The interpersonal dynamics of aggression and violence in mental health inpatient units

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The Interpersonal Dynamics of Aggression and Violence in Mental Health Inpatient Units

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Thesis Certification

I, Jane L. Middleby-Clements, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Psychology, University of Wollongong, is entirely my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Jane L. Middleby-Clements

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Abstract

Rationale: Mental Health professionals' ability to manage aggression and violence in mental health units is hampered by a lack of evidence-based research.

Aim: The research aimed to investigate the relationship between Health Professional attitudes and subsequent aggression by mental health inpatients.

Method: An interpersonal model specific to inpatient mental health units guided three empirical studies. Study one investigated patient views on staff management of aggression. Study two examined specific staff variables such as rigid attitudes in dealing with aggression. Study three investigated the impact of a management philosophy upon staff attitudes in a controlled design.

Results: In study one, patients reported that interpersonal factors with mental health staff were salient contributors to their aggression. Study two extended this and found that high staff rigidity was associated with low tolerance for patient aggression. Interestingly, staff characterised by low rigid attitudes were found to be more involved in high severity aggressive incidents. Study three found training in zero tolerance had the unintended consequence of increasing rigid attitudes, while reducing tolerance toward aggression.

Discussion: Staff play a role in helping or hindering inpatients with aggressive impulses. Staff with less rigid attitudes were those most likely to assist in difficult incidents, those incidents that are likely to be unavoidable. More rigid staff were involved in a greater proportion of low-medium severity incidents,

those incidents likely to be more easily avoided if managed well. Management approaches that reduced tolerance toward aggression appeared to have a negative impact on variables most likely to help patients manage aggressive impulses. Together these studies highlight that staff and management policy are critical variables in understanding and responding to aggression.

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CHAPTER ONE

Introduction

Chapter 1:

Introduction

1.1. Prevalence of Aggression and Violence in Mental Health Units

International and national statistics highlight the growing significance and magnitude of the problem of workplace violence (Chappell & Di Martino, 1998; Flannery, 1996; Fletcher, Brakel & Cavanaugh, 2000; Gerberich, Church, McGovern, et al., 2004; Perrone, 1999). Workplace violence includes the following types of behaviours: homicide, physical violence, verbal abuse and threats, stalking, bullying amongst workers or from managers, or any type of behaviour that induces fear in workers or that can result in stress or the worker avoiding the work environment (Mayhew & Chappell, 2001a). It has been noted that nurses, police, security and prison guards, fire service, teachers, welfare and social security workers are most at risk of violence in the USA and the UK (School of Industrial Relations and Organisational Behaviour, 2001).

In considering the problem of aggression and violence in mental health units, the larger issue of aggression and violence in mainstream culture at large must be acknowledged. In recent years several western nations have seen a decline in welfarism and a growth in individualism, the result of a neo-conservative political climate. Social inequity in areas such as housing, education, and health result in social exclusion and are examples of the direct

result of political ideas impacting vulnerable populations including the mentally ill. Discounting the influence that social inequality has upon aggression and violence in the general community, and hence in mental health facilities, is simplistic and leads to individualistic solutions that are ultimately untenable. Individualistic notions of disorder as deviancy, i.e. the assumption that problematic behaviour is chosen by particular individuals, leads to simplistic solutions premised upon control and punishment (Leadbetter and Paterson, 2005). Consideration of the broader socio-political climate should be acknowledged in any coherent attempt to explore the problem of aggression and violence in the broader society, the workplace and the more specific context of mental health facilities.

Aggression and violence in the health care sector is recognised as a growing problem. In the Australian health care sector violence initiated by patients is increasing with approximately one Australian health worker being a victim of homicide by a patient each year (Mayhew and Chappell, 2001a). In the UK, Whittington, Shuttleworth and Hill, (1996), found victims of assault in a sample of general hospital staff, to be predominantly nurses and staff working in medical wards. Accident and emergency departments had high rates of violence and staff working in mental health were found to be commonly exposed to threats. Flannery (1996) comments that providing health care in the USA (particularly in mental health) is a dangerous occupation, data suggesting that in some situations injury rates to nurses, from assaults by patients, are comparable to rates of injury experienced in the construction industry. The

American Nurses Association found that 17% of nurses had been physically assaulted in the past year and 57% had been subject to verbal abuse or threats (ANA, 2001). Gerberich et al., (2004) sought to identify the magnitude of violence within the Minnesota nursing population. A survey design was used and sent to 6300 Minnesota licensed nurses to collect data on violence during the prior 12 months. Results show that non-fatal physical assault and non-physical forms of violence were frequent among nurses and assault rates were higher for males than females. The study identified higher rates of violence for nurses working: in a nursing home/long term care facility; in intensive care, psychiatric/behavioural or emergency departments; and with geriatric patients.

When examining violence specifically in mental health care settings, it has been observed that assaults in mental health units appear to be happening more frequently with one review finding an increase from 270 in 1976 to 1,100 in 1984 (Noble and Rodger, 1989). In a sample of London mental health inpatient units Gournay et al., (1998) found an average of two assaults a week per unit, with most assaults being directed at nursing staff. It is important to note that reports of assaults upon psychiatric staff have been shown to be underestimates with discrepancies of up to 13:1 (Crowner, Peric, Stepcic and Van Oss,1994) being found. Reasons for such under-reporting have been suggested as possibly being related to organizational culture, embarrassment and excusing the behaviour of the patient (Mayhew, 2000). In addition, under-reporting of violence experienced by patients (perpetrated by other inpatients) in mental health units has been shown, with interview data suggesting rates that

are much higher than were found in patient notes (Thomas, Bartlett, and Mezy,1995). The problem of aggression and violence in mental health units has lead health services to focus on the importance of minimising and managing aggression and violence in these settings (Barlow, Grenyer & Ilkiw-Lavalle, 2000; Mayhew & Chapell, 2001b; Whittington & Wykes, 1996b).

An area of concern that has more recently been given a degree of focus in the research literature is the rate of patient injury that results from techniques used to manage violence and aggression in mental health units. Patient deaths during restraint have lead to inquiries into the management techniques used by mental health staff for dealing with aggression and violence (e.g., in the UK the independent inquiry into the death of David Bennett, 2003) and there has been some research and comment on patient death as a consequence of restraint (Morrison, Duryea, Moore and Nathanson-Shinn, 2002; Paterson, Bradley, Stark et al., 2003; Duxbury and Paterson, 2005). In addition, coercive measures typically used to manage aggression, such as restraint and seclusion, have been questioned as to their effectiveness (Whittington, Baskind and Paterson, 2006). Increasingly, at both a national and international level, responsibility for patient welfare, particularly in vulnerable populations, such as the mentally ill, is becoming a focus.

1.2. Effects of Aggression and Violence in Mental Health Units

The impact of aggression and violence in mental health units is substantial. Effects that have been documented include: physical injury; emotional or psychological harm; compromised patient care; and financial expense to the organisation.

1.2.1. Physical harm

In a review of the literature by the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, (2002), it was stated that inpatient mental health staff appear to be at a higher risk of serious injury through assault than the general population. In addition, male staff have been found to be more than twice as likely to be assaulted as female staff (Carmel and Hunter, 1989; 1993). Fortunately, rates of serious injury caused by patient violence are considered to be fairly low, for example a report by Gournay et al., (1997) indicated that between 67% and 93% of assaults, in surveys carried out between 1994 and 1997, resulted in no obvious injury.

1.2.2. Emotional harm

While most assaults in mental health inpatient wards result in no detectable physical injury, emotional harm has been a consistent finding. High levels of traumatic stress, anxiety and strain have been found among staff exposed to incidents involving both verbal aggression and physical violence (Caldwell, 1992; Whittington and Wykes; 1992). Whittington and Wykes (1992) found high levels of anxiety and strain experienced by nurses directly

after minor assaults, and symptoms were consistent with a PTSD diagnosis. While levels of anxiety and strain had reduced after two and a half weeks they were still high. The authors comment that their small sample of 24 makes it difficult to generalise, however they suggest the importance of the finding that the emotional impact of an assault can be out of proportion to the physical injury sustained. Caldwell (1992) found similar results but in a larger sample of 224 staff. The results of this study indicated that in a sample of clinical staff in a private psychiatric facility 62% had been involved in a serious incident involving a threat to life or safety and 61% reported symptoms of PTSD, with 10% reporting sufficient symptoms to match the diagnostic criteria for the disorder. The authors conclude that the number of staff emotionally affected is large.

1.2.3. Impaired therapeutic relationships

The quality of care that patients receive has been found to be adversely affected by staff having experienced verbal and physical aggression. Attitudes toward all patients, not just those who have been aggressive or violent, have been shown to be compromised and, counter intuitively, such reactions are shown to increase the possibility of further aggression and violence (Lion and Pasternak, 1973; Whittington and Wykes, 1994b). In brief Whittington and Wykes (1994a) propose a model that suggests that a patient's verbal and /or physical aggression increases stress and anxiety experienced by staff. This causes staff to avoid interactions with patients, to express hostility toward and

behave in an overly-controlling manner, which in turn increases the level of verbal and physical aggression expressed by the patient.

1.2.4. Organisational costs

The financial implications of aggression and violence in mental health facilities have been explored. Costs in terms of lost workdays, use of sick leave, compensation claims, medical expenses, vocational rehabilitation, and preventative strategies such as educational programs, have been identified and give an indication of the huge financial impact of aggression and violence (Hunter and Carmel, 1992; Lanza and Milner, 1989; Nijman, Bowers, Oud and Jansen, 2005). In addition, less overt effects that also have financial implications have been identified, such as job satisfaction, employee recruitment, retention and turnover (Alderman, 1997; Lanza, 1983; Poster and Ryan, 1994).

1.3. Responses to Aggression and Violence in Mental health Units

Since the early 1980s with the increasing emphasis on Occupational Health and Safety as a key workplace responsibility, focus on risks to workers from their employment has increased. In relation to aggression and violence, this has shifted from the view that these are inevitable aspects of working with the mentally ill, to the view that this problem should be recognized and minimised where possible. Specifically, responses to aggression and violence in

mental health, both nationally and internationally, have highlighted (a) the introduction of guidelines and policies for dealing with the issue and (b) training initiatives developed and implemented throughout mental health settings flowing from these policy changes. Both areas will be reviewed in the following sections.

1.3.1. Guidelines and policy initiatives

In February 2005 the National Institute for Clinical Excellence (NICE) published Clinical Guideline 25, Violence: the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments. This guideline relates to all adults aged 16 years and older and discusses the short-term management of disturbed or violent behaviour in adult psychiatric settings and in service users attending emergency departments for mental health assessments. The guideline covers various interventions and associated areas such as: environment, organisation and alarm systems; prediction (antecedents, warning signs and risk assessment); training; service user perspectives, including those relating to ethnicity, gender and other special concerns; searching; de-escalation techniques; observation; physical intervention; seclusion; rapid tranquillisation; post-incident reviews; and emergency departments.

Key priorities for implementation were highlighted in the guideline and include: prediction, i.e. comprehensive risk assessment and risk management strategies; training, i.e. appropriate policies around training; working with service

users, i.e. all service users should be provided with information regarding their treatment in a suitable format; rapid tranquillisation, physical intervention and seclusion as techniques to be considered if de-escalation and other strategies have failed to calm the service user; physical intervention guidelines, so that the level of force applied must be justifiable and appropriate and effort should be made to use techniques that do not deliberately apply pain. In their commentary about these key priorities for implementation, the Guideline Development Group suggest that there were few studies specifically addressing or identifying the issues they were describing, however comment that they used "formal consensus techniques" (p.6) to develop their recommendations.

In addition to guidelines, such as those above, a growing number of countries have implemented policies to address concerns about increasing levels of violence within the health sector. For example, in June 2001 in NSW, Australia, a Health Taskforce on the Prevention and Management of Violence in the Health Workplace was formed. A policy document, titled 'Zero Tolerance Policy and Framework Guidelines' (Zero Tolerance: NSW Health Response to Violence in the Public Health System Policy and Framework Guidelines, 2003), was a key outcome of this taskforce and was based on the 'National Health Service Zero Tolerance Zone' materials (NHS Zero Tolerance Zone: We Don't Have To Take This. Resource Pack. London, 1999) that were developed by the National Health Service (NHS) in the UK. The key message of the policy is that health services must establish and maintain a zero tolerance to violence culture.

Although zero tolerance policies have been introduced as a way of dealing

with problems of aggression and violence, the actual evidence supporting such policies, as an effective approach in mental health services, is lacking. Furthermore, several authors have claimed that zero tolerance campaigns are unlikely to succeed without examining the broader context within which aggression and violence occur (Secker, Benson, Lipsedge, Robinson and Walker, 2004; Rew and Ferns, 2005). Moreover, some researchers suggest that a zero tolerance approach toward aggression in the health sector may be associated with increases in the use of inappropriately high intensity interventions in response to aggressive behaviour (Whittington and Higgins, 2002) and that a varied response to aggression and violence, moving beyond zero tolerance, is necessary (Paterson, Leadbetter and Miller, 2005). Recent comment on zero tolerance policy in Australia suggests, at the very least, that zero tolerance is impractical for clinicians (Wand and Coulson, 2006) and at worst asserts that it is an "ineffective response to violence in health care settings" acting as a "convenient smoke screen" to the real issues of "resource allocation and marginalization" that governments continually fail to acknowledge (Holmes, 2006, p. 212, 222).

Indeed, recently the UK zero tolerance policy, as a response to the problem of workplace violence, has been abandoned in favour of a new strategy that aims to promote safe and therapeutic services. This broad strategy includes a range of new ideas including: the identification in every NHS Trust of an individual at board level who is charged with violence reduction; the creation of a network of Security Management Specialists based in every Trust, the development of new definitions of assault and reporting systems; and a two day training program titled 'Promoting

Safer and Therapeutic Services: Implementing the National Syllabus in Mental health and Learning Disability Services ‘ (NHS, Security Management Service). This approach stresses that the causes of violence within mental health and learning disability services are complex and can be caused by a range of factors and attempts to address some of these wider issues. The aim was to ensure that all staff working in mental health and learning disability areas receive a national standard of training prior to any training in physical intervention skills. Key principles of this new approach are to promote values that are compatible with professional ethics and principles of anti-oppressive practice; a focus on prevention strategies; a demonstrated commitment to service-user involvement regarding training; and a focus on staff support before and after violent incidents. Prior to the introduction of this new approach, the NHS in the UK had announced their zero tolerance policy toward aggression and violence in the health service in 1999, as a response to the setting of targets requiring the reduction of violence against staff. Resource packs were sent to all NHS trusts and a zero tolerance website was created. The recording of incidents between the period 1999 to 2003 indicated a 70% increase in recorded violent incidents in the NHS (Paterson, 2007). Obviously the reasons for this increase are complex and include, among others, a greater focus on reporting. However, Paterson (2007) suggests that this increase is also indicative of the failure of the zero tolerance policy and suggests several reasons including: the counter productive language of ‘zero tolerance’, i.e. implying a punitive approach to dealing with aggression and violence; a tendency to individualise the problem, for example an emphasis on training for direct care staff

rather than considering how to change the broader culture and; a focus on the management of aggression rather than its prevention.

1.3.2. Training

As suggested above another key response to aggression and violence in mental health has been to implement aggression minimisation training for staff (Barlow, Grenyer & Ilkiw-Lavalle, 2000; Baxter, Hafner, & Holme, 1992; Grainger & Whiteford, 1993; Mayhew & Chapell, 2001b). Typically training programs have primarily included de-escalation skills, and some instruction on the use of physical restraint in managing aggression and violence. Common strategies, identified in training programs, that are used in de-escalation of aggressive patients include giving positive and confirming messages, providing face saving alternatives, facilitating emotional expression, allowing time for calming, limit setting and personal control on the staff members part (United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, 2002). A review of the literature on de-escalation (United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, 2002) highlights many different approaches and models ranging from relatively prescribed methods to dynamic and flexible models, (Stevenson, 1991; Turnbull, Aitken, Black, and Paterson, 1990), to more refined models, (Paterson and Leadbetter, 1999b), that synthesise previous work exploring the necessary ingredients for a violent incident (Bailey, 1977) and the assault cycle, (Kaplan and Wheeler, 1983). With regard to physical restraint skills, Control and Restraint (C&R) is a common method used. C&R was developed in

the UK prison system in 1981 and from the mid 80's training in C&R was adopted in health and social care settings in the UK. Attention has been given to the problems in directly applying C&R methods to health settings and as a result guidelines for the use of C&R were developed (Royal College of Psychiatrists Research Unit, 1998).

Evaluations of aggression minimisation training programs are deemed essential in understanding which programs are effective, although it has been noted that only a few poorly controlled studies have been conducted (Farrell and Cubit, 2005; Morrison and Carney Love, 2003; United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2002). Early training programs began in the USA (Gertz, 1980; Rice, Harris, Varney, and Quinsey, 1989; Lehmann, Padilla, and Clark, 1983) and tended to be very simply evaluated (Infantino and Musingo, 1985). Since then it has been suggested that the number of training packages has "mushroomed" (Beech and Leather 2003; p. 604) and the requirement for training has lead to a "small cottage industry of mental health consultants selling a program usually based on some martial arts program" (Morrison and Carney Love, 2003; p.147). It has been suggested that the variation in the content and duration of programs as well as inadequate descriptions of the content of programs has prevented previous researchers from identifying approaches to training that represent 'best practice' (Paterson, & McCormish, 1998). In addition, research that has sought to evaluate approaches to managing aggression and violence, in mental health care settings, is difficult because the approaches typically focused upon, de-escalation and physical restraint, are

primarily taught together (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2002). A further confounding factor to assessing training has been that other policy and procedural changes have often been adopted in the same period that training was occurring (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2002).

Despite these problems several evaluations are worth reviewing as they have attempted to evaluate aggression minimisation training programs. One of the early, methodologically sound, evaluations of training was carried out by Whittington and Wykes (1996b) and involved evaluating a one day course in psychological techniques for the management of patient aggression. The training package was based upon Whittington and Wykes, (1994a) cyclical model of violence in psychiatric units, which is based upon Lazarus and Folkmans (1984) cognitive theory of stress and coping. The training included two components, one covering the prevention of violence and the other examining the potential psychological consequences of violent assaults. The latter component was included because of the author's model suggesting the cyclical impact of post assault stress upon the potential for future incidents. Training occurred over one day and was divided into four sessions. No physical restraint skills were taught, with the training being described as a study day on psychological techniques for managing violent patients. Two psychiatric hospitals in London were targeted and participants included 155 nurses working in these hospitals during the study period. Of the sample, 47 were attenders at the training and 108 were non-attenders and made up the control group. The measured variable was the number of notified

assaults on staff in a 28 day period prior to and post the training. Incidents taken into consideration were any aggressive physical contact by a patient toward a staff member regardless of the incidents severity. The study compared the number of incidents of the attenders (experimental group) with those of the non-attenders (control). Results indicated that the overall rate of violence on the study wards fell by 31%. Interestingly, the authors note that more attenders than non-attenders had been assaulted before training and that this difference actually increased after training, with twice as many attenders being assaulted compared to non-attenders. With regard to compliance (the proportion of staff from a particular ward attending training), the authors found that the frequency of assaults on wards with high compliance fell by more than two thirds whereas on low compliance wards assaults increased by over a half, this difference being statistically significant. The authors comment on the contradiction between the two "macro" effects versus no apparent impact at the "micro" level, i.e. the individual participant (Whittington and Wykes, 1996b, p 260). They suggest two possibilities: 1) attenders may have been more likely to notify assaults because of the training emphasising to them the issue of violence and/or; 2) attenders may have been more inclined to become involved in any violent incidents as a result of their attendance, either through the expectation of others (or themselves) due to notions of being more highly skilled. In summary, the authors conclude that their study provides evidence suggesting the efficacy of a training package in psychological techniques for managing aggression.

Morrison and Carney Love, (2003) evaluated four aggression minimization programs that were commonly in use, in the USA, at the time of their report. The

four programs chosen were: the Mandt System; Nonviolent Crises Intervention (NCI); Professional Assault Response Training 2000 (PART 2000); and Therapeutic Options Inc (TO). They chose five criteria upon which to base their evaluation of the programs: i) content (i.e. whether the program covered material on both physical and theoretical aspects of the topic, rather than minimising theory, which the authors comment as being more typical); ii) feasibility (the ease with which the program could be implemented, i.e. the complexity of the techniques and the skill required to perform the techniques); iii) psychological comfort of the staff (staff confidence for dealing with aggression after completion of the training); iv) effectiveness (whether the training had evaluation data indicating a decrease in clinical outcomes such as violent incidents, injuries sustained and rates of seclusion and restraint); and v) cost (the cost of the program to the facility, as this was suggested to be a barrier to implementation). The first four criteria were scored using a scale of 1 (not met) to 5 (well met). The cost criterion was reverse scored, and the potential range of scores was 5-25. Each criterion was weighted equally and the highest scoring program was considered to be superior to the others. Based on this method of evaluation the authors conclude that the TO (with a score of 23) and the PART (with a score of 21) were the better programs. Both programs were equivalent on content, feasibility and psychological comfort of staff. TO was rated higher than PART on cost and slightly higher on effectiveness, however both TO and PART were rated at similar rates for effectiveness as the other two programs (Mandt and NCI). The authors conclude that although the programs that they evaluated certainly assist staff to feel more comfortable dealing

with aggression, the answer to the question of whether the programs actually work remains unclear. This is because on the criteria measuring effectiveness all training programs were rated equally. Reviews of training based on such criteria are perhaps missing a crucial element of evaluation and therefore may not be as effective as they could be. Examining interactions between staff and patients and exploring staff attitudes and management approaches pre and post training may be a more salient and meaningful method of assessing training.

