Healthcare Professionals' Sense-making of Workplace Violence in Psychiatric Inpatient Settings

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Submitted to the University of Hertfordshire in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology

July 2025

Word Count: 31,298

Acknowledgements

Firstly, I would like to thank Maeve, Hassan, Kleo, Sarah, Sana, Eren, and Obinze. This study would not be possible without you. Thank you for your time, energy, and reflections. I would also like to thank Emma K, my research supervisor, for her tireless efforts and complementary supervision style. Thank you too for Rebecca, particularly for the help with recruitment, and thanks to Shaniah – Sorry I made you screen so many articles!

Thanks also go to my Mum, Dad, and Sister Ellie. Only one more graduation to go – hopefully I'll get to see you more now that this is done! To my Auntie Mandy, and to my Cousin Danni, who have all helped in their own way.

Special thanks to Natasha, Jamie, Seth, Ikraam, Yoni, Becca, and Georgia for everything over the last three years. We moaned, lost our minds, celebrated, and survived together. Lunches won't ever quite be the same without you all.

Thank you to Emma M, who sacrificed a lot throughout this whole process and supported me the most. Thanks also to Sheeva for helping me get on this wild ride in the first place. Thank you Sam, Robyn, Beth, Luke, Fish, and Clarkey for all the support and belief in me over the last three years. Elena you were a great support too and sorry you've still got another year to go!

This thesis is dedicated to three people. Firstly, to Fran – It was you who inspired me to apply one last time. You never got to finish your course, so I'll finish this one for you. Secondly, to Barry Kemp, my Gramp, who is still the kindest and best man I know, and lastly, to my Nan, Jenny Kemp. You won't get to read this, and you won't see me become Dr Kemp, but I know you would be proud!

Abstract

Violence in mental health inpatient settings affects the safety and psychological well-being of both patients and staff. Research has often focused on incidence and prevention, with less attention to how staff make sense of such experiences. This study explored how healthcare professionals understand and interpret violent incidents within inpatient settings and examined the sense-making processes that shape their emotional responses, coping strategies, and clinical decision-making. In addition, a systematic literature review was conducted to synthesise existing research on how patients, carers, and the public perceive violence in psychiatric inpatient settings, providing important context for the present empirical exploration of staff perspectives. Using a qualitative design, semi-structured interviews were conducted with seven healthcare professionals with experience of violence in mental health inpatient settings. Data were analysed using Interpretative Phenomenological Analysis to explore lived experiences and sense-making. Four key themes were identified: (1) coping, surviving, and the normalisation of violence; (2) navigating organisational failure and institutional betrayal; (3) the emotional and moral weight of violence; and (4) violence as a complex and relational communication. These findings highlight the emotionally and ethically complex processes through which staff attempt to make sense of violence, and suggest potential areas for further inquiry. Participants' accounts may point to a need to reconsider conventional definitions of violence, to include racial and more subtle forms, and to question models that locate the cause of violence solely within individual psychopathology. The findings tentatively indicate that trauma-informed approaches, reflective practice, and psychologically informed team formulations, may offer valuable avenues for supporting staff. Clinical psychologists, given their roles in leadership and supervision, may be well-placed to contribute. These exploratory findings raise important questions about how inpatient services might begin to address systemic contributors to violence, including staff burnout, institutional culture, and relational breakdowns, to promote safer and more compassionate care environments.

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1 Introduction

The NHS, as one of the largest employers in the world, has a duty to safeguard its staff members from violence (Armstrong, 2022). Just under 83,000 NHS staff members experienced at least one incident of physical violence in the last 12 months, according to the NHS staff survey (NHS England, 2023). Workplace violence within a healthcare setting is a recognised and increasing global issue (Ayres et al., 2022). Within the NHS, the almost 14% of staff members reporting physical violence is lower than the global average of 24% (Liu et al., 2019), with the figure being significantly higher for those working in mental health (MH) settings, of which 51% of staff reported physical violence. Across Europe, MH nursing has the greatest risk of workplace violence compared to general workers, other healthcare professionals (HCPs), and other nurses (Camerino et al., 2008). This is also true within the NHS (NHS England, 2023).

Undoubtedly, increased rates of violence have an impact on staff wellbeing. Nurses working in MH settings are at a high risk of being assaulted, with the lifetime risk approaching 100% (Bowers et al., 2011). There is a clear link between experiencing physical violence and impaired well-being (Edward et al., 2014). The impact that violence has on therapeutic relationships (Phillips, 2016a) as well as the impact on absenteeism and recruitment (Adams et al., 2021) harms service delivery and patient care. A culture of patient safety is associated with lower instances of workplace violence (Kim et al., 2023).

The frequency of these incidents is well established (NHS England, 2023), as well as discussion around the perspective of patients and staff on the causes of violence (Berzins et al., 2020; Bowers et al., 2011; Jansen et al., 2005). I am interested more specifically in how HCPs make sense of these incidents, to be best placed to support them from a psychological standpoint. This is a key role of Clinical Psychologists (CPs) within MH inpatient settings (Association of Clinical Psychologists, 2021).

In this introduction, I first position my research within its context and epistemological stance. I then define and justify the use of relevant terms, situating this within the literature. I provide relevant literature on the topic in question. I report on a systematic literature review (SLR) exploring views of patients, carers, and the public on violence in a healthcare setting. I examine models of sense-making and how these might relate to HCPs' experiences of violence. Finally, I introduce my research question and the objectives of the study, which focuses on exploring how HCPs make sense of patient violence within psychiatric inpatient services.

1.1 Personal and Philosophical Position

My identity and my role as an insider researcher have undoubtedly influenced the construction of this research. As such, I have used the first-person throughout this thesis. I have worked within MH inpatient services, and I have been verbally and physically abused, as well as witnessed the verbal and physical abuse of my colleagues. I am a white-British man from a working-class background. I work towards promoting anti-racism and trans-inclusivity, and these values form the foundation of my data analysis. I will attempt to observe these interactions.

A critical realist position has been used throughout this research. Within the literature, there are multiple perspectives around violence in psychiatric settings, which might suggest a relativist position. However, there are objective realities concerning violence and aggression, suggesting a realist position. Most constructivist research already employs critical realism, so this is in line with other qualitative research (Willig, 2016). A critical realist approach helps to demonstrate the subjective nature of experience and the commonalities within that experience that provide an idea of what reality may be like (Grace & Priest, 2015).

1.2 Terminology

1.2.1 Violence and Workplace Violence

Violence has many definitions, and I will use the following definition of interpersonal violence:

> "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." (World Health Organization, 2024)

This definition is also used within the NHS (NHS England, 2022). Furthermore, to add additional detail and clarity, the definition of workplace violence used is the following:

> "Any incidents of aggression that are physical, verbal or emotional that occurs when healthcare professionals are abused, threatened, or assaulted in circumstances related to their work." (Health and Safety Executive, HSE, 2024).

Definitions of violence are complex, and people have different definitions (Stevenson et al., 2015). Verbal violence is considered so common within healthcare workplaces that it is not conceived as a form of violence. Verbal violence is vastly under-reported in the healthcare sector (Findorff et al., 2005; Gillespie et al., 2016). As such, more emphasis will be placed on physical violence throughout this thesis when compared to verbal violence. I will use the term violence to refer to interpersonal violence and aggression throughout this thesis.

1.2.2 Use of the Term "Patient"

The term "patient" may not suit everyone, and I appreciate the challenge in terminology between the most popular terms: patient, client, and service user. Several studies have highlighted that when compared to service user or client, that the term patient

is frequently cited as the preferred term of patients themselves (Costa et al., 2019; Mcguire-Snieckus et al., 2003; Priebe, 2021; Simmons et al., 2010). Hence, this study will use the term patient to describe any person using health services, including MH. Moreover, within an inpatient context, I believe the term patient is accurate in terms of power, autonomy, and the medicalised setting.

1.3 Prevalence of Violence

According to the 2023 NHS Staff Survey, 27.5% of respondents reported experiencing at least one incident of harassment, bullying, or abuse from patients, patients' relatives, or members of the public within the previous year. Additionally, 14.3% reported having experienced at least one incident of physical violence during the same period (NHS England, 2023). The healthcare sector is at particular risk of workplace violence (Cooper & Swanson, 2002; Phillips, 2016a; Sun et al., 2017) and all forms of violence are under-reported for different reasons, including stigma of victimisation (shame, isolation, fear) and threat of further violence (Clements et al., 2005). The Department of Health and Social Care (2023) have outlined their commitment to continued work on reducing violence.

Violence occurs so frequently it is often seen as "part of the job" (Kennedy, 2005) and this further increases the risk of desensitisation. Across Europe, similar prevalences of violence are seen. The European Working Conditions Survey (Eurofound, 2012) showed that 23% of health-care staff had reported high levels of subjection to adverse social behaviour across 34 European countries. The most frequent verbal violence experienced is shouting, insults, manipulation, offences, and threats. The most frequent forms of physical violence is violence towards objects, grabbing, self-aggression, slaps, and spitting (Bizzarri et al., 2020).

1.3.1 Prevalence of Violence in Mental Health Settings

The highest risk for experiencing violence is for HCPs working within MH wards (Grottoli et al., 2007; Iozzino et al., 2015; McIlroy & Maynard, 2022). Staff in a MH setting are over seven times more likely to be assaulted than other staff (Health Service Journal & Unison, 2018). Vacancy rates in England for MH nurses (16.5%) are higher than the general nursing (10%) vacancy gap (NHS Digital, 2022b). This leaves services running with fewer staff than required or an increased use of agency or bank staff, unfamiliar with the service and patients (Curran, 2023). There is an established link between staff shortages and increases in incidents of violence from patients against staff (Bellman et al., 2022). Violence is so common in MH inpatient services that it is seen as normal by staff (Lim et al., 2023). A qualitative study exploring nurses' experience of the high rates of patient violence seen in psychiatric settings found that nurses report experiencing physical, emotional, and verbal violence (Stevenson et al., 2015) and that violence is considered a part of the job. The study explored the conflict between the duty of care and the duty to self when providing care following a violent incident. Issues of power, control, and stigma all influence perceptions and responses to violence.

1.4 Contexts

1.4.1 The Global Context

The topic of violent incidents and their importance to inpatient MH nursing is well recognised, albeit mainly focused on prevalence (Bowers et al., 1999). The awareness and profile of the issue in different European countries is highly variable. Bowers et al. (1999) compared five European countries: Italy, Norway, the Netherlands, Sweden, and the UK, and found that contextual factors are likely to determine the perception, recognition, and acknowledgement of the problem. These included the organisation of services, the training of nurses, and the methods used to control and contain patients. They found the incidents of

violence mirror the levels of serious violence seen across the country. Furthermore, the variation within a country can also be as extreme as the variation between countries.

Most studies on violence were conducted among nurses and found the highest rate in psychiatric services. This is true across the globe, including European (Franz et al., 2010; Fröhlich et al., 2018; Gascón et al., 2009; Merecz et al., 2006; Schablon et al., 2012, 2018), North American (Moylan & Cullinan, 2011; Ridenour et al., 2015), Australian (McKinnon & Cross, 2008), African (James et al., 2011), Chinese (Zeng et al., 2013), and Taiwanese (Chen et al., 2008, 2009) studies. The high variability across these studies on verbal violence (51-100%) and physical violence (11-71%) is perhaps due to differences in the country or setting studied, and assessment tool differences (Bizzarri et al., 2020). Within psychiatric wards, more specifically, episodes were seen more frequently than in physical health in the US (Davis, 1991), with similar prevalences seen in Italy (7.5%; Grassi et al., 2001) and Germany (7.7%; Ketelsen et al., 2007). Similar prevalences of between 11.3% and 15% are seen in Switzerland, Australia, and New Zealand respectively (Carr et al., 2008; El-Badri & Mellsop, 2006; Gale et al., 2002). Interestingly, rates are lower in Bahrain, 4.4% (Hamadeh et al., 2003), although this could be due to reporting not being mandatory at the time.

1.4.2 Legal contexts

Staff in NHS workplaces are protected by standard UK health and safety legislation (HSE 2024). There are additional protections from assaults with the Emergency Workers Act (UK Parliament, 2018). Punishment includes an unlimited fine and 12 months imprisonment, compared to six months for common assault. However, for inpatient MH staff, the legal context is more complex, as described below

1.4.3 NHS Standards and Guidelines on Violence

Improvements to NHS inpatient ward environments are a key priority in the NHS Long Term Plan (NHS, 2019). In the context of relational security and violence prevention within ward environments (Allen, 2015), specific guidance on adult acute MH unit design highlights the roles of relational, procedural, and physical security (NHS England, 2013). This includes natural light, colour, space, ventilation, temperature control, artwork, noise levels, external areas, and smoking. The use of physical measures such as locked wards has continued to be part of ward security arrangements (Allen, 2015). Relational security principles outline the prevention of violence through the ward environment: privacy, quiet and relaxed areas to socialise, good lines of sight, places staff can intervene therapeutically, agreed rules for living together, and regular access to fresh air (Allen, 2015). A randomised control trial found a 15% reduction in conflict events and a reduction of restrictive practice of over 25% in 30 NHS inpatient MH wards when these aspects were considered (Bowers et al., 2015).

The NHS Violence Prevention and Reduction Standard (VPRS; NHS England, 2021) outlines a risk assessment framework focusing on Trusts' responsibilities to commit adequate resources for preventing and reducing violence against staff. The VPRS is open to interpretation, designating appropriate and sufficient resources, yet offers no tangible definition of what this might look like. Staff should be trained in conflict management and verbal de-escalation techniques to prevent violence (National Association of Psychiatric Intensive Care and Low Secure Units, 2016; Royal College of Psychiatrists, 2019). The National Institute for Health and Care Excellence (NICE, 2015) suggest staff training in understanding the relationship between violence and MH along with improving de-escalation skills and responses. Hilton et al. (2022) found that recent and regular training in the management of violence has been associated with lower levels of hyperarousal in psychiatric inpatient nurses.

When incident reports are completed in MH inpatient services, they are dominated by violence (Berzins et al., 2020). A systematic review found that up to 80% of violent incidents remain unreported to managers (Edward et al., 2014). This review may be subject to errors, given that much of the data contained some biases and had small sample sizes. Unclear procedures, lack of management support, and previous inaction may all be barriers to reporting. Archer et al. (2020) suggested that time constraints, not knowing what would improve, fearing blame, perceived police inaction, high thresholds for verbal violence in "unwell" patients, not knowing what to write if "personality" was perceived as a factor, and a high tolerance for assaults against nurses compared to other staff groups.

According to the Care Quality Commission (CQC, 2021) MH services are high risk for developing "closed cultures" characterised by six common features: abusive and restrictive practices, inadequate training and staff competence, a culture of covering up when things go wrong, poor management and leadership, generally poor care, and an unacceptable quality of reporting. The CQC made clear recommendations for the reduction of the use of restrictive interventions such as chemical restraint, physical restraint, and seclusion (CQC, 2022). Despite this, there has been no reduction in these practices.

1.5 Violence in Mental Health Inpatient Settings

1.5.1 Contributing Factors to Violence

Patient variables are important factors to consider in violence, as well as the environment or setting, relational issues, and staff attitude (Jansen et al., 2006). The National Institute for Mental Health in England (2004) and NICE (2015) emphasise the importance of contextual factors when considering the cause and management of violence. These include alcohol use (Bowers et al., 2009), substance use (Salzmann-Erikson & Yifter, 2020; Stevenson et al., 2015), and boredom (Foye et al., 2020). Demographic risk factors such as younger age and male gender (Dack et al., 2013) have been identified, although the

studies within this review were highly heterogeneous. Some diagnoses have been associated with an increased risk of violence (Stevenson et al., 2015), including psychosis (Asikainen et al., 2020; Dack et al., 2013; Salzmann-Erikson & Yifter, 2020), affective diagnoses (Salzmann-Erikson & Yifter, 2020), and personality disorder (PD) diagnoses (Asikainen et al., 2020; Harford et al., 2019; Howard, 2015; Salzmann-Erikson & Yifter, 2020). A patient's previous history of violence may also be a contributing factor to violence (Stevenson et al., 2015). The social environment may play a role in violence. A lack of activity may be seen as a contributory factor (Berzins et al., 2020). Nursing-related factors to violence may be present, such as communication amongst nursing staff, engagement in debriefing following violent episodes, and quality of patient assessments. Furthermore, unit factors may persist, such as availability of nursing staff, limited or restricted physical space, and availability of activities for patients (Stevenson et al., 2015). Psychological safety may be threatened when staff do not listen and dismiss concerns. Local working conditions, including supervision and leadership, as well as staffing level management, are factors according to patients (Berzins et al., 2020). The focus on security and containment rather than therapy is highlighted as an important factor.

Mediating factors in violence suggested are: impulsivity (Harford et al., 2019; Howard, 2015), emotional dysregulation, delusional ideation (Howard, 2015), severe anger, and disturbance in identity (Harford et al., 2019). PD diagnoses have attracted criticism, and it is unclear whether these mediating factors have discriminant validity. Raising concerns about violence becomes more challenging with diagnoses of PD in an environment where it is already hard to raise concerns when detained. Patients worry about repercussions and unsatisfactory responses (Berzins et al., 2020). The most common factors identified as precipitating violence are rigid rules, inadequate communication, conflict with staff, insufficient staff empathy, and poor staff organisation (Bizzarri et al., 2020).

Findings regarding work experience are more controversial. Gascón et al. (2009) found that employees working for fewer years were more often victims of violence than those

working for more years, supporting other studies (Arnetz et al., 2015; Privitera et al., 2005). Maguire and Ryan (2007) however, found no significant difference between employment status in the management of violence, and some studies found a positive correlation between work experience and frequency of assaults (McKinnon & Cross, 2008; Moylan & Cullinan, 2011).

A systematic review of violence in psychiatric wards found that the main variables associated with violence were the existence of previous episodes, the presence of impulsivity or hostility, a longer period of hospitalisation, non-voluntary admission, and aggressor and victim of the same gender (Cornaggia et al., 2011). There are disagreements between patients and staff concerning the predictors of violence on psychiatric wards. In a study comparing perspectives, patients perceive environmental conditions and poor communication to be significant precursors of aggressive behaviour, whereas staff view the patients' mental illnesses as the main reason for violence, even though they recognise the negative impact of an inpatient environment (Duxbury & Whittington, 2005).

1.5.2 Psychiatric Diagnoses and Violence

The relationship between violence and psychiatric diagnoses[1] have been a subject of interest with many conflicting conclusions. In the mind of the public, and in the experience of some HCPs, the relationship remains a strong one. Historically, there was an identified correlation between psychiatric disorders and crime (Gunn & Bonn, 1971; Penrose, 1939), whereas others have found that the prevalence of crime is lower than in the general population (Steadman et al., 1978).

The diagnosis most associated with aggressive behaviour is paranoid schizophrenia. This may be due to patients having sufficient ability to plan and commit acts of violence

[1] There are obvious challenges with the categorisation of violence according to psychiatric diagnoses, given the lack of validity of some diagnoses. This however, is beyond the scope of the thesis.

related to their delusions, whereas disorganised schizophrenia is not planned and usually characterised by less severe consequential violence (Cornaggia et al., 2011). Violence is also reported more commonly in those with PD diagnoses (Dolan & Völlm, 2009; Richard-Devantoy et al., 2009). Other psychiatric diagnoses seem to be less frequently associated with violence. Violence is also common in psychiatric units where sub-acute or non-acute patients are treated (Bizzarri et al., 2020), which suggests that violence may be an artefact of the inpatient environment rather than psychiatric diagnoses as such.

1.5.3 Prevention and Management

The views of patients, their families, and carers about the safety of their care are paramount (Dewa et al., 2018). In a paper by Berzins et al. (2020) using qualitative interviews, patient perspectives were gathered on safety issues in MH inpatient services. Safety culture, including psychological concepts of safety and raising concerns, was an identified theme. Other themes included: social environment, involving threatened violence and sexual abuse, individual patient and staff factors, including not being listened to, management of staff and staffing levels, resulting in poor continuity of care, and service processes, typified by difficulty accessing services during a crisis. About 70% of staff identify interventions capable of improving staff safety in the workplace, including de-escalation training and supervision, an effective alarm system, and increased staffing (Bizzarri et al., 2020).

Cresswell (2017) argues that the prevention and management of violence is not possible without full state sponsorship, the engagement of professionals most in need of change, retributive justice, and legal reforms. Truth and reconciliation processes are also recommended (Spandler & McKeown, 2017).

1.5.4 Impact of Violence

1.5.4.1 Professional and Organisational Implications.

Burnout is defined as “becoming exhausted by making excessive demands on energy, strength, or resources” (Freudenberger, 1974, p. 159). Despite burnout being disputed and not recognised as a mental disorder in most countries (Heinemann & Heinemann, 2017), it is considered a serious threat to staff wellbeing, a financial risk in lost employment hours, and a compromise to good patient care (NHS England, 2022). A systematic review with inpatient MH nursing staff found that burnout was a potential risk factor for post-traumatic stress disorder (PTSD) following an experience of violence (Hilton et al., 2022). The addition of grey literature strengthened their review, but it suffers from methodological issues which limit the generalisability of any risk factors. Figley (1995) suggests that compassion fatigue occurs with violence. This is a process by which professionals absorb a patient’s suffering, resulting in a loss of compassion. Working with trauma and their own experiences of trauma makes staff more vulnerable to compassion fatigue. The occupational consequence of violence can impact professionals’ ability to maintain empathy and energy, resulting in burnout and compassion fatigue (Newell et al., 2016). Marshman et al. (2022) however, found no relationship between levels of workplace violence and compassion fatigue in a systematic review of international quantitative literature on compassion fatigue in MH nursing. They suggested this may have been due to protective factors such as culture and leadership, reflection, and clinical supervision.

Organisationally, workplace violence might lead to staff leaving the profession (Hampton & Rayens, 2019). This has a financial impact on healthcare institutions, with more resources needed for recruitment, and with increasing vacancies potentially leading to more violence (Merrifield, 2017). Staff retention and high turnover are established difficulties resulting from violent incidents (Kisa, 2008; Owen et al., 1998). Furthermore, decreased morale and hostile work environments are common in services with high rates of workplace violence (Pai & Lee, 2011). Additional organisational impacts include nurse absenteeism,

more frequent medical errors, more workplace injury claims (Ito et al., 2001; Roche et al., 2010), greater costs due to disability leaves, and reduced quality of patient care (Campbell et al., 2011; Pai & Lee, 2011). Reduced job satisfaction and productivity are potential consequences of violence (Dellasega et al., 2014). Furthermore, absenteeism and emotional trauma can result from violence (Magnavita & Heponiemi, 2012). These can all negatively affect the quality of patient care (Arnetz & Arnetz, 2001).

1.5.4.2 Physical Injury.

Physical injuries to staff are not uncommon, alongside increased anxiety, fear, anger, sadness, symptoms of post-traumatic stress, and reduced job satisfaction (van Leeuwen & and Harte, 2017). Injuries, including temporary or permanent disability caused by workplace violence, are present within psychiatric inpatient services (Pai & Lee, 2011). The most frequent injuries reported are pain, scratches, bruising, damage to garments, and fractures (Bizzarri et al., 2020). Work-related violence has been well established to cause physical injuries in HCPs occasionally (Magnavita & Heponiemi, 2012).

1.5.4.3 Psychological and Moral Injury.

Violence within inpatient services can result in staff experiencing anger, anxiety, fear, PTSD, guilt, self-blame, and shame (Nolan et al., 1999). This may come along with decreased job satisfaction and increased intent to leave the profession (Sofield & Salmond, 2003). Furthermore, workplace violence is also associated with lower health-related quality of life (Chen et al., 2010). Violence may be experienced as traumatic by staff members, according to Curran (2023), who, using Grounded Theory, suggested that there may be distress associated with being subject to violence, witnessing violence against colleagues, and enacting and witnessing the violence of restrictive practices against patients, resulting in moral distress and moral injury.

