002). Research studies have explored violence against healthcare staff, perpetrated by patients and in some cases their families, from the perspective of its prevalence, influencing factors, (Edward *et al.,* 2015) impact (Mento *et al.,* 2020) and prevention and management (Havaei *et al.,* 2019; Drew *et al.,* 2021). Liu *et al.*'s (2019) recent systematic review focussing on prevalence identified an increased research focus over the past two decades, with the majority of the studies included in their review (95 of 114) having been published since 2006. Very recently, the COVID-19 pandemic saw the problem receive further attention as articles reported rising violence against healthcare workers during its peak (McKay *et al.,* 2020; Brigo *et al.,* 2022). Horizontal violence and workplace bullying are also recognised problems in the nursing profession. This study did not however include these forms of violence because its focus was on assaults by patients.

The prevalence of violence towards healthcare workers has been a focus for research studies internationally. Liu *et a*l.'s (2019) systematic review and meta-analysis estimated that internationally, 61.9% of healthcare workers had experienced physical and/or non-physical workplace violence from patients or their families/visitors in the last twelve months. In their comprehensive review they identified that studies consistently reported the professional group facing the highest risk of being assaulted was nurses. The settings in which most violence was perpetrated were mental health and emergency healthcare services. The highest prevalence of physical violence was in mental health settings with 50.6% of mental healthcare workers reporting a physical assault in the last twelve months compared with an average across all healthcare settings of 24.4% (Liu *et al.,* 2019). A large European study included in this review (Estryn-Behar *et al.,* 2008) surveyed nearly 40,000 nurses across ten European countries including the UK and found that 22% of nurses across fields and clinical settings reported frequent episodes of violence towards them. At 48%, the prevalence was significantly higher in mental health settings.

Although there is a consensus within existing research that workplace violence is a significant problem in healthcare settings, estimations of its prevalence vary. Jang *et al.*'s (2021) systematic review looked specifically at violence (physical, verbal, psychological, sexual and racial violence/harassment) towards nurses in mental health settings. They found a broad range in terms of reported prevalence; the 16 quantitative studies they reviewed reported an overall prevalence of between 11.4 and 97.6%, although of those that reported an overall prevalence (*n* = 9*),* 6 reported rates of over 80%. Most studies (*n* = 11) measured WPV that had taken place in the last 12 months.

Consistent with other reviews (Bowers *et al.,* 2011; Phillips, 2016; Odes *et al.,* 2021), Jang *et al.* (2021) identified the variance in prevalence reports as being partly attributable to differences in the definitions and conceptualisations of violence in this context, and a lack of consistent and appropriate tools enabling its accurate measurement. Bowers *et al.'s* (2011, p. 23) review of inpatient violence and aggression identified a "huge variation" in the measurement of violence making comparisons between studies difficult. Further, they highlighted the variation in definitions as a "complicating factor" in attempting to calculate rates of violence.

Estimations of the prevalence of incidents of violence and aggression towards healthcare workers have been deemed to be further impacted by under-reporting in practice resulting

in what is seen across the literature as an underestimation of the problem (Bowers *et al.,* 2011; Phillips, 2016; Liu *et al.*, 2019; Odes *et al.,* 2021). The reasons cited for not reporting assaults - particularly those that are non-physical - have remained the same for many years. Gates (2004) identified reasons including there being no injury and no lost work time; the reporting process being too time consuming; and the belief that reporting would not have any impact or make a difference. Further reasons include fear of criticism, lack of understanding of reporting systems and complacency linked to viewing violence as 'part of the job' (Arnetz *et al.*, 2015; Phillips, 2016; Liu *et al.,* 2019).

Regarding the prevalence of violence against healthcare workers in the UK, data have demonstrated a year-on-year rise in the incidence of assaults on National Health Service (NHS) staff in the last decade (DoH, 2018). Surveys conducted by unions and the NHS in the UK indicate a continued rise in violence and abuse towards healthcare workers (HSJ, 2018). A more recent freedom of information request by a mainstream media outlet resulted in their report of rising (and likely under-estimated by at least half) rates of violence against NHS healthcare staff (Brunt, 2022 for Sky News).

As reflected in the systematic reviews discussed above, reported prevalence rates vary and it is difficult to get an accurate picture. The 2022 NHS staff survey reported 14.7% of those completing the survey had experienced at least one incident of physical violence in the last year (NHS Staff Surveys Coordination Centre, 2022). A significantly higher prevalence was identified in the Royal College of Nursing's employment survey undertaken in 2021. It found that 63% of all respondents had experienced 'verbal abuse' in the last 12 months, and 26% had experienced 'physical abuse'. For nursing staff working in mental health settings, those figures were the highest of all groups at 89% and 63% respectively. These figures are consistent with Renwick *et al's* (2019) survey study undertaken in acute mental health settings in London which found that 90% of nurses and healthcare assistants had experienced mild physical violence in the past year, and 30% had experienced severe violence in the same period. As is reflected in international prevalence data, UK studies demonstrate that nurses working in mental health settings are, with the exception perhaps of those working in emergency departments, at the highest risk of being assaulted.

As would be expected given the high prevalence, research focussing specifically on violence against mental health nurses, some of which has been mentioned above, has been

underway for several decades (Lanza, 1983; Whittington & Wykes, 1992; Nolan *et al.,* 1999; Bowers *et al.,* 1999). Beyond establishing prevalence, there has been much interest in understanding the causes and factors relating to violence and aggression (Bowers *et al.,* 2009; Fletcher *et al*., 2021) and strategies to prevent and manage it (Hallett *et al.,* 2014; Pekurinen *et al.,* 2017). Research has sought to understand these aspects from multiple perspectives, including those of mental health nurses, patients, and nursing students. Studies have also focussed on the impact of violence, aggression and assaults on mental health nurses, although surprisingly, as Renwick *et al*., (2019) identify, to a lesser degree than in relation to other fields and specialties. Associations have been established between exposure to violence and both physical and mental health problems including injury, anxiety, depression, burnout, and psychological distress (Hilton *et al.,* 2021). Symptoms of post-traumatic stress disorder were also related to experiencing violence (Hilton *et al.,* 2020).

Secure - also known as forensic - mental health services have been identified as having particularly high rates of physical violence (Bowers *et al*., 2011). There have been several studies that have examined violence and aggression towards nurses specifically in such settings. Newman *et al.*'s (2021) recently published scoping review exploring forensic mental health nurses' experiences of workplace trauma highlighted frequent exposure to physical violence and identified likely under-reporting of verbal abuse. The outcomes for mental health nurses in these settings are comparable to those reported in the wider mental health service context; post-traumatic symptomatology, burnout, job dissatisfaction and a negative impact on functioning outside work (Brown *et al.,* 2017). Working in a secure service has been identified as a particular predictor of post-traumatic stress disorder (Hilton *et al.,* 2020).

There are however no UK-based qualitative studies focussing specifically on nurses' experiences of being assaulted in a secure mental health setting. Given that the problem is and has been well-recognised for decades, it is possible that a shift in research focus and design is required if positive change is to be achieved. Qualitative approaches aimed at eliciting nurses' experiences may be necessary to develop a more comprehensive understanding of the problem, and therefore better inform practice.

Finally, it is important to recognise the implications of workplace violence for the nursing workforce. Workforce shortages are particularly a problem in mental health services with the percentage vacancy rates for mental health nursing in England consistently remaining the highest at an average of 19.5% compared with the overall average for nursing of 11.9% (NHS Digital, 2022). A recent systematic review exploring factors affecting retention within the mental health nursing workforce (Adams *et al*., 2021) identified that both being assaulted and being aware of the risk of being assaulted by patients significantly affected job satisfaction and retention, leading mental health nurses to consider leaving their jobs and/or the profession altogether. Further, sickness absence from work relating to assaults on nurses is recognised as considerable (Mento *et al*., 2020).

1.2 This research study

As has been discussed, there has been a significant amount of research demonstrating the high prevalence of violence against mental health nurses across a variety of settings. Studies have focussed on the factors affecting violence and aggression directed at nurses by patients, the impact it has, and the ways in which it may be prevented and managed. Quantitative approaches to researching this topic have dominated, with data collection methods most commonly using standardised measures and reviews of records. The extent to which the voice of nurses is represented in the literature is therefore limited with far fewer studies taking a qualitative, exploratory approach to developing our understanding of nurses' experiences of being assaulted. As a result, the complex and wide-ranging meanings that nurses attributed to their experiences in practice were not considered to be represented and understood in sufficient depth. Failing to incorporate such understanding, generated through exploratory approaches, risks limiting the extent to which questions relating to the reasons for and impact of assaults on mental health nurses can be effectively and comprehensively answered.

The research described in this thesis set out to address the broad question "what are the experiences of mental health nurses who are assaulted by patients in medium secure inpatient settings?". It aimed to develop what was understood about mental health nurses' experiences of being assaulted, and in particular to understand the interpretations they made of their experiences. The context for this practice-based research was medium secure

mental health settings because it is the clinical setting from which the idea for the study was developed. The decision to focus on this setting was reinforced by the fact there were no studies exploring in this way the experiences of nurses who have been assaulted. The decision was taken not to extend the context to include high and low secure mental health settings. This was due to the potential impact differences in physical and procedural security arrangements, and variations in the risks posed by patients, could have on nurses' experiences and the meaning they ascribed to them. The emphasis on meaning was shaped by experience in practice, and specifically the knowledge that nurses interpreted their experiences in diverse ways. By giving prominence to nurses' experiences as voiced by them, a further aim of this study was to use this understanding to better inform and improve approaches to supporting assaulted nurses.

In order to achieve the aims of this research, four objectives were set. These were:

1. To review and synthesise the existing qualitative evidence relating to mental health nurses' experiences of assault.
2. To review contemporary nursing literature in order to establish how the term 'assault' is currently used.
3. To describe mental health nurses' experiences of being assaulted by patients in secure settings.
4. To discuss and contextualise mental health nurses' experiences of assault within relevant conceptual and theoretical frameworks in such a way as to inform future research and approaches to assaulted nurses.

The methods used to meet these objectives are discussed in detail in the chapters that follow, and the following brief summary provides an introduction.

Objectives one and two were addressed by conducting two separate reviews of the literature; a meta-aggregative review and a focussed mapping review and synthesis. To meet objective three, an exploratory qualitative research study was undertaken. Data were collected through the use of semi-structured interviews with mental health nurses who had been assaulted by patients in secure settings. As I was both a practitioner and insider researcher, reflexivity was central to the research process, and Braun and Clarke's (2019) reflexive thematic analysis was used to analyse the data.

This chapter now describes the background to the study from a practice perspective, situating the research and positioning myself as a researcher. As will be seen throughout this thesis, the writing will move between using the third and first person. The two sections that follow will use the first person more frequently. It is acknowledged that the traditional approach to reporting research is to write in the third person - the *etic* voice - illustrating the maintenance of the researcher's objective stance. Increasingly however, qualitative researchers, recognising their positionality, reflect their experience using the first person - the *emic* voice - in their writing (Zhou & Hall, 2018). Not writing in the first person in this thesis would be incongruous with the study's philosophical basis, its methodological approach and my position as an insider-researcher. Therefore, in order to maintain a transparent, authentic approach, the first person is used when referring to my perspectives in relation to this research, and the third person is used where discussions of existing literature and evidence are required to reflect the objective, critical stance taken.

1.3 Situating the study and positioning the researcher

Situatedness, in broad terms, refers to involvement within a context (Given, 2008). In qualitative research, it consists of the interplay between the researcher, the situation and the context (Lave & Wenger, 1991). Maintaining a keen awareness of this interplay and the influencing factors was fundamental to the reflexive approach of this study, and important in addressing key ethical considerations. *Positionality* refers to the stance of the researcher; the position the researcher takes in relation to the context. This section considering the related positions of myself as a *practitioner researcher* and an *insider* provides the perspectives from which I approached this research, adding to the background of the study. Whilst mention is made of both the ethical considerations associated with these positions and the central role of reflexivity in this study, they are discussed in more detail in sections 4.2 and 4.4 of the methodology and methods chapter (chapter four).

1.3.1 Practice research and the insider researcher

Research grounded in practice and undertaken by practitioners is a key feature of professional doctorate programmes. 'Practice', or 'practitioner' research – the terms are used interchangeably in the literature - seeks to develop knowledge that informs and

reflects engagement with practice (Reed, 2010). Consistent with Schön's notion of the 'reflective practitioner' (Schön, 1983), there is a growing and widespread recognition of the value of increasing research activity among nurses. Indeed, the Chief Nursing Officer for England's recently published 'Strategic Plan for Research' has as its vision "... a people-centred research environment that empowers nurses to lead, participate in and deliver research, where research is fully embedded in practice and professional decision making for public benefit" (National Health Service England and & National Health Service Improvement, 2021, p. 12). Supporting this vision, the professional doctorate provides an opportunity for nurses to advance their clinical and academic career pathways through research training which is grounded in their own practice (Rees *et al.,* 2019), and it is in this context that the current study was undertaken. I was researching an issue that arose in my own professional practice, and aiming to "bring about change, or influence policy in the practice arena" (Gillman & Swain, 2006, p. 345).

The qualitative approach to this practice-based study was underpinned by Gadamer's philosophy of understanding and informed by "Big Q" qualitative research principles. These perspectives, discussed in detail in chapter four, emphasise the role of positionality and "preunderstanding" (Gadamer, 1989) in the development of knowledge and understanding. Thus, a reflexive approach that recognised the inescapable influence of my values, beliefs, prejudices, assumptions and characteristics was taken. Situating myself in relation to this setting involved making explicit my position as an insider researcher in relation to the context, the participant sample and the phenomenon being explored. I was a mental health nurse, working in a secure setting with experience of being assaulted by patients.

Maykut and Morehouse (1994) describe the qualitative researcher's perspective as paradoxical and say, "it is to be acutely tuned-in to the experiences and meaning systems of others—to indwell—and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand" (Maykut & Morehouse, 1994, p. 123). In the case of practice research, this perspective has particular resonance given the specific, contextualised knowledge the practitioner researcher brings to the enquiry which ultimately shapes its nature (Costley, 2019). Bringing such knowledge to empirical study is considered to present not only benefits and opportunities, but also potential risks (Fulton & Costley, 2019). The advantages of being familiar with the research context include what Berger (2013) refers to as the presence of 'cultural intuition', which

contributes to the identification of important questions in practice. In addition, and at the professional doctorate's 'philosophical core', is the potential for application to practice (Ellis & Lee, 2005; Oborn *et al.,* 2010). The impetus for the current study came from my desire to better understand and improve the experiences of mental health nurses who have been assaulted, and I see my position as a practitioner-researcher as contributing to my investment in both undertaking the research and actively disseminating and applying its findings.

The risks, or potential disadvantages, associated with what Glesne and Peshkin (1992) refer to as 'backyard research' stem from the traditional 'positivist-based' requirements of the researcher to maintain an objective, impartial and therefore bias-free stance. In their writing on practice-based research, Fulton and Costley (2019) acknowledge the argument that being a practitioner-researcher has the potential to compromise objectivity and impartiality. This risk was the subject of reflection from the initial stages of this research through to the process of reporting and discussing findings. I was aware, for example, that I may make assumptions about meaning considering my own experience of the context and my identification with their roles. As argued by Fulton and Costley (2019), maintaining a conscious and transparent awareness of the potential influence oneself and one's position can have on the study is essential if practitioner researchers are to conduct good quality, ethical and trustworthy research.

A further consideration for this study was what Gillman and Swain (2006) describe, in the context of practitioner research, as the potential for exploitation and oppression resulting from power imbalances in the researcher-participant relationship. The decision not to interview nurses for whom I provided clinical leadership was influenced by this risk, and by the concern that distinguishing between my practitioner and researcher roles may be more difficult. The sample for this study did not include nurses working in my immediate practice area, and most participants (n = 14) worked outside the Trust in which I was employed. Therefore, whilst my position in the context of this study was that of a practitioner-researcher, I was not undertaking the research in my own 'backyard'.

With its firm grounding in the researcher's clinical and leadership practice, this study did not seek to identify and mitigate against *researcher bias*, rather it viewed the researcher as an instrument; the primary tool for analysis (Braun & Clarke, 2022). This subjectivity was viewed as a resource as opposed to a problem to be controlled or overcome, a perspective

underpinned by the study's philosophical and theoretical basis borne out in its choice of methods as discussed later in this chapter. This being said, remaining conscious of and being transparent about the influence of the researcher's position at all stages of the study was crucial in maintaining integrity, demonstrating rigour, and conducting the research ethically. The ethical considerations relating to my position and the ways in which they were addressed are discussed in the methodology and methods chapter (chapter four). Having situated the current study as practice research, and described my position as a practitioner-researcher, this chapter now moves beyond this to consider the related notion of an *'insider researcher'*.

As has been established, the position of the researcher - both in relation to knowledge and experience of the context and own beliefs and values - is an important methodological concern. *Insider research* – of which practitioner research is an example – is the term used to describe research undertaken by a researcher who is part of the context and topic (Given, 2008). Insider research is broadly defined as "the study of one's own social group or society" (Naples, 2003, p. 46). The literature on insider research does not reflect a binary understanding of the insider/outsider relationship, rather it recognises different types of 'insider' and refers to its non-static nature (e.g. the degree of insider status may shift as the researcher relates to different interviewees) (Song & Parker, 1995; Tilley, 1998; Ross, 2017). In this study, I was an insider in relation to my profession, my experience in the clinical setting and my experience of being assaulted. I did not however, as with other examples of insider research, work together with the participants in a shared setting (Smyth & Holian, 2008). Whilst these aspects remained constant, there was a degree of shift in relation to certain participants. For example, I was more familiar with environmental factors referred to by participants when I had previously worked in or visited the hospitals in which they were situated.

Considering the potential impact of my insider position on the researcher-participant relationship was seen as important in this study. A potential benefit was that participants may have been more willing to share their experiences with a researcher whom they perceived as sympathetic to their situation (De Tona, 2006). Whilst I had not included my professional status and role in recruitment documents, participants were aware from the information sent to them that I was undertaking a professional doctorate in nursing and intended to disseminate findings in my own clinical area and beyond. Further, my Twitter

profile stated my role as being that of a Matron in a secure mental health service. Many of the participants asked me why I had chosen to research the chosen topic, and in these situations, I was honest about having both clinical experience in the settings, and experience of being assaulted by patients. As Cloke *et al.* (2000) argue, bringing the researcher into the researched has the potential to result in a degree of self-involvement that prevents the voice of the participant being heard. It may also impact the nature of the researcher–researched relationship such that the information that participants are willing to share is affected. At worst this could result in exploitation in that the participant is – possibly unconsciously – 'coaxed' into disclosing information they were ambivalent about sharing. Further, Reed (2010, p. 322) recognises the shared meanings and "taken for granted assumptions" that exist in insider research between the researcher and the participant. Whilst this has benefits in relation to the establishment of rapport, it increases the potential for assumptions based on this familiarity and perceived shared language and understanding, resulting in misinterpretations in meaning.

My position as an "insider researcher" in this study featured significantly in the ethical considerations for this project in the planning stages and during each stage of the process, particularly data collection. The ethical considerations are discussed in the methodology chapter (chapter four).

Finally, in-keeping with the philosophical perspectives and qualitative research principles underpinning the reflexive approach to this study, there now follows a statement of my "preunderstanding" - as is it described by Gadamer (1989) - in relation to this context and phenomenon.

1.3.2 My preunderstanding

Braun and Clarke (2022) emphasise the importance of developing an awareness of one's personal position, values and assumptions. I began my reflexive journal with a statement of my position and preunderstanding, and it informed my decisions, reflections and reflexive activity throughout the project. An updated version of this statement follows:

I began to develop the idea for this project while working as a Matron in a medium secure service. I have twenty-five years' experience of working in secure hospitals, a prison, and as a lecturer in mental health nursing.

I have been assaulted on several occasions during my career. The assault that had the most impact on me took place approximately a year after starting my first job as a staff nurse on an acute ward in a medium secure hospital. As I was emptying a bin, the person put his hands around my neck, squeezing it and making it difficult for me to get free of the hold. I was able eventually to pull my body away and as I did, the person's nails scratched my face from chin to forehead. My primary concern following the assault was that my colleagues, all of whom were more experienced than me, would consider me a liability. I believed that I had allowed myself to be assaulted and that I should 'brush it off'. Despite feeling shaken, sore and subsequently anxious around the person, I 'put on a brave face', minimised what had happened and said I was 'fine'. I remember laughing with my colleagues about the scratches on my face. The experience was significant for me in that it left me doubting my competence and feeling less able to 'fit in' with my colleagues, all of whom I perceived as more resilient than me.

Reflecting on this experience as my career progressed led me to believe that nurses might not feel able to communicate the way they felt and what they thought after being assaulted. This assumption was strengthened by a growing belief, formed through experiences in practice, that mental health nurses did not have a voice comparable to that of other disciplines and professions. My sense of injustice was one of the main driving forces behind this research, and it was important to recognise this and its potential influence on the project.

My clinical work, influenced by my training in cognitive behavioural therapy, shaped the way in which I approached this research. I believed that focussing on mental health nurses' *interpretations* of their experiences was essential if understanding was to be developed. This assumption reflected my perspectives on reality and knowledge being subjective and situated.

The way I conceptualised assault in this context was relatively narrow coming into this project. Influenced by definitions, reporting processes, policy and conceptualisations of 'harm' in practice, I saw assaults as predominantly physical acts. My conceptualisation and understanding has developed and broadened during this study, and it was important to explore this aspect of the study at the outset (in chapter three).

Finally, I considered personal and professional characteristics that may have had an influence on the study. Specifically, I recognised my privilege as a white woman holding a

leadership position in the profession, and the influence this may have on potential participants feeling able to be open about their experiences. This concern is addressed in the conclusion (chapter seven) as a limitation of the study.

1.4 Thesis style

This thesis has seven chapters. This chapter has introduced the project and described its background. Chapters two and three present two literature reviews conducted for this study. Chapter four describes the methodological approach taken and the methods used. Chapter five presents the findings of the research. Chapter six discusses the findings and chapter seven concludes the thesis and makes recommendations for practice and further research.

1.5 Chapter summary

This introductory chapter has provided the background to the current study, situating it both within existing research evidence and as practice research. An argument for the need to develop what is currently understood about the experiences of mental health nurses who have been assaulted in secure mental health settings has been made. The study's aims and objectives have been presented and the methods used to achieve these have been described. My position as an insider researcher has been discussed, and my preunderstanding coming into the project has been made explicit. Finally, the thesis structure has been presented.

The following chapter presents the primary literature review undertaken to inform and justify the focus of this doctoral study.

CHAPTER 2: PRIMARY LITERATURE REVIEW

2.0 Introduction

This chapter is based on a published article, but is extended to include a greater level of detail in relation to the application of the chosen method, the reporting of the findings and the discussion. Submitted to the journal *Mental Health Practice* in August 2022, this review underwent an external double-blind peer review and was published online on 21st February 2023. When referring to 'reviewers' in this chapter, these are myself and the co-authors of the paper who are my doctoral supervisors.

Reference: Ayres, H., Schutz, S. & Kozlowska, O. (2023) Exploring mental health nurses' experiences of assault by patients in inpatient settings. *Mental Health Practice*, 26(3), pp. 20-26, doi: 10.7748/mhp.2023.e1638

Violence directed towards healthcare workers is a recognised and increasing global problem (Liu et *al.,* 2019) with a high proportion being perpetrated by patients (Arnetz et *al.,* 2014). The prevalence of assaults by patients is particularly high in inpatient mental health settings (Mento *et al.,* 2020), with mental health nurses and healthcare assistants being most frequently assaulted (Estryn-Behar *et al.,* 2008; Ridenour *et al.,* 2015; Schlup *et al.,* 2022). Research to date has focussed on factors contributing to violence and aggression (Dickens *et al.,* 2013; Edward *et al.,* 2015), strategies for its prevention and management (Baby *et al.,* 2016) and approaches to providing support (Bakes-Denman *et al.,* 2021). There have also been multiple studies demonstrating associations between the experience of being assaulted and a range of negative consequences for nurses including depression and anxiety (Seto *et al.,* 2020); post-traumatic stress disorder (Hilton *et al*., 2021); reduced job satisfaction (Olashore *et al.,* 2018); burnout (de Loof *et al.,* 2018) and intention to leave the nursing profession or change employer (Estryn-Behar *et al.,* 2008; Happell, 2008). There is not only a significant detrimental impact on nurses' personal and professional wellbeing, but also on the therapeutic relationship (Stevenson & Taylor, 2020). Together with absenteeism and attrition resulting from assaults (Phillips, 2016), these outcomes have a negative impact on service delivery and patient care.

Systematic literature reviews have sought to synthesise evidence relating to different aspects of the topic. Recent reviews relating to violence against mental health nurses - two of which include other fields of nursing or professions - have focussed on the frequency of incidents in US hospitals (Odes *et al.,* 2021); the nature, extent and impact of workplace

trauma for forensic mental health nurses (Newman *et al.,* 2021); patients' and staff's perspectives on the causes of violence and aggression (Fletcher *et al.,* 2021); and the prevalence, associated factors and adverse outcomes of violence and aggression towards nurses in mental health settings (Jang *et al.,* 2021). The studies included in these reviews reported predominantly quantitative data, with two of the reviews excluding qualitative studies (Odes *et al.,* 2021; Jang *et al.,* 2021).

Given the widely recognised under-reporting of assaults on mental health nurses (Morphet *et al.,* 2019; Rodrigues *et al.,* 2021), the extent of the problem is likely underestimated. At a time when the nursing profession is facing substantial international shortages (US Dept of Health and Human Services, 2017; Borneo *et al.,* 2022), it is increasingly important that this problem is comprehensively understood such that policy, guidelines and practice are based on reliable evidence. It is important to include evidence gleaned through studies which gave mental health nurses' the opportunity to explore their personal experiences of being assaulted by patients if a comprehensive understanding of this phenomenon is to be achieved. There is no contemporary review and synthesis of such evidence. Therefore, the purpose of this review was to synthesise existing qualitative research on the experiences of mental health nurses who have been assaulted by patients in inpatient settings. In order to achieve a focus on individual experiences, the specific review question was as follows:

How do mental health nurses make sense of their experience of being assaulted by patients in inpatient settings according to reports of qualitative research?

Literature reviews and empirical research have acknowledged that definitions of violence, aggression and assaults vary in both practice and the literature (Odes *et al*., 2021). This review sought to synthesise findings relating to nurses' experiences of having violence and aggression – however individuals defined these terms – directed towards them. The term 'assault' was used in this review in order to maintain the focus on personal experience. Beyond this decision to use the term 'assault' for the reason given, there was no definition of terms for the purpose of the review.

2.1 Methods

This systematic review of qualitative evidence took a meta-aggregative approach as described by the Joanna Briggs Institute (JBI) (Lockwood *et al.,* 2020). This approach aligns with the recognised features of a systematic review (Aromataris & Pearson, 2014), which comprise a well-defined question and aim; a transparent and comprehensive search strategy; detailed inclusion and exclusion criteria; quality appraisal and analysis; synthesis, and presentation of findings. A range of approaches to qualitative evidence synthesis were explored, guided by Aveyard's flowchart and descriptions (Aveyard *et al.,* 2021, p. 121). The JBI method of meta-aggregation was selected for three reasons. First, it takes a systematic approach whilst being sensitive to the philosophical traditions and perspectives of qualitative research. Second, in-keeping with the aims of the review, it seeks to remain close to the data, aggregating findings as opposed to offering a reinterpretation. Third, in-keeping with the principles of practice-based research, a primary feature of meta-aggregation is the generation of recommendations for practice.

Meta-aggregation adopts a pragmatist perspective (Hannes *et al.,* 2018) which is borne out in its process-driven approach. The three-stage process involves identifying findings in the selected articles, categorising the findings based on similarities in meaning, and finally combining the categories into a set of comprehensive, synthesised findings. These systematically developed, overarching findings are intended to ensure the contribution qualitative research has made to what is known about mental health nurses' experiences of being assaulted is included in strategies to develop and improve practice.

2.1.1 Search strategy

Moher *et al*. (2015)'s Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) approach was applied to this search. The electronic databases CINAHL, PsychInfo and PubMed were searched between 15.1.22 and 21.1.22. Reference lists of identified articles were also manually searched.

The development of the review question was guided by Stern *et al.*'s *Population, phenomenon of interest, context* and *study design* (PICoS) framework (Stern *et al*., 2014):

How do mental health nurses ('P') make sense of their experience of being assaulted by patients ('I') in inpatient settings ('C') according to reports of qualitative research (S)?

Search terms were finalised following multiple test searches varying the use of terms, truncations (assault*; nurs*) and Boolean operators (AND; OR), and reviewing keywords used across a sample of the literature retrieved. The search terms are summarised in table 1.

Table 1: Search terms

Population	Phenomenon of interest		Context	Study
Nurs*	Assault* OR Violen* OR Aggress* OR Abus*	Mean* OR Interpret* OR Experien* OR Understand* OR Attribut* OR Perspective* OR Perception* OR Perceive*	"Mental health" OR psychiatr*	No search terms were used relating to the study design

2.1.2 Inclusion and exclusion criteria

Inclusion and exclusion criteria guided the search and the selection of the studies included in the review, and these are summarised in table 2. The inclusion criteria recognised that there are international differences in classification of mental health nurses; for some countries, mental health nursing is not a registered profession, rather nurses undertake additional post-registration training to enable them to work in mental health settings. Decisions as to whether some articles had met the criteria relating to experience required the forming of a consensus view among the review team. The focus was on the meaning of personal experiences of assault, and therefore papers that required participants to talk in more general terms about, for example, 'ward climate', in relation to violence and aggression, were excluded.

Table 2: Inclusion and exclusion criteria

	Inclusion criteria	Exclusion criteria
Population	-Mental health nurses -Nurses with experience of working in inpatient mental health settings	-Mental health professionals other than nurses -Nurses who are not mental health nurses or who do not have experience in inpatient mental health settings -Non-registered staff
Study characteristics	-Qualitative, empirical research papers -Mixed methods articles -Studies using questionnaires which include qualitative data	-Quantitative studies -Theses, dissertations, policies, guidelines, book abstracts, conference abstracts, commentaries and editorials -Studies eliciting attitudes, perceptions or experiences exclusively through the administration of standardised questionnaires, which provide little or no qualitative data
Topic of interest	-Experience of violence, aggression and/or assault in inpatient mental health settings	-Experience of violence, aggression and/or assault in non-mental health settings, for example emergency departments -Experience of violence in older adult mental health settings
Language	English	-Languages other than English

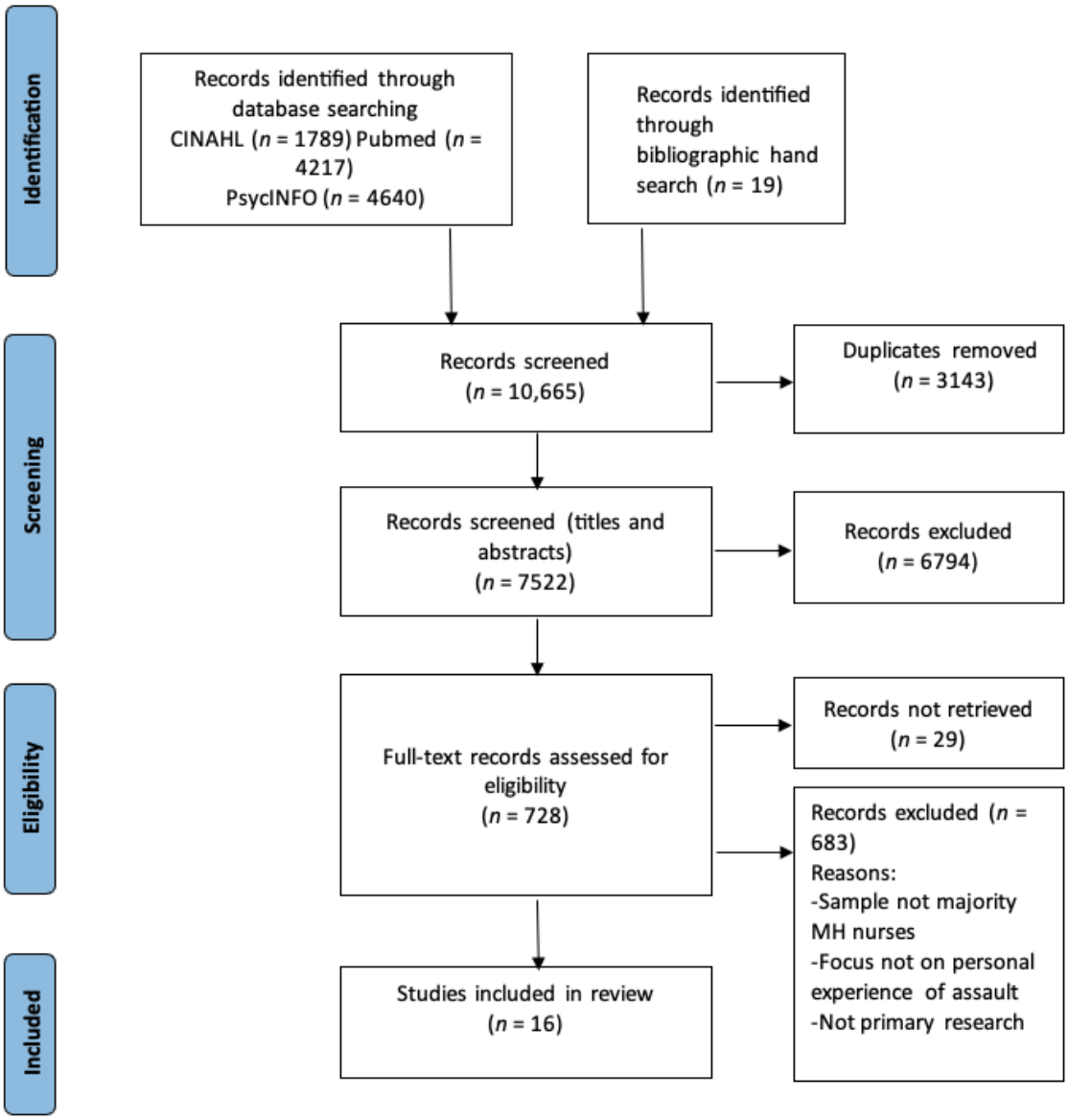
2.1.3 Study selection

A total of 10,646 studies were retrieved from the database search and exported into reference management software (Endnote). A further 19 were obtained through hand searching of reference lists. 3143 duplicates were identified and removed, and the remaining 7552 were screened by title and, where a decision to exclude was not clear from title only, abstracts were read. A significant number of articles excluded at this point centred on 'intimate partner' or 'domestic' violence, 'substance abuse' and 'lateral' or 'horizontal' violence.

Further screening of the final 728 records was completed with full texts retrieved and screened in all but 29 cases. These were mostly older articles and attempts to contact authors and source them from different libraries were unsuccessful. The search and selection of papers for inclusion were undertaken primarily by myself. However, search terms, inclusion and exclusion criteria and the final selection of articles were discussed and agreed with my supervisors, strengthening the rigorous approach taken in this review.

The search strategy is set out in the PRISMA diagram below (figure 1).

Figure 1: PRISMA Diagram



2.1.4 Search Outcome

The search resulted in sixteen records for inclusion, the characteristics of which were extracted and are presented in the table in appendix 1.

The selected articles were published between 1998 and 2021 with the majority (*n* = 11) being published in the last decade. They were conducted in nine different countries; US (*n* = 5); UK (*n* = 3); Australia (*n* = 1); Canada (*n* = 2); South Africa (*n* = 1); New Zealand (*n* = 1);

Taiwan (*n* = 1); Finland (*n* = 1) and Korea (*n* = 1). The designs of the studies varied, with different methodologies and frameworks described. Descriptive and hermeneutic phenomenology (*n* = 4) and thematic analysis (*n* = 5) were most frequently used, with interpretative phenomenological analysis (IPA) (*n* = 2), content analysis *(n* = 2), discourse analysis (*n* = 1) and qualitative descriptive (*n* = 2) being stated in the remaining seven studies. Ten studies used semi-structured interviews as their means of data collection, three used focus groups. Two used questionnaires with open-ended questions, and one used questionnaires followed by individual, unstructured discussions. Sample sizes ranged from 3 to 120 participants with the proportion of mental health nurses being between 33% (*n* = 1) and 100% (*n* = 13). The three studies where mental health nurses made up less than 100% of the sample were included in the review because findings were either directly attributed to mental health nurses or were stated as relevant for the whole or majority of the sample.

2.1.5 Critical appraisal

Records selected were independently appraised by the reviewers using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood *et al.,* 2015). A 95% consensus was achieved, and discrepancies agreed between reviewers. The results of the appraisals can be seen in table 3. The majority (*n* = 10) of articles lacked clarity as to the philosophical basis for the studies on which they were reporting. Most neither situated the researcher culturally or theoretically (*n* = 10), nor did they address the influence of the researcher on the research, and vice versa.

Table 3: Critical Appraisal results (JBI, 2020)

Paper	1	2	3	4	5	6	7	8	9	10
1. Baby, Glue and Carlyle (2014)	U	Y	Y	Y	Y	N	N	Y	Y	Y
2. Benson, Secker, Balfe, Lipsedge, Robinson & Walker (2003)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
3. Currid (2008)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
4. Cutcliffe (1999)	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
5. Dafny and Beccaria (2020)	U	Y	Y	Y	Y	N	N	Y	Y	Y
6. Dean, Butler and Cuddigan (2021)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
7. Ezeobele, Mock, McBride, Mackey-Godine, Harris, Russell and Lane (2021)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
8. Hiebert, Care, Udod and Waddell (2021)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
9. Kindy, Petersen and Parkhurst (2005)	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
10. Lantta, Anttila, Kontio, Adams and Valimaki (2016)	U	Y	Y	Y	Y	U	Y	Y	Y	Y
11. Moylan, Cullinan and Kimpel (2014)	U	Y	Y	Y	Y	N	N	Y	Y	Y
12. Sim, Ahn, and Hwang (2020)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
13. Stevenson, Jack, O'Mara and LeGris (2015)	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
14. Tema, Poggenpoel and Myburgh (2011)	U	Y	Y	Y	Y	N	N	Y	Y	N
15. Yang, Hsieh, Lee and Chen (2016)	U	Y	Y	Y	Y	Y	N	Y	Y	Y
16. Zuzelo, Curran and Zeserman (2012)	U	Y	Y	Y	Y	N	N	Y	Y	Y

1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?
5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the influence of the researcher on the research, and vice- versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Y = Yes N = No U = Unclear N/A = Not applicable

2.1.6 Data extraction

Findings relevant to the review question were identified using line-by-line coding (Thomas & Harden, 2008), extracted from each paper, and entered onto a table. Where findings appeared to have a high degree of similarity, the originating studies were consulted to identify any contextual differences impacting the meaning. Where meanings were consistent, findings were consolidated into one (for example, nurses described experiencing fear following an assault in 8 articles). Each of the remaining findings were reviewed against the sources and as described in the JBI approach to meta-aggregation, were appraised and

assigned one of three levels of credibility (Lockwood *et al.,* 2020). *Unequivocal* (*U*) findings (*n* = 130) were findings accompanied by clear illustrations and hence not open to challenge, and *credible* (*C*) findings (*n* = 8) appeared alongside illustrations but without a clear association between them, therefore they would be open to challenge. Findings that were not supported by the data (US) were not included. Findings were synthesised into categories according to similarity in meaning, and finally the categories were aggregated to form the synthesised findings of this review.

2.2 Synthesised findings

The process of meta-aggregation resulted in sixteen categories which were then aggregated into five synthesised findings (Hannes *et al.,* 2018). Appendix 2 presents the synthesised findings, the categories forming them, and the individual findings in each category. The synthesised findings were; i) mental health nurses consider violence against them – conceptualised in different ways - to be a significant, and unacceptable problem, particularly when perpetrated by patients who they deem to be in control of their behaviour; ii) being assaulted has the potential to have a significant and pervasive impact on mental health nurses' personal and professional lives; iii) following an assault, mental health nurses respond in different ways, including avoiding or suppressing their emotions, depersonalising and rationalising patients' assaultive behaviour and taking action; iv) sharing and reporting experiences of assaults is challenging, and often avoided, by mental health nurses; v) mental health nurses' perceptions of what contributes to, and can prevent, violence and assaults centre on factors relating to the environment, workforce, relationships, restrictive practices and gender.

2.2.1 Synthesised finding: Perspectives on violence against mental health nurses

The first synthesised finding comprised four categories which described mental health nurses' perspectives on violence against them. These perspectives related to the normalisation of violence, its conceptualisation in this context, its unpredictability, and perspectives on blame and responsibility.

Violence and assaults on mental health nurses were widely considered to be frequent, inevitable, expected and 'normal' - particularly in the case of verbal violence where it was

described as being 'part of the job' (Currid, 2008; Baby *et al.,* 2014; Moylan *et al.,* 2014; Ezeobele *et al.,* 2021). Despite this widely stated perspective, assaults were often described as unexpected, unpredictable and unpreventable (Tema *et al.,* 2011; Yang *et al.,* 2016; Dean *et al.,* 2021), leaving nurses feeling shocked and confused (Benson *et al*., 2003; Sim *et al.,* 2020). The consensus view among mental health nurses was that whilst violence and assaults were experienced frequently, they should not be considered acceptable or 'part of the job' (Baby *et al.,* 2014; Stevenson *et al.,* 2015). It was perceived as not always being taken seriously by managers and police (Currid, 2008; Baby *et al.,* 2014; Hiebert *et al.,* 2021), and nurses did not consider themselves to be protected by the law (Dean *et al.,* 2021). A perception that assaults on police officers and firefighters were taken seriously and responded to with compassion and support led to a sense of unfairness (Moylan *et al.,* 2014).

Conceptualisations of what constituted violence in this context varied across papers with one explicit finding being that it was subjective and influenced by multiple factors (Cutcliffe, 1999). If an act was believed to be intentional, deliberate and premeditated, nurses were more likely to define it as violence or an assault (Cutcliffe, 1999; Zuzelo *et al.,* 2012; Stevenson *et al.,* 2015; Hiebert *et al.,*2021). This intentionality and perception of control was linked by nurses to a diagnosis of personality disorder which both implied responsibility and attracted blame (Benson *et al.,* 2003; Stevenson *et al.,* 2015). Where a patient was believed to be mentally ill, their behaviour was more likely to be considered unintentional and beyond their control (Zuzelo *et al*, 2012; Moylan *et al*., 2014; Dean *et al*, 2021; Ezeobele *et al*., 2021), and was not conceptualised as violence (Cutcliffe, 1999; Stevenson *et al.,* 2015; Hiebert *et al*., 2021).

2.2.2 Synthesised finding: Personal and professional impact

The second synthesised finding related to the personal and professional impact of being assaulted on mental health nurses. It was made up of three categories comprising findings relating to the personal and professional impact of being assaulted; the impact of being assaulted on life outside work and the impact of being assaulted on nurses' approaches to patients. Being assaulted had the potential to have a significant and pervasive impact on mental health nurses' personal and professional lives. Nurses described the emotional

impact and the impact on the sense of themselves both personally and professionally. The impact of physical injury was not a prominent theme across the sample; it was explicitly stated that psychological trauma often had a more lasting impact than any physical effects (Yang *et al*., 2016). There was however fear and anxiety expressed in relation to the potential consequences of physical injury in terms of loss of employment and livelihood (Kindy *et al*, 2005; Stevenson *et al*., 2015). Nurses reported their self-esteem, confidence and sense of competency being negatively impacted after being assaulted (Baby *et al*., 2014; Hiebert *et al*., 2021), with nurses blaming themselves on occasions (Hiebert *et al*., 2021). The emotional impact was consistently described as being pervasive, with fear and anxiety (Dean *et al*., 2021; Ezeobele *et al*., 2021), frustration and anger (Stevenson *et al*., 2021; Hiebert *et al*., 2021) and guilt and shame (Dean *et al*., 2021; Hiebert *et al*., 2021) being described most frequently. There was less clarity within the articles in relation to cognitions associated with guilt and shame than the other emotions. Nurses' sense of agency was also negatively impacted with powerlessness and helplessness recognised as consequences of assault (Sim *et al*., 2020; Ezeobele *et al.*, 2021). Nurses experienced a loss of dignity, feeling "small" (Tema *et al*., 2011, p. 919) in the face of verbal abuse and "belittled" (Moylan *et al*., 2014, p. 6) when verbal violence was sexualised.

One finding indicated that nurses could become desensitised to violence "except the severe stuff" due to its frequency (Hiebert *et al*., 2021, p. 3).

The impact experienced by male nurses featured in the findings of six of the studies. Male nurses were found to be less likely to express emotions, "downplaying" them (Benson *et al*., 2003, p. 920) or viewing an assault as something to "just blow off" (Moylan *et al*., 2014, p. 39). Male nurses both saw themselves, and were seen by peers, as protective factors against assaults on female colleagues (Tema *et al*., 2011; Zuzelo *et al.*, 2012; Dafny and Beccaria, 2020), and male nurses felt responsible, emotionally drained, fearful of injury and undermined professionally when seen as 'bodyguards' (Tema *et al*., 2011; Dafny & Beccaria, 2020).

Nurses' approaches to patients was impacted by the experience of being assaulted. They felt less able to be empathic, compassionate and person-centred (Cutcliffe, 1999; Stevenson *et al*., 2015) distancing themselves and becoming more task-focussed as a means of coping and protecting themselves from further assault (Currid, 2008; Ezeobele *et al*., 2021). This,

together with a loss of trust and a sense of betrayal made establishing and maintaining therapeutic relationships more difficult (Kindy *et al*., 2005; Sim *et al*., 2020).

Mental health nurses experienced a conflict in relation to their roles as a result of being assaulted. They spoke of "[not feeling] like a nurse" after an assault (Kindy *et al*., 2005, p. 173) and struggling to reconcile feeling anger and frustration when their role was to care (Tema *et al*., 2011).

Assaulted nurses described the impact that being assaulted had on their lives outside work. Disturbed sleep and nightmares, hypervigilance, and increased smoking and consumption of alcohol were described (Tema *et al*., 2011; Stevenson *et al*., 2015; Hiebert *et al*., 2021). Personal relationships were negatively impacted with nurses describing themselves as "snappy" and "cranky" with family (Kindy *et al*., 2005, p. 173; Baby *et al*., 2014) and shouting at children "for nothing" because of suppressed feelings following assault (Tema *et al*., 2011, p. 922).

2.2.3 Synthesised finding: Response to the impact of being assaulted

The third synthesised finding related to mental health nurses' responses to assault. Three categories contributed to this finding, and these were titled 'attempts to cope through suppressing', 'avoiding and withdrawing'; 'making sense/understanding and active responses'.

Mental health nurses frequently described attempting to cope with the emotional impact by suppressing and avoiding feelings and by withdrawing from others (Kindy *et al*., 2005; Zuzelo *et al*., 2012). The suppression of emotions was also described as a protective strategy with nurses believing that showing emotion in front of patients was risky and left them vulnerable (Lantta *et al*., 2016; Zuzelo *et al*., 2016). As discussed in the previous finding, the suggestion that male nurses were more likely to suppress emotions could be perceived as a coping strategy or defence mechanism, however this was not explicitly explored.

Phrases such as "moving on", "get past it", "leave work at the door" (Zuzelo *et al*., 2012, p. 122) and "get back on the bike" (Baby *et al*., 2014) illustrated the nurses' perspectives on what they believed was important or required.

Many nurses made sense of their experience by seeking to understand and rationalise patients' assaultive behaviours. Not taking the assault personally was frequently referred to, and was linked to being more able to cope, forgive and move on (Benson *et al*., 2003; Sim *et al*., 2020; Dean *et al*., 2021). Nurses were, however, less able to understand, empathise and depersonalise when they perceived an assault as intentional and targeted as discussed in the first synthesised finding.

Finally, this finding incorporated active responses employed by nurses. The venting of emotions was referred to as helpful, however this was something that was done in private, hidden from others; "...nobody knows I'm in there crying. I will vent and let go of stuff" (Zuzelo *et al*., 2012, p. 122). Becoming hypervigilant was also described as a frequent response to being assaulted, driven by fear and anxiety (Kindy *et al*., 2005; Yang *et al*., 2016).

One finding described nurses' reflections on their experience positively and resulting in learning and adapted behaviour (Baby *et al*., 2014; Yang *et al*., 2016). This was not referred to frequently or in any depth.

Finally, being assaulted prompted some mental health nurses to consider leaving their job or the profession (Ezeobele *et al*., 2021; Hiebert *et al*., 2021).

2.2.4 Synthesised finding: Sharing and reporting experiences

The fourth synthesised finding comprising three categories related to the sharing and reporting of assaults experienced by mental health nurses, the responses they received from managers and peers, and barriers to reporting assaults. Sharing and reporting experiences of assaults was challenging, and often avoided, by mental health nurses. They avoided sharing their experiences with family members in order to protect them (Dafny & Beccaria, 2020) and because their families, and society more generally, would not be able to understand and empathise (Sim *et al*, 2020), and may not believe them (Dafny & Beccaria, 2020).

There were a large number (n = 35) of findings in this review that related to nurses' experiences of reporting incidents and their perceptions of the responses they received from managers and their peers. Overwhelmingly, nurses did not feel supported, perceiving responses from managers as critical, invalidating, blaming, punishing and stigmatising

(Ezeobele *et al*, 2021; Hiebert *et al*., 2021). An absence of a response and/or action was also found to be a common experience, leaving nurses feeling marginalised and ignored (Tema *et al*., 2011; Moylan *et al*., 2014). There was often a perceived lack of resolution following an assault (Kindy *et al*., 2005) including patients not being held to account by others for their actions. Doctors could be perceived as not listening and supporting nurses "in the trenches" (Kindy *et al*., 2005, p. 172).

After being assaulted, nurses perceived others to expect them to carry on, use their skills and continue to care for the person who assaulted them (Tema *et al.,* 2011; Stevenson *et al*., 2015; Yang *et al*., 2016).

Nurses felt that personal, direct support which recognised and acknowledged their experiences was important and required, as was having the time to access such support (Stevenson *et al*., 2015; Dean *et al*., 2021).

