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Mental health nurses' experiences of assault by patients in inpatient settings

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Abstract

Mental health nurses working in inpatient settings are at increased risk of being assaulted by patients. Systematic reviews have synthesised predominantly quantitative evidence relating to the prevalence, contributing factors, effects and adverse outcomes of violence towards mental health nurses. This article details a systematic review that used a meta-aggregative approach to provide a synthesis of qualitative evidence on the experiences of mental health nurses who have been assaulted by patients in inpatient settings. The review found that mental health nurses consider violence against them to be a significant and unacceptable issue that can have significant and pervasive effects on their personal and professional lives. Nurses may avoid or suppress their emotions following an assault, finding it challenging to share and report their experiences. Mental health nurses' perceptions of factors that contribute to and can prevent violence and assault included the environment, workforce, relationships, gender and restrictive practice. By focusing on findings generated through the use of qualitative research methods, this literature review enhances the depth of existing evidence, bringing the voice of nurses who have been assaulted to current understanding.

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Keywords

aggression, literature review, mental health, patient behaviour, patients, professional, qualitative research, research, staff welfare, violence at work, workforce

Key points

- ***The effects of being assaulted extend beyond physical injury, with mental health nurses experiencing pervasive negative effects on their personal and professional lives***
- ***Discussing violence against mental health nurses as being 'normal' or 'part of the job' risks invalidating and/or failing to recognise nurses' experiences***
- ***Open, supportive cultures where nurses feel safe to discuss the emotional effects of being assaulted are important***
- ***Practical, cultural and psychological barriers to mental health nurses reporting assaults have the potential to affect estimations of its prevalence and effects, as well as the provision of support for individuals***
- ***Supporting mental health nurses who have been assaulted requires an individualised, holistic and non-judgemental approach***

Background

Violence directed towards healthcare workers is a recognised and increasing global issue. Liu et al's (2019) systematic review and meta-analysis found that around 24% of healthcare workers had experienced physical violence in the past year, with the figure being significantly higher – at 51% – for those working in mental health settings. Those working in mental health trusts have been reported to be approximately seven-and-a-half times more likely to be physically assaulted than staff in other NHS trusts (Health Service Journal 2018, Mento et al 2020).

Research to date has focused on factors contributing to violence and aggression (Dickens et al 2013, Edward et al 2014), strategies for its prevention and management (Baby et al 2016) and approaches to providing support (Bakes-Denman et al 2021). Several studies have also demonstrated associations between the experience of being assaulted and a range of negative consequences for nurses (Seto et al 2020, Hilton et al 2022). There are significant detrimental effects not only on nurses' personal and professional well-being, but also on therapeutic relationships (Stevenson and Taylor 2020). Increased absenteeism following incidents of workplace violence was recognised in Phillips' (2016) review, while Adams et al's (2021) systematic review identified fear of assault and perceived risk of assault to be factors that increase mental health nurses' intention to leave either their jobs or the profession entirely. Such outcomes have a negative effect on service delivery and patient care.

Systematic literature reviews have sought to synthesise evidence relating to different aspects of the topic, including: the frequency of incidents (Odes et al 2021); the nature, extent and effects of workplace trauma for forensic mental health nurses (Newman et al 2021); the perspectives of patients and staff 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 (Jang et al 2021, Odes et al 2021).

Given the under-reporting of assaults on mental health nurses (Morphet et al 2019, Rodrigues et al 2021), the extent of the issue is likely underestimated. At a time when the nursing profession is experiencing substantial workforce shortages globally (Royal College of Nursing 2022), it is increasingly important that this issue is well understood to ensure 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 is to provide a synthesis of qualitative research on the experiences of mental health nurses who have been assaulted by patients in inpatient settings.

Aim

To provide a synthesis of qualitative evidence on the experiences of mental health nurses who have been assaulted by patients in inpatient settings.

Method

This systematic review of qualitative evidence used a meta-aggregative approach, as described by the Joanna Briggs Institute (JBI) (Lockwood et al 2020). This approach is sensitive to the philosophical traditions and perspectives of qualitative research, seeking to remain close to the data and aggregate findings rather than offering a reinterpretation. 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, then synthesising the categories into a set of comprehensive, synthesised findings. These systematically developed, overarching findings intend 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.