Farrell and Cubit, (2005) in their review of 28 aggression management programs highlight the concerning fact that currently there are an overabundance of programs, and sought to address the dilemma that very few have been properly evaluated. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting, (2002), published a report on the Recognition, Prevention and Therapeutic Management of Violence in Mental Health Care. Their main findings with regard to education and training programs are that although many programs are available they are not systematically examined, nor are their trainers. This report details standards for education and training in managing aggressive and violent behaviour in the mental health sector, and recommends that training programs include: i) the use of the overall treatment program and the therapeutic relationship as the overall context; ii) behavioural theories and functional assessment; iii) the necessity for staff to maintain control; iv) legal concepts and issues of patient abuse; v) pharmacologic treatment of violence; vi) review of alternative interventions; vii) team physical techniques (evasive techniques, breaking free, immobilization and transporting patients; viii) restraining patients

with certain medical conditions; ix) restraining children and elderly; x) movement in and out of seclusion; xi) risk of restraints; and xii) medicating a non-cooperative patient (United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 2002). Farrell and Cubit (2005) suggest that these standards are not dissimilar to those that earlier training reviewers highlighted (Rice et al., 1989), or to recommendations addressing workplace violence in the health sector (International Labour Office et al. 2002; p. 24), or to standards recommended in Australia for staff working in the Victorian mental health services (Victorian Department of Human Services et al. 2003). As a result, Farrell and Cubit, (2005) based their review of the training programs on the key recommendations made by these professional bodies, and concluded that several of the 28 programs reviewed were more superior based on 13 important areas derived from the recommended standards. They conclude that the Critical Incident Positive Outcome program covered 11 areas, the INTACT program covered 10 areas and the Aggression Management and Workplace Violence Prevention, the Mandt System and P3 programs each covered 9 areas. The authors comment that most of the programs reviewed failed to address the psychological impact and organisational costs of aggression in the health workplace. In addition, they comment that most training programs failed to include a systematic evaluation of their outcomes, i.e. evaluating how staff might cope in real situations rather than simplistic and subjective responses provided by participants. Finally, the reviewers comment upon the importance of managerial support in moving the problem from the individual level to that of the organisation and thus assisting in the prevention of

"band-aid" only solutions (Farrell and Cubit, 2005, p.51). These suggestions are coherent with the view developed in this dissertation, which seeks to explore the multifaceted causes of aggression in mental health units and investigate some of these hypothesized causes empirically.

Bowers, Nijman, Allan, Simpson et al., (2006), carried out a large scale study examining the impact of aggression management training upon actual violent incident rates on UK acute psychiatric wards. They retrospectively examined training records and violent incident rates over two and a half years on 14 wards. They found the undesirable result that course attendance failed to reduce violence and indeed some evidence suggesting that attendance at refresher courses triggered short-term increases in incident rates. In addition they found rises in aggression while staff were away from the ward attending training. In explaining their results they suggest that the most favourable view would be that violent incidents in the study district might have been reduced previously when training was initially introduced, as has been found in other studies, i.e. early impact of training. However, the authors suggest that alternatively, these early impact findings might be related to a novelty effect which may wear off over time. They suggest that the most negative interpretation of their findings is that training may induce clinicians to be more confident to confront patients in order to use the restraint techniques that they have been taught. In discussing this point they explain that this interpretation might be relevant for the more superficial update / refresher training, as in this particular area the focus was on restraint skills rather than refreshing participant's knowledge on violence prevention and de-escalation. They conclude

that future research needs to focus upon the effects of different aspects of course content, to identify which aspects of training lead to success in violence prevention. Indeed, knowledge about aggression and attendance at training as key variables might be missing the point that the more critical issue is possibly what the clinician brings to the therapeutic relationship by way of their attitudes and approaches, which may or may not be shaped by their training experiences.

1.4. Importance of Present Research

Responses to managing the problem of aggression and violence in mental health units, whether a focus on guidelines, policies or training, have not systematically made use of theoretical and empirical findings. For example, it has been suggested that most aggression minimisation training programs require a stronger theoretical basis especially with regard to how staff might unintentionally exacerbate violent behaviour (Morrison and Carney Love, 2003) and, it has been suggested that research should attempt to measure not only staff perception but how staff respond in real situations (Farrell and Cubit, 2005). Furthermore, it has previously been recommended that a shift is necessary from a relatively descriptive method of looking at aggression and violence in mental health to a more explanatory understanding of the underlying influences upon violence and mental health (Blumenthal and Lavender, 2000; Whittington and Richter, 2005).

To this end, there is a need for a careful analysis of the problem of aggression and violence in mental health units that takes into consideration multiple perspectives including: the socio-political context that health care systems

work within; individual risk factors within the aggressor and; dynamic theories that address core issues of frustration tolerance and the mentalising or reflective capacity of individuals, that may impact upon their interpersonal functioning. Furthermore, there has been a dearth of studies investigating staff factors that may contribute to aggression. Previous research has primarily looked at patient and background factors. Thus far very few have studied the impact of staff attitudes or management philosophies. However, there are some notable exceptions and some significant studies that have examined these important factors. A review and critique of the strengths and limitations of these research studies is provided in the literature reviews fronting each of the empirical studies included in this dissertation. These critiques are contained in Chapter 3 (section 3.2 p 61), Chapter 4 (section 4.2 p 95) and Chapter 5 (section 5.2 p 144).

The current work attempts to make an important contribution to the area by encompassing both theoretical and empirical approaches to examining the problem of aggression and violence in mental health units. The development of a model of aggression and violence specific to mental health units is the focus of chapter two. Chapters three, four and five introduce, describe and discuss three empirical studies that aim to further our understanding of aggression and violence in mental health. Chapter six discusses and integrates the major findings and concludes this dissertation.

CHAPTER TWO

The Development of a Model of Aggression and Violence Specific to Mental Health Inpatient Units

Chapter 2:

The Development of a Model of Aggression and Violence Specific to Mental Health Inpatient Units

2.1. Previous Interactional Models of Aggression and Violence in Mental Health Settings

A model that examines aggression and violence in the health service more generally, rather than specifically in mental health settings is that of Chappell and Di Martino (2003). Their model is important to mention because it links together personal, occupational and environmental factors that lead to aggression and violence. The model is particularly useful in that the individual characteristics of both the perpetrator and the victim are seen to play an important role in the precipitation of aggressive and violent situations.

More specific to mental health inpatient settings is a cyclical model of violence involving psychiatric inpatients, proposed by Whittington and Wykes (1994a). Their model includes three major variables: patient violence, nurse stress and nurse behaviour and suggests that being assaulted leads to an increase in stress which may lead to changes in staff behaviour toward patients, subsequently enhancing staff vulnerability to further assault. The authors consider two types of staff behaviour as potentially problematic: aversive stimulation and social distancing. In addition, Nijman (2002) has proposed a

model that suggests that patient, staff and ward characteristics interact and may produce a vicious cycle where inpatient violence is followed by an increase in environmental stress and thus increases the risk of further patient outbursts of violence, (Nijman, 2002).

These models are useful because they are inclusive of a range of factors that possibly interact to increase the potential for aggression in mental health settings. Further, Whittington and Richter (2005) have theorised about interactional aspects of violent behaviour on acute psychiatric wards and propose that there is a need for more complex and sophisticated explanations of aggression in psychiatric settings for interventions to be effective. They suggest that various psychological and sociological theories should be integrated to better explain aggression in these settings. They suggest that Whittington and Wykes (1994; 1996) findings, regarding aversive stimulation, be integrated with cognitive models of human aggression (namely ideas about cognitive appraisal: Lazarus, 1999; Lazarus and Folkman, 1984) and sociological theories on interaction and escalation. In developing their ideas, they propose that psychiatric aggression is more convincingly explained by considering it to be 'normal' aggression or akin to aggression in people without a mental health diagnosis, rather than related primarily to psychopathology or a concept of 'abnormal' aggression. They do not deny the influence of psychopathology, however state that many of the incidents in inpatient settings are the result of 'normal' interaction processes and suggest that a patient's psychopathology is simply an extra characteristic that triggers the level and pace of the patient's

response. Therefore, they propose that we can gain an enormous amount by observing the similarity between violent interactions in mental health settings and 'ordinary' violent interactions. As such it is important to explore ideas, theories and models that have attempted to understand aggression more broadly, the aim being to develop a model that may be more encompassing of the above suggestions.

2.2. The Development of Aggression and Violence within the Individual

Glasser (1996a) suggests that essentials to a thorough risk assessment are often neglected and include a general deficiency in examining the internal world of the individual behaving aggressively. By this Glasser (1996a) is referring to the impact of the individuals family background, in particular the violence experienced by the individual and disruption of bonds during childhood development.

2.2.1. Social learning and the cycle of violence

The cycle of violence is a well known hypothesis and proposes that victims of childhood violence often carry out violent acts later in life. Much empirical work has established this tendency for violence to be intergenerationally transmitted (Blumenthal and Lavender, 2000). For example, Grenyer, Ilkiw-Lavalle, Deane and Milicevic (2004), found that

aggressively repetitive patients in a psychiatric inpatient unit were significantly more likely to have had a history of aggression, sexual abuse, interpersonal problems, parental divorce and physical abuse than non-aggressive patients. Duton and Hart (1992), examined a large sample of 604 prison inmates and found that men who had been abused in childhood were three times as likely to be violent than those who had not been abused. Further analysis indicated that those who had been physically abused were more likely to engage in physical violence, and those who had suffered sexual abuse were more likely to be sexually abusive (Duton and Hart,1992).

The cycle of violence has been emphasised within social learning perspectives and has tended to look more specifically at parental punishment and neglect as crucial factors in determining later violent behaviour (Widom, 1989). Many studies have shown results that support this perspective, for example Farrington (1978) found that harsh parental attitudes and punitive discipline styles were an important precursor to violence in boys. This was validated in a later study by Weiss, Dodge, Bates and Pettit (1992), who found that punitive parental discipline was associated with later aggressive behavior in children. Of course other important influences have also been found to be associated with later aggressive and violent behaviour, for example low income, criminality in the parents, poor parental supervision, parental rejection, low parental involvement, high ratings for impulsivity and low IQ (Farrington, 1978; Loeber and Stouthamer-Loeber, 1986).

2.2.2. Developmental features of aggression

(i) Early attachment and the development of the psychological self

Why do abusive experiences in childhood have such an impact on future aggressive behaviour? Attachment theory (Bowlby, 1969) offers a starting point to examine the process by which childhood experiences of neglect and abuse tend to lead to later violent behaviour. Bowlby's (1969) attachment theory examines psychosocial personality development in the context of early attachment relationships. Fonagy and Target (1996) suggest that attachment processes may be critical to the development of intentionality, or seeing the behaviour of the self and others as being determined by mental states (thoughts, feelings, beliefs and desires). Fonagy, Target, Steele and Steele, (1998) have called this capacity Reflective Functioning (RF), defining the construct as the capacity to perceive and understand mental states (thoughts, feelings, beliefs and desires) in the self and others. They propose that the development of this capacity is what enables the individual to make sense of their own and others psychological experience. A high capacity for RF is thought to help make behaviour predictable, enabling adaptive responding to a variety of interpersonal situations (Fonagy et al. 1998). Fonagy and Target (1997) suggest that the process through which the infant develops this understanding of affect in self and other (RF) is enhanced by a secure caregiver / infant dyad. It is proposed that because the secure caregiver is sufficiently benign and reflective of the infants internal states, the infant feels safe to explore and make

attributions about the caregivers mental states and in turn their own (Fonagy and Target, 1997). Conversely, Fonagy and Target (1997) suggest that insecure attachment relationships may be associated with a reduced potential for developing a sufficiently intentional model of the mind, resulting in a limited capacity for accurate mentalising about the self and others.

Support for this view is indicated by studies that show strong associations between early trauma or abuse and the disorganised infant attachment classification, (Carlsson, Cicchetti, Barnett and Braunwald, 1989). Where severe childhood trauma has occurred, an extraordinary reduction in reflective capacity has been found and has been associated with disorders of the self (Fonagy et al, 1996). Consequently, these individuals may be left highly vulnerable in interpersonal relationships as their thoughts and feelings are felt to be inflexible, and as concrete and rigid as reality (Fonagy et al., 2000). A diminished capacity to understand affect in the self and others produces an inability to identify with or have empathy for other individuals, and may lead to a deficit in regard to the inhibition of violent impulses (Fonagy and Target, 1997).

(ii) The defensive role of aggression in the protection of the psychological self

Fonagy, Moran and Target, (1993) have produced a model explaining violent behaviour from a developmental perspective. They suggest that aggression is not inherently pathological and plays a defensive role in terms of

protection of the psychological self. Ideally, the inter-subjective process of shared understanding between the infant and caregiver serves the purpose of mirroring the infant's mental world, and thus having an organising effect upon the child's sense of self. However, a caregiver who cannot be reflective of their infant's mental state provides a threat to the infant's psychological self. The child resorts to the primitive defensive behavioural strategies of avoidance or aggression. In this way aggression may be adopted by an infant to fend off an immediate threat to its self understanding or psychological self.

Fonagy et al. (1993) suggest that in cases of parents with a mildly reduced reflective capacity these defensive behavioural strategies should succeed in protecting the child's psychological self. But in cases where the caregivers reflective functioning is extremely limited, such as in the case of a depressed parent whose responsiveness is inconsistent, or a caregiver who consistently interprets their infants self-expression as being malicious, or in more straightforward cases of abuse where a caregiver is openly hostile, the whole inter-subjective process between child and caregiver may come to represent danger to the infant's mental safety.

More specifically, Fonagy et al., (1993) suggest that pathological destructiveness may be a strategy that develops when faced with profoundly insensitive parenting. In these cases the young child's mental life will be extremely fragile, the ordinary frustration of goals / needs signaling the potential destruction of the psychological self and in turn producing intolerable anxiety. The aggression is, as previously mentioned, a defensive attempt at

protecting the self, however is only of short term success and inadequate for defending the fragile self structure. With this failed defensive strategy comes a fusion of the self structure and the aggression, such that self expression and aggression become pathologically confused. In extreme cases, the aggression becomes a part of the individual's experience of themselves and their drive for self-expression, autonomy and control.

(iii) The relationship between mental health and aggression and violence

Mental health patients often experience a reduced capacity to tolerate intense affect. It has been established that there is a modest association between particular mental health diagnoses and violence. Brennan, Grekin and Vanman (2000) carried out a meta-analysis and concluded that organic and affective psychoses have some association with violence. With special reference to schizophrenia the effect sizes were large and significant for violence. However, despite these findings, it has been acknowledged that other factors may contribute more to violence than mental health diagnoses in isolation. These findings, suggesting the vulnerability toward aggression in those with a psychiatric diagnosis, concur with Fonagy, Moran and Target's (1993) developmental model in that patients with a mental health diagnosis may have developed a particularly fragile sense of self, resulting in a reduced capacity to tolerate the intense affect caused by frustrated needs and wishes. As such, their aggression may serve a communicative / defensive purpose that assists in their 'psychological survival'.

2.3. The Dynamics of the Stressful Encounter and the Neurobiology of Stress

The Fonagy model helps understand individual constituent factors contributing to poor coping associated with aggressive responses. However, aggression and violence in mental health settings generally occur in an interpersonal context. Communication and self expression are fundamental to all interpersonal interactions. Indeed, attachment theory posits that attachment patterns and their principle defenses are dormant and only enacted under interpersonal stress. As such, considering individual patient factors alone as contributing to aggression and violence in mental health settings is inadequate. It is important to discuss theory that puts forward ideas about stressful human encounters.

Lazarus and his colleagues, (Lazarus and Folkman, 1984; Lazarus, Kanner and Folkman, 1980; Folkman, Lazarus, Dunkel-Schetter, DeLongis and Gruen, 1986; Folkman and Lazarus, 1988a, 1988b), developed a theory of stress and coping relating to stressful encounters that is useful for understanding the dynamics of aggressive incidents in mental health inpatient units. The theory recognises two processes as important mediators of stressful encounter outcomes: a) cognitive appraisal; and b) coping. The cognitive appraisal process is made up of primary appraisal, where the individual asks what they have ‘at risk’ in the encounter, and secondary appraisal where the individual is concerned with what their options are for coping and how their environment

will respond to their actions. The answer to these two questions influences: a) the emotion that tends to be experienced by the individual; and b) the kinds of coping strategies that will be used to manage the stressful encounter. Folkman and Lazarus, (1988a, 1988b) suggest that where the answer to the primary appraisal question "what is at risk?" is self-esteem, the potential emotion felt will be shame or anger, whereas if the answer is physical safety, worry or fear is more likely. The theory also distinguishes between problem-focused and emotion-focused forms of coping, suggesting that if the outcome of a particular stressful encounter is assessed, by the individual, to be amenable to change then problem-focused forms of coping are more likely to be used. In contrast, if the stressful encounter outcome is judged to be unalterable then emotion-focused forms of coping are more probable.

Lazarus and his colleagues' stress and coping theory can be applied to possible dynamics that occur in mental health inpatient units during stressful encounters. With regard to 'primary appraisal' it would be expected that mental health patients may be more likely to view their self-esteem as 'at risk' and would therefore tend to experience feelings of anger and shame. During the 'secondary appraisal' process the patient examines what their options are for coping and how their environment will respond to these actions. The theory states that if the individual assesses that the stressful encounter outcome is unchangeable then their coping strategy tends to be emotion-focused rather than problem-focused. Aggressive responding would be classified as 'confrontive coping' within this theory and is subsumed within the emotion-focused forms

of coping. As such it can be presumed that patients who respond aggressively typically believe that stressful encounters experienced in these settings are not able to end well.

Lazarus's model is particularly useful when applied to the context of the inpatient mental health setting. However, without considering the origins or development of aggression within the individual, it is descriptive only and lacks an understanding of the problems with impulse control that come from within the individual, often as a result of their early environments and an active mental illness. Therefore both Fonagy and Lazarus's models need to be encompassed in conjunction to gain a better understanding of aggression in inpatient settings. Nevertheless, even when considered together these models are still limited when searching for a comprehensive understanding of aggression in mental health settings. They fail to identify contextual factors that increase the likelihood of stress being experienced by patients. Indeed, recent neurobiological findings relating to stress and the impact that stress has upon aggressive responding is enlightening.

Stress is a factor that has been convincingly correlated with aggression and violence in humans (Barnett, Fagan and Booker, 1991; Tardiff, 1992; Guerra, Huesmann, Tolan, VanAcker and Eron, 1995). Research from the behavioural neuroscience domain has investigated how stress mechanisms interact with mechanisms involved in aggression in rats, and has found that stressful conditions may facilitate the escalation of violent behaviour (Kruk, Halasz, Meelis and Haller, 2004). More specifically the findings of Kruk et al.

(2004) suggest that rapid increases in the adrenocortical stress response in rats, caused by stressors unrelated to fighting, may precipitate violent behaviour by lowering thresholds for attack. They conclude that this mutual facilitation between the adrenocortical stress response and the brain mechanisms involved in aggression, may contribute to the initiation and escalation of violent behaviour under stressful conditions. Additionally, Kruk et al. (2004) assert that the adrenocortical stress response is an evolutionary mechanism in mammals that enables the fight-flight response. They propose that the similarity in organisation and function across many species suggests that this mutual facilitation or feedback, between the adrenocortical stress response and brain mechanisms involved in aggressive behaviour, also operates in humans. Kruk et al., (2004) affirm that treating pathological violence and lack of impulse control in humans is highly problematic, and their findings highlight the importance of lowering stress and aggression triggers. As aggression and violence in mental health settings generally occur in an interpersonal context it can be assumed that stressful encounters are common.

2.4. An Interpersonal Model of Aggression and Violence in Inpatient Psychiatric Units

Figure 1 presents an interpersonal model of aggression and violence in mental health units developed in the context of this thesis for application to a new training approach studied here, called the Interpersonal Protect Program

(IPP; Middleby-Clements, Biro, Grenyer and Ilkiw-Lavalle, 2004). The model is based upon a biopsychosocial theory of understanding human behaviour and is premised upon the concept that biological motivators or basic human needs profoundly influence psychological processes, which in turn influence interpersonal relations (Grenyer, 2002). This interpersonal model encompasses patient and staff factors and suggests that patients in psychiatric settings, similar to the general population, have basic human needs and wishes. The model proposes that triggers for aggression and violence are usually related to a patient's needs or wishes being blocked or frustrated. When a patient's needs are blocked their response to the ensuing frustration is moderated by their capacity to tolerate the intensity of their affect (impulse control). The model assumes that the presence of the many symptoms of mental illness that patients in psychiatric settings present with, produce a reduced capacity to tolerate the intense affect arising when their needs and wishes are frustrated or blocked. Fonagy et al. (1993) developmental theory corresponds with the established association between mental health and violence. In integrating this developmental theory with a biopsychosocial or motivational view of understanding human behaviour, aggression in mental health inpatient settings can be conceptualised as a behavioural expression of a patients inability to tolerate the intense affect brought about when their needs and wishes are blocked or frustrated.

In conjunction with this, the model presents staff attitudes and approaches as variables that may influence the triggering, duration and outcome

of an aggressive incident. Lazarus and his colleagues (Lazarus and Folkman, 1984; Lazarus, Kanner and Folkman, 1980; Folkman, Lazarus, et al., 1986; Folkman and Lazarus, 1988a, 1988b) theory of stress and coping assists in understanding the dynamics of stressful encounters in mental health inpatients units. In addition, recent advances in neurobiology have highlighted the potentially accelerating effects that stress may have on aggressive and violent behaviour (Kruk et al., 2004). The interpersonal model presented here suggests that particular clinician attitudes and approaches may act as additional stressors for those patients with a limited capacity to tolerate intense affect (low impulse control), resulting in an increased likelihood for patient aggression.

Finally, this model proposes that these interpersonal events occur within the broader organizational context, which in turn exists within the broader socio-political system. The model also suggests that these contexts and systems impact upon staff and patient dynamics in mental health inpatient units. At the organisational level factors such as organisational culture, management support of staff, staffing levels, ward rules and procedures all influence the manner in which staff and patients are able to relate to one another. For example, research has shown an increase in adverse incidents such as violence, self harm and absconding in mental health inpatient units, during periods of high staff absence (Bowers, Allan, Simpson, Nijman, and Warren, 2007).

In giving the previous example some clarification is required. The model does not assume that patient aggression is exclusively the result of external stimulation. The model should be understood as suggesting that a

patients internal desires (needs, wishes) when frustrated may lead to an aggressive behavioural response. The frustration of those desires may not be caused by external stimulation alone or, for that matter, external under-stimulation. Indeed, there are a plethora of reasons, both internal to the patient as well as external to the patient, that can lead to the frustration of a patients desires and hence the possibility of an aggressive behavioural response. As an on-looker one can never fully understand the internal world of a mental health patient. The interpersonal model presented here attempts to explain patient aggression in its many forms, but does not propose to know what is in the mind of the patient and as such does not presume a polarised view of aggression as either proactive or reactive. In saying this however, an important caveat to this model is that patient aggression comes in many forms. One that should not be overlooked is proactive or predatory aggression, which is commonly associated with patients who have anti-social personality disorder or psychopathic traits. This model does not exclude this form of aggression, however does focus more on reactive aggression, since this accounts for more than 90% of aggressive incidents

When considering the problem of aggression and violence in mental health units at the socio-political level, the issue of aggression and violence in mainstream culture at large must be acknowledged. In recent years several western nations have seen a decline in welfarism and a growth in individualism, the result of a neo-conservative political climate. Social inequity is the direct result of political ideas impacting vulnerable populations including the mentally

ill. Discounting the influence that social inequality has upon aggression and violence in the general community, and hence in mental health facilities, is simplistic and leads to individualistic solutions that are ultimately untenable.