Findings describing nurses' experiences of reporting assaults explained their reasons for not doing so. Nurses were less likely to report an assault if they did not consider it to be "serious enough" (Hiebert *et al*., 2021), believing there was an explicit expectation to "let it go" and fearing being seen as "making a big deal" of their experience (Moylan *et al*., 2014, p. 38). Nurses also had mixed experiences in relation to support from the police, perceiving that they had been discouraged on occasions from reporting (Stevenson *et al*., 2015), and believing that "nothing will be done" (Dafny & Beccaria, 2020, p. 3344). A lack of trust in managers, feelings of shame, and fear of blame, criticism and stigmatisation also made nurses reluctant to report (Dean *et al*., 2021; Ezeobele *et al*., 2021).

Other reasons given for not reporting assaults were a lack of time and cumbersome forms (Hiebert *et al*., 2021), and nurses not seeing the importance of reporting (Dean *et al*., 2021). Reporting in some cases was seen by nurses as being punitive in itself; they believed being required to do so implied they were to blame (Zuzelo *et al*., 2012).

2.2.5 Synthesised finding: Environmental and workforce factors

The final synthesised finding related to factors affecting violence and assault. Three categories contributed to this finding; 'environmental and workforce/team factors'; 'patient factors' and 'factors relating to gender'.

Mental health nurses' perceptions of what contributed to and could prevent violence and assault centred on factors relating to the environment, workforce, relationships, gender, and restrictive practice.

Nurses spoke in general terms about insufficient staffing, inadequate training and experience and poor physical security and environments – lacking space and privacy – as contributing to violence and assaults (Kindy *et al*., 2005; Currid 2008; Hiebert *et al*., 2021). Good relationships and having time to be with patients were seen as factors that reduced the risk of violence and assaults (Lantta *et al*., 2016; Ezeobele *et al*., 2021), however these were perceived as being compromised by high workloads and excessive paperwork (Kindy *et al*., 2005).

Effective, supportive teamwork was widely seen as important, and this included having a shared, consistent approach resistant to 'splitting' (Kindy *et al*., 2005; Yang *et al*., 2016; Dean *et al*., 2021). Nurses also perceived that teams failing to hold patients to account and agree consequences for their actions contributed to the ongoing problem (Dean *et al*., 2021).

Patients' experiences of being restricted, treated against their will, and not having their needs met, or as described in one article "getting their own way", were considered to be precursors to assaults (Currid, 2008, p. 883), as were reductions in psychotropic medication (Kindy *et al*., 2005).

Finally, mental health nurses discussed gender as a factor influencing the risk of assaults. Male nurses were perceived as being assaulted more frequently by male patients (Dafny & Beccaria, 2020) and female nurses were viewed as more vulnerable, particularly to verbal abuse (Zuzelo *et al.,* 2012; Sim *et al.*, 2020), and especially when the presence of male nurses was limited (Tema *et al*., 2011). In relation to physical assaults, it was perceived in one study that female nurses were less frequently assaulted due to it being less socially acceptable to be violent towards women (Dafny & Beccaria, 2020).

2.3 Discussion

This review has highlighted that there are relatively few qualitative studies focussing on mental health nurses' experiences of being assaulted. The extent to which nurses' voices and their subjective experiences shape the current understanding of the problem is therefore limited. Much of the data on which the broader evidence relating to violence in mental health settings is based are collected via the use of standardised measures such as the Management of Aggression and Violence Attitude Scale (MAVAS; Duxbury, 2003) or the Attitude Towards Aggression Scale (ATAS; Jonker *et al.,* 2008) or through reviewing documents including incident reports and patient records. There has been less attention paid to the meaning being assaulted has for nurses, and their interpretation of their experiences. This appears to represent a phenomenon that is echoed in the findings of this review; that violence towards mental health nurses is a recognised and significant problem, but their perspectives and experiences are not well understood. In particular, the emotional impact of being assaulted was acknowledged across studies but not explored in depth, mirroring what their findings suggested happened in practice.

The suppression of emotions is evident when comparing the findings from studies with different methods of data collection. There were three studies that used focus groups in this review (Zuzelo *et al.,* 2012; Lantta *et al.,* 2016; Dafny *et al.,* 2020). Interestingly, using this method appeared to limit the degree to which nurses discussed their emotional experiences, except for anger and frustration. Given the expression of emotions including fear, anxiety, guilt and shame in the studies that used interviewing and surveys to collect data, this observation is suggestive of a culture in which emotional expression is inhibited. In Lantta *et al.*'s (2016) study, nurses were reluctant to acknowledge fear as an emotion, agreeing together that "being alert" was a more favourable representation of their collective experience. In this study, and that of Zuzelo *et al*. (2012), fear was seen as an emotion that if felt, should be concealed.

Linked to the suppression of experiences is the way in which assaults in this context are defined and conceptualised. The first synthesised finding highlighted the complexity involved in defining violence, aggression and assault in this context, introducing and emphasising the subjective and conflicting ways in which they are conceptualised. Violence is described as both 'normal' and 'to be expected', whilst also being deemed unacceptable and - particularly when referring to personal experience of an assault - unexpected. Nurses'

descriptions of violence - including verbal abuse which they suggested was under-reported - being frequent were consistent with findings from Newman *et al.*'s (2021) recent scoping review of literature relating to forensic mental health nurses' exposure to trauma. The extent to which nurses perceived patients to be in control of their behaviour was not only found to influence their attribution of responsibility and/or blame, but also whether they conceptualised the behaviour as violence. This complexity raises the question as to whether achieving a consensus view – and consistent definition – of what constitutes violence, aggression and assault is possible, and what the potential implications of attempting to do so may be. Researchers have identified a problem with inconsistent definitions creating ambiguity in both reporting and comparing research findings (Odes *et al.,* 2020; Jang *et al.,* 2021), and would therefore see a benefit in achieving greater clarity. Given this review's finding relating to the subjective nature of what is deemed to be, for example, an assault, imposing a definition may serve to invalidate nurses' experiences in some circumstances. This is addressed and discussed in more detail in the focussed mapping review and synthesis reported in the following chapter.

In relation to the methodological approaches used to undertake the studies in this review, it is interesting that most of the papers did not refer to reflexivity, neither did the researchers position themselves culturally or theoretically. The three reports that did discuss and acknowledge the researchers' positionality (Kindy *et al.,* 2005; Stevenson *et al.,* 2015; Hiebert *et al.,* 2021) in relation to the setting and the phenomenon sought to eliminate their influence and maintain objectivity through the "bracketing" of their experiences. A further two (Dean *et al.,* 2021; Ezeobele *et al.,* 2021) referred to their use of bracketing without being explicit about the researchers' positions. There was a lack of evidence of authors taking critical approaches to considering the potential influence of researchers, and where referred to, it was broadly and uncritically assumed that the bracketing of experiences would eliminate any influence on the research. Only one study (Cutcliffe, 1999), which used Heideggerian phenomenology as its methodological approach recognised that the researcher would influence the research. The paper did not however make explicit the ways in which it was influenced, and how this was recognised.

The final point in this discussion relates to the samples and settings of the studies included in this review. Most studies were conducted in individual mental health wards, units or

facilities. Four recruited their samples from specific regions, counties or towns and one study (Stevenson *et al.,* 2015) described snowball sampling beyond a specific inpatient unit but did not specify the geographical spread of the final sample. The three UK studies (Cutcliffe, 1999; Benson *et al.,* 2003; Currid, 2008) were based either in one hospital or one NHS Trust. As a result, studies were not able to examine cultural differences between organisations and mental health services in different countries that may have impacted on mental health nurses' experiences.

2.4 Limitations

This review had a number of limitations. First, in-keeping with doctoral research, although my supervisors were involved in the selection of the final articles, critical appraisal and review of findings, the review was largely undertaken by myself. The risk of bias is therefore greater in this case than if the entire review was carried out by a team of reviewers. Second, papers not written in English were excluded which may have resulted in relevant findings being missed. Third, the number of databases and reference lists searched was limited by time and resources which may have further limited the findings of the review.

2.5 Implications for the current study

This review confirmed that there were relatively few studies that focussed on the experiences of mental health nurses who have been assaulted by patients, and none that examined these experiences in the context of secure mental health settings in the UK. This represented a lack of qualitative evidence available to inform strategies to improve the responses to assaults on mental health nurses and importantly the ways in which they are supported.

With respect to the methodological approach for this study, the findings suggested that data collection should take an individual as opposed to group approach in order to support nurses to speak openly, particularly in relation to their emotional responses to being assaulted.

A further methodological implication related to the importance of reflexivity, particularly when positioned as an 'insider researcher', and was emphasised by the fact that it was rarely mentioned in the studies included in this review. As a reader, not being able to

understand the perspective from which the researcher/s came, and the ways in which they influenced the research, impacted the extent to which I trusted their findings.
Finally, the absence of consistent definitions, conceptualisations and use of language relating to assaults in this context raised the question of how, or indeed if, 'assault' would be defined in this study. To inform this decision, a further literature review, with the aim of understanding how the term was being used in mental health nursing literature, was conducted. This review is reported in the following chapter.

2.6 Chapter summary

This systematic review of qualitative evidence identified that violence by patients against mental health nurses in inpatient settings is a significant and unacceptable issue that has harmful pervasive effects. Factors perceived by nurses as contributing to, or potentially preventing, violence and assault included the environment, workforce, relationships, restrictive practices, and gender. The review develops what is known about the experiences of mental health nurses who have been assaulted by patients, and its focus on findings generated through qualitative research enhances the depth of the existing evidence. As discussed earlier, this review was submitted and accepted for publication (Ayres *et al.,* 2023) in the hope that its synthesised findings could inform strategies to address the problem in practice.

CHAPTER THREE: A FOCUSSED MAPPING REVIEW AND SYNTHESIS

3.0 Introduction

As has been identified in the primary literature review for this study, there is a lack of clarity in relation to what constitutes an act of violence, aggression, abuse or an assault in the context of mental healthcare (Ferns, 2006; Ventura-Madangeng & Wilson, 2009; Stevenson *et al.*, 2015). This lack of clarity described in the literature resonated with my experience in practice - terms were used in different ways among nurses and multi-disciplinary teams, in clinical records, in reporting systems and in policies and procedures. This chapter describes a second literature review that was undertaken for the purpose of informing decisions relating to the definition and conceptualisation of 'assault' in the current study. Before describing this review and its findings, consideration is given to how assault is defined more generally.

Poster and Ryan (1993) argued that while assault had a legal definition, it was often used interchangeably with other terms such as 'physical violence' or 'physical aggression'. The Oxford English Dictionary defines an assault as a 'physical attack' whilst specifying that in law it is considered to be any act that "threatens physical harm to a person, whether or not actual harm is done" ('Assault': OED, 2018).

UK law states that an assault occurs "when a person intentionally or recklessly causes another to apprehend the immediate infliction of harm" (Crime Prosecution Service (CPS), 2018). *Harm* is acknowledged to encompass both physical and psychological harm including causing someone to fear for their own safety. The term assault is acknowledged to represent everything from threatening words or actions that lead the person to believe they are about to be attacked, to a severe physical attack that leaves the victim with a permanent disability (Sentencing Council, 2018).

In a healthcare context, assault is not consistently and clearly defined. The World Health Organisation (WHO) defines workplace violence as "incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health" (WHO, 2002, p. 3). Whilst the high prevalence and risk of harm associated with "psychological violence" is recognised, such acts are not defined as assaults. 'Assault' together with 'attack' is defined as a physical act; "intentional behaviour that harms another person physically, including sexual assault" (WHO, 2002, p. 4).

The National Institute for Health and Care Excellence (NICE) guidelines for the short-term management of violence and aggression define 'violence' and 'aggression' but not 'assault' (NICE, 2015). Assault is referred to in the guideline's introduction, but it is not defined. Similarly, local NHS Trust policy relating to the prevention and management of violence and aggression (Oxford Health NHS Foundation Trust, 2017) refers only to physical assault, the nature of which is not described.

Given the range of definitions and the recognition that definitions relating to workplace violence in a mental health nursing context lacked consistency, an understanding of the ways in which the term 'assault' was currently used was required. Therefore, a further review of the literature was conducted to establish the use and understanding of the term 'assault' within contemporary mental health nursing literature. This section describes the selected review method, presents the findings and discusses the implications for the approach to the current study.

The review question and aims were as follows: *How is the term 'assault', in the context of mental health nurses being assaulted by patients, used and understood in contemporary mental health nursing literature?*

The aim of the review was to identify how the term assault was used and defined in contemporary nursing literature. The intention was to use the information gleaned to inform decision making relating to how the term assault would be conceptualised and defined for the purpose of this study.

3.1 Methods

The method considered to best achieve this aim was the recently described Focussed Mapping Review and Synthesis (Bradbury-Jones *et al,* 2019). A Focussed Mapping Review and Synthesis (FMRS) aims to establish what is happening in a particular field at a given time; to provide a 'snapshot'. Rather than being a comprehensive, critical review of evidence judged to be of good quality, a FMRS seeks to elicit and provide a critical commentary on the "assumptions, boundaries and contours" in relation to the particular focus of the enquiry (Bradbury-Jones *et al.*, 2019, p. 453). The review that was undertaken therefore focussed specifically on identifying assumptions inherent in the use of the term 'assault', and mapping its use in order to illuminate the boundaries and contours within the

literature. Due to its specific aims, a FMRS does not require a critical appraisal of the articles included.

3.1.1 Search Strategy

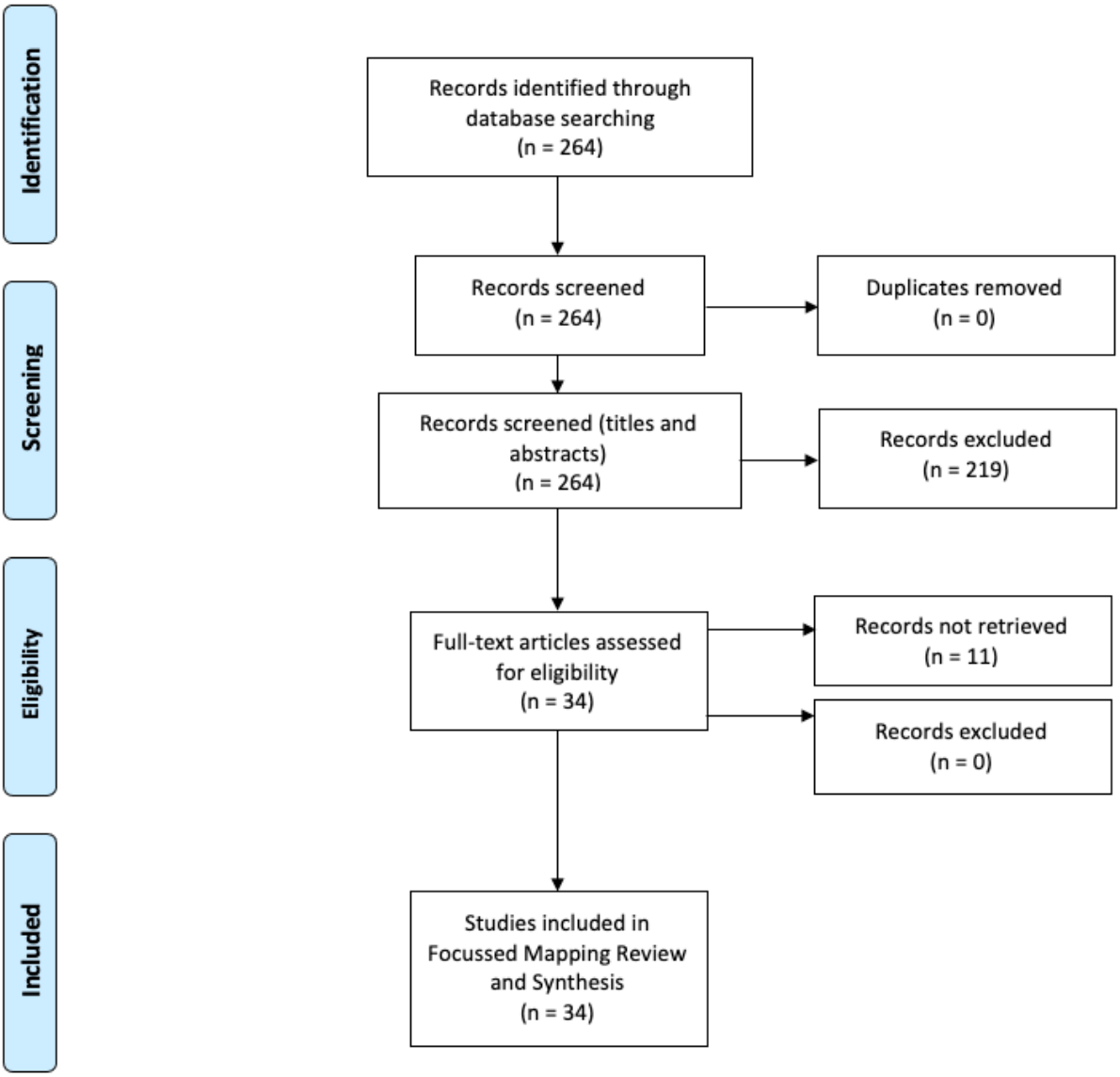
Two important decisions relating to the focus of the review concerned the timeframe and the journals to be included. First, the search was limited to include articles published in the previous ten years. Had there been too few articles to provide a 'snapshot', the dates would have been extended. Although this review was conducted prior to data collection, the search was repeated more recently so that articles published during 2021 (*n* = 6) could be included in order to identify any changes in the way the term was used. Second, as the aim was to examine the use of the term in a mental health nursing context only, the search was limited to one database - the Cumulative Index of Nursing and Allied Health Literature (CINAHL). Unlike in other examples of the FMRS approach to literature reviews, there were no restrictions placed on the journals searched. This was because an initial CINAHL search revealed that the number of hits was relatively small, and therefore limiting the sample to articles published in only one or two journals would not have yielded adequate results. Whilst attempts were made to access all full texts, where these were not readily accessible through the University and Trust libraries or via the authors directly (*n* = 11), sustained attempts were not made. Moher *et al.*'s (2015) Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) approach was applied to this search. The search terms, limits and inclusion/exclusion criteria are contained in table 4, and the search is further represented in a PRISMA diagram in figure 2.

Table 4 Search strategy

CINAHL |16.3.22 | Title and abstract

Keyword		Keyword		Keyword	Limits	Inclusion/Exclusion Criteria
Assault*	AND	"Mental Health" OR Psychiatr*	AND	Nurs*	Published between 2011 and 2021 English language Academic journals	Inclusion criteria: English language, focus on assaults on mental health nurses, last 10 years (contemporary understandings of the concept), research, articles, discussion Exclusion criteria: Pre 2011; articles relating to patient with a history of assaultive behaviour, survivors of sexual assault; patient on patient assaults; unable to access full text through library (or via authors directly where contactable)

Figure 2 PRISMA diagram for FMRS



3.1.2 Search results

The 34 publications included in this review consisted predominantly of primary research (*n* = 23), and also literature reviews (*n* = 3), reports (*n* = 6), a discussion piece (*n* = 1) and a service improvement project (*n* = 1). The primary research studies were predominantly quantitative, broadly identifying the prevalence, factors influencing and impact of violence and aggression against mental health nurses. A table detailing the publications' aims and

methods is provided in appendix 3. Articles originated from a wide variety of countries, although nearly half were the US (*n* = 9) and UK (*n* = 7). Others were from Australia (*n* = 3), New Zealand (*n* = 3), Ghana, South Africa, Taiwan (*n* = 2), Botswana, Malawi, Indonesia, Japan, Jordan, Italy, Spain and Switzerland.

3.1.3 Data extraction, data analysis and synthesis

All papers included in the review were screened and each mention of the term 'assault' was identified and highlighted. The highlighted sections from each paper were synthesised and examined. During this process distinct features associated with the ways in which the term was used became apparent. Five specific features were identified, and each paper was then re-examined and checked for evidence of each feature. The five features were; *differentiates between types of assault (uses terms verbal, physical, sexual)*; *implicit inference that assault is physical in nature*; *uses similes interchangeably (e.g. violence, aggression, assault, abuse)*; *refers explicitly and exclusively to physical assault* and *contains no definition of assault*. Table 5 indicates how the features appeared across publications.

Table 5: Features of the use of the term 'assault'

Article	Differentiates between types of assault (uses terms verbal, physical, sexual)	Implicit inference that assault is physical in nature	Uses similes interchangeably (e.g. violence, aggression, assault, abuse)	Refers explicitly and exclusively to physical assault	No definition of assault
Allen (2013)		x	x		x
Atinga *et al*. (2021)	x				
Baby *et al*. (2014)		x	x		
Banda *et al*. (2016)			x	x	x
Brady *et al*. (2012)					x
Bresler & Gaskell (2015)	x	x	x		x
Burns (2014)	x	x			x
Dafny *et al*. (2020)		x		x	x
Edward *et al*. (2015)				x	x

Foster *et al*. (2021)			x		x
Gascon *et al*. (2013)		x	x		x
Hallett & Dickens (2015)			x		x
Hamaideh (2012)	x		x		x
Hsieh *et al*. (2018)		x	x		x
Jeffery & Fuller (2016)		x	x		x
Jones-Berry (2017)		x	x		x
Kelly *et al*. (2015)		x	x		
Kleebauer (2016)			x	x	x
Magnavita & Heponiemi (2011)	x		x		x
Moylan *et al.* (2011; 2014)				x	
Newman *et al*. (2021)	x	x	x		x
Oates *et al*. (2020)	x			x	x
Okundolor *et al*. (2021)	x				x
Olashore *et al*. (2018)		x	x		x
Rathobei *et al*. (2021)	x		x		x
Ridenour *et al*. (2015)	x	x	x		x
Schlup *et al*. (2022)	x		x		x
Sprinks (2015)			x	x	x
Staggs (2015)	x				x
Stoddart (2014)		x			x
Yada *et al*. (2014)	x		x		x
Yang *et al*. (2016)	x		x	x	x
Yosep *et al*. (2019)				x	x
Zuzelo *et al*. (2012)		x	x		x
Totals 34	**14**	**15**	**23**	**9**	**30**

3.2 Results

The most striking observations related to the way in which assault was defined in the literature. Only four publications offered an explicit definition of the term. The other articles did not define the term and did not refer to this omission, implying an assumed shared understanding. The papers that did offer a definition referred only to physical assault (Moylan & Cullinan, 2011; Baby *et al.,* 2014; Kelly *et al.,* 2015; Atinga *et al.,* 2021). In their survey, Moylan and Cullinan (2011, p. 529) defined assault as "any noxious physical contact intentionally made by a patient in an aggressive situation". Baby *et al. (*2014) and Kelly *et al. (*2015) offered more detailed descriptions using explicit examples. Baby *et al*. (2014, p. 648) defined physical assault as "pinching, biting, hitting, grabbing, kicking or being struck by a weapon", while for the purpose of their questionnaire Kelly *et al. (*2015, p1119) graded the severity of "physical assault" using the following; "(1) spit at; (2) touched/grabbed aggressively; (3) kissed, fondled or patient sexually exposed themselves; (4) pushed or knocked down; (5) kicked, punched, bit or slapped; (6) hit on the head; (7) had object thrown at them and (8) other". Atinga *et al. (*2021) defined "violent assault" using the WHO definition for violence - "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (WHO 2002, p. 4).

In the majority of cases, papers conceptualised an assault as involving only physical contact although this was not generally made explicit, rather it was implied in the discussions. For example, whilst not defining the terms used, Edward *et al*.'s (2015) systematic review used the word assault only when preceded by 'physical'; they used the words 'abuse' or 'aggression' when referring to verbal acts. In their study of violence against nurses in Malawi, Banda *et al*. (2016, p. 416) defined 'workplace violence' as "physical violence (assault/aggressive behaviour) and psychological violence (verbal abuse, stalking, harassment)". With the exception of Burns (2014) and Okundolor et al. (2021) the eight report/discussion papers referred exclusively to assaults as being physical. It follows that this was the case given the topics of four of the articles (Sprinks, 2015; Kleebauer, 2016; Jones-Berry, 2017). Two related to national data on physical assaults or 'attacks' against NHS staff (Sprinks, 2015; Kleebauer, 2016); one was a comment on proposals for more

stringent laws for those who physically assault emergency workers (Jones-Berry, 2017), and reported outcomes of an education/training programme aimed at reducing assaults, injuries and lost work time (Allen, 2013). Stoddart's (2014) short piece entitled "nurses encouraged to report" referred to the prevalence, prevention and the response to assaults including the culture of reporting. Whilst the term was not defined, the report appeared to refer exclusively to physical assaults.

Five articles explicitly and consistently referred to assaults as being physical *or* verbal, and in some cases sexual (Magnavita & Heponiemi, 2011; Hamaideh, 2012; Yada *et al*., 2014; Atinga *et al.,* 2021; Okundolor *et al*., 2021). A further three made an initial distinction between physical and verbal assaults, but then, without explanation, discussed assaults that only involved physical contact (Burns, 2014; Bresler & Gaskell, 2015; Ridenour *et al*., 2015). Newman *et al. (*2021) referred to physical and sexual assault explicitly, and when 'assault' was used on its own, it appeared to imply physical. They used the term "severe assaults" but did not define "severe". Schlup *et al. (*2022) referred only to sexual assault, using the terms "physical attack" and "exposure to verbal, physical and sexual violence" when referring to other forms of violence. Ridenour *et al*.'s (2015) study of incidents and risk factors associated with workplace violence in mental health settings was particularly confusing in relation to its use of terminology. The authors referred to "physical aggression" and "verbal aggression" – both of which were defined – and also to "physical assault" and "verbal assault", which were not defined. Its results separated assault and aggression, however its discussion did not.

The interchangeable use of terms featured in most of the articles (*n* = 23). Terms included but were not limited to: 'workplace violence'; 'violence'; 'direct violence'; 'indirect violence'; 'physical assault'; 'verbal assault'; 'verbal threat'; 'attack'; 'injurious assault'; 'abuse'; 'threatening behaviour' and 'aggressive behaviour'. These terms were often preceded by terms such as 'exposed to'; and 'encountered'. In most cases the terms were not defined, and where they were, the definitions varied.

Whilst only nine articles used the term assault explicitly and exclusively in relation to physical assault, a further fifteen implied their use of the term as meaning physical assault. Yang *et al.'*s (2016) study of nurses' "assault experiences" focused on physical assault - which was not defined - but did not make this clear until they described their study design.

They referred to verbal assault once, made no reference to sexual assault, and did not give a rationale for focussing on physical assaults alone. Yosep *et al. (*2019) used the word assault only when preceded by the word physical. They used "verbal violence" and "sexual harassment" when referring to other forms of violence, although notably sexual *harassment* (termed *sexual abuse* by a participant) referred to acts including touching, "forcibly kissing" and holding "sexually sensitive areas" (Yosep *et al.,* 2019, p. 1875). In Kelly *et al.*'s (2015) abstract they referred to "physical and verbal assault". They then used the term 'assault' only - with the implication that it referred to physical assault - before making explicit that their survey sought to determine prevalence of *physical* assaults. Dafny *et al.*'s (2020) study used a range of terms interchangeably but appeared to use 'assault' only in the context of physical assaults. Gascon *et al. (*2013) also used several terms interchangeably, but when using 'assault' preceded it with 'physical'. Staggs (2015) used the term "injurious assault" stating this referred to physical or sexual assault. Olashore *et al. (*2018, p. 1) referred to physical assaults aside from one instance when they referred to "assault such as stalking".

3.3 Discussion

Nearly 30 years ago, Whykes (1994) insisted that defining violence was a crucial starting point in understanding, preventing, and managing violence in healthcare settings. This synthesis of a sample of contemporary nursing literature suggests that what she advocated for has not yet come to fruition, reflecting differences, inconsistency, and a broad lack of clarity in the use and understanding of the term assault. These findings are consistent with previous observations regarding the lack of consensus over what constitutes aggressive behaviour, violence, and assault in the nursing literature (Needham *et al*., 2005; Stevenson *et al*., 2015). Not only are definitions inconsistent, but also there is frequently no definition - the majority of papers neither discussed nor defined the term 'assault;' only three papers out of thirty attempted to specify what an assault may involve. The terms 'violence,' 'threat,' 'attack,' 'abuse,' 'aggression' and 'assault' and their various variations and combinations are used interchangeably. The term 'assault' is used to refer to physical, verbal, and sexual behaviours, sometimes with and sometimes without the descriptive terms. Meanings are often implied and shared understandings assumed.

There are several implications of the lack of clarity identified in this review. It calls into question the extent to which data can be compared both across studies, and also within each individual project. Banda *et al*. (2016)'s literature review acknowledges the significant variation in the use of terminology relating to the classification of violence towards nurses and argues that this results in difficulties when attempting to compare data and make generalisations. Similarly, Needham *et al*. (2005) argued that both the collection and comparison of data relating to the prevalence of assault are compromised by the inconsistency in operational definitions.

Further, failing to establish clear and consistent definitions in the literature perpetuates the lack of clarity in practice which has been demonstrated to influence the response to the assault including whether it is reported (Gifford, 2010; Stevenson, 2015). This has implications for understanding prevalence, directing resources, identifying learning, and also for clinical risk assessment and management planning.

The findings of this review highlight the primacy that physical assault appears to have over other forms of assault, both explicitly and implicitly. This emphasis in the news and discussion articles found in this review appears to reflect the wider discourse with national and international media coverage referring predominantly to assault as being a physical act (Robinson & Grant, 2017; Thompson, 2019). The priority given to physical assaults is likely a factor in the under-reporting of non-physical assault (Arnetz *et al.,* 2015) meaning that a clear understanding of nurses' experiences of non-physical assaults are not understood. Importantly, this has the potential to deny, undermine and minimise these experiences and negatively impact the extent to which nurses are supported.

3.4 Conclusion

This review was undertaken for the purpose of informing the way in which assault was defined in this study. The results highlighted inconsistencies in the way the term 'assault' is used in the mental health nursing literature, both across publications and within individual articles. The interchangeable use of terms and absence of explicit and consistent definitions reflected the lack of consensus over how the term is understood in this context. In many cases a shared understanding of conceptual meaning appeared to be assumed rather than explicated. The obvious conclusion in terms of the current study was that the term 'assault'

should be clearly defined, consistently used, and explicitly refer to all forms of assault. However, this review indicated a significant degree of subjectivity in relation to the way assault is defined in practice. Given the aim of this study was to understand nurses' *interpretations* of their experiences, the ways in which they conceptualised assault was viewed to be central to the way they would make sense of what has happened to them. Therefore, as the wide variation in definitions and conceptualisations persisted, imposing a definition at the outset could have served to exclude nurses who have different understandings.

Beyond this study, the results of this review have potential implications for the collection and reporting of prevalence data, the quality of research into violence and aggression against nurses, the reporting of assaults by nurses and the response both of the individual and the organisation. A greater degree of consensus is required if prevalence data are to be reliable and representative and policy, and guidelines are to be clear and meaningful. Furthermore, improving clarity could result in nurses feeling better able to report, seek support and make sense of their experience.

CHAPTER FOUR: METHODOLOGY AND METHODS

4.0 Introduction

The research process is a systematic one with stages that are common to all studies regardless of where, by whom and for what purpose they are being conducted (Lacey, 2015). Inherent in each stage - from the development of the question to data analysis - are the philosophical, theoretical, and conceptual considerations that influence and guide choices and decisions. These decisions and choices shape the research focus and question(s), the ways in which chosen methods are applied and the role and position of the researcher. Being transparent about the foundations underpinning a study's methodological approach is recognised as crucial for ensuring rigorous, good quality research (Topping, 2015; Holloway & Galvin, 2017; Maguire, 2019). Decisions as to the overall direction a research study will take should be well justified, and there should be congruence between its aims, the research question, the methodology and the methods (Holloway & Galvin, 2017).

The first section of this chapter describes the methodological approach adopted for this research project. With reference to the research question and aims, the decision to take a qualitative approach is discussed and justified. The philosophical and theoretical standpoints that underpin the nature of the qualitative approach taken are explored, focussing specifically on ontological and epistemological perspectives and their integral relationship with the study's exploratory, 'Big Q' qualitative methodology. The ways in which the study ensured rigour/quality/methodological integrity are critically considered throughout this chapter and summarised in the final section. Particular attention is paid to reflection and reflexivity and their central role in this study. Finally, the ethical issues and considerations involved in the project are discussed.

The second section sets out the methods used to collect and analyse the data, giving justification for their selection. The method for data analysis is introduced, and the process is described, using examples of activity during each phase. The results of the analytic process are presented in the following chapter.

4.1 Methodology

This section of the chapter begins by critically exploring the ontological and epistemological perspectives that underpinned this research. It then goes on to explain the way in which Gadamerian philosophy and cognitive behavioural theory influenced the approach taken. Finally, the notion of "Big Q" Qualitative Research is introduced and its relevance to this study is discussed.

The background section of this thesis situated the study as practice-based research, positioning myself as a practitioner-researcher and an insider in relation to both the context and the topic. These discussions are not repeated here, but it is recognised that they have a bearing on the methodological approach taken in this study, and also on the ethical considerations that arose out of the combination of the approach, the nature of the research topic and my position as an insider, practitioner researcher. This section on methodology ends with a summary of the key ethical considerations for this study, a discussion of the central role reflexivity played and an overview of how methodological rigour was conceptualised and demonstrated in this study.

4.1.1 Ontology and epistemology

The study of ontology is concerned with the nature of reality or being (Crotty, 1998) with the primary question being concerned with *what* is there to know. Epistemology, concerned with the nature and production of knowledge (Crotty, 1998) is concerned with *how* we can know. With its focus on the meaning of individuals' experiences, this research was underpinned by a relativist ontological perspective, and a constructivist epistemological stance. The rationale for taking these positions is now discussed.

Ontological beliefs can be viewed as being situated along a continuum with realist and relativist ontology at either end. A realist ontological position holds that reality is 'out there' and exists independently of human experience. It believes there are structures and objects that have a predictable cause-effect relationship with one another, and that reality is separate from human experience. A relativist position rejects this perspective, questioning the idea of an objective, ordered reality, and arguing that there exists a diverse range of interpretations of the world. It views 'truth' as subjective, context bound, dynamic and evolving. This perspective is reflective of the aims and research question relating to this

study, and was implicit in its planning stages when the focus was on the ways in which nurses interpreted their experiences of being assaulted.

Along the realist-relativist continuum sit ontological positions which differ in the degree to which they have confidence in our ability to define the nature of reality (Moon & Blackman, 2014). Interestingly, during the process of data analysis as patterns in meaning were identified, it became apparent that there was a form of shared reality experienced by participants which related to the normalisation of assaults. The data analysis and discussion chapters in this thesis reflect a tentative shift along the continuum as this shared reality, its origins, impact and maintaining factors are discussed.

The approach taken in this study was informed by a constructivist epistemology. Constructivism, a perspective that has increasingly influenced health service research (Appleton & King, 2002), views knowledge as a social construct (Creswell, 2014). It enables researchers to examine in detail the complex human experiences encountered as individuals live and interact within their own social worlds (Appleton & King, 2002). A constructivist approach to research employs the analysis of social discourse captured in data collected via methods such as interviews or observation. The aim is to reveal the perspectives, subjective meanings and world views held in a particular social context through the identification of patterns and themes within the data (Risjord, 2010). Constructivism seeks to understand the social world of the participants, holding that meaning can be both particular to individuals and mediated within social groups (Bogna *et al.,* 2020). The terms 'construct*ivism*' and 'construct*ionism*' are used in this thesis. The terms are sometimes used interchangeably in qualitative research literature, with Braun and Clarke (2022) arguing that this is partly the result of differences in disciplinary traditions. Rather than becoming embroiled in the debate regarding what are recognised to be contested and confused meanings (Braun & Clarke, 2022), the use of the terms in this thesis is aligned to Braun and Clarke's conceptualisation. Construct*ivism* is concerned with meaning-making in an individual's mind'; construct*ionism* is concerned more with the collective - or *social* - production of meaning. This thesis set out with a clear focus on the meaning being assaulted held for *individuals* (constructivism) moving, as patterns were identified, to consider the *social* processes involved in meaning-making (constructionism). The latter recognises to a greater degree the central role of the researcher in constructing knowledge - a position also taken in this research study.

The themes that were constructed in this study centred on the lived experiences of participants, structuring their talk around being assaulted by patients. As mentioned earlier, in the later stages of data analysis, the themes and in particular the shared experiences of not being heard, recognised, or validated prompted the question 'what is going on here'? The discussion therefore explores the social constructs that both inform and are informed by the dominant narratives relating to assaults on mental health nurses, and remains in-keeping with the constructivist perspective that there is a social reality which exists as individuals experience it (Appleton & King, 2002).

Finally, the philosophical assumptions underpinning this study informed the adoption of what Kidder and Fine (1987) termed 'Big Q' methodology. They made a distinction between qualitative research approaches that they consider to be 'fully qualitative' and those that use qualitative data in a way more aligned with positivist research values. For example, Willig (2013, p. 9) explains that 'little q' data collection and analysis methods start with hypotheses and categories defined by the researcher which qualitative data are then checked against. Braun and Clarke (2013;2022) expand on what they refer to as this 'qualitative sensibility', highlighting the emphasis on meaning and process over cause and effect, the desire for complex and nuanced understanding and the embracing of knowledge as *positioned* and *situated* as opposed to there being a discoverable and universal 'truth'. They warn against 'positivist creep', examples of which would be seeking to eliminate or control for 'bias', seeking data 'saturation', or 'validating' data through member checking. Finally, it is important to recognise that this study falls within a phenomenological research tradition. The adoption of a phenomenological *attitude* (van Manen & van Manen 2021 p. 1072) is manifested in the whole approach to this study, and pervaded the Big Q values that guided the choice and application of the methods used.

This chapter now moves on to discuss the theoretical perspectives that shaped this research, beginning with Gadamer's philosophy of understanding.

4.1.2 Gadamer's philosophy of understanding

Gadamer's hermeneutic philosophy influenced the approach to this study. Concerned with *how* we come to understand, his account of the nature of understanding – and interpretation – as dialogical, historically situated and evolving (Malpas, 2003/2022;

Smythe, 2019) - underpinned all stages of this study. Rather than providing a 'method' – Gadamer rejected the idea that understanding relied on a set of rules or a 'method' - the central tenets of Gadamer's hermeneutic philosophy guided the choice of methods for data collection and analysis and the ways in which they were applied.

Hans-Georg Gadamer (1900 – 2002) was a German philosopher who published his most influential work – *Truth and Method* – in 1960. Grounded in the work of Husserl (1859-1938) – 'the father of phenomenology' - and Heidegger (1889-1976), his aim was to "throw light on the fundamental conditions that underlie the phenomenon of understanding" (Linge, 2008, p. xi). Gadamer, like Heidegger, moved away from Husserl's essentialist approach to phenomenology which required the researcher to identify and 'bracket' their experiences and perspectives in order that the 'essence' of the phenomenon be revealed. Heidegger and Gadamer saw this as both an impossible and undesirable endeavour and instead embraced what Gadamer referred to as the *preunderstanding* and *prejudice* of the interpreter (Kvale & Brinkman, 2009). Heidegger took a contextualised perspective to the examination of lived experience, viewing *daesin* – *being in the world* – as comprising both our historical understanding and our immersion in that which was to be understood (Paley, 2014). Gadamer expanded this perspective when he developed his dialogical hermeneutic, seeing meaning and understanding arising through dialogue between the interpreter and the subject – be that through the reading of a text, the viewing of a work of art or a conversation with another human being. His dialogic stance meant he saw language as central to the hermeneutic approach and the means through which understanding is developed – and this is reflected in the 'conversational' tone evident in his writing (Malpas, 2003/22).

Gadamer referred to the encounter between interpreter and subject as a '*fusion of horizons*', describing a *horizon* as *"*the totality of all that can be realised or thought about by a person at a given time in history and in a particular culture*"* (Clarke, 2008, p. 58). He saw horizons, and understanding, as being temporally and culturally situated, and therefore transient and evolving. He believed that understanding the other can never be achieved totally (Fleming *et al.,* 2003, p. 117); we can never see all that is beyond our horizon. He said: "A person who has no horizon is a man who does not see far enough and hence overvalues what is near to him. Contrariwise, to have an horizon means not to be limited to what is nearest, but to be able to see beyond it" (Gadamer, 1989, p. 269). Gadamer viewed

our historically situated understanding – or *prejudice* – positively in relation to the ongoing development of knowledge and understanding, and held that consciousness was not independent of history (Gadamer, 1989).

Gadamer, as mentioned at the outset, did not offer a 'method' for achieving understanding, indeed he rejected the traditional notion, grounded in scientific enquiry, that one must maintain an awareness of the 'rules' in the pursuit of hermeneutic understanding. At the same time however he asserted that in order to achieve understanding a systematic approach must be taken (Fleming *et al.*, 2003).

The identification of Gadamer's work and its application to this study came early in the doctoral programme as the ontological and epistemological foundations of research into human experience were explored. His perspectives on understanding as a *fusion of horizons*, his recognition – and valuing – of *preunderstanding* and *prejudice* and his notion of understanding as incomplete, temporal and evolving, all added depth to the theoretical framework from the outset, guiding the development of the study. These core principles and ideas were kept in mind throughout the study, providing a foundation for choices and decisions, and shaping the ways in which methods were applied. They did not provide a method in themselves.

In 2003, Fleming, Gaidys and Robb – nursing and midwifery scholars - proposed a five-stage 'Gadamerian-based' method which was considered as an approach to the current study. It was not adopted in part due to some aspects seeming to lack congruence with the aims of my study and from my reading of Gadamer's hermeneutics, and also on reviewing accounts of its application by other researchers. An example of this related to their stipulations regarding data collection. They referred to it being 'essential' to speak to participants two or three times (Fleming *et al.*, 2003), and referenced Gadamer's assertion that understanding changes over time, arguing that the research process should facilitate this change. I questioned this from both a philosophical and practical perspective. First, I was not clear what this would achieve and from my reading of Gadamer did not agree that it was an essential task. If understanding is temporary and incomplete, when would this end? Whilst the authors did acknowledge that understanding remains transient, their 'rule' seemed to offer an artificial notion of a 'better' understanding which I was left questioning. Second, and in light of both the research aims and study resources, I questioned the value and practicalities of repeated interviews. The study set out to convey the many and varied

ways in which nurses interpret their experiences and therefore interviewing a range of nurses in order to reflect a breadth of experience was deemed necessary. Multiple interviews would result in fewer participants due to the time and resource limitations of this doctoral study. Smythe (2019), in her commentary on Fleming, Gaidys and Robb's method and analysis of its use by others (Fleming & Robb, 2019), pointed to the same observations, raised questions about their method and challenged the idea that an explicit method was either required or congruent with the 'hermeneutic spirit', arguing that whilst 'reassuring' for novice researchers, it risks limiting the quality of the findings. She viewed hermeneutics as opening oneself up to an "endless journey of waitful attentiveness, delighting in the insights that peek through the clouds. It is not to apply a method. It is rather to live hermeneutically" (Smythe, 2019, p. 5). In balancing this perspective with the requirement to conform to the systematic and structured research approach, the decision to resist a prescriptive method of applying Gadamer's philosophical perspectives, and instead remain open to possibilities – particularly in relation to data analysis – was taken.

4.1.3 Cognitive-behavioural theory

Cognitive-behavioural theory, introduced to me through my training and experience in cognitive behavioural therapy (CBT), formed an important part of my pre-understanding and influenced the focus of this research. The theory underpinning this psychotherapeutic approach (Ellis, 1957; Beck, 1979) holds that our emotional, physical and behavioural responses to situations are directly attributable to the way in which we think about them, i.e. it is the *interpretation* of these events, as opposed to the events themselves, that is considered important (Beck, 1995). This idea, forming the basis of Beck and Ellis' theories and practice, was not a novel one. Indeed, Ellis, in his development of Rational Emotive Behavioural Therapy - an approach sharing many features with Beck's CBT- acknowledged the influence of the first and second century Greek philosopher Epictetus who is quoted as saying "men are disturbed not by things, but by the principles and notions which they form concerning things" (Epictetus, 1759, p. 432). Beck was influenced by Ellis' thinking and also George Kelly's personal construct theory (Kelly, 1963) as he developed the theory that guided his cognitive-behavioural therapeutic approach. It was this theory that shaped my initial idea for the study and specifically the focus on interpretation as opposed to

description. My belief, informed by experience, was that the meaning for mental health nurses of being assaulted by patients was varied and nuanced. Also, the emotional impact of the event was often pervasive. Contemporary understanding of the phenomenon did not appear to include a focus on interpretation, focussing as described earlier (in chapters one and two) on prevalence, influencing factors and impact. Further, whilst studies elicited nurses' emotional responses to being assaulted, they mostly did not identify the cognitions associated with the emotions. As a result, our understanding of what it *means* to be assaulted was limited. Some of the questions asked during the interviews therefore aimed to explore what being assaulted meant to each participant. Most participants also wanted to talk about the way both their own and other's responses left them feeling, and therefore questions were used in order to understand the interpretations they made. For example, when Participant 6 said she was angry that her manager appeared to be excusing the person's assaultive behaviour, I asked the question "what did it mean to you that they'd said that?". Her response was: "That I didn't matter. I didn't count".

Cognitive-behavioural theory also shaped the approach I took to my reflections post-interviews. As is discussed in section 4.6.2, I completed thought records to help me identify the thoughts and feelings I noticed after speaking to each participant. The theory informed the study further during the data analysis stage. During coding and theme development, it prompted the identification of implicit and explicit connections between cognitions and emotions in the data. This is also discussed later in this chapter, in section 4.6.3.

Whilst cognitive-behavioural theory informed the study, it was important throughout to make the distinction between the theory and its application to therapy. My position as a practitioner-researcher heightened the requirement for the maintenance of clear boundaries, and this particular focus of reflexive activity is discussed further in the ethical considerations section that now follows.

4.2 Ethical considerations

Ensuring a study adheres to the ethical requirements for research is a fundamental task for all forms of enquiry – particularly in the field of health research (Holloway & Galvin, 2017; Health Research Authority, 2020). Ethical approval for this research was granted in July 2020 (see appendix 4 for confirmation). Review by an NHS Research Ethics Committee (NHS

Health Research Authority, 2021) was not required. This was due to the decision to recruit participants using social media; a decision taken with the aim of achieving a diverse sample of participants from different hospitals, regions and countries in the UK. Documents comprising the recruitment advert, participant information sheet, privacy notice and consent form template are provided in appendices 5, 6, 7 and 8 respectively.

Important ethical considerations identified during the planning stages of this project surrounded the sensitive nature of the research, and the potential impact of my position as a practitioner and insider researcher. Integral to my clinical role and professional code of practice (NMC, 2015) is the requirement to practice ethically, guided by Beauchamp and Childress' (2009) four principles; respect for autonomy, beneficence, non-maleficence and justice. In applying these principles to this study, the main considerations related to the requirement to respect participants' autonomy and to do no harm (non-maleficence). As in all research involving human subjects, respecting the autonomy of the nurses I interviewed meant ensuring they had all the information required at the outset, and were in control of their participation in the interviews. In relation to non-maleficence, the potential for harm in the form of distress given the sensitive nature of the topic was considered in detail. Below is a summary of each of the ethical considerations organised by the stages of the research process they related to.

Recruitment

Recruitment was undertaken via social media, with a link for potential participants to access information about the study and make direct contact with me as the researcher. To support participants to maintain their own confidentiality, I ensured I did not discuss specific issues relating to participation on open social media. The post clearly stated that all enquiries, requests for further information or expressions of interest should be made through direct email contact, and not through comments on the post.

An unanticipated ethical dilemma arose during the data collection process, and this was the focus of a comment piece published in the British Journal of Mental Health Nursing (Ayres *et al*., 2021). Recruitment began during the height of the COVID-19 pandemic, and as the second wave began, I questioned whether continuing to attempt to recruit participants was the 'right' thing to do. I was concerned about whether the pressures, stresses and trauma participants may be experiencing might compromise their ability to manage any distress

following the interview, and I wondered if it was fair to ask them to try. I was also conscious about how mental health nurses might view the ongoing attempts to recruit – perhaps it would be seen as insensitive, or selfish. My instinct was to pause the process of recruitment, and I did so due to the overwhelming idea that continuing would mean prioritising the progress of the research project over the wellbeing of participants. However, new insights gained through supervision, discussions with colleagues and further reflection led to the recognition and consideration of other perspectives. My hesitancy was rooted in my position as an insider researcher and influenced by my own emotional experiences of clinical practice during the pandemic. In previous interviews undertaken during the pandemic, participants had said they welcomed the study and thought it was important to highlight and improve the experiences of nurses who had been assaulted. Many had also said that it had felt good talking about their experiences suggesting, as has been acknowledged in the nursing literature, that being interviewed about a sensitive topic can be of benefit to participants (Alexander *et al.,* 2018). Their perspectives reinforced the aims of the study and brought into focus the ethical responsibility I had towards the participants and the mental health nursing community to progress the project and fulfil its aims despite the pandemic. Indeed, assaults on mental health nurses had not stopped during the pandemic; they continued and presented the additional risk of being infected with COVID-19. The reflexive approach to this dilemma aided its resolution and guided the decision to resume recruitment in early 2021.

With regard to consent, individuals were asked to read the participant information sheet prior to agreeing to take part in the study. I ensured via email that all potential participants were given the opportunity to ask questions and seek clarification in order to inform their decision. The consent forms were revisited at the beginning of each interview, and again participants were given the opportunity to ask questions.

Data collection

Potential for distress: The sensitive nature of the topic meant that participants may have experienced distress as a result of discussing what was likely to have been a traumatic event for them. Whilst a recent systematic review (Alexander *et al.,* 2018) identified a general consensus that participants derived benefits from discussing sensitive topics in the context

of research studies, it was important that the potential for distress is highlighted and planned for.

My experience as a forensic mental health nurse and clinical lead was viewed as a protective factor in relation to participant distress. The experience of supporting nurses who had been assaulted combined with a comprehensive understanding of the context, enabled me to respond in a sensitive and containing manner. I took a collaborative approach to managing distress, discussing and agreeing with the participant the approach to be taken prior to the interview. They were made aware that they could pause or end the interview at any time. I included decision points within each interview, for example, "I am going to ask you to describe how you felt immediately after the assault, are you okay to continue?". Participants were advised to seek support following their interview either through their employer or their general practitioner should they experience prolonged distress.