Moral distress is the distress felt by being in a situation where you cannot act in the way you know to be right (Jameton, 2017). Moral injury is a betrayal of what is right by

someone in authority in a high-stakes situation (Shay, 2014). Moral distress and injury are both relevant to inpatient MH settings. Restrictive practices may fit this context. Jones (2021) notes that understaffing can cause moral distress in a MH setting. A literature review of 29 international studies explored sources of moral injury for MH staff within an inpatient setting and found that some felt it stood against their values and moral standards to limit people's daily freedoms to the extent seen in services (Webb et al., 2024). Within this study, 19 mediating factors for moral injury in healthcare were found: the context of restrictive practices and coercion in care; medicalisation with a primary focus on risk and medication; depersonalisation – emphasis on task completion; a culture of dehumanisation of staff and patients; poor physical environments; staff hierarchy preventing challenges from nurses, and resulting in their role being minimised by senior colleagues; the challenge of balancing risk and care; and questioning their abilities to do the job well. Curran (2023) notes that burnout, moral injury or distress, and compassion fatigue may become diagnostic and medicalised.

1.5.4.4 The Impact of Patient Violence on Patients.

There is an impact of violence on patients, such as the threat of therapeutic counter-violence, such as physical control, seclusion, and restraint (Bowers et al., 1999). Violence and its impact on work, medical treatment, and psychological support may also impact patients (Itzhaki et al., 2015). The construction of difference and otherness that nurses can create as a response to violence can harm patient care (McKeown & Stowell-Smith, 2006). This is examined more within the SLR.

1.5.5 Trauma-Informed Approaches

PTSD is defined as direct or indirect exposure to death, serious injury, or sexual violence, followed by symptoms grouped into intrusion, avoidance, negative alterations in cognition and mood, and hyperarousal, persisting for over one month and impairing

functioning (NICE, 2018). Risk factors for PTSD within inpatient MH nursing staff who have been exposed to violence include: Assault severity; repeated exposure to violence; burnout; poor MH; low compassion satisfaction; and neuroticism (Hilton et al., 2020). Additional, less-established risk factors are female gender identity, poor training, compassion fatigue, and any exposure to violence.

The trauma-informed approach (TIA), developed by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), focuses on responses to trauma and targeting changes to the systems themselves that may perpetuate trauma responses. The TIA recognises the impact of trauma, aims to recognise it, and respond by ensuring the knowledge is embedded throughout system processes and aims to resist re-traumatisation. It also advocates for staff training at all levels and functions of the organisation. The NHS Long Term Plan (NHS, 2019) states that services should provide trauma-informed care but offers no definition, targets, or deadlines. There is no consistent England-wide NHS strategy for the implementation of TIA, nor dedicated funding (Emsley et al., 2022). In a literature review of TIA used within inpatient MH settings, Muskett (2014) found that there was a key focus on reducing restrictive practices. Practical strategies for improving wards' TIAs consisted of routine screening of past trauma, staff training, and improved environments. Another review by Saunders et al. (2023) suggested that TIAs had promising indications of reduced restrictive practices and improved relations between staff and patients.

The Power-Threat-Meaning Framework (PTMF; Johnstone & Boyle, 2018) is an alternative to medicalised narratives of distress on the basis that medicine has erroneously equated emotional responses with diagnosable and treatable physical diseases. The PTMF could be a practical conceptual framework within TIAs, although it is a conceptual model that extends beyond psychological formulation and trauma-informed approaches. One NHS Trust, which utilised PTMF team formulation and weekly TIA staff training, combined with other approaches, reported reductions in restraints by over 30% and seclusions by 40% (Nikopaschos et al., 2023). Acute ward staff in London found that team formulation, linked to

PTMF and TIA, was a safe space to discuss challenges, which improved relationships between staff and between staff and patients (Kramarz et al., 2023). The PTMF considers how power has operated in people's lives, the impact of distressing life events, and how individuals have responded to survive or cope, as well as how they have made meaning from their experiences. Drawing on a comprehensive review of the literature around power, threat, meaning, and corresponding threat responses, Johnstone and Boyle (2018) propose the PTMF as a resource for developing narratives at the individual, family, community, and societal level. The framework also outlines possible alternatives to the traditional diagnostic system, aiming to generate more hopeful explanations that connect social circumstances with psychological suffering. Importantly, it accommodates culturally specific accounts of distress without relying on Western diagnostic categories. Beyond its clinical applications, the PTMF has potential relevance for service development, commissioning, professional training, research agendas, and even broader issues of social policy, equality, and justice. These possibilities may appeal to CPs who are searching for different ways to conceptualise and address distress. PTMF applied to violence within inpatient MH may consider negative operations of power, experiences of violence, feelings of being trapped or being unable to escape, being unable to predict or control threats, threats of an interpersonal nature, whether the threat was intended, threats presented in emotional or attachment-based relationships, that the threats trigger automatic physiological threat responses in the body, and the potential for re-traumatisation by services or iatrogenic harm. It may offer an exploratory lens for violence, conceptualising violence as a response to threats embedded in relational, institutional, and social power. PTMF may provide conceptual depth to TIAs to reduce re-traumatisation, promote safety, and shift staff away from punitive or pathologising responses. The framework is not without limitations however; the source text itself is lengthy (414 pages) and has been criticised as difficult to engage with (Salkovskis & Edge, 2018). Furthermore, critics argue that some of its political implications appear problematic, as the suggestion that an ideal society could eliminate mental distress risks being interpreted as ableist or dismissive of lived suffering (Salkovskis & Edge, 2018).

1.5.6 Relevance to the Role of a Clinical Psychologist

A systematic review of international quantitative literature on compassion fatigue in MH nursing found that protective and mitigating factors for compassion fatigue include culture and leadership, reflection and clinical supervision, which are all influenced by clinical psychology work within teams. Psychology input is a priority in standards as an important part of the inpatient multidisciplinary team (Chaplin, 2019; National Association of Psychiatric Intensive Care and Low Secure Units, 2016; Townsend et al., 2021). Assistance with violence, as well as patient care within inpatient MH in general, CPs can offer: Psychological assessment; formulation; intervention; influencing team culture; supporting TIAs; providing post-incident support to teams; leading team supervision; helping staff retention through supporting wellbeing; and providing specialist training to increase psychological knowledge (British Psychological Society & Association of Clinical Psychologists, 2021).

CPs have always traditionally been considered well placed to facilitate reflective practice (RP). RP aims to bring staff together to reflect on clinical theory, experiences, and practice, enabling them to learn and improve. RP is valued by staff and nursing bodies, and unions have called for protected RP time (RCN, 2022). Despite this, RP groups are not mandated in standards (Chaplin, 2019; Townsend et al., 2021). There are several barriers to RP, including staff being unwilling or unable to attend, interruptions, hostility, lack of team cohesiveness, management support, staff, and time.

Debriefing is another area where CPs could support staff. The HSE (2025) suggests offering optional debriefing to staff as soon as possible following an incident, and offering counselling to staff impacted directly and indirectly following incidents of violence. NICE (2015) suggests post-incident debriefs after violence, which assess identification and response to physical harm to staff or patients and any continued risks. Debriefs offer an

opportunity for staff and patients to reflect together and prevent further occurrences (Asikainen et al., 2020). An evaluation across five MH wards found that staff valued incident-specific debriefs (Burman, 2018). Facilitating factors included a trusted, possibly senior facilitator, and conducting the debrief in a quiet place away from the site of the incident. Barriers included stigma for needing support, the narrative of violence as “part of the job” and time and staff pressures. NICE (2018) suggests not providing post-incident debriefing in order to prevent PTSD, and discusses that things may have worsened for some people following debriefing. However, Regel (2007) argues that psychological debriefing is not a preventative measure for PTSD, but instead a way to educate people about what is usual to experience following a traumatic incident, and encourage help-seeking if needed.

Training is another aspect that CPs could assist with in violence management. CPs in inpatient MH contexts are key providers of training. Support interventions such as psychoeducation on stress and coping, group psychological support, and mindfulness are suggested (Bekelepi & Martin, 2022). Team formulation which supports multi-disciplinary teams in contextualising understandings of patients' distress, such as trauma, TIA, emotion regulation, communication of needs via challenging behaviour, and the PTMF (Kramarz et al., 2023). There are good reasons to expect that training staff to deal with violence and improve the way ward rules and treatment strategies are communicated to patients might reduce aggressive behaviour (Bizzarri et al., 2020).

1.6 Violence and Inequality

In this section, I will consider how societal factors and systemic inequalities contribute to the normalisation of violence in psychiatric inpatient settings. I will also examine the use of restrictive practices within these services.

1.6.1 Restrictive Practices and Counter-Violence

Patients can be harmed while receiving healthcare services (WHO, 2019). Patient safety is well-researched; however, in a MH context, this has received less attention (D'Lima et al., 2017; Shields et al., 2018). Restrictive practices such as enforced medication and seclusion potentially breach a person's right to freedom from torture, inhuman and degrading treatment (Human Rights Act, 1998; United Nations, 1948). These rights are designated as absolute rights, meaning that there are no acceptable circumstances in which this right can be interfered with, unlike rights to liberty, which may be conditional depending on danger to others (Curran, 2023). Psychologists have agreed to the duty to work towards upholding human rights principles in their places of work and to protect and respect the rights of staff and patients (Patel, 2019). Staff members deserve a place of work free from abuse, and understanding the impact of violence towards staff must be considered with all these principles in mind (Curran, 2023).

1.6.2 Intersection with Race and Gender

1.6.2.1 Gender and Violence – A Feminist Perspective.

Women staff members are at increasing risk of physical violence, according to some studies (Ferri et al., 2016; Palumbo et al., 2016; Privitera et al., 2005). However, other studies have refuted this and failed to find any difference in the exposure to violence between men and women (Altinbaş et al., 2011; Wynn & Bratlid, 1998). Some studies found the opposite, that men were more frequently victims of assault than women (Camerino et al., 2008; McKinnon & Cross, 2008; Moylan & Cullinan, 2011). Despite this, there are some apparent gender differences in violence within MH inpatient wards. Women are more often affected by violence than colleagues who are men (Acquadro Maran et al., 2019; Liu et al., 2019). This suggests perhaps that men and women may require different interventions related to violence in the workplace. One hypothesis is that males tend to be at the forefront

in dangerous situations and to display confidence and bravado because of sex stereotypes (Barash, 2002; Harris, 2009). Women may view violence because of systemic issues rather than isolated incidents. This may reflect an outcome of gendered socialisation, where women are taught to consider broader relational and social dynamics. Men's focus on witnesses and potential stigma (Acquadro Maran et al., 2019) seems to align with patriarchal notions of masculinity, where admitting victimisation may be perceived as a threat to male identity. Feminist analysis could argue that this reflects the pressures men face to conform to stereotypes of strength and invulnerability. Feminist theory itself might critique the idea that women nurses are more often affected by workplace violence by suggesting that it mirrors the devalued nature of predominantly female professions, and is another example of a failure to prioritise women's safety. This could be due to systemic issues, such as staffing shortages, insufficient training, and inadequate workplace protections. Feminist theory might advocate for structural changes that dismantle gendered power dynamics and create equitable workplace environments (Nicki, 2001).

Women may experience more specific forms of violence, such as sexual harassment or assault, reflecting broader patterns of patriarchal oppression. This type of violence is much less researched (UN Women, 2024). Policies and interventions for violence may fail to account for intersecting identities (Crenshaw, 1991), which arguably is a failure to address systemic inequality. MH systems have historically been used to control and oppress women (Nicki, 2001) and violence on MH wards could be seen as an extension of this control, where patients who are women face coercive treatments, restraint practices, or neglect. TIAs may go some way towards addressing and advocating from a feminist perspective. Structural violence (Galtung, 1969) suggests that institutional structures harm individuals by failing to meet their needs. In the UK, the lack of TIAs may create an environment where violence is more likely to occur and less likely to be addressed.

There is a lack of research into non-binary gender identities and violence. NHS Digital (2022a) suggests that non-binary identifying people were repeatedly detained more often than those identifying as female or male (46% non-binary; 20% female; 18% male).

1.6.2.2 Race and Violence.

Thousands of global majority staff working in MH Trusts are subjected to harassment, bullying, or abuse from the public or work colleagues. 32.7% from the NHS Staff Survey (2022) reported experiencing harassment, bullying, or abuse from patients, their relatives, or other members of the public, and 86% of global majority staff said the discrimination was based on their ethnic background (Rimmer, 2021).

Black and Black British people are detained at over four times the rate of white people (NHS Digital, 2022a). They are more likely to be subjected to restrictive practices, including seclusion and prone physical restraint, compared to other ethnicities. There is a sparsity of research on how ethnicity might impact violence in MH inpatient services.

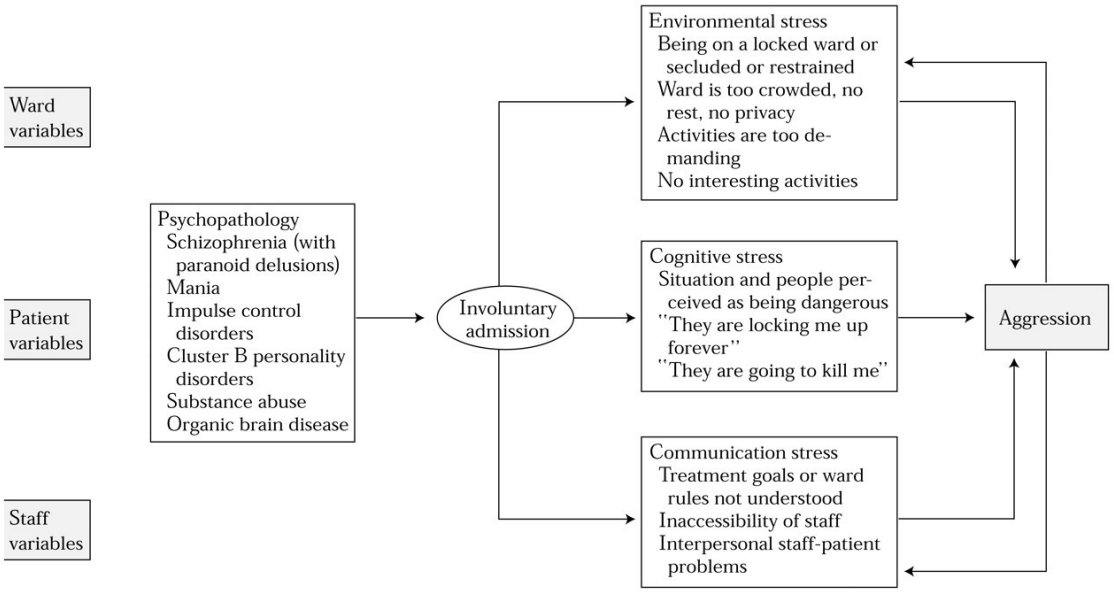
1.7 Theoretical Frameworks

1.7.1 Model of Inpatient Violence

There are many explanations and causal factors discussed when it comes to violence within inpatient MH wards. However, there are few clear models outlining how violence works. One such model is illustrated in Figure 1, outlining the factors as well as the maintenance cycle of violence.

Figure 1

A Tentative Model of Inpatient Violence



(Nijman et al., 1999).

The model proposes that underlying psychopathology and distorted cognitions are intensified by environmental and communication stressors on psychiatric wards, creating a vicious cycle in which patient violence leads to increased stress, thereby elevating the risk of further violent behaviour. Severe psychopathology was thought to be a source of inpatient violence. Psychotic disorders, mania, PD, substance use, and organic brain disease have all been associated with impulsive behaviour (Tardiff, 1992). The model also suggests environmental stressors play a role, namely being incarcerated, with little privacy, and over-stimulation through the environment, or under-stimulation through a lack of engaging activities. Staff variables include stressors, problematic communication between staff and patients (Whittington & Wykes, 1996), as well as inconsistencies in limit setting. The centre of the model is cognitive stress, whereby a patient's appraisal of the situation plays a key role in whether they will act aggressively. The cycle operates through environmental stress increasing in response to violence, further reinforcing distorted beliefs, negatively influencing the therapeutic alliance. Violence may result in negative countertransference reactions amongst staff, creating additional issues in communication. A repetitive pattern of violence

may emerge with the increase of environmental and communication stressors (Nijman et al., 1999). This model is the only one that explicitly addresses inpatient violence, and it has its uses, although I suspect that the model relies too heavily on patient variables. It is also not clear how the model was developed and tested.

1.7.2 Models of Sense-Making

Sense-making refers to the processes of interpretation and meaning production whereby individuals and groups interpret and reflect on phenomena (Bean & Hamilton, 2006; Leiter, 1980; Weick et al., 2005). People create the social world through sense-making (Brown et al., 2008). Sense-making is the pursuit of plausibility and coherence that feels reasonable and memorable, reflecting past experiences and expectations. It sustains one's sense of self while fostering meaningful connections with others. It can be shaped by looking back on events yet applied to future situations, encompassing both thoughts and emotions: “To engage in sensemaking is to construct, filter, frame, create facticity and render the subjective into something more tangible” (Weick, 1995: 14). There are many models of sense-making. I will consider the approach used within Interpretative Phenomenological Analysis (IPA), the research methodology for the thesis, and some alternative models for parity.

1.7.2.1 Weick’s (1995) Model of Sense-Making.

There are many models of sense-making across different disciplines. One such model widely used is the Weick (1995) model, whereby sense-making is triggered by disruption or unexpected events that challenge existing understandings. It is seen as a social process where individuals construct shared meanings through interaction and rely on retrospection, meaning people make sense of events by looking back and reconstructing their experiences. In the context of violence, this model could assist in considering how staff

and patients interpret violence, how teams create narratives around violence, and how policy evolves in response to violence.

Sense-making involves the placement of stimuli into a framework, usually categorisations, anticipations, or assumptions. When done without particular care, sense-making can highlight our inability to shift representations easily due to the inertia of our representations (Sharma, 2006). Beliefs held firmly are not questioned; rather, the focus is on confirming them, leading to the selection of attention to cues that confirm these beliefs. People engage in the fallacy of centrality, whereby they ignore warnings and cues (Weick, 1995). This can be helpful to promote continuity however, when the environment is dynamic and unpredictable, such as on a MH inpatient ward, inertia can give people a false sense of security.

Tighter social connections and active communication channels are needed for arguing, negotiating, and updating. Moving sensemaking from an individual act to something that happens between people is key (Sharma, 2006). Effective sense-making then needs beneficial people-people interactions.

1.7.2.2 Narrative Sense-Making.

Sense-making can be seen as a creative authoring on the part of individuals who construct meaning from initially puzzling and sometimes troubling data (Brown et al., 2008; Shotter, 1993; Weick, 1995). Narratives are central to how individuals make sense of chaotic or traumatic events. People use stories to create a coherent account of events, integrating acts, emotions, and interpretations. Narratives can often reflect dominant discourses. The argument that sense-making is a narrative process relies upon the view that “man is in his actions and practice, as well as his fictions, essentially a story-telling animal” (MacIntyre, 2007). A focus on narratives has also been deployed to analyse the idiosyncratic, context-dependent, and individual-specific nature of people’s sense-making (Giddens, 1984).

1.7.2.3 Sense-Making in Interpretative Phenomenological Analysis

IPA focuses on understanding how people make sense of their lived experiences. It employs a double hermeneutic, that is, the participant making sense of their experience, and the researcher interpreting the participant's sense-making. IPA also focuses on idiographic analysis, prioritising individual experiences, whilst making broader themes across cases (Larkin et al., 2006).

The double hermeneutic process acknowledges that the researcher is not neutral but actively involved in interpreting the participants' experiences through their lens and context. IPA draws heavily on phenomenology, that is, exploring a participant's lived experience of a phenomenon and how they make sense of it in their terms. It recognises sense-making as rooted in an individual's social, cultural, and historical context. IPA is particularly indebted to the work of Heidegger, Merlau-Ponty, and Sartre (Smith et al., 2022). Sense-making is not a linear but a cyclical process within IPA. It is a dynamic, iterative process of interpreting parts of an experience with the whole, and vice versa (Larkin et al., 2006).

IPA adopts an idiographic approach, meaning that it focuses on detailed, in-depth exploration of individual cases. Each participant's sense-making is seen as unique and shaped by their personal history, beliefs, values, and immediate environment. This allows the researcher to understand violence from multiple contextual perspectives (Larkin et al., 2006). Participants actively construct meaning from their experiences rather than simply describing them, and they are understood as unfolding over time and within a specific context.

1.8 Systematic Literature Review

1.8.1 Introduction

SLRs involve bringing together and integrating a body of studies to draw robust conclusions and explain how and why existing studies fit together. They involve a systematic search process and are methodical, comprehensive, transparent, and replicable (Siddaway et al., 2019).

The majority of studies in the area of healthcare violence have focused on incidence and examining patients as perpetrators of violence, and on staff safety issues (Gudde et al., 2015). There is a disagreement between patients and staff concerning predictors of violent episodes (Cornaggia et al., 2011). Having discussed these contexts, it seems helpful to explore, via a systematic review, attitudes of patients, carers, and the public on healthcare violence within a MH inpatient setting.

This SLR aims to answer the following question: *What are the attitudes of patients, carers, and the public on violence in mental health inpatient settings?*

1.8.2 Methodology

1.8.2.1 Search Strategy.

A systematic literature search was conducted between May and August 2024, with the following databases being used: PubMed, CINAHL Plus, Scopus, PsycARTICLES, and Google Scholar. These databases provide research from multiple disciplines such as psychology, medicine, and nursing. A search of the PROSPERO database was completed ahead of the review planning, and no similar reviews were being conducted. This SLR was also pre-registered with PROSPERO. The literature includes a vast array of search terms. During preliminary searches, I searched individual terms to assess their relevance. The search terms used in this SLR are listed in Table 1.

Table 1

Final Search Terms

Concept 1 (Phenomena of Interest): Violence	"violence in healthcare" OR "aggressive behavior" OR "aggressive behaviour" OR "aggressiveness" OR "attack" OR "hostility" OR "patient violence" OR "physical violence" OR "violence" OR "violent" OR "workplace violence" OR "physical harm"
AND	
Concept 2 (Phenomena of interest): Healthcare	("hospital" OR "healthcare" OR "health care" OR "A&E" OR "A and E" OR "accident and emergenc*" OR "inpatient" OR "in-patient" OR "psychiatric" OR "ward" OR "mental health" OR "primary care" OR "secondary care" OR "health services" OR "acute mental health wards"
AND	
Concept 3 (Evaluation): Attitudes	"attitudes" OR "exploratory" OR "exploration" OR "qualitative" OR "feedback"
AND	
Concept 4 (Sample): Patients/Carers/Public	"service user" OR "carer" OR "public" OR "user-led" OR "patient" OR "patients" OR "service users" OR "carers"

Inclusion and exclusion criteria are listed in Table 2. Excluding forensic wards was based on the different patient populations, specialised environment of forensic MH, and to improve the focus and relevance of the SLR. It is not easy to draw boundaries between forensic and general mental health care (Szmukler, 2002) however, the definition usually delineates between those struggling with “mental disorder” and those who are “mentally disordered offenders and those requiring similar services”[2] (Reed, 1992). There is evidence that staff on forensic wards feel less safe at work than staff on non-forensic (acute) wards,

[2] “Offenders” here can include not only those convicted but also those awaiting trial. Similar services refers to patients not within the criminal justice system but who pose a risk to others as a result of, or along with, their “mental disorder”.(Khosla et al., 2014)

despite acute wards recording higher levels of violence than forensic wards (Haines et al., 2017), therefore, this confounding variable was removed from the SLR. Quantitative, qualitative, and mixed methods research was included to provide a more comprehensive and nuanced understanding of violence within inpatient settings. Grey literature was not included in the SLR due to no relevant studies being found in preliminary searches of Google Scholar and open-access theses and dissertations. Consideration was given to screening out papers from before 2000; however, there has not been a dramatic shift in conceptions of violence within the literature, so it was decided to include all papers found.