Similar to the Whittington and Wykes (1994a), Nijman (2002) and Chappell and Di Martino (2003) models, the interpersonal model of aggression and violence developed here also encompasses patient, staff and external factors, as interacting to potentially contribute to an increased or decreased risk of aggression and violence in mental health inpatient settings. However, in addition this model includes the underlying motivational factors that influence 'normal' human aggression, and applies this knowledge specifically to understanding aggression and violence in mental health settings. This model specifically emphasises the impact of the individual patient's level of impulse control as a crucial element in the development of an aggressive or alternative behavioural response. Moreover, the model presented here overtly proposes that staff attitudes and approaches are crucial contributors to the fuelling or minimising of aggressive patient responses. Finally, this model is comprehensive in that it acknowledges background factors, such as the organisational context and the even broader socio-political systems within which mental health units operate, and suggests that these contexts and systems impact upon staff and patient dynamics in such settings.

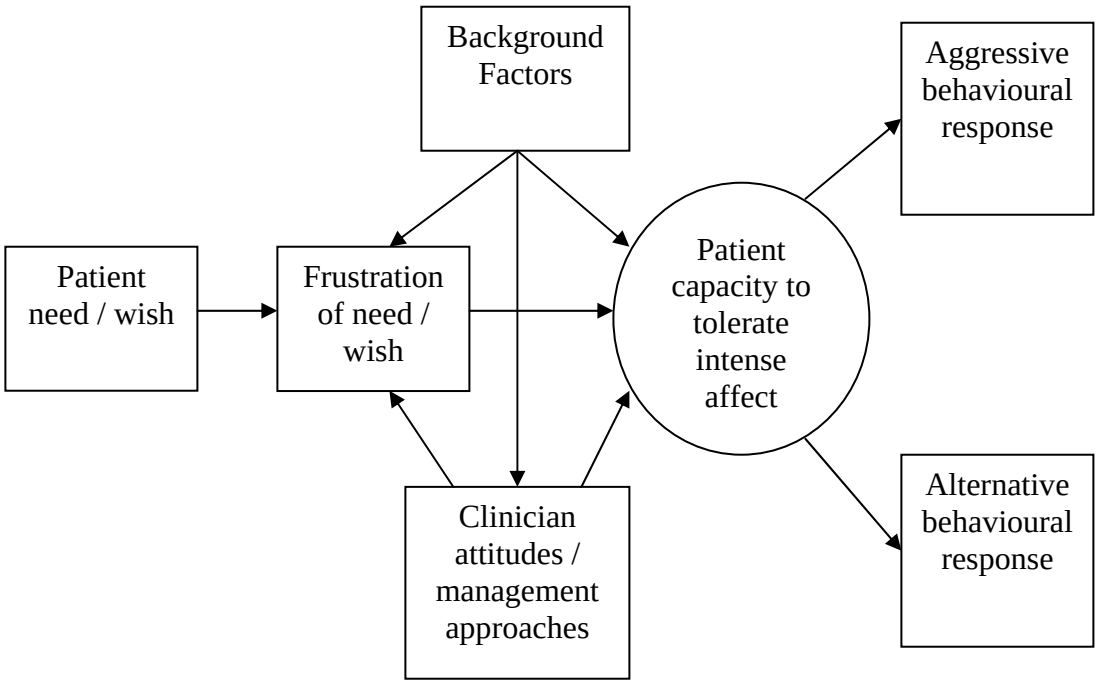

*Figure 1***.** Interpersonal model of aggression and violence in mental health inpatient units

2.5. Scope of Empirical Studies

The previous review of the research that has attempted to understand aggression in mental health units has highlighted an important area of research that requires further attention. More specifically, the influence of staff attitudes and approaches to aggression in such contexts has had less focus than patient factors. The interpersonal model proposed here suggests that factors that are internal to the patient interact in a dynamic way with staff attitudes and approaches, in addition to other background factors, to either increase or decrease the possibility of aggression in mental health units. This research is not intended to explore all facets of the model, since it is accepted that there are components that are well researched and less contentious (such as the contribution of a patient's psychopathology to violence, which concur with problems relating to impulse control and reflective functioning, as discussed previously in this thesis). As such, this research is not an attempt to test the entire model but only those areas that have had less focus in previous research. Three empirical studies were carried out and have focused primarily on staff attitudes and approaches that may influence aggression in mental health inpatient settings and on the influence of management upon such staff characteristics.

Study one (chapter 3) includes a review of the literature regarding patient and staff perspectives about the factors that may contribute to aggressive and violent incidents in mental health units. Subsequently, study one is a

qualitative exploration of patient perspectives on staff attitudes and approaches that they perceive as contributing to aggression and violence in mental health units. Study two (chapter 4) includes a review of the literature that has focused upon particular staff attitudes and approaches that appear to be problematic with regard to aggression and violence in mental heath units. Study two then quantitatively examines the influence of important staff attitudes and approaches upon aggression and violence in mental health units. Finally, it would be helpful to understand the impact of broader policy directives upon health staff attitudes and approaches. This was the aim of study three (chapter 5).

CHAPTER THREE

Study One:
A Qualitative Investigation of Patient Perspectives on Aggression and Violence in Mental Health Inpatient Units

Chapter 3

Study One: A Qualitative Investigation of Patient Perspectives on Aggression and Violence in Mental Health Inpatient Units

3.1. Literature Review

Studies have indicated that patients in psychiatric wards perceive imbalances in power between staff and themselves to be a source of anxiety, and a cause of violence in these settings. For example, an early study comparing staff and patient perceptions about the causes of aggression on a psychiatric unit found that patients experience a power differential between staff and themselves, and that staff tend to be unaware of this difference (Gillig, Markert, Barron and Coleman, 1998). The authors suggested that this factor may be an under-appreciated contributor to violence in psychiatric wards.

Such power imbalances and interpersonal problems have been found in other studies. For example, Kumar, Guite and Thornicroft (2001) conducted a focus group to elicit the experience of previous service users, in relation to aggression, within the mental health system. These authors used a grounded theory approach to analyse a focus group transcript and identified several interpersonally oriented categories. Three categories identified as contributing to aggression in the mental health system were: ‘Response or attitude of staff’;

'antecedents are ignored'; and 'provocation therapy'. The patient quotes presented below were given by the authors as examples of these categories:

Response or attitude of staff: "It annoys me that normal emotions that any person experiences such as fear, frustration and anger…you are not meant to have them because if you show signs of having them in certain situations you have violence used against you" (Kumar, et al. 2001, pg. 601).

Antecedents are ignored: "It is not actual violence but…the precursor, the thing that leads up to it…the things that can go on for weeks and weeks…has nothing to do with the aggression…are just pushed aside" (Kumar, et al. 2001, pg. 601).

Provocation therapy: "One of the staff members used to provoke me into getting violent…used to call it provocational therapy…I had no idea that there was no such thing. I usually would get at him, and then I would be jumped. I would be injected and it would happen again and again and again" (Kumar, et al. 2001, pg. 602).

Additionally these authors labeled another category 'a cry for help', suggesting that service users may resort to violence to procure help. The quotes presented below indicate that aggressive acts were perceived by patients to be a means of communicating their needs in situations where they felt disempowered:

"I said right…I will break your windows until they (doctors) come… so… I systematically broke the windows until they all came running out" (Kumar, et al. 2001, pg. 603).

"I wanted a cup of tea…I was kept waiting for 45 minutes…I got angry. I actually threw a mug…eight nurses from nowhere picked me up" (Kumar, et al. 2001, pg. 603).

Research has also looked specifically at particular practices utilized for managing aggressive incidents in mental health units. Johnson's (1998) research explored the impact of restraint upon the restrained person using unstructured interviews with 10 patients. The study reported themes of power and powerlessness and found that typically altercations between patients and staff lead to episodes of restraint using restraining devices. The interpersonal issues most frequently reported concerned ward rules and staff surveillance. These interactions were dominated by power struggles that ended in restraint. The main finding was that patients who were restrained felt powerless and their subsequent helplessness was experienced as dehumanizing. This was in contrast to assumptions that restraint can be therapeutic. Indeed, Johnson (1998) comments that none of the patients felt safe and protected, but experienced the practice of restraint as coercive. Similar results were found by Hoekstra,

Lendemeijer, and Jansen (2004) when they examined patient experiences of seclusion and subsequent relations between staff and patients following seclusion. Semi-structured interviews with 7 psychiatric outpatients were conducted. Results indicated that most seclusion experiences were perceived by patients to be negative. In addition, seclusion tended to impact the ongoing relationship with staff if patients felt they had been treated iniquitously by staff during seclusion, or when seclusion was used as a daily threat.

In addition to these studies, indicating perceived power differentials and potential interpersonal factors as contributors to violence, researchers have also explored the differences between staff and patient perceptions of aggression. Benson, Secker, Balfe, Lipsedge, Robinson and Walker (2003) explored attributions of meaning to violent or aggressive situations. Discourse analysis techniques were used to examine one patients account of two aggressive incidents in which she had been involved, in addition to accounts of the staff members who were involved. Authors of this study found that the central concern was the attribution of blame for the incident, with both patient and staff defending their own position. The study raises implications about the problems with the dominant discourse in mental health care. Ilkiw-Lavalle and Grenyer (2003) interviewed 29 staff and 29 patients who had been involved in aggressive incidents across four inpatient psychiatric units. They found that overwhelmingly staff perceived aggression to be the product of the patient's illness and that the management of aggression should primarily focus on

medication. In contrast, patients perceived interpersonal, environmental and illness factors as all equally being responsible for their aggression. The authors concluded that their research appeared to indicate that staff were not prepared to entertain the idea that interactional or relational aspects could be responsible for aggression in inpatient mental health settings. Hinsby and Baker (2004) also found clear contrasts between nurse and patient accounts. Similarly, a major area of difference included patients seeing violence as preventable and predictable where as nurses found it to be unpredictable and primarily due to patients being mentally disordered and out of rational control.

More recent work has sought to examine in greater detail the perceived differences in the contribution of interpersonal or interactional variables, between staff and patients. Duxbury and Whittington (2005) devised a new instrument, the MAVAS, and found that statistically significant differences existed between staff and patient perspectives on 'internal', 'external', 'interactional' and 'management' factors contributing to aggression in mental health settings. Of particular interest was the large degree of difference found in relation to the 'interactional' domain. Patient responses suggested problems with staff / patient interactions, in contrast to staff responses that failed to acknowledge this factor as a contributor. Finally, Meehan, McIntosh and Bergen (2006) have explored patient perspectives on aggression in mental health inpatient settings by conducting 5 focus groups, each including 4 to 7 patients, from a high-security forensic facility. In total 27 patients participated. Meehan et al., (2006) research findings are consistent with previous work,

patients highlighting a combination of patient, staff and environmental factors as contributing to aggression. The authors concluding that a balance between a focus on security and upon creating an effective therapeutic environment must be found.

In brief, research supports the interpersonal model of aggression developed here in that aggression and violence in mental health settings generally occur in an interpersonal context. As such investigations that examine patient risk factors alone, as contributing to aggression and violence in mental health settings, are inadequate. Patient perspectives about how staff interact with them are essential to a further understanding of aggression and violence in mental health units.

3.2. Limitations of Previous Research and Current Research Approach

In the previous section a review of the research found differences in staff and patient views about the causes and management of aggression and has provided further insight into the interpersonal or interactional factors that may be contributing to aggression. Overall, these studies suggest potential problems with attitudes held by staff and approaches used by staff in mental health inpatient settings. However, these studies have not directly targeted patient views about staff management of aggression with the explicit purpose of understanding particular attitudes and approaches used by staff that are

perceived by patients to be potentially fuelling aggression and violence in mental health units.

Meehan, McIntosh and Bergen's (2006) study involved focus groups and the authors comment on particular problems they found with this research method. Participants were reluctant to describe aggression that they were directly involved in, choosing rather to discuss incidents they had witnessed. Additionally, they suggested that the nature of the research method, i.e. the focus group, meant that some members were more dominant and therefore perspectives of the quieter members tended to remain unheard. This limit was also identified by Kumar et al, (2001) in their research using a focus group to provide data. Previous work that has made use of individual patient interviews has comprised small sample sizes, often interviewing only 4 or 5 patients (Hinsby and Baker, 2004; Duxbury and Whittington, 2005; Benson et al, 2003). These researchers have suggested this as a limitation in their work and have recommended that confirmatory research be carried out to increase external validity of their findings. In addition, several of the studies reviewed (Meehan et al, 2006; Duxbury and Whittington, 2005) included research procedures that allowed patients to self select rather than selection being based on actual involvement in a recent aggressive incident, which would be assumed to enhance valid research findings. A further limitation of the previously reviewed work is that interviews and focus groups have not targeted aggressive incidents that have involved the patient and a staff member, instead remaining broadly

inclusive of all aggressive incidents. As a result there has been a loss of specificity and patients have chosen to discuss patient to patient conflict or conflict that they have witnessed rather than actually experienced (Hinsby and Baker, 2004; Meehan et al, 2006).

These limitations were overcome in the design and execution of the present study. This research seeks to explore patient opinions about what they believe contributes to aggression and violence in mental health units. Interviews were chosen as the preferred research method to reduce patient reluctance to describe aggression they had been directly involved in. Semi-structured interviews allowed for specific questions to elicit patient perspectives on the actual management by staff of aggressive incidents in which the patients had personally been involved. A strength of this research is that interviews were conducted temporally close to the actual aggressive incidents, therefore limiting the decay of information that occurs when time elapses between an event and its recall. The sample size was deliberately increased and, despite being relatively small, is purposely larger than some of the other studies in order to address concerns (raised by previous researchers) about external validity.

3.3. Purpose of Research

The broad aim of this study was to elaborate one component of the interpersonal model presented in the previous chapter, namely clinician approaches and attitudes as they influence the patient. A useful theoretical

model must be cognizant of and encompass service user perspectives. A qualitative study exploring patient views is thus helpful to this task. The more specific purpose of directly asking patients for their perspectives was to understand more about particular staff attitudes and approaches that patients view as problematic and as potentially contributing to the occurrence of aggressive incidents in inpatient mental health settings.

3.4. Research Question

What staff attitudes or approaches do patients identify as contributing to an increased likelihood of fuelling aggressive incidents in mental health inpatient wards?

3.5. Method

(i) Participants

Participants comprised 12 patients of mental health inpatient wards who had been involved in an aggressive incident(s) during their current admission. Of the 12 participants 8 (67%) were male and 4 (33%) were female, with an average age of 32 years (range: 19 - 69). Participants primary psychiatric diagnoses reflected the ward's overall profile, and included Psychotic Disorders (7), Bipolar Disorders (3) and Borderline Personality Disorder (2). All participants were considered by mental health staff to be stabilised and were

undergoing pharmacological treatment during their admission.

(ii) Procedure

This research was conducted in accordance with institutional ethics protocols. In consideration of safety, and in an effort to ensure patient ability to provide informed consent, the researcher checked with senior staff not involved in the incident to ensure that the patient was sufficiently stable to give informed consent for interview. Each patient was informed that their involvement in the study was voluntary.When written informed consent was obtained, interviews were conducted in a private room and obtained information about patient perceptions of the way aggressive incidents were managed by mental health service staff. A semi-structured interview script was used and a typed interview transcript was derived from audio-taped recordings for later analysis.

(iii) Data collection instrument

Patient Interviews

Patients were interviewed using a semi-structured face to face interview schedule. The development of the interview schedule was based upon principles of IPA (Smith, 1996) i.e. semi- structured interview questions were designed to be open ended and flexible to obtain the respondent's unedited responses. The aim being to facilitate an understanding of the perspectives of the individuals (patients) who represent a particular area of experience (that of being involved in aggression while experiencing a psychiatric admission). The interview

questions were pilot tested to ensure adequate data could be obtained.The interviews were conducted by the researcher who was independent in affiliation to the psychiatric facility, benefiting the research by assisting participants to feel able to provide honest responses without repercussions. Interviews were conducted in private comfortable surroundings, and patients were asked to reflect upon an aggressive incident(s) that they had been involved in during their admission. In particular, their perceptions of how staff managed the incident(s), what they thought caused the incident(s) and any thoughts about how staff could improve their management of such incidents (see Appendix A).

(iv) Qualitative method

Patient narratives can be explored in greater depth by using a qualitative research methodology that allows themes to be derived from the data. A phenomenological qualitative research methodology was considered most appropriate to the purposes of this study because the aim was to understand the meaning or personal perception that individuals ascribe to a particular event, i.e. an aggressive incident they had been involved in. Interpretative phenomenological analysis (IPA; Smith, 1996) considers as centrally important the meanings that individuals assign to events, and aids the researcher in understanding, and representing as themes, the points of view of individuals who represent an area of experience. This methodology typically combines purposive sampling with flexibly used semi-structured interview schedules and small sample research designs. The approach is phenomenological in its focus

on how individuals make sense of their experiences that are related to the particular area being studied. The approach is interpretative in that it actively takes into account the researchers interpretations of the data in order to make tentative connections to existing theory (Smith, 1996).

Formulated Meanings

The analysis process was carried out in a stepwise manner. Initially, the transcripts were read several times and participant responses to each of the questions were grouped together to make it easier to identify common concepts being expressed. Key words and phrases (codes) were written in the left margin in order to summarise the meaning in small portions of the text (typically several sentences) for each participant's response to the same question. Once the responses had been coded, connections between codes were sought and clustered codes were given category titles. These categories were then given a fuller description and called 'formulated meanings'. Tables 1, 2 and 3 include verbatim statements from the interviews that contributed to the formulated meanings, and provide a sense of the qualitative process of deriving themes from the raw data. Due to repetition in the ideas that were discussed by the participants in answering each question, super-ordinate themes were subsequently derived from the formulated meanings. The themes were then checked against those found in previous studies of this type to ensure that the results were valid and legitimately applicable to this research population.

3.6. Results

The patient transcripts provided many significant accounts of patient views about: 1) the management of aggression by staff; 2) the causes of aggression; and 3) ways in which aggression could be reduced. The formulated meanings derived from each of the domains of questioning are presented in tables 1, 2, and 3, along with verbatim statements from the patient transcripts that contributed to the development of the particular meanings.

Table 1

Patient opinions on staff management of aggressive incidents

Verbatim statements from interviews	**Formulated meaning**
1. The staff can be rough. 2. They give injections wrongly, seclusion for nothing sometimes. 3. Some staff are too controlling ….I suppose it's about your personality, how you get along with different people. 4. They treat you like you're not a human being.	Patients stated that some staff exhibited inappropriate, disrespectful and/or controlling approaches to the management of aggression.
1. There were only three or four nurses that were nice to me. They treated me with respect. They do it calmly, they use their body language, they talked calmly…assisted me to cool down. 2. Sometimes they handled it well. Sometimes they're a bit over the top.	Patients reported differences between staff approaches and attitudes to aggression minimisation with some being more helpful and others problematic.
1. Staff have sometimes told patients to "fuck off" and slammed doors in their faces. That happened just yesterday with an older gentleman. The staff walk away instead of dealing with it. 2. You know, the Doctors give answers that are too in depth. They don't listen to the person, they don't just give you one answer, they give you lots of different things and it's confusing. It's not the patients fault, but it's not the Doctors either. It's just a misunderstanding. Problems, they're problems with communication.	Reports of patients feeling dismissed, ignored or confused by staff were expressed.

Table 2

Patient views about the causes of aggression

Verbatim statements from interviews	**Formulated meaning**
1. The doctors wanted to give me medication. I didn't want any, I didn't need any medication. They thought I was psychotic… He was putting on his gloves in a threatening manner and I thought 'here we go again'. Any trust I have had in these people has gone. It's difficult to understand. 2. They were all men and I didn't want them to pull my pants down but they did anyway. It was embarrassing. They threatened me with other needles because I was screaming and banging. 3. Not having the freedom of having my pack of cigarettes and being able to smoke them when I want. It's the basic of needs, especially if you're a smoker. 4. Another patient was annoying me. He wanted one of my smokes, fair enough we're all sick in here. I know that. The nurses got annoyed because they only saw one side of the story.	Patients suggested that conflicts occurred as a result of their preferences not being respected and their freedom to choose being restricted.
1. And there's no respect for you, for example when I asked for two Panadols I was told off. People are always asking me to "be patient", well I say to them "I am a patient". 2. If this is a place where people go who need help, I don't think it gives them any help… the staff are intimidating, they use rude language. 3. Just yesterday a male nurse was trying to force feed a patient that is a grown adult. He was very rude to this woman. He knew he was in the wrong because he approached me to apologise….he's not here to make a judge of character over us. He used hurtful statements.	Patients spoke about experiencing staff behaviour and attitudes that were disrespectful, feeling misunderstood and feeling that staff were unavailable.

4. They automatically think that they know what the person is thinking. They don't give the person a chance to think and to talk. They think they know what their talking about but they haven't really understood the patient. For example, I asked a nurse when the doctor was going to see me because I wanted to get some leave and the guy just said 'no' and I kept talking about it, like you know, when I was going to get it, that's what I wanted to know and he thought I'd threatened him, so I copped a needle. 5. The other thing is, that if I could tell someone else like I'm telling you, other than a doctor, that would help. 6. Somebody who is helpful that I could go and talk to if I was feeling stressed out.	
1. Other patients have sometimes caused problems…others can make it difficult. 2. Another patient tried to put my head down the toilet. I put his head in a headlock and we wrestled because he tried to attack me in the toilet. I had been drinking a lot, smoking marijuana, I couldn't sleep….I ended up with a paranoid diagnosis, a drug induced psychosis. 3. I wanted to get out but I was confused at the time, anyway I smashed a window.	Patients reported problems that had arisen because of conflicts occurring with other patients and acknowledged that their mental health status caused conflict

1. I didn't know what was going on. The police brought me in here…it was terrifying. 2. There are a couple of things that make me angry, one is that you never get leave when you need it and you want it. 3.Yeah when you ask if you're allowed out and they say 'no', that's the problem…its hard to be in hospital …you can't have a say in what you do…there's lots of restrictions. 4. The doctors refused to let me go. I felt like I might bust. They gave me some time out. 5. I wanted to get out; I didn't feel like I needed to be here. 6. The other thing that makes me angry is waiting for Doctors. They expect you to be happy and you've been waiting for so long for an appointment to see them. They need to be better organised with the times and let you know when you've got an appointment and then turn up for it. 7. The doctor or the nurse should bring it to the level so that the patients can understand what's happening for them.	Patients commonly reported that aggression was triggered at specific, stressful times (admission, requests for leave, Dr's appointments and discharge).