I also acknowledged that I may experience distress as a result of the interviews. I therefore ensured not only that I could request a debrief with one of my supervisors soon after the interview, but also that the impact of the experience of interviewing remained a standing item on the agenda for supervision whilst data collection was underway.

The impact of being an 'insider' researcher: Whilst there are potential benefits of being an insider-researcher – a mental health nurse who has been assaulted by a patient in secure settings - there are also potential ethical implications. One such implication, identified at the outset, was that participants may be more willing to share their experiences with a researcher whom they perceive as sympathetic to their situation (De Tona, 2006). At worst this could result in exploitation in that the participant is – possibly unconsciously – 'coaxed' into disclosing information they were ambivalent about sharing. A further risk of bringing the researcher into the researched, as Cloke *et al. (*2000) argue, is the potential for a degree of self-involvement that prevents the voice of the participant being heard. Remaining alert to and thus mitigating these risks was achieved through reflection-in-action during the interviews (Schön, 1983), checking and confirming meaning with participants, taking an open, collaborative approach to the researcher-participant relationship and reflecting post-interviews in my reflexive journal.

The impact of being a practitioner-researcher: For an insider-researcher, there exists a tension between immersion and maintaining researcher distance (Freshwater, 2007). This tension formed the basis for much of my reflexive practice while undertaking this study.

Conscious of the boundaries of my role as a researcher, steps were taken to mitigate the risks of the roles of researcher, nurse and leader/manager becoming conflated during the interviews. I was not a leader/manager/colleague supporting an assaulted nurse, and I was also not a nurse trying to understand the individuals' interpretation of their experience for therapeutic purposes. At the beginning of each interview, I consciously oriented myself to the role of researcher.

Finally in relation to reflexivity, the potential emotional impact of discussing the experience of being assaulted was of significant concern and will be addressed from an ethical perspective. Pillow (2003, p. 178) refers to reflexivity as "situating the researcher as non-exploitative and compassionate toward the research subjects", a view believed to be highly relevant in this study. With this in mind, priority was given to ensuring participants were well informed, afforded breaks, given the opportunity to withdraw at any time and directed to options for accessing support should they require it.

Confidentiality

Confidentiality with regard to data adhered to University guidelines, with measures taken approved by the research ethics committee. Participants were made aware at the outset that confidentiality would be maintained, with the only exception being the disclosure of clinical practice that contravened the Nursing and Midwifery Council (NMC) Code and posed a risk of harm to others. In such a case, I said I would inform the participant of my concern, escalate it to my supervisors and if required, report the concern to the NMC.

The reflexive approach taken in this study played a key role in ensuring this was an ethical and rigorous research project. The concept of reflexivity, as has been referred to previously, is discussed following a summary of the study's approach to ensuring rigour.

4.3 Rigour or Trustworthiness

The term 'rigour' refers to a concept that has been considered to have its roots in quantitative research, and as a result the extent to which traditional means of ensuring a rigorous research process can be applied to qualitative research has been questioned (Koch & Harrington, 1998). There is an ongoing debate over whether notions such as 'validity' and 'reliability' have a place in assessing the quality of qualitative research given their positivist

assumptions (Silverman, 2011; Maxwell, 2012). Whilst the philosophical basis for this study is not congruent with such assumptions, addressing the issue of rigour is essential in ensuring it is good quality research which contributes trustworthy evidence for practice. As there is no shared conceptual understanding of validity or trustworthiness in qualitative research (Sparkes & Smith, 2013), each of the most commonly cited criteria were considered in the context of this study. When applied to qualitative research these are dependability, credibility, transferability and confirmability (Guba & Lincoln, 1989; Holloway & Galvin, 2017), which together determine the extent to which the research is trustworthy. In this study, maintaining a reflexive approach and providing a thick description (Geertz, 1973) and audit trail were core means of ensuring and demonstrating the trustworthiness of each stage of the research process. The thick description comprises all elements of this thesis, from the background context and situatedness of the research through to the reflexive analysis of the data and the interpretations made as findings are summarised and discussed. The connections between the methods used, the data, the analytical activity and the constructed narratives are made explicit and illustrated in the descriptions and supporting documents. A summary of the means by which each of the criteria were addressed is in the table below (table 6) and are further described and discussed in the relevant sections of the thesis. The role of reflexivity is now discussed in the section that follows.

Table 6: Means of addressing criteria for trustworthiness

Criteria	Means of addressing criteria	Chapter in thesis
Dependability *Transparency, consistency and accuracy*	Rich data Thick description (of process and context) Data driven coding with audit trail of code generation Coding discussions during supervision sessions Use of quotes to demonstrate findings Decision making processes explicit throughout Prolonged engagement - in-depth interviews, immersion in data	Chapters 4, 5
Credibility *Recognising researcher's position* *Accurately reflecting social reality*	Explicit positioning of researcher Reflexive journaling Supervision conversations aimed at expanding perspectives Thick description Presentation of findings in fora representative of the study population	Chapters 1, 4, 5

Transferability (inferential) (Lewis *et al.,* 2014) *Knowledge is relevant across contexts*	Sample across multiple clinical settings and organisations in all 4 UK countries In similar situations and contexts, a degree of transferability is possible, however findings are recognised as being contextually bound limiting the extent to which transferability can be anticipated. Context, setting and participants are described such that reader is able to determine transferability to their setting	Chapter 1,2,4,7
Confirmability *Findings and conclusions achieve aims*	Clearly stated research questions, aims and objectives The relationship between the data, codes and themes is explicit in report (audit trail)	All chapters

4.4 Reflection and Reflexivity

In research terms, reflexivity represents "the process of continual internal dialogue and critical self-evaluation of the researcher's positionality" (Berger, 2013, p. 2). This process, integral to qualitative research (Ortlipp, 2008), was highly pertinent given the situatedness of this study as practice-based, and my position as an insider-researcher. As a mental health nurse, maintaining a conscious awareness of the beliefs, values, prejudices, thoughts and feelings I bring to clinical encounters is central to my practice. Reflective practice, often prompted by an emotional reaction to an event, has become an automatic response that prompts me to pause and think, to examine what happened, to consider different perspectives and often to discuss with others in order to learn and develop with the aim of improving my practice. The adoption of a reflexive approach to this study felt familiar and came naturally. However, it was important to make the distinction between reflexivity as a researcher, and reflection as a nurse. Reflexivity in the context of this study required me to take a curious, open and honest approach to my position and pay deliberate and ongoing attention to the way my presence and perspectives influenced the generation of knowledge. In taking this stance, I also realised the potential for confusing it with reflection in clinical practice. Holloway and Galvin's (2017) warning against taking self-reference too far (they refer to 'navel gazing') was a pertinent one, as was their reminder that participants' voices should have priority in the study of the phenomenon in question. Not paying attention to maintaining this boundary risked influencing the data and analytic activity.

A reflexive diary was maintained throughout the research process as a means of developing awareness of my subjectivity and reflecting critically on myself as a researcher (Bradbury-Jones, 2007). In the interest of transparency, excerpts from the diary are included in this thesis where significant insights, reflections and decisions occurred during the process.

Supervision sessions were also used to critically explore the impact of my position as a researcher in the study. The table below (table 7) provides an overview of the reflexive practices undertaken throughout the project, and includes references to relevant sections of the thesis.

Table 7: Reflexive practice

Stage in research process	Reflexive practice
Development of research question	I made explicit my preunderstanding including prejudices, assumptions, personal experience of mental health nursing, being assaulted and supporting nurses who were assaulted. I discussed my ideas, particularly relating to the focus on nurses' interpretations of their experiences, with nursing and other professional colleagues in order to broaden my perspective.
Literature review	The potential for my own experience and the cultural context I was familiar with had the potential to influence the search strategy, potentially by narrowing the terms to ones with which I was most familiar. Preliminary searches of keywords among studies undertaken in different contexts were conducted, and the collection of terms used was broad. In the final stages of the screening process, inclusion and exclusion decisions were undertaken with supervisors, with discussions focussing on what we each saw as important/relevant to the study.
Recruitment and data collection	The decision to recruit participants beyond my own working context was taken because I envisaged my personal experiences, preconceptions and assumptions would be enmeshed to a greater degree and therefore risked being more difficult to identify. I was interviewed by one of my supervisors using the interview schedule I had developed. This both further developed my insight into my own experiences and their impact on me, and identified aspects of the schedule requiring review. My preferences in relation to data collection (face-to-face) were made explicit and I explored the evidence for collecting data in sensitive qualitative research, informing my decision to offer participants a choice. Written reflections after every interview focussed on my thoughts and feelings and developed my insight into the ways I influenced the interview. These insights informed further interviews. In written summaries of the interviews, I documented what I noticed and thought was important/interesting. Critical reflection on these as I moved into data analysis gave me an insight into how my preunderstanding was influencing what I was seeing in the data.

Data analysis	The data familiarisation stage was prolonged and active with diary entries, analytic notes and summaries being made to ensure I remained conscious of what I was contributing to the analysis. Data were consciously 'over-coded' initially and several supervision sessions focussed on coded sections with discussions exploring different perspectives, assumptions and ideas relating to meaning and interpretation. Data extracts were retained against individual codes to ensure that the codes remained grounded in the data and were not being distorted by my influence. All iterations of theme development were retained which enabled ongoing evaluation of participants' voices remaining central to the narratives I was constructing.
Discussion	The discussion was centred on the prominent narratives constructed through data analysis. Critical consideration was given to narratives that I had not made a focus for the discussion, with explicit rationales given. Ideas relating to potential concepts, theories and discourses relevant for the discussion were noted, discussed with supervisors and colleagues.
Conclusion	Reflexive journal entries were reviewed and incorporated into concluding remarks particularly relating to the strengths and limitations of the study.

4.5 Methods

This section presents the methods selected for use in this study and describes their application.

4.5.1 Recruitment and sample

Participants were recruited via social media. This method meant that participation would be open to nurses across the UK, supporting the aim to represent a breadth of experience across different organisations and regions. An invitation, reviewed and approved by the research ethics committee, was posted on my Twitter account, created and used for professional purposes, and on a Mental Health Nursing Facebook group (see appendix 5 for the invitation). The invitations were posted on five occasions between 24th October 2020 and 6th March 2021. After each post, time for potential participants to respond and review the study information was allowed before re-posting. Most participants were recruited through the Facebook group. Communication was established either by participants emailing in response to the invitation, or through them expressing an interest via direct

messages or in the 'comments' attached to the posts. I did not enter into 'conversations' in the comments in order to promote confidentiality, rather sent them a private message thanking them for their interest and asking for their email address so that I could send them information about the study. Purposive sampling was required to ensure participants had the characteristics necessary for inclusion in the study. The table below (table 8) was included in the email in order that potential participants could check they met the requirements.

Table 8: Sample inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Registered mental health nurses	Student nurses, nursing associates, healthcare assistants, nurses on other parts of NMC register
Assaulted in medium secure inpatient setting whilst working in a frontline role	Assaulted in high secure, low secure, community or any other inpatient mental health settings
Registered mental health nurse at the time of the assault	Student nurse, nursing associate, healthcare assistant or any other profession/role at the time of the assault
Assault took place in the UK	Assault took place outside the UK

Participation was limited to registered mental health nurses. I did not independently verify their registration at the point of interview or at the time of the assault, however I was satisfied by their social media profiles and the content of the interviews that all had represented themselves faithfully. The decision to do this was carefully considered due to the recognition that healthcare workers other than registered mental health nurses – and in particular healthcare assistants – are assaulted by patients. The decision was based on two factors. First, the limitations associated with the nature of the study context – a doctoral study with limited resources and second, a non-homogenous sample would increase the potential influence of factors such as educational background and role experience on the ways in which assault is understood and experienced. I was concerned that if the study was open to all members of the nursing team, I risked being overwhelmed with potential participants and would then face the dilemma of having to turn people down due to resource limitations. This decision was challenged during the recruitment process when someone commented on my post. They said that healthcare assistants faced the highest

number of assaults and should therefore not be 'excluded' from the study. My response acknowledged their point, explained the limitations for this particular study and emphasised the need for further research on this topic.

A total of sixteen mental health nurses were recruited for the study. Participants communicated to me where in the UK they were located and where the assault they described took place. The majority came from England (*n* = 13), but there was representation too from Northern Ireland (*n* = 1), Wales (*n* = 1) and Scotland (*n* = 2). Participants worked in both the NHS and Independent Sector. Demographic data were not collected, however the way participants referred to themselves indicated that four participants were male and twelve female, and their ages, estimated in relation to conversations and interviews, ranged from early twenties to late fifties.

The requirement in terms of sample size was first estimated and then adjusted as data collection was underway. Based on Hennick *et al.'s* (2017) recommendation, the initial aim was to interview between twenty and twenty-five participants. This sample size was considered to offer the best opportunity for generating data with sufficient breadth and depth to address the research question. In exploring the literature relating to sample sizes through a 'big Q' lens, it was evident that those authors seeking to identify *valid* and *reliable* sample sizes remained wedded to positivist assumptions and their application to qualitative research (Mason, 2010; Patton, 2015). As discussed earlier in this chapter, there has been an increasing challenge to the quantitative sensibility that continues to prevail within qualitative research, and this extends to discussions about sample size and related concepts and practices. For example, Braun and Clarke have criticised the use of statistical models for establishing sample size in advance of data collection (Braun & Clarke, 2016). As data collection and recruitment took place simultaneously, the ultimate sample size was informed by the quality of the data being collected. This discussion, with reference to the concept of saturation, is continued in the following section.

Finally in relation to recruitment, the impact of COVID-19 is considered. It is not possible to know how the pandemic affected recruitment, however it is reasonable to assume that the pressure placed on mental health nurses in inpatient settings would likely have impacted their capacity and willingness to take part in a research study. As mentioned in the summary of ethical considerations, contained in the methodology section of this chapter, the pandemic led me to pause recruitment due to my concerns about whether it was 'right'

to continue recruiting to this study when nurses were facing such significant challenges. In the article published in the British Journal of MH Nursing (Ayres *et al.,* 2021) this dilemma was described and discussed, and the influence of my own experience of working during the COVID-19 pandemic was acknowledged and reflected upon. The pause to reflect and consider all perspectives - including those of participants already interviewed – was valuable and enabled me to be comfortable with the decision to continue.

4.5.2 Data collection

Data were collected using semi-structured interviews – a qualitative data collection method that involves the researcher asking participants pre-prepared, open-ended questions with the scope for follow-up probes (Given, 2008). Consideration was given to focus groups as an alternative option, however the review of qualitative literature relating to mental health nurses' experiences of violence and aggression suggested focus groups may inhibit the extent to which participants felt able or safe enough to express or share their emotional experiences (Zuzelo et al., 2012; Lantta *et al.,* 2016; Dafny & Beccaria, 2020). Further, it was considered that individual interviews would offer the best opportunity for the expression of the subjective interpretations of each participant and therefore meet the aims of the study. My preference from the outset was for face-to-face interviews. This was influenced by my clinical practice and my assumption that meaningful interaction is better achieved through in-person encounters than through virtual ones. However, this assumption was challenged by evidence in the qualitative research literature, and subsequently the way in which communication methods were adapted due to the onset of the COVID-19 pandemic. Heath *et al. (*2018) advocated for providing choice to participants, particularly when conducting sensitive research. They offered telephone, face-to-face, video and email interviews in their study, and this flexibility afforded participants the opportunity to select the most convenient means of communication for them, and the one they felt most emotionally safe with such that they could be open and comprehensive in their responses. Telephone or video calls via the participant's choice of application/platform were given as options for the interviews. Most participants selected video calls (*n* = 14), and they chose Microsoft Teams, FaceTime and Zoom as their preferred platforms. Face-to-face interviews were not offered

due to the restrictions imposed as a result of COVID-19 and the potential for a geographically dispersed sample population.

The interviews were semi-structured with the interview schedule providing the 'shape' of the interview, incorporating standard, broad and prompt questions (see appendix 9 for the interview guide). Broadly, the interviews contained three main parts – i) experience of working in secure settings and perspective on violence and aggression as a problem, ii) personal experience of assault, iii) perspectives on what constitutes an 'assault'. The last question was included following the review of how the term assault is used in the literature, and the subsequent decision not to define it for the study. This structure was not rigidly adhered to as the aim was to afford participants the freedom to focus on what they considered important and meaningful aspects of their experiences. Rubin and Rubin's (1995;42) description of "keeping on target while hanging loose" provided an accurate description of the approach to the interviews. In order to confirm the interview schedule offered sufficient guidance, my supervisor used it to interview me. This was recorded and discussed and resulted in slight changes of wording. The entry in my reflexive journal relating to my observations following the practice interview is contained in appendix 12 (RJE 1).

At the beginning of each interview, participants were welcomed, thanked for their interest and time, and asked to confirm that they gave their consent to be interviewed according to the form they had completed. The sensitive and potentially emotive topic was acknowledged, and it was explained that participants could have a break or end the interview at any point. During the interviews, participants were informed when questions relating to their own personal experience of assault would be asked, and their willingness to continue was again confirmed. Whilst participants became emotional at times during the interviews, there were no instances where they asked to stop.

A potential ethical issue explored in the planning stages of the study related to the risks associated with blurring the boundaries of my position as a researcher, and specifically of veering into a clinical and/or leadership position. I mitigated against this risk by orienting myself to the role of the researcher before each interview. This involved mentally rehearsing the role, its boundaries and making a conscious separation between my clinical and leadership roles and the forthcoming interaction and relationship. I also remained conscious of the basis for follow-up or prompt questions, and ensured the participant was in

control of the extent to which they shared their thoughts and feelings. My experiences of managing these boundaries featured in several of my reflexive journal entries. One in particular related to Participant 15, a relatively newly registered nurse whose emotionally detached description of being assaulted left me concerned about whether she was concealing how she really felt about it. Holding back from probing - as I would in a clinical situation and potentially also in my leadership role - was difficult for me to do, and I could see evidence of this as I transcribed the interview. I noted in my journal at this time that the process of 'orienting' myself prior to the interview had helped me to maintain a focus on the researcher-participant nature of this relationship.

I kept a thought diary, recording my emotional responses and associated thoughts immediately after each interview. I approached this with an open and honest attitude as I aimed to maintain a conscious and reflexive approach to what I was bringing to the interaction, and also how I was being impacted. I used the record to keep a check on whether my emotional experience during the interviews influenced the questions I asked or the ways I interacted, and also as a basis for discussion during supervision sessions. An example of this record is below in table 9.

Table 9: Post interview thought record

	Emotions	Thoughts
P 1	Sad	He was really badly affected by that – I wish he'd been treated differently
	Anxious	I hope he's okay
		I hope I did alright
		The call cut out so much – it must have been awful for him
	Guilt	He gave up his evening just to help me
		I used him
	Relief	Thank goodness it's over – my first one done

The above example details the thought record completed following the first interview. An unexpected emotion was guilt associated with the thought that I had 'used' the participant. This prompted further reflection, discussion and reading, with Darra's (2008) account of her experience of interviewing midwives providing helpful validation. Darra (2008, p. 255) described her perception that she was using her participants as a "means to my end" and highlighted the importance of "emotion work" – the work expended in managing emotions - in the research process, particularly in the case of novice researchers such as myself. The

thought record provided a useful mechanism for undertaking this work. A detailed reflection of the above interview expanding on the contents of the thought record is provided in the appendices (appendix 10).

All interviews were recorded and transcribed by myself using a broadly naturalised approach (Kelly, 2010) which involved transcribing verbatim, including hesitations (represented by "...") and other elements such as laughter as much as possible and particularly when they appeared to me to add to the meaning of the participants' words. The video-call platforms all included a transcription function however they were not found to be accurate and were therefore discarded. Transcribing was viewed as a first step in the process of data familiarisation, and analytic notes were started from this point forward.

4.5.3 Data saturation

The notion of 'data saturation' was problematic from the beginning of this project. One aspect of the 'preunderstanding' brought to this study was informed by exposure to the myriad ways in which nurses interpreted situations involving assaults. That I continued to hear nurses describe new interpretations - even after over twenty years in practice – emphasised the idea of data 'saturation', defined as "information redundancy" by Lincoln and Guba (1985), as being fundamentally at odds with the assumptions underpinning the study. The metaphor is unhelpful in that it indicates nothing more can be added, implying understanding is 'complete' (Nelson, 2017). The idea of completeness is not congruent with the study's underpinning philosophical and theoretical perspectives and specifically Gadamer's conceptualisation of understanding as temporary, evolving and incomplete (Corbin & Strauss, 2008, p. 263).

Data saturation continues to be considered by many as a requirement in qualitative research (Sandelowski, 1995; Morse, 2015), and measure of quality, featuring in widely used quality checklists including the Consolidated Criteria for Reporting Qualitative Research (COREQ Tong *et al.,* 2007) and the Critical Appraisal Skills Programme 10-item checklist for qualitative research (CASP, 2018). Braun and Clarke (2019a), among others (Mason, 2010; Nelson, 2017), challenge this widely held view and highlight the conceptual incongruence of what they describe as a positivist notion. They argue that where knowledge is conceptualised as being *generated* or *constructed* within research practice that is reflexive and situated, as opposed to being *revealed* or *discovered,* the potential for new

understandings is ever present (Mason, 2010; Braun & Clarke, 2019). Braun and Clarke describe the determining of a sample size in qualitative research as a pragmatic activity, acknowledging the part time and resources play in shaping project designs (Braun & Clarke, 2019a). This was certainly a factor taken into account for this study. A provisional upper and lower limit for the sample size was made based on the aims of the study and the resources available. As data collection commenced, the quality of the data was reviewed with supervisors. Guided by Braun and Clarke's (2019a) conclusions in their critique of data saturation in qualitative research, the final decision about the sample size was "shaped by the adequacy (richness, complexity) of the data for addressing the research question" (Braun & Clarke, 2019a, p. 211).

4.6 Data analysis

This section introduces Reflexive Thematic Analysis, the method chosen for this study. It describes the process of analysis used in this study incorporating examples and outcomes of each of the six stages of Reflexive Thematic Analysis (RTA) (Braun & Clarke, 2022); *familiarisation with the data; coding; generating initial themes; developing and reviewing themes; refining, defining and naming themes* and *writing the report.* The themes generated through the RTA process are presented and described in detail in the following chapter. The reflexive practices undertaken during data analysis are both summarised throughout this section with references to corresponding appended documents included in the text (e.g Reflexive Journal Entry 1 is labelled in the text RJE1).

4.6.1 Reflexive thematic analysis

Data analysis, a key feature of all research processes, refers to how data are made sense of – analysed – with the aim of generating findings/results that answer the research question. Holloway and Galvin (2017, p. 287) describe qualitative data analysis as being a "complex, non-linear process" highlighting its requirement for a reflective, intellectual approach, whilst ensuring systematicity and rigour. Popular for more than two decades, thematic analysis is one such approach. Both its definition and quality of application have been considered to vary (Terry *et al.,* 2017) with Braun and Clarke seeking to address both aspects, first in their widely cited paper in 2006 (Braun & Clarke, 2006), and more recently in

a series of publications including a textbook providing a practical guide to doing thematic analysis (Braun & Clarke, 2019, 2021, 2022).

Thematic analysis, with its aim being to identify patterns of meaning in qualitative data (Braun & Clarke, 2006), was identified as being the method of analysis most appropriate for addressing the research question and aims of this exploratory study. Far from describing one distinct method however, the term 'thematic analysis' (TA) represents a range of approaches underpinned by different epistemological and theoretical perspectives (Joffe, 2012). Selecting the most appropriate approach to TA for this study was therefore an important task in ensuring methodological integrity.

The 'family' of TA approaches are considered to be methods as opposed to methodologies (Joffe, 2012; Braun & Clarke, 2022), and as such are not tied to any particular theoretical or conceptual frameworks. Whilst there is flexibility in the way TA methods are applied, they are *not* atheoretical. It is therefore incumbent upon researchers to locate their approach to TA within a theoretical framework (Braun & Clarke, 2022).

Braun and Clarke separate approaches to TA into three categories; *reflexive* TA, *codebook* TA and *coding reliability* TA. Selecting the approach to this study involved gaining an understanding of each category including their underpinning philosophical perspectives. Approaches that Braun and Clarke argue fall within the 'coding reliability' cluster are situated within a 'small q' framework, adhering to positivist concepts of reliability with the analytical aim of reaching a bias-free, objective 'truth'. They are more structured than RTA and are typically guided by a coding frame or 'codebook' – a feature shared with 'codebook' TA approaches (Braun & Clarke, 2022). The final stage in the coding process involves a measurement of 'coding reliability' which assesses the accuracy and reliability of the process and the resulting codes (Braun & Clarke, 2022). 'Codebook' TA approaches such as framework analysis (Ritchie & Spencer, 1994) are described by Braun and Clarke as 'medium Q', sitting between coding reliability and reflexive TA and combining the values of qualitative research with more structured approaches to coding and the development of themes (Braun & Clarke, 2022). Neither 'codebook' nor 'coding reliability' approaches to TA were viewed as being comprehensively consistent with this study's theoretical framework, namely its conceptualisation of understanding, its acknowledgement of subjective realities and its recognition of the value and contribution of the insider researcher.

Reflexive Thematic Analysis (RTA) was selected as the TA approach that would be used for this study. RTA is the most recent iteration of Braun and Clarke's approach to thematic analysis, being first articulated in 2018 (Braun *et al*., 2018). Its evolution was further described in their 2019 article *reflecting on reflexive thematic analysis* (Braun & Clarke, 2019). Described as sitting firmly in the 'Big Q' approach to qualitative research, the core principles and features of RTA were considered to align well with all aspects of the basis for this study – its position as practice research, undertaken by an 'insider' researcher and informed by Gadamer's perspectives on understanding. The central feature of RTA and what distinguishes it from other forms of TA is the centrality of the researcher's role in the production of knowledge. RTA "emphasises the importance of the researcher's subjectivity as an analytic *resource*, and their reflexive engagement with theory, data and interpretation" (Braun & Clarke, 2020, p. 330). RTA as described by Braun and Clarke rejects the incorporation of positivist notions including that themes reside within the data and 'emerge' as analysis progresses. Rather they emphasise the researcher's role in *generating* themes, acknowledging their position and situatedness.

RTA comprises six *phases* which Braun and Clarke have reviewed and updated to reflect their more recent thinking. They are data familiarisation; coding; generating initial themes; developing and reviewing themes; refining, defining and naming themes; and writing up (Braun & Clarke, 2022). The process is deliberately described by Braun and Clarke in terms of *phases* as opposed to *steps*. *Steps*, they argue, evoke a "clearly segmented" path up or down, implying a linear, unidirectional approach (Braun & Clarke, 2022, p. 34) which I agree did not describe my experience of undertaking RTA.

4.6.2 Phase One: Familiarisation with the data

In this first phase of RTA, the aim is to become intimately familiar with the dataset through both immersion and critical engagement (Braun & Clarke, 2022, p. 42). Familiarisation began during the process of data collection. Conducting every interview myself was of significant value as I was immediately immersed in the participants' stories. I began also to engage critically with the data as I reflected on each interview. I noted my analytic observations, recognised and made sense of my own thoughts and emotions and began to develop analytic insights as I noticed similar and contrasting ideas. Familiarisation was further enabled through the transcribing of each interview.

After completing each transcription, the process of critical engagement continued as I wrote summaries of the participants' stories highlighting aspects of their experiences that were important to them and interesting in relation to the research question. Prompted by Braun and Clarke's recommended questions to ask of the data, I noted the meanings participants made in relation to their experiences, the assumptions they made in their descriptions, the kind of 'world' revealed in their accounts and how socially normative their depictions were (Braun & Clarke, 2022, p. 44). The summaries of each transcript incorporated my initial reactions to the narratives in order that a reflective and reflexive approach was maintained. Samples of transcript summaries are included in the appendices (appendix 11, transcript summaries).

The process of moving back and forth between the whole of the dataset and its parts – i.e. each transcript - began in this phase. Being close to and immersed in the data through listening back to interviews, transcribing the data and re-reading transcriptions was a priority. This phase prompted the greatest degree of emotional response in me as I was engaging with the stories without the pressure to formulate questions as in the interviews. At times I reflected on my own experiences in practice, and on one occasion this was confronting and exposing (RJE2, appendix 12). I felt guilt and shame when I questioned whether my response to assaults on nurses had always met their needs. This emotional response and reflection had the potential to influence my interpretation and analysis. The guilt and shame I felt due to the idea that I might have been perceived as uncaring could have led me to seek to defend managers that were described as unsupportive. This reflection shone a light on my experience as an insider-researcher and reaffirmed my decision to select a method of analysis that places emphasis on the requirement for openness and continuous, honest reflection and reflexivity.

Whilst the process of going back and forth prioritised remaining close to the individual data items, questions relating to similarities and differences in meaning began to arise, particularly as I summarised the transcripts and moved to consider them as a whole dataset. An interesting reflection of the familiarisation phase was the scope for noticing nuance through interacting with the data – or *fusing horizons* - in different ways. The experiences of interviewing the participants, listening to the interviews, transcribing and finally re-reading the transcripts led my understanding to evolve. I noted an example of this in my journal (RJE3, appendix 12) when returning to a transcript led to deeper insight into the

impact of the assault on the participant. Through re-reading the transcript, the extent to which being assaulted had affected her as a human being became clearer. I noted in my diary that *"I saw a real shift in the way the participant spoke and the emotional content of her speech – I think at the time I interviewed and then transcribed I noticed and 'heard' the words but perhaps not the change in tone and flow".*

Nowell *et al. (*2017) refer to 'prolonged engagement' with the data as a means by which rigour can be enhanced in the data familiarisation phase of TA. This was felt to be important in view of the study's rich data and the requirement for ongoing reflection and reflexivity given my position as a researcher. Due to the COVID-19 pandemic and increased clinical commitments, coding did not begin immediately after the final interview was undertaken. The experience of having time away from the data was valuable in relation to the analytic process. I identified with Smythe's belief that "walking away from the research is to open the space where thinking is free to come" (Smythe, 2019, p. 5). Leaving my desk and computer screen and allowing myself to reflect on the transcript/s I had just read became a regular activity. I found that ideas and insights came more readily, and I captured them by making notes or recordings on my phone.

Braun and Clarke (2022) caution against spending *too* long in the familiarisation phase, citing anxiety about coding and striving for a complete understanding of the data as reasons researchers may not move on. I related to both these hypotheses and reflected on my hesitancy to progress to coding in my journal (appendix 12, RJE4). There appeared to be two reasons for this - the fear of *"getting it wrong"* and enjoying *"creative open space"* that the familiarisation phase represented for me. I was reassured by the idea that familiarisation was about gauging "the lay of the land" (Braun & Clarke, 2022, p. 49) and that while coding meant moving into a systematic process, it was subjective, organic and evolving.

There were several outputs from this phase of data analysis. I was able to broadly describe the content of the dataset. I had started to identify features of the data that were interesting in relation to the research question and aims, and had begun to get a sense of possible patterns in – and differences between – meaning. I was confident the transcripts reflected the interviews accurately, and the transcript summaries produced during this phase provided a record of early analytical insights.

4.6.3 Phase Two: Coding the data

This section describes and illustrates the process used to code the data. Key considerations for coding in RTA are discussed and reference is made to how rigour was demonstrated. As there was a degree of overlap between the coding phase and phase three, the final set of codes are presented in the 'generating initial themes' section.

Whilst coding is a practice common to many approaches in qualitative analysis, its conceptualisation and application varies. More positivist-leaning approaches to TA (e.g. Boyatzis 1998; Crabtree and Miller, 1999) conceptualise coding as a process by which evidence for pre-existing or pre-determined themes are *found*, whereas other approaches, including RTA, see codes as analytic entities that are *developed*, and form the building blocks for analysis (Braun & Clarke, 2021). In RTA coding is described as "the process of exploring the diversity and patterning of meaning from the dataset, developing codes, and applying code labels to specific segments of each data item" (Braun & Clarke, 2022, p. 53). In parallel with how Gadamer views dialogue – be it with another human being or a text - Savage (2000), in his conceptualisation of *understanding,* sees coding as a means of *interacting* with the data. This idea of an interaction or dialogue was enacted during the coding process in this study. I responded to the data, asked questions of it and reflected on the ways in which it shaped my evolving understanding - or *horizon*. Braun and Clarke's (2022) notion of the researcher as active and creative reflected my experience.

The process for coding varies both across qualitative analytic approaches and within TA. RTA sees the coding process as "organic and evolving", with codes being reviewed and refined as insights and understanding develop through, as Savage (2000) described, the interaction with the data (Braun & Clarke, 2022, p. 54). Unlike the approaches termed by Braun and Clarke as 'coding reliability' TA, the focus is not on the *accuracy* or *reliability* of coding as these concepts are incongruent with the recognition of subjectivity, context and situatedness in 'Big Q' qualitative research (Braun & Clarke, 2021). Neither does coding in RTA use coding frames or codebooks to structure coding. That said, coding in RTA is systematic and rigorous, and the specific methods for ensuring trustworthiness are incorporated into the sections that follow.

Principles for coding in Reflexive TA

As a strategy to support and maintain adherence to the approach, the core principles of coding in RTA, as discussed in Braun and Clarke's recent publications (Braun & Clarke, 2019, 2022), were summarised in a Word document (see table 10). The points in this summary are incorporated into the descriptions and discussions in this section.

The summary was printed and regularly referred to during the process with the aim of maintaining focus and aiding reflexivity. Given *Reflexive* TA's very recent articulation (Braun & Clarke, 2019) the summary was also a helpful reference point in supervision to the approach during coding discussions with supervisors. Particularly pertinent was Braun and Clarke's perspective on the roles of additional coders, which is outlined later as the process is described.

This section will now move on to describe the process taken in this study, beginning with choices made regarding the mechanics of coding, the orientation to the data – *inductive* or *deductive* – and the level of coding – *semantic* or *latent*.

Table 10: Summary of key principles, values and ideas that form the basis for coding (summarised from Braun and Clarke, 2022: Chapter three)

Coding is...	-Engaged and systematic -A rigorous process -Never purely inductive due to researcher influence -Organic and evolving -Subjective and shaped by what we bring to it -Often completed by a single researcher - multiple coders can help to develop richer and more complex ideas, but the aim is not to reach a 'consensus' -On a continuum from inductive (data driven) to deductive (researcher or theory driven) -Also on a continuum from being semantic (surface level meaning) to latent (more implicit, deeper meaning)
Codes are...	-Singular ideas (not multi-faceted like themes) -Often semantic initially -To be evolved - supports more nuanced meaning and the identification of similarities and patterns -Not ontologically 'real', therefore cannot be 'right' or 'wrong'
In RTA coding the researcher should...	-Code only data relevant to the question -Not 'leap ahead' to developing themes - this risks foreclosing the analysis

The mechanics of coding

The decision as to whether to use qualitative data analysis software was approached critically; weighing the potential advantages of its use against the potential disadvantages or limitations and considering these in the context of the study's methodological approach and choice of method (St John & Johnson, 2000; Braun & Clarke, 2022). The potential benefits cited in the literature related mainly to increased efficiency, convenience and time saved; improved flexibility and thoroughness in the management of large amounts of qualitative data; and increased 'visibility' providing a basis for demonstrating validity and credibility (St John & Johnson, 2000). The arguments related to the risks or disadvantages of using data analysis software, particularly when applied to the approach to this study, proved to be more persuasive. St John and Johnson (2000) highlight risks as including shifting the focus from meaning to quantity, and distancing and distracting the researcher from the data. This led me to question the impact this could have on reflexivity – if there was a greater degree of separation then the researcher's ability to recognise their influence and therefore make informed decisions would likely be impaired. Their perspectives are echoed in more recent literature (Holloway & Galvin, 2017; Cypress, 2019), and whilst the potential benefits were acknowledged, the priority for this study was to maintain close, creative and active engagement with the data.

I chose to code the data on the electronic versions of the transcripts rather than printing them out and coding by hand. This decision meant I had electronic copies – Word documents - of coded data to share with my supervisors, and this was important as COVID-19 restrictions meant that face-to-face meetings were not possible. It also meant I could keep versions of transcripts from each round of coding in order that I maintained an audit trail.

After the final round of coding, codes were transferred to one document, printed and cut out so that they could be grouped, moved and organised. This visual, active part of the process maintained a sense of engagement and creativity.

Coding characteristics; inductive, deductive, semantic and latent

Braun and Clarke argue that whilst a project's orientation to coding is determined by its purpose, inductive and deductive approaches should not be thought of as dichotomous, rather as being either end of continuum (Braun & Clarke, 2022). Indeed, studies frequently

code both inductively and deductively (Trainor & Bundon, 2020; Byrne, 2021). Semantic and latent coding have a degree of alignment with inductive and deductive analysis. Theoretical, or deductive, codes tend to be more latent; data driven or inductive codes more semantic (Braun & Clarke, 2022).

The primary focus of the study was the nurses' experiences, and the aim was to ensure the codes captured the meaning that those experiences held for them. As coding began, the priority was to capture the nuanced meaning for the individual – to use their words and represent their perspectives. Doing so is recognised by Braun and Clarke (2022) as a typical feature of initial coding – particularly by less experienced researchers. I experienced incorporating the language used by participants as reassuring – I was able to clearly see initial codes as being grounded in the data. Examples of these early semantic, inductive codes are given in table 11 below.

Table 11: Example of early semantic/inductive coding

Data extract	Initial code
P2 "I was just left to crack on with it… yeah… you're just another number…"	Left to 'crack on' after assault I was just another number
P6 ..."and so my confidence was gone for a long time, I didn't feel as if what I was doing was good enough, I was second guessing myself"	Reduced confidence left me second guessing myself I'm not good enough
P9 "...because my life was in danger - because she was intent on killing me..."	She was intent on killing me

I identified with what Braun and Clarke (2022, p. 58) describe as a misconception; that semantic coding is more 'respectful' than latent coding as it captures what is there as opposed to looking for meaning beyond the data. I recognised that the emphasis cognitive-behavioural theory places on idiosyncratic meaning was influencing my perspective, and I reflected on this in my journal (appendix 12, RJE5).

To begin with, coding in this study was predominantly inductively driven and semantic in nature. As my confidence grew and I began to refine codes, the number of latent and both

theory and researcher-driven, deductive codes increased. For example, a repeating pattern in the data caused me to draw on knowledge relating to theories of dehumanisation (Stollznow, 2008), and begin to interpret what was being expressed with these theories in mind. The phrase "I was just a number" was repeatedly used by participants to describe the way in which they believed they were thought of by their managers. Not only did it point both explicitly and implicitly to perceptions of value and worth – but it also expressed a sense of being perceived as 'less than' human. The code *'Dehumanised'; I was just a number* was used to capture this latent meaning.

A further example of deductive, and *theory*-driven coding was when, guided by cognitive-behavioural theory (Beck, 1979), I searched for both explicit and implicit links between emotions and cognitions and endeavoured to represent these in the codes. I was particularly conscious of this when it came to the expression of shame. For example, the suppression of emotions following assault was interpreted as being driven by anticipatory shame, with the implicit assumption being "*if I show I'm anxious then they will see I'm weak*/*I'm a failure*". When this was the case, the code a*nticipated shame means emotions must be concealed* was applied to the data.

Latent coding takes the analysis beyond description and the explicit meaning and requires the researcher to take a more active and creative role (Byrne, 2021). As I began to consider more latent codes, I was conscious that in doing so I risked moving more towards the development of themes. 'Jumping ahead' too early is warned against by Braun and Clarke as the 'identification' of themes very early on risks underdeveloped themes and analytic foreclosure" (Braun & Clarke, 2021, p. 9). Being mindful of not jumping to theme development therefore impacted the extent to which I felt confident in moving to latent codes and exploring implicit meaning. However as analytic insights developed through making notes, discussing ideas and moving between individual transcripts and the dataset as a whole, I grew in confidence. Latent coding developed particularly where it was apparent that there were patterns of meaning being conveyed in different ways. One example was the feeling of isolation participants expressed after being assaulted. Participant 1 had not used the words 'isolated' or 'isolation', however implicit in the data was a sense of isolation as he described his reduced confidence and withdrawal from contact with patients, and his efforts to try to fit in after feeling criticised and unsupported by managers and colleagues. The code '*nurses can feel isolated after an assault'* was

developed and used to code data where this was explicitly and implicitly seen. The data extract and journal entry relating to this code are presented below in figure 3.

Figure 3: P1 data extract and corresponding journal entry

Data extract
P1: ...and then I kind of spent a lot of time in the office trying to avoid patient contact… due to kind of just wanting to avoid that conflict. And then trying to appease my peers… because my face didn't fit but I needed to do something…
Journal entry
I am coding participant one now and writing down my observations and thoughts as I read. I came back to it today and felt a real sense of him being isolated. It was not something I had thought the first time I had started making notes. But this time I really saw it in what he was saying. And I then couldn't help asking myself if I had seen this in other interviews. I definitely had, but for different reasons.

The development of this code illustrates the way insights develop through prolonged engagement with the data. It also relates to a further example of latent code generation. I began to establish links between the expressions of isolation and the experience of anticipatory shame as referred to earlier in this section. Participants did all they could to prevent others from seeing the emotional impact the assault had had on them. On further reflection and reviewing of the dataset, the link between anticipatory shame and feeling isolated became apparent. Both suppressing emotions and withdrawing in order to 'conceal' them meant participants were alone with their feelings e.g. *P2 I was struggling, alone*. The code '*anticipatory shame leading to isolation'* was the product of this analytic process.

To summarise, inductive, semantic codes, representing the surface level or explicit meaning of the data (Byrne, 2021) dominated the codes generated in this analysis.

The coding process

The coding process in this study consisted of three rounds of coding followed by the bringing together of all codes for ongoing review and refining. The end of the coding phase and the beginning of the developing themes phase were not distinct as a significant proportion of the refining of codes took place during the process of categorisation. This is discussed later in this section.

The first round of coding began with participant 1 and I coded all sixteen transcripts in turn, pausing at the halfway and end points for reviews with my supervisory team. Coding involved going through each transcript line by line and applying code labels where I considered the data could contribute to addressing the research question and aims (Braun & Clarke, 2020a, p. 42).

Alongside coding the data electronically on Word documents, I made handwritten notes containing my thoughts, insights and questions relating to the data contained in each transcript (an example of these is provided in appendix 13). I also recorded my observations on the *process* of coding in my reflexive journal. One of my first observations on the process, was that as I progressed through the dataset, the number of codes I applied reduced, and I became more consistent with the words I used to form codes. This indicated a greater degree of confidence in coding selectively – i.e. in relation to the research questions – and an increasing familiarity with patterns in meaning I was identifying in the data.

Coding was reviewed together with my supervisors at the halfway and end points of the first round of TA. The role of multiple coders in the case of RTA – and in this instance supervisors reviewing sections of codes – is to develop the insights such that they become richer and more nuanced. It is not to achieve agreement, consensus or *intercoder reliability* which is described by O'Connor and Joffe (2020) as a feature of 'small Q' qualitative research. Instead, the discussions in supervision aligned with Gadamer's *fusion of horizons* in that they represented the coming together of additional horizons, broadening the perspective from which I approached the data and making assumptions transparent. For the reviews of coding during supervision, I extracted sections of data together with the codes that I had attached. To ensure we were approaching the process from the same perspectives, we revisited the key principles of coding in RTA (above in table 10) prior to each of the discussions. During one discussion, we reviewed the coding in table 12, below.

Table 12: Participant 1, data extract and coding

Participant 1	**Codes**
Page 7 P1: Yeah. I kind of thought well, a) they don't value me as a nurse and they're not investing here in me… and I	 -Not valued as a nurse -Not investing in me

really felt let down by the kids as well. I was, like, here I am trying to open this space for you and to kind of give you this positive experience and you, you know, you've essentially assaulted me and treated me like rubbish.	-Let down by patients -Tried to care yet assaulted -Treated like rubbish [by patients]

The discussion centred on the code '*let down by patients'*. Perspectives I had not considered included that this may speak to an unrealistic, or 'naïve' expectation that in nursing, attempts to help, or acts of care, will consistently be met with gratitude and thanks. Also that naivety in this context could be represented by the assumption that expectations or 'rules' from life outside forensic services can be translated or applied to this setting. This discussion prompted me to make a link between earlier comments the participant had made including "*I thought it was going to be this really nice, fluffy therapeutic environment, and it quickly transpired, actually no...".* It also led to an insight into the relational aspect of being assaulted – and specifically the realisation that doing positive things for patients does not preclude you from being assaulted. This influenced the later development of the code '*a good therapeutic relationship does not protect against assault'.*

After completing the first round of coding, I returned to Participant 1 and compared the coding with transcript sixteen, identifying separate codes that spoke to the same meaning, for example "*assault can be in a look*" (P1) and "*assault can be unspoken*" (P16). I also identified coded sections of data that were not directly related to the research question, for example participant 3's description of his career progression, participant 10's perspective on the use of seclusion and participant 12's description of a person he nursed some years prior to the assaults. As a result, I made the decision to revisit and refine the codes in transcript one in order to establish the extent of the refining required, and I used this experience to inform my coding in the second round. I reduced the number of codes in transcript 1 from 210 to 140, though this included instances (n = 8) where the same code/code label was applied more than once.

I then completed a second round of coding, and as recommended by Braun and Clarke (2022), changed the order in which I coded the transcripts with the aim of creating a more evenly coded dataset. I coded from transcript 9 to 16 and then from transcript 8 to 1 alternately. The second round of coding saw a more selective approach to sections of data, more consistent wording, and as discussed previously, increased analytic activity resulting in

an increase in latent coding. I noted my observations during the second round of coding in my reflexive journal (provided in appendix 12, RJE6) with a coding example.

On completion of the second round of coding, the codes for each transcript were reviewed for a third time. My increased familiarity with the more regularly applied codes meant I could further consolidate some of the terms used. During this review I also removed further codes that were not directly related to the research question.

Looking across the codes over a more condensed period of time meant that I viewed the dataset as a whole to a greater degree. I found that I was able to make sense of patterns of meaning that I had been finding hard to 'capture' in a code label. An example of this related to the code '*expected does not mean normal*' and was the focus of the journal entry in appendix 12 (RJE7).

A further example of analytic insight – and one which reflects my situatedness as a researcher, related to the language used in describing assaults on nurses. I had begun to recognise patterns in words and phrases used by participants that served to downplay and normalise assaults (e.g. "low level spitting, biting, kicks..." and "the occasional punch"), however there was one term that I had missed in early coding. Participant 2 used the term "acuity" as she described volatile periods characterised by high levels of violence and aggression. The entry in appendix 12 (RJE8) was made as I made links between this data, other data extracts and the experience I was bringing to the data.

Following the third review, all codes were copied onto a separate Word document and the process of further reviewing, amalgamating and refining codes began. At this stage in the process there were a total of 1517 codes/code labels. The number of codes for each transcript was between 26 (transcript 12) and 168 (transcript 6). The mean number of codes was 95, and the median was 97. The variation reflects the extent to which the data were relevant to the research question and aims, and specifically the richness or 'thickness' of the data i.e. how much participants said in relation to the focus of the study.

As earlier stated, there was not a clear distinction between the end of coding and the beginning of theme development. I knew I needed to further refine and amalgamate the high number of codes, and this required me to begin to cluster codes according to similarities in meaning. I questioned therefore whether I was beginning to categorise the codes, an activity described by Braun and Clarke during phase three (Braun & Clarke, 2022). It was helpful at this point to refer back to Braun and Clarke's descriptions of RTA as "open,

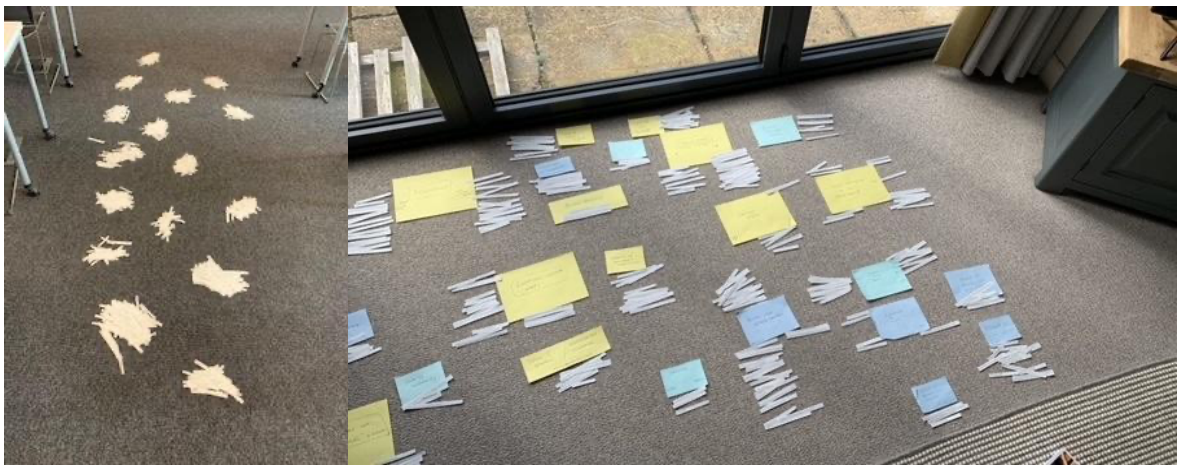
exploratory, flexible and iterative" (Braun & Clarke 2019, p. 593) as opposed to the more structured, linear 'coding reliability' approaches (e.g. Boyatzis, 1998). They argue that good quality RTA is not represented by the 'correct' following of procedures, but more by the researcher's "reflective and thoughtful engagement with their data ... and with the analytic process" (Braun & Clarke 2019, p. 594). Being clear at this point about the stage of analysis and the purpose of the activity was what was important, and this stage represented the somewhat blurred transition from coding to theme development. This was further supported by the idea that "coding is never completed, because meaning is never final" (Braun & Clarke, 2022, p. 71). This blurred transition makes describing the activity under the distinct headings of each phase a challenging task – indeed the refining of codes continued through to the writing-up phase.

In order to cluster the codes according to similarities in meaning, all 1517 codes were printed out and the transcript numbers from which each code came were written on the back (see image 1 below).