Search strategy

Moher et al's (2015) Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) approach was applied to this search. The electronic databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycInfo and PubMed were searched between 15 January 2022 and 21 January 2022. Reference lists of identified articles were also manually searched.

The formulation of the review question was guided by Stern et al's (2014) PICOS framework, as follows:

» P – population: mental health nurses.

» I – phenomenon of Interest: experience of being assaulted by patients.

» CO – context: inpatient settings.

» S – study design: qualitative research.

From this, the following review question was formulated: 'How do mental health nurses make sense of their experience of being assaulted by patients in inpatient settings according to reports of qualitative research?'

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 type of study

Inclusion and exclusion criteria

The inclusion and exclusion criteria are summarised in Table 2. An earlier scoping review indicated that there were few qualitative studies focusing on the meaning of personal experiences of assault, so no limiters with regard to publication dates were placed on this review.

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 mental health settings** » Non-registered staff
Study characteristics	» Qualitative, empirical research studies » Mixed-methods studies » 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**
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	» Other languages

Study selection

A total of 10,646 studies were retrieved from the database search, with a further 19 articles being obtained through hand-searching of reference lists. Following the removal of duplicates, 7,522 articles were screened by title and, where a decision to exclude was not clear based on the title alone, abstracts were read. Of the remaining 728 articles, 699 full texts were screened as 29 full texts were not obtainable. This process resulted in 16 articles for inclusion in the review.

Critical appraisal

The authors independently appraised the selected articles using the JBI Critical Appraisal Checklist for Qualitative Research (Lockwood et al 2015). The majority of articles (n=10) lacked clarity as to the philosophical basis for the studies on which they were reporting. Most of the articles (n=10) neither situated the researcher culturally or theoretically, nor did they address the influence of the researcher on the research, and vice versa.

Data extraction

Findings relevant to the review question were identified and extracted from each article. The findings were reviewed with reference to their sources and assigned one of three levels of credibility

(unequivocal, credible and not supported), as per JBI criteria (Lockwood et al 2020). Unequivocal and credible findings were included, but findings that were not supported were not included.

Findings

Table 3 provides a summary of the included articles.

The process of meta-aggregation resulted in 16 categories, which were then aggregated into five synthesised findings (Hannes et al 2018). The synthesised findings and categories are presented in

Table 4. Synthesised findings and categories

Synthesised findings	Categories
Perspectives on violence against mental health nurses Mental health nurses consider violence against them –conceptualised in different ways – to be a significant, and unacceptable issue, particularly when perpetrated by patients who they deem to be in control of their behaviour	» Violence as 'normal' and expected but not acceptable » Violence can be perceived as unexpected and unpredictable » The way in which violence and assault is conceptualised varies » Responsibility, control and blame
Personal and professional impact Being assaulted can have significant and pervasive effects on mental health nurses' personal and professional lives	» Effects on self as a person and as a nurse » Effects of being assaulted on life outside work » Effects of being assaulted on approach to patients
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 and/or withdrawing » Making sense and understanding » Active responses
Sharing and reporting experiences Sharing and reporting experiences of assaults is challenging, and often avoided, by mental health nurses	» Sharing experiences beyond the workplace » Response from managers and peers » Barriers to reporting assaults
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 or team factors » Patient factors » Factors relating to gender

Discussion

Perspectives on violence against mental health nurses

Violence and assaults on mental health nurses were considered to be frequent, inevitable, expected and 'normal' – particularly in the case of verbal violence, where it was believed to be 'part of the job' (Currid 2008, Baby et al 2014). Despite this widely expressed perspective, assaults were often described as unexpected, unpredictable and unpreventable (Tema et al 2011, Yang et al 2016), resulting in nurses feeling shocked and confused (Benson et al 2003, Sim et al 2020). In the literature, the consensus view among mental health nurses was that while violence and assaults are frequently experienced, they should not be considered acceptable or 'part of the job' (Baby et al 2014, Stevenson et al 2015). There was a perception that the violence they experienced was not always taken seriously by their managers and the police (Baby et al 2014, Hiebert et al 2021), and they did not consider themselves to be protected by the law (Dean et al 2021). A perception that, in contrast, assaults on police officers and firefighters were taken seriously and responded to with compassion and support led to a sense of unfairness among some mental health nurses (Moylan et al 2014).