Table 3

Patient opinions about how staff could improve their management of aggressive incidents and how aggression could be reduced

Verbatim statements from interviews	Formulated meaning
1. They could have sat back and observed my behaviour and then acted accordingly. 2. Sometimes you get blamed for something somebody else did. They should find out both sides of the story. Because they think one person is sicker than the other they blame the sicker person. 3. They could walk away or they could evaluate, assess the person before making any decisions…they could find out why he is going off his head rather than giving them a needle and locking them away. A couple of them in here do it. They do it the right way.	Patients reported that staff could more thoroughly observe and evaluate situations prior to intervening.
1. By over the top, I mean I don't like it when they grab people roughly and drag them off to seclusion. They don't get counselled they don't get talked to. They just leave them to cry and scream in their room and they give them needles. 2. They have mood swings and then they control everyone by just giving them medication. 3. I think that by talking to the person and giving them more of a chance to settle down before they drag them off to the room and give them needles.	Patients talked about the use of seclusion and medication for punitive reasons, rather than being provided with adequate clinical care.
1. Taking people out of the hospital for a	It was common for patients to

period of time. A walk down to the lake or outside for an activity day. You are in that yard 24 seven, going out of your nut. 2. Even if they just took a group of us across the road to the park to kick a football or something. 3. Another suggestion would be some exercise mats. I'm here against my will and I'm putting on weight because of the food and the medication. It would be good to be able to do some exercise.	comment on the need for more activity to help relieve levels of boredom.
1. You can't afford to ring people, no one knows where you are. You are often admitted without any money and the nurses are too busy to go to the bank. They need an ATM machine in here so you can get cigarettes, use the phone, buy a drink. 2. Like the men's toilets are unacceptable. There really dirty and filthy. That makes my anger level get higher. Then I ask them to clean it up and I go back and they are still the same….it nearly made me throw up. The only way I've been able to deal with it is to laugh. Then they think I'm crazy because I walk around laughing. The other thing is there is no fresh water. The water container has been empty for days. This also makes me get angry. It certainly doesn't help in any way. 3. It isn't supposed to be a prison in here...it's meant to be a sociable and fulfilling place to be…I think there should be a tree in the courtyard.	Patients observed that basic requirements to adequately meet their human needs and freedoms failed to be provided.
1. You don't hear "excuse me", they are	A common view was the

patronising to patients, very rude. They use loud voices, they're too direct. Stern movements and body language. They need to use holistic care. They need to concentrate on their verbal communication with patients. 2. People need to be kinder to each other you know. They need to show respect. 3. Some staff think they are better than the patients. Part of the aggression here is for survival. You've got to work out who is the top dog. 4. They need to understand our needs…no one wants to be in this environment where your bullied and pushed around. 5. They're just like us but they're in charge and bossy.	disrespectful manner in which patients believed they were treated including the presence of a power imbalance expressed through staff approaches.
1. We've got all day with nothing to do and	Patients expressed their desire to

no staff member will sit and talk and listen to you. Actually only one staff member will. 2. Things need to be more organised. You need to know about dates, times, when the doctors are going to see you. 3. They spoke to me privately about it, that was good. You've got to let people know where they stand. People in here are unstable. They need to have ground rules. 4. Sometimes it's nice for someone to listen rather than just pushing you out of the way. If it was me I would listen to the person first. Some staff are nice and others aren't.	speak with staff and to be provided with clear and frequent communication about their situation, including clarification about ward rules.
1. The nurses shouldn't treat everybody the same because we are all different and we want different things. 2. Like they should listen to them, give them a chance and then if they can't keep to the rules then they need to act. If they know that you're really, really sick then they can't really give you the options. They need to sort of have a better understanding of the individual rather then just seeing everybody as the same.	Patients reported that it would be more helpful to be seen by staff as individuals with different needs rather than as one homogenous group.

Due to repetition in the ideas that were discussed by the participants in answering each question, super-ordinate themes were subsequently derived from the formulated meanings. Table 4 provides the four broad themes with their subsumed formulated meanings, from each of the questions.

Table 4

Themes and their subsumed formulated meanings

Theme 1: Problematic staff attitudes / approaches indicative of a lack of respect shown to patients

Patients stated that some staff exhibited inappropriate, disrespectful and/or controlling approaches to the management of aggression. (Table 1)

A common view was the disrespectful manner in which patients believed they were treated including the presence of a power imbalance expressed through staff approaches. (Table 3)

Patients spoke about experiencing staff behaviour and attitudes that were disrespectful, feeling misunderstood and feeling that staff were unavailable.(Table 2)

Reports of patients feeling dismissed, ignored or confused by staff were expressed. (Table 1)

Theme 2: Patients expressed concerns about inadequate / inappropriate/ inconsistent clinical care exhibited by staff

Patients reported that staff could more thoroughly observe and evaluate situations prior to intervening. (Table 3)

Patients talked about the use of seclusion and medication for punitive reasons, rather than being provided with adequate clinical care.(Table 3)

Patients reported differences between staff approaches and attitudes to aggression minimisation with some being more helpful and others problematic. (Table 1)

Theme 3: Problems with individual needs not being adequately addressed by staff

Patients reported that it would be more helpful to be seen by staff as individuals with different needs rather than as one homogenous group.(Table 3)

Patients suggested that conflicts occurred as a result of their preferences not being respected and their freedom to choose being restricted.(Table 2)

Patients expressed their desire to speak with staff and to be provided with clear and frequent communication about their situation, including clarification about ward rules.(Table 3)

Theme 4: Patients acknowledged internal factors (patient's mental health status) and background factors (e.g. ward rules / procedures, institutionalisation, lack of organised activity) as contributing to aggression

Patients reported problems that had arisen because of conflicts occurring with other patients and acknowledged that their mental health status caused conflict. (Table 2)

Patients commonly reported that aggression was triggered at specific, stressful times (admission, requests for leave, Dr's appointments and discharge).(Table 2)

Patients observed that basic requirements to adequately meet their human needs and freedoms failed to be provided.(Table 3)

It was common for patients to comment on the need for more activity to help relieve levels of boredom.(Table 3)

3.7. Discussion

Broadly, for patients in mental health inpatient settings the results of this study illustrate the importance of interpersonal or interactional factors as contributing to aggression. Although patient responses to questions about aggression in these settings acknowledged internal patient factors and background factors as contributing to aggression, the majority of the responses were indicative of patients experiencing interpersonal or interactional factors as the more salient contributors to their aggressive responses. This is highlighted by the finding that three of the four final themes, derived from the patient responses, could be classified as falling within the interpersonal or interactional domain.

The first theme 'problematic staff attitudes and approaches indicative of a lack of respect shown to patients', highlights the concerning finding that patients often feel that those who are in a position to be offering care and support, at a time when patients have a sense of heightened vulnerability, are more commonly expressing attitudes and approaches that are taken by patients to be a sign of disregard or disrespect. Many responses made by patients highlighted this theme. The findings illuminated in theme one are consistent with and elaborate upon previous research. For example, Gillig et al., (1998) findings that patients in mental health settings highlighted a power differential between themselves and staff; and the identification by Kumar et al., (2001) of several interpersonal categories when discussing the context of patient

experiences of aggression, are consistent with the results found here. The present study's identification that patients who feel disrespected by staff find this to be a contributor to aggression, enhances our understanding of Duxbury and Whittington's (2005) statistically significant differences found between staff and patient responses to several items on the MAVAS. The present study's finding, that patients who feel disrespected by staff believe this to be a contributor to aggression, enlarges our understanding of Duxbury and Whittington's (2005) findings. Each significant MAVAS item implies approaches that would be considered by the patient to be indicative of disrespect.

The second theme 'patients concerns about inadequate, inappropriate, inconsistent clinical care exhibited by staff', highlighted that patients perceive a lack of appropriate clinical care and the use of inappropriate aggression management interventions to be contributors to fuelling aggression in inpatient settings. Additionally, this theme highlighted that patients believed some staff used more appropriate approaches than others and were more successful at minimising patient aggression. These findings are consistent with previous research that has highlighted differences between staff and patient perceptions about the management of aggression in inpatient settings. For example, Duxbury and Whittington's, (2005), quantitative results indicating that the use of medication and seclusion for managing aggression was supported by staff but not by patients, is consistent with this theme. In addition, their results showing that patients perceived deficits in staff interpersonal skills, where as

staff believed that their therapeutic interventions were effective, are also coherent in light of the present study's finding that patients are concerned about inadequate, inappropriate, inconsistent clinical care exhibited by staff.

The third theme 'problems with individual needs not being adequately addressed by staff' draws attention to patient beliefs that they are not treated as individuals during their admission, but rather feel that their identity is subsumed within the broader notion of the 'patient'. Following from this, patients indicated that this belief (that they were not being treated as an individual) could contribute to, or exacerbate aggressive responses. The findings illustrated in theme three, as with the other themes, are consistent with previous work. For example, Duxbury and Whittington's, (2005) finding that the MAVAS interactional scale item, 'improved one to one relationships between staff and patients can reduce the incidence of patient aggression', was agreed with by patients however denied by staff, is coherent when considering the present study's findings that patients perceive that their individual needs are not being adequately addressed by staff and that this may contribute to fuelling aggressive responses.

The fourth theme 'patients acknowledged internal factors (patient's mental health status) and background factors (e.g. ward procedures, institutionalisation, lack of organised activity) as contributing to aggression', emphasises that patients were able to acknowledge other contextual factors that influence their aggressive responses. The findings illustrated in theme four are a repetition of previous findings that have indicated that patients typically suggest

that factors contributing to aggression in mental health inpatient settings generally fall into three domains. Ilkiw-Lavalle and Grenyer,(2003) suggested interpersonal, environmental and illness factors. Duxbury and Whittington, (2005) proposed internal, external and interactional factors. Meehan et al., (2006) put forward a combination of patient, staff and environmental factors. As previously mentioned in Chapter Two, Kruk et al., (2004) have highlighted the importance of their findings regarding the adrenocortical stress response in rats, i.e. that stressors unrelated to fighting, may precipitate violent behaviour by lowering thresholds for attack. In the present study patient responses frequently identified low grade stressors that patients believe contributed to the occurrence of aggressive incidents. A number of environmental and interpersonal stressors were identified by patients and, in combination, would be presumed to contribute to increasing levels of stress. For example: not knowing what is going on with regard to admission/leave/discharge; boredom; not having a staff member to speak with when feeling agitated; aggravation caused by having to relate to other patients; agitation due to not being able to smoke; feeling ignored or not having requests responded to by staff; disagreements with staff over the need for medications. These findings lend support to the theory underlying the interpersonal model presented previously.

Similarly, as discussed in the previous chapter, Lazarus and his colleagues' stress and coping theory can be applied to possible dynamics that occur in mental health inpatient units during stressful encounters. Patient responses in this study indicated that patients commonly felt disrespected by

approaches used by staff. With regard to ‘primary appraisal’ it would be expected that patients who regularly feel a lack of respect from staff would typically view their self-esteem as ‘at risk’ and would therefore regularly experience feelings of anger and shame. During the ‘secondary appraisal’ process the patient examines what their options are for coping and how their environment will respond to these actions. The theory states that if the individual assesses that the stressful encounter outcome is unchangeable then their coping strategy tends to be emotion-focused rather than problem-focused. Aggressive responding would be classified as ‘confrontive coping’ within this theory and is subsumed within the emotion-focused forms of coping. As such it can be presumed that patients who respond aggressively typically believe that stressful encounters experienced in these settings are not able to end well. This analysis of the dynamics of stressful encounters within inpatient settings begs the question: are we setting patients up to fail with regard to experiencing negative emotions and problematic forms of coping in mental health inpatient environments? It is probable that particular mental health staff attitudes and/or behavioural approaches toward aggression management, may contribute to added stress for mental health patients.

In the interpersonal model presented in the last chapter aggression in mental health inpatient settings was conceptualised as a behavioural expression of a patient’s inability to tolerate the intense affect brought about when their needs and wishes are blocked or frustrated. Patient responses in this study, highlight the propensity for patients to identify common human needs as not

being responded to in a way that was helpful in satisfying them, and the tendency for this to be identified as a precursor to aggression. For example, the need to be listened to by staff, be provided with clear communication about their situation and to be treated respectfully by staff. These findings lend support to the interpersonal model presented earlier that highlighted the dynamic interaction between a patients level of internal impulse control and the responses and approaches from staff that can act to either increase or decrease a patients tendency to respond aggressively.

This study brings to light interpersonal deficits in staff and patient interactions, as perceived by patients. No objective measures of staff behaviour were utilised. Therefore the findings relate primarily to staff as viewed through the patient's eyes. All of the patients interviewed had diagnosed mental health conditions. The reality of being a patient in a mental health setting suggests a limited capacity to interpret and understand the behaviours, thoughts and feelings of others (reflective functioning; Fonagy et al., 1993). Therefore, attributions made by patients about staff are likely to be seen through the filter of the patients own needs and problems.

Indeed, in the previous chapter theoretical assumptions about the development of aggressive responding were elaborated upon. It was suggested that aggressive behaviour can develop as a result of inadequate parenting in childhood and remain throughout adulthood as a form of communication or self expression, in an attempt by the individual to defend or protect the psychological, rather than physical, self (Fonagy et al., 1993). It has been

theorised that pathological destructiveness may be a strategy that develops when faced with profoundly insensitive parenting, (Fonagy et al., 1993). In such cases the young child's mental life will be extremely fragile, the ordinary frustration of goals signaling the potential destruction of the psychological self and in turn producing intolerable anxiety. In this context aggression is understood to develop as a defensive attempt at protecting the psychological self, such that self expression and aggression become pathologically confused. In extreme cases, the aggression becomes a part of the individual's experience of themselves and their drive for self-expression, autonomy and control (Fonagy et al., 1993).

These concepts are highly salient for patients in inpatient settings and suggest that the theory underlying the interpersonal model may inform the results of this study. It would be expected that patients with a tendency to confuse aggression with self expression would be more easily triggered by even mildly insensitive responses or approaches by staff. As suggested previously the relatively 'ordinary' frustration of goals or needs may be felt by patients to signal the destruction of their psychological self and aggressive responding may occur as a defensive strategy to protect the psychological rather than, as more typically seen in those without a mental health condition, the physical self. In light of these theoretical assumptions a key finding in this investigation is the strong emphasis patients placed upon how staff interacted with them. Three of the four major themes emphasized interpersonal and interactional factors as being important contributors to aggression. Thus the patient responses in this

study provide support for the interpersonal model, presented again below, and highlight the importance of the attitudes and approaches of mental health staff, with regard to fuelling or minimising aggression, in this vulnerable patient group.

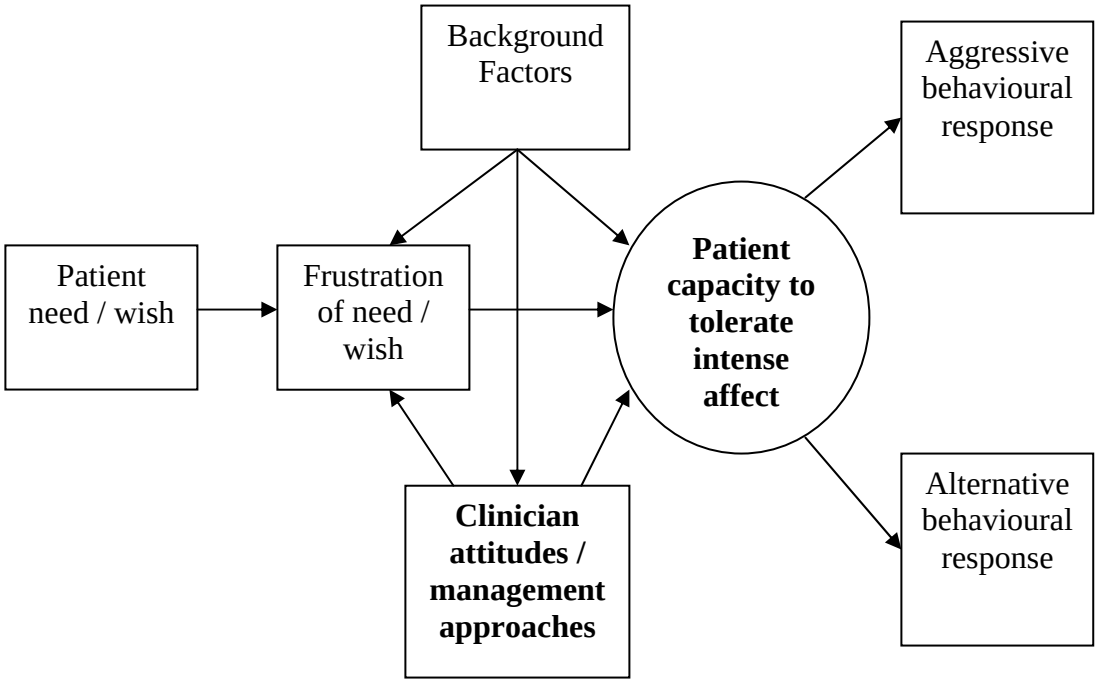

*Figure 1***.** Interpersonal model of aggression and violence in mental health inpatient units (with specific areas of interest highlighted)

Limitations

As alluded to previously in the discussion a limitation of this study is that staff perspectives of the aggressive incidents were not captured. As has

been suggested by previous researchers in this field, research methods that attempt to measure both staff and patient perspectives rather than simply one viewpoint of the event would enhance this area of research significantly. Another limitation of this study is that perspectives were sought of patients in only one mental health unit. It would be useful to carry out such as study across several mental health units in order to understand if the themes obtained from this work are typical of patients in other psychiatric facilities.

Conclusion

This study aimed to understand more about patient perspectives on staff attitudes or approaches that patients believe may fuel aggressive incidents in mental health inpatient settings. In order to examine these questions patient views about how staff managed an aggressive incident(s), what they believed caused the incident(s) and their thoughts about how staff could improve their management of such incidents, were sought.

The findings suggested that patients experience interpersonal and interactional factors as highly salient contributors to their aggressive responses, however patients also identified internal and background factors as contributing to aggression. These findings lend support to the interpersonal model presented in the previous chapter, in particular highlighting the dynamic interaction between a patient's level of internal impulse control and the responses from staff that can act to either increase or decrease a patient's tendency to respond aggressively. More specifically, within the interpersonal and interactional

domain, patients identified staff approaches that indicate: 1) a disregard for, or lack of respect of patients; 2) inadequate, inappropriate, inconsistent clinical care; and 3) problems with individual needs not being adequately addressed, as likely to contribute to aggressive incidents in mental health inpatient settings.

Although the problems that patients perceive between themselves and staff are likely to be at least partially the result of the patients impaired capacity to judge others, the results of this study suggest that there are common, identifiable approaches used by staff that appear to be problematic for patients in these settings. The implications for staff practice in mental health settings is substantial and further research into staff attitudes and approaches in these settings is paramount. Ilkiw-Lavalle and Grenyer, (2003), suggested that staff were not prepared to entertain the idea that interactional aspects could be responsible for aggression. Similarly, Hinsby and Baker, (2004), noted that the function and meaning of patient behaviour remains largely unquestioned by staff working in these settings. Further work is needed to review empirical studies that have examined particular staff attitudes and approaches that may be problematic and then to examine how these attributes may be associated with aggressive incidents in order that an important goal, suggested by Meehan et al., (2006) be more effectively worked towards, i.e. the need for a balance between a focus on security and upon creating an effective therapeutic environment.

CHAPTER FOUR

Study Two:
The Influence of Clinician Attitudes and Approaches on Aggression and Violence in Mental Health Inpatient Units

Chapter 4

Study Two: The Influence of Clinician Attitudes and Approaches on Aggression and Violence in Mental Health Inpatient Units

4.1. Literature Review

The following section reviews research that has specifically examined clinician attitudes and approaches that potentially contribute to aggression and violence in psychiatric settings.

Madden, Lion and Penna (1976), investigated psychiatrists experiences and views on assaults by patients. They found that most clinicians believed that assaults did not occur randomly or without their own contribution and in conclusion recommended that clinicians become more aware of their own part in dealing with potentially violent patients. Similarly, Katz and Kirkland (1990), observed that psychiatric hospital wards where Psychiatrists facilitated and supported staff analyses of counter transference in the workplace, provided more effective therapeutic environments for their patients. The above findings are particularly relevant when considering Shepherd and Lavender's, (1999), finding that aggressive incidents are more likely to be preceded by antecedents that are external rather than internal to the patient.

Lanza, Kayne and Hicks, (1994), found trends between the number of assaults in inpatient wards and low scores on autonomy and high scores on staff control. On an individual rather than a ward level, Lancee, Gallop, McCay and Toner (1995), found that nurses limit-setting styles influenced patient levels of

anger. They found that for impulsive patients, only affective involvement with options kept anger low. The authors suggest that improving nurse limit setting styles may possibly be a way of reducing patient anger. Ray and Subich, 1998, conducted a more specific analysis of the relationship between staff characteristics and number of assaults and injuries experienced by staff. Their findings indicated that a lower right wing authoritarianism (RWA) score was associated with more annual assaults as was a more external locus of control. However, these two variables were not predictive of number of injuries. In contrast anxiety did not predict assaults, however was associated with injuries in the past year. The authors comment on the surprising finding that lower RWA was associated significantly with a greater number of assaults, the opposite of their hypothesis.

A cyclical model of violence involving psychiatric inpatients has been proposed by Whittington and Wykes, (1994a), including three major variables: patient violence, nurse stress and nurse behaviour. Their model suggests that being assaulted leads to an increase in stress and that this stress may lead to changes in nurse behaviour toward patients that may enhance their vulnerability for further assault. The authors consider two types of staff behaviour as potentially problematic: aversive stimulation and social distancing. The authors found some tentative evidence of a relationship between social distance, aversive physical contact and patient violence. Further work by Whittington and Wykes, (1996a), found more evidence in support of their proposals that aversive stimulation is a precursor to patient assaults. They conclude that their

finding that such a high percentage of assaults by patients were preceded by aversive interpersonal stimulation indicates that interpersonal factors play a major role in increasing the risk of aggression in psychiatric inpatients, just as they do in 'ordinary' people, i.e. those without a mental health diagnosis. Interestingly, in a later study Winstanley and Whittington, (2002) carried out an investigation in a general hospital setting rather than a psychiatric one. Their findings highlight the similarity in aggression by 'ordinary' patients in hospital, to that exhibited by psychiatric patients.

Another study by Whittington, (2002) examined the circular model proposed above in the context of a mental health setting and also included an additional variable for consideration. At the time, the introduction of a zero tolerance to aggression policy, which aimed to reduce the risk of aggression in mental health settings, meant that it was timely for Whittington, (2002) to explore the impact of tolerance for aggression, as an attitude in mental health staff. Results indicated a tendency for tolerance to be associated with length of experience. Whittington, (2002) interpreted these findings to be suggestive of a possible counter-intuitive, professional wisdom with regards to seeing all possible angles of aggressive behaviour. Additionally, tolerant staff reported less burnout. Whittington, (2002) interpreted these findings as suggesting that emotionally depleted staff may find it difficult to see things from their patient's point of view, and that this may be reflected in their difficulty in tolerating patient aggression. Similarly, Secker, Benson, Balfe, Lipsedge et al, (2004) sought to further understand the social contexts in which violent and aggressive

incidents occur on inpatient wards by the use of staff interviews. A thematic analysis of the staff accounts found a prominent theme: a "lack of staff engagement with clients, and particularly an inability to look at the world through their clients eyes in interpreting their behaviour" (Secker et al., 2004, p. 172). The authors are critical of the zero tolerance approach to aggression and highlight its limited ability to succeed without understanding what actually contributes to aggression in the social context of inpatient wards.