They were worked through one by one, and similar codes/code labels were grouped and duplicates that featured in the same transcript were removed (see figure 4 below). This process reduced the remaining codes to 1300. I was initially hesitant to 'discard' any codes/code labels, but felt reassured knowing each iteration of coding had been saved, and therefore the original codes could therefore be returned to/searched if required.

Figure 4: Images of printed codes (1) and clustering process (2)

1 2



The process of arriving at the final codes was lengthy and required sustained focus and attention. An extended period of leave was taken in order to limit distraction and enhance the depth of my engagement.

As categories formed, the temptation to begin to consider potential themes was apparent. Conscious of the purpose of this stage in the process, the 'pull' to move to theme development was managed by making analytic notes as categorising codes continued. These notes would then support the development of candidate themes later. Examples of theme notes are contained in appendix 14.

During one period of reflection, I identified with the descriptions of the 'messiness' of thematic analysis at this stage – both figuratively and literally. Whilst the forming of categories involved a systematic process of considering each code label one by one, the categories changed and evolved as more were added. Sub-categories were created to encompass different aspects of the same group, and some were later then collapsed. At one point I felt I was drowning in pieces of paper and ideas; instead of what I hoped would be a sense of the data coming together to form a story. It felt chaotic and confused. Taking a break from the process at this point was important as the feeling of being overwhelmed was hampering my ability to think creatively.

The process from beginning the second round of coding to arriving at the final codes took 21 days. 168 codes were generated and transferred to an electronic document together with a representation of original 'codes'/'code labels' that were associated with code, and the transcript number from which they originated. Table 13 below provides an illustration.

Table 13: Example of code with data

Code	Transcript number and original code labels
Criticism and scrutiny after assault	1 I was criticised; undermined by manager; managers scrutinised; boundaried approach criticised; expected support from colleagues was absent; colleagues undermined me; unempathetic colleagues 2 there is a stigma to being assaulted; we need to challenge the stigma 6 punished for the assault; management made me feel like I couldn't do my job 8 they tried to find fault with my actions 9 you're not performing 11 colleagues' initial criticism left me feeling offended, and sad; some colleagues first response was to criticise 14 there were some people that were kind, but there was a split

At this point, the analysis moved on to phase three of the process – generating initial themes. As with the transition from familiarisation to coding, the organic and evolving nature of RTA meant that I did not feel restricted by a linear process, rather I felt free to be creative, develop my ideas and move between analytic phases as required.

4.6.4 Phase Three: Generating initial themes

Previously referred to as 'searching for themes' the change in name reflects the shift in thinking away from the positivist notion of the truth being inherent in the data, waiting to be 'found'. Instead, this phase is seen as an active process undertaken but the researcher whose position shapes the outcome. Crucial to this phase was being clear about what constituted a 'theme' in RTA. Braun and Clarke (2019, 2022) describe a theme as "creative and interpretive stories about the data, produced at the intersection of the researcher's theoretical assumptions, their analytic resources and skill, and the data themselves" (Braun & Clarke 2019, 594). Rather than categories or summaries of data domains as may be seen in codebook or coding reliability TA, they represent patterns of shared meaning organised around a central concept.

The first task in this phase was to categorise codes; to group codes together according to similarities in meaning. This process began in the previous phase as I worked to consolidate similar codes by beginning to group them. I therefore took some time away from the analysis at this point in order that I could return to the remaining codes with a clearer perspective from which to generate initial themes. I developed initial themes by grouping the 168 printed codes according to shared meaning and noting potential theme ideas against the groups. I also drew diagrams to assist me and made notes recording where I thought there may be gaps or where codes could potentially fall into different groups.

The output from this phase was the first iteration of a theme map comprising five candidate themes titled "Alone in the aftermath"; "We may expect violence but it doesn't mean it's normal"; "Emotions under wraps"; "It's not okay to not be okay" and "Value/worth", and eighteen subthemes (a diagram of the first theme map is provided in appendix 15). At this point there were codes that I had not placed in categories and I added notes relating to these on the map for further consideration and discussion in supervision. An example related to the codes that referred to a lack of care following the assault. At this stage I was

unclear about where these would best fit, although I had made a link between these codes and the negative impact on self-worth that was evident in the data. I was also unclear about the theme I had provisionally titled 'Value/worth' as it represented a domain summary as opposed to a theme. As I began to consider this and other uncertainties, the process of developing the themes began and the analysis moved into phase four.

4.6.5 Phase Four: Developing and reviewing themes.

This stage of the analytic process saw the development of themes' central organising concepts and the establishment of not only the boundaries of each theme, but also the links between them. I reduced the number of themes to four, replacing 'Alone in the aftermath', 'It's not okay to be not okay' and 'Value/worth' with 'The meaning of assault and its impact' and 'The response to an assault can be make or break'. I also represented on the second iteration of a theme map the connections I saw between themes (see appendix 15 for theme map version 2). For example, one of the subthemes of 'The meaning of assault and its impact' titled 'Something about me?' was related to one of the subthemes of 'The response to assault can be make or break' titled 'Facing blame and criticism'. The former reflected nurses' questioning themselves in relation to the reasons they were assaulted, while the latter described the experience of being blamed or criticised by others following an assault. Therefore, whilst different in terms of how it originated, being assaulted prompted an undermining of nurses' self-confidence.

A first draft of brief theme descriptions was written as a means of clarifying their central ideas and focus (see table 14 below) and developing the analysis.

Table 14: Draft 1 of theme descriptions

Theme name	Description
The response to an assault can be make or break	The central organising concept for this theme is that the response mental health nurses receive following an assault on them greatly influences the impact the experience has on them. The most frequently expressed aspect of this idea was the absence of care nurses received after they had been assaulted, and that this was understood as forming part of the culture. As well as an absence of care, the experience of being criticised, blamed and held responsible was apparent within the dataset. This included criticism related to asking for/requiring help and support and included explicit and implicit suggestions of there being a stigma associated with being assaulted.

Emotions under wraps and crack on	This theme describes expectations of mental health nurses – both of themselves and placed on them by others – to be able to keep their emotional experiences under control, contained such that they are able to continue in their work. When, after being assaulted, these expectations are not able to be met, mental health nurses draw conclusions about what this says about them as nurses and people. The assumptions that seem to underpin these expectations are; 'a 'good/strong/resilient' nurse contains their emotions and carries on'; 'emotions/emotional expression is to be avoided because it is risky - exposes weakness/vulnerability and a lack of professionalism'.
The meaning of assault and its impact	This theme explores the meaning of the assault, highlighting the serious nature of assaults, the sense nurses make of being assaulted and the impact the assault has on them. MH nurses ascribe meaning to their experience during, and on reflection of, the assault. Patterns of meaning across the dataset, exploring at times contradictory perspectives, related to perceptions of personal safety, risk and control; attributions of responsibility, to both themselves and the patient; and more general ideas about the reasons patients may assault nurses in secure settings. In relation to the impact the assault had on the nurses, this theme describes the effect on the nurses' mental health, professional competence and identity, practice and behaviour with some effects being described as 'long-lasting'.
Expected does not mean normal	This theme comprises the attitudes to, perceptions of, beliefs about and experience of violence and assaults in secure mental health services. Mental health nurses, often setting out with a 'naivety' in their underestimation of personal risk, 'acclimatise' to violence and recognise the risk to themselves. In doing so, violence including assaults, are described as being expected and treated as normal, or 'coming with the territory'. Across the data, repeated ideas relating to the perceptions of others described assaults on nurses as being underestimated, rejecting the idea that assaults should be considered by others, and nurses themselves, as being 'part of the job'. One aspect of this idea was the view that normalising spoke to the worth of nurses as compared with other disciplines/professionals.

Describing the central concept for the theme 'The meaning of assault and its impact' presented a greater challenge than the other themes. Its subthemes, 'A traumatic experience'; 'Why do patients assault nurses'; 'Something about me?' and 'Lasting impact' reflected the nature of the assaults nurses experienced and the meanings and interpretations of both their personal experiences and more generally about violence and aggression in this context. On reflection, I realised my commitment to having these experiences accurately represented and clearly heard influenced my repeated attempts to

identify a central idea that brought them together. I returned to the paper codes and drew out further maps in an attempt to establish links and ensure the theme portrayed a coherent story. The result was that I was not satisfied the subthemes, when put together, formed a coherent story with clear boundaries. I therefore made the decision to retain the subthemes and consider their relationships to the other three themes. This process continued into phase five and was not completed until phase six began. At the end of this phase therefore I had developed three themes that were organised around central concepts, had clear boundaries and were grounded in the study's data.

4.6.6. Phase Five: Refining, defining and naming themes

The final two phases of analysis merged as I went back and forth between writing the report of the study's findings and refining the themes. During these phases I also further refined some of the codes until the final list of 127 codes was complete (the final code and theme list is included in appendix 16). It had not been anticipated that the refining of themes would continue in the writing up, however the task of communicating the findings in a coherent manner and with a clear thread to the narrative was found to form an important part of the method as discussed further in the following section. This is consistent with Braun and Clarke's (2022) assertion that the refining of codes and themes continues at all points of engagement in the process.

4.6.7 Phase Six: Writing the report

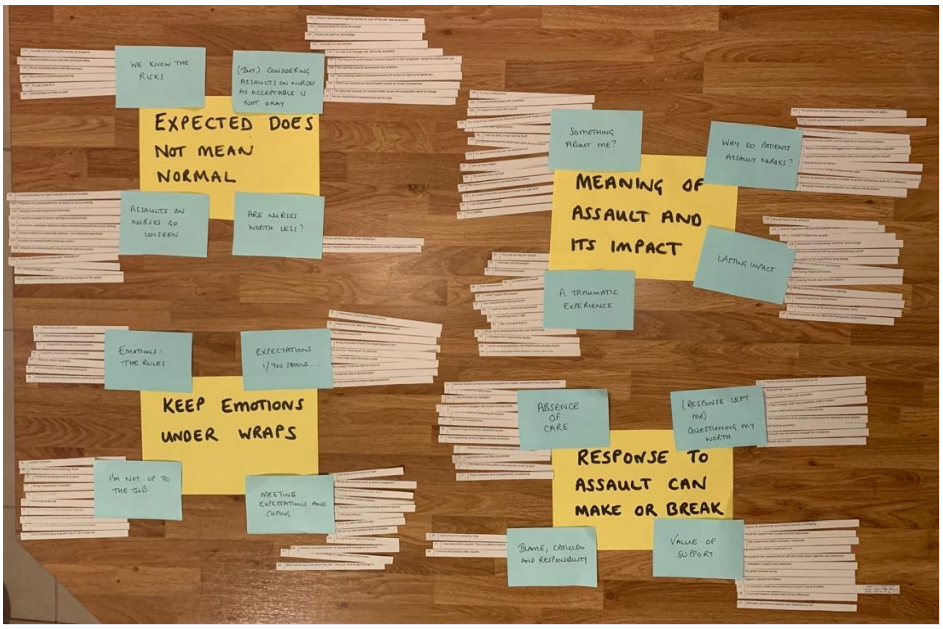
Braun and Clarke (2022) cite their preference for an integrated results and discussion section, with the analytic narrative being positioned within, and developed with respect to, other literature. This preference stems from what they see as implicit ideas underpinning the traditional model of separating findings from what the researcher makes of them. They do however acknowledge that there is no inherently right or wrong approach. In this thesis, the analysis and discussion are presented in separate chapters. The reason for this relates to the study's research question and aims, and its methodological approach. The analysis chapter reports the experiences of the participants, staying close to the data and reflecting the inductive and predominantly semantic approach taken. The aim is to illuminate the experiences of assaulted nurses, identifying patterns of meaning through interpretation. A constructivist perspective underpinned this process. The discussion then moves the analysis

towards a more critical/latent orientation, taking the analytic narrative beyond theme summaries and descriptions and locating it theoretically (Braun *et al.,* 2016). Data extracts included in the analysis chapter provide evidence for the analysis and illustrate the basis for the interpretations made. The balance of analytic narrative and data extracts in the analysis chapter is about 50:50, in-keeping with Braun and Clarke's (2022) recommendations for RTA positioned towards the inductive/experiential end of the spectrum.

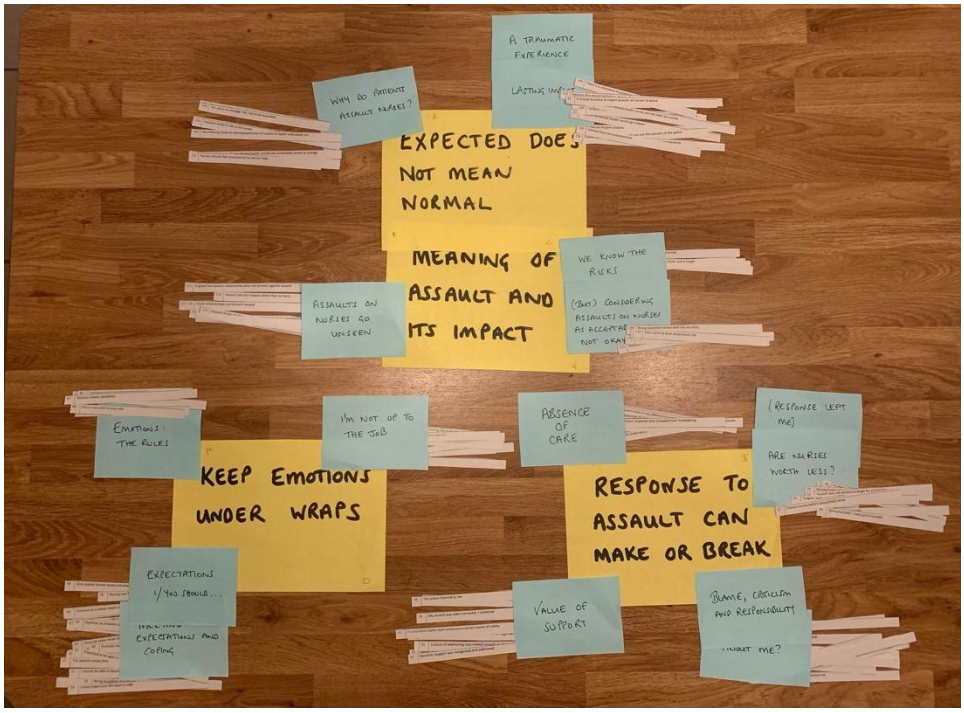
Consistent with other researchers' experiences (Trainor, 2020; Braun & Clarke, 2022), analytic activity continued during the writing-up phase, with ongoing refining of codes and restructuring of themes. After drafting the chapter for the first time, the theme "meaning of assault and its impact" continued to be problematic as it did not 'fit' in the narrative. Its boundaries were unclear and I was not confident about the central idea. These concerns were shared by my supervisors. At this point I returned to the paper codes, subthemes and themes and reconsidered their arrangement, relationships and the story they collectively told. As a result, I integrated the codes and subthemes for this theme into two others. Photographs of the original four themes and sixteen subthemes, and the way in which they were integrated are below in figure 5. The order in which the themes are presented was decided based on their relationships to each other and the story they told, and again this was finalised during this phase of the process. The final themes and subthemes are presented in the following chapter.

Figure 5: Themes pre (1) and post (2) final review

1



2



4.7 Chapter Summary

This chapter has described the methodological approach to the study, and the methods used to collect and analyse the data. The philosophical, theoretical, and conceptual frameworks that underpinned and shaped the study have been discussed and justified. The study's key ethical considerations have been explored, and the means of ensuring trustworthiness, with a focus on reflection and reflexivity have been explained.

The methods used in the study have been explained and justified, and their application described. The process of undertaking reflexive thematic analysis has been explained in detail with examples provided for illustration. The following chapter presents the results of the analysis.

CHAPTER 5: FINDINGS

5.0 Introduction

This chapter presents the outcome of data analysis undertaken for this study and details the three themes and eleven subthemes that were generated during the analytic process. Codes and data extracts are used to expound each of the themes. Each section begins by explaining the theme's central organising concept and key features. Congruent with the aims of the study - and as recommended by Braun and Clarke (2022) - data extracts form a significant part of the chapter, bringing participants' individual experiences to the presentation of the findings.

First, a theme map and summary give an overview of the results of the reflexive thematic analysis process.

5.1 Summary of the themes

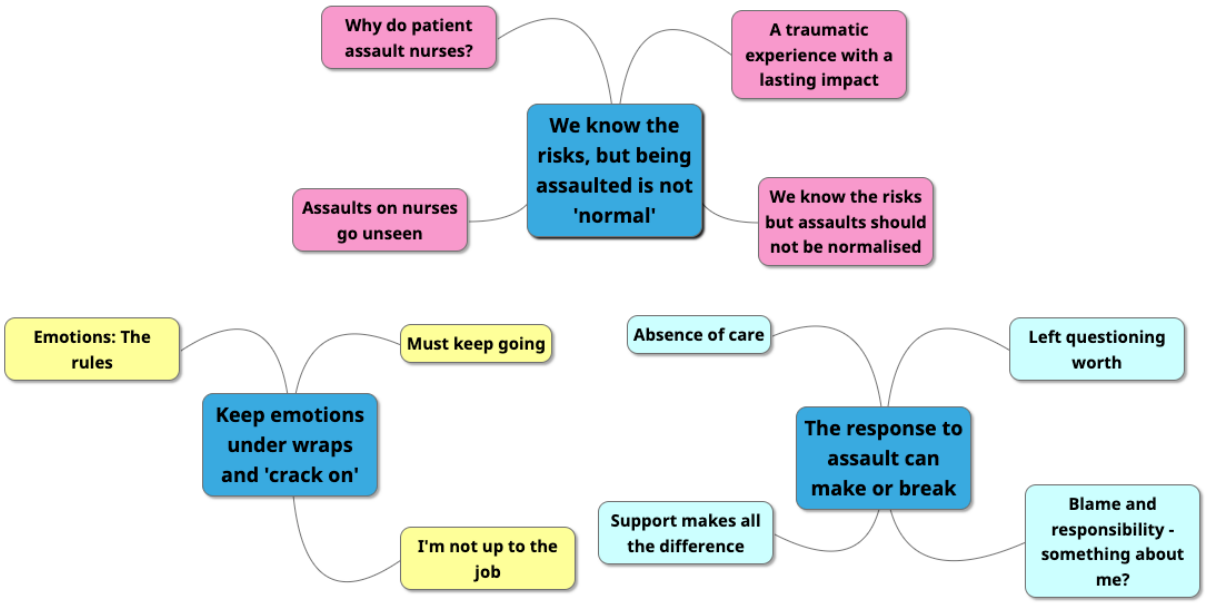
The three themes that were constructed were named as follows: '*We know the risks, but being assaulted is not 'normal''; 'Keep emotions under wraps and crack on'* and *'The response to assault can make or break'.* The table below (table 15) gives a brief summary of each theme.

Table 15: Summary of themes

Theme	Characteristics
We know the risks, but being assaulted is not 'normal'	Whilst mental health nurses seek to explain and understand assaults, they are often traumatic experiences which have a lasting and pervasive impact on their personal and professional lives. Nurses recognise the risk of being assaulted in secure mental health settings and describe 'getting used to it'. However, they simultaneously believe that talking about assaults as being 'normal' is problematic in that it implies assaults as acceptable in this context. This normalising and sense of acceptability contributes to nurses' experiences of assaults not being recognised or going "unseen".
Keep emotions under wraps and crack on	Experiencing and expressing emotions such as anxiety and fear following an assault is viewed negatively, and mental health nurses both expect and are expected to be able to suppress their feelings and continue to function as normal. Nurses who are not able to do so appraise themselves as weak and/or a failure.
The response to assault can make or break	Mental health nurses can feel uncared for, unsupported and judged in the aftermath of an assault. This leads them to question their value and worth, describing themselves as being seen as "just a number". When nurses feel validated, worthwhile and cared for, it has a positive effect on nurses' wellbeing, sense of safety and ongoing clinical practice.

The theme map below (figure 6) sets out the three themes described above and their corresponding subthemes. The 127 codes used to construct each of the subthemes and themes are contained in appendix 16.

Figure 6: Final theme map



5.2 Detailed presentation of findings

An overview of the themes constructed during the process of analysis has been presented. Each of the themes and subthemes are now described in detail, with data extracts used to illustrate throughout. The terms participants and nurse/s are used interchangeably throughout this chapter.

5.2.1 Theme 1: We know the risks, but being assaulted is not 'normal'

The central idea in this theme relates to the normalising of assaults on mental health nurses in secure settings. Participants recognised the risk of being assaulted and sought to make sense of this risk. There was a tension between the ways in which they believe assaults *are* and *should be* conceptualised, both by themselves and others. Whilst they said that it was expected, they rejected the idea that an assault in this context should be considered *normal*. Conflating the two implies a notion of acceptance, and this notion was rejected by participants.

The serious nature of assaults in relation to their physical and psychological impact is highlighted in this theme, creating a stark conflict with the normalising narrative. However, whilst nurses rejected this narrative, they described beginning their career naïve to personal risk, and then 'acclimatising' to violence. Nurses therefore described violence including assaults as expected, treating it as normal, whilst also opposing the narrative. Nurses felt angry when they perceived the risks they face to be underestimated by others, be they managers, police or society in general. A lack of understanding and recognition of the seriousness and impact of assaults on nurses by others was frequently voiced, and this contributed to a sense of isolation. Whilst being assaulted was recognised as being seen to be 'part of the job' both within and outside nursing, this was simultaneously implicitly and explicitly rejected.

This theme has four subthemes which, when considered in turn, reflect the story created through the process of analysis. The subthemes have been named '*why do patients assault nurses?'; 'a traumatic experience with a lasting impact'; 'we know the risks, but assaults should not be normalised'; 'assaults on nurses go unseen'.*

Subtheme 1: Why do patients assault nurses?

Participants described how they made sense of assaults on mental health nurses, drawing on both their own experiences of assaults and their experience in secure services more generally. First, they made the distinction between a non-intentional, psychosis-driven assault and an intentional, targeted, instrumental assault perpetrated by patients with diagnoses of personality disorder. Second, nurses considered the part previous traumatic experiences played in violent behaviour, including violence used as a means of rejecting

protection. Third, the gender of both patients and staff was considered by some participants to influence patterns and risk of assault. Fourth, nurses described the therapeutic relationship as *not* being a protective factor against being assaulted. Finally, nurses reflected on the qualities, behaviours and attitudes that reduced the risk of being assaulted, citing respect, fairness and honesty as being most important.

Some participants made an explicit distinction between being assaulted by a person who was diagnosed with a mental illness versus a personality disorder. This distinction centred on the perception that the latter group had a greater degree of control over, and responsibility for, their behaviour, and therefore assaults were intentional and interpreted as targeted and 'personal' acts which were more difficult to cope with:

> *"I just viewed it as like, you know, this, this wasn't him doing it, this was his illness doing it. So, you know, I've never borne any, you know, I've never thought about it as like, that it was personal."*
> *Participant 3*

> *"I think there's something about, somebody who's psychotic their connection with reality is very different. Their interpretation of their surroundings is very different. But there's an element of calculation and premeditation for somebody with a personality disorder, I think."*
> *Participant 2*

Whilst the 'mental illness versus personality disorder' debate was frequently evident in the discourse relating to factors affecting assaults, it did not reflect a straight-forward dichotomy as is generally represented in the literature on violence and aggression against mental health workers. Participants implicitly considered those with diagnoses of 'personality disorder' when they compassionately referred to the influence past traumatic experiences have on violent behaviour. An example of this contradiction is seen in the second extract from Participant 2:

"...we had a very robust formulation of her risks and why she behaved in the way that she does, so understanding the family dynamic… so that was incredibly helpful in terms of managing the difficult, violent incidents because we understood the position from where she was coming"
Participant 2

The language used by participants in relation to 'personality disorder' risked simplifying and misrepresenting the more complex and nuanced interpretations they made in relation to patients' violent behaviour. The nurses made a variety of interpretations relating to patients' reasons for assaulting them, often reflecting formulations incorporating past trauma and its impact on emotional regulation and interpersonal relationships. Some nurses described how they were assaulted as they acted to keep individuals safe and prevent or minimise self-harm, and others described violence as a means of communication/expression. Most did not consider the patient's primary goal was to harm them, and described understanding this as helpful for them:

"...experiencing violence while trying to stop people from hurting themselves, you know...being assaulted because people are trying to hurt themselves...instinctively our job is to save lives and not let them come to harm"
Participant 7

"I took it as when someone is aggressive that that's a sign of needing help as opposed to it being a vicious, intended thing"
Participant 14

"I knew that their goal wasn't to hurt me, and I think it's different if their goal is to hurt you isn't it, because the risk of what they're doing is greater if their intention is to hurt you, whereas their intention was to escape. So I think probably that helped."
Participant 5

The genders of both patients and members of the nursing team were referred to by participants as they offered perspectives on the prevalence, nature and factors affecting violence and aggression in secure mental health settings. The gender of the perpetrator was

seen by some participants as being an influencing factor. Violence among female patients was considered more frequent, and among male patients more serious, when it occurred:

> *"...aggression was definitely a thing on the female wards probably more frequently but perhaps less intense, but then working on the male wards you would tick along day by day generally nothing would happen but then when it did happen, it would happen big."*
> *Participant 13*

Interpretations made by a small number of nurses related to the presence of male staff as being both a protective and risk factor in relation to violence and aggression. Two participants felt reassured and safer with a male presence among the staff team, while the other saw benefits to an increased female presence and pointed to an increased risk of assaults among teams that were 'macho'. This perspective is interpreted as relating to an attitude and behaviour as opposed to an innate feature of the male gender:

> *"I think that's why I never really, you know, got injured or anything… that I always also understood that the patients, when they're making demands, you have to give them a way of saving face… there's, there's no point in, in mirroring that behaviour and escalating, which is what a lot of people do, because they think it's a macho thing to do…"*
> *Participant 3*

Participants talked about the part the interpersonal relationship they had with patients played in assaults, voicing two seemingly opposing perspectives. Most participants said that having a good therapeutic relationship with a patient did not preclude you from being assaulted by them. Participant 2 described her interpretation that the assault on her was an assault on the relationship itself, pointing again to the impact of trauma on relationship dynamics:

> *"I had a really strong therapeutic relationship with her… it was… when it was good and positive, it was really good and positive and we would move heaps* [sic] *and bounds*

forward. Um… but when it was bad then I felt, her escalation was a target, it was, yeah, she, I guess she threatened our relationship, targeted our relationship in that moment."

Participant 2

For some participants, including Participant 8, being assaulted in the context of a 'good' relationship was recognised as a possibility at the outset. For Participant 7 it came as a shock. Their perspectives are seen in the quotes below:

"I was actually the primary nurse to this patient and the day before [the assault] *he'd told me I was his favourite nurse ever, you know, like, you take that with a pinch of salt..."*

Participant 8

"I was like 'oh my god, she did that, despite the fact we've got a good relationship'"

Participant 7

Finally, a small number of participants referred to communication styles, values and behaviours that serve to reduce the risk of being assaulted. Respect, honesty and fairness were held as important principles guiding their approach:

"I'm a big believer - and always have been throughout my career - that I talk to people how I expect to be spoken to myself and I always tried to be honest with a sense of fairness to avoid big explosions in people. You know, 'you can't do this, and this is why, but we can do this' you know? So I didn't have many major incidents..."

Participant 11

This subtheme demonstrates nurses' understanding of assaults in the context of their roles. If it were to be seen in isolation, it could be assumed that by making sense in this way, assaults would be less impactful. Contrary to this assumption the data indicate that mental health nurses can experience assaults as highly traumatic and endure significant negative consequences, as is seen in the subtheme that follows.

Subtheme 2: A traumatic experience with a lasting impact

This subtheme captures participants' experiences of being assaulted. The assaults varied in their nature and the impact they had on participants. Interestingly, all participants talked about physical assaults despite 'assault' not being defined for the purpose of this study. This mirrors the nursing literature reviewed at the outset which was found to give physical assault primacy, without in some cases acknowledging other forms of assault. This relates to the criteria for determining 'harm' which was a feature of data contained under theme three.

Despite their descriptions of assaults as 'to be expected', many of the nurses were surprised and shocked by the assaults on them. They talked about their thoughts and feelings during and after being assaulted, describing a lasting impact on their mental health and their personal and professional lives and identities. In a small number of cases (*n* = 4) participants did not describe any significant physical or emotional impact post-assault. Patterns of meaning in their accounts related to their sense of safety and perception of risk, the extent to which they felt in control during the assault and their colleagues' responses during the assault.

Nurses described a range of physical assaults, the nature and degree of which varied both objectively and subjectively. The severity of some assaults is striking – and shocking – as are participants' descriptions of their thoughts and feelings. This highlights a disconnect between the somewhat sanitised discourse relating to assaults on healthcare workers and their lived experience. Examples of the descriptions participants gave are below:

> *"He cut my head open, he had a ring on, and he cut my head open. I probably received about seven or eight blows to the head, and to the face"*
> *Participant 1*

> *"He hit me over the head with a chair and I went down* [participant was 8 months pregnant]"
> *Participant 4*

"He'd pulled me down into his very immediate personal space and was pulling on my hair and was pulling my hair out...I'm on the floor, I'm stuck, I can't really move"
Participant 6

"I've been assaulted numerous times, you know, bitten, punched, kicked, spat at all of that but the main incident for me was I got stabbed through the face with a cutlery knife by one of the patients...it went in my cheek and into my mouth"
Participant 8

"The patient threw 2 pool balls at my head, one embedded in the wall, and the other one smashed in half"
Participant 11

Many of the participants described the assaults they experienced as serious and potentially life threatening/changing, recognising this either during or after the event:

"When I look back now I think, God, it could have been, I could have literally died..."
Participant 8

"I'm in danger, my life's in danger, the staff can't get her off me."
Participant 9

"I was very aware for a long time that, you know, that was the day that had things gone differently I may not have been around after that or I may have been eating things through a straw for the rest of my life."
Participant 11

The extent to which nurses described their experience of being assaulted as traumatic varied, and was frequently influenced by the response they received in the aftermath, as is later explored in the theme *the response to assault can make or break.* Those that did not describe their experience as traumatic – irrespective of the nature of the assault - spoke of having faith in their colleagues and their training, resulting in them feeling safe and in

control during and after the assault. As a result they had not thought about what could have happened had circumstances been different:

> *"...even though that's happening to me* [gestures ligature around neck] *I'm still in control. And hopefully, so are the rest of the team … the staff were always very, very quick to intervene if something happened to try and stop it going too far."*
> *Participant 3*

> *"...had he gone on and injured someone else, or had he come back at me then I think I would have felt different about it but by the time I'd sort of realised what was happening and* [my colleagues] *had appeared and restrained him all in one. So by the time I realised what was going on he was restrained on the floor."*
> *Participant 4*

> *"There wasn't a time, and I never ever thought "oh my God, she's going to kill me". I trusted my colleagues, I knew my colleagues were going to help me."*
> *Participant 9*

Where the assault was described as traumatic, nurses felt unsafe, out of control, powerless and helpless:

> *"...what seemed like a long time for the staff to be able to get him off me, 'cause we were on the floor and because of my position, because I'm like, he's got me here* [gestures – holding the back of her hair with face down], *as I'm on the floor so I'm stuck I can't really move."*
> *Participant 6*

> *"I kept thinking about when I was being held on the floor, how I wasn't able to move, you know, literally I was powerless in that situation, everything kept coming back to that."*
> *Participant 13*

Other contributing factors were described as help not being immediate, patients and colleagues being distressed, and fear being exacerbated by knowing the risk history of the perpetrator:

> *"And I think for a split second I thought could I die right now, could she…? And I think in terms of her ability to do it, yeah, I think she had, she has the ability to do it… she probably was capable in that moment of doing that"*
> *Participant 2*

> *"My colleagues couldn't get to me, she had hold of my hair and she was beating me like punching me in the back, slamming my head into the door. Eventually, it took around 20 to 25 minutes to get her off me, we'd even pressed the alarms. Nobody came."*
> *Participant 9*

> *"...in a way it was people's anxieties I suppose at seeing me on the floor that it was almost making it worse because they were sort of trying to desperately get his hands out of my hair..."*
> *Participant 13*

Nurses described a range of thoughts and feelings in the immediate aftermath of the assault. Several felt shocked and 'shaken' after being assaulted. Participant 4 felt shocked as she had been taken by surprise by the assault, but having quickly realised she and her baby – she was eight months pregnant – had not been harmed she described moving on easily, returning to work and not being emotionally impacted. For context, this assault on Participant 4 took place over 20 years ago, and current medium secure policy and risk assessment processes would require women to be given a role which minimised direct patient contact. Participant 13 described feelings of anger and rage, directed towards the patient who had assaulted her, for leading her to feel out of control and powerless. Many nurses described how they suppressed their thoughts and feelings in the aftermath, and this response is explored under the theme *Keep Emotions Under Wraps and Crack On.*

Many nurses said their experience of being assaulted had had a lasting impact:

> "*I mean I'm okay but it definitely left a mark, it was a really negative experience"*
> *Participant 1*

> *"I didn't recover from it. I didn't get over it at all"*
> *Participant 13*

The nature of the long-term impact participants experienced was wide-ranging. They described negative effects on their physical and psychological wellbeing, relationships, and professional lives. In their professional roles, nurses talked about their confidence being undermined leading them to question their clinical competence. More than ten years after being assaulted, Participant 1 attributed his preference for operational leadership over clinical roles in part to the way in which being assaulted affected his confidence in his clinical skills and abilities:

> "*I find that I worry too much about my own clinical judgement, so I second guess myself a lot of the time now. And I shouldn't because I'm a good clinician… I know I'm a good clinician…"*
> *Participant 1*

Other participants described similar consequences for them, acknowledging that the impact on their confidence was significant, leading them to doubt their ability to undertake routine tasks:

> *"...it really did affect my confidence as a person and as a nurse and as a leader. I wasn't just a nurse, I was a leader, you know"*
> *Participant 6*

> *"I'd be doing medication and I'd be like "what you doing this for? You're not qualified to do this?""*
> *Participant 9*

Some participants linked their decreased confidence to an ongoing sense of threat which led them to feel anxious and experience panic in some instances. Several participants described heightened vigilance which in two cases was viewed as an adaptive, 'normal' response. For others the impact went beyond increased vigilance with enduring feelings of anxiety being experienced for significant periods of time after the event. Participant 9 talked about how she felt in the months after the assault, and Participant 14 described how she felt when, some years later, she saw a member of staff who had been present during the assault:

> *"I was terrified of going to work, I'd sit and cry in my car, uh, before going on to the ward."*
> *Participant 9*

> *"I felt just quite panicked when I saw him because that's what he reminded me of - that incident."*
> *Participant 14*

The anxiety Participant 8 felt resulted in her resolving never to return to work in a secure mental health setting:

> *"The thought of working on a ward again fills me with absolute dread."*
> *Participant 8*

The impact the assault had on the therapeutic relationship with the perpetrators was discussed by over half of the participants. Most described a negative impact, with only two of the nurses saying the assault had not impacted the therapeutic relationship. The negative impact nurses described related to the way the assault had undermined trust, their sense of injustice and being 'let down', ongoing anger and/or fear:

> *"I didn't want to see him or speak to him. But he had said he was sorry. But to me that didn't really cut it. He had stabbed me through the face and sorry wasn't going to be any good."*
> *Participant 8*

For Participant 16, the meaning of the racially motivated assault – being spat at in the face in front of others – meant that she saw the patient in a different light. His actions meant for her that he despised her, he was "condemning" her. Participant 16's shame - related to her belief that she had been publicly humiliated - combined with a lack of any response from her colleagues and managers meant there was no discussion and opportunity for resolution:

> *"Did it make me hesitant about nursing him? Yes, I'd think twice, like if he asked for a one-to-one I'd think twice about it, yeah...I think I was a bit more careful around him ... afterwards I didn't find anything amusing with him anymore, as if to say how can he...how can he joke with me after spitting at me?"*
> *Participant 16*

Some nurses described the way they changed their behaviour to manage their feelings of anxiety and threat. One strategy was to withdraw, avoiding patients in order to avoid conflict. Reducing the sense of being 'out front' and therefore being a 'target' was important for some, undermining their confidence as leaders. Participant 6 spoke in detail about the ways in which she altered her physical appearance with the aim of "blending into the background". She changed her block heeled shoes for flat ones, stopped wearing make-up and dyed her hair dark:

> *"I think because I'd had a couple of assaults within a relatively short space of time, what felt like very targeted assaults, by two individuals, similar presentations, same service, zero support from managers, I literally changed everything about me. I needed to just disappear."*
> *Participant 6*

Participant 14 changed her behaviour believing she should stay away from escalating situations:

> *"I felt like I would be causing a lot more problems, and therefore by being reserved and away from things a bit more it would potentially be a way to stop that I suppose I thought."*
> *Participant 14*

Another example of the lasting impact being assaulted had on nurses was the need to take time off work, and for some their decisions to leave their jobs in the secure mental health setting. Contributing factors to sickness absence were described as anxiety associated with ongoing risk, physical injury and a lack of support. Five nurses made the decision to leave their roles in secure services, clinical practice and, in one case, mental health nursing after being assaulted:

> *"I remember when I left I was just like "oh I can breathe" … literally, I felt like a weight had come off my shoulders and it took me probably about two, three weeks in my new job just to kind of be okay and just go "actually I can breathe"."*
> *Participant 1*

> *"I love doing the* [new post], *I absolutely adore it but I think there's a part of me that really wanted it so that I wasn't dealing with those situations...I'm very aware – I've acknowledged - that it's actually meant that I'm not having to face those situations on a regular basis, and the chances of me having to face those situations are few and far between. So it became, it's been my safety net."*
> *Participant 6*

> *"I had to give up, I ended up giving up mental health nursing which in a way is a shame... But yeah, I had to retrain, and that was stressful, and it makes me sad that I had to give it up, but I don't have the passion for it anymore, it's been beaten out of me by experience."*
> *Participant 8*

Experiencing trauma in the form of an assault left some participants with lasting psychological and physiological effects. Participant 1 described low mood and decreased concentration alongside anxiety and fear. Participant 2 talked about how the vivid memory of being held around her neck remained distressing, impacting her sleep:

> *"I wasn't really sleeping very well. I'd wake up feeling like I couldn't breathe and pressure on my throat and neck. I couldn't button my shirts up to the top button*

anymore, still can't. I've got quite long hair and so if I slept with my hair open and it would be around my neck at any point throughout the night, that would wake me up."
Participant 2

The anxiety Participant 13 felt led her to experience panic attacks at work. She and Participants 8 and 9 developed post-traumatic stress disorder (PTSD) for which they received psychotherapy:

"Every time anybody asked about what had happened I literally was turning into a jelly mess on the floor, crying, sobbing, wailing and that was equally frustrating because I couldn't control it, and that wasn't me."
Participant 13

For some nurses, the impact of their traumatic experience had a negative effect on their relationships outside work:

"It's impossible to ever say to someone you leave your work at the door or you leave your home life at the door. You can't do that with human beings. On both occasions when I've been assaulted it's affected my home life quite significantly. I'm a single mum so there's no one to sort of buffer my emotion when I'm coming through the door."
Participant 6

"It impacts on my personal relationships as well. Over a period of time as well, because I distanced myself, people didn't know how to speak to me"
Participant 9

Participants also described distancing themselves due to their beliefs that others would not understand their experience given its context. This contributed to their sense of isolation – an aspect of nurses' experience that features in all themes:

"...I had people to talk to, but not any that was also doing a similar style of job, so it was just too much hassle to have to try to explain everything why things were the way they were and I hadn't got the energy. And I just thought it's easier to not bother and I just felt well… and my mood did drop quite a lot around that time as well, and I spent a lot more time bed-bound - not bed-bound - but house-bound. And just kind of doing things by myself I suppose."
Participant 14

Finally in this subtheme is the impact on nurses' sense of their professional and personal identity. Beyond the impact on confidence described earlier, nurses spoke in profound ways about how the assault experience changed the way they saw or thought about themselves. During data analysis, this effect was identified and coded both semantically and latently. The first quote below illustrates semantic meaning, and the second is an example of where latent meaning was identified:

"I'd get this wave of "they're going to come in and tap me on the shoulder and ask me to leave because I'm not a nurse"' ...And I'd be sat there some days and I'd be like "what are you doing? You're not even a real nurse". It was madness, um, but it's, it's imposter syndrome, apparently."
Participant 9

"I guess I see myself as quite a strong person, hold a lot of the team's anxieties and difficulties and most of the time quite well and at this point I felt like I had dropped the ball and I wasn't coping myself and, and to be told that you're experiencing trauma following something like this is really difficult, I found that really hard. I didn't want to be that person I felt."
Participant 2

Nurses spoke about both change and loss in relation to their identity after being assaulted.

"...that incident in itself really, really changed my whole perception really of how I am, how I was as a nurse..."
Participant 13

"In a way it's a grief, it's like anything because I'd lost... I've lost the person that I was before. So I'm slightly more cynical, I'm slightly more on edge, I'm slightly more hypervigilant, so in a way for me it was like a grieving process. I had to come to terms with the person that I was before that assault. I am not that person now."
Participant 6

This subtheme captures the stark reality of nurses' experiences, highlighting the pervasive impact being assaulted by patients can have. Their subjective realities are particularly striking when set against the narrative that assaults on mental health nurses are 'normal'. The following subtheme reflects participants' perspectives on this narrative.

Subtheme 3: We know the risks, but assaults should not be normalised

In this subtheme the tension between assaults on nurses being expected, normalised and accepted is exposed. Further, the lack of understanding and recognition of nurses' experiences heightens the sense of isolation nurses experience when assaulted. Nurses' perceptions relating in a more general sense to violence and aggression in secure settings are explored. Nurses recognise the risks of being assaulted but reject the normalising of assaults, and the resulting disempowerment of nurses, which impacts the extent to which nurses report assaults and ask for help. The normalising of assaults and its impact on nurses' experiences and the extent to which they are seen and understood is a common thread in all themes generated in this analysis. This subtheme focusses on normalising assault as it is perceived and experienced by nurses, with subsequent themes considering the impact of the normalising narrative and behaviours on their responses to being assaulted.

All participants spoke about violence, aggression and assaults as being a feature of their work in secure mental health settings, with many describing them as frequent:

"It's assaults on a daily basis, very much so"
Participant 7

"Oh god, it was daily, if not more... I've been assaulted numerous times"
Participant 8

Whilst not defined at the outset, the assaults participants talked about were exclusively physical in nature. There was however reference, in more general terms, to other forms of violence, aggression and abuse, namely 'verbal abuse' or 'verbal aggression' and 'racial abuse':

"it was something every day staff being injured or assaulted or verbally abused, yeah"
Participant 9

"We experience a lot of that as well, racial abuse"
Participant 7

"And there was a race issue as well. Mainly from the male patients. It could be out of the blue - you might have tried to intervene in something and there was always race brought in "don't talk to me" etc etc"
Participant 16

Some nurses went beyond describing assaults as frequent, explicitly and implicitly indicating that assaults were to be expected in medium secure settings. The way in which nurses described assaults illustrated this degree of expectation and sense of inevitability e.g. "the *occasional punch*" (Participant 1) and "[I've been] bitten, punched, spat at – *you know, all of that*" (Participant 8), "*low level* spitting, biting, kicks in the faces" (Participant 10). They also made explicit statements indicating their expectations:

"I've always thought 'it's the nature of the beast.'"
Participant 4

"So I expected there to be risk, and violence towards myself and towards peers, all those sorts of things so I was expecting to be exposed to that in some way"
Participant 14

Despite this recognition of expectedness, nurses spoke about not always having thought this way. Several reflected on their naivety early in their careers explaining that their expectations had not matched the reality they were faced with:

"I was a bit naive to it and I thought it was going to be this really nice, fluffy therapeutic environment"
Participant 1

"I was 22 at the time, I felt that initial sort of 'superhero' mode, you know 'it won't happen to me' and I thought I'd be exposed to it but I'd always be on the outskirts looking in as opposed to being the person in the middle so I suppose I was in denial a bit that it could happen to me"
Participant 14

Most nurses described how, in time, they became 'desensitised' or 'got used to' violence. A process of acclimatisation or 'cultural assimilation' appeared to take place as they became unwitting actors in the 'normalisation' narrative:

"...there is an element of becoming desensitised to the level of violence that you're exposed to"
Participant 2

"I don't know if I'm just programmed now because I've been doing the job so long, you factor [being assaulted] *into your work"*
Participant 7

"I don't think that I appreciated what situations and circumstances you're working in until I've stepped away from it...I feel like I've desensitised to quite a lot of things"
Participant 13

As well as the frequency of assaults, nurses spoke of their seriousness, and the ongoing threat to their physical safety. They said:

"...committing your team to that intervention [to prevent a person from harming themselves] *has its own difficulty because you're almost certain that somebody is going to get hurt"*
Participant 2

"...sometimes staff would just be stood there, or sat there, or even playing a game of pool with somebody and they just get attacked with pool cue or have a cup thrown at them in the kitchen, or be just walking down the corridor and get punched in the face when they're doing the checks"
Participant 9

"...every one of those people (patients) are potentially only a small amount of time away from disastrous behaviour at any time. You see, because the potential is there - something has happened in the past where they were a great danger to others, so you have to be mindful of that."
Participant 12

Whilst only a minority of the nurses interviewed explicitly said that they and colleagues 'normalised' assaults as a means of helping them to cope with their experiences, it was apparent in most participants' descriptions that there was a level of 'desensitisation' as described earlier:

"...we normalise that kind of attack, that assault, that behaviour, the racist, the derogatory terms that we get called, we normalise it and we grow thicker skin"
Participant 10

Whilst nurses acknowledged the risk of being assaulted in secure settings and either cited or implied the process of adapting to a culture of normalisation, they made a distinction between knowing there were risks, and considering assaults on nurses as acceptable:

"I didn't ever expect to go to work to be assaulted but by the same token I wasn't ever naive enough to think that that's not got the potential to happen."
Participant 13

This tension was expressed by some nurses in relation to both the way that they and nursing colleagues conceptualised assaults and also the way in which it is conceptualised by others. Participant 4, after describing being assaulted as 'the nature of the beast', went on to say:

> *"You know, you work in a secure unit with some people who are quite unwell, some people who aren't so unwell, and it's awful but it almost becomes part of the job, which is awful, 'cause, you know, you shouldn't… nobody should have to go to work and expect to be assaulted."*
> *Participant 4*

Nurses spoke generally about a 'culture of acceptability' with respect to assaults on nurses. They identified individual groups who they perceive consider violence against nurses to be 'normal' and/or 'acceptable'. These were their managers, other mental health professionals, patients and the police:

> *"I think sometimes people think they can just hit nurses and you know, it's part of what they do, it's part of the nurse's everyday life"*
> *Participant 4*

> "[from manager] *it was almost like 'oh well it is a forensic unit' like 'what do you expect love?'"*
> *Participant 8*

> *"I was told by the police it was my job to be assaulted by mental health patients, that's why they're there, that's why I'm there."*
> *Participant 10*

> *"..it's almost normal for nursing staff to be assaulted. It's like an expectation. There's this saying that it goes with the job..."*
> *Participant 16*

The impact of others seeing assaults on nurses as being normal and part of their job led nurses to describe themselves as 'punch bags' or 'cannon fodder'. This sense of being dehumanised – in this case through the normalisation and acceptance of violence against nurses – is compounded by the responses nurses reported receiving when they were assaulted. This aspect is captured in the theme '*the response to assault can make or break'.* As nurses discussed their perceptions of how others view assaults on nurses, they explicitly refuted the idea that being assaulted should be considered 'part of the job' and made a distinction between something being 'expected' and being 'normal'. As they did so, many reflected again on how becoming desensitised, learning to expect assaults and normalising them as a means of coping contributes to this narrative. Doing so was also recognised as contributing to assaults not being taken seriously. This uncomfortable tension is seen both explicitly and implicitly across the dataset:

> *"I think there is an unhealthy, I guess - but I can see how it happens - acceptance of that level of behaviour because of where we work, which shouldn't be there. I don't agree with it, but it's there."*
> *Participant 2*

> *"We discuss it in such a strange way, we don't put it down as an attack ... and the idea that we do that takes away everything that we should be doing really, because we don't see her being spat at as an attack or assault we just see it as oh it's just another day at work"*
> *Participant 10*

Participants challenged the normalising of assaults on nurses by making a distinction between being required to manage risk, and being assaulted. Participant 14, after being told by a Consultant Psychiatrist that being assaulted was part of her job, described the response from her senior nursing colleague:

> *"...that's not true - it's part of our job to manage risk not to be assaulted."*
> *Participant 14*

Nurses recognised the impact that conceptualising assaults as normal and part of their jobs has on the extent to which they are reported. Nurses expressed the effect normalisation has on their actions following an assault explicitly and implicitly, reflecting a sense of disempowerment and reticence – a resignation that their experience would be viewed as consistent with their role.

> *"Yeah. I know most nurses wouldn't report to police… assaults… it seems part of… what do you expect? You work in forensic services, it's to be expected."*
> *Participant 1*

Participant 6 described her experience of a system in which assaults are considered normal and thus not recognised. This contributed to managers failing to respond in supportive and caring ways, and left Participant 6 feeling disempowered – unable to "fight" for her experience to be heard and understood. When her family told her she shouldn't "put up with it" she said:

> *"...you're telling me to fight a system, when I'm already vulnerable, when I'm already feeling isolated, and yet you're still telling me to fight a system. I haven't got it in me to fight."*
> *Participant 6*

In relation to verbal and psychological abuse/assault, Participant 7 said:

> *"...it's definitely brushed over, but I think we as a staff group deal with it internally with each other. I don't think it's put out there in the wider sense – i.e. it's police reportable or the managers are particularly concerned about it."*
> *Participant 7*

In relation to the police specifically, nurses spoke frequently about their sense that assaults on nurses are trivialised and seen as unimportant. They told stories about their experiences of reporting assaults to the police – separate aspects of which are included in other themes

– and drew conclusions including that decisions regarding action are made in relation to the context, not the assault itself.