Table 2

Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Qualitative design	Literature Reviews
Quantitative design	Commentaries
Mixed-methods design	Editorials
Reference to violence in healthcare settings	Violence in other settings
Mental health settings	Studies focusing only on staff attitudes
Focus on patient, carer, or public views	Studies only in forensic wards
Studies written in English	Child or adolescent participants
Published in peer-reviewed journals	Dissertations/theses
Adult participants	

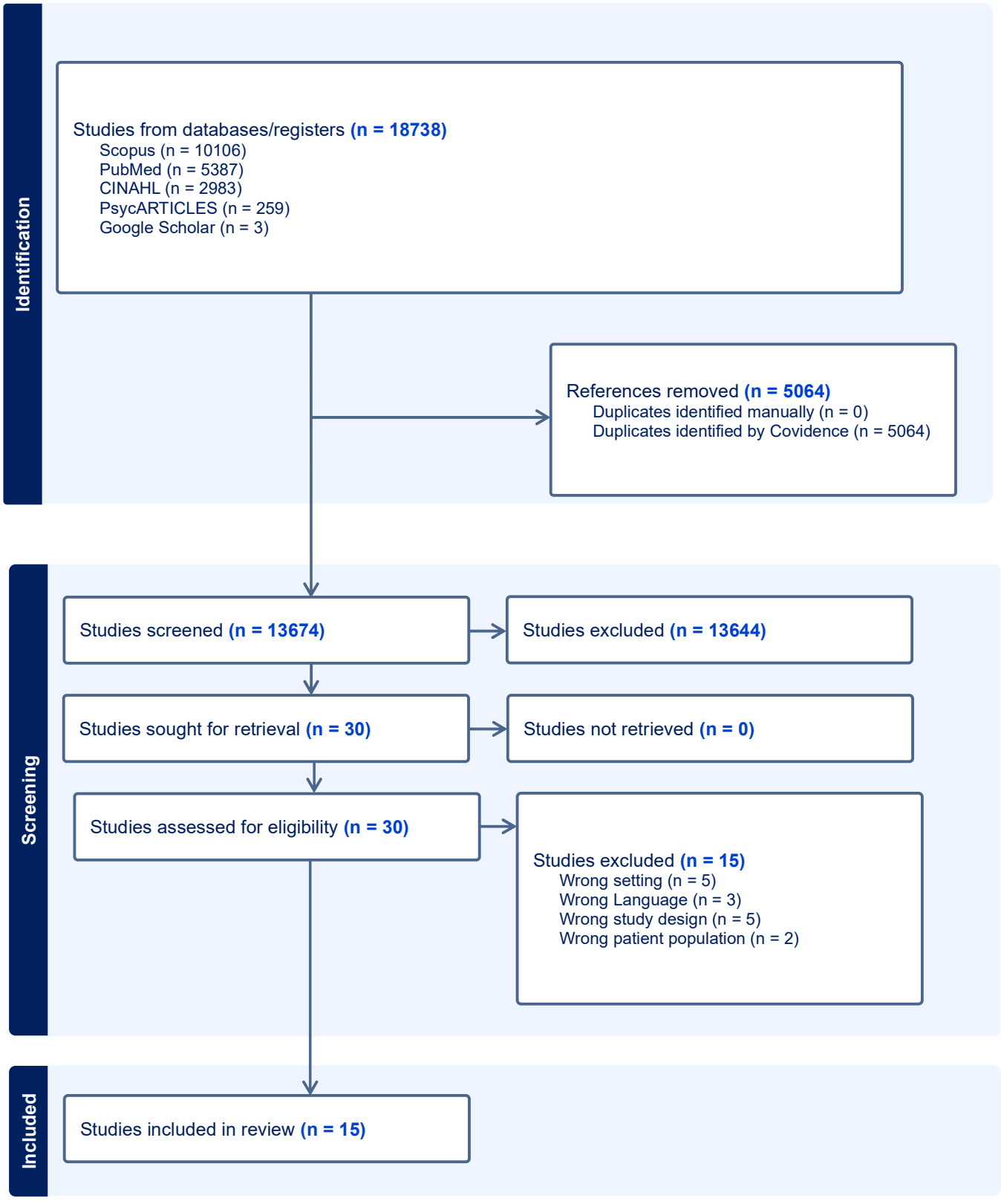
1.8.2.2 Study selection process.

The Covidence application (Veritas Health Innovation, 2024) was used to assist in the study selection. The PRISMA (Moher et al., 2009) flowchart in Figure 2 highlights the study selection process. A total of 15 studies were selected for synthesis. A summary of these studies can be found in Table 3. During the title and abstract screening stage, two independent reviewers (Author and Second Reviewer) assessed studies for inclusion. Overall, the reviewers demonstrated a high level of consistency, with a proportionate agreement of 99.6%. To adjust for chance agreement, Cohen's kappa was calculated. The analysis indicated fair agreement (Landis & Koch, 1977), $\kappa = .35$, which likely reflects the

high base rate of exclusions (both reviewers excluded 13,674 studies) and the smaller proportion of potential inclusions. Although Cohen’s kappa indicated only fair agreement, this was primarily due to the highly imbalanced distribution of screening decisions, with most records excluded by both reviewers. Disagreements were confined to a small number of borderline cases and were resolved through discussion. Overall, the screening process was reliable, with no anticipated impact on the comprehensiveness or validity of the final synthesis.

Figure 2

PRISMA Flowchart



Following the initial search and removal of duplicates, titles and abstracts were screened against the eligibility criteria in Table 2. 30 texts were assessed as potentially relevant, and 15 were chosen for the synthesis. Another researcher screened all titles and abstracts, and a consensus was sought to resolve any discrepancies.

1.8.2.3 Data Extraction and Quality Assessment.

1.8.2.3.1 Data Extraction.

An example data extraction table is provided in Appendix 26. Once all relevant information had been extracted, the data was collated into Table 3 to form the summary of reviewed studies. The data included within the extraction were: lead author, year, country, design, analysis, participants, and main findings.

1.8.2.3.2 Quality Assessment.

The Critical Skills Appraisal Programme (CASP, 2023a, 2023b) checklists for qualitative and quantitative studies was used to assess the quality of each article chosen. The Mixed Methods Appraisal Tool, MMAT, (Pluye et al., 2011) was used for mixed-methods research. These tools are widely used to assess the quality of research, and the MMAT is designed explicitly for mixed-methods research. They provide comprehensive assessment criteria for the quality of studies. The summary of reviewed studies, along with the accompanying quality assessment, can be found in Table 3. These methods of quality appraisal have been chosen due to their endorsement from the Cochrane Qualitative and Implementation Methods Group (Long et al., 2020).

Each paper was deemed to be strong enough for inclusion within the review. The reviewed studies all evaluated patient violence within MH inpatient settings from the perspectives of the patients. Some studies included staff perspectives and comparisons. Methodologies varied across qualitative, quantitative, and mixed-methods research. Most

studies were qualitative. Nearly all studies articulated their research aims clearly, with the exception of Gillig et al. (1998) and Nolan et al. (2009). All studies employed suitable methodologies for their research aims. Data collection and analysis also seemed strong across all the studies. All studies had practical applications for the reduction of violence within MH inpatient services.

Several studies lacked transparency in recruitment strategies (Kontio et al., 2014; Lamanna et al., 2016). Ethical considerations were also not addressed in some studies, for example Nolan et al. (2009). No studies considered the influence of the researcher-participant relationship on data collection, which could introduce bias. Bensley et al. (1995) lacked statistical rigour, reducing the strength of the findings.

Table 3

Summary of Reviewed Studies

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal

Jenkin et al. (2022)	New Zealand	Qualitative
		
		Semi-structured interviews
		
		Thematic Analysis
			N = 43 Patients
			
			34.9% Māori
			
			51% Female; 49% Male
				"Causes of violence" themes:
				• Individual service user factors:
				  ○ Illness/psychosis
				  ○ Self-perception (top-dog)
				• Built environment:
				  ○ Confined spaces
				  ○ Nurses' station design
				• Organisational factors:
				  ○ Smoking and rules
				  ○ Staffing
				• Social milieu:
				  ○ Locked unit
				  ○ Paternalistic atmosphere
				  ○ Boredom
					Clear statement of aims: Yes
					
					Appropriate methodology: Yes
					
					Appropriate research design: Can't tell
					
					Appropriate recruitment strategy: Can't tell
					
					Appropriate data collection: Yes
					
					Researcher-participant relationship: Can't tell

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				○ Restraint, seclusion, and medication • Consequences of violence: • Fear • Impeded recovery • Stigma • Co-designed units may reduce violence, or least some factors contributing to it. Addressing environmental and systemic issues may have the most benefit	**Ethical issues considered**: Yes **Rigorous data analysis**: Yes **Clear statement of findings**: Yes **Valuable**: Yes
Välimäki, Lantta et al. (2022)	Hong Kong, China SAR	Qualitative Focus group interviews Thematic Analysis	N = 58 Patients, P = 28 Caregivers, C = 30 Age: • 18–35 years: ○ P: 13 ○ C: 2 • 36–50 years: ○ P: 9	The Meaning of Aggression Themes: • Types of Aggression: ○ Physical aggression ○ Verbal aggression ○ Threat • Target of Aggression: ○ Other people ○ Objects ○ The patient themselves	**Clear statement of aims**: Yes **Appropriate methodology**: Yes **Appropriate research design**: Yes **Appropriate recruitment strategy**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
			○ C: 3 • 51–60+ years: ○ P: 6 ○ C: 25 Gender: • Male: ○ P: 12 ○ C: 12 • Female: ○ P: 16 ○ C: 18	The Reason for Aggression Themes: • Unstable mental status • Unmet needs • Social conflicts • No clear reason (Not present in informal caregivers) Consequences of Aggression Themes: • Action: ○ Seeking help ○ Controlling ○ Calming down • Burden: ○ Physical Burden (not present in informal caregivers) ○ Psychological Burden Development Ideas Themes: • Helping attitude	**Appropriate data collection**: Yes **Researcher-participant relationship**: No **Ethical issues considered**: Can't tell **Rigorous data analysis**: Yes **Clear statement of findings**: Yes **Valuable**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				• Communication • Structural changes • Restrictive interventions • Self-management • Assessment (not present in informal caregivers) • Creative activities • Safety measures (not present in patients) The study highlighted that patient aggression in psychiatric hospitals is influenced by a range of factors, including unmet needs, unstable mental status, and social conflicts. Caregivers experience significant burdens from managing aggression. Effective handling of aggression often requires teamwork, negotiation, and consensus on coercive measures.	
Carlsson et al. (2006)	Sweden	Qualitative – Semi-structured interviews	N = 9 Patients Women: 2 Men: 7	The study explores the deep emotional experiences of patients regarding violence in psychiatric care settings.	**Clear statement of aims: Yes**

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
		Phenomenological analysis	Age Range: 20-48	Patients express a strong longing for authentic personal care that respects their vulnerability and humanity. The violent encounters are seen as dehumanising, leading patients to feel more unsafe and alienated. There is a tension between “authentic personal” care and “detached impersonal” care Tension or movement between these are characterised between: • Invitations to genuine presence • The primacy of caring stability • Unbearable violation • Uncontrolled insecurity full of risks • Displaced caring focus The study concluded that violent encounters in psychiatric settings exacerbate patients' feelings of alienation and vulnerability. Patients expressed a longing for authentic personal care where their	**Appropriate methodology: Yes** **Appropriate research design**: Yes **Appropriate recruitment strategy**: Can’t tell **Appropriate data collection**: Can’t tell **Researcher-participant relationship**: No **Ethical issues considered**: Yes **Rigorous data analysis**: Can’t tell **Clear statement of findings**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				humanity is recognised and respected. Providing such care requires psychiatric settings to prioritise deep, meaningful interactions rather than mere procedural safety measures. Authentic personal and undisguised caring could help to prevent violent encounters occurring or continuing.	**Valuable**: Yes
Lamanna et al. (2016)	Canada	Qualitative Semi-structured interviews Thematic analysis	N = 14 Patients Age (years) Range: 18–77 Mean (SD) 49.1 (18.9) Gender, % (n) Female 64.3% (9) Male 35.7% (5) Psychiatric diagnosis: % (n)	Personal Factors: • Major life stressors • Experience of illness • Interpersonal connections with clinicians Organisational factors: • Physical confinement • Behavioural restrictions • Lack of engagement with clinicians and treatment decisions	**Clear statement of aims: Yes** **Appropriate methodology: Yes** **Appropriate research design**: Yes **Appropriate recruitment strategy**: Can't tell **Appropriate data collection**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
			Psychotic disorder 35.7% (5) Mood disorder 50.0% (7) Other 42.9% (6) Previous hospitalisations: Range 0–30 Mean (SD) 9.0 (9.6) Length of current hospitalisation:(days) Range 14–202 Mean (SD) 41.5 (47.4)	This study reinforces earlier findings that link patient aggression to illness, staff attitudes, communication, and restrictive environments, while adding that stress and major life stressors also play significant roles. Confinement and restrictions heighten feelings of entrapment and aggression, and while patients view life stressors as key triggers, clinicians emphasise psychiatric symptoms. The study calls for comprehensive prevention strategies focusing on patient engagement, improved communication, reduced restrictions, and increased activity opportunities, underscoring the need to address both personal and systemic factors in reducing aggression.	**Researcher-participant relationship**: Can't tell **Ethical issues considered**: Can't tell **Rigorous data analysis**: Yes **Clear statement of findings**: Yes **Valuable**: Yes
Vermeulen et al. (2019)	Netherlands	Qualitative Semi-structured interviews	N = 15 Patients Males: 10	Themes: • Humane treatment and freedom	**Clear statement of aims: Yes**

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
		Grounded theory analysis	Females: 5 Age range: 26 - 37	• Ward routine • Interpersonal contact • Personalised-escalation interventions • Shared decision making during a coercive measure. Patient perspectives are crucial for improving care quality and safety, especially in involuntary admissions. Incorporating psychiatric inpatients' views on aggressive behaviour is feasible and beneficial for improving care. Recommends debriefing aggressive incidents with both patients and staff to identify common ground and improve outcomes. Collaboration between patients and staff is essential in developing strategies to prevent dangerous situations and reduce coercive measures. Shared crisis management plans and patient safety plans can provide frameworks for preventing future aggression. Debriefing soon after incidents may restore patients' sense of control and autonomy.	**Appropriate methodology: Yes** **Appropriate research design**: Yes **Appropriate recruitment strategy**: Yes **Appropriate data collection**: Yes **Researcher-participant relationship**: No **Ethical issues considered**: Yes **Rigorous data analysis**: Can't tell **Clear statement of findings**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				Evaluating past aggressive incidents could prevent new ones and contribute to a safer psychiatric inpatient environment.	**Valuable**: Yes
Kumar et al. (2001)	United Kingdom	Qualitative – Focus group interviews Grounded theory analysis	N = 6 Patients Male: 4 Female: 2 Demographics Caucasian: 3 Afro-Caribbean: 2 Indian: 1	Experience of violence perpetrated by service users: • Experienced violence but never asked about it • Antecedents are ignored • Witnessing violence dominates memory of hospital stay • Response or attitude of staff • Few means to seek help Experience of violence perpetrated by staff: • Being jumped is punitive (C&R) • Abandoned after being jumped • Witnessing being jumped is frightening • Provocation therapy • Assaults by non-clinical staff	**Clear statement of aims:** Yes **Appropriate methodology:** Yes **Appropriate research design**: Yes **Appropriate recruitment strategy**: Yes **Appropriate data collection**: Yes **Researcher-participant relationship**: No **Ethical issues considered**:

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				• Victims of staff violence left unsupported Precipitants: • In-built in the system • Inadequate training • Staff responses to aggression • A cry for help SU's views on approaches to reduce violence: • Staff service user interaction • Staff recruitment • Staff training • Approach to manage violence • Physical environment • System to address complaints and monitor incidents Themes:	Can't tell **Rigorous data analysis**: Yes **Clear statement of findings**: Yes **Valuable**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				• Imbalance of power • Violence has psychological sequelae • Mental health services are not geared to help victims of institutional violence • The present mental health system fosters violence • A radical change is needed in the infrastructure of the mental health system • Reinforcements and reforms may come from parallel efforts	
Nolan et al. (2009)	USA	Quantitative Rank ordered coding McNemar test for significance	N = 42 (42/66 patients enrolled in parent study exhibited aggression during participation) Women: 3 Men: 39 Ages: 20-60 Mean 39.1	Moderate agreement between patient and staff reasons. Patients chose being teased or request being refused by staff the most. Correlation between aggression severity and intervention level Patient aggressors and staff witnesses report differing views of reasons for aggressive incidents. Patients report more interpersonal	**Clear Issue addressed:** Can't tell **Appropriate methodology:** Can't tell **Appropriate recruitment strategy**: Can't tell **Accurate measure of**

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				conflicts whereas staff tend to attribute aggression to mental illness. Interventions delivered in response to aggressive behaviours were related to the type and severity of aggression, rather than to the reasons for aggression. While this may be practically necessary, investigating the reasons for specific incidents might prove useful to preventing and responding to future incidents.	**measures:** Can't tell **Appropriate data collection:** Can't tell **Study power:** Yes **Presentation of results:** Yes **Rigorous data analysis**: Can't tell **Clear statement of findings:** Yes **Applicability of results**: Can't tell **Valuable**: Can't tell
Kontio et al. (2014)	Finland	Qualitative	N = 9 Patients (One dropout)	Themes: • Loneliness:	**Clear statement of aims:** Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal

		Semi-structured focus group interviews
		
		Content analysis
			Females: 2
			
			Males: 7
			
			One participant had experienced outpatient care only
				• Strange environment
				• Patients alone
				• Nurses' absence
				• Boredom:
				  • No activities
				  • Waiting
				• Control and rules:
				  • Lack of individualism
				  • Variable treatment
				  • Authoritarian staff
				• Fear and insecurity
				• Lack of information
				
				Service users' suggestions for management of aggression and violence on psych wards:
				• Adequate treatment:
				  • Right diagnosis
				  • Adequate medication
					Appropriate methodology: Yes
					Appropriate research design: Can't tell
					Appropriate recruitment strategy: Yes
					Appropriate data collection: Yes
					Researcher-participant relationship: No
					Ethical issues considered:
					Can't tell
					Rigorous data analysis: Yes
					Clear statement of findings: Yes
					Valuable: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				• Constant observation • Patient information • Caring physical environment • Meaningful activities: • Groups • Daily activities • Humane nursing style • Nurses' motivation and competence • Nurses' presence • Conversation with the primary nurse Delayed perceptions are similar to those perceived by patients immediately after the violence. More focus on examples of attentive nurses creating an atmosphere of safety in delayed perceptions.	

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				Long-term delay does not heal untoward emotional perceptions.	
Bensley et al. (1995)	USA	Quantitative Interviews coded into quantitative data. Generic analysis	N = 69 Patients	Patients' beliefs about hospital practices and aspects of the physical environment influencing assaults: • Smoking policies • Access to outdoors • Respect from staff • Seclusion and restraint • Not enough explanation of rules • Not enough to do • Not enough staff attention to patients Patients and staff had many concerns in common regarding situational and environmental factors related to patient assaults on hospital employees. Smoking and access to the outdoors, respect of staff, and use of seclusion and restraint are important sources of conflict.	**Clear Issue addressed:** Yes **Appropriate methodology:** Cannot tell **Appropriate recruitment strategy**: No **Accurate measure of measures:** No **Appropriate data collection:** Yes **Study power:** Can't tell **Presentation of results:** Yes **Rigorous data analysis**: No

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
					Clear statement of findings: Yes **Applicability of results**: Can't tell **Valuable**: Can't tell
Omérov et al. (2004)	Sweden	Quantitative Semi-structured interviews	N = 41 Patients Men: 17 Women: 24 Age Range: 20 - 65	Staff judged violence to be unprovoked much more (22 occasions) than patients (3 occasions) No relationship between the patients and the staff experiences regarding if violence was provoked. Medication experienced as provocation in 9 cases by staff but 14 by patients Discrepancy between the staff and patients' judgements on whether the violence was provoked or not was substantial. Knowledge on how to interpret patients' body language and other signals and how staff behaviour is perceived are important pieces of information that should be included in staff training.	**Clear Issue addressed:** Yes **Appropriate methodology:** Can't tell **Appropriate recruitment strategy**: Yes **Accurate measure of measures:** Can't tell **Appropriate data collection:** Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
					Study power: Can't tell **Presentation of results:** Yes **Rigorous data analysis**: Can't tell **Clear statement of findings:** Can't tell **Applicability of results**: Can't tell **Valuable**: Yes

Duxbury et al. (2005)	United Kingdom	Mixed Methods
		
		Survey and follow-up interviews
			N = 82 Patients
			
			Male: 40
			Female: 42
			
			Illnesses from schizophrenia to depressive disorders
				Causes of patient aggression:
				• Internal factors:
				  • Nurses saw mental illness as a strong precursor to aggression whereas patients did not share this view
				  • Opposing views on use of medication in this instance
				• External factors:
					Clear research questions: Yes
					Appropriate data collection: Yes
					Data sources suitable: Yes
					Qualitative analysis suitable: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal

			Admission from 1 week to 6 months	• Deemed problematic by both patients and staff, although staff responses were stronger
				• "Environment" was seen more broadly with patients
				• Interactional/situational factors:
				  • Poor communication
				  • Ineffective listening skills
				
				Management of aggression:
				• Medication considered by staff but not by patients
				• Seclusion opposed by patients but supported by staff
				• Restraint is sometimes inevitable
				• Deficits in interpersonal skills
				
				Attempts to foster approaches that move away from crisis management must address the concerns identified in this study. Major environmental, organisational and cultural
					Researcher influence discussed: Yes
					Appropriate sampling: Yes
					Appropriate measurements: Yes
					Acceptable response rate: Can't tell