Summary

Previous research indicates that antecedents to aggressive incidents in inpatient settings are more likely to be external to the patient than internal (Shepherd and Lavender, 1999). There has also been some tentative evidence that clinicians acknowledge that aggressive incidents are not entirely random or attributed only to the patients mental health condition (Madden et al., 1976). Indeed, research has found that where clinicians are assisted to become more aware of the impact of their own behaviour upon patients, wards are more peaceful (Katz and Kirkland, 1990).

Investigations into ward climate have shown that wards where patient autonomy is low and where staff control is high, report more aggressive incidents (Lanza et al., 1994). Although these findings are of interest this study was limited by its lack of specificity, as both staff and patient reports were combined, due to small numbers, prior to data analysis. More specific investigations have shown that nurse limit setting styles that include empathy

and options are associated with lower levels of patient anger and are of particular importance for patients with low impulse control (Lancee et al., 1995). Limits to this study are due to its methodology being role-play rather than looking at actual staff behaviour and patient responses. Right wing authoritarianism has shown a counterintuitive finding with staff lower on this scale being involved in a greater number of aggressive incidents (Ray and Subich, 1998). In the same study external locus of control has been found to be associated with more aggressive incidents, where as anxiety has been found to be related to number of injuries and not number of incidents. This study was limited by its data collection method, i.e. staff self reported the number of incidents and injuries they had experienced rather than actual incident reports being used as the source for data.

Cyclical models have elaborated on staff behaviours that may contribute to patient violence, namely aversive stimulation and social distance (Whittington and Wykes, 1994; 1996). In addition attitudes of tolerance have been found to be associated with lower levels of staff burnout and more experienced clinicians (Whittington, 2002). Whittington, (2002) has proposed that raised levels of emotional exhaustion may induce elevated levels of depersonalisation, manifesting as negative behavioural change toward patients, which possibly feed back to the staff member by increasing their vulnerability for interpersonal conflict (Winstanley and Whittington, 2002). These studies have proposed tentative models and have produced sound findings. Such ideas invite further investigation and elaboration. Indeed, Whittington and Richter,

(2005), suggest that there is a need for more complex and sophisticated explanations of aggression, in psychiatric settings, for interventions to be effective.

The previous studies highlight various unhelpful staff attitudes and approaches, such as: where patient autonomy is low and where staff control is high; nurse limit setting styles that fail to include empathy and options; constructs indicative of staff behaviours that have been described as: aversive stimulation, social distance, external locus of control, and low tolerance for aggression. More broadly, Secker et al., (2004) found an inability in staff to reflect upon the patient's world in interpreting their behaviour. Similarly, Ilkiw-Lavalle and Grenyer (2003), indicated that staff were not prepared to entertain the idea that interactional or relational aspects could be responsible for aggression on the wards, pointing to potential problems with attitudes held by staff. Likewise, in the qualitative study presented in the previous section of this dissertation, it was evident that patient perspectives also point to the importance of staff attitudes and approaches in contributing to aggression and violence.

4.2. Limitations of Previous Research and Current Research Approach

There is a paucity of research investigating which staff attitudes and approaches potentially interact with internal patient vulnerabilities to actually increase aggression and violence in mental health units. The above studies have proposed some interesting ideas, however more work is needed if this area is to

be given the significance that is required to effect ongoing change in the practical realm of reducing aggression in inpatient settings. The major limitations of the previous work reviewed above include: 1) the lack of specificity, such as the use of role-play and; 2) the use of self-reported incident involvement.

The current research approach was designed to address these limitations. A novel and parsimonious way of consolidating and furthering this area of research was to devise a scale that attempts to target staff approaches that are indicative of a rigidity in managing aggression versus a more flexible approach, and thus encompass various of the previous constructs that have proven informative. The scores from this clinician self report instrument can then be used to compare individual differences on clinician self reported clinical expertise in managing aggression and then, more importantly, to explore actual clinician aggression management responses reported over time. This methodology will address the specific limits of previous work by: 1) examining actual staff behaviour and subsequent patient responses and; 2) longitudinally collecting data of actual reported incidents.

4.3. Purpose of Study

The interpersonal model, presented in chapter two, guides the current research by suggesting the importance of the interaction of staff and patient characteristics in the triggering of aggression and violence in mental health

settings. This study is not intended to explore all facets of this model, since it is accepted that there are components that are well researched and less contentious (such as the contribution of a patient's psychopathology to violence, which concur with problems relating to impulse control and reflective functioning, as discussed previously in this thesis). In contrast, the specific role of staff in relation to their perceived and actual responses to patients is gaining increasing interest for researchers in this area. This study was guided by that particular component of the interpersonal model presented in chapter two. The aim was to add to our knowledge about staff attitudes and approaches that may increase the likelihood of an interpersonal vulnerability for experiencing aggression and violence in mental health units.

First, this research will quantitatively investigate staff tolerance for aggression and rigidity toward the management of aggression and the relationship of these variables to each other and to perceived clinical expertise and dimensions of staff burnout (hypotheses 1, 2 and 3). Second, this study will explore whether these particular staff attitudes and management approaches are expressed differentially in behavioural responses to aggressive incidents on the ward (hypothesis 4). Finally, this research entails a qualitative examination involving cognitive appraisals of staff experiences of aggressive and violent incidents. The capacity of staff to reflect upon or understand the mental states of their patients, (Reflective Functioning (RF); Fonagy et al., 1998), will be studied. The aim is to understand more about the particular staff attributes of tolerance for aggression and rigidity toward the management of aggression, and

what they mean (hypothesis 5).

4.4. Hypotheses

In consideration of the previously referred to theoretical ideas and recent research findings the following hypotheses are proposed:

Hypothesis 1:

Tolerant attitudes toward aggression will be associated with less rigid approaches to managing aggression.

The tolerance scale (Whittington, 2002) seeks to discern between individuals who are able to elaborate more fully on the therapeutic meaning of patient behaviour and are thus able to identify more sophisticated views of aggression, from those individuals who have a more limited understanding of the varied causes of aggression. This hypothesis is proposed because it is likely that staff with more tolerant attitudes about aggression will have a more varied repertoire of behavioural responses to assist aggressive patients and therefore would report less rigidity and more flexibility in their approach to managing aggressive patients. A specifically designed scale that measures rigid management approaches for dealing with aggression was devised for this study as a novel way of looking at this relationship.

Hypothesis 2:

Tolerant attitudes toward aggression and less rigid approaches to managing aggression will be associated with greater perceived clinical expertise (skill and confidence) in dealing with aggression.

This hypothesis is proposed for several reasons: 1) as mentioned above Whittington, (2002) purports that the Tolerance Scale identifies more sophisticated views of aggression such as a tendency to look for the therapeutic meaning of individual patient behaviour, suggesting that this is crucial to effective clinical decision making; 2) similarly, as mentioned previously, a unique way of looking at these issues is to use a specifically designed scale that measures rigid management approaches for dealing with aggression. It is likely that staff with a rigid approach to managing aggression may also be less able to see things from their patient's point of view. For these reasons it seems likely that staff with tolerant attitudes about aggression and less rigid management approaches may be more likely to express greater perceived clinical expertise in dealing with aggression, as measured by higher levels of confidence and skill in dealing with aggression.

Hypothesis 3:

Tolerant attitudes toward aggression and less rigid approaches to managing aggression will be associated with lower levels of staff burnout.

This hypothesis is predicted because a previous study found that tolerant attitudes toward aggression were associated with less staff burnout

(Whittington, 2002). It seems likely that this finding will be repeated and elaborated in that staff with less rigid management approaches may also report less burnout.

Hypothesis 4:

Type of intervention used by staff, in response to aggressive incidents, will be predicted by tolerance for aggression and rigidity in managing aggression.

This hypothesis is proposed because it is likely that the staff attitudes and management approaches that are being explored within this study will be expressed differentially in behavioural responses to aggressive incidents on the ward. That is, those individual staff who express greater tolerance for aggression and less rigid management approaches for dealing with aggressive patients would be expected to behave differently, in relation to aggressive incidents, than those who express less tolerance for aggression and use more rigid management approaches for dealing with aggressive patients.

Hypothesis 5:

Hypothesis 5: The clinician's capacity for reflective functioning will predict tolerant attitudes toward aggression, less rigid approaches to managing aggression and greater perceived clinical expertise (skill and confidence).

The reason this hypothesis has arisen is because, as mentioned previously, tolerant attitudes toward aggression may represent an ability to acknowledge or understand the multi faceted causes of aggression

(Whittington, 2002), which has lead to the conjecture that tolerant staff may be more able to see things from their patient's point of view. Reflective functioning (RF) (Fonagy et al., 1998) is the capacity to reflect upon the mental states (thoughts and feelings) of the self and others. As such, staff with more tolerant attitudes might be expected to have higher ratings of RF.

In addition, this hypothesis uses an innovative approach for examining staff behaviour: as mentioned previously, a specifically designed scale that measures rigid management approaches for dealing with aggression. It seems likely that staff with a less rigid approach to managing aggression may be more able to see things from their patient's point of view and therefore would have higher ratings of RF (Fonagy et al., 1998).

Finally, it is likely that staff with a greater capacity to reflect upon the thoughts and feelings of their patients, i.e. higher ratings of RF (Fonagy et al., 1998) will also have greater perceived levels of clinical expertise, expressed in terms of confidence and skill.

4.5. Method

(i) Participants

Participants included mental health staff working in acute and community mental health settings. Data was available to be collected from mental health staff attending training. A smaller sub sample, who were actively involved in managing aggression, were available to provide interview data.

Staff members who participated in this study were informed that their involvement in the study was voluntary. Informed consent was obtained and the research was in accordance with institutional ethics protocols.

(ii)Training

All participants completed a five day manualised aggression minimisation training package, titled the Interpersonal Protect Program (IPP; Middleby-Clements, Biro, Grenyer and Ilkiw-Lavalle, 2004). The interpersonal model presented in chapter two of this dissertation was fundamental to the development of the training program.

The IPP is based on a motivational model of aggression and suggests that frustrated needs and wishes may lead to aggression in high-risk settings. An individual's ability to tolerate the frustration of their needs and wishes is a critical factor in determining the likelihood that an aggressive incident will occur. Similarly the degree to which an individual's needs are effectively responded to by others around them, is an important factor as it may mediate an aggressive response escalating.

Seeking to understand an individual's needs and then putting in place effective techniques for responding to those needs is a fundamental principle of the IPP. Accordingly, the IPP emphasises personalised care, aiming to help clinicians respond in more adequate ways to the frustrated needs and wishes of those individuals they come into contact with in their work environments. A clinician's ability to reflect upon another's thoughts and feelings is essential to

this task.

(iii) Data collection instruments

a) Rigid Approaches Toward the Management of Aggression (IPP Rigidity Scale)

Pre and post measures of health staff rigidity toward the management of aggression were obtained using a specifically designed self report instrument (Appendix B; Grenyer, 2003). The scale comprises 10 items (rated on a likert scale) indicating agreement or disagreement with statements that indicate rigid approaches toward the management of aggression (e.g. 'People who are aggressive should not be tolerated', 'Patients who are aggressive should not get the support of staff'). All items are scored in the same direction with high scores indicating a rigid approach to managing aggression. Previous pilot data has found the instrument to have high internal consistency with an alpha coefficient of .82.

b) Tolerance for Aggression

Pre and post measures of health staff tolerance for aggression were obtained using the Tolerance Scale (Appendix C; Whittington, 2002). This scale was derived from the Perceptions of Aggression Scale (Jansen, Dassen and Moorer, 1997) in particular the subscale that characterises ‘aggression as a normal reaction’. The tolerance subscale is made up of 12 items (rated on a likert scale) indicating agreement or disagreement with four items that

positively evaluate patient aggression (e.g. 'Aggression helps to see the person from another point of view') and eight that indicate an awareness of the possible causes of patient aggression (e.g. ‘Aggression comes from feelings of powerlessness’). All items are scored in the same direction with high scores indicating a high tolerance for aggression. This scale has been reported to have a high internal consistency with an alpha coefficient of 0.82 (Whittington, 2002).

c) Confidence in Dealing with Aggression

Pre and post measures of health staff confidence were obtained using the Confidence in Coping with Patient Aggression Instrument (Appendix D; Thackrey, 1987). The instrument is a 10-item self-report questionnaire that addresses areas pertaining to ability, preparation, comfort in safety, effectiveness in intervening psychologically and physically with aggressive patients for self-preservation and therapeutic intervention (e.g. 'How comfortable are you in working with an aggressive person?' (rated from very uncomfortable-very comfortable)). Participants indicate their degree of confidence using a 10 point likert scale with higher scores indicating greater confidence. During its development Thackrey, (1987), found the instrument to have a high degree of internal consistency with an alpha coefficient of 0.92.

d) Skill in Dealing with Aggression Scale (IPP Skill Scale)

Pre and post measures of health staff skill in dealing with aggression

were obtained using a specifically designed 10 item self-report instrument, (Appendix E; Grenyer, 2003), that addresses areas pertaining to: identifying high risk patients, awareness of response options when faced with aggression, use of verbal and physical skills and awareness of legal issues and procedures that should follow an incident. Participants indicate their degree of skill and higher scores indicate greater skill (e.g. 'How good are your current assessment skills for identifying high risk aggressive people?' (rated from very poor - very good)). Inter-item reliability was assessed for this instrument and the questionnaire was found to have a high degree of internal consistency with an alpha coefficient of .91.

e) Maslach Burnout Inventory (MBI)

Occupational stress was measured with a 22 item health services questionnaire developed by Maslach and Jackson, (1986). The scale supplies scores on three subscales: Emotional Exhaustion (EE), Depersonalisation (DP) and Personal Accomplishment (PA), and has strong psychometric properties. Reliability estimates have been reported by Maslach et al., (1986) on each subscale: EE = .90; DP = .79; PA = .71. Personal Accomplishment is negatively correlated with Emotional Exhaustion and Depersonalisation. Validity of the scale has been demonstrated in several ways. One example of a large scale study is the correlation of the presence of particular job characteristics that would be expected to contribute to the experience of burnout. In a survey of 845

public contact employees it was found that when caseloads were very large scores were high on Emotional Exhaustion and Depersonalisation, and low on Personal Accomplishment (Maslach and Jackson, 1984b).

f) Aggressive / Assaultive Incident Form

The Aggressive Assaultive Incident Form (AAIF; Barlow et al., 2000), (Appendix F), is completed by staff immediately following any aggressive incident. Data recorded includes demographics, severity of the aggressive behaviour using Morrison's hierarchy (Morrison, 1992), and the interventions used from the Overt Aggression Scale (Yudofsky, Silver, Jackson et al., 1986).

g) Staff Interviews

Staff were interviewed using a structured face to face interview schedule (Appendix G). The interviews were conducted by the researcher who was independent in affiliation to the psychiatric facility. The aim of this was to assist in generating unbiased responses. Staff were asked to reflect upon the aggressive incident and their perceptions of it, their feelings about the incident, what they thought caused the incident and how they believed the patient felt after the incident. More specifically, the first four questions in the structured interview were formulated in order to align with the intended rating scale that would be used to score the interview data, i.e. the Reflective Functioning (RF) scale. The aim of using this scale was to measure the degree to which staff were able to reflect upon

their own and their patient's responses to aggressive incidents. Two 'demand' questions and two 'permit' questions were developed in line with theoretical and scoring requirements. 'Demand' questions are defined in the RF scoring manual as a clear request for a mentalising response, such as the interview question developed for this study: "how do you think the patient felt after the incident?". 'Permit' questions are defined in the RF scoring manual as those that allow the respondent to answer using mental state language, such as the interview question developed for this study: "what do you see as the triggers and factors contributing to the incident?". Scoring the data provided by the staff interviews is explained in greater depth in the next section.

h) Reflective Functioning

The staff interviews were transcribed and rated using the Reflective Functioning scale (RF, Fonagy et al., 1998). The RF assessment (Fonagy et al., 1998) measured the degree to which staff were able to reflect upon their own and their patient's responses to the aggressive incident. The RF scale (Fonagy et al., 1998) measures metacognitive skill. The scale is an observer rating that examines the extent to which an individual's interpersonal narrative makes use of mental state language, to indicate an understanding of the characteristics of mental or internal states. The RF manual gives guidelines for rating RF on an 11 point scale with scores ranging from –1 indicating negative RF (distinctly anti reflective) to 9 denoting full (or exceptional RF). An ordinary population's

mean level of reflective functioning is suggested to be 5. Moderate to high RF includes characteristics such as: an awareness of the nature of mental states; an explicit effort to tease out mental states underlying behaviour and; recognising developmental aspects of mental states. Negative or limited RF includes characteristics such as: the rejection of RF; unintegrated, bizarre or inappropriate RF; distorted or self-serving RF; naïve or simplistic RF and; overly-analytical or hyperactive RF. The RF manual (Fonagy et al., 1998) provides detailed information regarding the rules for coding narratives.

The RF scale was devised for use with the Adult Attachment Interview (AAI; George, Kaplan & Main, 1985). Within the context of scoring AAI's, narratives are given greater weight in the overall score if they are responses to 'demand' questions, which are defined as a clear request for a mentalising response. Other questions in the AAI are considered to be 'permit' questions and responses to these are only rated if they indicate a capacity for RF above the level of 3. However distinctly anti-reflective responses to 'permit' questions are taken into consideration when the final score is aggregated.

RF was rated according to the rules set out in the RF manual, (Fonagy et al., 1998), however these rules were applied to the staff interview transcripts which consisted of staff responses to two permit questions ('Can you describe the incident in your own words?'; 'What do you see as the triggers and factors contributing to the incident?') and two demand questions ('How did you feel after the incident?'; 'How do

you think the patient felt after the incident?'), for each interview. Answers to each question were individually rated and the most common level of RF expressed in the interview as a whole became the aggregated score. Training in using the RF scale involved a combination of practice in coding and discussion between judges about the ratings. Subsequently each interview transcript was blindly rated for RF, i.e. blind to other measures. The data was coded twice by independent judges and inter-rater reliability was assessed and found to be high, with a correlation coefficient of .93. The two judge's scores were then averaged to reach a final set of scores to use in the analyses.

(v) Procedure

The participants completed a series of questionnaires immediately pre and post an aggression minimisation training program. Pre data collection occurred on the first day of training prior to commencement and post data collection occurred on the final afternoon of training". Training occurred over a period of 18 months in the Illawarra region, and 15 - 25 participants were trained in each session. Service data on reported aggressive incidents was also compiled prior to and during the period of data collection. The overall service data collection for the study spanned three years in total. Interviews were conducted at a follow-up period with mental health staff involved in aggressive incidents, to obtain their views on and perceptions of the way aggressive incidents were

managed. During the follow up data collection period, as aggressive incidents occurred staff completed the Aggressive / Assaultive Incident Form immediately after the event. The completion of these forms then triggered an interview with the researcher within one month of the incident occurring. When informed consent was obtained from staff, a narrative description of the aggressive incident was elicited from the respondent using a semi-structured interview script. The interviews were audio recorded and transcribed. This data was then rated using the Reflective Functioning Scale.

(vi) Statistical analysis and data handling procedures

Preliminary data screening procedures were carried out on this data set to assess normality of the distributions. To test hypotheses 1, 2 and 3 pre training data was used. To test hypotheses 4 and 5 data collected at the temporally closest period to the predicted variables was used. In all analyses, the criterion for statistical significance was set at $p < .05$.

(a) To broadly examine the impact of the training program, quantitative data collected prior to and post training was analysed. Paired samples t tests were conducted comparing pre to post mean scores on: confidence and skill for dealing with aggression; tolerance for aggression; rigidity in managing aggression; burnout (personal accomplishment, emotional exhaustion and depersonalisation).

(b) To test hypothesis 1, a Pearson correlation was conducted exploring the relationship between clinician tolerance for aggression and rigidity in managing aggression.

(c) To test hypothesis 2, Pearson correlations were conducted exploring associations between: rigid approaches for managing aggression and skill and confidence in dealing with aggression; tolerant attitudes toward aggression and skill and confidence in dealing with aggression.

(d) To test hypothesis 3, Pearson correlations were conducted exploring associations between: rigid approaches to managing aggression and the subscales of burnout (personal accomplishment, emotional exhaustion and depersonalization) and; tolerant attitudes toward aggression and the subscales of burnout (personal accomplishment, emotional exhaustion and depersonalization).

(e) To test hypothesis 4, the AAIF data was examined in order to distinguish between the use of high and medium severity interventions. High severity interventions were classified as such based on meeting all three criteria: i) the use of physical restraint; (ii) the administration of medication orally and/or by injection; and (iii) the use of seclusion and/or isolation. Medium severity interventions were classified as such based on meeting one or two such criteria. Each participants average intervention severity was calculated individually based on the proportion of high severity intervention incidents in which they had been involved. Pearson correlations and a simple, linear regression analysis were conducted,

exploring the ability of staff tolerance for aggression and rigidity in managing aggression to predict staff involvement in high severity interventions.

(f) To test hypothesis 5, Pearson correlations followed by a stepwise multiple regression analysis was conducted exploring the ability of: confidence and skill in dealing with aggression; tolerance for aggression; and rigidity in managing aggression, to predict RF.

4.6. Results

Of the 200 participants who completed evaluations 52% were males and 48% were females, with an average age of 40.96 years (SD = 9.84; range = 21 – 61years). 68% of participants worked in an inpatient mental health setting and 32% worked in a community mental health setting. Occupationally 59% of the sample were nursing staff, 29% were security staff, 9% were allied health staff and the remainder (3%) were made up of staff carrying out domestic duties.

For hypothesis 4, a sub sample of the original 200 participants, consisting of 55 participants, were included. The basis for inclusion was involvement in a reported aggressive incident during the three year period in which the AAIF data was being collected. Participants were all primary reporters of the aggressive incident(s) they had been involved in. Of this sample 100% were clinical nursing staff working in psychiatric inpatient wards. Males made up 42% and females 58%, with a mean age of 38.75 years (SD = 10.41;

range = 21 – 60 years). The mean number of reported aggressive incidents of the sample were 11.75 (SD = 9.45; range = 1 – 46 incidents).

For hypothesis 5, a sub sample of the original 200 participants was used and consisted of 26 participants who were interviewed at follow up to training. Of this sample 100% were clinical nursing staff working in psychiatric inpatient wards. Males made up 41% and females 59%, with an average age of 37.29 years (SD = 8.80; range = 21 – 53 years).