> *"...it's your job, why would we pursue this, she's in a mental health service, this is what you get paid for"*
> *Participant 10*

> *"...the actions that follow don't marry up to what happens in the community. For example if I was assaulted outside work the police would automatically be involved, there would be a crime reference number, there would be follow up, I'd be offered victim support, there would be that whole range of things. But when it happens in the mental health system that doesn't always happen"*
> *Participant 6*

The idea that assaults on mental health nurses are normal and acceptable was widely challenged by participants and was deemed to be a belief that needed to change. Participant 5 said "*in the NHS and particularly in mental health and particularly in forensics, it's more acceptable and I think that's wrong".* Participant 11 spoke about assault being the same for her in any context be it in her marriage, friendship group or community life and she said, *"I don't really judge that any differently".* Participant 6 said a *"culture change"* in the health service was required in order for assaults on mental health nurses to be thought of differently. During the analysis, it was apparent that a motivation for participants to take part in the study was to contribute to change and improve both nurses' experiences and their confidence in being able to speak out and ask for help. Participant 13 said:

> *"I'm really pleased that you're doing research into this, and highlighting the issues, because it does need to change I think. The expectation that violence and aggression becomes part of daily life, it shouldn't be like that".*
> *Participant 13*

This extract speaks to the complex tension between nurses' acknowledgement of the personal risks they face in secure mental health settings, and their simultaneous rejection of

the normalisation of assaults. As illustrated in this subtheme, the result of this normalisation which serves to disempower nurses and invalidate their experiences is that the impact of being assaulted is frequently overlooked, suppressed or *unseen*. This idea forms the basis for the following subtheme.

Subtheme 4: Assaults on nurses go unseen

The reality for the mental health nurses interviewed was that many of the assaults they experienced failed to be acknowledged and at times were ignored. Contributing to assaults going 'unseen' is their normalisation and the ways in which assaults are conceptualised and discussed both among and beyond nursing teams. Mostly linked to the extent of physical harm inflicted, the 'thresholds' for what are considered to be 'assaults' are perceived to be higher in secure mental health settings than elsewhere. Acts resulting in psychological rather than physical harm are less likely to be recognised as assaults. Assaults being considered *normal* within teams also leads to them being overlooked and minimised:

> *"there's assault that's happening all the time and, in all manner of ways, within the environment so I think we overlooked so much of it"*
> *Participant 13*

> *"I think we definitely downplay any type of aggression in a medium secure unit, as how we would in the community."*
> *Participant 5*

The language used to describe assaults, as discussed earlier, contributes to this normalisation and 'downplaying' of violence and aggression. Analysis also recognised an instance of language 'pathologising' violence. Participant 2 used the words "high acuity" when referring to high levels of violence and aggression, a term that features frequently in discourse relating to inpatient violence. The result is the projection of a 'sanitised' reality that conceals the experience of nurses.

The absence of a shared definition of assault in secure settings is also seen to be important in perpetuating the lack of visibility in relation to assaults on nurses. However, whilst nurses

saw this lack of consensus on assault as problematic, recognising the subjective nature of the assault experience was considered important. Participant 2 said:

> *"it's about the impact it's had on the person, and that it doesn't have to be physical and you don't have to have an injury from it for it to be assault".*
> *Participant 2*

All participants, when prompted to consider what assault meant to them, spoke in broad terms about what they thought constitutes an assault. They emphasised the subjective experience as a determining factor, which, when considered against the wider definitions of assault and the thresholds for harm/reporting, means such experiences are likely not recognised beyond the individual and in some cases their immediate colleagues:

> *"...that sense of waiting for something to happen… I kind of see that as an assault… it's that intimidation, it's the sense of that… look you get from service users that you're going to get it… and the threats. That's how I see assaults now… it's that psychological stuff"*
> *Participant 1*

> *"So for me assault is verbal, physical, you know even setting up traps in a building, you don't have to physically touch that person, but you've done something, you've orchestrated something"*
> *Participant 9*

> *"Assault is to be made fearful"*
> *Participant 12*

However, despite intellectual recognition of a broad definition of assault, participants expressed that physical acts, particularly those resulting in injury, were what constituted assaults in practice. The broader definitions they had discussed were deemed to apply beyond the secure setting, but not within it. The fact that all participants described their

experience of *physical* assaults for the study, despite not being prompted by a definition to do so, illustrates this point:

> *"...certainly the psychological stuff isn't recorded as an assault… I don't know if the bodily fluids is recorded as assault… certainly if somebody spat at you on the street that's an assault isn't it… but then I suppose forensic environments are such an odd environment."*
> *Participant 1*

> *"I think most of us interpret assault as being a physical attack, don't we. Even though we know it's not necessarily a physical attack, but as a physical attack, somebody hitting you, kicking you, punching you."*
> *Participant 5*

Similarly, thresholds for when a physical act would be considered an assault were expressed as being different in secure settings. In addition to thresholds being influenced/determined by subjective experience, there was also some indication of thresholds being imposed, including among nurses:

> *I mean I've worked with people and they've said 'ooh, he's just assaulted me' and I think don't be such a fanny* [laughs]...*like maybe somebody's thrown a book at them, and it's you know, just a half-hearted attempt, you know, like a little Mills and Boon book and you just think…* [rolls eyes]. *That doesn't mean that I don't take it seriously for that person because for that person it's real isn't it. Whereas for me to say somebody has assaulted me they would have to have punched me or…"*
> *Participant 4*

> *"I think when you're referring to a medium secure environment it's more, has to be more serious to be an assault, cause those little things are just 'scuffles' more than 'attacks'."*
> *Participant 5*

Nurses spoke about assault being generally linked to the requirement for objective evidence of harm, mostly in the form of a physical injury. The determination of harm was often described as not taking into account their subjective experiences, and this included the lack of acknowledgement of the impact of non-physical assaults:

> *"...that psychological stuff… that's totally… I kind of feel like it's disregarded almost. If you get assaulted, if you get punched, people go "oh, you've got a black eye, off you go" but when it's just little… death by a thousand cuts… that is just the worst feeling."*
> *Participant 1*

> *"...when a staff member goes off sick for a longer period of time they are encouraged to report it as assault."*
> *Participant 10*

> *"And then whoever has received the incident report sent a message back saying "we've downgraded this to no effect" or something and I'm like "how do you get to make that decision of what effect this has had" and they will say "well no one got hurt"."*
> *Participant 15*

Contributing to assaults on mental health nurses going unseen was the commonly held perception that they were not treated as criminal offences and were not considered to be the concern of the police. They explained that there was a reluctance to prosecute individuals considered to have a mental illness or disorder:

> *"And when they are victims of – and it's true, we are victims - when you're victims of assault, you're victims of violence and aggression, you have to look after those staff."*
> *Participant 6*

> *"I found out that the knife* [used by the patient to stab P8 in the cheek] *had been picked up, washed off and put back in the cutlery drawer. I had no contact from anyone so essentially what was a crime scene was cleaned up and everyone got on with their day. Nobody phoned the police or anything"*
> *Participant 8*

"...you're just not supported, you can be assaulted at work, it isn't seen as anything by the police, it's not seen as a criminal act."
Participant 10

"Even if you ring the police - I remember there was a nurse I supported two months ago to ring the police after an assault and the police were like "you are in a place where it's supposed to be safe for patients so why are you calling us""
Participant 16

Nurses expressed a sense of injustice when patients did not face any consequences for their actions. They saw patients being held to account as important and felt angry when this did not happen. On some occasions actions taken were seen to positively reinforce the idea that assaulting nurses was acceptable:

"...the other thing that really got to me was he was put in isolation as a result of that and within two hours he had a TV and an Xbox and a couple of support workers playing with him… and that was just like… so that's what happens, you attack a member of staff and you essentially get a couple of your support workers, who he really liked and to play with him in isolation… and I think he was out in 24 hours and you think...really?"
Participant 1

Participants also highlighted nurses' tendency to forgive assaults, being likely to 'put up with' them or 'let them go':

"Within the realms of our profession, we're incredibly forgiving. And I don't think it's a conscious thing a lot of the time."
Participant 2

"I love what I do and it keeps me going back. Something keeps me going back because it's not an environment for everybody, it can be very distressing"
Participant 7

Participant 2 described being forgiving as an innate characteristic of the nursing profession, speaking potentially to it being perceived as an intrinsically feminine and nurturing 'vocation'. This is echoed by Participant 7 when she talks about her 'love' for her job. This is important when considered in relation to the constructs of 'angels' and 'heroes' that have been used to describe nurses – most recently in the context of the COVID-19 pandemic – and have served to undermine the professionalism of the nursing workforce (Stokes-Parish *et al.,* 2020). The argument that this narrative persists in part due to the 'invisibility' of the profession resonates with this theme; nurses speaking up about their experiences of being assaulted by patients in mental health settings is at odds with the current narrative. This topic is further explored in the discussion chapter.

5.2.2 Theme 2: Keep emotions under wraps and crack on

This theme describes expectations of mental health nurses – both of themselves and placed on them by others – to be able to keep their emotional experiences under control and contained such that they are able to continue in their work. When, after being assaulted, these expectations are not able to be met, mental health nurses draw conclusions about what this says about them as nurses and people.

Consistent with the narrative that assaults on mental health nurses are 'normal' are underpinning ideas such as a "good/strong/resilient nurse contains their emotions and carries on" and "emotions/emotional expression must be avoided because it exposes weakness/vulnerability and unprofessionalism".

The theme comprises three subthemes: '*Emotions: the rules'*; *Must keep going'* and *'I'm not up to the job'.* Together they provide an insight into the ways in which nurses believe they are expected to think, feel and behave; what it means to not meet these expectations; and the ways in which they attempt to cope.

Subtheme 1: Emotions: The rules

Contained in this first subtheme are the nurses' perspectives of the expectations – or 'rules' – relating to emotional expression in the context of their roles. Remaining calm, in control and rational were expressed as being important requirements, alongside the 'containment'

or suppression of emotions. In conflict with these expectations are participants' experiences of mental health nursing as "emotional work". The meaning of both the experience and expression of anxiety in this context is also included in this subtheme. Most participants were clear that containing emotions and remaining 'in control' were shared expectations:

> *"I felt like I had a responsibility to just, to keep myself composed a lot of the time and try to maintain as best as possible quite a neutral position about her assaults"*
> *Participant 2*

> *"You are almost forced to be numb. You're not supposed to feel anything when all this aggression is coming to you, whether it's verbal or whether it's physical, you're almost expected to accept it or just get on with it"*
> *Participant 16*

Participant 14 talked about the way in which she was expected to conform to cultural expectations relating to personal boundaries and the sharing of emotions. She described how being "blunted" was part of the culture:

> *"...you always keep personal boundaries very serious. It's something else that helps you to cope - maybe a coping mechanism for some people - I don't know... I felt like I had to make sure I stuck by those rules"*
> *participant 14*

Participants saw distress as undesirable both to feel and to express. For many it signified weakness, often implied in the way that they spoke about their own emotional experiences. Participant 2 recalled not being able to admit she was 'traumatised' because she "*should* be stronger"; while Participant 6 interpreted the distress she experienced as a result of being assaulted as an indication of weakness:

> *"I would not class myself as a weak person, by any stretch of the imagination, but I surprised myself in just how much I was affected by that last assault on every level"*
> *Participant 6*

The desire to conceal emotions from others was interpreted as being due to anticipated shame. If they were to express their fear and anxiety, they would reveal themselves to be weak and/or a failure:

> *"...because I felt like I had an appearance to maintain all of the time because I didn't want to be this quivering wreck who was still dealing with an incident that happened months ago. I didn't, I didn't want my team to see me like that because I was embarrassed or ashamed of...and worried about what they might think"*
> *Participant 2*

> *"I just felt like an absolute failure, not because of the assault, not because of what happened, but because of how it affected me"*
> *Participant 9*

> *"I think for people to see that you're not coping, to me that was a real sign of weakness."*
> *Participant 13*

This defence against shame contributes to, and perpetuates, the shared expectation that mental health nurses should be in control of and 'manage' their emotions. This relates to the way in which assaults on mental health nurses are normalised as discussed in the theme *'we know the risks, but being assaulted is not 'normal''*. Nurses not being seen by others to respond emotionally reinforces the idea that being assaulted must be 'part of the job'. The unseen reality however is that intense emotions are often felt despite not being expressed. Participants identified this experience as adding to the feeling of being alone and isolated.

Subtheme 2: Must keep going

Beyond the concealment of emotions, there are further expectations among and on nurses who are assaulted. These relate to how they *should* feel and what they *should* do. The expectation that following an assault nurses should continue to work with no or minimal interruption was placed, by some, on themselves. Doing so was also interpreted in some

cases as being a strategy intended to help them to cope. They believed they should be able to 'bounce back' from being assaulted – not being able to do so led to negative evaluations of themselves professionally and personally.

Nurses saw their primary responsibilities during and in the aftermath of an assault as ensuring the team's safety, continuing to lead, and prioritising patient care. The expectation that nurses should be able to continue was also placed on them by others. Terms including "crack on", "bounce back" and "get on with it" were used frequently, reflecting pervasive cultural expectations.

Participants had high expectations of themselves in relation to their resilience. Not being able to 'carry on' led them to see themselves as defective in some way as can be seen in the following data extracts:

"...what is wrong with me, why can't I just bounce back?"
Participant 6

"I just really struggled to come to terms with the fact that I just wasn't being able to move on and I was really finding that quite frustrating"
"...there was that sense of just feeling a bit of a baby and just feeling that I should be bigger than this and better than this"
Participant 13

"I had this kind of in-built pressure to be okay - "yes, it has happened, so what, get on with it" kind of a thing"
Participant 16

Many participants spoke also about the pressure to demonstrate resilience as being externally driven, with managers, other health professionals and the police being named as sources of this pressure:

"...there's an expectation, written or unwritten, that you just kind of crack on, it's to be expected"
Participant 1

"Speaking from personal experience, it really is a case of "get on with it""
Participant 6

Participant 9 had been diagnosed with PTSD following her assault and had needed to reduce her hours and avoid night shifts. The response she received from her manager communicated to her what was expected:

"...my manager came to me and said we need to have a talk about what you're going to do, and I was like what d'you mean about what we're going to do? He went "well [Provider's name] *want all-singing-all-dancing staff, and you're not. And I was like "what do you mean?" He went "well you only work part-time and you don't do nights, so I suggest that you have a think about things and either do, or leave"."*
Participant 9

The quote above indicates a system-wide expectation in this organisation that nurses should work at full capacity, which risks nurses' experiences being denied and their needs not being recognised.

Some participants named the expectation to deal with assaults in this way as being part of the culture - the requirement to "keep going" or "get on with it" were considered to be "the norm". Others reflected this implicitly in the way they spoke about their experiences. For example, Participant 4, after being hit with a chair across her back when in the late stages of pregnancy, said:

"I was made to go to hospital for a check-up, for the baby more than me, and things were fine, everything was fine, and I was back on duty the next night, as you do [laughs]."
Participant 4

The idea that being assaulted should not negatively impact those around you was voiced when participants talked about patients and colleagues. Participant 5 was assaulted by two patients in an isolated room in order that they could take her keys and attempt to escape

from the unit. She described resisting and trying to "fight the patients off" in order to protect others. As she reflected, she said:

> *"...looking back thinking you know, why didn't I just give them the keys, it would've been easier, but obviously the instinct is to protect the rest of the patients and staff on the ward and that's the drug keys, and the keys to the unit"*
> *Participant 5*

With respect to patients, nurses both described and implied in their actions that patients should come first at all times; being assaulted should not affect the care patients receive. This perspective reflects and perpetuates the "angels and heroes" narrative; the nurse demonstrating bravery and self-sacrifice (Stokes-Parish *et al.,* 2020):

> *"I was a bit kind of taken aback, but then you just immediately focus back on the job you don't think about yourself, your uppermost thought is to help your patient, to be there for your patient and to listen to your patient...and I think it's the same with every time I've been assaulted, your first thought is of your patient's welfare"*
> *Participant 7*

For some however this perspective created a conflict for them, particularly when they found themselves unable to put aside their own needs (for example in the case of physical injury or experiencing panic at work), or in cases where they felt angry with the patient for assaulting them.

Nurses, including Participant 2 spoke about the particular weight of expectation they felt in their roles as leaders. Their priority was to maintain their position and effectiveness as a leader, in some cases because they felt they had no option. Participant 2 saw it as her responsibility to put her emotions aside and set an example to her team, while Participant 6, who was duty manager when she was assaulted, did not see that they had a choice but to continue:

"I felt like I had a responsibility to just, to keep myself composed a lot of the time and try to maintain as best as possible quite a neutral position about her assaults"
Participant 2

"I was obviously hurt, I was already having, I had sores on my head, and I was missing hair from my head and then I was kicked again, and, unfortunately where I work, like anywhere, staffing is horrendous and I had to stay in work, I wasn't able to go home, I had to carry on with the situation"
Participant 6

In addition to remaining at work, nurses viewed themselves as being expected to actively, and successfully 'manage' the impact of being assaulted; to 'be okay':

"We've all just been expected to carry on and just get on with it. You know, have a brew, sort yourself out, stop crying and get back to work."
Participant 9

"I created pressure for myself to be okay. Of course it affected me, but then I had this kind of in-built pressure to be okay - 'yes, it has happened, so what, get on with it' kind of a thing. So I just carried on..."
Participant 16

Nurses spoke about the adversity they faced and the ways in which they attempted to cope. For many, they had in the past successfully employed strategies that centred around avoidance e.g. not thinking about the assault, focussing on tasks, using humour to "laugh it off" and "leaving work at work". It appears that these avoidance strategies were both influenced by and reinforced the cultural expectations they had described, and served to perpetuate and potentially strengthen such expectations. When avoidance strategies were not effective, as was the case for many participants in this study, this was interpreted as indicating a flaw or defect (e.g. weakness, failure) in themselves, as is captured in the following subtheme.

Carrying on, focussing on tasks and 'getting back on the horse' were frequently described as immediate responses to being assaulted. Whilst these behaviours mostly served as ways of avoiding or masking emotions, for some they served a useful function. Focussing on the task of reporting the assault and writing in clinical notes helped Participant 7 process what had happened to her. Participant 5 said she felt she had to return to her place of work immediately after the assault as putting it off would make returning harder. Her description implied a process of reassurance – if she was able to walk into the building, see other patients and her colleagues and be okay, then she would be okay:

> *"...there's a lot to go through – you've got to go through the airlocks, you've got to walk down the corridor, you've got to get to the unit, you've got to walk on the unit, get to the office before you might see another person and so just all of those things I just thought no, I just need to do it once and then I'll have a week off or whatever"*
> *Participant 5*

Most participants described 'carrying on' as an automatic response. Participant 4 described continuing to assist in the management of the incident as her usual practice, and Participant 7 said she had 'got used to' carrying on. Immediately after being assaulted, Participant 9 began making tea for other patients:

> *"...when I was let go I managed, because staff had then responded, I took all the other patients to the kitchen and started making them all cups of tea* [laughs]. *And then my manager came in and was like "*[participant's name], *what you doing?" I was like "just making everybody a brew, do you want one?" and he was like "get off the ward" and I was like "no, it's fine I'm just making everybody a brew" and then when he took me off the ward and I just burst out in tears"*
> *Participant 9*

Remaining at work and continuing to function was important for Participant 13, being able to do so was normal for her:

"I never went home from being assaulted, never. And that's why on that day I think as well there was a reluctance there. It was like "no don't be silly, don't be silly, of course I'm going to stay on duty, what else would I do? That's what I normally do""
Participant 13

Remaining at work and engaging in tasks helped nurses to avoid thinking about their experience, which was interpreted as being viewed as emotionally risky:

"It's done now [laughs], *you have to have that approach, don't you?...I think that's my approach to most things, in a box, that'll do* [laughs]."
Participant 15

This included nurses' efforts to separate their professional life from their home, to 'switch off' when they left work. Those that were able to achieve this spoke about it as an important and necessary requirement:

"I sort of got on with it really cause, I'm very much like that… I compartmentalise things and, you know, this is work, this is home so when I was at home then I didn't really think about it"
Participant 4

"I don't know if I'm just programmed now because I've been doing the job so long, you factor it into your work and you don't actually take it out with you"
Participant 7

The experience of isolation features in this theme as it does in two others. Here it is seen as a result of nurses' attempts to meet the expectations placed on them. The requirement to carry on and 'manage' did not allow for the acknowledgement and sharing of experiences, and therefore contributed to the sense of being left to cope alone.

"You don't talk about feelings, how it affected you and stuff like that. So when certain things happen, even now, I close my curtains, close myself off."
Participant 9

Finally, both semantic and latent meaning was interpreted in the ways in which participants used and talked about humour. Some participants' use of humour when describing their experiences of assault seemed to be an attempt to minimise or avoid discussing the emotional impact it had had on them. There was in some cases an incongruity between the seriousness of what they were describing and their use of humour:

> *"I was two weeks away from going on maternity leave, so I was 36/37 weeks pregnant, and I got hit with a chair from behind as I was writing the allocation board which really annoyed me because I went down the board and smudged it all* [laughs] *and I got blue lines all over my face from the ink* [laughs]"
> *Participant 4*

Some participants explicitly named humour as a means of both coping and communicating emotions in an 'acceptable' way. Participant 10 saw it as a mechanism by which to gauge how each other is feeling, maintain 'camaraderie' and provide a safe outlet for emotions:

> *"It's expressing emotion isn't it and I think it's trying to work out how everyone else is"*
> *Participant 10*

The risk remains that, as with other means of coping, it becomes an expectation – e.g. "I should be able to laugh it off" – that individuals may feel under pressure to meet.

This subtheme exposes the expectations and assumptions that exist in the culture within secure mental health settings, and highlights the personal strategies nurses use to 'keep going'. The culture places nurses' professional – and self - esteem under ongoing pressure as they strive to live up to expectations. The final subtheme describes the interpretations made by and about nurses when they are not able to meet expectations.

Subtheme 3: I'm not up to the job

When nurses are not able to suppress or contain their emotional responses to being assaulted, they see themselves as having 'fallen short'. Being unable to contain their emotions and 'carry on', continue working or maintain the home-work separation led participants to make profoundly negative judgements about themselves. Nurses believed themselves to be 'weak', 'a failure', 'defective', 'not good enough' or 'crazy'. These beliefs led to feelings of shame, guilt and embarrassment. For some, simply the fact that they experienced an emotional response to being assaulted led them to draw the same conclusions and feel the same way.

Participants talked in various ways about what not being able to 'bounce back' said about them as nurses. They equated being a 'good nurse' with unwavering resilience; the successful containment – or absence of – emotions such as fear and anxiety; minimal or no disruption to performance following an assault; and being able to maintain the focus on meeting the needs of patients and colleagues.

> "...[the assault] *was an indicator that I hadn't… done… or hadn't acted in a way that could have prevented that... That was the beginning of me then questioning my therapeutic ability, almost, as a nurse. ... those key, kind of, nursing skills that we talk about… they were either not present or they weren't up to scratch."*
> *Participant 1*

> *"I think maybe it just made me doubt my own capabilities a lot more. And that actually maybe I'm not as good at managing this as I thought"*
> *Participant 14*

Beyond not 'performing', participants spoke about their beliefs that they were defective in some way:

> *"...people can't rely on me because I'm weak. I'm damaged and, does that make sense?"*
> *Participant 9*

Experiencing emotions that could not be 'controlled' or concealed left some nurses feeling exposed and vulnerable. Participant 2 found the prolonged impact of the assault, and particularly in relation to her performance in practice, particularly difficult to reconcile. She did not allow herself to share how she was feeling with the nursing team, fearing the shame that would come with being exposed as 'weak'. This was not how she saw herself as a nurse and a leader:

> *"I felt exposed and vulnerable. I didn't like that at all, at all, it was one of the most difficult few months I had at work because I felt like I had an appearance to maintain all of the time because I didn't want to be this quivering wreck who was still dealing with an incident that happened months ago."*
> *Participant 2*

Similarly, Participant 13 believed that her colleagues being aware of how she felt meant that she was weak, and this was incompatible with being a good nurse and leader. Being emotionally affected and experiencing a panic attack at work led her to see herself as a failure:

> *"I felt it kind of spelled failure in my head I think, you know that I wasn't being the professional that I usually am...I think for people to see that you're not coping, to me that was a real sign of weakness... It just left me feeling, I can't do my job, I'm not a good leader, they're having to look after me, what does that say about me?"*
> *Participant 13*

Participants, including Participant 13 who believed she had failed as a leader, described an actual or anticipated sense of letting their colleagues down. Being unable to conceal the impact that being assaulted had on her caused Participant 6's colleagues to feel angry on her behalf. She said:

> *"It felt like I was responsible for their anger and in the position I was in, which was invariably the more senior one on the team, I'd let them down in that respect because I'd evoked a really strong emotion that I had no control of fixing."*
> *Participant 6*

Some also believed they had let patients down by adding to their worries or 'burdening them'. For Participant 14 it was the response from patients, and the responsibility she felt for their distress that led her to seek help:

> *"So when I came back to work afterwards, I noticed that a couple of the patients... were asking me if I was okay and that worried me 'cause they shouldn't be checking on me, I should be checking on them. And for them to see me like that makes me think well clearly I'm not doing a very good job of acting like I'm okay, and I don't want it to impact on them ...I don't want that to be part of their worries."*
> *Participant 14*

Nurses who believed they had not met expectations concluded they were 'not up to the job'. Participants used the words 'inadequate', 'not a good nurse', 'useless', 'damaged', 'crazy', 'a failure' and 'weak' to describe themselves. For some these negative appraisals extended beyond their professional identity and applied to them as people:

> *"I just felt like an absolute failure, not because of the assault, not because of what happened, but because of how it affected me, that I couldn't even, I couldn't do my job and all I'd ever been since I was seventeen was a healthcare worker."*
> *Participant 9*

> *"...it challenged everything about me, it challenged my whole being I think as an individual not just as a nurse just because all of a sudden I was realising that my response was different to how it had been previously...that really troubled me, it troubled me."*
> *Participant 13*

This subtheme has examined the ways in which cultural expectations impact mental health nurses who are assaulted, and the sense that nurses make when they are not able to meet these expectations. Not only, as explored in the first theme, does the distressing and shocking nature of assaults on mental health nurses not feature in the common discourse,

but neither does the pressure to live up to the '*keep emotions under wraps and crack on*' narrative that appears to pervade mental health nursing in this setting.

5.2.3 Theme 3: The response to assault can make or break

This theme is concerned with the impact that the responses mental health nurses receive when they are assaulted have on their experiences. The most frequently expressed aspect of this idea was the *absence of care* nurses received after they had been assaulted, and that this was understood as being part of a culture. As well as an absence of care, the experience of being *criticised, blamed* and *held responsible* was interpreted as being an important influencing factor in nurses' experiences. This included criticism related to asking for or requiring help and support and included explicit and implicit suggestions of there being a stigma associated with being assaulted. Nurses were frequently *left questioning their worth* after being met with an uncaring or dismissive response. The responses participants received following being assaulted comprise the final subtheme which explores the nature and value of support.

The final theme captures the ways in which different responses to being assaulted influenced nurses' experiences.

It contains four subthemes, '*absence of care'; 'left questioning worth'; 'blame and responsibility – something about me?'* and '*support makes all the difference'.*

Subtheme 1: Absence of care

In this subtheme, participants' experiences of an absence of care and support are presented. They relate to the immediate aftermath and the days and weeks that followed. As nurses described being assaulted, the lack of care received by some was apparent. After being stabbed in the cheek by a patient, Participant 8 described her experience of being left alone immediately afterwards:

> *"I walked up and down and I remember thinking there's nobody here, I don't know what to do and I remember having, like my sleeve down over my hand, and I had my hand to my face and all this blood was coming out and I was like oh god, shall I go and*

look at it, and I went into the toilet and I looked and I thought oh shit...I couldn't get out on my own, but also I couldn't drive, because I had a hole in my face, so it took like probably a good two hours before I actually got to the hospital."
Participant 8

Several participants, including Participant 8, recalled feeling alone and responsible for accessing support or help for themselves. This was seen in the data as being either explicitly communicated, or implied by the inaction of others.

Participant 16 was spat at by a patient. She felt singled out and humiliated as this had taken place in front of a number of colleagues. She described being asked if she was okay "in passing" while also being expected to continue participating in the management of the patient. When asked what stuck in her mind about this assault, she said the cultural meaning of being spat at and the lack of support following the incident:

"I don't feel like anyone really cared about me at that moment in time. Instead there was this expectation - go and get the depot, go and do this and that… - and after that not very much. It was just in passing 'are you okay'. It was like something normal has just happened, irrespective of how it affected me. So I think the impact wasn't taken into consideration at all."
Participant 16

The meaning of her colleagues' responses – that it was "like something normal has just happened" relates to theme one – '*we know the risks but being assaulted is not 'normal''*. It illustrates the potential impact of normalising assaults on mental health nurses – doing so influences the ways in which others respond and as in this case risks nurses feeling uncared for.

Half of the nurses interviewed felt unsupported by their managers. Their descriptions reflected them not being listened to and experiencing a lack of compassion, empathy, concern. A relationship between this subtheme and the subtheme '*must keep going'* is seen as the expectations placed on nurses – particularly to 'get on with it' after being assaulted –

are manifested in the behaviours of others. Participant 1 felt strongly that the response he received following the assault was "almost as bad as the assault itself"; his distress was not recognised and he was expected to "crack on". He was not supported to debrief or reflect on the assault; it was evident from his description that his managers did not understand the psychological impact the assault had had:

> *"it's what happens afterwards… because you kind of… in some ways you can think "okay, I've been hit, but now what?"… where do I find my sense of self? Because it not just impacts your nursing judgement but you as a person as well and I think you need to be rebuilt or supported in that… and if you're not you're left floundering aren't you? So yeah… assault… okay… the other stuff… yeah, that was the bigger deal almost."*
> *Participant 1*

Participant 6 described responses to assaults as "business-like" with nurses not being thought about as individuals who are affected by what happens to them. She continued to feel at risk from the patient who assaulted her, describing ongoing threats of violence and aggression. When she talked to her manager about her experience of ongoing 'targeting', she received the following response:

> *"...well can you not just deal with it until the new building opens up, can you not just deal with it and put up with it"*
> *Participant 6*

Participant 7's experience reflects the "business-like", process-driven approach Participant 6 referred to. When asked whether she thought her managers had ever understood her distress, Participant 7 responded:

> *"I did try to get that across but they were like "oh, yeah, well, the Trust won't put up any resistance for the, you know, they'll admit liability" so from that point on they weren't going to put up any barriers, but the emotional support was definitely lacking"*
> *Participant 7*

She also compared the experiences of nurses to the experiences of patients in relation to not being listened to, suggesting a shared experience of not being acknowledged and valued as a 'knower':

> *"...the most disheartening thing about the job, that you know these things are going to happen and you try to do something about it and people don't listen. And it gives you a better understanding of how frustrated the patient feels because they must feel as though people aren't listening. So in a sense there's a bit of empathy there because we sense their frustrations."*
> *Participant 7*

For Participant 9, the absence of any contact from managers left her feeling uncared for. It also contributed to the sense of isolation she and others experienced as a result of not talking about the assault and its impact due to others not understanding (as in theme one) and guarding against anticipated shame (as in theme two):

> *"I wasn't even working on my ward that day. I was working on another ward so the ward manager of that ward never contacted me, the ward manager of my ward, my line manager, never contacted me. The lead nurse never contacted me."*
> *Participant 9*

She went on to talk about how her response to an assaulted colleague had been received by both the colleague and her managers. Her colleague contrasted the caring response with her previous experiences, and her managers criticised her for allowing her colleague to leave her shift after the assault. This example served to illustrate Participant 9's experience was not an isolated one, rather it was indicative of a culture that did not prioritise a caring response, expecting nurses to "keep going" after an assault (as in theme two, subtheme two):

> *"...she started crying because she'd been assaulted like a couple of months before I started there and she was just told to carry on and I'd sent her home... And, and even then afterwards she kept bringing it up in supervision. You know, like "nobody's ever*

cared when staff have been injured. We've all just been expected to carry on and just get on with it. You know, have a brew sort yourself out, stop crying and get back to work." So that seemed to be the kind of culture that I went into"
Participant 9

There were many expressions of a culture in which caring for assaulted nurses either did not feature or was not prioritised. Participant 1 reflected on a 'poisonous' culture characterised by criticism, blame and a lack of care and compassion. Participant 7 described the approach to care and support from those outside the nursing team as reactive and not proactive. She considered listening and responding only when something happens "helped nobody". This approach was interpreted as reflecting a broader culture of failing to fully recognise nurses' experiences.
Participant 10's description of the lack of support and validation he received from his managers as 'normal' further indicated this cultural lack of recognition:

"...the way the managers work with the staff there you're used to it anyway, so when they do stuff like that you're not shocked, you just accept it in a way, again that lack of support that you have from the managerial side of it, people who haven't worked on wards for years and years and then they lose sight of what actually is going on so yeah I wasn't shocked it was just normal"
Participant 10

"It was part of the reason that led me, I think the assault kind of led me, after my therapy and things like that, led me to realise a lot about [employer] *and gave me the push to leave."*
Participant 9

As participants discussed their experiences, some considered the wider impact of a culture which fails to recognise assaults on nurses and to respond in a caring, compassionate and validating manner when they happen. As described in the data extract above, participants attributed high rates of attrition and sickness absence to this absence of care and recognition.

Finally, Participant 14 saw the lack of compassion, care and support she received as being, amongst other things, an extension of the cultural requirement to maintain personal distance and emotional 'bluntness'. The assault she experienced involved being kicked in the head by a patient. She recalled being told to leave the situation afterwards, and then being asked to "go and be checked at A&E" and she got a taxi alone because there were not enough staff to accompany her. While she was off work recovering, she did not receive any contact from her managers. She was reluctant to view what happened as an absence of care, and this was interpreted as being influenced by her belief that she was at fault, responsible for the assault and therefore undeserving of care. When this was observed during the interview, she said:

> *"I guess that's me I suppose, trying to make a silver lining. Otherwise the world just fills you up with a lot of darkness, especially in this line of work. We need something positive to hold on to."*
> *Participant 14*

This quote illustrates the further burden on nurses to 'bear' the reality of not being cared about, and in Participant 14's case to find alternative explanations for others' behaviour in order to protect herself.

This subtheme has described nurses' experiences of not being cared for or supported after being assaulted. The following subtheme moves to consider the interpretations they then made in relation to their worth and the extent to which they were valued.

Subtheme 2: Left questioning worth

The responses participants received when they were assaulted left many questioning their worth and the extent to which they were valued. There was a striking use of similar language when nurses were asked what it meant to them that their managers, colleagues or the police did not take action or offer care and support. The phrases "just a number" and "I didn't matter" were used by several participants, reflecting dehumanising, disempowering and devaluing experiences. The idea that nurses were replaceable, or dispensable was either made explicit or interpreted as implicit meaning:

"I was just left to crack on with it… yeah… you're just another number… you're somebody else just to make up the numbers and that's how it was, essentially."
Participant 1

"I'm just a number, I am literally just a number so that [managers] *don't have to deal with what's actually going on...you just feel worthless, absolutely worthless"*
Participant 6

"...but looking back they knew that they'd messed up, but they took no responsibility for that and just continued to treat me like I was nothing and didn't matter. I was replaceable"
Participant 9

"...it's that reinforcement of being a number and not a person."
Participant 14

"I didn't feel like I mattered"
Participant 16

Following her experience of being stabbed in the face with a cutlery knife, Participant 8 described the response from her managers, particularly their lack of empathy and their lack of action in relation to preventing future similar incidents. When asked what this response said about the way her managers thought about her, she said:

"That I didn't matter, that I was just a number. That there's more nurses, it was probably an inconvenience that I was off sick, with all the shifts to be filled."
Participant 8

Participant 13 described the distress she experienced as a result of the response by the police. The assault involved her being held by her head on the floor for 20 minutes. She developed PTSD for which she sought trauma counselling. The response she received after

reporting the assault to the police lacked sensitivity and failed to recognise the harm that had been done:

> *"I got a text message back - it was ages afterwards, and this really, really distressed me actually - I got a text message back from the police just basically saying that there was no damage caused really. And physically there wasn't, but mentally at that point I was still absolutely reeling from the whole situation...and because I hadn't left duty at the time that it had happened - that I had carried on working - that they weren't going to take it any further. And that really made it feel quite trivial."*
> *Participant 13*

Participants spoke also about the meaning of uncaring, dismissive and critical responses in relation to the value that is placed on them as mental health nurses:

> *"I kind of thought well, a) they don't value me as a nurse and they're not investing here in me…"*
> *Participant 1*

The prioritisation of patients' needs over the needs of assaulted mental health nurses was featured in most transcripts. For some participants, the principle of putting patients before oneself was stated as a requirement, or implied as such in the descriptions of their behaviour. Several participants reflected on the unjust nature of their needs 'coming second' in this situation. This further reinforced the sense of worthlessness which was discussed earlier. Participant 8 described the effort made to ensure the patient who assaulted her was cared for and 'not left out' in the aftermath – and he contrasted this with her own experience:

> *"...so he got put into seclusion and then 'high-care', and another female patient on the ward was leaving, and normally when patients are leaving they would do like a little buffet for them and the ward manager was like 'you must make sure that he gets taken some party food down to high-care'. It just really made me feel like it just actually didn't matter at all what had happened to me."*
> *Participant 8*

Similarly, Participant 1 recalled his experience as compared with that of the patient who had assaulted him, viewing it as unfair and unjust and concluding:

> *"I was secondary to the care of the patient."*
> *Participant 1*

Participants also expressed their belief that for managers and organisations, matters such as tasks, targets and possible reprisal took priority over their wellbeing:

> *"...it was always, "are you going to seek legal action, are you going to sue the company?""*
> *Participant 9*

When asked what it meant that her managers had not tried to contact her following the assault, Participant 14 said:

> *"I just kind of assumed, I tried to assume more positive connotations on their behalf because if I'm off sick that's extra stress on them trying to find people to come in and then I get lower and lower on that list. But I did think that it wasn't something they quite wanted to prioritise either to be honest because it doesn't take 5 minutes just to check"*
> *Participant 14*

The absence of action some participants identified following their assault led them to believe that their experience of being assaulted was 'in vain'. This related to both a lack of consequence for the patient, or a failure to review practices:

> *"...it would have been nice from management, a bit of recognition and 'this is what's happening, this is what we're doing' would have helped in some ways. To know that potentially they were doing something"*
> *Participant 14*

"I think there is still a long way to go to starting to bring these patients to justice. Because that's another thing, there is often not a result. Even if you report, then what?"
Participant 16

Nurses considered that their managers, organisations and the police frequently failed to recognise the impact the assault had had on them, invalidating their experience. Participant 15 said:

"...it makes me cross sometimes actually, I've done incident forms and sent them off, even when it's just been threats, like verbal threats, and I've incident reported it and I've put, like, it's had a moderate impact on staff because it has. Words can be just as important as being punched in the head, can't they, in the way that makes you feel. And then whoever has received the incident report sent a message back saying "we've downgraded this to no effect or something" and I'm like "how do you get to make that decision of what effect this has had" and they will say "well no one got hurt". How can they say that? We're working with people here and we're very conscious of how people feel, and if it's having an effect it's having an effect"
Participant 15

She went on to say that while parity of esteem – the principle by which mental health must be given equal priority to physical health – is a core value of mental health services, physical harm is paradoxically given primacy over psychological harm in the event of an assault on staff. She challenged the decision to downgrade the effect, pointing to parity of esteem and saying:

"...don't you tell me that it's not had an effect when we should be driving, leading the way in encouraging people to talk about what they're feeling."
Participant 15

Participant 16 recalls her experience of being spat at as being 'minimised' by those around her. When considering why this might have been, she referred to the meaning for her not being shared, and like participant 15, harm being associated with physical injury:

> *"I don't know to be honest. Maybe because it doesn't mean that much to many people... So I think people are so used to dealing with the physical injury rather than the emotional impact"*
> *Participant 16*

Responses from others led to participants reflecting on their worth in relation to other disciplines (e.g. psychiatrists and psychologists) and other professions (e.g. police, paramedics). Those who did perceived unequal treatment and concluded that they were viewed by others as having less worth:

> *"I still maintain to this day if that had have happened to a manager or to a doctor the outcome would have been very very different...Because it's hierarchical isn't it. Doctors are always going to be far more important than the nursing staff on the shop floor. We're kind of more disposable, aren't we."*
> *Participant 8*

> *"...so the police can get assaulted and they follow it through, a member of the public can get assaulted and it's followed through, but as nurses we go and we work to help patients, we definitely don't go to get assaulted, for some reason it's never followed through it's never understood"*
> *Participant 10*

> *"...it almost felt like nurses were punchbags rather than the other disciplines. Because if another discipline was involved, they wouldn't stop talking about it. It would be addressed everywhere, at every level... And we've seen people being transferred to high secure units after assaulting Consultants."*
> *"It's, it's like we're a lesser discipline than others"*
> *Participant 16*

Nurses' acknowledgement that assaults on others were conceptualised - and therefore responded to – differently amplified their belief that what happened to them didn't matter:

> *"It just really made me feel like it just actually didn't matter at all what had happened to me. If it had been a manager or a doctor it would have been a completely different reaction."*
> *Participant 8*

The meaning of this for nurses, seen across the dataset, was that, where experiences following assaults had been negative, they didn't matter:

> *"...you don't matter, you don't count, that it's part of the job, it comes with the territory. It feeds into this culture of 'we don't matter'. We are not worthy of people taking the time out to protect us, we're not worthy of people taking the time out to talk to us about it and to stop it from happening."*
> *Participant 6*

This subtheme identifies the meaning that normalising assaults on nurses holds in relation to their perceived worth. Worth and value are further discussed in the theme 'the response to assault can make or break' when participants reflected on the ways in which others responded when they were assaulted.

Subtheme 3: Blame and responsibility - something about me?

This subtheme comprises data that reflected participants' experiences of being held responsible, blamed and criticised after being assaulted. Participants both described explicit criticism and an implied attribution of blame or responsibility. Some were directly criticised for their actions or omissions, while others interpreted the focus or 'scrutiny' on their practice as communicating or finding fault. Participants' attributions of responsibility for their assault were complex; they simultaneously saw patients as having been in control of their actions, while also finding fault in themselves. Some later reflected on their position

as a leader making them more of a target, and a Black participant said the assault she was a victim of was racially motivated.

Participant 1 was assaulted when he was asking a young person not to knock on other patients' windows while outside in the ward garden. He was punched in the head and face and sustained a cut. As he talked about the response he received from colleagues and managers, he said:

> *"I think they thought I was in the wrong. That I brought this upon myself...It was never said to me, it was never verbalised as such but that was the non-verbals and that was the sense I had really."*
> *Participant 1*

Participant 9 was assaulted as she and her colleagues were attempting to lead a patient to a de-escalation area. She was held by the hair and punched in a prolonged assault. After the assault she was off work and realised she had not been paid. She described her managers' response, which led her to believe they thought she was to blame:

> *"...when I brought it up apparently it was because I had my hair down. And I didn't have my I didn't have my hair down, which is...regardless of the situation whether I did or did not, did not contribute to the patient wanting to kill me."*
> *Participant 9*

Some nurses talked about others stating or implying that they allowed the assaults to happen:

> *"I didn't really get much support from work, I mean after the hostage situation one of my senior managers actually turned round and said, 'well why did you let it get to that point?' And it was like well I didn't let it get to any point, you know these things happen."*
> *Participant 6*

"I think initially I felt that there was some scorn from some of the other members of staff – 'I wouldn't have let this happen...this wouldn't have happened on my shift'"
Participant 11

"...if there were incidents on the ward, like a bad restraint, it was more pointed at the staff for doing it wrong, rather than the patient who had done the assault, it would be looked at like why did the staff allow that to happen"
Participant 10

Participant 8 interpreted the focus on their own actions – including what they could have done differently – as an attempt to attribute blame or responsibility:

"the woman who went through it with me, she was another manager, she just like read it to me as a story and picked out all the bits, like 'it says here at one point you had your back to him' like trying to find fault with something that I'd done, even though they'd taken responsibility it felt like she was trying to...you know it felt like they were nit-picking, trying to find things that could be attributed to me, trying to make out it was my fault."
Participant 8

As well as facing criticism from others, nurses reflected on their experience of being assaulted and frequently questioned whether aspects of themselves had caused or influenced the assault. Nurses who believed they had influenced, caused or failed to prevent the assault made interpretations relating to their skills and actions:

"I hadn't… done… or hadn't acted in a way that could have prevented that. So, my therapeutic input and my skills as a nurse failed to recognise that was going to happen."
Participant 1

"I felt like I'd let myself down, that I should have known better and I shouldn't have let that happen to me."
Participant 2

"...you wonder what you've done wrong - I must have done something wrong to get struck."
Participant 12

"...well of course she bloody hit me - I did the one thing that they told me not to do in the training - to walk into someone who's got leg range' and I just felt well of course, it's my own fault."
Participant 14

Some nurses described themselves as being considered 'targets' by the person who assaulted them. They believed there was something about them that meant they were singled out for an assault – a vulnerability, weakness, or a feature they could not specify - and this was expressed both explicitly and implicitly:

"I guess I would say that I was angry, of all the staff on the ward, that they picked me. Like, you know, did they think that I was going to be the easy target."
Participant 5

Participant 16 identified her race as being the reason the patient assaulted her:

"...as soon as I walked in the patient stood up and spat at me. I think it was a racial issue at that point"
Participant 16

For some, they believed they were assaulted due to their position as a leader and the requirement in that role to make and communicate decisions. Participants described this role as putting them "in the line of fire" and making them a "target":

"...as the nurse with the keys, the nurse in charge, you're the one making those decisions and if they're not happy with the decisions that you've made based on risk then you get the brunt of that."
Participant 9

As also reflected in the subtheme *why do patients assault nurses,* this subtheme captures the nurses' interpretations of why they are assaulted, focussing in this theme on their personal experience. Further, it highlights the influence of others' responses on the extent to which they believe they are responsible or to blame.

Subtheme 4: Support makes all the difference

This subtheme captures both the experiences of participants who felt supported after being assaulted, and the difference being supported might have made for those that were not. Receiving meaningful support led participants to feel valued, helped them to make sense of their traumatic experiences, aided their recovery and reduced self-blame.

Participant 5's experiences of debriefing, empathetic colleagues, supportive managers and a validating response from the police led her to conclude that what had happened to her mattered. Despite no charges being brought against the person, the response by the police meant for Participant 5 that they had taken her report seriously:

> *"...it felt like it mattered. Even though, you know, the police wouldn't do anything, or couldn't do anything and all the other things. It just felt like it mattered."*
> *Participant 5*

Similarly, the notion of being taken seriously made a difference to Participant 11's experience. Despite an initial negative response from some colleagues as described earlier, her experience was validated and she felt safe:

> *"...having the confidence in the managers and the staff that you work with that it would be dealt with, that the consultant was taking it seriously and that measures were put in place and that reviews happened."*
> *Participant 11*

Several nurses spoke about the way in which the provision of psychological therapy had enabled them to recover. Participant 13 recognised the role it played in helping her to make sense of her feelings:

"...you know I didn't think I needed trauma counselling or anything but it was other people that identified that and made those referrals and, yes, it did, it made me feel so much better, it validated it all and made me understand what process I'd been through and why I was feeling the way I was feeling"
Participant 13

Participant 13 recalled the fact that it was her colleagues who identified a need and supported her to access therapy. The anticipated shame and stigma associated with the perception of 'not coping' meant that she and others were unlikely to ask for help. Participant 2 described a colleague noticing a change in her behaviour and asking her how she was. She found it difficult to talk initially – due to anticipated shame and fear - but when she did, her colleague encouraged her to accept help. She spoke about the impact this had:

I wouldn't have been able to process this without that. Yeah, 'cause it was paralysing me. It was affecting my life outside of work as well.
Participant 2

Similarly, Participant 11 recognised the importance of the support they received. They described it as being critical in their recovery – reducing the impact the traumatic event had on them, and preventing longer-term absence from work.

Participant 16 reflected on her experience of being spat at, and the absence of any acknowledgement within her organisation that the assault was racially motivated. Whilst the emotional impact of being spat at was not considered by her colleagues and managers some 10-12 years ago, she discussed the fact that "emotional injuries" are now increasingly recognised. In her organisation she said that the response to racially motivated assaults on staff has improved, but that this has only been very recently:

"...there is a link which is going on with the police - we have a liaison officer who comes in and talks to the patients, talks to the staff and takes it through to the CPS

route. It's all because that has been recognised. That's very recent. So all this time these things have been happening and talked about but nothing tangible being done"
Participant 16

Finally, nurses spoke in general about what would have helped them when they were assaulted. They spoke of the need for an increased focus on support mechanisms for staff who are victims of assault, improved access to trauma services, guidance for managers and improved debriefs. Participant 6 talked about the importance of consultation, choice and being listened to in the approach to supporting assaulted nurses:

"...we do need to think more about asking the staff, do you want to move, or is there somewhere possibly that this person can go. Because that would make staff feel that they mattered. I think when you're a victim of an assault you suddenly feel that you don't matter"
Participant 6

This subtheme has highlighted the difference feeling cared for, supported, and validated can make to the impact being assaulted has on their emotional wellbeing, self-esteem and practice.

5.3 Chapter Summary

This chapter has reported the results of the reflexive thematic analysis undertaken in this study. It has presented the three themes and eleven subthemes that were constructed, summarising each of their central ideas. Broader narratives have been explored with relationships between themes and subthemes being identified. Extracts from the data have been used throughout this chapter to illustrate and bring to life the narratives described, and to ensure that the participants' voices remain at their centre.
The chapter that follows will move from the data and focus on the story told through the themes.

CHAPTER 6: DISCUSSION

6.0 Introduction

This thesis has explored the experiences of mental health nurses who have been assaulted by patients in secure settings. A discussion of the findings presented in the previous chapter now follows, beginning with a summary focussing on the dominant narratives arising from the analysis. The findings are then situated within the existing literature – primarily that identified in the reviews undertaken for this study. To further enable this contextualisation, reference is made to the wider literature comprising quantitative studies and literature reviews - both focussing on contributing factors prevalence, management, and impact of violence against mental health nurses. The ways in which this study's findings develop the current knowledge and understanding of mental health nurses' experiences of assault are then discussed, with the focus being on the narrative that assaults on nurses in secure settings are perceived as being normal.