Conceptualisations of what constituted violence in this context varied across the articles. One article included the explicit finding that such conceptualisations were subjective and influenced by multiple factors (Cutcliffe 1999). For example, 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). Some nurses linked this intentionality and perception of control to a diagnosis of personality disorder which 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, beyond their control and not conceptualised as violence (Cutcliffe 1999, Hiebert et al 2021).

Personal and professional impact

Being assaulted had the potential to have significant and pervasive effects on mental health nurses' personal and professional lives. The effect of physical injury was not a prominent theme across the sample; it was explicitly stated that psychological trauma often had a more lasting effect than any physical effects (Yang et al 2016). Nurses reported their self-esteem, confidence and sense of competency being negatively affected following an assault (Baby et al 2014, Hiebert et al 2021), with nurses blaming themselves on occasions (Hiebert et al 2021). The emotional effects were consistently described as being pervasive, with fear and anxiety (Dean et al 2021, Ezeobele et al

2021), frustration and anger (Stevenson et al 2015, Hiebert et al 2021) and guilt and shame (Dean et al 2021, Hiebert et al 2021) being reported most frequently.

There was less clarity in relation to cognitions associated with guilt and shame than other emotions. Nurses' sense of agency was also negatively affected 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) in the face of verbal abuse and 'belittled' (Moylan et al 2014) 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).

The effects of assaults experienced by male nurses featured in the findings of six of the studies. Male nurses were found to be less likely to express emotions, instead 'downplaying' them (Benson et al 2003). They often saw themselves – and were seen by their peers – as protective factors against assaults on female colleagues (Zuzelo et al 2012, Dafny and Beccaria 2020). However, many male nurses felt responsible, emotionally drained, fearful of injury and undermined professionally when seen as 'bodyguards' (Tema et al 2011, Dafny and Beccaria 2020).

Many nurses who had been assaulted felt less able to be empathic, compassionate and person-centred (Cutcliffe 1999, Stevenson et al 2015), often distancing themselves and becoming increasingly task-focused as a means of coping and protecting themselves from a further assault (Currid 2008, Ezeobele et al 2021). This, together with a loss of trust and sense of betrayal, made establishing and maintaining therapeutic relationships increasingly challenging (Kindy et al 2005, Sim et al 2020).

Some mental health nurses experienced a conflict in relation to their roles as a result of being assaulted. One nurse spoke of '[not feeling] like a nurse' after an assault (Kindy et al 2005), while others found it challenging to reconcile their feelings of anger and frustration with their caring role (Tema et al 2011).

Nurses described the effects of being assaulted on their lives outside work, which included disturbed sleep and nightmares, hypervigilance, and increased smoking and alcohol consumption (Stevenson et al 2015, Hiebert et al 2021). Their personal relationships were often negatively affected, with nurses describing themselves as 'snappy' and 'cranky' with family (Kindy et al 2005, Baby et al 2014) and shouting at their children 'for nothing' following an assault (Tema et al 2011).

Response to being assaulted

Mental health nurses frequently reported attempting to cope with the emotional effects of being assaulted by suppressing and avoiding their 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 many nurses believing that showing emotion in front of patients was risky and left them vulnerable (Zuzelo et al 2012, Lantta et al 2016). Phrases such as 'moving on,' 'get past it,' 'leave work at the door' (Zuzelo et al 2012) and 'get back on the bike' (Baby et al 2014) illustrated the nurses' perspectives on what they believed was important or required following an assault.

Many nurses made sense of their experience by seeking to understand and rationalise patients' assaultive behaviour. Not taking the assault personally was seen as important in being better able to cope, forgive and move on (Benson et al 2003, Sim et al 2020, Dean et al 2021).