Training outcomes

To explore training outcomes, data collected using the instruments measuring clinician tolerance for aggression, rigidity in managing aggression, confidence and skill for dealing with aggression and the subscales of burnout, (personal accomplishment, emotional exhaustion and depersonalisation) were used. As shown in figure 2, and as presented below, the results indicate that the training program was successful in significantly increasing perceived staff expertise, improving staff attitudes and reducing staff burnout:

(i) Confidence in dealing with aggression significantly improved from pre to post training (pre mean = 62.40, SD = 18.61; post mean = 80.62, SD = 11.48; t = -15.60, df = 175, p = .000).

(ii) Skill in dealing with aggression significantly improved across training (pre mean = 64.99, SD = 18.16; post mean = 84.16, SD = 9.96; t = -15.91, df = 173, p = .000).

(iii) Tolerance for aggression significantly increased over training (pre

mean = 52.22, SD = 17.39; post mean = 62.54, SD = 19.05; t = -7.84, df = 168, p = .000).

(iv) There were no changes in rigid management approaches over training. (pre mean = 38.67, SD = 13.61; post mean = 39.05, SD = 17.13; t = -.34, df = 167, p = .74).

(v) Personal accomplishment significantly increased across training (pre mean = 34.46, SD = 8.03; post mean = 35.93, SD = 7.27; t = -2.87, df = 146, p = .005).

(vi) Emotional exhaustion significantly decreased across training (pre mean = 15.36, SD = 9.77; post mean = 14.14, SD = 9.49; t = 2.85, df = 154, p = .005).

(vii) There were no changes in Depersonalisation over training (pre mean = 5.10, SD = 4.63; post mean = 5.03, SD = 4.88; t = .22, df = 153, p = .83).

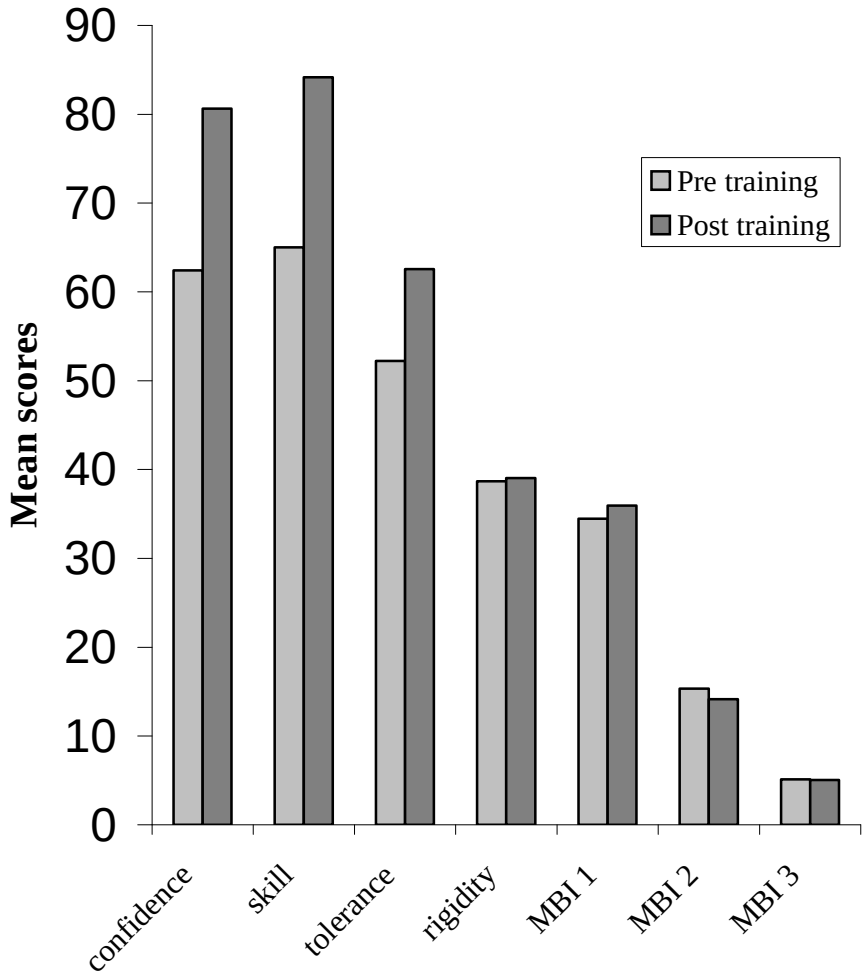

Figure 2. Mean Confidence, Skill, Tolerance, Rigidity and Maslach Burnout Inventory subscale scores, (MBI 1 = Personal Accomplishment; MBI 2 = Emotional Exhaustion; MBI 3 = Depersonalisation), pre and post training

Hypothesis 1: Tolerant attitudes toward aggression will be associated with less rigid approaches to managing aggression.

To test this hypothesis data collected using the instruments measuring clinician tolerance for aggression and rigidity in managing aggression were used. A Pearson correlation found that tolerant attitudes about aggression are

negatively associated with rigidity in managing aggression ($r = -.16$, $p = .03$). This statistically significant finding suggests that the more tolerant the attitudes about aggression the less rigid the approaches for managing aggression.

Hypothesis 2: Tolerant attitudes toward aggression and less rigid approaches to managing aggression will be associated with greater perceived clinical expertise (skill and confidence) in dealing with aggression.

To test this hypothesis data collected using the instruments measuring clinician tolerance for aggression, rigidity in managing aggression, confidence and skill for dealing with aggression (perceived clinical expertise) were used.

Pearson correlations indicated:

(a) A statistically significant inverse relationship between rigid approaches for managing aggression and skill for dealing with aggression ($r = -.162$, $p = .03$). This finding suggests that less rigidity in managing aggression is associated with higher levels of perceived skill for dealing with aggression.

(b) No relationship between rigid approaches to managing aggression and confidence for dealing with aggression ($r = -.10$, $p = .20$).

(c) No relationship between tolerant attitudes toward aggression and skill in dealing with aggression ($r = .12$, $p = .10$).

(d) Marginal relationship between tolerant attitudes toward

aggression and confidence in dealing with aggression ($r = .14$, $p = .05$). This finding suggests that tolerant attitudes toward aggression are marginally associated with confidence in dealing with aggression.

Hypothesis 3: Tolerant attitudes toward aggression and less rigid approaches to managing aggression will be associated with lower levels of staff burnout.

To test this hypothesis data collected using the instruments measuring clinician tolerance for aggression, rigidity in managing aggression and the subscales of burnout (personal accomplishment, emotional exhaustion and depersonalisation), were used.

Pearson correlations indicated:

(a) A statistically significant inverse relationship between rigid approaches to managing aggression and personal accomplishment ($r = -.34$, $p = .00$). This finding suggests that less rigidity in managing aggression is associated with greater levels of personal accomplishment, (indicative of lower levels of burnout).

(b) No relationship between rigid approaches to managing aggression and emotional exhaustion ($r = .09$, $p = .27$).

(c) A statistically significant positive relationship between rigid approaches to managing aggression and depersonalization ($r = .33$, $p = .00$). This finding suggests that less rigidity in managing aggression

is associated with lower levels of depersonalization, (indicative of lower levels of burnout).

(d) No relationship between tolerant attitudes toward aggression and any of the subscales of burnout: personal accomplishment ($r = .11$, $p = .16$), emotional exhaustion ($r = -.13$, $p = .09$) or depersonalization ($r = .02$, $p = .82$).

To further illustrate the statistically significant results found in hypotheses 2 and 3, i.e. the relationship between low rigidity and high skill, and the relationship between low rigidity and several of the subscales of burnout (i.e. high personal accomplishment and low depersonalisation), it is illustrative to look in particular at those staff who were most characteristic of high ($N = 24$) and low ($N = 26$) rigidity. Highest possible level of rigidity was 100, lowest was 0. Those staff who scored 60 or above for rigidity were considered highly rigid and those staff who scored 20 or below were considered low in rigidity. As shown in Table 5, independent samples t tests found significant differences between the two groups. The low rigidity group was significantly more skilled, more personally accomplished and less depersonalized than the highly rigid group.

Table 5

Mean (standard deviation) and independent samples t test (sig p) scores for the low and high rigidity groups on the variables of interest (skill, personal accomplishment and depersonalisation)

Variable	Low rigidity M (SD)	High rigidity M (SD)	T Test (df)	(p)
Skill	89.46 (7.85)	84.00 (9.55)	2.20 df = 47	.03*
Personal accomplishment	38.95 (6.80)	32.17 (8.78)	2.89 df = 43	.01*
Depersonalisation	3.17 (5.18)	9.17 (5.55)	-3.79 df = 44	.00*

Note. * $p < .05$

Hypothesis 4: Type of intervention used by staff, in response to aggressive incidents, will be predicted by tolerance for aggression and rigidity in managing aggression.

To test this hypothesis data collected using the instruments measuring clinician tolerance for aggression, and rigidity in managing aggression were used. In addition, data from the Aggressive Assaultive Incident Form (AAIF), recording the actual reported number of incidents and the type of intervention used by staff members during the management of aggressive incidents, was

utilised.

The AAIF data was examined in order to distinguish between the use of high and medium severity interventions. High severity interventions were classified as such based on meeting three criteria: i) the use of physical restraint; (ii) the administration (coerced) of medication orally and/or by injection; and (iii) the use of seclusion and/or isolation. Medium severity interventions were classified as such based on meeting one or two such criteria. Each participant's average intervention severity was calculated individually based on the proportion of high severity intervention incidents in which they had been involved.

Initially, Pearson correlations indicated:

a) No relationship between tolerance and proportion of high severity intervention incidents ($r = .05$, $p = .69$).
b) A statistically significant relationship between rigidity and proportion of high severity intervention incidents ($r = -.42$, $p = .00$). As shown in figure 3 this finding suggests that clinicians with less rigid approaches to the management of aggression were involved in a greater number of high severity intervention incidents of aggression.

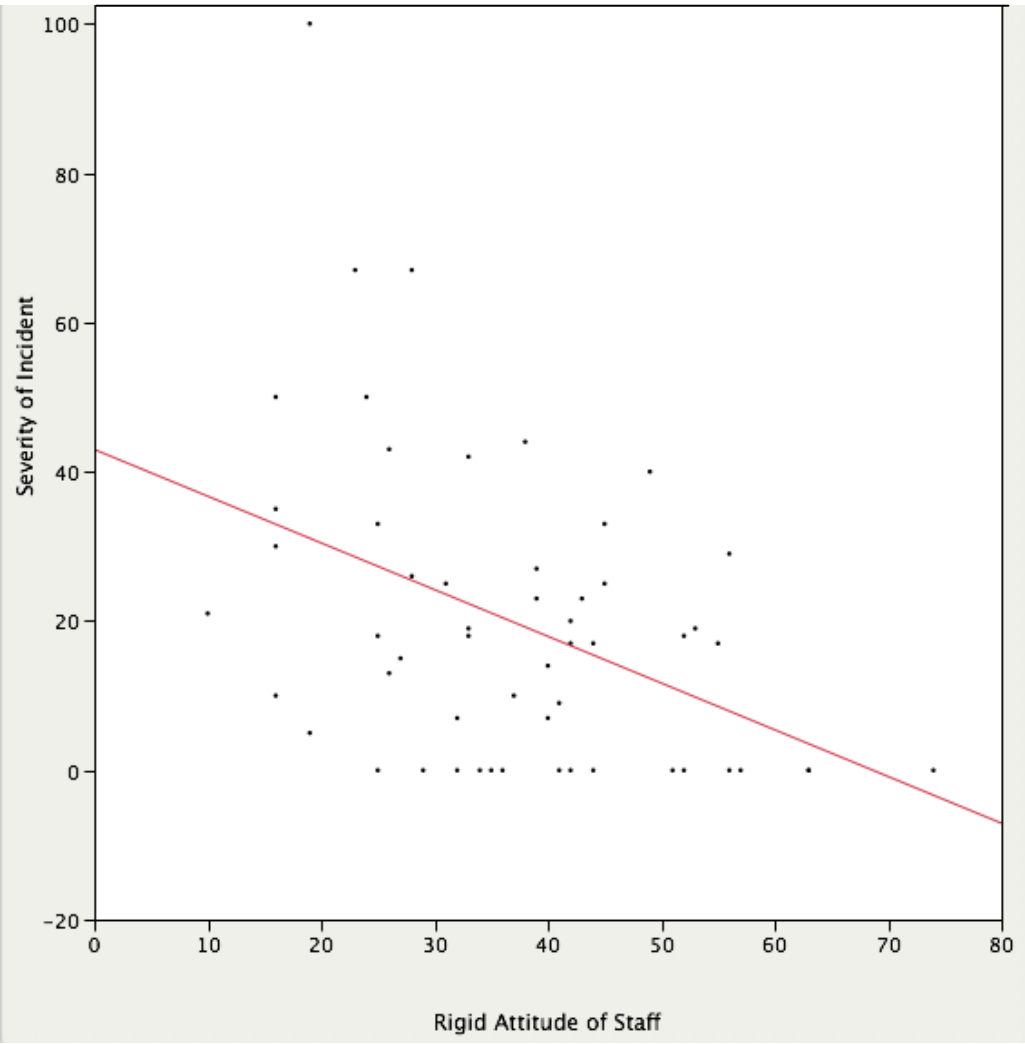

Figure 3. Pearson correlation between rigid attitudes of staff and mean severity of reported aggressive incident

A simple, linear regression analysis exploring the ability of clinician rigidity to predict clinician involvement in high severity interventions was then conducted. Rigidity explained 18% of the variability in the proportion of high severity intervention incidents staff are involved in, F (1,53) = 11.27, p = .00. Examination of the beta weight for rigidity (*B* = -.63) indicates that rigidity

contributed significantly to the prediction of the proportion of high severity intervention incidents in which staff were involved.

Hypothesis 5: The clinician's capacity for reflective functioning will predict tolerant attitudes toward aggression, less rigid approaches to managing aggression and greater perceived clinical expertise (skill and confidence).

To test this hypothesis the reflective functioning (RF) scale was used to rate the qualitative interview data. This instrument contributed by measuring the clinician's capacity to reflect upon the thoughts and feelings of their patients. The mean RF for the sample was 4.73 (SD = 1.78; range = 2 - 9). These findings are consistent with Mean RF in the general population. In conjunction with the RF scale the instruments measuring clinician tolerance for aggression, rigidity in managing aggression, and confidence and skill for dealing with aggression (perceived clinical expertise) were used.

Initially, Pearson correlations indicated that three of the four variables were associated with RF:

(a) As shown in table 6 a statistically significant relationship between RF and tolerant attitudes to aggression ($r = .48$, $p = .01$). This finding suggests that a higher capacity for reflective functioning is associated with a more tolerant attitude to aggression.

(b) No relationship between RF and rigid approaches to managing aggression ($r = -.30$, $p = .14$).

(c) As shown in table 6 a statistically significant relationship between

RF and skills for managing aggression (r = .61, p = .00). This finding suggests that a higher capacity for RF is associated with more perceived skill in managing aggression.

(d) As shown in table 6 a statistically significant relationship between RF and confidence for managing aggression (r = .41, p = .04). This finding suggests that a higher capacity for RF is associated with more perceived confidence in managing aggression.

Table 6

Pearson correlations and p values for significant associations between RF and variables of interest (tolerance, skill and confidence)

	Tolerance	Skill	Confidence
Reflective Functioning	.48*	.61*	.41*
P Value	p = .01	p = .00	p = .04

Note. * p < .05

A stepwise multiple regression analysis indicated that two of the three predictor variables entered into the analysis were included in the regression equation. Tolerance and skill explain 54% of the variability in the RF of clinicians, F(2,21) = 12.54, p = .00. Examination of the beta weights of these variables indicates that tolerance (*B* = .42) and skill (*B* =

.56) contributed significantly to the prediction of the RF of clinicians.

4.7. Discussion

The aim of this study was to add to our knowledge about staff attitudes and approaches that may increase the likelihood of an interpersonal vulnerability for experiencing aggression and violence in mental health units. In a preliminary analysis the impact of the IPP training package upon staff was investigated. Following this, with regard to the proposed hypotheses, this study quantitatively investigated staff tolerance for aggression and rigidity toward the management of aggression and the relationship of these variables to each other and to perceived clinical expertise and dimensions of staff burnout (hypotheses 1, 2 and 3). Subsequently, this study explored whether these particular staff attitudes and management approaches were expressed differentially in behavioural responses to aggressive incidents on the ward (hypothesis 4). Finally, this research entailed an examination of cognitive appraisals of staff experiences of aggressive and violent incidents. The capacity of staff to reflect upon or understand the mental states of their patients, (Reflective Functioning (RF); Fonagy et al., 1998), was studied. The aim was to understand more about the particular staff attributes of tolerance for aggression and rigidity toward the management of aggression, and what they represent (hypothesis 5).

Training outcomes

Analysis of the impact of the IPP training package indicated that the training program was successful in increasing perceived staff expertise (skills and confidence), improving staff attitudes (tolerance) and reducing staff burnout (increasing personal accomplishment and decreasing emotional exhaustion). It was interesting that training did not impact upon the variable measuring rigid management approaches. This perhaps indicates that rigidity in managing aggression is not easily modified through aggression management training packages, but rather is indicative of entrenched behavioural approaches that require more intensive learning experiences to effect change. Alternatively or in elaboration of this point, this finding could be indicative of an organisational culture at the time of training supporting and encouraging more rigid approaches to the management of aggression that were not able to be easily challenged in a five day training package. Indeed the Interpersonal Model, presented in chapter two of this dissertation, highlights the important influence of systemic organisational and even broader socio-political influences upon aggression in mental health units. To expect a five day training package to influence such entrenched, systemic attitudes and approaches may have proven to be unrealistic. In saying this however it was encouraging that some improvement in attitudes was found, i.e. tolerance for aggression improved across training. This measure specifically targets staff understanding of the multiple and complex causes of aggression in mental health settings.

Hypothesis 1: Tolerant attitudes toward aggression will be associated with

less rigid approaches to managing aggression.

The results suggested that, as predicted, staff who expressed more tolerant attitudes about aggression also expressed less rigid approaches for managing aggression. The tolerance scale (Whittington, 2002) seeks to discern between individuals who are able to elaborate more fully on the therapeutic meaning of patient behaviour and are thus able to identify more sophisticated views of aggression, from those individuals who have a more limited understanding of the varied causes of aggression. Therefore, the above finding is expected as staff with more tolerant attitudes about aggression would understandably see themselves as having a more varied repertoire of behavioural responses to assist aggressive patients, and therefore have tended to self-report less rigidity and more flexibility in their approach to managing aggressive patients.

This is an important finding when considering previous research that has highlighted the impact of ward climate on patient assaults in psychiatric units. As part of a study investigating environmental characteristics related to patient assault in psychiatric wards, Lanza, Kayne and Hicks, (1994) found trends between the number of assaults and low scores on patient autonomy and high scores on staff control in inpatient units. The authors found that the ward with the highest frequency of assaults reported the lowest score on patient autonomy and the ward with the fewest assaults showed the highest score on patient autonomy. The subscale autonomy assessed “the degree to which patients (were) encouraged to be self-sufficient and independent in their

personal affairs and in their relationships with staff" (Lanza et al., 1994, p. 322). In addition, the authors found that the ward with the fewest assaults reported the lowest scores on staff control and the inverse was found for the ward with the highest number of assaults. The subscale staff control measured "the extent to which it (was) necessary for the staff to restrict patients" (Lanza et al., 1994, p. 322). Both these measures of ward climate can be related to the variables measured in the current study. Rigidity and tolerance encompass ideas that are expressed within the ward variables staff control and patient autonomy, such that highly rigid staff approaches to the management of aggression and low tolerance for aggression would presumably contribute to the development of wards that are high in staff control and low in patient autonomy. Thus the finding for hypothesis one is coherent with previous work and contributes to a growing understanding of staff factors that may play a role in creating an unhelpful ward culture, in relation to aggression and violence.

Hypothesis 2: Tolerant attitudes toward aggression and less rigid approaches to managing aggression will be associated with greater perceived clinical expertise (skill and confidence) in dealing with aggression.

The findings show that, as predicted, less rigid approaches to managing aggression were associated with higher levels of perceived skill for dealing with aggression. It appears that staff who are less rigid in their approach to managing aggression perceive themselves to have higher levels of skill in dealing with

aggression. Less rigidity and greater flexibility in approaches to managing aggression perhaps assist staff to feel a greater sense of clinical expertise (skill) because they believe they have a broader range of approaches for managing aggression. It is interesting that the results also indicated no association between rigid approaches to managing aggression and level of confidence in dealing with aggression. This suggests that skill and confidence are quite different indicators of clinical expertise and is consistent with previous work. For example, previous studies measuring staff confidence in managing aggression have shown somewhat controversial findings. Bowers, Nijman, Allan, Simpson et al., (2006), carried out a large scale study examining the impact of aggression management training upon actual violent incident rates on UK acute psychiatric wards. They retrospectively examined training records and violent incident rates over two and a half years on 14 wards. They found the undesirable result that course attendance failed to reduce violence and indeed some evidence suggesting that attendance at refresher courses triggered short-term increases in incident rates. One concerning interpretation they provided for this finding was that training may induce clinicians to be more confident to confront patients in order to use the restraint techniques they have been taught. These results suggest that confidence is perhaps an easily manipulated staff variable and says more about staff feelings of coping than actual clinical expertise. The results found in this study also reinforce that confidence and skill are different concepts. Skill is perhaps more of a measure of behaviour and is therefore more related to either rigid or flexible approaches,

whereas confidence is perhaps more of a feeling, or a way of coping, and is therefore not associated in any particular direction with behavioural approaches, i.e. a staff member might be either rigid or more flexible in their approach to managing aggression and their confidence be more based upon how strongly they believe in their approach.

The findings also indicated no relationship between tolerance for aggression and skill, however found a marginal positive relationship between tolerance and confidence. These findings were not predicted and suggest that tolerance for aggression is not strongly associated with staff perceptions about clinical expertise (skill and confidence). This suggests that more sophisticated views of aggression such as a tendency to look for the therapeutic meaning of individual patient behaviour (high tolerance) is unrelated to staff perceptions of skill and only marginally associated with staff perceptions of confidence. This finding could be interpreted as being indicative of the organisational culture at the time of data collection not supporting or encouraging staff to place importance upon sophisticated views of aggression, such as looking for the therapeutic meaning in patient behaviours. Indeed, this interpretation is consistent with a previous study by Benson, Balfe, Lipsedge et al, (2004). They sought to understand the social contexts in which violent and aggressive incidents occur on inpatient wards by the use of staff interviews. Their thematic analysis of the staff accounts found a prominent theme: a “lack of staff engagement with clients, and particularly an inability to look at the world through clients eyes in interpreting their behaviour” (Secker et al., 2004, p.