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				changes are required. Approaches must be targeted carefully and based on the identified perspectives of those involved. Only then can more effective ways of dealing with and understanding patient aggression be implemented and tested empirically.	
Välimäki, Lam, et al. (2022)	Hong Kong (China, SAR)	Quantitative Cross-sectional survey Analysis using: • Chi-Square tests • Correlation using Pearson's r • ANOVA/MANOVA • R Squared Nahelkerkes	N = 1651 Patients = 886 Informal caregivers: 765 Male and Female equal	Differences in 11 items. Nurses agreed more often than patients or informal caregivers that aggression is unpleasant and repulsive, is unnecessary and unacceptable, and hurts others mentally or physically. Nurses agreed that aggression constitutes violence against nurses, is always negative and unacceptable, and that feeling should be expressed in another way as it is a disturbing intrusion to dominate others Nurses most often disagreed that aggression can be the start of a positive nurse-patient relationship, that is its healthy reaction to feelings of anger, and it allows a better understanding of the patient's situation, and that aggression is a form of communication	**Clear Issue addressed:** Yes **Appropriate methodology:** Yes **Appropriate recruitment strategy**: Yes **Accurate measure of measures: Yes** **Appropriate data collection:** Yes **Study power:** Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				Nurses had more negative views and a lower tolerance toward patient aggression. Second, regarding the sub-scores, nurses perceived aggression as a 'dysfunctional or undesirable phenomenon' and a 'functional or comprehensible phenomenon' more often than patients and informal carers. No group differences were found in attitudes toward aggression as a 'protective measure' Young informal caregivers may be in the most vulnerable position with regard to experiencing aggression	**Presentation of results:** Yes **Rigorous data analysis**: Yes **Clear statement of findings:** Yes **Applicability of results**: Yes **Valuable**: Yes
Lenk-Adusoo et al. (2022)	Estonia	Quantitative Cross-sectional questionnaire Analysis:	N=199 Patients Male: 117 Female: 82	Patients strongly agreed with "patients who are aggressive towards staff should try to control their feelings" and "when a patient is violent, seclusion is one of the most effective approaches to use" compared to psychiatrists and nurses. "Patient aggression could be handled more effectively on this ward" was more strongly disagreed with by patients than staff.	**Clear Issue addressed:** Yes **Appropriate methodology:** Yes **Appropriate recruitment strategy**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
		• Descriptive statistics • Mann Whitney U or Kruskal-Wallis • Spearman's rho correlation coefficients		Compared to psychiatrists, patients found it difficult to prevent aggressive behaviour restraining and isolating aggressive patients was an effective way of dealing with aggression. Compared to nurses, patients were more likely to agree with statements that reflected patients desire to be left along and calm down and that one-to-one communication between staff and patients was effective in reducing the likelihood of aggressive behaviour. All groups agreed that certain types of patients frequently become aggressive, and all had a agreeable attitude that aggression is caused by mental illness and restrictive care environment, that medication can effectively manage violent behaviour, and that the use of negotiation and de-escalation are effective in preventing aggressive and violent behaviour.	**Accurate measure of measures:** Yes **Appropriate data collection:** Yes **Study power:** Yes **Presentation of results:** Yes **Rigorous data analysis**: Yes **Clear statement of findings:** Yes **Applicability of results**: Yes **Valuable**: Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
Gillig et al. (1998)	USA	Quantitative Questionnaire design Analysis: Chi-Square tests with Yates correction	N = 54 Male patients 22 patients with schizophrenia, 11 with major depression, 5 with bipolar disorder, 8: Adjustment disorder	**Contributors to aggression**: • Both patients and staff agreed psychotic patients were more likely to be involved in physical aggression. • Patients attributed more aggression to **staff behaviors** (e.g., violent lifestyles, substance abuse) and **racism**, which staff did not acknowledge equally. **Staff-patient dynamics**: • Patients reported more aggression from staff than staff reported from themselves. • Patients perceived a **power differential** and felt staff were unaware of their experiences, contributing to aggressive incidents. **Verbal aggression**: • Patients found staff's verbal aggression toward each other disturbing, though staff reported less disruption from these interactions. **Emotional reactions**: • Patients experienced **worsening symptoms** due to worries about physical	**Clear Issue addressed:** Can't tell **Appropriate methodology:** Yes **Appropriate recruitment strategy**: Yes **Accurate measure of measures:** Can't tell **Appropriate data collection:** Yes **Study power:** Can't tell **Presentation of results:** Yes **Rigorous data analysis**: Yes **Clear statement of findings:** Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				aggression, including depression and anger. • 34% of patients reported **increased anger or rage**. **Recommendations**: • Patients need reassurance and **debriefing** after aggressive incidents to reduce emotional distress. • **Workgroups** should be implemented to address potential conflicts. • **Verbal aggression** should be addressed seriously as it contributes to emotional distress and may escalate to physical aggression. • Patients should be taught **nonviolent conflict resolution** skills.	**Applicability of results**: Yes **Valuable**: Yes
Duxbury (2002)	United Kingdom	Mixed Methods Factor analysis Meaning categorisation	N = 80 Patients *Comparison of Patient and Staff Perspectives*	Prevalence of Aggression: Patient aggression, particularly verbal abuse, is more common than physical violence. This aligns with growing reports in the literature. Inappropriate Strategies: The staff's reliance on traditional strategies like medication may be inappropriate, as these approaches are often	**Clear Issue addressed:** Yes **Appropriate methodology:** Yes

Lead Author (Year)	Country	Design & Analysis	Participants	Main Findings	Quality Appraisal
				based on unproven assumptions that internal patient factors cause aggression. Staff may prefer medication to prevent escalation, but this doesn't address underlying issues. Disparities in Perspectives: Patients view staff's controlling behaviour as a major contributor to aggression, while staff do not recognise this. These disparities between staff and patient views need to be addressed. Need for Organisational Change: There is a call for a shift in organisational culture in psychiatric settings and improvements in staff training. Current training approaches are seen as inconsistent and reactive, focusing on managing aggression rather than preventing it. Improved Communication and Proactivity: A more proactive approach to communication and interaction with patients is needed. This would foster better relationships and understanding between staff and patients.	**Appropriate recruitment strategy**: Yes **Accurate measure of measures:** Yes **Appropriate data collection:** Yes **Study power:** Can't tell **Presentation of results:** Yes **Rigorous data analysis**: Yes **Clear statement of findings:** Yes **Applicability of results**: Yes **Valuable**: Yes

1.8.2.4 Data Synthesis.

A thematic synthesis was used to summarise the findings of the final 15 papers selected (Thomas & Harden, 2008). Each paper was read multiple times, with relevant sentences extracted. Concepts were then sorted into themes, the process of which is depicted in Appendix 18. Thematic synthesis was used (See Appendix 18 and 19 for more details) due to its suitability for qualitative and mixed data, as well as its capacity for integrating diverse perspectives (Dixon-Woods et al., 2005). Line-by-line coding was used for each results and discussion section, both for the qualitative and quantitative papers. The systematic approach to identifying themes also lends itself to this review methodology.

1.8.3 Results

Table 4 highlights the themes and sub-themes elicited from the thematic synthesis. Six themes were identified, each with multiple sub-themes. Each theme will be examined in turn. Primary quotes have been included to demonstrate the themes with more richness.

Table 4

Synthesised Themes

Theme	Sub-Theme
Control and Restriction	Seclusion as punishment Reactive crisis management Lack of autonomy and control
Agony of a Non-Encounter	Impersonal care Power imbalances Violation of dignity Emotional consequences of no interaction Violation of respect Authenticity
Patient Lifeworld	Vulnerability and emotional exposure Boredom and its role in aggression Powerlessness
Wider Practices and Physical Environment	Punitive practices Poor environment Need for a therapeutic environment Stigma and discrimination
“Psychosis is dangerous”	Frustration with symptoms Dangerous dynamics
Staff Factors	Inconsistent staff behaviours Communication Training and supervision

1.8.3.1.1 Theme 1: Control and Restriction.

Nine studies (Bensley et al., 1995; Duxbury, 2002; Duxbury & Whittington, 2005; Gillig et al., 1998; Jenkin et al., 2022; Kontio et al., 2014; Lenk-Adusoo et al., 2022; K. A. Nolan et al., 2009; Omérov et al., 2004) identified that patients viewed seclusion as a punitive measure, used to punish rather than to treat. Seeing seclusion as punitive highlights that, at times, patients may consider staff members as overly controlling and perhaps exhibit violence in response. Three studies (Carlsson et al., 2006; Duxbury, 2002; Duxbury & Whittington, 2005) highlighted that patients see seclusion as a violation of their human rights. Being punished and being treated like prisoners was another key aspect of this theme. This is highlighted in the following quote: “They treat us like prisoners and try to lock us up. It’s the regimes and the atmosphere” (Duxbury & Whittington, 2005). The use of

language like “prisoners” contributes to the group identity and binary opposition seen within services, and could be a contributing factor to violence.

The use of seclusion, restraint, and medication as reactive crisis management strategies is common, but patients often feel that these interventions are employed in a way that further exacerbates feelings of powerlessness, according to three studies (Carlsson et al., 2006; Duxbury, 2002; Duxbury & Whittington, 2005). Reactive crisis management strategies, whilst potentially being a response to a violent environment, can be interpreted by patients as a further attempt to control and reduce power. The restrictive nature of the care environment may lead patients to feel controlled rather than treated, creating frustration and aggression.

Eight studies (Carlsson et al., 2006; Duxbury, 2002; Duxbury & Whittington, 2005; Gillig et al., 1998; Jenkin et al., 2022; Lamanna et al., 2016; Omérov et al., 2004; Vermeulen et al., 2019) highlighted the frustration that patients express over the lack of autonomy in their treatment and the rigid control imposed upon them. Autonomy is seen as a human right and may contribute to feelings of frustration and anger. Their liberties are restricted, and the absence of meaningful activities and the imposition of restrictive rules might contribute to distress and violence.

1.8.3.1.2 Theme 2: The Agony of a Non-Encounter.

Authenticity and the lack of genuine authentic connection contribute to the “agony of a non-encounter” (Carlsson et al., 2006). Patients describe staff as detached, and the care they receive often feels like tasks are prioritised over the person. The lack of authenticity can lead to patients feeling invalidated, rejected, and emotionally exposed, according to Carlsson et al. (2006). This can potentially manifest in defensive violence as patients try to protect themselves from further emotional harm. The following quote demonstrates the importance of an authentic encounter to patients: “Well you can tell that she is serious, that she cares

about you and that there is no cheating, you can tell that she simply cares. (Int: That she cares?) Yes, it is authentic, no ingratiating just so that I will behave and to avoid outbursts, there is truthfulness in it, sort of, she tells me that she cares and shows me respect" (Carlsson et al., 2006). Staff members opening themselves up to understanding the world of the patient is important to the patient.

Patients feel "left outside looking in" (Carlsson et al., 2006) as though they are treated as less than human and denied the opportunity to engage in meaningful dialogue. The power differential is noted in five studies explicitly (Carlsson et al., 2006; Gillig et al., 1998; Jenkin et al., 2022; Omérov et al., 2004; Välimäki, Lantta, et al., 2022) and is a significant source of frustration, particularly when patients feel that staff are not listening to or acknowledging their needs. When this happens, frustration and violence may occur.

Four papers (Carlsson et al., 2006; Kontio et al., 2014; Välimäki, Lantta, et al., 2022; Vermeulen et al., 2019) highlighted the absence of authentic care and the use of impersonal, task-oriented interactions as violating the dignity of patients. This could potentially catalyse violence. When patients are not treated as individuals, they may experience a loss of self-worth, leading perhaps to anger and a need to reclaim power through violence. Task-oriented actions might occur as a response to violent encounters; however, these are perceived as a rejection by the patients, which is potentially painful. Patients may then reject staff members through violence before they can be rejected, or in response to perceived rejection.

The emotional consequences of the non-encounters are severe. Patients report loneliness, isolation, and feeling neglected, compounding MH struggles and increasing the likelihood of violence. Feeling unheard, rejected, and misunderstood can perpetuate this agony of a non-encounter.

1.8.3.1.3 Theme 3: Patient Lifeworld

Patients describe their vulnerability and exposure within the hospital as contributing factors to violence. Feeling powerless and dependent on staff places them at the mercy of others. This vulnerability may lead to defensive violence, as suggested in several studies (Carlsson et al., 2006; Kontio et al., 2014; Omérov et al., 2004) as a means of protecting themselves from further emotional harm or mistreatment. A quote within Carlsson et al. (2006) highlights this: “I feel that he treats me as if he is of greater worth than I am, I am like garbage to him that you can just shove away in a corner.” This quote highlights the dehumanisation that can occur to patients in these environments. Dehumanisation puts the staff members in a more powerful position according to patients, and it is possible that violence results as a defence against this dehumanisation.

Boredom is a significant factor, highlighted by seven studies (Bensley et al., 1995; Carlsson et al., 2006; Jenkin et al., 2022; Kontio et al., 2014; Lamanna et al., 2016; Välimäki, Lantta, et al., 2022; Vermeulen et al., 2019) as a possible factor for violence, patients consistently report that a lack of engaging, meaningful activities intensifies their frustration and can act as a trigger for violence. There is a pronounced sense of monotony within a MH inpatient ward. When patients are subjected to this, the ability to feel fulfilled or engaged diminishes. This limits opportunities for meaningful interactions, further isolating patients and potentially increasing the risk of violence.

The experience of boredom is closely tied to feelings of powerlessness. Two studies (Kontio et al., 2014; Lamanna et al., 2016) highlighted this, suggesting that feeling trapped in a space with limited opportunities for engagement contributes to emotional distress, and perhaps violence. Lack of personal agency can increase hopelessness, and this frustration can manifest as violence, particularly when patients feel unable to express their needs or emotions in more constructive ways.

There is no clear consensus on internal motivations for patient violence, however Carlsson et al. (2006) discusses violence as expressing needs or as a defence from

rejection. Not feeling wanted is particularly poignant in this quote from a patient: “I feel that he treats me as if he is of greater worth than I am, I am like garbage to him that you can just shove away in a corner.” (Carlsson et al., 2006). Feeling degraded and not respected can cause anger. This quote, similarly to others, highlights the dehumanising feeling that can occur to patients in these environments. It follows, then, that violence may be a defence from the rejection or dehumanisation of the self.

Racism is highlighted in one study; however, this is not fully elucidated. Gillig et al. (1998) highlight that patients consider racism an important factor regarding violence and suggest that patients may experience a power differential between themselves and the nursing staff which may be an under-appreciated contributor to aggressive incidents. There are no quotes suggesting that racism is a factor in violence within MH inpatient units. Gender is also not discussed by patients as a potential factor in violent incidents.

1.8.3.1.4 Theme 4: Wider Practices and Physical Environment.

Four studies discuss punitive practices (Bensley et al., 1995; Duxbury, 2002; Gillig et al., 1998; Jenkin et al., 2022). The use of seclusion and restraint is seen to exacerbate feelings of frustration, isolation, and violence in patients. Bensley et al. (1995) argues that ”patients believed that seclusion and restraint were used in some cases as a first resort, when verbal interventions might have been effective”. Interestingly, however, one study found that patients view seclusion as an effective strategy for managing violence, even more so than staff members (Lenk-Adusoo et al., 2022). This may be due to this paper asking about violent encounters in general, rather than the patient’s violent encounters. Patients might find seclusion for other violent or disruptive patients favourable. Furthermore, there may be something about how seclusion is used in Estonia, where the study was based. Four studies (Bensley et al., 1995; Duxbury, 2002; Jenkin et al., 2022; Kontio et al., 2014) mention the environment specifically as a factor for violence. Overcrowding, lack of open spaces,

poor comfort, and lack of meaningful activities can all contribute to a sense of confinement and powerlessness, perhaps increasing the likelihood of violence.

Patients emphasise the need for a more therapeutic environment that prioritises comfort, emotional engagement, and meaningful activities. Bensley et al. (1995) note that comfort is the most significant factor. Patients discuss open spaces and areas where patients can engage in positive, relaxing activities and how this may reduce feelings of frustration and violence. Patients additionally reported that after an outing with staff members, they would see each other more positively, and tensions would ease (Bensley et al., 1995). Open spaces and areas where patients can engage in positive activities can also reduce violence. Poorly designed spaces exacerbate violence and where co-design principles inform facility design patients feel safer, suggesting that newer co-designed MH units may reduce some violence-contributing factors (Jenkin et al., 2022).

Two studies (Bensley et al., 1995; Jenkin et al., 2022) discuss stigma and discrimination. Patients report that they feel stigmatised by the perceptions that staff have of them. This can contribute to the cycle of violence. Perhaps this is why patients have a strong desire to be treated with respect and dignity. The following patient quote highlights this: "It’s stigma, yeah, yeah. It feels like they’re working with prisoners. It almost feels like we’re criminals, even though, some of us can function, and others can’t. Different degrees, obviously, on the spectrum but at the end of the day, it just feels like they don’t want to be near you. You know, everything’s blocked off, everything’s, yeah, it’s just, it’s really, really is over the top." (Jenkin et al., 2022).

1.8.3.1.5 Theme 5: Psychosis is Dangerous.

Patients discuss how psychosis can contribute to violence, particularly in the context of heightened distress, hallucinations, and paranoia. The following quote within Jenkin et al. (2022) from a patient highlights this succinctly: "It’s very dangerous and they [people with

psychosis] are also ... easily angered because of the pent-up frustration from hearing the voices… If you are having a psychotic breakdown like he was, it's just quite blood rage. You could see it in his face, and he was just puffed up like a blimmin' silverback gorilla, basically that's what he looked like." The apparent dehumanisation of violence, with potential racial undertones, is poignant here. This may be a defence against psychosis itself, seeing it as something that happens that is detached from the self.

Some patients report that the frustration with their symptoms, side effects from medication, and the lack of understanding from staff can exacerbate violence. Patients can internalise their histories of violence, becoming embedded as part of their identity or self-perception. They may internalise violence as a way of coping with their MH, or as a learned behaviour in response to institutional dynamics. Violence could also be seen as a defence against the irrational apprehension seen in some MH conditions, according to Omérov et al. (2004).

1.8.3.1.6 Theme 6: Staff Factors.

Variability in staff behaviour is cited in three studies (Jenkin et al., 2022; Kontio et al., 2014; Lamanna et al., 2016). Some being kind and empathic, and others being cold and authoritarian, creates confusion and can elicit negative emotional responses. This can be even more confusing when these changes occur in an individual staff member, perhaps because of a violent incident. Inconsistent care makes patients feel unsafe and uncertain, contributing to violence.

Four studies (Bensley et al., 1995; Carlsson et al., 2006; Lamanna et al., 2016; Vermeulen et al., 2019) talk about communication as a key factor in violent incidents. The common perspective was that poor communication contributes to the development of patient violence. One quote highlights this in mentioning that negotiation was poor and de-escalation ineffective: "Staff don't use de-escalation as well as they could here, but I feel it

could be a good approach" (Duxbury & Whittington, 2005). Another highlights the importance of communication to patients: "I find the talking helpful...if I've felt triggered by something, I could talk about it, and they would put a different perspective on it." (Lamanna et al., 2019).

Staff training and supervision were highlighted as a crucial factor in ensuring that care is both compassionate and effective in three studies (Bensley et al., 1995; Duxbury, 2002; Duxbury & Whittington, 2005). More training in emotional intelligence, communication, and de-escalation may be beneficial, although Duxbury and Whittington (2005) note that nurses tend to perceive their abilities to de-escalate using therapeutic communication as effective.

1.8.3.1.7 Recommendations for Preventing Violent Encounters.

Several recommendations were made and synthesised from the papers examined. The first factor that had consensus across several studies was enhanced staff training. Training in de-escalation, conflict resolution, and emotional intelligence may be helpful to equip staff to manage violence through effective communication and interpersonal skills, rather than relying on measures seen as more punitive, like seclusion and restraint. Furthermore, creating a therapeutic environment is crucial for fostering emotional well-being. This includes open spaces, meaningful activities, and ensuring comfort. Patients should be involved in the co-production of these spaces.

Several studies suggest an increased focus on respect and autonomy. Staff should prioritise patient autonomy where possible, involving them in care decisions and respecting their individual needs. Additionally, addressing the power differentials between staff and patients is another area for improvement. Working to create an atmosphere of mutual respect and collaboration is a challenging endeavour, but can be facilitated through training and supervision. Encouraging collaboration between staff and patients is also an important recommendation. Patient workgroups on violence and safety could allow for greater patient

input and the development of shared solutions to reduce violence. Ultimately, implementing meaningful activities to combat boredom and frustration is crucial in reducing violence. This factor was the most often cited reason for violence.

1.8.4 Discussion

This SLR set out to explore the following research question: *What are the attitudes of patients, carers, and the public on violence in mental health inpatient settings?* The review highlights how violence is perceived not merely as a symptom of mental illness but as a complex interplay of interpersonal, environmental, and systemic factors. The theme of "*control and restriction"* suggests that patients perceive interventions such as seclusion and restraint as punitive and controlling. These findings echo longstanding concerns around coercive practices (Cusack et al., 2018). Patients often experience these interventions as violations of autonomy, leading to further distress and as counter-violence. The framing of restrictive practices in this way highlights the need for trauma-informed care approaches (SAMHSA, 2014) that seek to minimise re-traumatisation. *"The agony of a non-encounter"* theme describes a lack of authentic connection and highlights experiences of being objectified or dismissed. When considering models of therapeutic alliance (Safran & Muran, 2000), violence may function as a defence against emotional invalidation. The absence of meaningful interpersonal contact diminishes patients' sense of worth and might contribute to feelings of rejection and anger.

Patients can feel emotionally exposed, powerless, and dehumanised within the *"patient lifeworld"* theme. The monotony of inpatient life, coupled with a lack of meaningful engagement, intensifies feelings of boredom and frustration that might precipitate violence. This underscores the importance of understanding violence as relational and contextual. (Caruso et al., 2021). Environmental conditions, including poor design and lack of access to therapeutic space, were consistently cited as contributing factors to violence in the *"wider*

practices and physical environment" theme. This SLR supports research that shows how environmental stressors can exacerbate feelings of confinement and powerlessness (Ulrich et al., 2008). Conversely, co-designed spaces were perceived as safer and more respectful. Some patients acknowledged that psychosis may contribute to violent behaviour within the *"psychosis is dangerous"* theme. This was often framed as the result of heightened distress and miscommunication. The internalisation of this theme could reinforce stigma, where individuals see violence as part of their identity. Diagnostic overshadowing, in which symptoms are attributed to illness rather than context, underlies the importance of not pathologising violence without addressing underlying environmental and relational triggers. The final theme, *"staff factors," underlines* inconsistencies in staff behaviour and poor communication as key factors in violence. This might support findings from studies on therapeutic boundaries and emotional labour in nursing (Edward et al., 2017; Kamp & Dybbroe, 2016). The need for improved training in de-escalation and interpersonal skills was repeatedly noted.

The findings from this review tentatively support systemic, relational, and trauma-informed models of violence (SAMSHA, 2014) and call for a shift to co-produced care where the experience of patients is central to the design and delivery of services. The SLR also supports the integration of patient perspectives into policies on violence prevention and risk management. Future research in this area may want to consider participatory methodologies, or perhaps explore the role of race, gender, or culture in shaping experiences of violence, examining how ward environments and organisational culture impact violence may be helpful.

1.8.5 Limitations

This SLR has been useful in highlighting the attitudes of patients concerning violence within inpatient units. There are, however, some limitations to the SLR. Firstly, the studies

were conducted across nine countries. While this may be beneficial for providing a clearer picture of patient attitudes worldwide, it may affect the generalisability of any recommendations or themes established. It is worth noting that during the synthesis, I was struck by the numerous similarities between countries, even those with vastly different health systems. Cultural and systemic differences may shape how violence is experienced and managed. I suspect that had the SLR involved non-English studies, then there would have been an even wider array of countries represented. The studies were all peer-reviewed and assessed for quality, which may introduce bias and potentially miss some unpublished theses that might be relevant. Many studies lacked discussion of researcher reflexivity, and few addressed how intersectional factors such as race or gender might shape experiences of violence.

1.9 Current Study

1.9.1 Purpose of the Study

Few studies have explored the topic of using a qualitative approach to describe and understand the experience of violence from staff perspectives. To date, to the best of my knowledge, no studies have used IPA for this research aim. The majority of violence research focuses on the epidemiology of violence, various risk factors, and outcomes of the events (Stevenson et al., 2015). The literature, therefore, would benefit from more qualitative research, focusing on sense-making. An examination of the sense-making of HCPs within MH inpatient settings concerning violence is, therefore, timely and relevant. Data collection will not be restricted to one ward, hospital, or Trust. Broader themes gathered from the data may inform staff support and policy regarding.