The discussion then moves on to argue that the experiences of mental health nurses as described in this study represent an epistemic injustice which is both reinforced by, and reinforces, the narrative that being assaulted is normal and to be expected. This is explored in detail with reference to mental health nursing's historical context, the concept of associative stigma as it relates to mental health nursing and the impact of enduring narratives relating to nurses as 'angels' and 'heroes'. This exploration remains grounded in the study's findings, examples of which are included throughout the discussion.

6.1 Summary of findings

This research set out to answer the question "What are the experiences of mental health nurses who have been assaulted by patients in secure settings?" The process of data analysis resulted in the generation of three themes and eleven sub-themes, each capturing aspects of mental health nurses' experiences, the interpretations they made and the meaning the events held for them. Before situating the findings of this study within the existing evidence, the findings described in the previous chapter are summarised.

The participants spoke about both their broader perspectives on violence, aggression and assaults in secure services and their personal experiences of being assaulted. They offered

explanations as to why patients might assault nurses, and these included factors relating to aspects of the illness or disorder with which they were diagnosed, experiences of trauma, resistance to physical interventions (e.g. to prevent self-harm) and gender. In terms of factors relating to staff, they believed that the extent to which the nurse is seen to be honest, respectful and fair had a bearing on how likely patients were to be violent towards them. Interestingly, positive therapeutic relationships were not described as being protective against assaults, indeed one participant described the assault as an "attack on the relationship". These findings, whilst not the focus of the study, are important because they convey the attempts by nurses to make sense of assaults in this context. Nurses talked about why they thought patients assaulted nurses, demonstrating a thoughtful and compassionate approach in spite of their personal experiences.

Despite seeking to understand the reasons for assaults, being assaulted was reported as often – though not always - a traumatic experience which can have a lasting impact on psychological and physical wellbeing, mental health nurses' professional practice and their personal lives. All the assaults nurses described were physical, ranging from being stabbed in the face with a knife to being spat at. During the assaults, nurses described feeling helpless, powerless, and in some cases fearing serious harm including a risk to their life. Where nurses felt confident in the response of colleagues, they felt a greater degree of safety during and immediately following being assaulted. The assaults affected nurses' professional and personal identities, their confidence and their psychological wellbeing, with many being left anxious and hypervigilant. The impact of the traumatic experience could be lasting and "left a mark" for many.

Nurses reflected on the way they and others - including colleagues, managers, other disciplines, the police, and the wider society - viewed assaults in the context of a secure mental health setting. Whilst the risk of being assaulted was recognised by participants, the ongoing narrative that assaults on nurses were normal was rejected and seen to imply that they were *acceptable*. They highlighted the likelihood of being assaulted, and frequently made statements such as "it comes with the territory" which appeared to reflect the "normalising" narrative. This included nurses' reflections on becoming "desensitised" or "getting used to" assaults; several nurses described themselves as "naive" initially, not aware of the extent to which assaults occurred. They saw this as normalising assaults and described it as a means of coping. However, without exception, a distinction was made

between recognising the risks and allowing assaults to be normalised, and therefore *accepted*. They included themselves when they said the practice of normalising assaults should cease. The impact of normalising assaults was considered by some participants as having a disempowering effect, inhibiting nurses' confidence to report assaults or "speak out".

The broader consequence of normalising assaults on nurses was that they are not acknowledged or recognised as assaults. It includes ideas relating to the disparity between what is considered an assault in this context versus in society in general, and the extent to which they are seen as crimes, including by the police. Participants saw the thresholds for deeming an act an assault as being significantly higher in secure mental health settings. Further, harm was also seen to be minimised and narrowly defined (i.e. relating only to physical injury) in this context. Participants perceived there to be a reluctance to prosecute individuals with mental illnesses which together with the organisational responses to patients, meant that they did not face any consequences. They also recognised their tendency to 'forgive' assaults, contributing to the risk that assaults are not recognised.

A powerful narrative conveyed through this study's findings relates to the expectations that were explicitly and implicitly seen to dictate the ways in which nurses *should* experience and manage their emotional responses to being assaulted. The nurses conveyed a shared understanding of the 'rules' surrounding the requirement to suppress emotions, and ideally not experience such emotions at all. The suppression of emotions is described as "part of the culture", and this expectation is internalised as nurses talked about how they *should* be in control of their emotions. An important, novel finding is that when nurses are not able to successfully meet these expectations - i.e. they feel frightened or anxious and are not able to conceal this - they appraise themselves as weak and/or a failure, and feel shame. The anticipation of such shame reinforces the need to adhere to the expectations and keep their emotions hidden. The use of humour was used to convey emotions in an acceptable way. Resisting or suppressing emotions was seen as important in enabling nurses to carry on in their work. "Keeping going" in relation to fulfilling tasks, leading teams, and caring for patients is what they believed was expected of them, and, as in the previous theme, the expectation to "bounce back" was internalised. Doing so is also described as a coping mechanism that in turn further reinforces the narrative in this theme. When nurses were

unable to meet these expectations, they interpreted this as meaning they were inadequate, deficient, not a good nurse, a failed leader and therefore *not up to the job*. They described feeling exposed and vulnerable, neither of which they considered compatible with them being a good, competent and professional nurse. Some saw themselves as "not functioning", "adding to the 'worries' of patients" and "letting the team down".

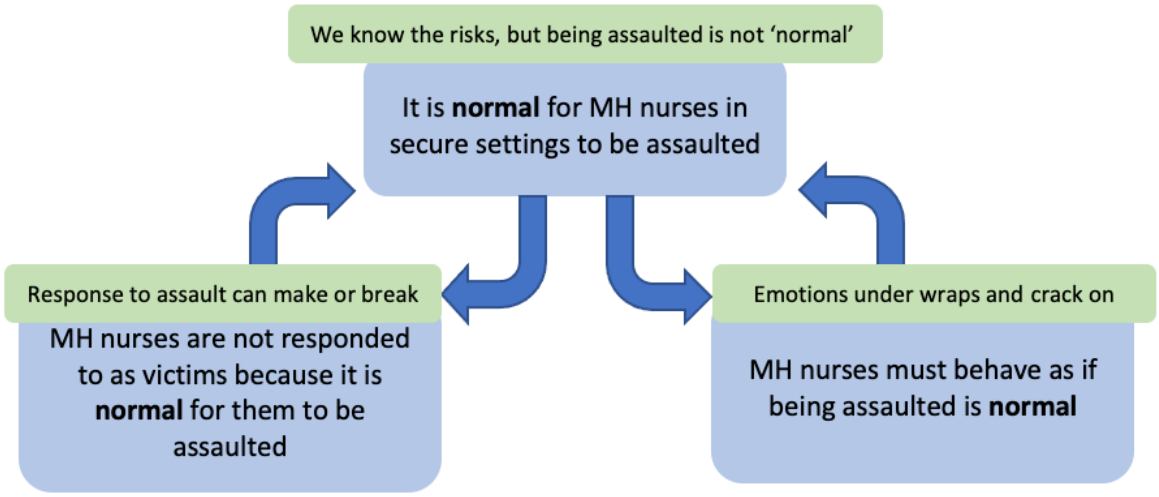
The normalising of assaults both shapes and is maintained by the responses nurses receive from others when they have been assaulted by patients. The response from others was seen to play a pivotal role in the outcomes for nurses who had been assaulted by patients. The response some nurses received - predominantly from within their organisations, and also from the police - led them to feel uncared for, isolated and alone. Some also described these responses as invalidating. The extent to which nurses have their experiences validated, feel supported and view their assault as being taken seriously significantly affects the impact of the experience on their psychological wellbeing, confidence and sense of value and worth. A prominent finding related to the language participants used to describe their experience of not being cared for, supported or taken seriously. "Just a number", "disposable", "dispensable", "replaceable", "punchbag" and "cannon fodder" were phrases and words used to convey the dehumanising meaning of the responses nurses received. The overwhelming conclusion nurses came to was that they didn't matter. Some compared their worth to that of other professions and disciplines, observing that nurses are considered to be of less value than others.

The absence of care and support to make sense can leave nurses feeling responsible for the assaults and blaming themselves. Nurses described their reflective approaches to thinking about the assault they experienced, centring on what it was about themselves, their practice and their behaviour that might have contributed to the assault. Being in a position of authority, enforcing limits and boundaries, appearing "weak" and having "good enough" skills were among the interpretations nurses made. One nurse believed she was assaulted because she was Black. Nurses also recognised the responsibility and culpability of the patients who assaulted them with most considering them to have had capacity to understand what they were doing, to have made a choice and to have been in control of their actions.

Nurses felt valued and cared about when their assaults were taken seriously, and their experiences were validated. They also benefited from opportunities to make sense of their experience and to receive trauma informed support. For the few participants who described a supportive and caring response from within their organisations and from the police, it was seen as critical in minimising the potential negative personal and professional impact of being assaulted and contributed to them being able to continue in their work.

The themes generated during the data analysis process are united by the idea that assaults on mental health nurses in secure settings have been normalised. They separately and collectively speak to how this normalisation impacts individuals' thoughts, feelings and behaviours, and the behaviours of others as they respond to assaulted nurses. The ways in which the narrative that assaults are normal is enacted and reinforced are inherent throughout the study's findings. The diagram below (figure 7) illustrates the relationships between the three themes, and the story they tell. The first theme, *we know the risks but being assaulted is not 'normal'* demonstrates that while mental health nurses do not think being assaulted should be considered normal, they both recognise that it is normalised, and consider this to be evident in the responses from others. The impact of this normalisation is that nurses suppress and hide the emotional impact of being assaulted as in theme two, *keep emotions under wraps and carry on*. To admit anxiety, fear or panic would be inconsistent with the narrative, and would lead to shame as a result of being exposed as weak and a failure. As is indicated in the diagram, not responding emotionally also maintains the narrative within the social reality of this context. As captured in theme three, *the response to assault can be make or break,* nurses describe the response from others (e.g. managers and police) as predominantly being in keeping with the narrative. They were not responded to as victims of assault because assaults were considered normal and to be expected in this context. Again, as indicated in the diagram, such responses serve to reinforce the narrative.

Figure 7: Diagram illustrating the impact and maintenance of the normalising narrative



It is important at this point to consider narratives constructed during analysis that offer different or contrary perspectives, and also narratives that were hinted at but not fully developed in this study. Doing so maintains the transparent and reflexive approach to this study, particularly in light of the potential for critique relating to *cherry-picking* data to support an argument (Braun & Clarke, 2022) or misrepresenting the dataset (Morse, 2010).

First, as the findings demonstrate, participants offered some different perspectives on the central organising concepts that were based on their experience. The aim of this study was not to search solely for *consensus* views or areas of agreement, rather to explore subjective realities and the dominant narratives - or patterned meanings (Braun & Clarke, 2022) - that were identified during engagement with the data. For example, not all the nurses interviewed described being assaulted as traumatic. The code *felt safe during assault* was applied to data that described - for reasons including previous experiences of well-managed incidents, training and trust in colleagues' responses - participants' feelings of safety as they were being assaulted. However, one participant who described this sense of safety also questioned whether them not feeling anything in the aftermath was due to it being "drilled" into him that their experience was "normal". Another participant was ambivalent about describing their experience of a patient attempting to strangle them as an assault, and said

"I didn't feel any pain, wasn't injured". Another spoke about being hit from behind with a chair with humour, joking about their annoyance that as they fell, they smudged the allocation board they had been writing. They went on to talk about her threshold for considering an act an assault as higher, and was critical of someone who considered, for example, having a book thrown at them as an assault. While these participants did not describe their experiences as traumatic or having a lasting impact, their perspectives on what an assault in this context is spoke to the normalising narrative and the ways in which it is internalised and maintained, including from within the nursing profession. Others, as captured by the code *normalising can help us cope* spoke to a defence mechanism that serves to perpetuate the unhelpful narrative rather than a healthy coping mechanism.

The theme "*the response to assault can make or break*" speaks to the central role validation, support and care play in the outcomes for nurses who are assaulted. Not all nurses experienced a lack of support, and their experiences are reflected in the sub-theme *support makes all the difference*. While the dominant narrative is one of normalisation negatively impacting nurses' experiences, the sub-theme comprises data that did not fit the narrative that assaults are normal. When considered within the normalising narrative, where nurses described an experience of feeling supported beyond their immediate nursing colleagues, the difference appeared to be that the response was not guided by this narrative.

The sub-theme also includes data that reflected assaulted nurses' ideas about what they would have liked to have been different for them, and what they would like to see more generally e.g. robust, prioritised support for nurses with particular attention being paid to newly registered nurses; a commitment to consult with, listen to and offer choices to assaulted nurses; routine debriefing; a less process driven and more 'human' approach and improved access to trauma services.

Second, there were two particular narratives that were interesting and, while incorporated into the analysis during coding, were not emphasised within the dominant narrative. It was decided that doing so would distract from the focus of the research question and the aims of the study which centred on giving voice to assaulted nurses. Both narratives were concerned with perspectives relating to why assaults in secure settings happen. One related to therapeutic relationships and the extent to which they affected the likelihood of being assaulted, and the other to the *'mad' versus 'bad'* or *mental illness versus personality disorder* dichotomies when considered in relation to responsibility, intent and blame.

A decision to feature but not focus on the data relating to diagnoses and their relationship to patients' levels of self-control - and therefore intent and responsibility - was taken. This was because participants' perspectives reflected a long-standing and well-rehearsed discussion in the literature relating to attitudes towards personality disorder and aggression/violence (Cutcliffe, 1999; Markham & Trower, 2003; Dickens *et al*., 2016). Patients with a diagnosis of personality disorder were mostly deemed to be in control of their behaviour, and it was therefore deemed to be intentional and deliberate, making them responsible and accountable. However, there was one aspect of the data that introduced a greater degree of complexity and nuance to the prominent dichotomous perspective. Alongside perspectives relating to intent and responsibility, the data reflected thoughtful, trauma-informed explanations for aggression and violence, including the assaults nurses themselves had experienced. They simultaneously saw a greater degree of accountability for assaults not driven by psychosis, while also seeing violence as a means of expressing emotions, stemming from abuse, a sabotaging of progress and a sign of needing help. This is suggestive of a less dichotomous and more compassionate perspective in spite of having experienced an assault.

The therapeutic relationship featured in four data codes; *assaulted in spite of good therapeutic relationship; assault negatively impacted therapeutic relationship; being assaulted did not affect the therapeutic relationship* and *being assaulted should not impact patient care* (interpreted as including the relationship). These codes represent what some participants discussed as being the impact of being assaulted on the therapeutic relationship, and vice versa. They spoke about the relationship not being a protective factor – one participant understood the assault as having been "an attack on the relationship" which was an interesting finding, both in the context of how nurses made sense of what happened, and more broadly in relation to the complexity of the therapeutic relationship in mental health nursing. The findings were incorporated into the themes as opposed to being developed into a central organising concept for a further theme. This was because there was not a dominant pattern in meaning across the dataset making interpretation and the development of a more comprehensive understanding impossible. Neither was there a *depth* in meaning. For example, as in other studies (for example Benson *et al.,* 2003) the data did not elucidate the participants' conceptualisations of what they termed a "good" relationship. This integral part of the mental health nurse's work, described using a variety

of terms, has, as Wright (2021) argues, the potential to be taken for granted due to its familiarity. Beyond recognising the importance of fairness, honesty and respect with regard to reducing the risk of assault, they did not elaborate on what a "good relationship" constituted. There was no discussion for example about the part the power dynamic may play, though the data identified the setting of limits and boundaries, and being seen as a 'leader', as reasons for being assaulted. Baby *et al. (*2014) highlight the imbalance of power, heightened in a secure setting where freedom, choice and agency are restricted, and identify perceived disempowerment as a catalyst for violence. Whilst factors such as the limitations on freedom and choice were seen to contribute to the frustration and anger expressed by patients, they were not considered from an interpersonal perspective by participants.

In light of the recognition in mental health nursing literature of the part the nurse-patient relationship plays in reducing and managing conflict, aggression and violence (Bowers, 2014; Gildberg *et al*., 2021) the idea that nurses are assaulted *in spite of* or as one participant described, *because of* their therapeutic relationship is one that has the potential to enhance understanding of conflict in these settings. The data suggest that further exploration of assault *in the context of* the therapeutic relationship, drawing on theories of attachment, and examining the complex challenge of maintaining the relationship while experiencing fear, anxiety and potentially anger and disgust, is required.

6.2 Findings in the context of current evidence

The discussion now moves on to situate the findings of this study in the context of the current evidence. The ways in which this research develops the understanding of mental health nurses' experiences of assault and provides new insights into their interpretations of both their own and others' responses are discussed. The literature referred to includes that which was reviewed in this study's meta-aggregative review of qualitative evidence and also in the focussed mapping review and synthesis relating to the use of the term 'assault'.

The first synthesised finding presented in the primary literature review for this study, headed 'perspectives on violence against mental health nurses' highlighted the evidence

that nurses saw violence against them as a significant but expected problem which was considered normal. The findings of the current study echo these perspectives, and also the simultaneous rejection of the idea that being assaulted was normal or acceptable. The fact that mental health nurses working in inpatient settings are at a high risk of being assaulted has been increasingly recognised across empirical studies over the past few decades (Nolan *et al.,* 1999 and others). Likewise, the narrative that assaults on mental health nurses are considered 'normal' is not a new one. Many studies have explicitly described violence/ aggression/assault as being considered to be 'normal', 'part of the job' and 'the nature of the work' (Ward, 2013; Baby, 2014; Stevenson, 2015; Dafny & Beccaria, 2020; Dean *et al*., 2021; Hiebert *et al*., 2021). Those that do not explicitly state such interpretations nevertheless implicitly convey the narrative as they discuss the frequency of assaults and describe them using terms such as 'expected' and 'inevitable' (Currid, 2008; Moylan *et al*; 2014).

The findings of this research focus on the normalising of assaults on mental health nurses in a way that previous literature has not. In keeping with Danermark and Ekström's (2019) perspective on the value of the *recontextualization* of empirical data, the dominant narrative identified in this study gives new meaning to an already known phenomenon. It makes connections and suggests relationships between the narratives that assaults on nurses are normal and the responses of both assaulted nurses and their managers/ organisations. In particular, the recognition of normalisation as a social process, and one that both impacts and is maintained by the responses of all involved, represents a novel explanation of the phenomenon. This discussion will later consider normalisation from a conceptual and theoretical perspective, and explore possible explanations for the enduring narrative. However, before doing so, the findings relating to the impact and maintenance of the narrative are further considered with reference to existing literature.

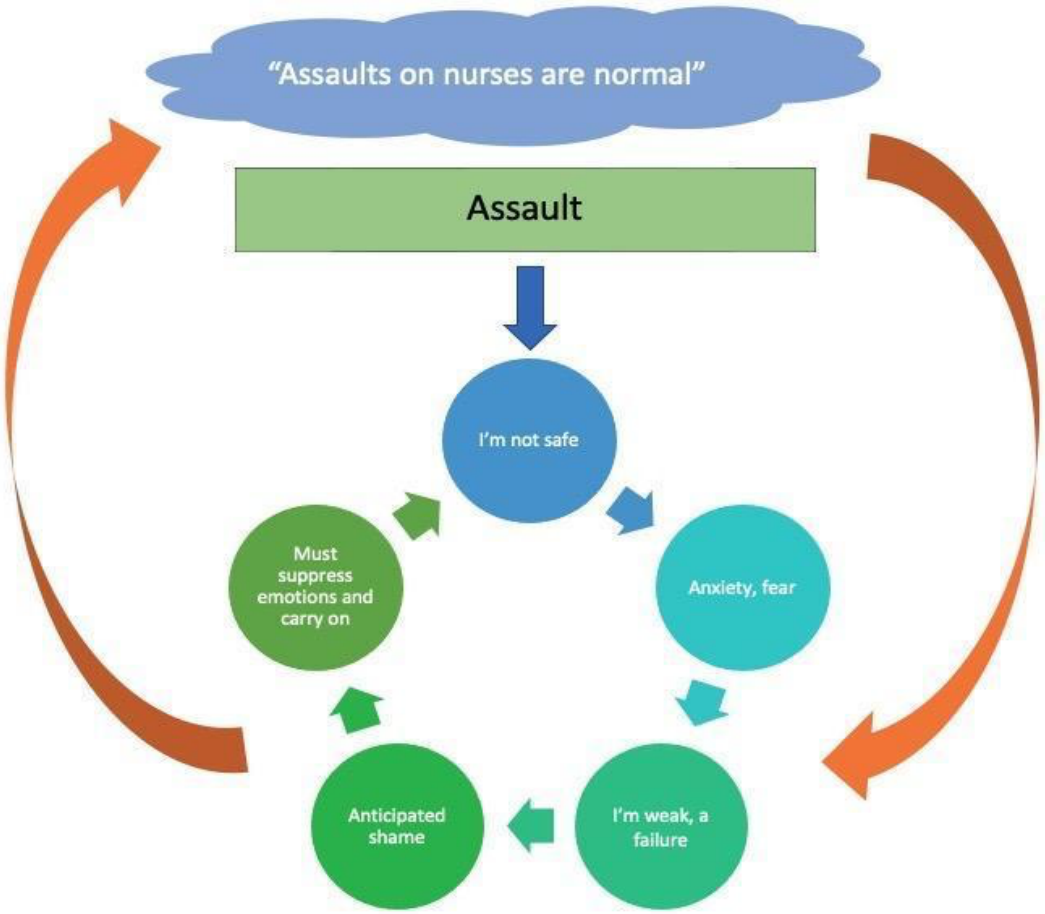
The theme *Emotions under wraps and carry on* captured the expectations that nurses had on and of themselves in the aftermath of being assaulted. The emotions they experienced were anxiety, fear, guilt and shame. The approach to data collection in this study was informed by cognitive behavioural theory - the assumption that it is not an event in itself that determines human beings' emotional responses, it is the *meaning* of the event for the individual - their *interpretation* (Ellis, 1957; Beck, 1979). During the interviews, participants

were asked questions such as “what was going through your mind as X happened?”; “what did it mean to you/say about them that they didn’t call?”; “you say you should have ‘been stronger’- what did it say about you that you weren’t?” in order to elicit their thoughts, beliefs and emotions. Doing so resulted in rich data that, through analysis, contributed to a deeper understanding of nurses’ emotional experiences and the beliefs that underpinned them.

An important insight that develops our understanding of nurses’ experiences relates to anticipatory shame and the part it plays in emotional suppression. Nurses’ suppression of emotions has been both explicitly described and implicitly recognised in the findings of qualitative studies of nurses’ experiences of violence, aggression and assault (Kindy *et al.,* 2005; Moran *et al.,* 2009; Tema *et al.,* 2011; Zuzelo *et al.,* 2012) with terms such as ‘desensitisation’, ‘hardening up’ and ‘growing a thick skin’ being used in both the current study and others. Attempts by nurses to ignore, deny, hide or distract from their emotional responses to being assaulted, and more generally to being exposed to violence and aggression, have been explained in the following ways; as means of protection against assault (e.g. can’t let patients see emotions such as sadness or they’ll ‘break you down’, Kindy *et al.,* 2005) as a coping mechanism, and as a pre-requisite to being able to continue to function/work (Moran *et al.,* 2009). While shame has been identified in some studies as an emotion assaulted nurses experience (Needham *et al.,* 2005; Dafny & Beccaria, 2020; Sim *et al.,* 2020; Dean *et al.,* 2021), it features less frequently and is discussed superficially. The thoughts, assumptions and beliefs that lead to the anticipation of shame and therefore the suppression of emotions have not been identified. The findings of the current study expose the relationship between the fear and anxiety nurses can experience after being assaulted, the meaning of these emotions (and their impact) for them, and the shame they anticipate were they to express how they felt. Eliciting the interpretation not only of the event, but also their emotional response to it has enabled a deeper insight into the reasons nurses guard against shame. Shame in this case is a meta-emotion - a feeling about a feeling - and it results from the negative self-appraisals nurses make about their responses to being assaulted. Participants in this study judged themselves as being “weak”, “a failure”, “a bad nurse” and “a poor leader”. These beliefs stemmed from the assumption that a good mental health nurse should not be adversely affected by being assaulted - they should be able to carry on and bounce back. This assumption is in keeping with the narrative that

assaults on mental health nurses are normal. Therefore, in order to guard against the shame they would experience were they exposed as being weak/a failure, nurses suppress their emotions and engage in behaviours including focussing on tasks, "laughing it off' and avoiding talking about it. As a result they are less likely to seek support and more likely to remain anxious. Nurses also described withdrawing from other people and feeling alone and isolated as a result. Guilt - another emotion referred to in previous studies - is also experienced as nurses describe their belief that in not "coping" or "carrying on" they are "burdening" or "letting down" others. The diagram below represents this explanation (figure 8).

Figure 8: Diagram illustrating the impact of the normalising narrative on nurses' responses to being assaulted



I argue that understanding the impact normalising assaults has on the meaning nurses attribute to their experiences of what are widely considered 'normal' emotions when a person is assaulted is of significant importance. Unless we understand this aspect, the response to assaulted nurses risks overlooking the profoundly negative ways in which nurses' self-esteem can be affected. This is particularly the case given the effort nurses described going to to conceal their emotions.

The suppression of emotions in nursing was the focus of an important piece of research by Isabel Menzies-Lyth in 1960, which, although undertaken in an acute hospital context, resonates with the findings of this study. She conceptualised emotional suppression or "detachment and denial of feelings" (Menzies-Lyth, 1960:102) as a defensive technique, which, together with other mechanisms, serves as a social defence system against anxiety. In her study, she emphasised that the "full, immediate and concentrated impact of stresses arising from patient care" were borne by the nursing team (Menzies-Lyth, 1960:97), and as a result, socially structured defence mechanisms develop. These mechanisms, she argued, develop within the context of the organisation, and become aspects of its shared external reality with which its members must come to terms. It is apparent in the findings of this study that anxiety is an emotion - whether described explicitly or seen as implicit in their behaviour - common to mental health nursing teams in secure settings. The ongoing threat to participants' personal safety and that of those around them was referred to directly when they described a "sense of fear" and "emotional pressure" and was implicit in participants' descriptions of their thoughts and behaviour; "I was very aware of his presence" and "you're just constantly aware of everything that's happening around you". In Menzies-Lyth's study, emotional suppression was expected and enforced through advice from seniors to maintain a "stiff upper lip"; an expectation echoed in the findings of this study.

The findings of this study expose a global - or systemic - normalisation of assaults on mental health nurses. Menzies Lyth's work brings to this understanding the theory of social defences against anxiety, conceptualising normalisation and the ways in which it is enacted as a means of denying, or neutralising, an anxiety provoking reality. Not doing so would risk overwhelming an already pressurised system and threaten its ability to achieve/deliver what it needs to. Instead, nurses and the wider organisation/system resist thinking about it and acknowledging the reality through purposeful normalisation. In terms of solutions, Menzies

Lyth rejected the interpretation that the answer to the problem of anxiety-provoking work was to provide support groups for staff. Rather she argued the focus for the organisation should be on the effective containment - the provision of a safe space to express and make sense of emotions (Bion, 1955) of staff anxieties (Lawlor & Webb, 2009). This perspective resonates with participants' expressions of wanting to be heard, taken seriously, validated, and cared for. It is also supported by nurses' descriptions of the negative impact of being unable to safely express their emotions after being assaulted.

As captured by the code, *we know the risks, but assaults should not be normalised*, participants in this study simultaneously acknowledged and rejected the normalising of assaults on mental health nurses. This tension is consistent with the findings of previous studies (Stevenson *et al.,* 2015; Dafny & Beccaria, 2020; Dean *et al.,* 2021). While some participants in the current study recognised their parts in perpetuating the narrative, with one referring to an "unhealthy acceptance" of violence, the majority did not explicitly express the same, rather it was interpreted during data analysis as being implicit in their responses to being assaulted. These included the use of humour, the focussing on tasks and also the typically high threshold for defining an act as an assault.

Approaching 20 years ago Kindy *et al. (*2005) observed that mental health nurses, in the face of a continual threat of assault, "quietly continue to assume their role with minimal recognition, recourse or dedicated attempts by those in power to remedy the situation" (Kindy *et al.,* 2005:174). More recently, Dafny and Beccaria's (2020) study indicated that nurses believed they should not tolerate violence, but they felt powerless to prevent it. In their discussion, Stevenson *et al. (*2015:11) reflected on their participants' statements that they did not want to "accept violence as tolerable or part of their reality" and suggested this may indicate that nurses were becoming more empowered to "take a stand". The current study's findings echoes both perspectives - a desire for change combined with a sense of powerlessness/resignation. There is a question therefore about why the narrative continues to endure. What factors may be contributing to the continued normalising of assaults on mental health nurses in this context? The discussion now moves on to explore these questions and begins by offering Fricker's conceptualisation of epistemic injustice as means of understanding mental health nurses' experiences.

6.3 Epistemic Injustice

Many participants in the current study described their experience of being assaulted as traumatic. They also described a lasting psychological impact, not only from the assault itself, but also from the way in which others responded to them. As one of the participants said, "the response to it [the assault] I think compounded it and made it a lot worse". There was a strong feeling among participants that assaults on mental health nurses "go unseen", and this, combined with an absence of care, validation and support following an assault led nurses to question their worth. Many used terms such as "I didn't matter" and "I was just a number" to describe the meaning for them of the response from their managers, organisations, and the police. The experience of being unheard was a dominant one in the findings of this study, and it is proposed that its enduring presence can be understood within the philosophical framework of epistemic injustice.

Epistemic injustice is a term referring to phenomena that exist where epistemology and ethics meet. Miranda Fricker, a British philosopher, first used the term in her book Epistemic Injustice: Power and the Ethics of Knowing (Fricker, 2007). Fricker argued that there existed a particular kind of injustice that was distinctively epistemic in nature; "a wrong done to someone specifically in their capacity as a knower" (Fricker, 2007, p. 1); and that the ways in which epistemology had traditionally been pursued meant that the ethical and political aspects of epistemic practices - how we propose, communicate, assess and legitimise knowledge claims (Kelly & Licona, 2018) - had not been revealed. For Fricker, this was in part due to there being an absence of a theoretical framework within which to reveal these phenomena. Importantly, she approached her exploration through the lens of human practice as being socially situated. Only through viewing human practices in this way, she argued, could the political and ethical features of epistemic activity be revealed (Fricker, 2007).

Epistemic injustice results in those it affects being unable to contribute their knowledge or have their experiences heard, recognised and validated. Fricker argues there are two forms of epistemic injustice; *testimonial* and *hermeneutical*. *Testimonial* injustice refers to the speaker being taken less seriously because of ingrained prejudice on the part of the hearer. As a result of a specific characteristic of the speaker (e.g. gender, race or class), they are found to be less credible. The knower, or speaker is then the subject of a testimonial injustice. *Hermeneutical* injustice refers to injustice that occurs due to the knower not

having the means to communicate their experience because the concepts required to properly understand the experience are not sufficiently shared across the social space. Fricker (2007) uses the example of women experiencing sexual harassment prior to its conceptualisation as such. There is therefore a gap between the experience, the ability to express it and the ability to hear it. I argue that mental health nurses can be subject to hermeneutical injustice.

The findings of this and previous studies have included mental health nurses' experiences of not being heard or taken seriously when they talk about their experiences of being assaulted by patients (Kindy *et al.,* 2005; Currid, 2008; Stevenson *et al.,* 2015). Examples include participants making statements including "the most disheartening thing about the job, that you know these things [assaults] are going to happen and you try to do something about it and people don't listen" and "we shouldn't accept it not being taken seriously". One participant talked in detail about not feeling heard or taken seriously by either his managers or by the police, and said "for some reason it's never followed through and it's never understood".

As has been discussed in this thesis within the literature reviews and the findings of this study (coded *absence of a shared definition of assault in secure settings*), there is a problem in relation to the lack of a conceptual understanding of assaults in the context of inpatient mental health settings. The focussed mapping review and synthesis found that very few studies defined 'assault', and frequently used terms such as aggression, violence, assault and abuse interchangeably. Those articles that did define assault referred to it as a physical act, with the majority of the others implying the same. I suggest that the concept of nurses being assaulted by patients in mental health hospitals is not adequately defined and shared across social spaces. This has been the case for decades as Nolan *et al. (*1999) argued, and it has impacted the extent to which the prevalence of assaults on mental health nurses is known. As identified in the focussed mapping review and synthesis, the language used to describe assaults is frequently inconsistent, and of concern can be misleading and serve to dilute or sanitise nurses' realities. Phrases used in the literature such as "experience violence"; "encounter violence"; "exposed to violence" and "face verbal aggression" frequently refer to a nurse being assaulted. Use of language in this way understates the seriousness of the assaults nurses face and minimises the harm they can cause. It also implies "facing violence" in a mental health unit is different to, and more acceptable than,

"being assaulted" in the community. The problems associated with definitions and use of language relating to violence in this context have parallels with those described in the literature relating to domestic violence (Gracia & Herrero, 2006; Kelly & Westmarland, 2014). Kelly & Westmarland have argued that inconsistent definitions and changes in language have "progressively disguised, diluted and distorted the reality of gender-based violence", and to extend the parallel, others have conceptualised the silencing of victims' experiences as examples of epistemic injustice (Jenkins, 2017; Warman, 2021). Jenkins specifically refers to hermeneutical injustice, likening domestic abuse to Fricker's example of sexual harassment which until the 1960s/70s was not recognised as a concept. Similarly, when combined, the absence of a concept to describe nurses being assaulted by patients, and the enduring narrative that assaults are "normal", mean that nurses are unable to properly understand and communicate their experiences to other social groups (e.g. the wider organisation, other disciplines and the police).

I suggest that a further concern is the way in which "harm" is defined and determined in healthcare organisations when it relates to nurses who have been assaulted by patients. The focussed mapping review and synthesis conducted for this study identified the primacy given to physical assaults, and this was echoed in the code *in practice assaults in secure settings are physical acts.* Whilst there are studies exploring the psychological impact of assaults (e.g. Hilton *et al.,* 2021), more often a reductionist approach to defining harm is seen in the literature, largely guided by the degree to which the victim is physically injured. This has the potential to silence nurses through a denial of experiences that do not meet the operational definition of assault. This is echoed within organisational incident reporting mechanisms and processes. One participant in this study reported her experience of having the impact of incidents downgraded due to there being no physical injury. She went on to point to the irony of mental health services overlooking psychological harm experienced by its staff. I therefore argue that together with the need to establish a clear contextualised conceptualisation of assault, we also need to examine the definition of harm in this setting. The concepts of trauma, and of 'victims' of assault exist – they are just not readily applied and recognised when the assaulted person is a mental health nurse and the person responsible for the assault is an inpatient in a secure unit. There appears to be no straight-forward response to the question over why such vagueness, and in relation to harm, reductionism, continue despite overwhelming evidence that both contribute to

underreporting and therefore problems identifying the extent and nature of assaults on nurses. The findings from this study continue to suggest that the evidence and recommendations for greater clarity have not been operationalised, and nurses in practice continue to describe high thresholds for an act being considered an assault, inconsistent definitions and narrow definitions of harm. One possible explanation is that the continued inconsistency, vagueness and reductionism represents what, as discussed earlier, Menzies-Lyth described as a social defence against anxiety. In not conceptualising assaults and harm more clearly and more inclusively, organisations continue to avoid the reality which has the potential to overwhelm mental health services, particularly in the context of increasing workforce pressures.

On attempting to understand nurses' experiences within the theoretical framework of epistemic injustice, hermeneutical injustice provided the most obvious explanation. However, I then began to question whether there were characteristics associated with the mental health nursing profession that may be the subject of prejudices of some kind and therefore result in testimonial injustice, i.e. what mental health nurses say is less worthy of being heard and/or judged as being less credible by those hearing them. This discussion now moves to consider this possibility with reference first to mental health nursing's historical context, second to the concept of associative stigma and third to the broader narrative of nurses being viewed as 'angels' or 'heroes', and the association with nursing as a gendered profession. It is argued that these three factors have a bearing on the way mental health nurses are regarded and hence the extent to which their experiences are recognised and taken seriously.

6.4 History of Mental Health Nursing

Mental health nursing's history in the UK dates back to the mid-nineteenth century, however until recently there was relatively little written about the history of mental health nursing as compared to both general nursing and to psychiatry (Nolan, 2021; Thomas, 2023). This in itself raises questions as to the status of mental health nursing. Most historical accounts of nursing and its development focus on Florence Nightingale and her

influence on nursing in the Victorian era. For Florence Nightingale, nursing was considered a vocation, or a 'calling' and defined as women's work. Chatterton (2000) writes about this in the context of mental health nursing, and explores through a study of its history, the conflicts, tensions and challenges women in mental health nursing have faced. She writes that nursing required women of good 'moral fibre' (a 'good woman = a 'good nurse') and 'obedient' dispositions reflecting the middle-class construct of the family (Chatterton, 2000), and contrasts this with how mental health nurses were seen, as is now discussed.

As Florence Nightingale opened her first school of nursing in 1860 in St Thomas' hospital, the care of the mentally ill was undergoing significant development, and alongside the growth of asylums, another branch of nursing began to emerge (Bradshaw, 2023). Nurses began to join the male "attendants" or "keepers" in the asylums, living, as the men did, in the asylums themselves. The asylums were built away from populated areas, with the aim being to keep the mentally ill separate from society. The work was considered to be low status, working conditions were poor and they were, like the patients, isolated. Their wages were lower than their general counterparts and mental health nursing, in direct contrast to Nightingale's conceptualisation of nursing, was seen then as an occupation rather than a vocation. As such, working class women were recruited as nurses in asylums (Chatterton, 2000), and mental health nursing's position as the 'Cinderella' of the nursing profession, which persists today (Coleman, 2019), was cemented. Nurses in asylums were disempowered within what was a paternalistic culture; the (male) medical superintendent held the power, and the nurses were bound by similar rules of obedience as the patients (Chatterton, 2000). Stigmatised for working in asylums with the mentally ill, nurses were described in the Nursing Times in 1922 as a 'pariah' among nurses (Beaton, 1922). The lower status of mental health nursing is further evidenced by its journey to professionalisation and registration. Mental health nurses' training and registration - initially conducted and controlled initially by psychiatrists - began some 40 years after general nurse training, and there was resistance among general nurses to those working in asylums being deemed nurses and therefore eligible to join the general nursing council's nursing register. When mental health nurses were included in the 1919 Nurses Registration Act, it was on a supplementary part of the register (RCN, 2021).

A further series of events important in mental health nursing's historical legacy (Chatterton, 2000) involved the unionisation of nursing and the key part mental health nurses played in the disputes over increasingly poor pay and conditions following the First World War. Clearly seen as incompatible with Nightingale's moral philosophy of service, their prominent role in action against poor pay and conditions was condemned by the wider profession and the nursing press as shameful, and their actions "deplorable" (Chatterton, 2000, p. 18).

It is argued here that the legacy of mental health nursing's history and low status remains and is apparent in society, in nurse education and in the findings of the current study. For example, social discourses, reflected in film and television, portray the ways in which society views people with mental illness and those who nurse them. In his ethnographic study of American films and their depictions of mental health nurses, de Carlo (2007) described the "lowly" status of the profession being surmisable by the fact that in only one of the nineteen films the nurse was played by a well-known actor (unlike the patient or psychiatrist), and this film was the sole representation of a mental health nurse as a skilled, autonomous practitioner. Portrayals of mental health nurses are summarised as being "one dimensional clichés...custodial companions and doctor's handmaidens" (de Carlo, 2007, p. 346).

The findings of this study suggest that some participants continued to have a felt sense of being less visible, less well regarded and of somewhat lower value than other fields and professions. One participant described mental health nursing as a "hidden frontline" (Participant 6). This reflects the literature in which mental health nursing has been described as the least respected and appealing field of nursing (Happell & Gaskins, 2012; Molloy *et al.,* 2016). Furthermore, a sense of disempowerment among mental health nurse academics is currently being voiced as they argue that the NMC's standards for pre-registration nursing programmes (NMC, 2018) have resulted in a dilution of mental health nursing content in undergraduate curricula (Warrender, 2022). They contest that as generic nursing programmes give primacy to adult nursing, mental health nursing is being "denied the opportunity to determine its own future" (Mental Health Nurse Academics UK (MHNAUK), 2016).

Mental health nurses, together with the people they cared for, were from the outset distanced from both society and the nursing profession itself (and mainstream healthcare services in the case of patients). The history of mental health nursing highlights the

dissonance between the image of 'angelic' female nurse and the custodial nature of the work, the gendered division of labour and the tensions between professionalisation and unionisation. It is argued that this historical legacy continues to influence perceptions of mental health nursing today, and that its lower status influences the experience of testimonial injustice faced by nurses.

Two features of mental health nursing exposed through examining its history influence the status it holds within healthcare and in society more generally. First, the nursing profession is rooted in gendered stereotypes, with nursing being established by Nightingale as women's work, and as such is recognised as being subjugated (Chatterton, 2000; Stokes-Parish *et al.,* 2020). Whilst mental health nursing in the UK has a more balanced workforce in terms of gender (Bowers *et al.,* 2009) it is argued that it remains a gendered profession with male nurses being subject to the same subjugation by association. Secondly, attitudes towards mental illness and those experiencing it have always been heavily influenced by stigma (Tyerman *et al.,* 2021), and in recent years there has been increasing acknowledgement of the stigma being extended to those caring for the mentally ill (Domingue *et al.,* 2022). In relation to both its gendered and stigmatised associations, the history of mental health nursing also highlights the problematic dissonance between the image of the 'angelic' female nurse and the custodial nature of the work. It is suggested that both the gendered nature of nursing, and the stigma affecting mental health nurses further impact the extent to which nurses' voices are heard. These two aspects are now discussed.

6.5 Associative Stigma

It is argued in this discussion that there is a stigma associated with working with people with mental disorders, and this contributes to the epistemic injustice mental health nurses face. First explained by Goffman in 1963, using nurses who care for people with mental illnesses as an example, associative - also known as courtesy - stigma refers to negative perceptions of individuals based on their cultural, social or political relationships with a stigmatised group. He argued that in these circumstances wider society treats the stigmatised individual and those associated with them "as one" (Goffman, 1963, p. 30). When applied to the

context of mental healthcare it is defined as "stigma that mental health professionals experience because they are associated with persons who belong to a stigmatised category in society, namely, people with mental health problems" (Verhaeghe & Bracke, 2012, p. 18). As patients receiving care and treatment in secure mental health settings are subject to dual stigmatisation due to the majority having engaged in offending behaviour, there is also a reasonable argument for extending this double-stigmatisation to mental health nurses working in secure settings.

The origins of the associative stigma nurses experience can be seen in the development of mental healthcare and the mental health nursing profession. People with mental illnesses and disorders were stigmatised and removed from society, and by association so were the mental health nurses who not only cared for but lived together with those incarcerated in asylums. It has even been the case that, through this close connection, mental health nurses have been seen by both the public and other fields of nurses (Sabella & Fay-Hiller, 2014) as becoming mentally ill *or* "crazy" themselves (Ebsworth & Foster, 2017; Waddell *et al.,* 2020).

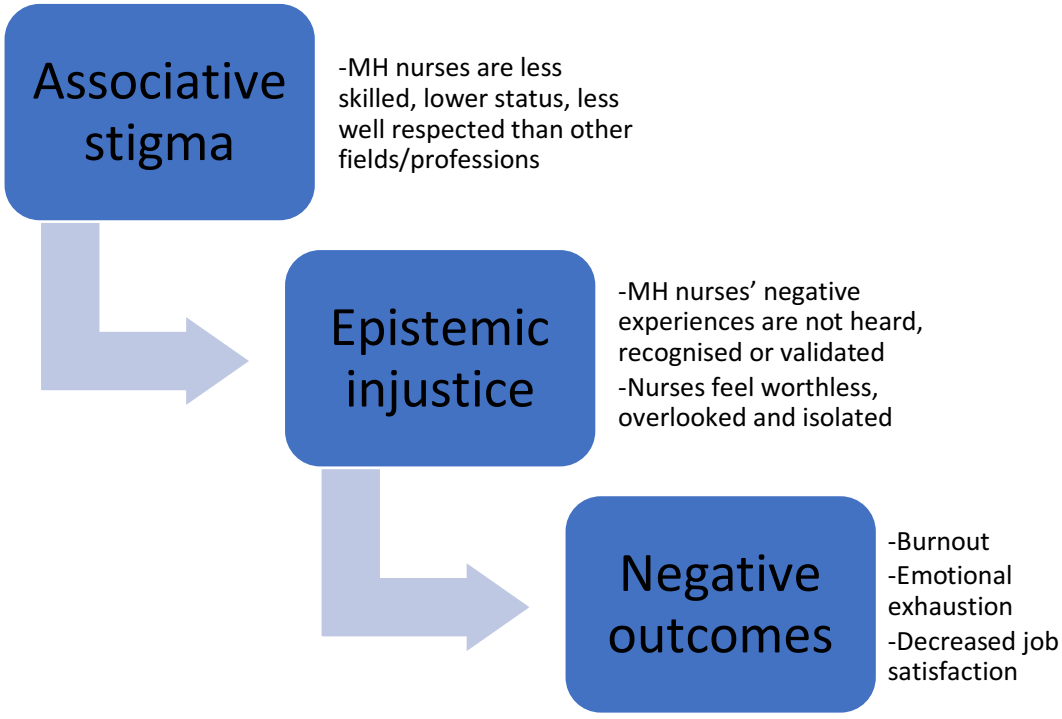
Mental health nursing has been described as an invisible or 'hidden' branch of nursing (Fourie *et al.,* 2005), and this was echoed in the findings of this study. One participant said, "psychiatric nurses are hidden, forensic nursing's hidden, like the patient population is and has been for over a hundred years". She compared the ways in which other healthcare professionals were more favourably perceived both within healthcare and in wider society, as did Domingue *et al. (*2022) in their recent integrative review of experiences of associative stigma among mental health nurses and other professionals. They found that the literature described mental health nursing as an "undervalued specialty in the nursing discipline" (Domingue *et al.,* 2022, p. 847), again echoed in the perspectives of nurses interviewed for this study. The degree to which mental health nursing is seen as "real" nursing is therefore in question (Waddell *et al*., 2020), as is the degree to which it requires specific knowledge and skills. Described in the literature as "soft skills", core aspects of the mental health nurse's job, such as the development and maintenance of therapeutic relationships are deemed to require less knowledge and technical skill than some of the "hard skills" associated with medical practice (Ng *et al.,* 2010; Happell *et al.,* 2013; Waddell *et al.,* 2020). A study which asked a sample of American nurses to rate ten nursing specialties on eight

attributes found that mental health nurses were least likely to be rated as skilled, dynamic, logical or respected (Halter, 2008).

Waddell *et al*. (2020) make the point that the stigmatising narrative is internalised and intertwined with mental health nurses' professional identity and experience.

The recent integrative review highlighted links between associative stigma and higher emotional exhaustion, burnout, lower job satisfaction (Domingue *et al.,* 2022). I suggest however that the relationship between being stigmatised and the negative outcomes Domingue *et al.* cite is more complex and can be understood with reference to epistemic injustice. The stigma, resulting from prejudices, diminishes the extent to which mental health nurses are heard and their experiences understood. As has been found in the current study in relation to assault experiences, nurses' interpretations are therefore that they are not valued and "don't matter". Hence the negative outcomes are a result of the impact of associative stigma on the extent to which nurses' experiences are heard, recognised and validated. This suggestion is illustrated below in figure 9.

Figure 9: Diagram illustrating the suggested relationship between associative stigma, epistemic injustice and negative outcomes for mental health nurses



6.6 Angels, heroes and nursing as a gendered profession

Finally, this discussion moves to consider the constructs of 'angels' and 'heroes' and their relationship to mental health nursing, and to discuss the ways in which these constructs may impact nurses' experiences of being assaulted by patients. Mental health nursing has long had a problematic and complicated association with the construct of nurses as "angels", and nursing as a vocation or 'calling'. Chatterton's paper, with its title, "Women in mental health nursing: Angels or custodians?" reflects through the examination of mental health nursing's history, the dissonance between the image of the angelic female nurse and the custodial aspect of the work (Chatterton, 2000). With its roots in the custody and containment of a stigmatised section of society, mental health nursing did not from the outset fit the narrative of the female servant of God providing care and comfort in the way that general nurses did. In contrast with the image of the adult nurse caring for patients at the bedside, care in this setting can for example require nurses to administer medication under restraint, and limit individuals' choice, autonomy and freedom. For mental health nurses, never being able to 'live up to' Nightingale's vision of a 'good nurse' no doubt has a fundamental impact on both nurses' sense of professional worth and belonging, and the esteem in which mental health nurses are held among other healthcare professions, and in society.

The findings of this study spoke to narratives of what was a 'good nurse' in mental health nursing, and these were evident in participants' attempts to meet the expectations contained within them. While the existence of the "angel" narrative reinforces mental health nursing's separation from other fields, the construct of nurses as "heroes" appears to have a more direct influence on nurses' responses to being assaulted. Stokes-Parish *et al.* (2020) cited the main features of heroes as being courage, bravery and self-sacrifice. The findings of the current study appear to indicate that this image has an influence on mental health nurses' professional identity. Nurses in this study endeavoured to emulate these qualities which they implicitly and explicitly identified as synonymous with being a good nurse and leader. This resulted in role conflict when, in the aftermath of being assaulted, nurses described endeavouring to prioritise the needs of patients over their own (codes - *being assaulted should not impact patient care*; *the patient comes first*) and feeling guilty if they were unable to do so. A conflict also arose for nurses as they decided how to describe what had happened to them - would naming an act as an assault, reporting it and holding a

patient to account be interpreted as blaming and reinforcing stigma? According to the "angels and heroes" narrative it likely would, and one nurse's response to the subject of this study reinforced its ongoing influence. A fellow doctoral student spoke to her mental health nurse colleague about my study. On hearing that it was focussed on nurses' experiences of being assaulted by patients, she expressed disappointment and frustration, believing that, by choosing this focus, I was perpetuating the belief that all people with mental illnesses were violent. She believed by talking about this topic I was contributing to the stigma towards those with mental illnesses, and as a nurse this was not acceptable.