172). The authors were critical of the zero tolerance approach to aggression that was prominent at the time of their study, and highlight its limited ability to succeed without understanding what actually contributes to aggression in the social context of inpatient wards. A zero tolerance approach to aggression was also being promoted at an organisational level at the time data was being collected for the current study. This supports the interpretation, suggested previously, that the organisational culture at the time of data collection may not have supported or encouraged staff to place importance upon sophisticated views of aggression, such as looking for therapeutic meaning in patient behaviours. This may have impacted upon the results found for hypothesis two, which suggest that tolerance for aggression is not associated with staff perceptions of skill and is only marginally positively related to confidence.

Hypothesis 3: Tolerant attitudes toward aggression and less rigid approaches to managing aggression will be associated with lower levels of staff burnout.

No association was found between tolerant attitudes toward aggression and any of the subscales of burnout. This finding was not expected and is interesting in that an association between tolerance for aggression and burnout has been found in previous studies (e.g. Whittington, 2002). It was expected that this finding should have been replicated in the current study. It is possible that, as suggested above, attitudes that might suggest greater tolerance for aggression had been undervalued by the organizational culture, at the time of

data collection, to the degree that staff perceptions of tolerance for aggression had no impact upon staff perceptions of burnout.

The results for hypothesis three also show that, as predicted, less rigidity in managing aggression is associated with greater levels of personal accomplishment and lower levels of depersonalization (both indicative of lower levels of burnout). It is understandable that staff, who perceive themselves to be more flexible in their approaches to managing aggression, have a greater sense of personal accomplishment as their interactions with patients may feel more successful. Indeed, this more flexible approach might also enhance feelings of understanding and relating to patients, rather than becoming depersonalized to the thoughts and feelings of patients. This interpretation is consistent with the findings in hypothesis one of this study, i.e. tolerance was inversely related to rigidity. Although the instrument measuring tolerance for aggression hasn't shown the findings in relation to burnout that Whittington (2002) has previously found, the current study's findings are consistent with his in that high rigidity in managing aggression, similarly to low tolerance for aggression, is also associated with higher levels of staff burnout.

It is interesting that no relationship between rigid approaches to managing aggression and emotional exhaustion was found. This finding was not predicted and appears to suggest that a staff member's level of rigidity in their approach to managing aggression does not impact upon their level of emotional exhaustion. Perhaps this is because emotional exhaustion may be more likely to be associated with other variables such

as case load, staffing variables, self care, management and clinical support, e.g. high case loads and too few staff in the unit may be more likely to impact upon emotional exhaustion. Furthermore, perhaps personal accomplishment and depersonalization are variables that are more directly associated with level of rigidity in aggression management approaches, because they are more overtly examining patient-staff relationships.

Hypothesis 4: Type of intervention used by staff, in response to aggressive incidents, will be predicted by tolerance for aggression and rigidity in managing aggression.

The results indicated that rigidity in managing aggression contributed significantly to the prediction of the proportion of high severity intervention incidents staff were involved in. These findings showed that staff who reported being less rigid in their approaches to managing aggression were involved in more high severity incidents and less medium severity incidents. The inverse was also the case, i.e. that staff who reported being more rigid in their approaches to managing aggression were involved in fewer high severity incidents and more medium severity incidents.

This is an interesting finding that at first may seem counter-intuitive. However, a possible explanation for this finding is that staff who see themselves as having more flexible and varied approaches to managing aggression, (which, in an earlier result, was also associated with self

perceptions of greater skill), might indeed be more successful at de-escalating more medium severity incidents. This may be the case because medium severity incidents are realistically more able to be de-escalated by staff who can flexibly choose from a range of options for managing the situation. Whereas, higher severity incidents are perhaps relatively unavoidable and staff who see themselves as more flexible in managing aggression (which was, as previously mentioned, associated with self perceptions of greater skill) are perhaps more likely to volunteer to assist in these more severely aggressive incidents. That is, staff with greater skills and less rigid approaches appear to self select to care for more aggressive prone patients. Senior staff may also be more likely to appoint staff with such attributes to care for these types of patients.

In continuing this explanation the reverse must also be the case, i.e. that staff with high rigidity might be involved in a greater number of medium severity incidents because they are less capable of flexibly coming up with approaches for managing aggressive situations, and are therefore not as likely to be successful in de-escalating situations that are realistically more able to be de-escalated. It also makes sense that such staff would be less likely to volunteer to become involved in highly aggressive situations because of their tendency to be more rigid and have perceptions of less skill in managing aggression.

A further possibility is that those staff with a more rigid management style might also unintentionally trigger aggressive incidents by their rigid approach that perhaps would not have been triggered if the patient had been

dealing with a staff member with a more flexible approach. This might also explain the tendency for high rigidity to be predictive of involvement in a greater proportion of medium severity incidents than low rigidity.

To further elaborate upon the above interpretation, a closer examination of several examples from the qualitative interview data collected from staff will be examined. In one case a staff member had been involved in a reported high severity incident. The staff member's rigidity score was low. The cause of the incident could objectively be attributed to the patients extremely severe drug induced psychotic state at admission. It would be realistic to suggest that this aggressive incident had been unavoidable. In contrast another staff member had been involved in a reported medium severity incident. The staff members score on rigidity was high. The cause of the incident was objectively attributed to a conflict with the patient about their use of the ward telephone. It would be realistic to suppose that this incident might have been avoided depending upon the management approach used by the staff member. That is, a staff member with a more flexible management approach may have had more success at preventing this situation from escalating into an aggressive incident.

Interestingly this finding appears to be consistent with Ray and Subich's, (1998), finding that lower Right Wing Authoritarianism (RWA) was associated significantly with a greater number of assaults, the opposite of their hypothesis. RWA appears to be measuring a similar construct to rigidity and therefore their counter intuitive finding that low RWA was associated with a greater number of assaults might simply be the result of the analysis not being

finely tuned enough. Indeed, the present study's more detailed analysis of the data suggests that a more expected finding for Ray and Subich's, (1998) data might have been possible if they had examined their data by taking into account the level of severity of the aggressive incidents being studied. Perhaps Ray and Subich's (1998) analysis and subsequent interpretation of their findings failed to understand a subtle feature of their findings. It is possible that staff who were low in RWA were involved in the more unavoidable incidents of aggression, and of course the inverse of this proposition, that individuals who were high in RWA might have been involved in less high severity incidents but more low to medium severity incidents, those that perhaps were less likely to be accurately reported. Incident involvement in Ray and Subich's, (1998) study was measured in a relatively crude way, i.e. a self-report by participants.

Tolerance for aggression failed to have any predictive power with regard to the proportion of high severity intervention incidents staff were involved in. This finding was not expected, however was consistent with the overall findings for tolerance for aggression in this study, and might be explained in a similar manner as previously. That is, it is possible that attitudes that might suggest greater tolerance for aggression had been undervalued by the organizational culture, at the time of data collection, to the degree that staff perceptions of tolerance for aggression had no impact on the findings. Of course, an alternative explanation is that this variable is not an important predictor of aggression. Staff may be able to hold views about the complex causes of aggression without allowing these to influence their actual approaches

to managing aggression, and the inverse may also be true, i.e. that staff with limited understanding of the complex causes of aggression may still be able to respond toward aggressive patients with flexible management approaches.

Hypothesis 5: The clinician's capacity for reflective functioning (RF) will predict tolerant attitudes toward aggression, less rigid approaches to managing aggression and greater perceived clinical expertise (skill and confidence).

The results indicated that clinician RF significantly predicted two of the variables (tolerance and skill). It was predicted that staff who express attitudes of greater tolerance for aggression would also show a greater capacity to reflect on the mind of their patients. As mentioned previously, tolerant attitudes toward aggression may represent an ability to acknowledge or understand the multi faceted causes of aggression (Whittington, 2002), which has lead to the conjecture that staff who are more able to see things from their patient's point of view may express more tolerance for the many causes of aggression in their patients. RF (Fonagy et al., 1998) is the capacity to reflect upon the mental states (thoughts and feelings) of the self and others. Indeed, this finding suggests that staff with higher ratings of RF do have more tolerant attitudes. These findings also indicated that staff with a greater capacity to reflect upon the thoughts and feelings of their patients, i.e. higher ratings of RF (Fonagy et al., 1998) had greater perceived levels of skill. This is understandable in that it

would be expected that staff who are able to reflect upon the thoughts and feelings of their patients would likely believe themselves to be more skilled at managing aggression.

It was also predicted that staff who express less rigid management approaches for aggression and more confidence for dealing with aggression would also show a greater capacity to reflect on the mind of their patients. This hypothesis was not found and suggests that there is no difference in the ability to reflect upon the thoughts and feelings of patients between staff who tend to be rigid and those who tend to be more flexible in their approach to managing aggression. One explanation for this finding is the possibility that even when staff are able to reflect upon the thoughts and feelings of their patients, some staff may not be supported in allowing this reflective capacity to influence their management approach, resorting to rigid approaches that are perhaps more likely to be an accepted part of the organisational or clinical culture. This interpretation is consistent with a finding by Secker, Benson, Balfe, Lipsedge et al, (2004). In a qualitative investigation of 15 staff accounts of 11 aggressive incidents on one inpatient ward, the researchers explored violent and aggressive incidents from a systemic approach. Interestingly, the authors say that the one incident that was described by a staff member as being managed empathically, and that did not result in any of the typical aggressive incident management techniques, was later criticised in a team discussion because it had undermined another staff member who had been involved in a power struggle with the patient. This highlights the potential power of the organisational culture to

impact upon approaches that staff tend to use in managing aggression in mental health units.

Confidence also failed to predict a staff member's capacity for RF. Although this finding was not expected it appears to fit with the previous results, found for hypothesis two, that suggest that confidence is measuring an aspect of clinical expertise that is quite different from skill. Therefore, a similar interpretation for this finding can be suggested, i.e. that confidence was not predictive of an ability to reflect on the thoughts and feelings of patients because confidence is possibly more of a belief in your approach.

Limitations

Despite the importance of the findings in this study, there are limitations to what can be concluded from this work. Primarily the instruments used to measure staff attitudes and approaches were simple self report measures and can not therefore be considered to be objective, observable measures of the attitudes and approaches being explored. Future work might seek to examine objective, observable, behavioural correlates of these simple self-report measures in order to see if the findings from this more parsimonious methodology are able to be replicated and better understood. It would be informative to this area of research to understand the actual behaviours that might be representative of the constructs explored in this study, i.e. tolerance and rigidity.

In addition, the measures themselves may need a more rigorous

specification. Specifically, the tolerance and rigidity measures contain some items that tend to overlap. Therefore the problem of insufficient discriminant validity could also be producing the results found in the correlational analyses, rather than association. In saying this however, it should be acknowledged that the two instruments are not perfectly correlated and therefore do tap different constructs, and that there are inherent limitations in any instrument designed for measuring new concepts. Further, greater refinement of the rigidity scale is required, particularly in light of the important results found in this study, i.e. is rigidity the key concept being measured or would other concepts such as 'punitiveness' more appropriately represent the items in the scale.

Conclusion

The aim of this study was to add to our knowledge about staff attitudes and approaches that may increase the likelihood of an interpersonal vulnerability for experiencing aggression and violence in mental health units. Importantly, this study found that rigid approaches to managing aggression were influential. Specifically, high rigidity is correlated with low tolerance for aggression, with perceptions of low skill and higher levels of burnout (i.e. lower personal accomplishment and higher depersonalization). A critical finding was that low rigidity predicted a greater involvement in actual incidents of aggression that were classified as being of high severity. That is, incidents that would be considered less able to be verbally de-escalated and more likely to be unavoidable. An important interpretation for this finding is that staff with less

rigid approaches and with greater skill in managing aggression possibly self select to care for more aggression prone patients, and senior staff may also be more likely to appoint staff with such attributes to care for these types of patients. Indeed, the research findings suggest that staff with less rigid aggression management approaches are less likely to be involved in aggressive incidents that tend to be of low to moderate severity, i.e. those that are realistically more able to be verbally de-escalated. This has substantial implications for the problem of aggression in inpatient units, primarily because the inverse is also true. That is, this research indicated that staff with more rigid aggression management approaches are more likely to be involved in aggressive incidents that tend to be of low to moderate severity, and are therefore the type of incidents that would realistically be more able to be verbally de-escalated. The problem appears to be that staff who are high in rigidity are not as likely to be successful in de-escalating such incidents and therefore aggressive incidents are occurring that could possibly have been avoided. An even more serious implication is that staff with a more rigid approach to managing aggression might unintentionally trigger these lower severity aggressive incidents.

CHAPTER FIVE

Study Three:
The Influence of Policy on Clinician Attitudes and Approaches Concerning Aggression and Violence

Chapter 5

Study Three: The Influence of Policy on Clinician Attitudes and Approaches Concerning Aggression and Violence

The first two empirical studies in this thesis establish that particular staff attitudes and management approaches toward aggression and violence are important when exploring aggressive incidents in mental health inpatient units. This next study seeks to examine whether management plays a role in disseminating helpful or unhelpful attitudes and approaches in health settings.

5.1. Literature Review

A growing number of countries have implemented policies to address concerns about increasing levels of violence within the health sector. For example, several prominent cases of assault in the New South Wales, Australia, health care setting led to the recognition that uniform aggression and violence minimisation policy and training were a high priority for the health service. In June 2001 a NSW Health Taskforce on the Prevention and Management of Violence in the Health Workplace was formed. A policy document, titled "Zero Tolerance Policy and Framework Guidelines" (Zero Tolerance: NSW Health Response to Violence in the Public Health System Policy and Framework Guidelines, 2003), was a key outcome of this taskforce and was based on the "National Health Service Zero Tolerance Zone" materials (NHS Zero Tolerance Zone: We Don't Have To Take This. Resource Pack. London, 1999) that were

developed by the National Health Service (NHS) in the UK. The key message of the policy is that health services must establish and maintain a zero tolerance to violence culture. This message was disseminated throughout the health service via posters which include slogans such as “NSW Health is a zero tolerance zone”, “Violence and verbal abuse will not be tolerated” and icons giving visual reminders of a zero tolerance culture such as the palm of a hand in a position indicating ‘stop’.

Although zero tolerance policies have been introduced as a way of dealing with problems of aggression and violence, the actual evidence supporting such policies, as an effective approach in mental health services, is lacking. Indeed, the confidence with which zero tolerance initiatives have been implemented has been questioned (Brockmann, 2002), with attempts to understand the social context of violent and aggressive incidents being explored in the literature (Ilkiw-Lavalle and Grenyer, 2002). Furthermore, several authors have claimed that zero tolerance campaigns are unlikely to succeed without examining the broader context within which aggression and violence occur (Secker, Benson, Lipsedge, Robinson and Walker, 2004; Rew and Ferns, 2005). Moreover, some researchers suggest that a zero tolerance approach toward aggression in the health sector may be associated with increases in the use of inappropriately high intensity interventions in response to aggressive behaviour (Whittington and Higgins, 2002) and that a varied response to aggression and violence, moving beyond zero tolerance, is necessary (Paterson, Leadbetter and Miller, 2005). Recent comment on zero tolerance policy in

Australia suggests, at the very least, that zero tolerance is impractical for clinicians (Wand and Coulson, 2006) and at worst asserts that it is an "ineffective response to violence in health care settings" acting as a "convenient smoke screen" to the real issues of "resource allocation and marginalization" that governments continually fail to acknowledge (Holmes, 2006, p. 212, 222). Indeed, recently the UK zero tolerance policy, as a response to the problem of workplace violence, has been abandoned in favour of a new strategy that aims to promote safe and therapeutic services

Furthermore, Whittington has examined the concept of tolerance empirically amongst 37 mental health staff (Whittington, 2002). The Tolerance Scale (Whittington, 2002) was used to examine the extent to which an individual expresses an awareness of the possible reasons that a person may act aggressively. Results of Whittington's study indicated more experienced mental health staff reported a higher tolerance for aggression, which was also associated with lower staff burnout (Whittington, 2002). Whittington interpreted these findings to suggest a possible counter-intuitive, professional wisdom for understanding the function of aggressive behaviour within the context of mental health (Whittington, 2002).

5.2. Limitations of Previous Research and Current Research Approach

The major limitation for this area of study is the distinct lack of research on the effectiveness of zero tolerance approaches to aggression and violence in mental health inpatient settings. A unique situation provided a context for

assessing the effect of a Zero Tolerance Policy approach on staff attitudes to be explored naturalistically, through a comparative study. During the development of an aggression minimisation training program for NSW health staff, the NSW Zero Tolerance Policy, (NSW Health, 2003) was adopted and key elements were included in the training initiative. This study compares a training program that had been used to train health service staff in aggression minimisation just prior to the introduction of the new policy, with the same intervention after the zero tolerance policy was included. Both training interventions included participants from the same participant pool, i.e. from the NSW Health Service, and the same trainers trained both groups using similar training materials. Furthermore, trainers were blind to the purpose of the study and as such implemented the training in good faith, i.e. the trainers and the training were independent of the research and the researchers.

5.3. Method

(i) Training

Data was collected on two aggression minimisation training programs for health staff. Data collected for this study is independent of data collected for study 2 presented in this dissertation. Prior to training and at follow up participants completed a series of evaluations. Both training programs were manualised and were essentially modules one and two of the statewide program, (Grenyer, Ilkiw-Lavalle and Biro, 2003), before and after the zero

tolerance content was added. That is, the only difference in content between the two programs was the new zero tolerance policy information for dealing with aggression and violence in the health workplace, contained in intervention 2. Several key points found in the new training program listed as 'zero tolerance attitudes and behaviours' reveal the zero tolerance content delivered during the training. In abbreviated form these key principles are: 1. Putting up with violence is not an acceptable part of the job; 2. Know your options; 3. Management will support you, it is their responsibility; 4. Report; 5. Be aware of violence as an occupational risk; 6. Be vigilant. These key messages were delivered during training in a manner which emphasised being alert and cautious and focused on attributing responsibility for violence to others. As training intervention 1 was developed prior to the policy introduction it did not include information on the new zero tolerance approach. Training duration was two days and the programs were identical in terms of trainers and target audience. Participants each attended only one of the training courses. Training occurred over a period of 6 months in regional areas of NSW and 15 - 25 participants were trained in each session.

(ii) Participants

117 health staff completed training evaluations. 57 staff were trained with intervention 1 and 60 staff were trained with intervention 2. Participants provided written informed consent to allow the training program data to be used

for research evaluation.

(iii) Data collection instruments

Four instruments were completed by the participants:

a) Rigid Approaches Toward the Management of Aggression (IPP Rigidity Scale)

Pre and post measures of health staff rigidity toward the management of aggression were obtained using a specifically designed self report instrument (Appendix B; Grenyer, 2003), as described in Chapter 4.

b) Tolerance for Aggression

Pre and post measures of health staff tolerance for aggression were obtained using the Tolerance Scale (Appendix C; Whittington, 2002), as described in Chapter 4.

c) Confidence in Dealing with Aggression

Pre and post measures of health staff confidence were obtained using the Confidence in Coping with Patient Aggression Instrument (Appendix D; Thackrey, 1987), as described in Chapter 4.

d) Skill in Dealing with Aggression Scale (IPP Skill Scale)

Pre and post measures of health staff skill in dealing with aggression

were obtained using a specifically designed 10 item self-report instrument, (Appendix E; Grenyer, 2003), as described in Chapter 4.

(iv) Statistical analysis and data handling procedures

First, independent samples t tests and chi square analyses were carried out on the sample to test for any pre training differences between the groups. Second, t tests were carried out to examine within group differences from pre to post training on rigidity, tolerance, confidence and skills for each training intervention. Finally, an ANCOVA was carried out to examine post training differences between the training groups on rigidity, tolerance, confidence and skills, (controlling for pre training scores). In all analyses, the criterion for statistical significance was set at $p < .05$.

5.4. Results

There were no significant differences between the groups with regard to age (38 years vs. 41 years; $t = -1.70$, $p = .09$), sex (63% vs. 68% female; $X^2 = .35$, $p = .56$) or occupation (54% vs. 47% nursing; $X^2 = .56$, $p = .46$). Half the sample from each group had a nursing background with the rest comprising allied and support staff (e.g. psychiatry, allied health, and security). Prior to training the two groups did not differ with regard to rigid attitudes toward the management of aggression ($N = 117$, $df = 1$, $t = .02$, $p = .99$), tolerance for aggression ($N = 117$, $df = 1$, $t = 1.17$, $p = .24$), confidence in managing

aggression (N = 117, df = 1, t = -1.20, p = .23) or skills for dealing with aggression (N = 117, df = 1, t = -1.10, p = .27). Figure 4 reports the baseline and post-training means and standard error scores for each group on the four attitude and skill scales.

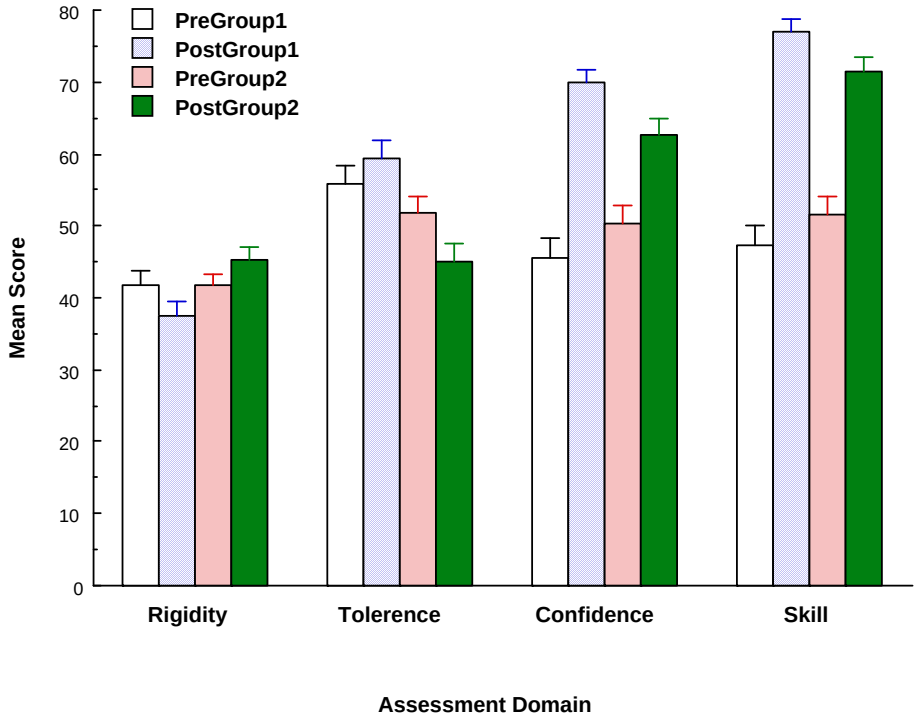

Figure 4. Pre and post mean scores and standard error bars for each aggression minimisation training intervention (Group1 = pre-zero tolerance training and Group 2 = includes zero-tolerance training) on the staff variables of interest (staff rigidity, tolerance, confidence and skill in managing aggression)

Analysing the groups separately, both interventions were effective in increasing confidence and skills for dealing with aggression ($p<.05$). However, intervention 1 significantly decreased rigid attitudes toward the management of aggression whilst intervention 2 significantly increased rigid attitudes toward the management of aggression and decreased tolerance for aggression. In order to assess the significance of these findings, an ANCOVA analysis controlling for initial scores was computed between groups. When controlling for initial scores there were significant differences between the groups post training on confidence (69.89 vs. 62.62, N= 117, df = 1, F = 16.48, p = .00), skills (76.95 vs. 71.55, N = 117, df = 1, F = 8.55, p = .00), rigid attitudes (37.28 vs. 45.28, N = 117, df = 1, F = 12.81, p = .00) and tolerance (59.33 vs. 45.13, N = 117, df = 1, F = 19.74, p = .00). Overall, after training, group 2 were significantly more rigid, less tolerant, less confident and less skilled than group 1.