This research aims to gain an understanding of the sense-making of HCPs who have been involved in or witnessed violent incidents; to explore HCPs' perceptions of workplace violence in psychiatric inpatient settings; and to understand the impact of workplace violence

on HCPs' wellbeing and job satisfaction. The hope is that this will, in turn, positively impact patient care and experience. It may also highlight possible avenues for CPs to support HCPs within these environments.

1.9.2 Research Question

The primary research question is: “How do healthcare professionals make sense of patient violence within inpatient mental health units?”

2 Methods

2.1 Design

Critical realism consists of three key components: ontological realism, which asserts that a real world exists and persists independently of our knowledge or perception of it; epistemological relativism, which acknowledges that individuals interpret the world in varied ways, and that specific interpretations evolve into societal and cultural discourses; and judgemental rationalism, which suggests that, by considering the above, we can assess what may be true, while recognising that no knowledge is without flaw (Pilgrim, 2019). The methodological approach was chosen to complement this epistemology. The research question aims to make sense of a person's experiences, so a qualitative approach was necessary to facilitate in-depth exploration of lived experiences. The scarcity of this evidence highlighted in the introduction further adds weight to a qualitative approach. Qualitative approaches are considered more appropriate for under-researched psycho-social phenomena (Barker et al., 2016).

Interpretative Phenomenological Analysis (IPA) was selected as the most suitable method in line with the research question. See Table 5 for a consideration of other approaches. IPA closely examines how people create meaning over complex life experiences and focuses on lived experiences and associated significance (Smith et al., 2022). Its theoretical foundations in interpretation and hermeneutics align with the research question and epistemological stance (Smith & Nizza, 2022). Furthermore, analysis is viewed as a joint project between the researcher and participant (Smith et al., 2022) aligning with my values on research and co-production.

IPA has been criticised for its rigour in psychological research (Smith et al., 2022). It is time-consuming, particularly for less experienced researchers, but can be successful with appropriate guidance and supervision. Despite these criticisms, many studies support its

utility in generating theory and providing in-depth personal accounts (Pringle et al., 2011; Smith et al., 2022).

Table 5

Alternative Qualitative Methodologies

Qualitative Methodology	Reasons for Unsuitability
Thematic Analysis (Braun & and Clarke, 2006)	Thematic Analysis was considered for its flexible and accessible approach, which seeks to identify significant patterns across the dataset (Braun & and Clarke, 2006). However, given the aims, philosophical stance, and target population, TA would fall short in providing the richness and depth of a phenomenological approach, which focuses on subjective lived experiences. Additionally, TA would not facilitate the 'double hermeneutic' process, where the researcher interprets both the participants' experiences and their self-reflections in the process of meaning-making (Smith & Osborn, 2015).
Narrative Analysis (Bamberg, 2012)	Narrative Analysis was thoughtfully considered for its focus on storytelling, temporality, and the interpretation of individual stories (Bamberg, 2012). However, given the research question and objectives, Narrative Analysis would not provide a thorough exploration of the experience of violence in inpatient settings, nor would it enable the identification of more collective narratives. Furthermore, this study did not seek to examine how participants conceptualise violence over time.
Grounded Theory (Glaser & Strauss, 2017)	Grounded theory, although a valuable approach for developing theories grounded in data, was not chosen for this study because its primary focus on theory generation was not aligned with the research aims. Grounded theory is often used to explore broad phenomena and develop conceptual models. However, this study was more concerned with understanding the lived experiences of healthcare professionals about violent incidents within psychiatric inpatient settings.

2.1.1 Consultation

Engaging Experts by Experience (EbE) and stakeholders is increasingly encouraged in MH research (Brett et al., 2014; Deverka et al., 2012). From a decolonisation standpoint, involving EbE in research fosters inclusion and equality (Atallah et al., 2018), rebalances the power dynamics between researchers and participants (Smith, 2021) and challenges

dominant narratives in academic discourse (Sunkel & Sartor, 2022; Todowede et al., 2023). Engaging diverse stakeholders strengthens the translation of research findings into clinical practice and enhances the impact of research within local communities (Beeken et al., 2024; Kujala et al., 2022; Miller et al., 2021). In this study, EbE consultants were recruited via the supporting Trust's EbE programme, while professionals from clinical, research, and academic backgrounds were also sought for their expertise. Consultants were invited to determine their level of involvement, commitment, and incentives. EbE consultants played a significant role in shaping the interview schedule and developing the themes that emerged from the interviews. Both EbE consultants and clinicians contributed to the interpretation of data and the development of themes and subthemes, offering valuable insights that refined the final conceptualisation.

2.2 Ethics

2.2.1 Ethical approval

Ethical approval was granted by the University of Hertfordshire's (UoH) Health, Science, Engineering and Technology Ethics Committee with Delegate Authority with protocol number LMS/PGR/UH/05612 (Appendix 4). Further ethical approval was granted by the NHS Health Research Authority (IRAS ID: 337316; REC Reference: 24/HRA/2908) to allow the research to take place within NHS settings (Appendix 5).

The study was designed and research conducted according to the British Psychological Society (2021) Code of Human Ethics and the UoH's ethical guidelines concerning studies involving human participants (UoH, 2024).

2.2.2 Informed Consent

Research materials were shared with participants prior to the interview. A participant information sheet (Appendix 9), which contained information about the research purpose and procedures, as well as risks, data management, and withdrawal rights, was part of the research materials shared. Confidentiality and anonymity were also outlined within the participant information sheet. These materials were provided in print to individuals who had face-to-face interviews and via email to those who had online interviews. Participants were reminded of their right to withdraw at any time up to the date specified in the information sheet. Written consent was obtained prior to the interview and reaffirmed before the start of each interview.

2.2.3 Participant Well-being

Violence within mental health (MH) inpatient services is potentially a sensitive topic and could lead to emotional distress within the participants. A distress protocol was developed (Appendix 11) to assist in the steps taken following any distress. Participants were reminded of their right to withdraw from the interview and that they did not have to answer any questions that made them feel uncomfortable. A debrief was provided following the interview (Appendix 12).

2.2.4 Researcher Well-being

The researchers' well-being and associated challenges are an important consideration. Violence within MH inpatient settings has a personal resonance with my position as an insider researcher. Reflexivity journals, which began with the first interview and continued through to the data analysis, enabled me to be more aware of my processes. This was also discussed within the supervisory team.

2.2.5 Confidentiality and Data Protection

Confidentiality and anonymity were discussed with participants and formed part of the participant information sheet (Appendix 9). Participant data was anonymised and stored in the UoH secure, encrypted OneDrive. Interviews were saved directly into this drive. Hard copies of consent forms were uploaded to OneDrive and then destroyed. Anonymised interview transcripts were also saved to OneDrive, and any identifiable information removed (names, places, people, services). I transcribed interviews and extracts shared with my supervisor and consultant, as well as an advanced methods IPA workshop organised by the UoH for doctoral students. Participants were offered the opportunity to create a pseudonym for themselves. Anonymised data will be destroyed after five years. The interview recordings will be destroyed when data analysis is complete. Consent forms and participant data will be deleted by September 2025.

2.3 Participant Characteristics

The inclusion criteria were healthcare professionals (HCPs) who work or have worked in (within the last five years) MH inpatient services and had been witnesses to or victims of physical violence. Participants could be of different grades with different years of experience. Permanent staff members and bank staff were included. Exclusion criteria were as follows: workers in specialist services such as forensics or mother and baby units, individuals not completing the consent form, individuals not agreeing to the procedures for the time-bound withdrawal of information, and individuals not agreeing to anonymised quotes being used within the report. The mean age of participants was 28.14. The average experience in years was 2.86 years. Participants all worked within the NHS; however, some discussed incidents that occurred in non-NHS settings. Some participants no longer worked within inpatient services in line with the inclusion criteria.

Table 6

Participant Demographics

Pseudonym	Gender	Age at time of incident	Ethnicity	Experience at time of incident (years)	Role at time of incident
Maeve	Woman	20-25	White British	>1	Therapy Assistant
Hassan	Man	26-30	Arab	1	Healthcare Assistant
Sarah	Woman	20-25	Mixed (British and Asian)	1	Assistant Psychologist
Kleo	Woman	26-30	White Other	5	Healthcare Assistant
Obinze	Man	36-40	Black African	2	Healthcare Assistant
Eren	Woman	31-35	White British	2	Support Worker
Sana	Woman	26-30	British Pakistani	8	Charge Nurse

2.4 Data Collection

2.4.1 Sampling and Recruitment

IPA samples focus on capturing unique first-person accounts of lived experiences rather than representing the broader community being studied. Due to the rigorous and time-intensive analysis process, IPA typically involves smaller sample sizes, ranging from four to ten participants (Smith et al., 2022). While some diversity among participants is common, maintaining a level of homogeneity is recommended to minimise significant variations arising from social characteristics. Participants were identified and recruited through a purposive sampling strategy, facilitated by the project consultants, to enhance the validity and potential applicability to inpatient MH services more broadly. All participants were HCPs with experience working in MH inpatient services and experiencing violence in these settings.

2.4.2 Data Collection Method

Semi-structured interviews were conducted, facilitated by an interview schedule (Appendix 13). The questions were initially developed based on available literature and gaps in relation to violence within MH inpatient services. These were then amended following consultation with EbEs. Semi-structured interviews provide rich, firsthand accounts, which are well-suited to IPA. They allow for flexibility in adapting questions and provide confidentiality and participant comfort. Pietkiewicz & Smith (2014) highlight that semi-structured interviews are the most popular method in IPA, as they allow the researcher to give enough space and flexibility for original and unexpected issues to arise. Semi-structured interviews are seen as a valuable qualitative research instrument in a variety of research fiends (DeJonckheere & Vaughn, 2019; Ruslin et al., 2022).

2.5 Data Analysis

2.5.1 Interpretative Phenomenological Analysis

Smith et al. (2022) proposed an updated framework for IPA, outlining the process that researchers should follow. According to Smith et al. (2022), IPA is a multi-step approach that requires time, attention, and the researchers' active participation. Transcripts of the interviews were generated in Microsoft Teams using the recording and transcription function. These were then checked for errors by listening to the recordings of the interviews. Table seven highlights the processes followed for the current research, adapted from Katsampa (2024).

Table 7

Stages within IPA

Stage	Activity	Action
1	Reading and re-reading	The process begins with reviewing the first interview transcript and immersing in the data. The researcher reflects on their experience conducting the interview and documents initial interpretations, patterns, and explanations, including the rapport between the interviewer and participant, the flow, rhythm, and structure of the conversation.
2	Exploratory noting	This stage involves analysing semantic content within participants' life stories and language use. The researcher documents exploratory notes, interprets the meanings of experiences and relationships, and highlights key words and phrases. A linguistic focus helps identify specific word choices, metaphors, tone, emotional cues, and repetition.
3	Developing experiential statements	The researcher distils complex meanings from the participants' experiences into preliminary experiential statements. These statements reflect key concepts from exploratory notes, capturing both the participant's perspective and the researcher's interpretation.
4	Mapping connections across experiential statements	The researcher identifies connections between statements, considering both the research question and the project scope. Each statement is equally valued, and the data is reorganised to uncover associations with an open and innovative approach.
5	Developing Personal Experiential Themes (PETs)	After mapping connections, the researcher consolidates experiential statement clusters into PETs, the highest level of organisation for each case, with optional sub-themes. To ensure rigor, techniques such as member-checking and consulting co-researchers can be employed.
6	Repeating the process with other interview transcripts	The researcher independently follows the same analytical steps for each interview, treating each as a unique story and avoiding influence from previous findings.
7	Developing Group Experiential Themes (GETs) across interview transcripts	In the final stage of IPA, participants engage with PETs to identify cross-data patterns, forming GETs. This analysis highlights unique aspects of the lived experience across participants. It is a dynamic process that requires creativity to reorganise statements in a way that aligns with participants' narratives and key experiences.

Before beginning the stages outlined in Table 7, I listened to the interview recordings multiple times to familiarise myself with participants' stories and note my initial reactions and

reflections. The analysis progressed from an in-depth examination of individual interviews to a broader cross-analysis of transcripts. This approach ensured each participant's story was focused on individually, with unique insight about how HCPs make sense of violence in MH inpatient services.

Each transcript was freely annotated with experiential notes, including descriptive, linguistic, and conceptual comments. To facilitate this process, I used a three-column table (Smith et al., 2022), with the original transcript in the centre, experiential notes on the right, and experiential statements on the left (Appendix 14). The analysis was conducted manually to encourage innovation, creativity, and deep engagement with the data.

In the final stage, cross-data examination revealed similarities, differences, and shared experiences of HCPs' sense-making of violence within MH inpatient settings, leading to theme development (Appendix 15). To ensure analytical rigour and a more comprehensive interpretation, member-checking was conducted with two participants who expressed interest in further involvement, as well as reviewing themes with my supervisor and consultant. They revisited their narratives and my interpretations with complete transparency, offering additional reflections on meaning-making and refining PETs before the cross-case analysis.

2.5.2 Reflexivity

Reflexivity and active self-awareness are important aspects, particularly relevant within IPA (Smith et al., 2022). I am a white British man from a working-class background in my mid-30s who is training to be a Clinical Psychologist. I have a background in forensic medium-secure MH settings and consider myself an insider researcher as I have both witnessed and been a victim of violence within this setting. I have also been complicit in

"counter-violence"[3] seen within these settings. As a trainee at UoH, my training has been grounded in social constructionist theories of distress. However, my background as a Cognitive-Behavioural Therapist has been more aligned with a critical realist perspective. The biomedical model, in which much of NHS MH services are rooted, is firmly positivist. As such, each of these epistemological positions is familiar to me, and I can consider different perspectives on distress and consider myself a pragmatist in philosophical and epistemological positioning. No narrative concerning distress is inherently good or bad; How the person experiencing the distress plays a key role in considering factors that may be harmful or helpful. My background is important to consider, given that within IPA, the researcher and the participant co-create the meaning-making from the data.

My interest in this research topic was born from my experiences within these settings and the violence I experienced. Furthermore, the Clinical Psychology training has given me a greater appreciation of the iatrogenic harms and stereotypes, racism, and inequalities that can be perpetuated in these environments. There is potential for bias given my experiences; however, being an insider researcher has advantages when considering sense-making approaches.

Bracketing was employed to aid reflexivity. This occurred before data collection, before data analysis, and before write-up. This facilitated the self-reflective process and encouraged me to consider with honesty and transparency my values, beliefs, biases, and assumptions about violence within MH settings (Tufford & Newman, 2012). The advanced methods IPA workshop and monthly research supervision sessions provided a space for self-reflection, aiding in the deeper interpretation of findings. This is an essential element of interpretative research (Smith & Nizza, 2022). I kept a reflective journal to aid in mapping interpretations (Appendix 1).

[3] For example, being involved in restraints, the use of seclusion, and forced medication, as well as the general deprivation of liberty that happens in inpatient services.

2.5.3 Rigour

Smith et al. (2022) recommends a quality appraisal framework for IPA research. One such framework is that used by Yardley (2000) which was the basis for assessing rigour in this research. The process of this is highlighted in Table 8, adapted from Katsampa (2024).

Table 8

Yardley (2000): Principles of Good Qualitative Research

Principle	Application to the study
Sensitivity to context	Smith et al. (2022) emphasise the importance of incorporating sensitivity to context from the outset of research using IPA. This involves critically considering alternative methodologies and understanding the reasons for adopting an interpretative approach. Sensitivity is a fundamental aspect of IPA, as demonstrated by its thorough and individual-focused approach. In my research, I prioritised this sensitivity by consulting with experts, reviewing literature, and aligning my work with the philosophical foundation of critical realism. My in-depth knowledge of the settings helped me stay connected to the HCPs' lived experiences, allowing me to approach the interviews thoughtfully. As I analysed the data, I continued to approach the process with sensitivity, immersing myself in the participants' perspectives and amplifying their voices through direct quotes, which further enriched the contextual understanding.
Rigour	Developing qualitative skills demonstrates rigour. This is something I have done throughout my career as a researcher. This has allowed me to increase my confidence in conducting rich interviews and mitigate risks. Methodological rigour, according to the IPA framework outlined by Smith et al. (2022), is a focus I have endeavoured to maintain throughout the research process. Rapport with participants was developed and benefited from being an insider researcher. Consultation with EbEs, both patient and staff, allowed for increased rigour and additional consideration of my interpretations. Bracketing further enhanced rigour, allowing for an increased awareness of my own beliefs and assumptions. My use of a reflective diary also supported this. PETs and GETs were discussed both within the supervisory team, via member checking, and with peers within the context of an advanced methods IPA workshop. Participants were offered the chance to examine PETs and GETs, further supporting the rigour of this study.
Transparency and coherence	Yardley (2000) notes that transparency and coherence relate to the clear and sound presentation of the research process, evidence,

	and arguments. I consider that my research process has been transparent and that I have provided step-by-step accounts of the process. The sense-making discussed, I believe, is grounded in the participants' meaning-making. Stating my personal and epistemological context has allowed for greater transparency. Furthermore, linking meanings and associations between the existing literature, research question, findings, and interpretations has improved transparency and coherence. Discussing interpretations transparently, highlighting my interpretations and the excerpts that led to those interpretations, allowed participants to member check and provide feedback on the PETs accurately. I have used people's accounts verbatim within PETs where possible to maintain authenticity.
Impact and Importance	Yardley (2000) determines the importance and value of research as the decisive criterion against which a study's quality is appraised. Given the information provided within Chapter 1 about the prevalence and incidence of violence within MH inpatient units, as well as the current crisis in recruitment and retention of nurses within the NHS, my study seems important, relevant, and timely.

3 Results

This chapter presents the study's findings using an IPA framework, outlining areas of convergence and divergence across individual stories (Smith et al., 2022) to balance the representation of mutual experiences and single voices. My interpretation of the accounts of sense-making concerning violence within mental health (MH) inpatient services is informed by my critical realist epistemology and my insider researcher role. I aim to demonstrate the subjective nature of the experience, as well as the commonalities within that experience, suggestive of a shared reality (Grace & Priest, 2015). Table 9 outlines the Group Experiential Themes (GETs) and sub-themes.

Table 9

Table of GETs and Sub-themes

Group Experiential Themes (GETs)	Sub-themes
Coping, surviving, and the normalisation of violence	1. Normalisation and daily survival 2. Adaptive strategies
Navigating organisational failure and institutional betrayal	1. Systemic invalidations 2. Institutional neglect and responsibility 3. Environmental stress and containment
The emotional and moral weight of violence	1. Moral dissonance and identity conflict 2. Emotional responses and isolation 3. Oppression and identity-based harms
Violence as a complex and relational communication	1. Co-construction of violence 2. Violence as communication 3. Complexity of causes

The recurrence of themes is shown in Table 10. Throughout the following section, I have used direct quotations[4] to position the healthcare professional's (HCP) sense-making centrally, followed by my interpretations.

Table 10

Recurrence of Themes Across Participants

	Maeve	Hassan	Sarah	Kleo	Obinze	Eren	Sana
GET 1: Coping, surviving, and the normalisation of violence	X		X		X	X	X
GET 2: Navigating organisational failure and institutional betrayal	X	X	X	X	X	X	X
GET 3: The emotional and moral weight of violence	X		X	X	X	X	X
GET 4: Violence as a complex and relational communication	X	X	X	X	X	X	X

3.1 GET 1: Coping, Surviving, and the Normalisation of Violence

This theme explores how violence becomes embedded in the ward culture or is "*par for the course",* as Eren discusses. It also explores how staff survive the "*warzone*" (Obinze) through humour, detachment, camaraderie, and reframing, but at a psychological cost.

3.1.1 Normalisation and Daily Survival

When working within MH inpatient units, violence is seen as inevitable and predictable. When considering a violent encounter, Maeve discusses that "*it was kind of… a daily thing",* indicating a sense of routine to violence. Her hesitation ("*kind of")* may suggest a

[4] Direct quotations are presented: "*within quotation marks*". **Bold text** indicates an emphasis on words or phrases. [...] indicates omitted words to improve clarity. (*description*) indicates pauses or other non-verbal signs of communication. ( ) indicates words that have been inserted to improve coherence.

struggle to accept this normalisation. When discussing the first time she was a victim of violence, Maeve says:

> *"I don't remember the first time. I feel like the first time it happened it was probably a bit more scary, but I think by this point … It was like a daily (pauses) a daily thing. Yeah, but (pauses) It was (pauses) I think the other thing was it always felt quite sad that it just didn't feel like it was the right setting for her." – Maeve*

Her inability to recall the incident might suggest that violence had become blurred into the everyday fabric of ward life. This forgetting may reflect a coping mechanism that allows her to function in an environment where violence is routine. The quote serves to reinforce the idea that violence had become a habitual and expected occurrence. The pauses might suggest that this normalisation is uncomfortable, and that she is processing the emotional cost of this transformation in real-time. Maeve concludes this reflection with a shift in focus; she appears to retain a deep sense of empathy, and there is an acknowledgement that the system itself may sometimes fail patients. Obinze speaks more to the ward environment and the struggle for survival:

> "(The ward) is *a danger zone. It's a war (pauses) a warzone…I see it as…dangerous, a risky environment…I see it as a risky place to be, a risky place to work*". *– Obinze*

The repetition of the word *"risky"* as well as the strong metaphor of a *"warzone"* evokes an environment where threat is not only ever-present, but expected. The ward is framed as an adversarial space, echoing the language of combat and survival:

> *"We're like soldiers. You go to the warfront…You don't know where the next bullet is coming from" – Obinze*

This suggests that Obinze sees the work not just as challenging, but as psychologically and physically perilous. His characterisation reflects individual perception, and it hints at a systemic atmosphere of threat, where violence is so ingrained that describing the ward in militaristic terms feels natural. This may speak to a broader

normalisation of violence, where survival is equated with vigilance, and where staff are compelled to adopt defensive psychological positions just to function. Eren adds an extra layer of interpretation, suggesting that working with people with MH conditions creates an expectation for violence:

> *“and it was almost like (pauses) You know these people are unwell (pauses) It's, you know (pauses) You know it's normal for them to act in this way (violent) or it's expected for them to act in this way because of their mental health condition.” – Eren*

The repeated pauses throughout the statement may reflect hesitation and discomfort, perhaps suggesting an underlying moral conflict. This does not seem a rehearsed belief, but rather one that is being actively negotiated in real-time. The repetition of *“you know”* may serve to seek affirmation and soften the harshness of the idea being expressed. This view may serve as a coping strategy, allowing her to rationalise and emotionally distance herself from the trauma of violent incidents by attributing them to the patients’ diagnoses rather than to systemic or relational dynamics. She may be aware that this kind of expectation risks reinforcing stigma and dehumanisation. The expectation that violence is *"normal"* for people with MH conditions reflects a dangerous form of adaptation that protects the HCP emotionally but potentially contributes to a culture where violence is tolerated rather than challenged. Sana has more to say on these ideas:

> *“I think because (violence is) such a regular occurrence on the unit. Where, when service users are unwell (pauses) they just are more verbally abusive because they don't want to be in that setting and staff get used to it. (It’s the) same with racial abuse, even though it's not something that the Trust does take lightly...because it's been when the patient has MH…it stops there rather than OK, they do understand what they're doing in that aspect, maybe not their MH, but yeah, that's what I've seen.” – Sana*

The pause following *"when service users are unwell"* might suggest a reflective moment, indicating some discomfort with the logic being used to justify abusive behaviour. She highlights the desensitisation process by saying *"staff get used to it",* where repeated exposure to hostility reshapes what is considered routine. In the latter part of the quote, Sana might be implying that patients, whilst unwell, might still have awareness of the impact of targeted verbal abuse. This could create a moral and ethical tension, where Sana feels pressure to accept behaviours even when those behaviours are harmful or discriminatory. Sana draws a parallel with racial abuse, perhaps pointing to a systemic minimisation of harm, where deeper structural change is cut off by the assumption that racist abuse is simply the symptom of illness. Sana goes on to talk more generally about how violence is perceived in a MH unit:

> *"There also seems to be this kind of (idea that) violence is acceptable in MH. It's kind of like, oh, work in MH. It's it's going to happen whether you want it to or not. And it's that kind of (pauses) you become kind of used to it…when people are like…why did this happen? And you're just like, oh, it's just a normal behaviour here – Sana*

There is a resignation that violence is something inevitable and uncontrollable, that it is embedded into the identity of the profession itself. Sana highlights the core paradox of this theme, both coping with violence through normalisation and retaining an awareness that something is not right about this adaptation.