Although not a prominent feature, evidence of this role conflict exists in the literature relating to assaults on mental health nurses (Baby *et al.,* 2014; Kindy *et al.,* 2005, Dean *et al.,* 2021). These studies highlighted the dilemma nurses face when balancing their duty of care to patients with their own safety and wellbeing. Kindy *et al. (*2005) went on to say that responses to being assaulted, including becoming hypervigilant and distrusting, were for nurses in direct conflict with the core values of nursing, and resulted in withdrawal and emotional suppression. This role conflict, underpinned by the construct of a good mental health nurse displaying the qualities and behaviours associated with 'heroes', contributes to the sense of failure if s/he experiences normal responses to trauma.

The "angels and heroes" narrative has been the subject of increased criticism among nurses, particularly recently in relation to the public response to the COVID-19 pandemic. Whilst Stokes-Parish *et al.* (2020) recognise the perception of these images as complimentary, they argue that they serve to undermine the professionalism of nursing. Further, they raise, as did Chatterton (2000), the way these images and narratives reinforce the feminised, gendered workforce. The way in which these gendered stereotypes so readily featured in the public response during the pandemic highlights their enduring presence. The concept of epistemic injustice, rooted in feminist philosophy, recognises the prejudices that women can be subject to in their capacity as "knowers". Fricker (2007) argues that what they have to say - their "testimony" - by virtue of the fact they are female has the potential to be deemed less credible by those hearing it. Stokes-Parish *et al.* (2020, p. 463) come to this conclusion when they make the case that perpetuating gender stereotyping of nursing "serves to disempower and silence nurses".

Stokes-Parish *et al.* (2020) directly question the hero narrative when they say "clearly nurses should possess integrity, compassion, and competence, but are the characteristics bravery

and self-sacrifice necessary to be an effective health professional?" (Stokes-Parish *et al.,* 2020, p. 463). This is an important and pertinent question in the context of the current study given participants' interpretation of their anxiety as indicating weakness and professional failure. In addressing this question from an ethical perspective, Baby *et al*. (2014, p. 653) argue that "while nurses are obligated to treat all patients with dignity, they are not obligated to perform heroic acts of self-sacrifice". Given the enduring expectations nurses have on and of themselves, it seems incumbent upon organisations to communicate this perspective and ensure it informs the responses nurses receive when they are assaulted. The impact - brought into acute focus in the aftermath of being assaulted - of attempting to maintain a heroic, self-sacrificing approach is well articulated by Watson who said "nurses often become pained and worn down by trying to always care, give, and be there for others without attending to the loving care needed for self" (Watson, 2008, p. 47). This emphasises the need for a focus on changing the narrative that assaults on mental health nurses are normal, acceptable and 'part of the job'.

6.7 Chapter Summary

This chapter has discussed the findings of the current study in the mental health and wider nursing literature. The normalisation of assaults on mental health nurses influences the way in which they make sense of their emotional responses to being assaulted, frequently leading them to believe they are weak and/or have failed. The invalidating responses from others, also in keeping with the normalising narrative, can lead nurses to question their worth and value.

It has been argued that mental health nurses are subject to epistemic injustice in relation to their experiences of being assaulted in secure settings. The prejudices are rooted in mental health nursing's historical legacy and its enduring status as less skilled, less well respected and undervalued field of nursing and profession within mental healthcare. This status is recognised as being inextricably linked to the gendered nature of the nursing profession more broadly, which it is argued forms the basis not only for subjugation but also in the case of mental health nurses for further critique due to its less straight-forward association with the "nurses as angels and heroes" narrative. Finally, the relationship between epistemic injustice and associative stigma has been highlighted.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

7.0 Introduction

This chapter gives a summary of the conclusions drawn from the research project described in this thesis. A discussion of the strengths and limitations of the study follow, and recommendations are made for practice, policy and future research. The chapter ends with a reflection on the experience of conducting this doctoral research.

7.1 The study and its findings

The prevalence of assaults on mental health nurses in secure and other inpatient mental health settings is among the highest of all healthcare workers (Liu *et al*., 2019). It is widely argued that the frequency of assaults is significantly underestimated due to under-reporting in practice, the absence of clear and consistent definitions and inadequate measuring tools (Jang *et al*., 2021). Research on this subject has been dominated by quantitative approaches, which beyond establishing prevalence, has focussed on the prevention, management and impact of violence against nurses. Significantly fewer studies have taken exploratory approaches seeking to understand in depth the experiences of mental health nurses who have been assaulted. No such studies had been undertaken in the context of secure mental health settings.

The focus of this qualitative, exploratory study was on the experiences of mental health nurses who have been assaulted by patients in secure mental health hospital settings. The aim was to develop what was currently understood about the meaning of being assaulted for nurses in this context. The study was underpinned by Gadamer's philosophy of understanding which was congruent with the values and principles of reflexive thematic analysis - the method chosen to analyse the data. The focus on meaning and interpretation was influenced by cognitive behavioural theory, which in turn informed aspects of the methods used to collect and analyse the data. Sixteen mental health nurses were interviewed about their experiences of being assaulted in medium secure mental health settings. Reflexive thematic analysis of the data generated findings that were united by a central narrative deemed to exist in the study context. This narrative was that assaults on mental health nurses were normal in the context of their work. This research has approached this narrative from a perspective not previously examined. It proposed that the narrative normalising assaults on nurses both impacts, and is maintained by, the responses

of nurses, their colleagues and managers, and the wider system. It has been suggested that this narrative, and the assumptions/expectations arising from it, served to silence nurses, preventing them from being able to acknowledge the impact of being assaulted. Emotional responses were suppressed as nurses guarded against the shame they anticipated they would feel as a result of being exposed as weak or a failure. It was also argued that the narrative shaped the responses from others, experienced by nurses as uncaring, invalidating and dismissive, and this led the nurses to feel uncared for and of low worth.

The discussion chapter in this thesis argued that the study's findings could be understood within the philosophical framework of epistemic injustice, as described by Fricker (2007). Contributed to by the legacy of mental health nursing's history, the experience of associative stigma and the enduring 'angels and heroes' narrative, it was suggested that mental health nurses' experiences are not well understood and often denied. This study aimed to develop the existing understanding of mental health nurses' experiences of being assaulted in medium secure settings, and to give voice to nurses who had had such an experience. These aims were justified by finding that nurses' voices were suppressed, as participants described being ignored, with their experiences going unheard. This study has shone a light on the often-traumatic assaults nurses face, and the complex ways in which, driven by the narrative that being assaulted is normal, nurses can make sense of both the assault itself and their emotional responses to it. Ultimately, this research has highlighted the need for mental health nurses' voices to be amplified, their experiences to be recognised, and the normalising narrative to be challenged.

The findings of this study have implications for practice, research, and education. Before discussing these implications and the recommendations arising from this study, its strengths and limitations are considered.

7.1.1 Limitations and strengths of the study

The study set out to explore the experiences of mental health nurses who had been assaulted by patients in secure settings. Before identifying the strengths of the study its limitations are acknowledged.

Whilst the recruitment approach was successful and yielded a sample across the UK, it excluded nurses who were not active on social media. It also, due to the COVID pandemic,

relied on video conferencing for the interviews which potentially excluded those who may not have been comfortable being interviewed via this means.

Demographic data were not collected and this meant that two aspects arising in the data - namely ethnicity and gender - were not able to be fully explored in this study. However, where participants referred to ethnicity or gender as part of the narrative of assault, this was reflected and discussed. Experience in practice leads me to believe that racially motivated assaults on nurses were under-represented in this study, but it is not possible to analyse this further due to the absence of demographic data relating to ethnicity.

Finally, participants in this study were required to be registered nurses. This meant that a large part of the nursing support workforce was excluded from the study.

The strengths of this research include the geographically and organisationally diverse sample, the approach to eliciting meaning, and the practice-based nature of the study. Whilst demographic data were not collected, participants told me where in the UK they were located either explicitly or through naming their employer. The sample included participants from England, Scotland, Wales and Northern Ireland, who worked in both National Health Service and Independent Sector Secure Hospitals. Unlike studies interviewing participants in one or two hospitals/regions, this means that the findings for this study are more likely to be representative of a national perspective, and therefore transferable to a greater degree.

This nursing research, grounded in practice experience, has produced findings that can be used to improve the experience of assaulted mental health nurses. It produced rich data that reflected the complex, often traumatic experiences of nurses, and the reporting of findings - including the use of the participants language - ensured they were authentically represented in this study and not diluted or sanitised.

A further strength was the use of cognitive-behavioural theory to guide the focus on meaning during data collection and analysis. This contributed to the development of new knowledge about the interpretations mental health nurses make in relation to their emotional responses to being assaulted. As a result, links between emotional suppression and anticipated shame have been made.

Finally, the reflexive practice in this study has enabled a transparent, honest and open approach to all aspects of the project including methodological decisions and analytic

activity. It has enabled me to maintain the balance between being an insider and a researcher, harnessing the contextual knowledge whilst remaining focussed on participants' experiences.

7.2 Recommendations

An important aim of this practice-based research study, undertaken for a professional doctorate in nursing, was to generate findings that could be used to inform practice and improve the experiences of assaulted mental health nurses. Recommendations for practice, nursing education and future research now follow. Inherent in all the recommendations that follow is the need to identify, challenge and resist perpetuating the narrative that assaults on mental health nurses in secure settings are normal. This requires systemic culture change, and whilst specific recommendations target individual parts of the system (e.g. the manager's response to an assaulted nurse, or the language used in incident reporting systems), it is argued that for sustained change to be made, a whole system approach is required.

Before setting out the recommendations from this study, rather than repeat it in each section, there is one recommendation that spans all areas. This is the recommendation - echoed in existing research - that clear and consistent definitions of workplace violence and assault be established and used in policy, guidelines, reporting processes and measurement/data collection tools.

7.2.1 Recommendations for practice

The findings of this research study indicate that improvements to the support mental health nurses receive when they are assaulted are required. The recommendation that a systemic approach is what is required if meaningful, sustainable change is to be achieved resonates with Menzies-Lyth's reflections on the response to her 1960 study. She argued that the answer to anxiety-provoking work of the nurses was not the provision of "support groups", rather she believed required organisations needed to be designed to contain anxiety effectively (Lawlor & Webb, 2009). In a similar way, whilst the processes and resources required to provide support to mental health nurses need to be reviewed and improved, the

findings of this study have implications that extend beyond organisations' responses to individual nurses. It is recommended that organisations critically review the ways in which the normalising of assaults is maintained within cultures, policies, systems and processes.

Whilst a systemic approach to cultural change is required, it is important for this research to provide explicit recommendations to guide changes to current practice. The recommendations for practice and mechanisms for change are therefore as follows.

1. Organisations should take measures to reduce the 'burden' associated with reporting assaults. They should therefore ensure that reporting systems are accessible, straightforward, clear and coordinated.
2. There should be reviews of organisational and policy definitions of terms including 'assault', 'harm' and 'impact'. It is suggested that engagement with nursing staff is incorporated in these reviews in order to ensure subjective experiences are better reflected and recognised in definitions and processes.
3. At all levels of the system (for example within policy, guidelines, reporting processes and in day-to-day conversations in practice), language that has the potential to sanitise or dilute nurses' experiences should be removed and every effort made to use terms that reflect the reality of mental health nurses' experiences. As with the above recommendation, the involvement of nurses should be prioritised. Suggested mechanisms for eliminating 'sanitising' language in practice include ensuring reporting guidelines prioritise the requirement for accurate descriptions of assaults, including their antecedents, and explicitly addressing in staff – including leadership – training, and inductions, the importance of using language which accurately reflects assault experiences.
4. Organisations should ensure that resources are available to provide sensitive, individualised support to nurses who have been assaulted, and that these are easily accessible and well advertised. The aims should be i) to allow nurses the opportunity to identify and discuss their interpretations of their experiences, and in particular any negative personal/professional interpretations, and ii) to identify any ongoing needs.
5. Organisations should ensure that training on the prevention and management of violence and aggression for all mental health professionals gives clear guidance relating to responses

to being assaulted, and explicitly rejects the idea that assaults on any member of the workforce should be considered normal or acceptable.

6. Policy, reporting processes, support systems and day-to-day conversations should promote the notion that experiencing emotions such as anxiety and fear are normal responses to being assaulted in any setting, including in secure inpatient mental health settings. In particular, in fora including clinical supervision, reflective practice, case formulations and debriefs, leaders from all professions should act as role models and support nursing teams to safely express their emotions, while compassionately challenging any expression of perceived weakness or failure.

7. Organisations should foster close relationships with criminal justice departments, particularly the police, in order to raise awareness of mental health nurses' experiences, improve understanding of the context and challenge the idea that being assaulted is part of their job.

8. Effective processes for appropriate and equitable responses to assaults in mental health contexts as compared with any other setting should be agreed between organisations and police departments.

7.2.2 Recommendations for education

There were findings in this study that identified a disconnect between what participants expected in relation to violence and aggression when they began their careers, and what they experienced as they began working. This meant that they experienced what they described as a process of 'desensitisation' or 'hardening up'. It is therefore recommended that nurse educators work with practice settings to better prepare newly registered nurses for the reality. It is suggested that incorporating opportunities - both group and individual - for student nurses to reflect on their experiences of violence, aggression and assault during their clinical placements is important. Also important is ensuring time to explore the potential impact of being assaulted, and crucially normalising emotional responses such as anxiety. The stigma associated with such emotions should be challenged and the importance of talking about experiences and seeking support emphasised.

7.2.3 Recommendations for research

This research represents the first qualitative study focussing specifically on the meaning of being assaulted for mental health nurses in secure settings in the UK. It is recommended that this approach is adopted in other studies to develop the current understanding of mental health nurses' interpretations of both their experiences and their emotional responses. It is also recommended that this approach is extended beyond registered nurses in secure mental health services to nursing support workers and RNs in other settings in order to better understand their experiences.

This study exposed the ways in which the normalising of assaults on mental health nurses impacts and is maintained by the responses of both assaulted nurses and those around them. Given these findings, it is suggested that going beyond the boundaries of constructivism and moving along the realist-relativist continuum to approach the topic from a critical realist perspective would support the development of a more comprehensive understanding. Doing so could allow researchers to explore the causal mechanisms and explanations (Hoddy, 2019) for the shared experiences and narrative identified in this study. It is suggested that one particular focus should be to identify possible causal explanations for the responses mental health nurses receive from their managers. The normalising narrative is identified in this study as having influenced their responses, however a more in-depth exploration of this aspect of the topic would support the approach to addressing responses experienced by nurses as negative and un-caring.

Finally, as was mentioned in the discussion chapter, further exploration of assault in the context of the therapeutic relationship is recommended.

7.3 Personal reflection on the research experience

In-keeping with the reflexive approach to this study, this thesis ends with a reflection on being an insider researcher and the impact this had not only on the study, but also on me professionally and personally.

In the first chapter of this thesis I established my position as a practitioner and insider researcher. As a mental health nurse, working in a medium secure setting, with experiences of being assaulted by patients, I was invested in exploring, and importantly sharing, the

ways in which mental health nurses understood and made sense of their experiences. I wanted those outside of what one participant described as the medium secure "bubble" to know what being assaulted *meant* to nurses. This was driven by my assumption that nurses' experiences of assaults in this context were not recognised and understood. My influence on this study was inescapable, and as such the impetus for me to remain honest, curious and transparent about the ways in which it influenced the research process was present throughout. On reflection I see my influence in a positive light - the contextual knowledge and practice experience I brought to the enquiry informed my decision making and guided the application of the methods, particularly in relation to data collection. Fundamental to my practice as a mental health nurse is the maintenance of an awareness of my 'self' as I engage therapeutically with patients. I realised that I brought this aspect of my practice to the experience of being a researcher as I recognised and carefully reflected upon my own thoughts and feelings.

I had not expected some of the emotional responses I experienced. At times these had the potential to influence the study and/or lead me to step outside the boundaries of being a researcher. Reflecting on these occasions emphasises the importance of reflexivity as a qualitative researcher and supports its central role in the methodological approach to this study.

The stories participants in this study shared with me were in essence not unfamiliar. However, the experience of listening to them as a researcher, and not a colleague or manager was markedly different. Firstly, there was no impetus on me to *do* anything in practice; my task was to create a space for participants to talk openly about their experience, and to try to develop an understanding of what their experiences meant to them. Secondly, I stayed with their stories for a long time - playing their interviews back and reading the transcripts over and over. As I did, I noticed different things including the ways in which my attention had the potential to shape my understanding. Ultimately, being able to immerse myself in the honest, open accounts participants generously shared with me was a privilege. The impetus I came to this project with - to ensure mental health nurses' experiences of being assaulted are heard - was strengthened through the interactions I had with the data.

Finally, I have reflected on how my *horizon of understanding* (Gadamer, 1989) has changed, both relating to mental health nurses' experiences of assault and in relation to the concept of understanding itself. I came to the study with an understanding that mental health nurses interpreted their experiences of being assaulted in many different ways. Through the in-depth analysis of participants' experiences, I understood in more detail nurses' beliefs about themselves, their responses to being assaulted, and the meaning of others' responses. My horizon broadened further as I contextualised the narrative that assaults on mental health nurses are normal within Fricker's conceptual framework of epistemic injustice (Fricker, 2007). I looked beyond the experiences themselves and considered the influence that both mental health nursing's history and the construct of associative stigma potentially have on the extent to which the experiences are heard and understood.
With regard to understanding, through conceptualising it within this study as situated, temporal, and evolving (Gadamer, 1989; Braun & Clarke, 2021), my approach to seeking to understand has changed. I see understanding more as an ongoing exploration than an end point. My approach to the *way* in which we come to understand has also changed. Rather than viewing it purely as a linear and internal process involving an individual receiving information and making sense of it internally, I recognise the value and importance of dialogue and interaction - the *fusion of horizons* (Gadamer, 1989) - be it with another human being or a text.

In conclusion, carrying out this study has proved to be the adventure Braun and Clarke (2022) suggested it could be. I have gained so much from it, personally, professionally and academically. Most importantly though it has ignited in me a desire to contribute further to our understanding of the challenges mental health nurses in secure settings and beyond face as they carry out their increasingly important work.

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APPENDICES

Appendix 1: Literature review 1: Study characteristics

Author, year, Country	Aim	Method (M), sample (S) and context (C)	Main findings	Quality Appraisal
Baby et al. (2014) New Zealand	To explore and describe mental health nurses' experiences of patient assaults	**M:** Exploratory, descriptive study using semi-structured interviews **S:** Registered nurses (*n*=14) whose scope of practice permits work in mental health settings **C:** 1 District Health Board Community and inpatient MH services	● Assaults were often considered normal, though not acceptable ● Assaults can lead to loss of confidence and self-esteem and burnout ● Peer support and debriefing were considered important, but managerial support was described as inconsistent	7/10
Benson et al. (2003) UK	To explore the ways in which staff and clients constructed accounts of violent or aggressive incidents in which they were jointly involved	**M:** Qualitative study using semi-structured interviews and discourse analysis **S:** *n*=3 (1 mental health nurse, 1 psychiatrist, and 1 patient) **C:** 1 acute inpatient unit	● Both (male) professionals acknowledged a definition of assaults but questioned the extent to which they 'felt' assaulted and adopted an emotionally uninvolved stance ● The predictability of the assaults whether they could be attributed to 'personality' or 'mental illness', and the attribution of blame were key dilemmas	8/10
Currid (2008) UK	To explore stressors, lived experience and meaning of the lived experiences of mental health nurses	**M:** Interpretative phenomenological analysis using semi-structured interviews **S:** Mental health nurses (*n*=8) from 1 NHS Trust **C:** Acute inpatient wards	● Stressors were identified as being heavy workloads and frequent violence and aggression ● Nurses avoid challenging or engaging with patients to feel safe ● Managers were seen as not taking violence and aggression seriously, and not acting when it occurred	8/10
Cutcliffe (1999) UK	To develop a more complete understanding of qualified nurses' lived experiences of violence perpetrated by individuals suffering from enduring mental health problems	**M:** Hermeneutic phenomenology using semi-structured interviews **S:** Mental health nurses (*n*=6) **C:** Mental health unit for individuals suffering from enduring mental illness	● Constructs of violence were found to be varied and subjective ● The extent to which violence is perceived to be intentional affects the ability to empathise ● Support was an important factor in being able to continue to cope with violence and aggression	9/10

Dafny and Beccaria (2020) Australia	To explore how workplace violence (WPV) from patients and visitors impacts nurses	**M:** Exploratory, qualitative study using semi-structured focus groups **S:** Nurses *(n*=23), including mental health nurses (*n*=10) **C:** Regional hospital psychiatric department comprising 3 units; open, closed and adolescent	● Workplace violence is increasing, unacceptable and potentially life-threatening ● Male nurses described being seen more as 'bodyguards' than professional nurses ● Some nurses considered that there was an "acceptance of violence as part of the job", feeling powerless to prevent it	7/10
Dean et al. (2021) USA	To explore the impact of workplace violence on mental health nurses, and gain their perspectives on supportive resources.	**M:** Qualitative descriptive study using surveys **S:** Registered nurses (*n*=23) for survey 1 (prevalence and form of violence) Registered nurses (*n*=17) for survey 2 (meaning and effects) **C:** MH facility providing acute, sub-acute and emergency services	● Nurses who had been assaulted described a range of emotions including fear, depression, anger, guilt and shame ● Nurses' shame and lack of trust in employers, led to a reluctance to report assaults and access support ● Nurses believed support from judicial system and employers required improvement	9/10
Ezeobele et al. (2021) USA	To explore mental health staff's experiences of physical assaults by patients	**M:** Phenomenology using survey **S:** Mental health staff (*n*=120), including registered nurses (*n*=70) **C:** 274 bed psychiatric hospital	● The emotional effects of assaults included anxiety, fear, helplessness and hopelessness and guilt ● Participants described assaults as unprovoked, and in some cases 'to be expected' ● Feeling incompetent, blamed and stigmatised made nurses less likely to report assaults	9/10
Hiebert et al. (2021) Canada	To raise awareness of workplace violence, give voice to nurses' experiences, promote commitment to reducing violence towards nurses and to increase understanding of this phenomenon.	**M:** Descriptive phenomenology using semi-structured interviews **S:** Mental health nurses (*n*=9) **C:** Acute care units and crisis unit settings for older adult, adult and young people across Western Canada	● Behaviour seen as being a result of mental illness was less likely to be conceptualised as violence ● Violence was seen as frequent and 'part of the job', leading to desensitisation which, together with the fear of criticism and the belief that reporting was a 'waste of time', contributed to underreporting ● Negative emotional responses to workplace violence included frustration, anger, fear and anxiety	9/10
Kindy et al. (2005) USA	To understand the lived experience of nurses working in psychiatric wards where there is a high risk of violence	**M:** Interpretive phenomenological analysis using semi-structured interviews **S:** Registered nurses (*n*=10) working or have worked in mental health/forensic facilities **C:** Psychiatric/forensic facilities across 3 towns in Northern California	● Nurses described suppressing emotions to appear less vulnerable ● Nurses described feeling blamed and punished following an assault ● Nurses experienced stress and fear, feelings of conflict about nursing roles and negative effects on their personal life	9/10

Lantta et al. (2016) Finland	To explore nurses' descriptions of violent events on psychiatric wards, the ward climate and suggestions for preventive activities	**M:** Descriptive exploratory design using focus groups **S:** Registered and enrolled nurses (*n*=22) **C:** 3 secure psychiatric wards in 3 hospital organisations in one district of Southern Finland	● Verbal violence was seen to be common, part of the job and under-reported ● Nurses were reluctant to acknowledge fear speaking instead of 'healthy fear' being required to maintain 'alertness' ● Suggestions for violence prevention included training, improving interactions, increasing presence of nursing staff, improving privacy and reducing overcrowding	8/10
Moylan et al. (2014) USA **supplemental findings from one segment of a 2011 study (Moylan and Cullinan, 2011)	To explore gender differences in relation to responses to assault. **The aims of the 2011 study were: To establish the frequency of assaults and severity of injuries across sample To examine assault and injury in relation to decisions to physically restrain	**M:** Moylan and Cullinan's (2011) study used mixed methods – this article reports on the qualitative findings **S:** Survey and one-to-one discussions were used with the 'vast majority' of participants Mental health nurses (*n*=110) **C:** 5 acute care facilities across 2 counties	● Both male and female nurses considered assault to be expected, frequent and 'part of the job' ● Female nurses underreported assaults within this study and they feared reprisal both from managers and colleagues ● Female nurses questioned their own competence and discussed the emotional impact often lasting longer than any physical impact ● Some nurses perceived unfairness/inequity in relation to the response a police officer/fire fighter may receive when assaulted ● Male nurses did not discuss the emotional impact of being assaulted, nor did they question their own competence	7/10
Sim et al. (2020) Korea	To explore the nurses' experiences and perceptions of violent, angry and aggressive patients, and identify the impact on personal and professional attitude and behaviour.	**M:** Phenomenology using semi-structured interviews **S:** Registered nurses (*n*=12) with experience of working in mental health ward **C:** 1 mental health ward in a general hospital	● Nurses described a sense of helplessness in relation to coping with violence, with female nurses in particular relying on the support of male nurses ● Nurses described feeling betrayed and confused when patients were violent ● Nurses felt shame, humiliation, a loss of pride, reduced self-esteem and isolation because of exposure to violence ● Nurses highlighted an absence of support	8/10
Stevenson et al. (2015) Canada	To understand how nurses describe (i) their experience of violence in psychiatric settings; (ii) the personal and professional outcomes of exposure to patient violence; (iii) their descriptions of strategies that influence current practices of patient violence	**M:** Interpretive descriptive study using semi-structured interviews **S:** Registered nurses (*n*=12) with experience in adult inpatient acute mental health care **C:** 1 acute Inpatient MH Unit, 'snowball sampling' and advertisements in provincial and international MH nursing organisations (locations of final sample not specified)	● Verbal violence was considered normal and under reported ● Personal and professional outcomes of assault included hyper-vigilance; physical injury; reduced ability to carry out role; reduced empathy; a change in confidence; reduced trust; cynicism and impaired therapeutic relationships ● Some nurses felt blamed and criticised, or had no support, and others felt supported	9/10

Tema et al. (2011) South Africa	To explore and describe psychiatric nurses' experiences of hostile behaviour by patients in a forensic ward	**M:** Qualitative, exploratory, descriptive study using semi-structured interviews **S:** Mental health nurses (*n*=9) **C:** 1 Forensic mental health ward	● Verbal and physical assaults left nurses feeling worthless ● Nurses described a lack of support from managers, which led them to feel ignored and demotivated ● Suppressing anger and fear negatively affected relationships and sleep, and increased unhelpful behaviours such as smoking and alcohol consumption	6/10
Yang et al. (2016) Taiwan	To understand mental health nurses' experiences of being assaulted, the influences on their patient care, and their perspectives of the effectiveness of violence prevention education.	**M:** Qualitative, descriptive study using semi-structured interviews **S:** Mental health nurses (*n*=10) **C:** 2 MH facilities in central Taiwan	● Nurses saw assaults as being unpredictable and inevitable ● Assault led to hypervigilance, negative effects on therapeutic relationships and lasting psychological trauma ● Support from peers and managers was seen as important but limited ● The requirement to report incidents signified a lack of trust and sometimes punishment	8/10
Zuzelo et al. (2012) US	To explore nursing staff's individual and group responses to violent incidents	**M:** Qualitative, descriptive study using focus groups **S:** Registered nurses (*n*=8) and behavioural health associates (*n*=11) **C:** 2 acute inpatient behavioural health nursing units	● Participants were aware of the risk of violence, did not think it acceptable, but believed it could not be prevented ● Feeling scared should not be displayed to patients as it would indicate they had 'won' ● Team support was seen as a protective factor	7/10

Appendix 2: Literature review 1: Synthesised findings

Synthesis	Categories	Findings
Perspectives on violence against mental health nurses Mental health nurses consider violence against them – conceptualised in different ways - to be a significant, and unacceptable problem, particularly when perpetrated by patients who they deem to be in control of their behaviour.	Violence as 'normal' and expected but not acceptable	Violence is normal **U**
		Violence is part of the job **U**
		Violence is frequent **U**
		Violence is increasing/escalating **U**
		Violence is to be expected **U**
		Police think we should expect it **U**
		Verbal violence is most common **U**
		Violence is not acceptable **U**
		Violence should not be considered part of the job – this needs to change **U**
		Nurses believed they could be seen as 'available targets' **U**
		Nurses perceive that violence against nurses is not taken seriously **U**
		It is unfair that assaulted nurses are treated differently from police/firefighters who are considered to be 'heroes' **U**
		Nurses do not believe they are protected by the law **U**
	Violence can be perceived as unexpected and unpredictable	Violence can be unpredictable **U**
		Violence can be unexpected **U**
		Violence towards nurses can be perceived as shocking by them **U**
		Being assaulted can leave nurses feeling confused **U**
	The way in which violence and assault is conceptualised varies	Perception of what constitutes violence is subjective **U**
		Behaviour is more likely to be considered violence if nurse feels threatened **U**
		Behaviour is more likely to be considered violence if premeditated/intentional **U**
	Responsibility, control and blame	The extent to which the person is responsible for their violence/aggression/ assault depends on their understanding, intent and level of control **U**
		Mental illness can make people explosive, antagonistic/impulsive – a 'symptom' **U**
		Nurses perceived that violence can be a means of communication **U**
		If someone has a personality disorder they have control over their behaviour and are responsible **U**
		If someone is mentally ill they are not in control/lack capacity and are therefore not responsible **U**
		Nurses are likely to have empathy for someone who is violent and mentally ill **U**
		Nurses are more likely to be angry and blame someone who is violent and has a personality disorder **U**

		Male nurses attribute blame/responsibility externally **C**
Personal and professional impact Being assaulted can have a significant and pervasive impact on mental health nurses' personal and professional lives.	Impact on self as a person and as a nurse	WPV has a detrimental impact on both personal and professional life **U**
		Psychological trauma often more lasting than physical effects **U**
		Self-esteem can be negatively impacted by the experience of assault **U**
		Being assaulted leads to reduced confidence **U**
		Nurses can feel powerless/helpless in relation to violence **U**
		Nurses may experience humiliation, feeling belittled/small after being assaulted **U**
		Nurses can feel ashamed following an assault **U**
		The experience of being assaulted leaves nurses feeling anxious, fearful, unsafe, scared and vulnerable **U**
		Being assaulted can lead to anger and frustration **U**
		Nurses can experience feelings of guilt following an assault **U**
		Nurses can blame themselves for being assaulted **U**
		Being assaulted leads nurses to question their own competency **U**
		Being assaulted can lead to a sense of role conflict **C**
		Frequent violence can lead nurses to be 'desensitised' to it **U**
		Male nurses feel responsible (for protecting colleagues) **U**
		Male nurses feel emotionally drained **U**
		Male nurses fear injury **U**
		Male nurses believe they are seen as 'bodyguards' **U**
		Male nurses' professionalism undermined when viewed as protectors / 'bodyguards' **U**
		Male nurses are less likely to question their own competence following an assault **C**
	The impact of being assaulted on life outside work	Being assaulted has a negative impact on relationships with friends and family **U**
		Being assaulted can lead hypervigilance outside work **U**
		Being assaulted can lead to sleep disturbance and nightmares **U**
		Nurses report drinking alcohol and smoking more following as a result of experiencing patient violence **U**
		Nurses worry about losing their job/livelihood if they get injured in an assault **U**
	Impact of being assaulted on approach to patients	The experience of being assaulted makes being compassionate, empathic and person-centred in their approach challenging for nurses **U**
		Nurses distance themselves from patients as a means of coping **U**
		Being assaulted has a negative impact on the ability to establish and maintain therapeutic relationships **U**

		Being assaulted can make nurses become more task-focussed **U**
		Being assaulted results in a lack of trust **U**
		Nurses can experience being assaulted by a patient as a betrayal given they were trying to help **U**
		Nurses sometimes avoiding engaging with/challenging patients following an assault in order to reduce the risk of being assaulted **U**
Response to being assaulted Following an assault, mental health nurses respond in different ways including avoiding or suppressing their emotions, depersonalising and rationalising behaviour and taking action.	Attempts to cope through suppressing, avoiding, withdrawing	Getting past the experience, 'letting go' 'moving on' and 'keeping going' are cited as strategies nurses use to cope **U**
		Nurses try to avoid negative feelings following an assault **U**
		Need to avoid grudges **U**
		Nurses 'shut down' and withdraw as a means of coping **U**
		To be safe, nurses suppress/avoid expressing/displaying emotions in front of patients **U**
		Need to try to 'leave work at the door' in order to cope **U**
		Male nurses downplay emotions relating to assault **C**
	Making sense/understanding	Depersonalising assaults is seen as important and helpful **U**
		Nurses report that understanding reasons for behaviour in order to be able to cope **U**
		Nurses rationalise/patients' violent/aggressive behaviour as being due to their illness **U**
		It helps to hold in mind the trauma the patient may have experienced **U**
	Active responses	Venting is important after being assaulted **C**
		After being assaulted, nurses can become hypervigilant **U**
		Looking for another job **U**
		After being assaulted, nurses reflected, learnt from the experience and adapted their behaviour **U**
Sharing and reporting experiences	Sharing experiences beyond the workplace	Nurses don't talk to family about violence and aggression/personal experiences of assault as they believe they would not understand **U**
		Nurses don't talk to family about the high level of violence in order to protect them **U**
		Nurses who are assaulted believe that society won't believe them/understand how they feel **U**
	Response from managers	Managers can blame the assaulted nurse **U**
		Managers criticise nurses who are assaulted **U**
		Nurses can be stigmatised if they are assaulted, labelled 'not fit for the job' **U**
		Nurses who are assaulted are made to feel like the perpetrator **U**
		Nurses who are assaulted feel punished **U**
		Nurses are expected to carry on following assault **U**

Sharing and reporting experiences of assaults is challenging, and often avoided, by mental health nurses.	and peers	Nurses are expected to continue to care for the perpetrator **U**
		Nurses who are assaulted feel that they are avoided, marginalised **U**
		Nurses who have been assaulted have had their competence questioned **U**
		Nurses perceive others to expect them to be able to use their skills to manage violence/prevent assault **U**
		Nurses can experience no contact from managers following an assault **U**
		Nurses experience a lack of support from managers when they are assaulted **U**
		Nurses' emotional experiences are ignored / invalidated by managers **U**
		Nobody does anything **U**
		No resolution to the assault **U**
		There is no time to access support **U**
		Nurses believe managers should provide personal, direct support **U**
		Having the experience recognised and acknowledged by managers is important and helpful **U**
		Nurses find their peers to be supportive **U**
		Peers can tease following an assault **U**
		Drs don't listen to nurses; they stay away **U**
		Patients need to be – but are not - held to account for their behaviours by other team members **U**
	Barriers to reporting assaults	Nurses don't report assaults for fear of criticism **U**
		Lack of trust in managers/administrators leads nurses to not report assaults **U**
		Fear of blame/stigmatisation leads nurses to not report assaults **U**
		Nurses feel that police discourage them from reporting assaults **U**
		Nurses don't report assaults because they believe that nothing will be done **U**
		Nurses perceive that there is an implicit expectation from managers to 'let it go' (ie not report) **U**
		Nurses do not report assaults due to feeling ashamed **C**
		Nurses believe that they shouldn't be required to report as assault on them as reporting signifies blame and responsibility in itself **U**
		Nurses do not report assaults due to a lack of time **U**
		Cumbersome forms contribute to underreporting of assaults **U**
		Nurses don't report as they don't want to be seen to make a 'big deal' of an assault **U**
		Nurses do not see the importance of reporting assaults **U**
		The perception that an assault is not serious enough reduces the likelihood of nurses reporting it (e.g. verbal assault, no injury) **U**
		The risk of violence is raised when there is insufficient staffing **U**

Factors affecting violence and assault Mental health nurses' perceptions of what contributes to and can prevent violence and assault centre on factors relating to the environment, workforce, relationships, gender, and restrictive practice	Environmental and workforce/team factors	Inadequate training contributes to an increased risk of violence **U**
		Inadequate security contributes to violence and aggression **U**
		A poor physical environment increases the risk of violence and aggression **U**
		The lack of space contributes to the risk of violence **U**
		A lack of privacy contributes to the risk of violence **U**
		Increased presence with patients is required to reduce the risk of violence **U**
		A good relationship with patient is important in reducing the risk of violence and assault **U**
		Helps to have experience **U**
		Excessive paperwork leads to nurses not having time to be with patients which compromises safety **U**
		Team-work important in preventing and managing violence and aggression **U**
		Nurses had trust in their colleagues, they 'have each other's backs' **U**
		It is important to be consistent as a team – have a shared approach and follow treatment plans **U**
		Splitting increases the risk of violence **U**
		Patients don't always experience consequences when they assault nurses **U**
		Failure to hold patients to account increases violence **U**
	Patient factors	Patients are violent when their needs not being met or they don't get own way **U**
		A reduction in medication can contribute to a patient being violent **U**
		Being detained and restricted increase the risk of violence **U**
		Administering medication without consent can be a trigger for violence **U**
	Factors relating to gender	It is less socially acceptable to be violent to women makes violence against female nurses less frequent **C**
		Male nurses are a protective factor against violence **U**
		Male patients are more violent to male nurses **C**
		Female nurses are seen to be more verbally abused **U**
		Female staff are more vulnerable **U**

Appendix 3: Literature review 2: Summary of articles

Author, title and country of publication	Type of study/ publication	Aim of study/report
Allen (2013) Staying Safe: Re-examining Workplace Violence in Acute Psychiatric Settings USA	Report / Discussion	To describe the outcomes of the 'Staying Safe' educational programme for mental health staff in a hospital setting.
Atinga *et al*. (2021) Measures and narratives of the nature, causes and consequences of violent assaults and risk perception of psychiatric hospitals in Ghana: Mental Health workers' perspectives GHANA	Mixed methods - sequential, explanatory. Survey and interviews	Examine the nature, perceived causes, experiences, and consequences of patient violent assaults among clinical and non-clinical health workers, including how patient violence shapes staff perception of safety. Guide decisions and actions towards building safety climate and culture
Baby *et al*. (2014) 'Violence is Not Part of Our Job': A Thematic Analysis of Psychiatric Mental Health Nurses' Experiences of Patient Assaults from a New Zealand Perspective NEW ZEALAND	Qualitative, Interviews	To explore and describe mental health nurses' experiences of patient assaults.
Banda *et al*. (2016) Violence against nurses in the southern region of Malawi MALAWI	Mixed methods. Descriptive, cross-sectional survey	To investigate and describe the nature of and extent of violence against nurses and the perceived effects thereof.
Brady *et al*. (2012) The Impact of Mindfulness Meditation in Promoting a Culture of Safety on an Acute Psychiatric Unit USA	Quantitative, descriptive, evaluation of intervention	To examine the impact of a mindfulness-based stress reduction (MBSR) program as an intervention for behavioural health staff to manage their work stress and improve patient safety and satisfaction.
Bresler & Gaskell (2015) Risk assessment for patient perpetrated violence: Analysis of three assaults against healthcare workers USA	Discussion paper	To present an analysis of three cases of assault against healthcare workers, focussing specifically on the assessment of risk.
Burns (2014) Assaults leave nurses fearful NEW ZEALAND	Report	Report on prevalence and impact of violence against nurses.

Dafny *et al*. (2020) I do not even tell my partner: Nurses' perceptions of verbal and physical violence against nurses working in a regional hospital AUSTRALIA	Exploratory, qualitative. Focus groups	To explore how regional registered nurses perceived vertical violence from patients and visitors. To investigate themes surrounding gender and the incidence and severity of violence towards male and female nurses by patients and visitors in three regional hospital departments: ICU, ED and Psychiatric department.
Edward *et al*. (2015) A systematic review and meta-analysis of factors that relate to aggression perpetrated against nurses by patients/relatives or staff UK	Systematic literature review with meta-analysis	To examine occupational anxiety related to actual or potential aggression in the workplace for nurses.
Foster *et al*. (2021) Mental health matters: A cross-sectional study of mental health nurses' health-related quality of life and work-related stressors AUSTRALIA	Quantitative, cross-sectional survey	To identify MHN health-related quality of life (HR-QoL) and work-related stressors; associations between stressors and HR-QoL; and predictors of HR-QoL.
Gascon *et al*. (2013) The role of aggressions suffered by healthcare workers as predictors of burnout SPAIN	Quantitative, survey	To ascertain the weight that aggression (physical, threats, verbal abuse, etc.) could have when it comes to explaining burnout levels in the healthcare sector and if it is produced in a similar way in doctors and nursing professionals.
Hallett & Dickens (2015) De-escalation: A survey of clinical staff in a secure mental health inpatient service UK	Mixed methods survey	To explore the views of a range of clinical staff about de-escalation.
Hamaideh (2012) Occupational Stress, Social Support, and Quality of Life among Jordanian Mental Health Nurses JORDAN	Quantitative, descriptive correlational, survey	To examine the level of occupational stress, social support, and quality of life among Jordanian mental health nurses
Hsieh *et al*. (2018) Predictors of depressive symptoms among psychiatric nurses who suffered from workplace violence TAIWAN	Quantitative, cross-sectional and correlational study, survey	To examine the possible factors that contributed to or prevented developing depressive symptoms among psychiatric nurses who suffered from workplace violence under Hill's ABC-X Model.

Jeffery & Fuller (2016) Witnessing violence: what are the experiences of mental health nurses? UK	Qualitative, grounded theory	To explore the experiences of psychiatric nurses who have witnessed violence.
Jones-Berry (2017) Attitudes harden towards assaults on staff UK	Report and discussion	Report on the prevalence of assaults on mental health workers and the parliamentary debates on the proposed 'thought' law against those who assault emergency workers.
Kelly *et al*. (2015) A cross-sectional survey of factors related to inpatient assault of staff in a forensic psychiatric hospital USA	Quantitative Cross-sectional survey	To understand staff factors associated with patient aggression towards the staff of an inpatient forensic psychiatric hospital.
Kleebauer (2016) NHS reveals level of attacks on staff by over 75s UK	Report	Report on levels of violence against healthcare staff by people over 75
Magnavita & Heponiemi (2011) Workplace Violence Against Nursing Students and Nurses: An Italian Experience ITALY	Quantitative, survey	To compare the characteristics and effects of violence in nursing students and nurses in order to assess the phenomenon and take preventive action
Moylan *et al*. (2014) Differences in Male and Female Nurses' Responses to Physical Assault by Psychiatric Patients (supplemental findings of Moylan and Cullinan 2011 - both papers reviewed for completeness) USA	Mixed methods	To present a supplemental finding of a mixed methods study: Gender differences in perceptions of and responses to physical assault by psychiatric patients.
Newman *et al*. (2021) Exposure to workplace trauma for forensic mental health nurses: A scoping review AUSTRALIA	Scoping review	To identify the key concepts related to the nature, extent and impact of workplace trauma for forensic mental health nurses.
Oates *et al*. (2020) An integrative review of nursing staff experiences in high secure forensic mental health settings: Implications for recruitment and retention strategies UK	Integrative review	To identify the experiences of nursing in high secure forensic mental health settings that may affect recruitment and retention

Okundolor *et al*. (2021) Zero Staff Assaults in the Psychiatric Emergency Room: Impact of a Multifaceted Performance Improvement Project USA	Quality improvement project	To develop, implement, and evaluate a multifaceted approach to reducing the number of physical assaults on staff.
Olashore *et al*. (2018) Physical violence against health staff by mentally ill patients at a psychiatric hospital in Botswana BOTSWANA	Quantitative, retrospective survey	To present the prevalence of violence, related factors and the available sources of support for the victims of workplace violence in a psychiatric hospital.
Rathobei *et al*. (2021) Nurses' Perceptions regarding Types of Aggressive Behaviour displayed by Patients in a Selected Psychiatric Hospital in Lesotho SOUTH AFRICA	Quantitative descriptive survey	To determine nurses' perceptions regarding the types of aggressive behaviour displayed by patients in a selected psychiatric hospital in Lesotho
Ridenour *et al*. (2015) Incidence and risk factors of workplace violence on psychiatric staff. USA	Quantitative, records analysis and survey	An evaluation of risk factors associated with patient aggression towards nursing staff at eight locked psychiatric units.
Schlup *et al*. (2022) Prevalence and severity of verbal, physical, and sexual inpatient violence against nurses in Swiss psychiatric hospitals and associated nurse-related characteristics: Cross-sectional multicentre study SWITZERLAND	Quantitative, Cross-sectional survey	To describe the 30-day prevalence and severity of inpatient verbal, physical, and sexual violence against nurses in the German-speaking part of Switzerland and to investigate the association between nurse-related characteristics and nurses' exposure to the selected types of psychiatric inpatient violence.
Sprinks (2015) Fall in staff assaults is recorded but acute care attacks on the rise UK	Report	Report on prevalence of assaults on healthcare staff.
Staggs (2015) Injurious Assault Rates on Inpatient Psychiatric Units: Associations With Staffing by Registered Nurses and Other Nursing Personnel USA	Quantitative, aggregation and analysis of administrative data	To assess trends in use of seclusion and restraint in response to injurious assault.

Stoddart (2014) Nurses 'encouraged to report' [incidents affecting their safety] NEW ZEALAND	Editorial report	Report on the response to assaults on mental health nurses.
Yada *et al*. (2014) Differences in job stress experienced by female and male Japanese psychiatric nurses JAPAN	Quantitative, survey	To compare gender differences quantitatively in job-related stressors, stress levels, and reactions to stressors in psychiatric nurses.
Yang *et al*. (2016) Assault experiences: Lessons learned from mental health nurses in Taiwan TAIWAN	Qualitative, descriptive, interviews	To understand mental health nurses' experiences of being assaulted, the influences on their patient care, and their perspectives of the effectiveness of in-service, violence-prevention education
Yosep *et al*. (2019) Mental Health Nurses' Perspective of Work-Related Violence in Indonesia: A Qualitative Study INDONESIA	Qualitative, interviews	To explore nurses' perspective of work-related violence and traumatic experience related to workplace violence in Indonesia
Zuzelo *et al*. (2012) Registered Nurses' and Behavior Health Associates' Responses to Violent Inpatient Interactions on Behavioral Health Units USA	Qualitative, focus groups	To explore nursing staff 's individual and group responses to violent incidents performed by patients against caregivers.

Appendix 4: Ethics Approval Oxford Brookes University

OXFORD BROOKES UNIVERSITY

Dr Olga Kozlowska
Director of Studies
Faculty of Health and Life Sciences
Oxford Brookes University

20th July 2020

Dear Dr Kozlowska,

UREC Registration No: 201408 Ayres
Study Title: An exploration of the experience of mental health nurses who have been assaulted by patients in secure mental health settings

Thank you for the email of 18th July 2020 outlining the response to the points raised in my previous conditional approval letter regarding the PhD study of your research student, Helen Ayres and attaching the revised documents. I am pleased to inform you that, on this basis, UREC is happy to grant full approval for this study.

The UREC approval period for the data collection phase of the study is two years from the date of this letter, so until 20th July 2022. If you need the approval to be extended please do contact me nearer the time of expiry.

Should the recruitment, methodology or data storage change from your original plans, or should any study participants experience adverse physical, psychological, social, legal or economic effects from the research, please inform me with full details as soon as possible.

Yours sincerely,

Dr Sarah Quinton
Chair of the University Research Ethics Committee

cc Dr Sue Schultz, Supervisory Team
Helen Ayres, Research Student
Ms Kellie Tune, Research Ethics Officer
Ms Jill Organ, Research Degrees Team

Appendix 5: Recruitment advert

Appendix 6: Participant information sheet

OXFORD BROOKES UNIVERSITY

Participant Information Sheet

Study Title
An exploration of the experiences of mental health nurses who have been assaulted by patients in secure mental health settings.

Invitation to participate
You are being invited to take part in a doctoral research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of this study?
It is widely reported that along with other health professionals, mental health nurses are at risk of being assaulted during the course of their work. The purpose of this study is to explore the experiences of forensic mental health nurses who have been assaulted by patients in medium secure settings. This findings of this study may inform future service improvement activities relating to the response to nurses who have been assaulted.

Who is eligible to take part?
The study aims to recruit 20-25 UK based mental health nurses who have been assaulted by a patient or patients while working in a UK medium secure mental health unit.

Do I have to take part?
Participation in this study is entirely voluntary.

If you are interested in taking part, you will be given this participant information sheet along with a privacy notice for your consideration, and you will then be asked to give consent to be interviewed and for the content of the interview to be incorporated into the data that will be analysed by the researcher.

You will be able to withdraw entirely from the study at any time. If you decided to withdraw, you could ask for your data to be withdrawn up until the point that the data analysis has begun. After this point your data would be retained.

What will happen to me if I decide to take part?
If you decide you would like to take part, you will be asked to contact the researcher, Helen Ayres, by email in order to arrange an interview at your convenience. The interview will be conducted by the researcher over either over the telephone or via a video call using Google Meet at a time that is convenient for you. It is anticipated that the interview will take a maximum of 45 minutes. The researcher acknowledges that some experiences may be difficult to talk about, and as such will be guided by you in relation to the pace of the conversation and the level of detail you wish to go into.

The interview will be audio-recorded and then transcribed by the researcher. Should you choose to be interviewed via a video call, visual data will not be recorded. Only the transcribed form will be used in the data analysis.

Will what I say in this study be kept confidential?

All information collected about you will be kept strictly confidential subject to legal limitations. Your privacy will be protected and only the researcher will know your identity. Pseudonymised quotations will be used in the dissemination of the study's results. Your contact details will be used for the purpose of arranging and conducting the interview, and they will then be deleted. The recording and interview transcription will be pseudonymised and kept on the researcher's University Password-Protected Google Drive. The recording on the digital recorder will be downloaded to the researcher's Google Drive immediately after the interview takes place and deleted from the recording device. The recording and transcriptions will be heard/viewed only by the researcher and her supervisors. Data for publication (the researcher's thesis, academic papers and conference submissions) will be pseudonymised in order that you are not identifiable.
Any hard copies of pseudonymised data will remain in a locked cabinet and will be accessible to the researcher and her supervisors. Data will be stored for 10 years in accordance with Oxford Brookes' policy for academic integrity.