5.5. Discussion

This study found that training in zero tolerance had the unintended consequence of increasing rigid or inflexible attitudes toward the management of aggression in the health workplace, while reducing tolerance toward aggression. In light of previous research findings indicating that: 1) health staff with more experience tend to have a more tolerant attitude toward aggression and, 2) that higher tolerance for aggression is associated with less staff burnout, this study's results suggest problems with a zero tolerance policy approach to

aggression management.

It is of interest that intervention 2 did not increase confidence and skills to the same degree as intervention 1. Possibly these variables were impacted upon by the increase in rigid attitudes that intervention 2 appeared to generate. Perhaps being more rigid and less tolerant leads to a perception of lower confidence and skill when responding, i.e. reduces perceived options and confidence in handling violent incidents. Zero tolerance implies that staff should be fearful of all aggression, which might engender a more negative perception of the helpful role.

The results of this study support other findings that have identified confusion in the zero tolerance message (Grenyer, Ilkiw-Lavalle, Biro, Middleby-Clements et al., 2004). Pilot testing of an aggression minimisation training program that was based on the new NSW policy indicated that zero tolerance was interpreted by participants as implying an attitude of withdrawal and punishment toward any individual exhibiting aggressive behaviour, when in fact the intended meaning of the zero tolerance policy was that all instances of aggression and violence should be taken seriously rather than treated simply as 'part of the job' (Grenyer et al., 2004). It seems possible that the salience of the terms ‘zero tolerance’ and ‘elimination of violence’ may confuse the actual definitions put forward in the policy such that the practical interpretation of the policy may be quite different to its intended meaning.

Limitations

This study was unique in that a rare opportunity provided a naturalistic context for exploring the impact of a zero tolerance policy, in relation to aggression and violence, on health staff attitudes. Despite the methodological advantages of this study, it is possible that subtle differences in the training interventions could have impacted upon the findings in a way that was difficult to identify. If this was the case there may have been factors other than the zero tolerance policy approach that brought about the attitudinal differences between the training groups. Furthermore, as the training groups were separated by geographical areas within the state, unknown factors specific to the area might also have been partially responsible for the findings. Nevertheless, these results suggest that a zero tolerance focused training initiative may negatively impact upon staff attitudes for dealing with aggression in the health workplace. Future research, such as staff and patient interviews and/or focus groups, might add to these findings in relation to the impact of zero tolerance approaches to the management of aggression and violence.

Conclusion

Whittington and Higgins, (2002), suggested that government policy that promotes an attitude of zero tolerance may encourage practitioners to assume that any aggressive behaviour by a patient is inappropriate, resulting in the use of immediate, high intensity interventions that may not match the appropriate level of intensity of the aggressive behaviour. In light of this possibility future

work should seek to clarify and expand on the important results found in this study. It is undesirable that the introduction of a zero tolerance policy toward aggression and violence might impact negatively on staff attitudes for dealing with aggression, as this may counteract its original intention of reducing aggression and violence in the health workplace. As mentioned earlier the introduction of this policy in New South Wales, Australia, was the result of a taskforce that was set up after several prominent cases of assault in the health care setting. Importantly, concerns have been raised about the influence of media focus on associating violence with mental illness, because of the potential for reinforcing stereotypes that subsequently lead to the adoption of populist policies, (Paterson, 2006) such as 'zero tolerance', that may be ineffectual in achieving their goals.

In the UK National Health Service the recording of incidents between the period 1999 to 2003 indicated a 70% increase in recorded violent incidents (Paterson, 2007). Obviously the reasons for this increase were complex and include, among others, a greater focus on reporting. However Paterson (2007) suggests that this increase is perhaps indicative of the failure of the zero tolerance policy to reduce aggression and violence in these settings. Paterson (2007) suggests several reasons for this, including: the counter productive language of "zero tolerance", i.e. implying a punitive approach to dealing with aggression and violence; a focus on the management of aggression rather than its prevention; and a tendency to individualise the problem, for example an emphasis on training for direct care staff rather than considering how to change

the broader culture. Indeed, it has been suggested that training must be part of a much broader organisational response if it is to be effective at all (McKenna and Paterson, 2006). Indeed, the relatively new strategy emphasizing safe and therapeutic services that has replaced zero tolerance in the UK, highlights that the causes of violence within mental health services are complex and can be caused by a range of factors and attempts to address some of these wider issues, training being only one aspect of a new, broader strategy.

CHAPTER SIX

Conclusion

Chapter 6

Conclusion

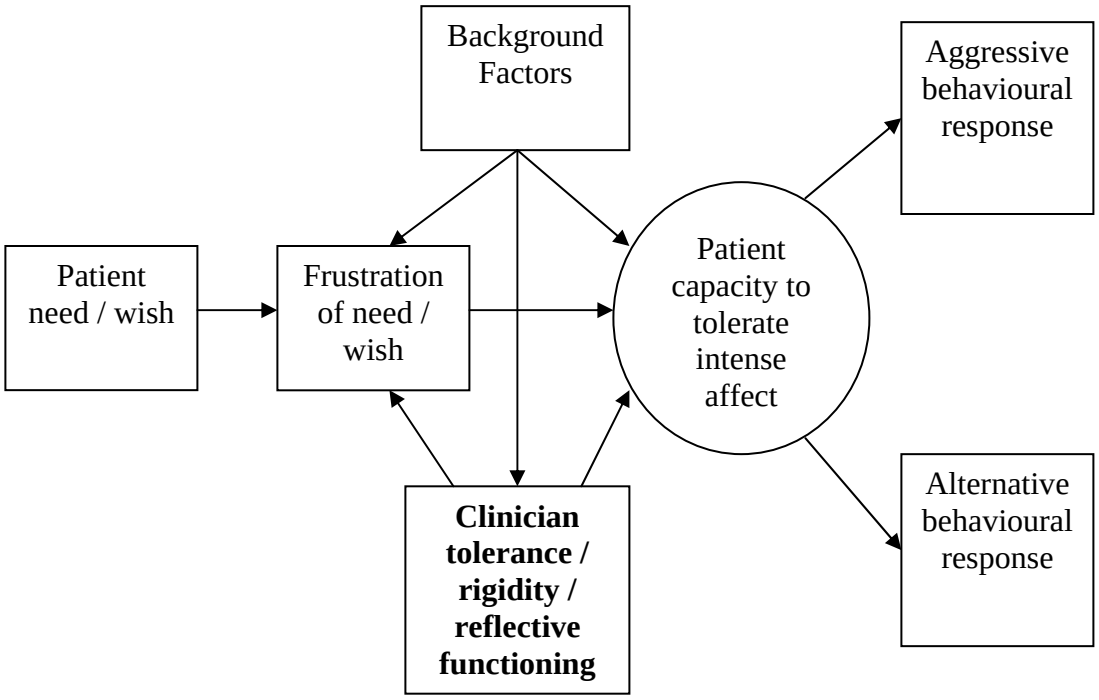

*Figure 1***.** Interpersonal model of aggression and violence in mental health inpatient units (adjusted to highlight new findings)

Responses to managing the problem of aggression and violence in mental health units, whether a focus on guidelines, policies or training, require a theoretical underpinning. There are a small number of theoretical models

specifically aimed at understanding aggression and violence in mental health units (Whittington and Wykes, 1994a; Nijman, 2002). These models are helpful and inclusive of a range of factors that contribute to the problem. However, it has been recommended that a shift is necessary from a relatively descriptive method of looking at aggression and violence in mental health to a more explanatory understanding of the underlying influences upon violence and mental health (Blumenthal and Lavender, 2000; Whittington and Richter, 2005). This dissertation has sought to fulfill this task by engaging in an analysis of the problem of aggression and violence in mental health units that takes into consideration multiple perspectives including: the socio-political context that health care systems work within; individual risk factors within the aggressor and; dynamic theories that address core issues of impulse control and the mentalising or reflective capacity of individuals, that may impact upon their interpersonal functioning. In doing so this research makes an important contribution to the area by encompassing both theoretical and empirical approaches to examining the problem of aggression and violence in mental health units. Chapter one introduced the problem of aggression in mental health units and explored responses to this problem. The development of a model of aggression and violence specific to mental health units was the focus of chapter two. Chapters three, four and five introduced, described and discussed three original empirical studies that contribute to an understanding of aggression and violence in mental health settings.

Broadly, study one explored patient perspectives on staff attitudes or

approaches that patients believe may fuel aggressive incidents in mental health inpatient settings. The findings suggested that patients experience interpersonal and interactional factors as highly salient contributors to their aggressive responses, however patients also identified internal and background factors as contributing to aggression. These findings lend support to the interpersonal model presented in chapter two, in particular highlighting the dynamic interaction between a patient's level of internal impulse control and the responses and approaches by staff that can act to either increase or decrease a patient's tendency to respond aggressively. Furthermore, the results of this study suggested that there are common, identifiable approaches used by staff that appear to be problematic for patients in these settings. Specifically, within the interpersonal and interactional domain, patients identified staff approaches that indicate: 1) a disregard for, or lack of respect of patients; 2) inadequate, inappropriate, inconsistent clinical care; and 3) problems with individual needs not being adequately addressed, as being most likely to contribute to aggressive incidents in mental health inpatient settings.

Following on from this exploratory study of patient perspectives, study two added to our knowledge about specific staff attitudes and approaches that may increase the likelihood of an interpersonal vulnerability for experiencing aggression and violence in mental health units. Study two found that clinician rigidity in managing aggression was an important variable in relation to an individuals increased vulnerability for experiencing aggression in mental health inpatient units. Specifically, high rigidity is correlated with low tolerance for

aggression, with perceptions of low skill and higher levels of burnout (i.e. lower personal accomplishment and higher depersonalization). A critical finding was that low rigidity predicted a greater involvement in actual incidents of aggression that were classified as being of high severity. That is, incidents that would be considered less able to be verbally de-escalated and more likely to be unavoidable. An important interpretation for this finding is that staff with less rigid approaches and with greater skill in managing aggression possibly self select to care for more aggression prone patients, and senior staff may also be more likely to appoint staff with such attributes to care for these types of patients. Indeed, the research findings suggest that staff with less rigid aggression management approaches are less likely to be involved in aggressive incidents that tend to be of low to moderate severity, i.e. those that are realistically more able to be verbally de-escalated. This has substantial implications for the problem of aggression in inpatient units primarily because the inverse is also true. That is, this research indicated that staff with more rigid aggression management approaches are more likely to be involved in aggressive incidents that tend to be of low to moderate severity, and are therefore the type of incidents that would realistically be more able to be verbally de-escalated. The problem appears to be that staff who are high in rigidity are not as likely to be successful in de-escalating such incidents and therefore aggressive incidents are occurring that could possibly have been avoided. An even more serious implication is that staff with a more rigid approach to managing aggression might unintentionally trigger aggressive

incidents.

The first two empirical studies in this thesis established that particular staff attitudes and management approaches toward aggression and violence are important when exploring aggressive incidents in mental health inpatient units. The third study then examined whether management plays a role in disseminating helpful or unhelpful attitudes and approaches in health settings. This study found that training in zero tolerance had the unintended consequence of increasing rigid or inflexible attitudes toward the management of aggression in the health workplace, while reducing tolerance toward aggression. In light of the findings presented in study two this is highly problematic with regards to the negative impact that such policy initiatives may have on heath staff approaches and attitudes. More importantly the ultimate consequences of these unhelpful attitudes being disseminated throughout mental health units may indeed be to increase the possibility of aggression rather than the intended decrease.

The theoretical work and empirical studies reported within this dissertation are unique and offer a significant contribution to this field of research. Primarily, the development of an interpersonal model for aggression that is specific to inpatient mental health settings is important in that the model is inclusive of a range of factors, some that have repeatedly been found to contribute to aggression, in addition to several factors that have tended to be neglected in the empirical literature. The model includes the underlying motivational factors that influence ‘normal’ human aggression, and applies this

knowledge specifically to understanding aggression and violence in mental health settings. This model acknowledges the impact of the individual patient's level of impulse control as a crucial element in the development of an aggressive or alternative behavioural response. However, importantly the model overtly proposes that staff attitudes and approaches are crucial contributors to the fuelling or minimising of aggressive patient responses. Finally, this model is comprehensive in that it acknowledges background factors, such as the organisational context and the even broader socio-political systems within which mental health units operate, and suggests that these contexts and systems impact upon staff and patient dynamics in such settings. The research reported in study three emphasises this point, in that management philosophy impacts on staff attitudes in a way that goes against the intended purpose of the philosophy. In addition, this is the first piece of research to use an instrument that seeks to measure metacognition (Reflective Functioning Scale, Fonagy et al., 1998) to assess staff appraisals of aggressive incidents. In doing so this research has attempted to deepen our understanding of the self – report instruments that are often used when seeking to understand staff attitudes. Similarly, this study has devised a new scale for measuring rigid staff attitudes and this scale has proved to be of empirical use in differentiating between individuals actual behavioural responses to aggression. Indeed, this research examined actual reported incidents of aggression and differentiated between levels of severity, a fine grained analysis that is not typical in this research area. As a result of this more detailed investigation, this research has found statistically significant findings

that are counterintuitive and as such have important implications for practise, as highlighted previously in this conclusion. Finally, this research has found that management plays an important role in disseminating helpful versus unhelpful attitudes to staff.

Together these studies have substantial implications for management direction and clinician practice in mental health settings. Whittington, (2002), has suggested that an intolerant attitude toward aggression may represent an inability to acknowledge or understand the multi faceted causes of aggression. Similarly, rigid approaches toward the management of aggression may limit the flexible responses necessary for effectively dealing with aggression in mental health units. Such approaches may act as additional stressors for patients with a limited capacity to tolerate intense affect (low impulse control). In contrast, more flexible management approaches, may enhance the therapeutic relationship between clinicians and patients. That is to say, by helping patients to feel understood and respected as individuals, encounters that are typically felt to be stressful by patients may be reduced.

Furthermore, the findings of this research imply that reductions in aggressive incidents may require significant improvements in clinician practise rather than just a focus upon patient factors as contributing to aggression. It is informative that as early as 1990 research by Katz and Kirkland found that where clinicians were supported to become more aware of their own therapeutic approaches with patients, aggression and violence were less prevalent. The above recommendations are, of course, not new, however require restatement.

That is, an effective and practical manner of assisting mental health unit clinicians to enhance their ability to understand their patients would be to provide opportunities for staff to engage in reflective practice / supervision on a regular basis. This would assist staff to work toward understanding the internal world of their patients, in addition to exploring their own thoughts and feelings that are inevitably aroused when working with acute mental health patients. If this practice were more common in mental health units one would expect an enhancement of clinician reflective functioning (RF). In addition, perhaps greater emphasis on concepts such as RF and, more broadly, ideas about emotional intelligence should be considered during the recruitment of clinicians working in mental health inpatient wards.

However, as proposed throughout this dissertation the organizational culture that dominates in any particular mental health unit may be an overriding factor to a clinician's capacity for RF, i.e. the unit culture may be a greater determinant of actual clinician behaviour than their capacity for reflective practice. Fostering clinician approaches that emphasise reflection and flexibility rather then rigidity is only realistically attainable if management provides the support for clinicians to reflect upon and understand their patients as human beings, with normal needs and wishes. To be of assistance the management culture in the unit needs to foster clinicians who put into practice developing therapeutic rapport with their patients through working at understanding their patient's internal world (i.e. thoughts, feelings, wishes). Perhaps training senior management about the importance of therapeutic rapport between patients and

staff, and consequently the necessary structures that are required to support clinicians to develop these capacities, are more important than excessive amounts of training offered to direct care staff. In sum, this research has provided further empirical evidence to inform the practical directions that are required to lower aggression and violence in mental health units.

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Appendix A

Code No. _ _ _ _

Patient Interview

MRN Date:
Age: Incident No.
Gender: M / F
Ward:
Admission Date:
Diagnosis:

"We are currently looking at aggressive incidents and are interested in your views on the causes of these incidents, how they can be minimized and your views on how the staff are managing these incidents. This interview gives you the opportunity to have your say and assist us in looking at ways aggression can be reduced and managed better. I'd like you to be aware that you are free to withdraw from the interview at any time. Your responses in this interview will in no way affect your treatment or relationship with staff and will be used only for the purposes of this research."

1. While in hospital you've been involved in some aggressive situations…how well do you think staff managed these situations?

_____

_____

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2. Do you have any suggestions for how these kinds of situations could be reduced in the future?

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3. Do you have any suggestions for how staff could respond in a better more helpful way during these situations?

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4. Can you recall any of these situations in particular?

5. If yes…what happened

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6. What do you think caused this situation?

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7. Can you recall feeling any pain during the staffs management of this situation?

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8. Did a staff member speak with you about the situation afterwards?

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“Thankyou for participating”

Appendix B

Ways of Dealing with Aggression (Grenyer, 2003)

Please see print copy for Appendix B

Continued.....Please see print copy for Appendix B

Appendix C

Aggression as an emotion (Whittington, 2002)

Please see print copy for Appendix C

Continued.....Please see print copy for Appendix C

Appendix D

Confidence in Coping with Aggression (Thackrey, 1987)

Please see print copy for Appendix D

Continued.....Please see print copy for Appendix D

Appendix E

Current Aggression Skills (Grenyer, 2003)

Please see print copy for Appendix E

Continued.....Please see print copy for Appendix E

Appendix F

Please see print copy for Appendix F (pages 202-206)

Appendix G

Code No. _ _ _ _

Staff Interview

"We are currently looking at aggressive incidents and are interested in your views on the aggressive incident you have recently experienced. This is your opportunity to have your say on the causes and the ways in which aggressive incidents can be minimised as well as your perceptions on the aggression management training and its effectiveness in managing these incidents. This is your opportunity to have your say. You will not be identified by your responses in any way and nor will your responses affect your position, or your relationship with other staff and management. Your responses will be used only for the purposes of this research."

1. Can you describe the incident in your own words? (what was said, what occurred)

2. What do you see as the triggers and factors contributing to the incident?

3. How did you feel after the incident?

4. How do you think the patient felt after the incident?

5. Prior to this incident are you aware of any discussion with the patient about their potential aggression triggers? (describe)

6. Was the patient known to be at risk of aggression?

7. Please rate how fearful you were during the incident:
   1. Had no emotional effect

2. Created low grade fear/anxiety
3. Created moderate fear/anxiety
4. Created high fear/anxiety
5. Created extreme fear/anxiety

8. Are you aware of any complaints of pain from the patient in regards this incident?

9. Have you talked to anyone about the incident and what form did it take?

□ Talk to colleague

□ Talk to Peer Supporter (A peer trained in the knowledge of acute stress reaction and in defusing)

□ Defusing (An informal session conducted by a peer support person. Involves the sharing and validation of emotions and reactions. Generally occurs within 10 hours of an incident)

□ Operational Peer Review (Held by the most senior nurse and investigates the when, how, what and who did of an incident. Emotions are not discussed)

□ Debriefing (A formal structured process that occurs generally 24-72 hours after the critical incident. The aim is to help the person to understand and manage their reactions thereby accelerating a normal recovery)

□ EAP/External counselling

□ Talking to a friend or family member

□ Other

10. Do you have any suggestions for how these kind of incidents could be minimised in the future?

11. How would you rate the overall management by this unit in these circumstances?

Room for improvement 1 2 3 4 5 6 7 8 9 10 Perfectly managed

Any comments?

Now I'd like to ask you a few questions about our staff aggression management

training in order to see what is done well and what could be improved".

12. Have you participated in an aggression management program?
    YES / NO

    If yes type and when:

If no how have you learned to deal with these incidents?

13. Have you been able to incorporate any of the information and skills gained from the aggression management program attended?

14. Were there any things you learned in the program that you were able to apply to this incident?

15. Do you have any suggestions for how the aggression management training could be improved?

"Now I'd like to check a few personal details to complete the research. This information will not be used to identify you but will assist in reporting the results"

Gender: M/F
Current Age:

Date:
Incident No.:

Position:
No. of years working in the psychiatric field:

"Thankyou for participating"

Candidate's publications and presentations relevant to doctoral thesis

1. Refereed Journal Articles

Middleby-Clements, J.L., and Grenyer, B.F.S. (2007). Zero tolerance approach to aggression and its impact upon mental health staff attitudes. *Australian and New Zealand Journal of Psychiatry*, 41, 187–191.

Grenyer, B.F.S., Ilkiw-Lavalle, O., Biro, P., Middleby-Clements, J., Comninos, A., and Coleman, M. (2004). Safer at work: Development and evaluation of an aggression minimisation training program for health staff. *Australian and New Zealand Journal of Psychiatry*, 38, 804-810.

2. Books

Middleby-Clements, J.L., Biro, P., Grenyer, B.F.S., and Ilkiw-Lavalle, O. (2004). *The Interpersonal Protect Program (IPP).* Wollongong: Illawarra Institute for Mental Health and Illawarra Mental Health Services, University of Wollongong.

3. Conference Papers

Middleby-Clements, J.L., Grenyer, B.F.S., Biro, P. & Ilkiw-Lavalle, O. (2006, December). Interpersonal Protect Program: An aggression minimisation approach. Achievements in Mental Health Research Conference, Wollongong.

Middleby-Clements, J.L. & Grenyer, B.F.S. (2006, June). Capacity to tolerate and flexibly manage aggression in acutely unwell patients: a marker of clinician skill, confidence, burnout and reflective functioning. Society for Psychotherapy Research Conference, Edinburgh, Scotland.

Middleby-Clements, J.L., Grenyer, B.F.S., Biro, P., Ilkiw-Lavalle, O. (2005, August). Area-wide Aggression and Violence Minimisation Project – IPP. Illawarra Mental Health Nurses conference, Wollongong.