3.1.2 Adaptive Strategies

The impact of the normalisation and daily survival of ward life leads to a sense of camaraderie, particularly during or following a moment of violence. Sarah remarks that *"you could really get the sense that…the people on the floor really did care and look out for each other"*. This sense illustrates how interpersonal connection acts as a buffer to the impacts of violence. Peer support may become not just helpful, but essential for survival. Sarah's use of

the word *"sense"* suggests that the caring was not necessarily stated but was deeply felt. The camaraderie may serve as an emotional anchor, with violence being a collective experience, potentially reducing feelings of helplessness. Sarah goes on to discuss this togetherness in the context of two violent incidents, one shared and one individual:

> *"I don't know again because it was aimed at the group (pauses) there was a less of a…feeling like oh, does that mean I've done something wrong that this is a collective mistake that's gone on here and we need to resolve it? The other one, it was very much starting to feel like, you know, maybe there's something I've done wrong (pauses) somewhere I've slipped up, which I've just not realised." – Sarah*

Here, she illustrates the adaptive function of togetherness, particularly in how violent incidents are emotionally processed. The quote might suggest that when violence is perceived as collective, it is less psychologically damaging, and that there is a shared accountability. The use of *"we"* and *"collective mistake"* indicates that the sense of togetherness provides emotional cushioning. Sarah highlights an important adaptive strategy of reframing violence as collective, which shapes how incidents are interpreted. Maeve discussed a more conflicting strategy, whereby she felt safe with colleagues, but also felt judged.

> *"There was…knowing how…quickly they might respond if you raise the alarm. But also there was… a couple of people who would…make comments about like (pauses) It was something like, oh, almost like, if you're not OK with being attacked, then you shouldn't work on a ward (pauses)…That just felt very judgy (pauses) I think that was in the context of…my friend had been attacked and was then quite upset by it. It's…like, well, maybe you're just not made for this job... So that…judgement of how you might respond." – Maeve*

Maeve highlights a discrepancy between feeling safe and feeling judged by colleagues if she displays any emotion. The idea that emotional distress following violence

makes someone unfit for the job might reflect an internalised standard of emotional toughness that, whilst protective, risks silencing natural human reactions. It may reflect a broader cultural script in inpatient settings, where struggling emotionally is interpreted as a personal or professional failing rather than because of traumatic exposure. In such a culture, stoicism becomes necessary to fit in. In contrast to Sarah, Maeve suggests that team dynamics can both be supportive and undermining. Eren has a different adaptive strategy, namely that of contextualising the experience of violence:

> *"I guess more just seeing it from both sides rather than…my take on the situation initially like I said, you know this isn't fair. I don't deserve this. But actually if you think about it from her point of view as well (pause) it…gives it (pauses) more context, I suppose." - Eren*

Eren's cognitive reframing highlights that adaptive strategies to violence are individual. This quote may hint at a shift from reactive distress to deliberate reflection. This reframing might allow her to hold her emotions and the patients' struggles simultaneously. The dialogical adaptation, rooted in clinical insight and emotional maturity, allows for continued engagement with the patient without burnout or withdrawal. Eren's framing of violence does not minimise the harm but places it within a broader narrative of meaning. Maeve discusses another strategy, of using humour as to cope:

> *"I guess kind of joke with it… I think generally on the ward (pause) there wasn't necessarily (pauses) incidents weren't necessarily taken very seriously, so I think some of the nurses…were sort of older. Maybe like older men and they would sort of, I guess, make jokes about things sometimes I think...And maybe there was…just a bit of that like culture of that like kind of how you deal with it, like it's just a bit funny." - Maeve*

Humour seems to be used both individually and culturally to manage the emotional impact of violence. Her fragmented delivery suggests a degree of uncertainty and

discomfort, as if she is weighing up how appropriate this coping mechanism is. She seems to hesitate between acknowledging humour as helpful and questioning whether it reflects a problematic dismissal of serious events. The observation of *"older men"* might suggest a gendered and generational cultural norm. Humour might become an expected way of processing violence, offering psychological distance. The closing comment encapsulates the emotional tension at the heart of Maeve's strategy. Whilst humour might provide momentary relief or solidarity, it risks minimising the seriousness of violence.

3.2 GET 2: Navigating Organisational Failure and Institutional Betrayal

This theme involves HCPs making sense of violence partly through their experience of being unsupported, blamed, or let down by the system that employs them. Maeve discusses how *"senior management need to take (violence) seriously"* and Kleo talks about violence being a "*systemic issue".*

3.2.1 Systemic Invalidations

Violence is not taken seriously enough, according to Maeve. She discusses how senior management and systems can perpetuate violence but not consider the needs of the patients. Maeve discusses how systemic priorities can override clinical judgment, which contributes to a broader sense of institutional failure and moral compromise.:

> *"All the beds weren't filled and so they would accept people (pause) who arguably, they shouldn't accept so with it being predominantly (a) MH ward, I think the criteria was…in terms of people, the learning disability, they would accept people with a mild learning disability as long as it was the difficulties were primary primarily related to their MH rather than their learning needs. But they (pause) accepted*

some…moderate learning difficulties…So (it) seems they were making…interesting decisions about admitting people that seemed more from a perspective of filling beds…The woman with (a) moderate learning disability who was accepted, had been on one-to-one or three-to-one. I think actually for years before coming to us (pause) So there was quite (pause) concerning decisions really about who is…being accepted." - Maeve

Her pauses might indicate discomfort or a cautiousness in how she phrases her critique. Nevertheless, she seems to believe that operational pressure to fill beds was taking precedence over clinical appropriateness. Her use of the phrase *"interesting decisions"* might be a subtle indictment of what she perceives to be financially motivated decisions at the expense of patient care and staff safety. Maeve highlights the example of a woman with learning disabilities who had previously required intensive staffing, who was admitted to a general MH setting that was unequipped to meet such needs. This potentially destabilises the environment, as well as creating a sense of institutional betrayal for Maeve and her colleagues, who were expected to absorb the consequences. The quote reflects a deep frustration at the system, as well as Maeve's discomfort at witnessing organisational decisions that feel unsafe and unethical. It may also be a recognition from Maeve that such failures perpetuate violence as an outcome of systemic invalidation. Maeve describes how *"the management was just declining"* and *"I had a lot of anger and frustration at the service"*, highlighting the emotional toll of the systemic invalidation. Both Maeve and Sarah discuss how this is particularly prevalent following an incident:

"I think that can be…a result of systems that don't. (pauses) typically provide much support to staff (pauses) don't necessarily provide many spaces for (pauses) debrief (or) reflection (pauses)…(or) genuine…employee care.. I think the…welfare support can be very tokenistic. And so then I think a lot of people can end up being very burnt out… I think senior management can be very dismissive. That was always my

experience that it can be really downplayed that like the impact that it can have on people" – Maeve

"To be honest with you, I felt like (the debrief) was more about they just wanted to know what happened (pauses).. It was like a police interview rather than a are you all right? It was like, OK, just deal with it, get on with it because, you know, (it's) kind of what you signed up for. But it was like, but really, how did this fuck up happen really? (pauses)… I guess at the end it was a bit of a well, you know, if you, you know, if you want to talk again about it or if you feel anything or you want to have. (pauses) a bit of time to think about it and you just, you know, where we are." - Sarah

Maeve and Sarah describe how organisational responses following violent incidents often lacked genuine emotional support, reinforcing a deeper sense of systemic invalidation. Maeve conveys a sense that institutional responses are performative rather than meaningful with her use of the word *"tokenistic".* She goes on to talk about *"burnt out"* suggesting that this has cumulative effects on emotional sustainability. Maeve might be suggesting that this is not about missed opportunities for support but about a systemic culture that deprioritises staff welfare. There is a strong statement from Maeve about senior management being dismissive, suggesting an expression of institutional betrayal, that those in power minimise the emotional consequences of violence, implicitly invalidating Maeve's lived experience. Sarah echoes this, reflecting how debriefs felt procedural over compassionate. Her use of the phrase *"police interview"* reflects a shift from support to scrutiny. For Sarah, the vagueness and detached tone of the end of the quote might reinforce the idea that the burden of seeking support is placed on the employee, not the system that has failed them. Both Sarah and Maeve illustrate how post-incident responses can compound the emotional impact of violence by failing to validate staff experience. Kleo offers some contrast to Maeve and Sarah, suggesting that *"it needs to be massive systemic change"* rather than *"employers and management".* Kleo articulates a vision for transformative care based on curiosity and dialogue, but laments that systemic barriers often prevent this:

"I don't know how much employers and managers can do (massive systemic change) (pauses). They're so bound to (pauses) targets and (pauses) very small funding and little work, like little work is available. Everyone is underpaid, so I don't think that…they can do very much... I just don't think that they can do very much. I don't think these systems should be the way that they are. I think it should be completely different." – Kleo

This reframing of institutional failure as a product of wider socio-political systems appears hesitant, perhaps suggesting a difficulty in naming a system that feels both overwhelming and entrenched by economic logic and bureaucratic constraint. Her use of *"completely different"* suggests both radical disillusionment and a desire for reimagining services. Whilst Sarah and Maeve expressed a betrayal of the organisation, Kleo expresses a more macro-level betrayal by the wider structure of MH. The quote embodies a quiet, ethical idealism. Kleo speaks of valuing *"curiosity"* and *"dialogue"* in other parts of her interview, indicating a contrasting vision of care that she currently perceives as rigid, reactive, and punitive. Ultimately, Kleo's quote highlights that systemic invalidation is not always experienced as active dismissal but can be felt in the very design and limits of the system itself.

3.2.2 Institutional Neglect and Responsibility

Obinze discussed the conflict between emotional and professional responses to violence in a MH inpatient setting:

"I'm trying not to react (pauses)…in a way that is not appropriate, you know, so you try to still maintain the professional conduct. So…it's, it's a lot like your your your your ***tied*** *(Places his wrists together as if they were tied). You're being stabbed at the same time you're not allowed to speak. You're not allowed to act. Because…when you do, when you say anything or when you do anything… The service user goes*

free and you get into trouble, you're suspended, you lose your job, you lose your PIN. As a case. Maybe. So…it's tough." – Obinze

This quote reflects the emotional suppression required of Obinze to uphold professional standards, even when under direct threat. The pause may suggest a struggle to contain intense emotions that are deemed unacceptable within these professional standards. The powerful metaphor of being *"tied"* and gesturing speaks to the embodied sense of entrapment and being restrained by service providers and regulatory bodies, illustrating perhaps a lack of emotional support and a neglectful institutional attitude of enduring violence without protest. Obinze also suggests an institutional abandonment, reflecting a belief that even minimal self-protective responses could lead to disciplinary action. This could perhaps signify a moral inversion where Obinze, the victim, becomes the one penalised. His final words, *"it's tough",* carried an emotional gravity and gestured towards an institutional mistrust, where he must suppress his most human reactions to remain employed, act professional, and survive. The institutional neglect is more pronounced for Obinze here:

"I tried to avoid being in the midst of such, but unfortunately, like I said, the environment itself is risky and you can't predict what will come in the next minute. So I would prefer if I am not involved in any incident (pauses). Because I know nothing, ***nobody*** *has got my back. Nothing will happen. So you are…the losing end or do (pauses) I don't know if that's the right word to use. You're the one that's going to lose at the end of the day because nobody will fight for you. You know? So yeah (pauses). That I feel." – Obinze*

Avoidance might arise as a defensive response to violence, which seems rational in a setting where support structures are experienced as unreliable or absent. The candid admission that *"nothing, nobody has got my back"* lays bare the lack of psychological safety he feels. The repetition of *"nothing"* and the use of *"nobody"* hints at a sense of abandonment and a belief that there will be no justice. The avoidance, therefore, may be a

defence against the emotional cost of not only the violence, but of being failed by the institution in its response. Obinze's uncertainty over the language in the final part of the quote might reflect how hard it is to articulate the neglect and betrayal he feels. Obinze might be saying that staff like him are sacrificed by a system that demands so much and gives little in return. *"Nobody will fight for you"* suggests a theme of institutional abandonment. There is a genuine emotional authenticity within this quote, tying into the lived reality he is witnessing. Sarah suggests that violence is the responsibility of all staff members. When discussing a violent incident with a weapon, she mentions that *"Really, someone had an epic mess up there that he got hold of this knife"*, suggesting that the responsibility for violence rests on the staff members. She discusses the incident further:

> *"And I think that's why then it all came down hard on us afterwards about (pauses) that really the opportunity should not be there for this to happen again and I think everything was then removed and it was…literally a case of cut things with a butter knife…the young people wouldn't have hold of the knives. It would be the staff and then they would be locked away." – Sarah*

The abruptness of the organisational reaction suggests a punitive and managerial environment. Sarah might be suggesting that she feels less like a victim or a collaborator in problem-solving, and instead as someone that is accountable and blamed. The focus on tightening control measures illustrates how operational safety measures are used rather than understanding behaviour, suggesting a risk-averse institutional mindset from the organisation. The quote suggests that Sarah feels disempowered following a more restrictive and less flexible environment. This type of response fails to engage with the emotional impact of the event or the systemic issues that may have contributed to it. Sarah discusses responsibility more:

> *"It was very important that we kind of establish what the triggers were. We let all the staff know that that, you know, seeing the colour red was a trigger for one of them." - Sarah*

Sarah reflects on how staff often take on the task of proactively managing risk, highlighting a sense of moral and professional accountability. She might be suggesting a desire to protect patients and staff by promoting awareness and sensitivity to psychological triggers. This act of proactive risk management may reflect the internalised responsibility she feels, particularly in the context of institutional failures or neglect, evidenced by the burden of safeguarding and communication being managed between frontline staff, rather than through formalised structures, processes, or leadership. The example provided within the quote suggests a constant cognitive and emotional pressure felt by Sarah. The intensity of detail and hyper-awareness required, often without training, supervision, or reflection, suggest a high degree of hypervigilance to psychological needs of patients. This could be an excellent example of how staff compensate for systemic shortfalls.

3.2.3 Environmental Stress and Containment

Kleo discusses how *"The setting of it was depressing",* and the inpatient environment itself is an important factor in making sense of violence. She describes the environment more:

> *"It's already a bit of a sad and depressing and (an) upsetting place where you (pauses) absolutely the last place that you would consider is, well, one of the last places that you would consider is therapeutic. You know, tables are bolted to the ground, along with chairs (pauses). There is no colour, it's just the hospital blue (pauses) or white (pauses). People are so drugged that they're kind of literally falling over. There was one young guy who was falling against the wall" – Kleo*

Kleo's visceral description indicates emotional weight, and the pauses suggest difficulty articulating the extent of her disillusionment with the setting. This quote perhaps suggests that the institutional aesthetic is not neutral but actively contributes to emotional dysregulation and despair. The physical constraints of *"tables bolted to the ground"* point to

an atmosphere where security and control are prioritised over warmth and recovery. The bolting of furniture could be interpreted as a symbolic reminder for Kleo of containment and restriction, while the lack of colour evokes flatness and coldness. Her reflections also speak to the impact of medication and sedation. Kleo's comments may suggest that she sees over-medication as another form of containment and systemic control through pharmacological means. Kleo seems to invite the interviewer to question the ethics of a system that is more invested in pacification than in care. The environment may contribute to the normalisation or escalation of violence, with people becoming trapped in a fundamentally non-therapeutic setting. Kleo goes on, stating: "*Horrifying is the word that comes to mind (pauses). Already the setting…it felt like a prison".* The association with the word *"prison"* evokes a setting of punishment, surveillance, and loss of autonomy rather than safety or recovery. She continues, describing a power imbalance where a set of keys symbolises freedom: *"there is a collection of people who have the keys and are allowed to go out, and another collection of people who are never allowed to go out and they can't make any decisions about that unless decided by the people with the keys".* In this framing, the inpatient environment becomes about containment and disempowerment. Kleo provides another rich and compelling contribution, shifting the lens from the environment itself to containment within the environment:

> *"I'm sure there are… Loads of things. I so now my head is thinking, well, if you've got nothing to do all day, don't you get really pent up and stressed out? I mean, I definitely do. I as much as I wish to believe that people do have access to psychological support and therapy, I don't actually think people do so. Do people have? Yeah, as a contributing factor, I guess it's do people have any sort of understanding of what it is that's going on and why it is that they're in the place that they are and…if they're not, they're being kept in a cage. So would you not try and get out as much as possible? Would you not hate everyone who's locking you in there? Yeah." – Kleo*

Beginning with a relatable, humanising comparison highlights the empathy Kleo has for the patients she works with. She frames violence and distress as a natural reaction to deprivation rather than some pathology. She seems to express doubt about the availability of psychological support and positions violence as an outcome of unmet emotional and therapeutic needs. She makes sense of violence as a lack of meaningful engagement. The language of *"being kept in a cage"* suggests that whilst Kleo does not condone the violence, she frames it as a form of protest, a natural consequence of institutional containment without care or explanation.

3.3 GET 3: The Emotional and Moral Weight of Violence

With this GET, violence is seen as physical and procedural, as well as deeply emotional and ethically destabilising. Professionals wrestle with moral conflicts, identity struggles, and a need to remain human in inhuman situations. There are also oppression and identity-harms considered within this GET, such as gender-based violence and racism.

3.3.1 Moral Dissonance and Identity Conflict

This sub-theme captures the emotional strain that the participants of this study report experiencing when their professional roles come into tension with their ethical beliefs. Maeve sees inpatient services themselves as violence, creating a sense of moral dissonance about working in that environment:

> *"I that I think services in themselves are very violent and I don't want to be a part of that violence rather than because I'm worried about violence happening to me, it's more that I don't want to be complicit in violence, I think." - Maeve*

Maeve's quote reflects a deep internal conflict about complicity. Her framing reflects a conceptualisation of violence as structural and institutional. Her primary concern seems to

be ethical contamination, that she is morally implicated by participating in services that cause harm through coercion, containment, overmedication, and emotional neglect. She suggests with her statement that there is a conflict between a high level of moral awareness and a significant emotional burden. Maeve hints that it is difficult to reconcile her presence in an unjust system with her professional values or personal integrity. She appears to be negotiating a painful moral position. Her broader understanding of violence as institutional contributes to the emotional weight she carries, both as a victim of violence and a reluctant instrument in a system that reproduces harm. Kleo echoes Maeve's reflections, going even further, expressing moral injury and even outrage at times over the use of counter-violence in one violent encounter:

> *"The consequences of that, which was the security coming, throwing him down on the floor. Taking off all of his clothes (pauses). Putting him into seclusion… he was so, so, so distressed and screaming and shouting, throwing himself against the door, trying to smash the door open (pauses) and I was just made to sit there and observe him…It was all very distressing and unpleasant and scary on both ends. (It) created just a lot of heart racing and stress and upset…Scared. Vulnerable. Confused. Erm. (pauses) (I was) unsure what to do. Unsure what (pauses). Sounds weird to say, but what side to be on? You know, am I on the side of the professionals? Am I on the side of the patients? But actually, I don't really believe in any of that (pauses)…(I felt) fury I think there was an element of furious. This is how we handle people who are in distress (pauses). (I felt) scared for…others, unjust the…humiliation of him having his clothes taken off in front of everybody.…everyone decided what was going to happen to this person and it is punishment." - Kleo*

This account is an emotionally raw display of moral injury. Kleo's measured yet graphic description evokes a disturbing level of force and humiliation, presenting the institutional response to distress and one of containment rather than compassion. She implies a lack of agency, echoing the powerlessness that the patient may also be

experiencing. This blurs the line between patient and professional, and Kleo makes this more explicit when she talks about *"what side to be on"*. The counter-violence may have triggered an identity conflict where she is unable to reconcile the violence witnessed with her values. The use of the word *"furious"* might suggest a moral stance against what she sees as punishment disguised as care. The quote demonstrates how the emotional and moral weight of violence extends beyond physical incidents. How violence is managed, and how institutional practices strip patients and professionals of dignity, is also key. Her experiences of observing seclusion might exacerbate moral injury, forcing her to participate in practices she sees as morally and ethically indefensible. Sana adds some nuance to these views, particularly with the use of chemical restraint such as intramuscular injections (IM):

> *"When it was burnout, I felt drained and tired because I was like, I'm not doing anything with them. I'm just going (and) giving IM, which I didn't find helpful, but they themselves did. They said it works for them, but I thought I was just…not helping them as I should be and not…giving them tools or skills to learn behaviours that they can manage those emotions with (long pause)…I felt) frustrated because…you can't do anything and a lot of staff were getting injured, so there was also anger. And there was, I think, kind of…this dissociation from the service user at the time (pauses) that there was this breakdown in the therapeutic relationship." – Sana*

Sana reflects on how she was carrying out procedures rather than offering support. There was a gap between what care could be and what it was, which left her feeling drained. Interestingly, Sana experiences the use of IM as a symbol of disconnection, that is, as a mechanical act rather than a relational one. She reflects on a reduction of her professional role, which seems to be a core moment of moral dissonance, realising that her actions, however institutionally sanctioned, diverge from her values around long-term, relational, skill-building care. Sana suggests a mental, physical, and existential exhaustion whereby the predictability of violence bred a sense of futility and dread. The perceived loss of role identity is suggested by her use of the phrase *"dissociation from the service user";* this is perhaps a

defence mechanism in a system that demands action and containment over connection. Obinze deepens this conversation, suggesting that there is a battle between personal and professional that can also create a moral dissonance:

> *"I still relate in the professional way (pauses) because…it's normally the natural human behaviour, we want to keep malice when you have offended me, and then when I come to work the next day, I don't want to talk to you even when you're calling me. Please Obinze. Please. I need my medication. I'll say. Oh, I'm not listening to you. Because no, no, no (gestures wagging his finger)…That is wrong…I will not deprive you…Another reason why I said it's painful it is… (a) very tricky and painful role to play." – Obinze*

Obinze's statement affirms a deep commitment to professional values, yet simultaneously introduces the painful internal contradiction that arises when the person you are caring for causes harm to you. Wagging his finger might suggest the extent to which Obinze has to suppress his natural emotional reactions in the service of values that the institution demands but does not emotionally support. It might suggest how moral discipline has become a performance of professionalism. His professional identity has become a form of emotional self-regulation and suppression, which is likely to cause distress and fatigue. His repeated use of *"painful"* underscores the moral injury embedded in the role. Namely, to care without conditions, to forgive without resolution, and to hold responsibility without power.