The venting of emotions was referred to in the studies as helpful, but this was typically something that was done in private; for example, one nurse stated: 'Nobody knows I'm in there crying. I will vent and let go of stuff' (Zuzelo et al 2012). Becoming hypervigilant was also described as a response to being assaulted, driven by fear and anxiety (Kindy et al 2005, Yang et al 2016). Being assaulted also prompted some mental health nurses to consider leaving their job or the profession (Ezeobele et al 2021, Hiebert et al 2021).

Learning and behavioural changes were identified as positive outcomes of nurses' reflections on their experiences (Baby et al 2014, Yang et al 2016); However, this was not referred to frequently or in any depth.

Sharing and reporting experiences

Mental health nurses often found sharing and reporting their experiences of assault challenging, and many of them avoided doing so. Reasons they avoided sharing their experiences of being assaulted with family members included to protect them and because their families – and society more generally – would not be able to understand and empathise (Sim et al 2020), and also may not believe them (Dafny and Beccaria 2020).

Overwhelmingly, nurses did not feel supported, perceiving responses from their managers as critical, invalidating, blaming, punishing and stigmatising (Ezeobele et al 2021, Hiebert et al 2021). For example, one nurse described those reviewing reports as being 'only concerned with what the nurse did or didn't do' (Hiebert et al 2021), while another believed they were seen as 'the perpetrator of the assault and not as a victim' (Ezeobele et al 2021). Other nurses described critical comments such as 'you are responsible for maintaining safety, can't you do that?' (Moylan et al 2014).

The absence of a response and/or action following an assault was also found to be a common experience, leaving nurses feeling marginalised and ignored (Tema et al 2011, Moylan et al 2014). There was a perceived lack of resolution following an assault (Kindy et al 2005), including patients not being held to account by others for their actions. Following an assault, nurses perceived that others expected them to carry on, use their skills and continue to care for the person who assaulted

them (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 being given the time to access such support (Stevenson et al 2015, Dean et al 2021).

Findings relating to the reporting of assaults highlighted several explanations for underreporting. 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). Nurses also had mixed experiences in relation to support from the police, perceiving that they had been discouraged from reporting on some occasions (Stevenson et al 2015), and believing that 'nothing will be done' (Dafny and Beccaria 2020). A lack of trust in managers, feelings of shame and fear of blame, criticism and/or stigmatisation also made many nurses reluctant to report assaults (Dean et al 2021, Ezeobele et al 2021).

Other reasons given for not reporting assaults were a lack of time and the cumbersome forms involved (Hiebert et al 2021), and nurses not recognising the importance of reporting (Dean et al 2021).

Factors affecting violence and assault

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 mentioned various factors as contributing to violence and assaults, including insufficient staffing, inadequate training and levels of experience, suboptimal physical security and environments lacking space and privacy (Kindy et al 2005, Hiebert et al 2021).

Developing effective therapeutic relationships and having sufficient time to spend 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. This included having a shared, consistent approach that minimised the risk of individuals being targeted for violence (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 issue (Dean et al 2021).

Patients' experiences of being restricted, treated against their will and not having their needs met were considered to be precursors to assaults (Currid 2008), as were reductions in medicines (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 and Beccaria 2020) and female nurses were viewed as more vulnerable, particularly to verbal abuse (Zuzelo et al 2012, Sim et al 2020), and particularly when the presence of male nurses is limited (Tema et al 2011).

Limitations

While the review team collaborated in the selection of the final articles, critical appraisal and review of findings, the review was largely undertaken by the primary author (HA), thus increasing the risk of bias. Articles not written in English were excluded, which may have resulted in relevant findings being missed. The number of databases and reference lists searched was limited by time and resources, which may have further limited the findings of this review.

Conclusion

This systematic review of qualitative evidence develops what is known about the experiences of mental health nurses who have been assaulted by patients. The focus on findings generated through the use of qualitative research methods enhances the depth of existing evidence, bringing the voice of nurses who have been assaulted to current understanding.

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