The hard copy of the consent form will be scanned and stored electronically in a separate in a secure location separate from the study data. The digital recording of the consent will be encrypted and stored on Google Drive. You can find out more about the management of your information at https://www.brookes.ac.uk/it/information-management/gdpr/ or by contacting the information security management office by telephoning 01865 484354 or emailing info.sec@brookes.ac.uk .

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter. If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO). You may contact our Information Compliance Officer via email at info.sec@brookes.ac.uk or by telephoning 01865 484354. The privacy notice for this study is attached at the end of this Information sheet.

Confidentiality will be protected within the limits of the law, this includes mandatory reporting, subpoena and freedom of information requests. The disclosure of any criminal offence will be reported to the police.

Are there any possible disadvantages or risks of taking part?

The interview will require that you are able to set aside time during which you will not be interrupted. During the interview you will be asked questions about your experiences of being assaulted. It is possible that in remembering and talking about this you might experience distress and you may feel sad, angry, guilty, embarrassed or ashamed. These are normal responses to discussing what was likely a traumatic event for you. The researcher will take a collaborative approach to the interview, discussing this with you before beginning, and agreeing with you how you will both respond if you do become distressed. During the interview the researcher will check with you that wish to continue, and you will be able to take a break or stop the interview at any time.
The researcher will discuss with you the options for support should you require it after the interview. You will be advised to consider approaching your employer/line manager, your organisation's occupational health department, your Trade Union/Professional Body or their general practitioner should you experience prolonged distress. You will also be signposted to the Royal College of Nursing's counselling service (https://www.rcn.org.uk/get-help/member-support-services/counselling-service), Unison's Welfare Service (https://www.unison.org.uk/get-help/services-support/there-for-you/) and the Victim Support service, (https://www.victimsupport.org.uk/?gclid=CjwKCAjwt-L2BRA_EiwAacX32QTzHVv12069o7MOR0X7PSz_UlONCQ7rmCmUzqStpbwW7SvVDNzxBBoC4sQQAvD_BwE)

What are the possible benefits of taking part?

Taking part in the study does not have any direct benefit to you. However, having the opportunity to share and reflect on your experiences may be beneficial. Studies of the experiences of people participating in research into difficult/traumatic events suggest that benefits may include feeling relief

at being able to tell your story, developing personal insight and making sense of your experience, and feeling satisfaction in contributing to a study that aims to improve others' experiences.

Will I be reimbursed for taking part?
You will not be paid for taking part in the research study.

What will happen if I don't want to carry on with the study?
You are free to withdraw from the study at any time, without giving a reason. As described earlier, if analysis of the interview transcripts is underway it will not be possible to extract your data from the study.

What will happen to the results of this study?
The researcher intends to share the study's findings with the aim of informing and assisting both individual managers and organisations in the support of nurses post-assault.

The aim is for findings to be shared both locally within the researcher's own clinical setting and more widely via publication/s in nursing journal/s and through conference presentations. It is common practice for direct quotes to be used in the data analysis and thus feature in the dissemination of the research, but these will be pseudonymised and you will therefore not be identifiable.

The researcher is undertaking a Professional Doctorate in Nursing programme at Oxford Brookes University, for which this study forms a major part of the educational requirement.

A summary of the findings will be published on RADAR, Oxford Brookes University's digital repository. The estimated time for publishing is mid 2022. There will be open access to the findings via the Oxford Brookes University website should you wish to view them.

Who is organising and funding the study?
The principal investigator is Helen Ayres, a Doctorate in Nursing student at Oxford Brookes University. There is no direct funding attached to this study.

Who has reviewed the study?
The research has been approved by the University Research Ethics Committee, Oxford Brookes University, (UREC Registration Number 201408 Ayres / 20 July 2020).

What if there is a problem?
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you should contact Kellie Tune, Chair of Faculty Research Ethics Committee at Oxford Brookes University. Email: frec@brookes.ac.uk

What should I do if I wish to take part?
If you would like to join this study, please contact Helen Ayres by email:
Email: helenayres@brookes.ac.uk

Further information and contact details:
Please contact
Helen Ayres
07979954517
Email: helenayres@brookes.ac.uk

Thank you for considering taking part in this study.

Appendix 7: Privacy Notice

OXFORD BROOKES UNIVERSITY

Privacy Notice

Oxford Brookes University (OBU) will usually be the Data Controller of any data that you supply for this research. This means that we are responsible for looking after your information and using it properly. The exception to this is joint research projects where you would be informed on the participant information sheet as to the other partner institution or institutions. This means that they will make the decisions on how your data is used and for what reasons. You can contact the University's Information Management Team on 01865 485420 or email info.sec@brookes.ac.uk.

Why do we need your data?

We are undertaking a research study into the experiences of mental health nurses who have been assaulted in secure mental health settings. We will need personal details (an email address and telephone number) so that we can contact you to discuss the study and arrange an interview. Your responses to questions asked during the interview will form the data for the study, and will be analysed. The results of the analysis will form the findings of the study.

OBUs legal basis for collecting this data is:

- You are consenting to providing it to us; and/ or,

- Processing is necessary for the performance of a task in the public interest such as research

What type of data will Oxford Brookes University use?

If you are selected to be interviewed we will use your personal data (your email address) to contact you during the study. We will audio record the interview. The interview will be transcribed into words and we will keep a copy of this without any identifying data related to you.

Who will OBU share your data with?

The research team includes researchers from the Oxford Brookes University, who will have access to anonymised data; this data will be stored on Google drive. Only the research leads at Oxford Brookes University will have access to your name and contact details.

The anonymised data set, gathered for this study may be stored in a specialist datacentre/repository relevant to this subject area for future research.

Will OBU transfer my data outside of the UK?

No

What rights do I have regarding my data that OBU holds?

- You have the right to be informed about what data will be collected and how this will be used
- You have the right of access to your data (until data is pseudonymised)
- You have the right to correct data if it is wrong (until data is pseudonymised)
- You have the right to ask for your data to be deleted (until data is pseudonymised)

- You have the right to restrict use of the data we hold about you (until data is pseudonymised)
- You have the right to data portability (until data is pseudonymised)
- You have the right to object to the university using your data (until data is pseudonymised)
- You have rights in relation to using your data automated decision making and profiling (until data is pseudonymised)

Are there any consequences of not providing the requested data?

There are no legal consequences of not providing data for this research. It is purely voluntary.

Will there be any automated decision making using my data?

There will be no use of automated decision making in scope of UK Data Protection and Privacy legislation.

How long will Oxford Brookes University keep your data?

In line with Oxford Brookes policies data generated in the course of research must be kept securely in paper or electronic form for a period of time in accordance with University policy.

Your personal information (name and contact details) will be retained for three months after the study concludes. Your research data (anonymised information coming from an interview and/or a questionnaire) will be kept for 10 years after the study concludes.

Who can I contact if I have concerns?

You can contact the Information Management team.
Postal Address: Information Management Team, IT Services, Room 2.12, Gibbs Building, Headington Campus, Gipsy Lane, Oxford, OX3 0BP

Email: info.sec@brookes.ac.uk

Tel: 01865 485420 in UK
+44 1865 485420 outside the UK.

Appendix 8: Consent form

OXFORD BROOKES UNIVERSITY

Consent Form

Title of Study: ***Forensic mental health nurses' experiences of assault.***

Researcher: Helen Ayres, Professional Doctorate in Nursing Student
Supervisory Team: Dr Olga Kozlowska and Dr Sue Schutz

	Please initial box
1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2. I understand that my participation is voluntary and that I am free to withdraw any time prior to completion of data transcription, without giving reason.	☐
3. I agree to take part in the above study.	☐
4. I understand that the interview will be audio-recorded	☐

	Please initial box	
	Yes	*No*
6. I agree to the use of anonymised quotes in publications	☐	☐

Name of Participant	Date	Signature	☐ ☐
Name of Researcher	Date	Signature	

Consent Form Version 02 / 20 July 2020
UREC Registration Number 201408 Ayres

Appendix 9: Interview guide

OXFORD BROOKES UNIVERSITY

Study title: An exploration of the experience of mental health nurses who have been assaulted by patients in secure mental health settings.

Prompt: explain right to withdraw, pause or pass on questions, take breaks if required, reminder re. not disclosing confidential information

Opening questions

Can you tell me a bit about your experience as a mental health nurse in a secure/forensic setting?
Do you think violence and aggression is a significant issue in this setting?

Decision point: I am going to ask now about your own experience of being assaulted. Are you okay to continue?

Participant's experience

-Can you tell me about your experience of violence and aggression in the context of your role as a nurse working in a medium secure setting?
-How often have you been assaulted by a patient in this context?
-Can you tell me about one or two experiences that have particularly stayed with you and/or that you consider had a particular emotional impact?
**Prompts related to possible emotional responses will be provided should the participant be finding the identification of an experience difficult e.g., anxiety/fear, anger, sadness, shame, guilt, embarrassment*
-Can you describe these experiences to me in as much or as little detail as you feel comfortable?

Decision point: I am going to ask about how you have made sense of this experience and what is mean to you at the time and since, are you okay to continue?

Interpretation of experience and the attribution of meaning

- How did you feel when you were assaulted?
- What did it mean to you that you had been assaulted?
- How did you make sense of your experience?

Possible prompt questions:

- Why do you think you were assaulted?
- What do you think may have contributed?
- How did it make you feel about you/the patient/others/the environment?
- What was the worst thing about the assault?
- Were there any positive aspects or outcomes relating to the assault?

- How do you feel now when you think about the assault?

- How do you make sense of it now? Has your perspective changed over time?
Prompt question: Does the experience of the assault influence how you think about yourself now? Your colleagues? The patients you work with?

Can you tell me a bit about your understanding of the term 'assault'? Does the way you think about it differ in this context? Have you thought about why this may be?

Is there anything else you would like to say about your experience of being assaulted that we have not covered?

The interview will last for approximately 40 minutes and will take place either in person, over the telephone or video call on a date and at a time that is convenient for the participant.

Appendix 10: Reflection on interview with Participant 1

Reflection on first interview

Completed my first interview tonight. Over Teams at 7pm. Felt nervous and an overwhelming sense of responsibility - this man who I had no connection to and had never met, was talking to me in his own time about an experience of being assaulted. I was thinking about why he had agreed to talk to me, what he would be thinking and expecting, and whether I'd do it 'right'. I was also worried about the technology and had tested everything more than once so I was satisfied I could record and fulfil all the ethical requirements re storage etc.

The interview went okay - he was forthcoming and spoke freely and honestly - he shared the meaning of the experience for him and it really was what I was looking for - he said one thing about 'I was just a number' that has already made me think about the potentially depersonalising impact of such an experience.

I found two things particularly hard. The first was resisting the pull to reassure, reflect back my own interpretation, agree with him, offer support and advice. The second was ending the interview knowing there was no ongoing relationship. I felt like I had 'used' him. As I write this my eyes are filling up which hasn't happened until now. I feel bad for leaving him alone with it and knowing I can't check up. I wanted to email him today just to say thank you and check he's okay but I knew I couldn't do that.

I'm thinking about why this is and how he seemed - he said he thought the research was really important said he was glad he was able to take part, and said if I needed any further help to contact him. So given that I don't think he felt used. It is something I think about the nature of the nursing relationship - I have never had this kind of interaction and then not been able to reassure myself that the person is okay.

I'm finding this so in a way I didn't realise I would - this is what matters - I have such a responsibility to these people and to my profession.

Appendix 11: Examples of transcript summaries

P2 Transcript Summary

Sad	She had an awful experience
Grateful	She let me hear her story
Privileged	She hasn't spoken about this much at all
Anxiety	I hope she'll be okay for the rest of her day and afterwards
Excited	Wow, there was loads there – really rich stuff, she was so reflective and insightful

This participant was very reflective and began talking about her understanding of violence and aggression in the secure women's setting in which she works, its influencing factors and the task for nurses to contain their own emotional responses. She spoke of nurses as teachers/role models, being required to model healthy relationships, but often in the face of 'interpersonal relationship violence'. So while feeling anxious or angry or fearful, nurses need to respond in a way that is often counter to these emotions. She refers to this as a skill and explains this with reference to psychodynamic theory, explaining the interpersonal processes that are at play, giving a sense of her formulation not only of individuals but of the wider group dynamics.

She describes 'phases' of violence and aggression which can be prompted by changes in the team, changes to management which result in the dynamic becoming less stable; more inconsistent. She describes the beginning of the phase resulting in high levels of anxiety and adrenalin among nurses, before they seem to acclimatise – or become desensitised – as this becomes what is expected.

She begins to talk about factors that impact the way in which the nurse feels following an assault – the severity in terms of physical injury, and the intent on the part of the person. She makes a distinction between the visible and non-visible assaults – physical versus psychological/emotional in the context of the relationship.

In discussing the person who assaulted her, she describes an inevitability in relation to staff getting injured. They do so as they intervene to prevent her from hurting herself.

This participant described really clearly her beliefs in the moment as she was being assaulted. She feared for her life, and she felt that the person could have killed her. She believed she was capable. She described the sense of powerlessness, and particularly of paralysis, was what scared her the most. She knew what she should do – move her hands up to her neck – but she was unable to do so.

I notice as I read the transcript that her speech changes as she talks about the point that she began to acknowledge and talk about how she was feeling. She is less considered, less controlled at this point. This is perhaps reflective of the distinction she makes between herself as a professional, a leader; contained and 'neutral' and herself as a person, experiencing emotions. Her response is immediately critical of herself, with implicit expectations that's he should be able to 'manage' and either not 'feel' or be able to deal with it. She says "I can't deal with how it makes me feel".

The assault left this participant questioning herself as a nurse and a person, doubting her competence, her 'resilience', her strength. She believed she was weak, inadequate, not coping and she felt shame, embarrassment and unable to talk about how she felt for fear of others confirming her beliefs about herself.

This participant received support after the impact of the assault on her was noticed by a colleague. It seems from what she said about her concerns' about how she would be seen – being 'exposed', that this would have been a barrier to her being able to seek help.

She talks towards the end about assault more generally, and makes a distinction between the impact being assaulted by someone with a psychotic illness has versus being assaulted by someone with a personality disorder. The former is more premeditated, controlled and calculated whereas the latter is someone who is in a different reality. She speaks about remorse and understanding the patient's perspective being helpful in reducing the negative impact of assault.
Finally, she highlights the importance of talking about how assault affects nurses, and how being adversely affected carries a stigma that needs to be discussed and challenged if others are going to feel able to talk about their experiences.

Participant 7 Transcript Summary

Happy	She loves her work She seems really suited to working with women in this setting Sounds like the nursing team is really close and supportive
Curious/ sceptical	She seemed reluctant initially to talk about difficult experiences and how she feels Does she feel she shouldn't say anything negative, particularly about patients? She seemed to need permission to talk about feelings of frustration, anger and the sense of injustice she feels
Anger	The nursing team is alone in its experience Others pay lip service The nursing team isn't listened to
Guilt	Nobody recognises what it's really like for them I was one of those people 'in a different building'

This participant worked in a female secure service and she spoke early on and then frequently about the nature of this work and her perspective on the characteristics and behaviour of the women in the service, contrasting with men. She said that most violence and aggression in the service took place on the women's wards, with there being high numbers of assaults – assaults every day. Assault for her was implicitly physical. She spoke of men being violent, but it being 'over and done with' quickly, and intervention being effective due to its reassuring impact. She talked about male patients not hitting females 'out of respect', despite the extreme violence they had perpetrated in the past. Women, she said, did not have that same respect, and would assault female nurses often, with intervention having less positive an affect.

The assault happened in the context of her trying to prevent a woman from harming herself. She was punched in the face, and she referred to it as 'a cracker' and 'the best assault' – laughing as she acknowledged how she was describing them. She said she was shocked, and that her first thought was for the patient, making sure she was okay. She then went on to complete the tasks required following the assault (incident reporting, entering into clinical notes). She described her nursing colleagues and immediate line manager as concerned and supportive both at the time and later on. She said she 'just carried on' and that this is what tended to happen within the team. She said she thinks the process of completing the paperwork started the mental processing and making sense of what happened, and this can continue with colleagues. She talked about reflective practice, led by a psychologist, taking place but she said that sometimes it was difficult for nurses to get off the ward to be there.

The assault was reported to the police – she described this as a process that takes place after all physical assaults and says the team and patients are aware that this happens. She said that she went to court, the hearing was delayed, and then she received a letter to say that the case had been dropped due to it not being in the public interest. She was left feeling disheartened and said 'we're just punchbags'.

She spoke about the role of the nursing team in supporting each other – in identifying where someone may lack confidence, be struggling – and acting to help each other to feel safe. She said it was very important to really know each other and be alert to vulnerabilities that arise out of past or current experiences, this way incidents could be prevented. She described most of the support, processing and maintaining a sense of safety took place within the nursing team. She said that other disciplines didn't understand the nurses' roles, didn't appreciate how difficult the work was, didn't always listen to the nursing team and were supportive reactively but not proactively. In particular, she said the frequent verbal abuse was not recognised or dealt with outside of the nursing team. Participant 7's account reflected a tension between her experience in the context of her colleagues and line manager – which was one of care and empathy – and the way in which those beyond the nursing team perceive and respond to her and her colleagues' experiences.

Appendix 12: Reflexive journal entries

RJE 1

August 2020
Practice interview
OK [supervisor] *interviewed me today using the interview guide I have prepared. The aim was to test the questions, have me experience the questions from a participant's perspective, learn from OK re interview techniques and identify the sense I have made of my own experience.*

Observations
- I felt slightly nervous, and was thinking about how I may react to talking about my experiences of being assaulted. I know what the questions are and yet I was still feeling this! I need to acknowledge that this is a possibility for participants and not only use the decision points but also normalise this experience at the outset.
- I talked about an assault that did not happen in a medium secure setting! I was really surprised when we realised I had done this. I got caught up in telling my story of experiencing violence and aggression in my career. We discussed what I needed to do and the questions needed to draw the participant back to the MSU setting. However how will I respond if a participant wants to talk about an assault that did not happen in a secure setting? I need to read and think more carefully about how to validate their experience and acknowledge the importance whilst achieving the aims of the interview and study.
- One question did not make sense to me – and I had written it!! It was 'how does this make you feel about yourself, the patient, others...' I didn't know who others meant! So I will need to clarify, other patients/colleagues.
- OK asked me if I had talked about this before. I realised I really hadn't in any detail until I began the DNURS programme. I considered why this was and I think the influencing factors were shame (I did something wrong), embarrassment and trying to maintain a resilient, 'tough' forensic mental health nurse persona. I reflected on how this may have impacted me in my career, and thought about what I might do to challenge this. I hadn't considered there may be benefits of this process for participants in relation to their own practice/ development/wellbeing.
- The interview lasted for over an hour. I had underestimated the length of time it might take. I will need to be mindful of time and consider factoring in time checks/prompts.

I thought again after the interview about the role conflict issue – I am a nurse and a manager and am used to talking to patients and nurses about traumatic experiences in those roles. This is something different and from an ethical perspective, as well as a methodological (re. rigour) perspective I need to ensure I am clear of my role and the requirements of the interview.
The interview has clarified for me the sense I made of my experience; it centred around my feelings of inadequacy, getting it wrong and being seen as weak/incompetent. I need to ensure that I am aware of these and that they are my interpretations of an event, and not allow them to bias my questions/follow-up questions.

I plan to read more about role conflict and as I think so much of my interpersonal communication in relation to this topic will unconsciously lean towards my clinical and leadership roles, I will put together a prompt to read prior to each interview to ensure I bring to my consciousness each time to the researcher role, its purpose and the potential for bias/assumptions/role conflict to impact the interview.

RJE 2

October 2021

Immersing myself in the data – reflection on my emotional response and how this may inform my analysis

I am re-reading transcript one and something has struck me. I found reflecting on my emotional response to the story of this young nurse - being shocked at the level of violence he was exposed to and being seriously assaulted - to be interesting. In particular I feel reassured that I can still 'feel' for someone in this position, and to a significant degree (I felt sad again reading the transcript - I can hear his voice and picture his face), after 25 years of nursing. This however, I realise, is in contrast to how I have felt in practice at times. I have not responded in the same emotional way. I think this was because I had so many competing responsibilities, I was anxious and under stress myself at times and didn't have the capacity, emotionally or practically to immerse myself in the experience of nurses, and therefore to feel what I feel now. I am reflecting on what this might say about how the response from managers may be perceived by those who are assaulted. I wonder if I would have been perceived at times as not caring, and this makes me feel very guilty. It is important that I am honest about this and recognise the potential for my emotional response to impact the way in which I interpret the data.

RJE 3

December 2021

Re-reading transcripts

It's so interesting how each time I read them I see something new or I make links that I had not made before. I'm trying to think about whether I've had this experience before and I think I may have done to some degree when reading back over clinical reports.

I re-read one particular transcript – P6 - and I saw a real shift in the way the participant spoke and the emotional content of her speech – I think at the time I interviewed and then transcribed I noticed and 'heard' the words but perhaps not the change in tone and flow. I didn't completely see the shift in her – she was open and honest but controlled, but after one particular question ('what did it mean that they [manager] said ['we know you didn't mean to hurt her']?) her responses became more raw, she spoke more about her personal feelings and the impact on her. She repeated 'I didn't count' 'I didn't matter' and expressed feelings of worthlessness, helplessness and isolation/loneliness. I saw more of the impact on her as a

human being, whereas before this I think I was seeing more of the 'nurse' – the professional who was more controlled – perhaps more what was expected of her (and others) in these situations.

RJE 4

January 2022
Anticipating coding
During the month before I began coding, I became aware of my hesitancy to move away from the familiarisation phase. I reflected on two possible reasons for this, the first being my uncertainty around the process of coding and fear of getting it wrong. The second was that I was enjoying being close to the data as a creative, open space allowing for new insights and ideas. I realised however that I was comfortably passing Braun and Clarke's 'test' for having achieved familiarisation – I was confident that if I were to lose my dataset, I would be able to describe its broad content. I could go beyond this as I knew the participants' stories and significantly for me I could describe what was important to them, their perspectives and emotions. I had begun to gain analytical insight and had started to see patterns of meaning relating to beliefs about failure and weakness, I could also hear their voices and picture their faces which I was reassured by as I felt it supported me to continue with integrity; their experiences were at the centre of the study.

RJE 5

January 2022
Beginning to 'code'
This is so much harder than I thought it would be! I'm second guessing everything I write and I'm worried about making assumptions and interpretations that are not accurate. I think part of this concern comes from my CBT training – it was drummed into me that meaning comes from the individual and making assumptions and enforcing meaning risks undermining the therapy. So normally I would go back and check with the person. I do that in the interview at times – e.g. 'it sounds like you're saying...is that right' but not all the time

RJE 6

June 2022
Second round of coding
I'm in the process of reviewing my initial codes and have had the following insights...

I coded too much of the data to begin with. I can see that as I went on, I became more confident to leave sections of data that were not directly relevant to the research question.

Some participants talked in detail and at some length about their clinical experience, their careers, their insights and observations along the way. I think because I was interested, and in a couple of cases inspired, I wanted to capture what they had said because leaving it out felt like a waste. I found myself trying to find meaning relating to the question, and where I didn't, I coded anyway so as not to lose something important. In this second round of coding, which I'm completing in a different order, I feel more able to take an objective approach, holding the research question in mind. At first it felt a little brutal, and there are still parts that I think I will need to 'let go' of, but the process of refining feels like I am being more focussed and I am encouraged that I will have a more manageable – and relevant set of codes as I move towards generating themes.

I have also noticed my coding, and struggle with coding more broadly, is influenced by my aim to capture the exact meaning attributed by the participants. I am concerned that by not having separate codes which capture subtle difference in meaning, that I may dilute the breadth of interpretations made by nurses. And it was this that at the outset I most wanted to bring attention to – the many, varied and nuanced ways nurses interpret their experience of being assaulted. I recognise that some of the codes are more extracts from data that I feel capture something – I can return to these and use to illustrate such that the participants words are not lost. I feel such a responsibility to conveying their perspectives as they put them – the tension between representing what they meant and interpreting is tricky – sometimes I need to interpret, sometimes they have conveyed it so well it needs no more. I have read more about coding in light of this and am reassured that different approaches to coding include broad versus detailed, an also that I am not 'getting it wrong'.

The coding of transcript one below provides an illustration of the above reflection.

Data extract (Participant 1)	**Coding round 1**	**Coding round 2**
I'm a big lad, you know, I'm not small and you're beaten up by a fifteen, sixteen year old lad… it was just odd. I didn't know quite how to feel after it. Maybe a bit of shame… a bit, a sense of, I don't know, how do you describe… almost like my masculinity as such had kind of taken a knock… and then he tried to shake my hand when I came back onto the ward and I went "no, …it doesn't work like that mate". And then he went off and gave me some verbal abuse. And then the other thing that really got to me was he was put in isolation as a result of that and within two hours he had a TV and an Xbox and a couple of support workers playing with him… and that was just like… so that's what happens, you attack a member of staff and you essentially get a couple of your	-I'm a big lad, yet I got beaten up -odd, didn't know how to feel -shame -masculinity took a knock -tried to shake my hand [immediately after assault] -rejection of immediate reconciliation attempt -wouldn't shake his hand= verbal abuse -Lack of negative consequence -Rewarded -assault = positive reinforcement	Shameful for male nurse to be assaulted Assault dents masculinity Expecting immediate reconciliation is not okay No negative outcome for patient from assault Patient's needs prioritised after assault

support workers, who he really liked and to play with him in isolation…	-he assaulted me and got more attention	Positive reinforcement for assault

RJE 7

January 2022
Insight during coding

I have just experienced a moment of insight – a code that I have been grappling with. It is around the repeated data extracts that discuss violence as normal, with the caveat that it shouldn't be considered so. Nurses repeatedly talked about knowing they were working in high-risk areas, expecting violence, recognising risk to themselves, but then also expressing their belief that it should not be viewed as part of their job. I struggled, on each transcript, to code this in a way that I thought captured the meaning. I then re-read a sample of data which said "and it becomes… not normal… but you expect it more". The code "'expected' does not mean 'normal'" seemed to fit and to encapsulate the idea. It feels really good to have a code that communicates the idea, and points to a nuanced meaning that I can then explore further. This may be an example of a code becoming a theme/sub theme, but I think it's too early to tell as yet.

RJE 8

May 2022
Reflection on language

I have been thinking about how the way we talk about assaults on nurses both demonstrates and perpetuates their normalisation. As I returned to P2's transcript I noticed and reflected on her use of the word 'acuity' when talking about times of volatility, at one point clarifying its use by saying 'lots of violence and aggression'. The use of this word is interesting as in my practice experience, its use has become increasingly widespread including among senior and commissioning teams. I cannot bring to mind a time in my own practice when we either agreed or /questioned interrogated its meaning – suffice to say it is understood to mean high risk, and most often violence. So I am wondering what is influencing its use – why do we not say 'high risk' or 'high levels of violence'? I suspect there are a number of factors at play – one of which is that 'acuity' feels more comfortable and potentially less stigmatising. But I think it has the effect of suppressing or denying the experience of nurses. I had not thought about this before, but realise I have been part of exactly this – sanitising the reality. Yet it is only in this process of analysis that I am recognising and reflecting on it. I think this is really important and I will think more about it over the course of my analysis.

Appendix 13: Participant 4 notes

Participant 4

- 'Pride'? is the idea that as (forensic) MHN's we 'crack on' - we get knocked down & get up again (literally) + back to work?

- This participant seemed to hold this expectation and meet it. - she got checked out, was okay, felt the incident was managed well, and was back to work. What if she wouldn't been able to do this - how would it have affected her?

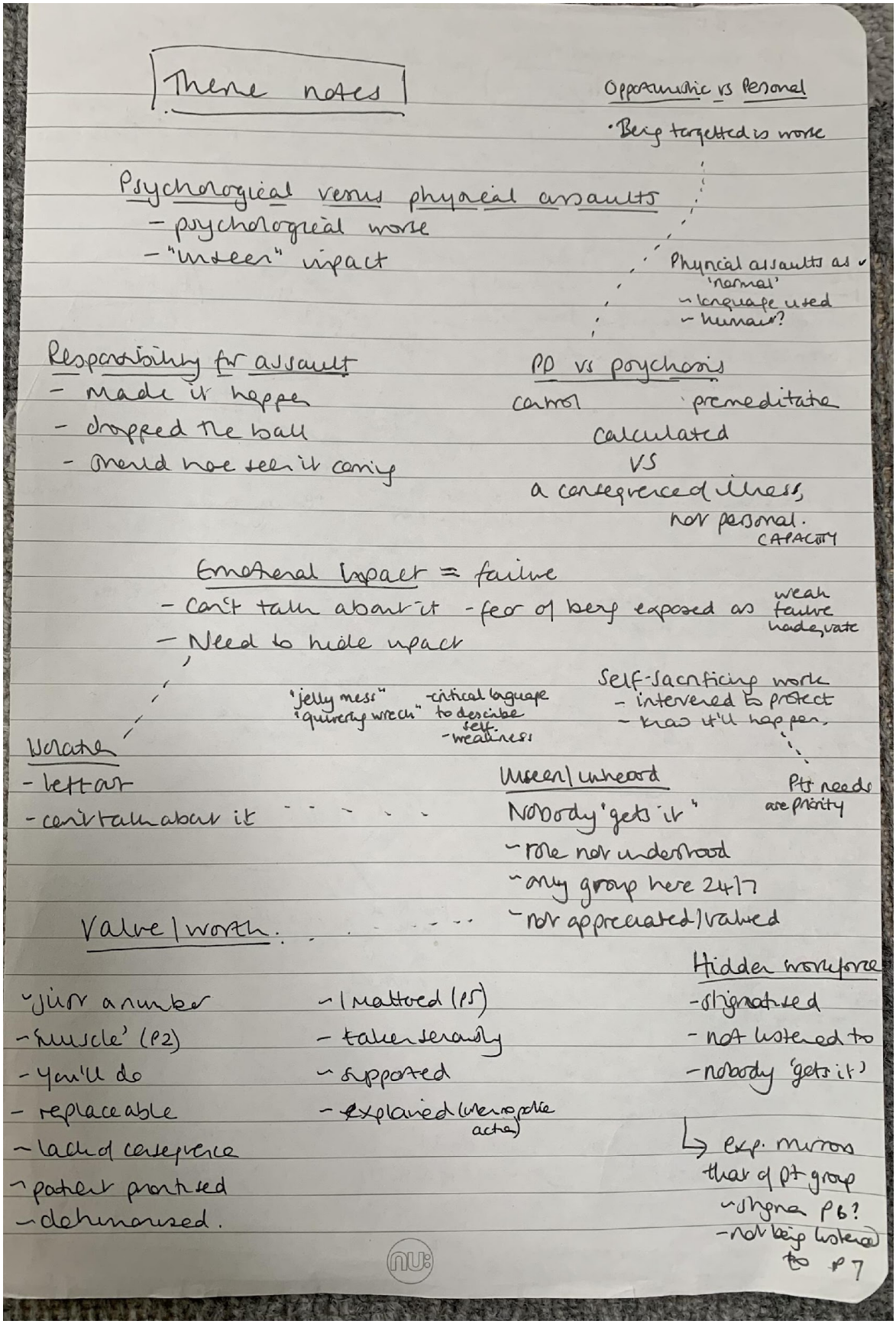
- Machoism is unhelpful + stature can be misinterpreted

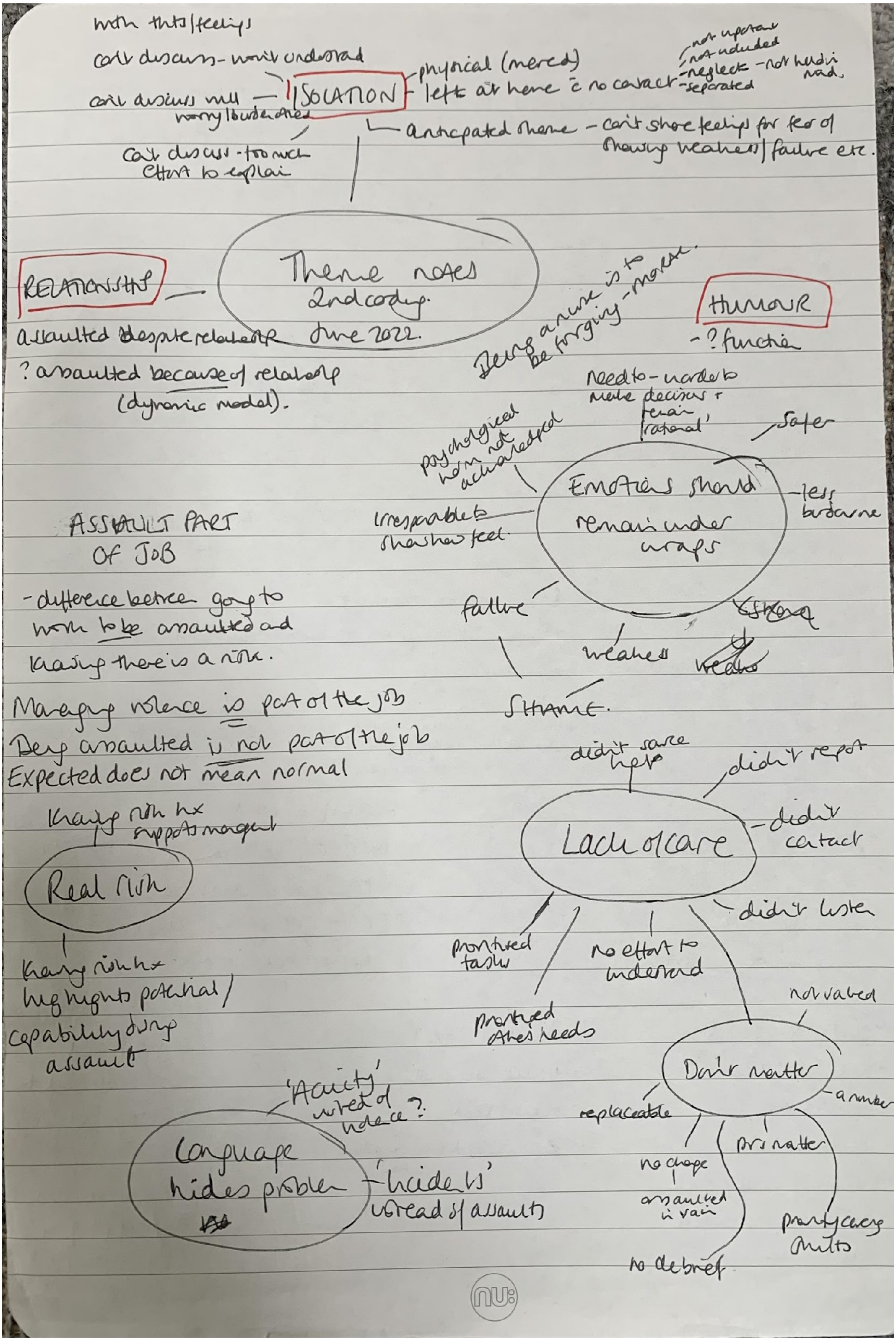
- Male staff should protect female staff.

  - High threshold for assault
  - Team supportive + protective
  - Incident managed well
  - Can separate work from home
  - No 'harm' done - harm = physical
  - Assault is physical (acknowledge can be other than for duff people)
  - Judgement of those whose threshold is lower ('funny').

- Nurses response to 'behaviour' (inc spitting, verbal abuse/threats) affect whether they then define the behaviour as an assault. If you identify, address, de-escalate, communicate clearly then less likely to feel assaulted. ⇒ ?"by remaining in control, you can avoid the feeling of having been assaulted"

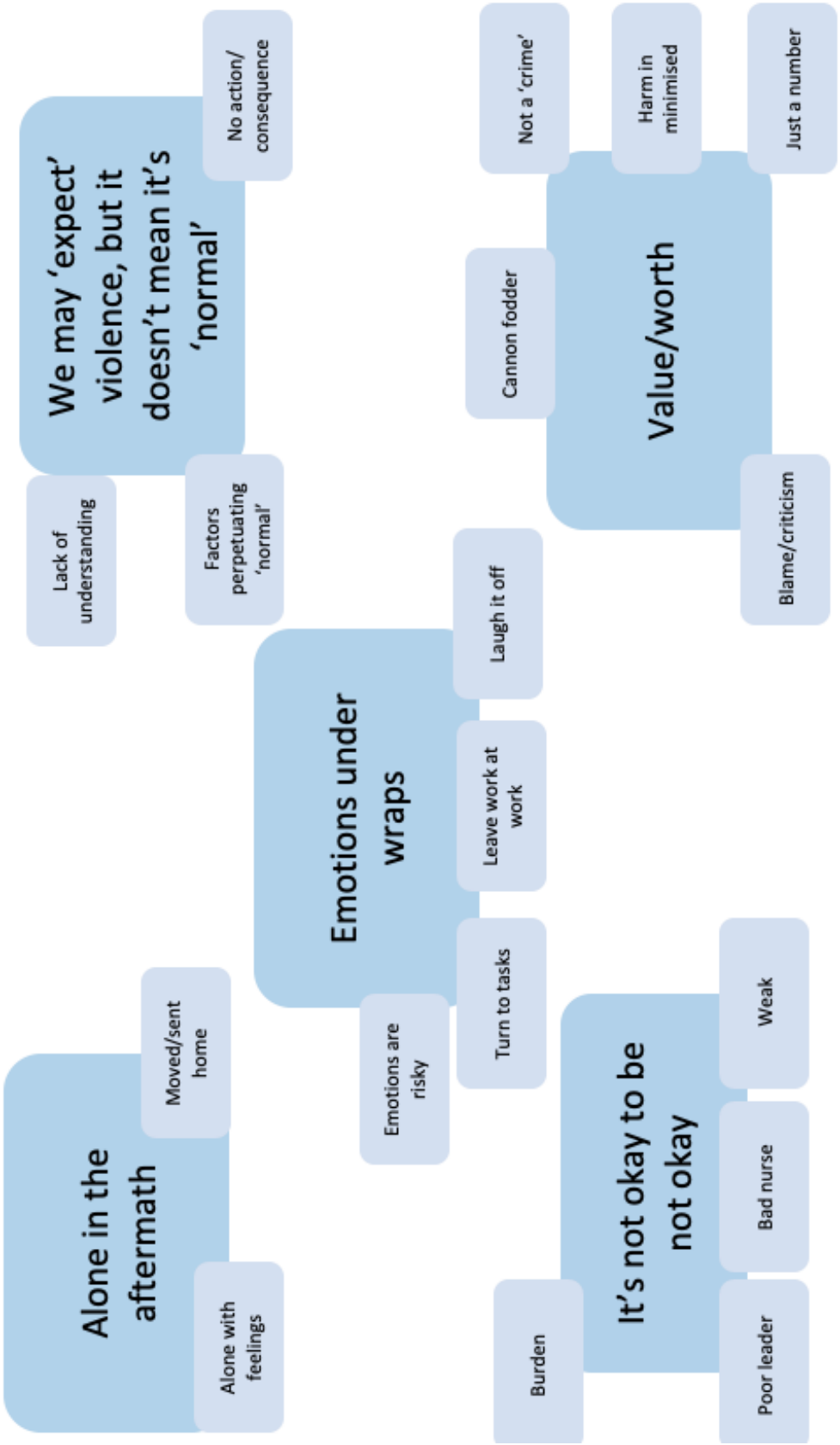
Appendix 14: Theme notes



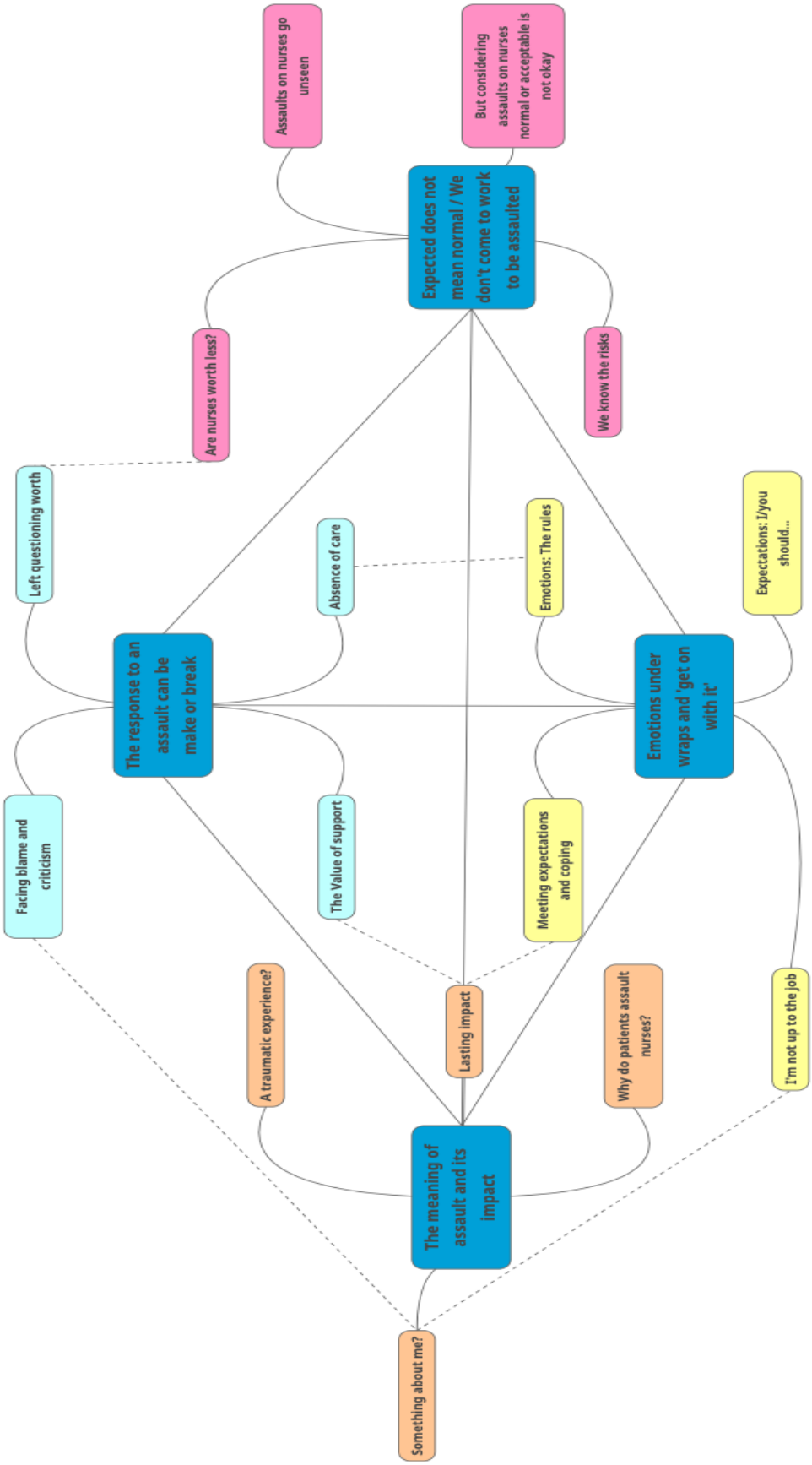

Theme notes
2nd coding.
June 2022.
ISOLATION
with thts/feelings
can't discuss - won't understand
can't discuss will worry/burdened
can't discuss - too much effort to explain
physical (moved)
left at home c no contact
not important
not included
neglect
not having need
separated
anticipated theme - can't share feelings for fear of showing weakness/failure etc.
RELATIONSHIPS
assaulted despite relationship
? assaulted because of relationship (dynamic model).
HUMOUR
- ? function
Being a nurse is to be forgiving - moral.
Need to - in order to make decisions + remain 'rational'
safer
less burdensome
psychological harm not acknowledged
irresponsible to show how feel.
Emotions should remain under wraps
failure
weakness
SHAME.
ASSAULT PART OF JOB
- difference between going to work to be assaulted and knowing there is a risk.
Managing violence is part of the job
Being assaulted is not part of the job
Expected does not mean normal
knowing risk hx supports management
Real risk
knowing risk hx highlights potential/capability during assault
didn't source help
didn't report
didn't contact
didn't listen
Lack of care
prioritised tasks
no effort to understand
prioritised others needs
not valued
Don't matter
a number
replaceable
no change
assaulted in vain
no debrief
don't matter
priority carers' needs
'Acuity' instead of violence?
Language hides problem
'incidents' instead of assaults

Appendix 15: Theme maps

Theme map version 1



Theme map version 2



Appendix 16: Final Theme, subtheme and code list

Theme: We know the risks, but being assaulted is not 'normal'		
Why do patients assault nurses?	1	Assaulted by illness, not person
	2	Assaults in the context of personality disorder are intentional, instrumental and feel personal
	3	Attempts to protect and keep safe met with assault
	4	Assault reflected vulnerability and past trauma
	5	Nature of violence and aggression is different according to gender
	6	The presence and attitude of male colleagues can affect risk and management of violence
	7	Assaulted in spite of good therapeutic relationship
	8	Being fair, honest and respectful can reduce risk of assault
A traumatic experience with a lasting impact	9	I didn't expect the assault
	10	Something wasn't right
	11	Serious physical assault
	12	Sense of powerlessness and helplessness during assault
	13	Felt safe during the assault
	14	A prolonged, traumatic assault
	15	In shock post assault
	16	It could have been more serious, I could have died
	17	Distressed by the distress of others
	18	Colleagues felt responsible/ guilty
	19	Reduced confidence left me second guessing myself
	20	Ongoing sense of threat lead to anxiety/ panic
	21	Retreated to avoid being 'out front' and a target
	22	Assault negatively affected therapeutic relationship
	23	Being assaulted did not affect the therapeutic relationship
	24	The lasting impact of trauma
	25	Impacted personal relationships
	26	Lack of understanding contributes to isolation
	27	Being assaulted can impact your identity
	28	Leaving the job was the only option
We know the risks but assaults should not be normalised	29	Assaults on mental health nurses are frequent
	30	Racial abuse from patients is common
	31	Being assaulted comes with the territory
	32	Mental health nurses risk their personal safety
	33	Was naive to level of personal risk
	34	You get used to it
	35	Normalising can help us cope
	36	Others view violence against nurses as 'part of the job' and acceptable – nurses as 'punchbags' / culture of acceptability
	37	Patients think it's ok to hit nurses
	38	Actually, it's not normal
	39	Our job is to manage risk, not to be assaulted
	40	The impact of verbal abuse/ threats/ assaults is not recognised - death by a thousand cuts

	41	Normalising leads to disempowerment of nurses to report and speak out
	42	Police see assaults on mental health nurses as trivial/ unimportant
	43	The idea that assaults on mental health nurses are acceptable needs to change
Assaults on nurses go unseen	44	Assaults are overlooked and minimised
	45	Absence of a shared definition of assault in secure setting
	46	In practise assaults in secure settings are physical acts
	47	Assault has a broader definition when considered beyond the secure setting
	48	Assault and harm is externally defined – not individual experience
	49	Assaults on mental health nurses go unseen
	50	Assaults on mental health nurses are not seen as a crime
	51	It should be policy to report assaults on nurses to police
	52	There is a reluctance to prosecute “mentally ill”
	53	Patients face no consequences
	54	Assaults in mental hospitals are not the concern of the police
	55	Nurses forgive assaults
Theme: Keep emotions under wraps and crack on		
Emotions: The rules	56	Containing emotions is what is expected
	57	I should be in control of my emotions
	58	Distress means weakness
	59	Anticipated shame means emotions must be concealed
	60	Anticipatory shame leads to isolation
	61	Mental health nursing is emotional work
Must keep going	62	I must make sure the team is safe
	63	As a leader I must be able to carry on
	64	Expectation [from others] to crack on
	65	I should be able to bounce back
	66	Being assaulted should not impact patient care
	67	Expected to be able to ‘manage’ impact of assault
	68	The patient comes first
	69	Focus on tasks helps to cope
	70	Being able to leave work at work is important
	71	Get back on the horse to cope
	72	Thinking about assault is risky- avoid
	73	Humour as a social means of coping with colleagues you trust
	74	Humour as a means of avoiding emotion (latent)
	75	What nurses say is not what they feel- they just need to get through it
	76	You just carry on
	77	Humour communicates emotion
I’m not up to the job	78	I'm not up to the job
	79	There's something wrong with me if I can't move on
	80	Emotional response left me exposed and vulnerable
	81	Exposing vulnerability means letting the team down
	82	I failed as a leader
	83	A nurse should not add to patients worries
	84	I couldn't function
	85	I failed by bringing home in to work
	86	I feared I would lose something I loved

Theme: The response to assault can make or break		
Absence of care	87	I was not cared for following the assault
	88	Absence of care, empathy and support from managers
	89	No support to make sense
	90	Go and sort yourself out
	91	Response can leave you isolated
	92	Inaction from managers due to lack of time/ skills
	93	I was let down by managers
	94	Mental health services are not equipped to support assaulted (traumatised) nurses
	95	Not supporting nurses impacts service provision
	96	Culture of lack of care for assaulted nurses
	97	Police response was unsupportive/ invalidating
Left questioning worth	98	Left feeling worthless
	99	'Dehumanised'; I was just a number
	100	It didn't matter that I was assaulted, I don't matter
	101	Assault was in vain
	102	Patient comes before [assaulted] nurse
	103	Assault was not serious enough for a response
	104	Targets, tasks and reputation took priority
	105	The impact/harm of an assault is minimised by individuals and system
	106	Nurses worth less than other disciplines
	107	'Unseen' mental health nurses of less value than other emergency workers
Blame and responsibility – something about me?	108	I was blamed for assault; There is a blame culture
	109	Criticism and scrutiny after assault
	110	The assault was my fault
	111	I did my best, it was not my fault
	112	I was an easy target
	113	I was targeted as a leader
	114	I was assaulted because I am black
	115	An assault that feels personal is harder to cope with
	116	The patient was responsible for the assault
	117	The assault was because I set boundaries/ limits
Support makes all the difference	118	My assault was taken seriously- I mattered
	119	Being supported meant I could carry on
	120	Need for support was recognised and addressed by colleagues
	121	Being given the opportunity to talk and make sense together was important
	122	Support reduced self-blame
	123	Colleagues support was important
	124	Manager and service support was important to me
	125	The police listened to me
	126	Culture of addressing race related assaults is changing
	127	Care and support would make all the difference