3.3.2 Emotional Responses and Isolation

There are a wide range of emotional responses to violence within the participants' accounts. Common themes were denial (*"Is this really happening?"),* feeling angry, scared, sad, and struggling not to bring the emotions home. When considering denial, Sarah discusses:

> *"(I) think during it you…are like is this really happening? Like seriously this is not happening like you're in denial. You're kind of like, yeah, he's going to put… (the knife) down. It's fine." – Sarah*

Her words reflect the immediate psychological dissonance in the face of danger, namely, the inability to fully register what is happening in a way that maintains composure and protects the self. The hope that *"he's going to put the knife down"* implies a cognitive reframing to help manage fear and reduce the perceived risk; however, this also allows familiarity to mask the real danger. The quote illustrates how denial serves as a protective mechanism in response to a heightened threat. It also hints at a form of emotional isolation because these emotional responses are unspoken, Sarah may feel alone in the emotional aftermath. Anger is another emotion discussed, this time by Eren:

> *"I mean, I'd be lying if I said that…being assaulted didn't (pauses) you know? Make me feel anger as well…I'm not pretending to be…a perfect practitioner... It did…make me angry and make me think…I don't deserve this. But then I guess it kind of in my head, it always comes back to (pauses) I know that I'm trying to help but they can't see that at that moment in time, but it is hard to keep that in mind…all the time. So there's definitely anger and…a sense of injustice that it's not fair for. You know, I don't get paid enough for this. Essentially is, I guess…how the saying goes." – Eren*

Eren offers an honest and self-aware reflection here; her statement suggests a more human, conflicted narrative than others. The fragmented structure and repeated qualifiers may reflect a reluctance to own the emotion fully, suggesting internalised pressure to minimise or rationalise anger, even when it feels justified. Her moment of protest in *"I don't deserve this"* reveals a deep emotional boundary being breached. Eren's rationalisation in this quote suggests a cognitive strategy to manage distress and some emotional fatigue of having to continually reinterpret her victimisation through a clinical lens. She admits *"It's hard to keep that in mind"* which highlights the psychological cost of her empathy. Her final line is a strong one, cutting through the emotional complexity with a raw expression of frustration,

and perhaps even burnout. You could even tentatively suggest that she is hurt not just by the incident itself, but by the wider structures that normalise violence, and the expectation of staff to endure without adequate support or recognition.

Obinze mentions anger too, using a powerful metaphor describing how *"is like a bomb, like a volcano, is a lot inside you"* when he is experiencing *"someone is insulting you and calling you terrible names, racially abusive towards you and you can't call them back. You can't challenge them, so you just keep quiet."*. His repetition of *"you can't"* is striking, reading like a mantra of self-repression. His evocative imagery of a *"bomb"* or *"volcano"* might communicate the intensity and danger of unexpressed emotional distress. Obinze's quote might suggest that emotional responses to violence can accumulate over time, speaking to a broader pattern of isolation through emotional silencing.

Feeling scared was another emotional response that surfaced for many participants. Kleo talks about how *"it was quite scary because I was in a little room, and I was in a corner when she came at me".* She captures the feeling of fear here, as well as a potential disempowerment and entrapment of being in a confined space. The simplicity of the statement may reflect the difficulty of fully processing or articulating such moments. Her experience highlights how violence in inpatient settings is also about where and how it happens. Space, power, and proximity can possibly shape emotional responses. Eren also discloses this, and talks more about how her fear carried over into future decisions: *"So yeah, I mean, I'm not ashamed to admit that, you know, that was scary. There were times because I was a bank member of staff (pauses) If I'd done, say, you know. One shift and I was booked on for the next day. If it had been a particularly bad day, I might cancel my shift for the next day"*. There is a suggestion from Eren that fear is something HCPs feel pressure to suppress, perhaps reinforcing emotional isolation. Her bank role provided a rare opportunity for choice, and her ability to opt out of re-exposure might be a coping strategy. In contrast, sadness was expressed by Sana when considering violence:

"I think it's sad that that they can't manage. What someone could do on a normal day to day and it's (pauses) tough to see people go through so much and then end up in mental health and be violent and aggressive." – Sana

Sana expresses a deep sadness watching people struggle with behaviours that feel unmanageable. She takes a compassionate stance following violence, as well as an empathetic grief, that is, a sadness rooted in witnessing how people's life experiences, distress, and MH struggles can result in violence. Despite standing in contrast to more self-protective responses, the sadness she discusses can be just as emotionally burdensome and isolating, particularly if not acknowledged or processed. Sana's emotional attunement to sadness may be a source of emotional fatigue. Sana goes on to talk about this fatigue and how it can impact home-life:

"It was draining (pauses) because you come home and you'd just be too physically tired to even talk to family members or sometimes even eat, you just want to sleep because it drains you like emotionally and physically." – Sana

Her quote captures the effect of daily exposure to violence. The post-shift collapse she discusses highlights the emotional toll of the work. Disconnection and isolation in other domains of life are inevitable when basic activities like eating or speaking with loved ones become too difficult. She reinforces that violence is traumatic on both a psychological level and embodied through fatigue and disengagement. Sarah offers a unique view on the emotional impact of violence, discussing trauma responses. Hypervigilance and being more on guard after violence were common for her: *"not going to joke with you as much…I need some time to just get over what you've just done".* She highlights that withdrawal and being on guard are strategies she uses. She goes on to say:

"I think it just made me a lot more…like on guard with everything, just…keeping a lot more of a closer eye. I think also I felt a bit maybe naïve with this…patient because I thought a lot of things before that, you know, he doesn't seem like he should be

here…I think I was just…a bit shocked at my own, like, lack of correct judgement in that scenario.“ – Sarah

Sarah's use of *“on guard”* suggests perhaps a loss of psychological safety. This shift from therapeutic presence to heightened alertness might be isolating and exhausting over time. The word *“naïve”* is also striking. This could perhaps reflect an internalisation of failure, which suggests a possible trauma response, as well as moral self-judgement for not anticipating violence. Sarah's quote also highlights the potential fragility of professional confidence in the aftermath of violence. As was the case with other participants, Sarah has turned inwards. She goes on to express what she would have wanted after a violent incident occurred:

“I would like to have someone explain to me what potentially might happen to me now that I've witnessed something like this. The fact that I am going to dream about it. The fact that I potentially might think about it. I might ruminate on it. I might find myself, maybe a bit worried about watching people with knives on screen for a little bit.” – Sarah

Sarah highlights the neglect often embedded in institutional responses. She names the common psychological sequelae of trauma and expresses a desire for normalisation and validation. She offers an internal script of care that she was never given but perhaps desired. Her quote reinforces the idea that the emotional impact of violence does not end when the incident is over.

3.3.3 Oppression and Identity-Based Harms

3.3.3.1 Racism.

Obinze discusses the impact of racism within the inpatient environment and how it links to violence. He reflects on the impact of being racially abused whilst offering care:

> *"I feel (pauses) I feel sad, I feel (pauses) when somebody…makes you feel you're (pauses) you're worthless and you're trying to help someone and the person is attacking you in the process…and then they call you names and ask you to go back to your country, call you different things (like) black monkey. I'm sorry for my language. You know, things like that. So it makes you feel depressed. You're…depressed. You're feeling. I really don't have words to describe how I feel it's really a terrible feeling (pauses) It's not a nice feeling at all." – Obinze*

The fragmented phrasing, punctuated by pauses, might reflect the weight of emotion as well as the struggle in articulating. His apology underscores the internal regulation of racialised staff and might suggest that systemic expectations of professionalism can invalidate expressions of racial pain. Obinze may be suggesting that racism within care work undermines caregiving. He may be expressing a form of moral injury when fulfilling a caregiving role, being devalued and dehumanised. The experience of needing to assert his humanity in the face of systemic and interpersonal invalidation exposes a tension that white colleagues may never be required to confront: the effort not just to perform his role, but to continually defend his right to be seen as equal within that role. He focuses more on the systemic injustices of escalating violence:

> *"Because (in) my experience there are issues that (pauses) you escalate (it's not) taken seriously because you are black (pauses) but if a white person should escalate or report…it is taken seriously. So I have thousands of examples that I can give as regards cases where…issues or situations or problems (where) you have the whites going free and then you have the black suffering." – Obinze*

Obinze suggests a racialised hierarchy of credibility, describing a structural silencing where the same concerns voiced by black staff are dismissed or downplayed, while those of white staff are validated and acted upon. His repetition of *"the whites"* and *"the blacks"* suggests an interpretation where black staff are subject to harsher scrutiny, greater consequences, and less support. This reflects Obinze's view on the racialised enforcement

of rules, suggesting that policy and professional standards are not applied equally. Instead, they become tools of selective discipline and are weaponised against black staff while offering protection to white colleagues**.** Obinze describes a situation where a patient offered support following racist abuse:

> *"I appreciate equality, you know, diversity equality is something very beautiful. We are from different backgrounds and we are meant to use that (pauses) difference. So our diversity to help each other…it was a service user that…told me that and I kept in my head (pauses) you know…This was a service user, they are trying to fight for me. And they said, I mean, we are all the same, you know, different skin colour but same blood colour. So for me that's the…sentence or that phrase." – Obinze*

His aspirational opening statement highlights a possible belief in the potential of diversity as a form of moral support and drive for improvements in care. Significantly, the belief is linked to the actions of a patient, disrupting the narrative of patients as violent and abusive. Instead, Obinze suggests a moral awareness, empathy, and allyship, offering a restorative counterpoint, perhaps, to Obinze's earlier experiences of injustice. When discussing the phrase: *"We are all the same, you know, different skin colour but same blood colour"* he hints at it being deeply symbolic, touching on shared humanity in the face of racial difference, and providing a sense of emotional repair after prior dehumanisation. Obinze notes that he has held onto this phrase, suggesting its resonance and healing power, especially when contrasted with the silence or complicity of colleagues and systems. Obinze finishes discussing racism:

> *"Yeah that is racism not violence because violence (pauses) racism is part of violence but violence is not (pauses) Racism anyway." – Obinze*

Though halting in delivery, Obinze asserts that racism is inherently a form of violence. The attempt to distinguish and then re-integrate the terms suggests that racism can be

downplayed or categorised as “non-violent”[5], when in fact it is violent in its emotional, moral, and existential terms.

3.3.3.2 Gender Based Violence.

Another identity-based harm linked to violence is that of gender. Kleo discusses how gender plays a role when working with men:

> *“Men in these settings have typically taken quite a protective role over me (pauses) because I'm small because I'm blonde. Because I'm sweet, I smile, I'm friendly. So they (pauses) I don't know if that violence would go into a different direction, a more sexual direction in a different occasion (pauses) but in the occasion of wanting to harm me physically, to hurt me in a different way (pauses) I feel that that's less likely to happen because they take a bit of a protective role. (I) don't know. I mean, I do know why society and so on and patriarchy and blah blah. Probably because I don't seem very threatening. I'm not very threatening.” – Kleo*

Kleo reveals the gendered assumptions about femininity, vulnerability, and threat that she considers when working with patients who are men. Making sense of her safety, she considers how she is positioned within a protective dynamic, one that is possibly deeply gendered and paternalistic. Her awareness of sexual violence as a gendered threat suggests that this is something Kleo, understandably, considers often. Her phrase *“patriarchy and blah blah”* captures a critical feminist awareness and a frustration with the normalisation of these dynamics. When considering violence, Kleo recognises broader societal and patriarchal structures that shape the harm that she, as a woman, might face. She goes on to crystallise this:

[5] The quotes are the authors

"I think I've got other things that cause more anxiety… Like violence from men. But that seems more stressful in life, but more on the street. Not a guy with a in an inpatient ward. Although I don't know." – Kleo

This quote highlights how Kleo associates men with a greater sense of threat, but that this is not uniformly distributed across contexts. There is perhaps some ambiguity and internal conflict here. The phrase *"more on the street"* implies that in the outside world, male violence feels more immediate or uncontained. In contrast, in an inpatient setting, even though risk exists, it is mediated by unknown factors. These might be roles, rules, or relational dynamics. Kleo offers a reflection on gendered power and safety, discussing an interaction that felt invasive and controlling:

"It was a man, and he would call me by a pet name and he wouldn't stop talking. It was very strange. He just would not stop talking. And I would have to say his name multiple times to get him to listen to me. It was a thing about power. It was trying to be in control of our sessions. And I was just (a) really young trainee…it can feel very scary because I can feel under a lot of threat. Because that's my life." - Kleo

Kleo is perhaps reflecting a struggle for authority in a complex therapeutic relationship that was subtly but persistently undermined. The use of a pet name might suggest a boundary violation, stripping away her professional role and positioning her within a gendered frame. Whilst the interaction is not overtly violent, there is an interpretation that it triggered a deep sense of unease and vulnerability within Kleo. It is possible that Kleo cannot separate her professional role from her embodied identity as a woman, and the breach in boundary may be a threat to safety, autonomy, and emotional well-being. Kleo's discussion of gender highlights how violence is relational and psychological, not just physical, as well as illustrating how gender and profession can interact.

3.4 GET 4: Violence as a Complex and Relational Communication

This theme highlights how HCPs make sense of violence not as isolated, random acts, but as deeply communicative, context and relationally driven interactions. The co-construction of violence through relational ("*Certain things can be prevented or the way we…communicate with patients" – Sana)* and environmental factors (*"What was happening is kind of a almost like a symptom of the problem of the setting." – Maeve)* is discussed, as well as how violence is a form of communication. Finally, other factors and complexities are elucidated.

3.4.1 Co-Construction of Violence

3.4.1.1 Relational Factors.

Maeve considers how violence arises as a result of not making attempts to understand patients. She suggests violence may be misread or oversimplified:

> *"Yeah, so I think. It was just seen as, oh, she's being (pauses) violent or aggressive? Or, like almost because, you know, kind of almost like being difficult rather than perhaps trying any kind of genuine attempts to understand what might be going on for her." – Maeve*

Maeve highlights a common narrative in inpatient care, namely that distress is often labelled as defiance. She criticises this and suggests that the conditions for violence may be co-created by relational inattention, dismissal, or a lack of curiosity. Maeve's quote pushes back on the framing of patients as inherently violent. It suggests that how staff choose to interpret and respond to distress, plays a significant role in whether that distress escalates into violence. Hassan also reflects on the relational foundation of violence:

> *"If I was on a ward with a patient and every time I went in they would just hated me, that would not…you know I don't want to work with that guy or person. So I think I*

think your frequency and the relational side of things. But yeah, we're relational. So we're relational as a principle, isn't that so therefore? (pauses) If someone is behaving a way to you. (pauses) Consistently, you would look at it relationally if it was a one off, you could probably not look at it relationally and just kind of make sense of it as a random event." – Hassan

Hassan highlights the emotional toll of repeated negative interactions. He hints that the accumulation of hostility might shape how staff engage with patients in a feedback loop. He goes on to say that people are fundamentally shaped by their interactions, and he displays his interpretations through relational lenses. He ends the quote by suggesting that not all violence is relational, but that when patterns emerge, relational factors become meaningful and worthy of exploration. Sana adds more to this idea, suggesting that communication styles play a significant role in violent encounters:

"And it's something that kind of it helps me (pauses) Understand that sometimes (pauses). Certain things can be prevented or the way we…communicate with patients does have an impact on these (violent) incidences or you know." – Sana

Her realisation seems personally meaningful, and the pauses might suggest that this is arising from experience. She might be coming to terms in real time with the idea that violence is not always inevitable, but relationally mediated. Framing violence as a relational process implies a relational accountability, perhaps in a way that recognises the influence that she holds in shaping the atmosphere and therefore violent encounters. This quote resonates with Maeve's earlier reflection about missed opportunities; however, Maeve critiques the system, whereas Sana is more inward-looking, focusing on her learning and growth. Hassan seems to agree with the idea of violence being shaped by interpersonal dynamics, as well as environmental factors:

"So there are a couple of factors I think that contribute to (pauses) to restrictive environments, yeah (pauses) and then obviously, you've got the personalities and the

temperaments of the staff, and that's like very complicated variable. How that interacts with the rules and so on." – Hassan

Hassan introduces the idea that emotional reactivity, patience, and communication styles can either limit or exacerbate distress. Violence becomes co-created, and he and other staff are active participants in relational dynamics. He seems to suggest that staff behaviours as well as institutional frameworks are interdependent.

3.4.1.2 Environmental Factors.

Sana speaks to institutional routines and how they can become flashpoints for violence:

"Someone waiting an hour to get their phone out of the cupboard is not really ideal or something like that. Like just little things that we can kind of. Minimise the risk of increasing violence and aggression, maybe." – Sana

This quote is a succinct but powerful example of how procedures can contribute to the co-construction of violence. She suggests that restrictions like this might heighten feelings of powerlessness, irritation, or perceived injustice. Her use of the phrase *"little things"* suggests that violence prevention can come from minor, thoughtful adjustments that respect patients' time, autonomy, and humanity. Sana echoes Kleo's earlier comments about confinement, reinforcing the idea that compounded distress through minor inefficiencies can contribute to violence. Hassan speaks more deeply about this idea:

"Every time I would witness a violent incident, it was essentially because someone had been deprived of something that they perceived (pauses) they needed or wanted, or the right to, so it was usually a denial of freedom in some way, or denial of a right." – Hassan

Hassan explicitly links violence to perceived deprivation and powerlessness. He goes further than Kleo and Sana by suggesting that it is not the objective denial that can spark violence, but rather the subjective experience of deprivation or injustice. This speaks to Hassan's conception of violence as a reaction to a perceived violation of autonomy or freedom. Hassan seems to suggest this more explicitly in another quote: *"This is a question of freedom and I think for the fundamental human need is freedom…..",* where he frames violence within a human rights framework. This suggests that restrictive environments themselves can create distress and thus violence. Obinze adds more to the idea of the co-construction of violence, suggesting that constraints such as staff shortages also play a role:

> *"I'll give you an example. So I'm at the door and you are a service user and you need to…go out to smoke and you can't go on your own because you are escorted because the leave status says that (you have) to be escorted when he is going to the grounds to smoke…I need to get his staff to go with you… Now if I if there is staff shortage, another factor that can cause these things is staff shortage. The staff wants to though, is not available to escort you to go to smoke. Then you're getting agitated because time is passing. And then because you are addicted, you can't. You're becoming impatient, aggressive and you start shouting at me… and then it escalates." – Obinze*

This concrete and relatable example highlights how the interactions between policy, addiction, staff shortages, and power can converge to exacerbate violence. The environment creates a dependency where the staff are both the gatekeepers and the potential obstacles for patients. The environmental constraint of staffing levels can prevent timely support even when the intention is there. Violence, then, for Obinze, is perhaps not just interpersonal, but is also triggered by environmental factors. He appears to suggest that staff are caught between patient needs and systemic dysfunction.

3.4.2 Violence as Communication

Several participants discussed how violence can be understood as a form of communication. Whilst this overlaps with relational factors, it seems distinct enough to warrant its own sub-theme. Maeve describes a context of disempowerment and systemic neglect. Within this coercive containment, violence emerges as a communicative strategy:

> *"Where you're locked in and where people often don't have or don't make the time to listen and understand and communicate with you, and decisions are made for you…Violence is a way of trying to be heard, trying to be seen. It gets a response. It gets people on your one to one or your two or three to one." – Maeve*

Maeve sees violence as an attempt to gain recognition or acknowledgement. She highlights that the institutional response is often increased surveillance, which confirms to the individual that violence works as a way of communicating their needs. Maeve might be suggesting that cognitive or language differences increase the likelihood of misunderstandings, increasing the risk of violence as a communication strategy. Maeve goes on:

> *"She's trying to like, let people know how she's feeling, and then instead she's just being (pauses) more and more restrictions and restraints are being put on her. And I don't remember there being any attempts to think with her or the people that know her or knew her about how best she communicated…There weren't many attempts to get to know her, I don't think." – Maeve*

She explicitly names the idea that the patient's escalating behaviour was an attempt to communicate distress, which was then misunderstood and met with increased restriction. Maeve vividly illustrates how violence can emerge from environments that fail to listen, and how coercive responses can reinforce isolation and fear. Eren has similar thoughts, and positions violence as a communicative act rooted in relational failure:

> *"I mean, I think (pauses) I think with all kinds of challenging behaviour, all types of violence, whether it's physical, verbal, whatever, like the definition says, I think fundamentally what somebody is trying to do is communicate something with you (pauses) and for whatever reason, they don't feel like. They can do that in any other way other than violence (pauses) but I think ultimately what it comes down to is that someone is trying to communicate something with you." – Eren*

Eren suggests that all types of violence represent a message or a communication. She pauses multiple times, perhaps suggesting she is grappling with the emotional and moral complexity of the insight. There is perhaps a frustration rooted in compassion, and it seems tied with violence as a form of communication. She suggests that there is an intention in violence that we should attempt to understand. According to Eren, when other communicative pathways are not available, violence becomes more likely. This echoes Maeve's perspective above and ties in with Kleo's quotes concerning violence as a relational phenomenon. Sarah talks more about how violence is used as a communication strategy, but in contrast to Eren, suggests it might also be tied to early experiences and upbringing:

> *"It's…either the only way of knowing how to get their point across and it ends up coming out that it's a violent, socially unacceptable way, a harmful way. But it's their only way to communicate. – Sarah*

Sarah expands upon Eren and Maeve's understanding by introducing a broader developmental and historical framework. Violence is seen as perhaps being learned and internalised. For Sarah, violence might be the only mode of expression available to someone. Sarah considers a more biographical context, whereas Eren focuses more on situational dynamics. Kleo supports Sarah's view:

> *"If you feel that (pauses) your (pauses) this is hard (pauses) If you feel you (pauses) let's say the models that you have in life are to express violence in order to be heard, which is not an uncommon experience where people have to shout in a family in*

order to have their voices heard, and even then it doesn't work anyway (pauses) then that's then what you might do, if that's what you've learned. And that's the only way that you've managed to get your things come like things heard in the past. Then that's my most likely what you'll do, because that's what works." - Kleo

This quote powerfully reinforces Sarah's interpretation. It begins with a visible hesitation of *"this is hard"*, signifying perhaps Kleo's difficulty in articulating a painful truth, or her empathy for patients. Kleo seems to view violence as a legacy of relational learning, as well as relational in the present moment. The example she gives of shouting in a family just to be heard evokes the painful normalisation of emotional neglect, where only threat or escalation guarantees attention. Violence, then, becomes a predictable response. Kleo also suggests that violence is instrumental and understandable: *"that's what works"*.

3.4.3 Complexity of Causes

Interestingly, in addition to the factors discussed, participants mentioned a variety of other factors that might contribute to violence. This highlights the multifaceted nature of violence as well as some differences in how participants have made sense of the causes of violence specifically. There is some agreement that past experiences have played a role in violent encounters:

"I think it's a cry for help… they've sensed some kind of threat to themselves and they're just doing what they think in that moment is the right thing to do. Sadly… it's wrong (pauses) but that there's always (pauses) there's always a kind of a reason, even if it yeah, I don't think anyone was born a dickhead I think you just become it. Through what you're put through". – Sarah

Sarah immediately positions violence as an expression of threat perception and unmet need. She seems to have embedded a trauma-informed approach into her understanding of violence. There is a moral conflict suggested in her use of the word *"sadly"*,

recognising that violence is harmful, but stems from survival and upbringing. Sarah reveals a profound moral belief in her statement that *"I don't think anyone was born a dickhead"*. She appears to believe that violence is influenced by social and relational factors. Sarah suggests that adversity, trauma, and neglect all shape violent behaviour. Sana discusses a similar idea:

> *"I think they haven't had, hey haven't learned how to. Cope well, with situations that…if I was to experience something (that) doesn't go my way, I wouldn't act in a violent way. They haven't learned to how to manage those skills and have that good skill, upbringing or whatever they went through when they were young or as well. It seems to have a lasting effect on them." – Sana*

Sana, along with Sarah, interprets violence through the lens of developmental experience. Violence for Sana might be seen as evidence of a lack of alternative responses. Violent behaviour may be perpetuated through environments where expression, negotiation, and boundary setting are not reinforced. She compares her strategies to those of patients, suggesting that responses are shaped by a lack of exposure to the tools, rather than by inherent pathology or moral failing. She draws a clear link between early life experience and behavioural expression. Kleo does the same:

> *"There will be lots of things about, you know, what have they learned in terms of throughout their life, in terms of how they get things the way that they need them to be." – Kleo*

Kleo further echoes that individuals resort to violence because it has functioned as a successful means of navigating past environments. Kleo appears to see violence as a tool of influence or self-advocacy, where other forms of communication have been ineffective. Whilst there is convergence on this view, Obinze discusses how MH pathology might play a role in violence:

"You know, so is a risky environment because sometimes you can't help it because these guys are unwell because of their psychotic episodes." – Obinze

Obinze acknowledges that violence may stem from a psychotic episode, where, presumably, insight, reasoning, or impulse control is compromised. It is important to note that it seems Obinze is not pathologising people as violent, but rather that he interprets non-racialised violence as symptoms that emerge from illness, rather than personality or intention. Kleo acknowledges that some view psychosis as a factor in violence, she goes further by explaining how not feeling listened to because of psychosis can be unjust:

"There's a collection of people who (pauses) How was he ever listened to…was his view ever heard? And he is in no position of being listened to. It felt like, and he has psychosis so… Already, the experiences of people with psychosis are labelled as untrue and not real, and therefore we can ignore them and brush them away (pauses)… Already that felt very unjust." – Kleo

Kleo highlights a deep concern with epistemic injustice, drawing attention to how clinical labels have become mechanisms of silencing. This might suggest that violence is itself linked with epistemic injustice and invalidation. Eren adds to the complexities of understanding the causes of violence. She talks about how coping plays a role:

"I think that to me it showed how distressed they were. And it was. Yeah, kind of a reaction to not knowing how to regulate those emotions and not having any other ways of coping…." – Eren

She reflects a psychologically compassionate interpretation of violence, framing it again as communication, but this time of overwhelming distress. This might be a useful cognitive strategy to being on the receiving end of harm, to reduce the emotional toll. Echoing trauma-informed perspectives, Eren perceives the limited emotional and coping resources of some patients to be key in violent encounters. This perhaps creates more

empathy for Eren when she is a victim of such violence. Eren expands on this by suggesting that sometimes, violence is a learned and deliberate act:

> *"I think it like in inpatient settings, if you.. If you see somebody acting violently and it gets them, I don't know a response or it gets them out of something they don't want to do, then other service users viewing that might be like Oh well, you know, next time I'll try that because that's worked for them… Yeah." – Eren*

Eren may be highlighting that institutional responses to violence can unintentionally reinforce aggressive behaviour, especially when other patients observe these outcomes. Significantly, this does not undermine earlier interpretations of violence as emotional or trauma-based. Instead, it adds complexity by showing how learned behaviours and institutional contingencies interact with distress. Eren's insight positions violence as both relational and communicative, but also as functional within a system that may fail to offer safer, more therapeutic alternatives. Obinze suggests something similar:

> *"Some reactions and some presentations are behavioural and (are) strategies to get what they want. So you smash the door, you break the door, you smash the glass because you know if you do that, they'll say, oh, OK, what do you want to take? Just to get attention. So you do some things to get attention…You push boundaries." – Obinze*

This explicit account of violence as a behavioural strategy highlights how violence can function as a negotiation tactic. According to Obinze, there is an instrumental logic for violence. His perspective here underscores a tension in many of the participants' accounts. That violence is both a product of individual distress and a response to systemic structures that leave few other viable options for self-expression or need-fulfilment.

4 Discussion

In this chapter, the study findings concerning how healthcare professionals (HCPs) make sense of violence will be discussed. I will then integrate them with the existing literature, discussing both theoretical implications and any clinical significance. Finally, I will critically evaluate the study and examine areas for future research.

4.1 Study Findings

The research question guiding this Interpretative Phenomenological Analysis (IPA) study was:

> *How do healthcare professionals make sense of violence in mental health inpatient services?*

Seven HCPs, all with experience of violence in mental health (MH) inpatient settings, were interviewed. While all participants worked in the NHS, some reflected on incidents in non-NHS settings, and not all were employed in inpatient services at the time of interview. I identified four group experiential themes, each with sub-themes. HCPs described coping, surviving, and the normalisation of violence. Within this, adaptive strategies, as well as normalisation and daily survival, were considered. Navigating organisational failure and institutional betrayal was another key theme regarding the sense-making of violence. Systemic invalidation, institutional neglect and responsibility, and environmental stress and containment were referred to by participants. HCPs reflected on the emotional weight of violence. Moral dissonance and identity conflict, emotional responses and isolation, and oppression and identity-based harms were sub-themes within this category. Finally, HCPs conceptualised violence as a complex and relational communication. They considered how

violence was co-constructed, both relationally, and due to the environment. Violence was also seen as a form of communication. Finally, HCPs discussed the sheer complexity of the causes of violence within MH inpatient services. This study increases our understanding of how HCPs make sense of violence within MH inpatient services, suggesting that staff see violence as complex and relational, and gives weight to the emotional and moral impact of violence.

4.2 Integration with Existing Literature

4.2.1 Coping, Surviving, and the Normalisation of Violence

Normalisation appears less an individual coping style than an organisationally patterned adaptation to chronic threat. Prior work notes violence as “part of the job” in inpatient care (Clements et al., 2005; Iozzino et al., 2015; Kennedy, 2005; Phillips, 2016b). This study extends this view by showing that anticipated inaction and routine exposure make survival strategies normative, thereby sustaining a culture that tolerates everyday aggression. Instrumental under-reporting may emerge from learned futility rather than fear alone, echoing other research (Cooper & Swanson, 2002; Lim et al., 2023; Sun et al., 2017). Normalisation is reframed as a property of the system, shaped by leadership and psychological safety. It is contestable when reporting is followed by action; where it is not, normalisation becomes a natural defence.

Implications shift from simply recording incidents to interrupting the normalisation cycle via visible action after incidents, clear feedback loops, and explicit standards. Relational infrastructures, such as reflective practice and routine debriefs, that re-sensitise moral boundaries may support the de-normalisation of violence. Furthermore, teaching and training of de-escalation of communication skills, alongside attention to the environmental stressors, should be considered.

4.2.2 Navigating Organisational Failure and Institutional Betrayal

This theme highlights organisational ethics as central to how staff understand inpatient violence. Participants' sense-making repeatedly located violence at the intersection of resource constraint, ward culture, and leadership, indicating that incidents are more common when systems are strained and containment replaces care. This interpretation extends prior work linking staffing and local conditions to aggression (Berzins et al., 2020; Stevenson et al., 2015) by showing how these pressures are experienced as organisational failure and institutional betrayal, which impacts morale, risk perception, and the normalisation of counter-violence.

Despite the Department of Health and Social Care (2023) stated commitment to reducing violence, participants in this study expressed feeling unsupported by institutions, echoed in the theme of organisational failure. The Violence Prevention and Reduction Standard (VPRS) outlines Trust's responsibilities to commit adequate resources for preventing and reducing violence against staff (NHS England, 2021). Participants speak to organisational failures, suggesting that perhaps this target is not being achieved. Participants reinforced established links between staff shortages and increases in patient violence (Bellman et al., 2022; Stevenson et al., 2015). They considered environmental stress a factor in violence. Services operating below safe staffing levels were perceived as violence flashpoints, aligning with Berzins et al. (2020), who reported that patients link violence to local conditions such as supervision, leadership, and staffing. Higher staff-to-patient ratios can reduce violence (Rogerson et al., 2021); however, participants suggest that predictable, values-led practice and responsive leadership are also essential to prevent escalation.

Participants within this study, particularly Eren, discussed the idea of containment within the environment and how this can contribute to violence, giving voice to the influences of violence identified in Stevenson et al. (2015). Participants' descriptions resonated with concerns about "closed cultures" in MH services (The Care Quality Commission, 2021), offering details on how such cultures might be felt as silencing and unsafe. It appears that organisational factors are central in shaping both staff and patient experiences, bolstering the findings by Jenkin et al. (2022).

The insights from participants might begin to shift the explanatory lens from individual dangerousness to systemic conditions that co-produce violence. Rather than viewing policy as a static safeguard, the findings might suggest that policies function relationally, and are only effective when enacted through consistent, value-congruent leadership and resourced teams.

4.2.3 The Emotional and Moral Weight of Violence

Historically, issues of social control, coercion, and violence, were rarely acknowledged within MH care (O'Brien & Golding, 2003). These findings frame violence as a moral as well as emotional event, locating distress at the junction of professional values, coercive practice, and organisational conditions. Stevenson et al. (2015) explored the conflict between the duty of care and one's duty to self when providing care following a critical incident involving violence. Participants spoke to this often within the moral dissonance of caring for a patient who has been violent towards you. Compassion fatigue is known to be impacted by violence, which supports the participants' accounts (Figley, 1995; Newell et al., 2016). Marshman et al. (2022) identified protective factors, such as organisational culture, leadership, reflection, and clinical supervision, that can buffer against

compassion fatigue, suggesting potential clinical and systemic implications of the current findings.

Although the CQC (2022) recommends reducing restrictive practices such as chemical restraint, physical restraint, and seclusion, participants described these as routine in MH inpatient care. Some participants spoke to these as forms of counter-violence and reflected on the moral injury these practices can cause. Even the use of physical security, such as locked wards (Allen, 2015), seems to perpetuate moral injury in HCPs. Participants discussed moral injury and distress when considering counter-violence. While Jones (2021) highlights understaffing as a key factor, participants focused more on environmental and relational dynamics, though these were acknowledged as shaped by staffing levels. Webb et al. (2024) noted that limiting patients' daily freedoms often clashes with staff values, a conflict shared in participants' reflections on human rights and moral dissonance. As NHS staff, including Clinical Psychologists (CPs), are expected to uphold human rights principles (Department of Health and Social Care, 2023b; Patel, 2019), it is unsurprising that participants reported distress when restrictive practices potentially violated rights to freedom from inhuman and degrading treatment (Human Rights Act 1998, 1998; United Nations, 1948). Across accounts, participants discuss an identity conflict, where care ideals collide with counter-violence, generating moral dissonance. They highlight the cumulative load of this, which seems to amplify compassion fatigue.

It is perhaps unsurprising that violence carries an emotional weight given the risk of physical injuries, which are not uncommon (Bizzarri et al., 2020; Magnavita & Heponiemi, 2012; Pai & Lee, 2011; van Leeuwen & and Harte, 2017). Common psychological impacts include anxiety, fear, anger, sadness, and Post Traumatic Stress Disorder (PTSD) symptoms (Nolan et al., 1999; van Leeuwen & and Harte, 2017). In this study, some HCPs reported feeling hyper-aroused, on edge, or experiencing trauma symptoms. These accounts align with broader research highlighting the professional and organisational implications of

violence. Hilton et al. (2022b) found that burnout, common in response to violence, was a potential risk factor for PTSD.

Cornaggia et al. (2011) found that gender concordance between aggressor and victim was a significant factor in violence. In this study, Kleo, a woman working on a men's unit, identified certain protective factors, which potentially support the finding. Other participants, however, described being assaulted by the opposite gender, so it is not clear whether the results from Cornaggia et al. (2011) are supported in this case.

Existing research offers no consensus on gender differences in the frequency of violence in MH inpatient wards (Altinbaş et al., 2011; Camerino et al., 2008; Ferri et al., 2016; McKinnon & Cross, 2008; Moylan & Cullinan, 2011; Palumbo et al., 2016; Privitera et al., 2005; Wynn & Bratlid, 1998). With a small sample and a focus on lived experience rather than frequency, this study cannot meaningfully address gender-based patterns. While Magnavita and Heponiemi (2012) suggest gender differences in reporting violence, this was not evident in participants' accounts. It is not possible to say whether the current study supports this. Kleo reflected on patriarchal dynamics shaping gendered expressions of violence, supporting findings by Wright et al. (2013). Her account supports the feminist critique that violence against staff may reflect the broader devaluation of predominantly female professions (Nicki, 2001). The discussion of gendered and racialised harms supports an intersectional lens, where professional devaluation, patriarchal dynamics, and racism may shape exposure, interpretation, and sense-making.

Obinze spoke to the impact of racism within MH inpatient settings and suggested that racism is a type of violence. There is little evidence on how ethnicity and violence interact within MH inpatient services, but most global majority staff consider harassment, bullying, and abuse to be based on their ethnic background (Rimmer, 2021). It seems clear that the emotional and moral weight of violence can impact patient care negatively. This is supported by Arnetz & Arnetz (2001).

4.2.4 Violence as a Complex and Relational Communication

These findings position violence as an interactional communication shaped by power, unmet needs, and the ward milieu, rather than individual pathology. Participants' accounts of escalation through poorly attuned responses and opaque rules align with relational models of inpatient aggression (Jansen et al., 2006). Many participants spoke of how incidents could have been avoided with more adequate responses from HCPs. This perhaps supports the assertions from the National Association of Psychiatric Intensive Care and Low Secure Units (2016), Royal College of Psychiatrists (2019), and National Institute for Health and Care Excellence (NICE, 2015) that staff should be trained in conflict management and de-escalation techniques. When considering the co-construction of violence, some participants spoke to environmental factors as a key contributor to violent incidents. Allen (2015) highlighted how the use of natural light, colour, space, ventilation, temperature control, artwork, noise levels, external areas, and smoking, could all reduce violence. Several participants, Kleo in particular, discussed how environments were not spaces for caring and probably exacerbated violent incidents. The environment and setting are important factors to consider in violence, according to Jansen et al. (2006). This is supported by the current study, where participants suggest that the environment helps to co-construct violence. Bizzari et al. (2020 suggested that violence is common in MH units where sub-acute or non-acute patients are treated. This might lend support to the accounts of participants that suggest violence is a co-construction of environmental and relational factors associated with the inpatient environment.

Acquadro Maran et al. (2019) suggested that staff working with patients perceived as more dangerous due to mental illness may feel more comfortable reporting violence. While some participants acknowledged MH pathology as a factor in violent incidents, they did not

express increased comfort with reporting. One participant noted that violence often goes unreported due to the expectation that no action will follow. This aligns with Edward et al. (2014), who found that up to 80% of violent incidents remain unreported. The supposition by Archer et al. (2020) that not knowing things would improve as a factor in why violence is under-reported was supported by the current study.

Participants in the study viewed violence as having complex causes, although these did not always align with the literature. Alcohol and substances are frequently cited as contributing factors; however, participants did not discuss these (Bowers et al., 2009; Salzmann-Erikson & Yifter, 2020; Stevenson et al., 2015) possibly due to the restricted access. Boredom was another key factor (Foye et al., 2020; Berzins et al., 2020) and was also a key theme within the systematic literature review however, was only mentioned by one participant (Kleo). Perhaps HCPs do not see boredom as a factor because of its transience. Dack et al. (2013) suggested that the "male gender"[6] and age are risk factors for violence. Most participants did not mention gender when considering violence. While Kleo noted some gender-related nuances, gender was not framed as a key factor. This could indicate that participants perceived violence as a gender-neutral phenomenon. This may be due to the study design, which did not explicitly prompt discussion of demographic risk factors such as age or gender.

Only a minority of participants identified psychosis as a factor in how they conceptualised violence, aligning with findings by Asikainen et al. (2020), Dack et al. (2013), and Salzmann-Erikson and Yifter (2020). Duxbury and Whittington (2005) reported a disconnect between staff and patient perspectives. Patients cited environmental and communicative issues, and staff attributed violence primarily to mental illness. This dichotomy was not reflected in the current study; participants cited multiple contributing factors, including relational and environmental dynamics. While two participants mentioned diagnostic factors, the broader focus remained on context rather than clinical labels. Notably,

[6] In quotes because generally male is a term used for biological sex, not gender.

diagnoses such as affective disorders and personality disorders, often linked to violence in the literature (Asikainen et al., 2020; Harford et al., 2019; Howard, 2015; Salzmann-Erikson & Yifter, 2020), were not mentioned. This omission may reflect a shift towards trauma-informed approaches, which de-emphasise pathologising explanations. Internal traits like impulsivity, emotional dysregulation, and delusional ideation, cited as mediators of violence (Harford et al., 2019; Howard, 2015), were absent. This may be due to the nature of the study, which centred participants' lived experiences rather than diagnostic or theoretical constructs. Some participants referenced early life experiences as shaping violent behaviour, supporting Stevenson et al. (2015) who suggested that a previous history of violence may be a contributing factor.

4.2.5 Patient and Staff Views

There is some overlap between themes identified by staff and patients. Table 11 highlights the convergence and divergence of staff GETs from the current study and the thematic analysis from the SLR. The patient theme of *"control and restriction",* reported by nine studies (Bensley et al., 1995; Duxbury, 2002; Duxbury & Whittington, 2005; Gillig et al., 1998; Jenkin et al., 2022; Kontio et al., 2014; Lenk-Adusoo et al., 2022; K. A. Nolan et al., 2009; Omérov et al., 2004), seems to be echoed by staff within the theme of *"navigating organisational failure and institutional betrayal"*. Staff and patients both echo the use of seclusion as a violation of human rights studies (Carlsson et al., 2006; Duxbury, 2002; Duxbury & Whittington, 2005).

Table 11

Convergence and Divergence of Themes Between Staff and Patients

Staff Group Experiential Themes	Staff Sub-Themes	Patient Themes (SLR)
Coping, surviving, and the normalisation of violence	1. Normalisation and daily survival 2. Adaptive strategies	
Navigating organisational failure and institutional betrayal	1. Systemic invalidations 2. Institutional neglect and responsibility 3. Environmental stress and containment	1. Wider Practices and Physical Environment 2. Control and Restriction
The emotional and moral weight of violence	1. Moral dissonance and identity conflict 2. Emotional responses and isolation 3. Oppression and identity-based harms	
Violence as a complex and relational communication	1. Co-construction of violence 2. Violence as communication 3. Complexity of causes	3. Agony of a Non-Encounter 4. Staff Factors 5. Patient Lifeworld 6. “Psychosis is dangerous”

The patient theme of *“the agony of a non-encounter”* aligns with the staff GET of *“violence as a complex and relational communication”.* Staff suggest that violence is co-constructed and relational, which also mirrors the *“staff factors*” theme identified by patients. Both themes are championed by Carlsson et al. (2006). The patient theme *“patient lifeworld”* is somewhat supported by the staff GET of *“violence as a complex and relational communication”.* Within this, staff discuss the *“complexity of causes*”; however, they do not emphasise the internal world of the patient as much as patients do (Bensley et al., 1995;

Carlsson et al., 2006; Jenkin et al., 2022; Kontio et al., 2014; Lamanna et al., 2016; Välimäki, Lantta, et al., 2022; Vermeulen et al., 2019) . *"Wider practices and physical environment"* are discussed by both patients and staff; however, staff place more emphasis on *"organisational failures"* and *"institutional neglect".* Patients discuss alternative issues such as comfort (Bensley et al., 1995), the use of punitive practices (Bensley et al., 1995; Duxbury, 2002; Gillig et al., 1998; Jenkin et al., 2022) and stigma (Bensley et al., 1995; Jenkin et al., 2022).

Patients spoke more often of *"psychosis is dangerous",* whereas only two staff members from the study mentioned psychosis as a factor in violence. Patients discuss how psychosis contributes to violence in the context of heightened distress, hallucinations, and paranoia (Jenkin et al., 2022), whereas staff discussed a *"complexity of causes"*. Jenkin et al. (2022) suggest that staff, more commonly than patients, cite "mental illness"[7] as a key factor, which is not supported by the current study. Staff factors in violence were discussed within the staff sub-theme of *"co-construction of violence".* For staff, these typically consisted of relational and environmental factors, whereas patients discussed more specifically variability in staff behaviour (Jenkin et al., 2022; Kontio et al., 2014; Lamanna et al., 2016) as well as how poor communication from staff can result in violence (Bensley et al., 1995; Carlsson et al., 2006; Lamanna et al., 2016; Vermeulen et al., 2019). The *"emotional and moral weight of violence"* was discussed by staff but not by patients, perhaps due to conflicting perspectives.

4.2.6 Theoretical Frameworks

4.2.6.1 Models of Violence.

Participants' accounts map strongly onto environmental and communication paths in Nijman et al. (1999). There is less emphasis on internal cognitive drivers. Violence was understood to escalate through ambiguous rules, stress, and poorly attuned responses,

[7] This is the language used within Jenkin et al. (2022).

consistent with the model's interactional cycle, whilst psychopathology was mentioned only occasionally. The theme of *“navigating organisational failure and institutional betraya*l” aligns with environmental stress in the model as a factor in violence. Kleo’s description of the ward as non-therapeutic and prison-like, along with Obinze’s framing of the environment as a “war-zone”, illustrates how the environment can play a role in how HCPs make sense of violence. Furthermore, the *“co-construction of violence”* sub-theme might be in line with the communication stress that Nijman et al. (1999) suggest is a part of the cycle of violence. HCPs within the study recognised that violent incidents were often the outcome of strained or unresponsive staff-patient relationships. Maeve and Sana both reflected this, suggesting that a failure to understand or appropriately respond to distress could escalate to violent behaviour. The model considers that underlying psychopathology plays a role, and some participants did speak to this; both Kleo and Obinze discussed how psychosis can play a role in violence. The internal (cognitive) aspect of the model was less supported, perhaps due to the relational and systems-focused perspective of participants, the other elements were robustly supported. This suggests that violence is most meaningfully understood not in isolation but through the interplay between setting, systems, and relationships. The repetitive pattern of violence suggested by Nijman et al. (1999) appears to be supported by the participants of the current study.

4.2.6.2 Models of Sense-Making.

The results of the study are consistent with theoretical frameworks on sense-making. In line with the model proposed by Weick (1995), participants often began to construct their meaning in response to disruption or unexpected events, that is, violence, which challenged their professional identities, moral beliefs, or assumptions about the safety and function of the ward environment. Sense-making was primarily retrospective, although at times participants were seen to be making sense in real time, looking back on moments of violence and constructing an account of the violence. Maeve, for example, revealed how the

normalisation of violence destabilised prior expectations of care. Sharma (2006) notes that sense-making can highlight our inability to shift representations due to the inertia of those representations. Participants often described how violence had been normalised, even when it clashed with their values, highlighting a resistance to challenging dominant narratives to survive.

Participants' accounts also align with narrative models of sense-making. Narratives are central to how individuals make sense of chaotic or traumatic events, and this undoubtedly is what violence is. As discussed previously, narratives can reflect dominant discourses. Individuals are storytelling agents within narrative sense-making models (MacIntyre, 2007), and this seems to be the case with the participants of the current study. They repeatedly constructed accounts that moved from description to embedding violence within broader relational, environmental, and moral storylines. For example, Kleo's deeply moralised reflection of observing seclusion, Obinze's metaphor-laden accounts of the institutional betrayal, and Sarah's trauma-informed desire for narrative closure after violent incidents.

Within IPA, sense-making is seen as an embodied, emotional, and socially situated process (Smith et al., 2022). Participants' accounts were not linear, but circular, iterative, and interpretive, often marked by uncertainty and emotional weight. This is evidenced by the fragmented speech, pauses, and moral dilemmas that surfaced within the interviews. The double hermeneutic of IPA is particularly relevant in this context. Participants were actively engaged in the sense-making process, which at times seemed complicated, and I then engaged in interpreting those interpretations through the lens of my own knowledge as an insider researcher and the critical realist framework employed.

4.3 Implications

Given the nature of IPA as an idiographic approach where participants actively construct meaning from their experiences, along with each participant's sense-making being seen as unique, implications should be treated very cautiously. With that in mind, I have been able to understand violence from multiple contextual perspectives, and some shared themes may suggest some theoretical, clinical, and organisational implications.

4.3.1 Theoretical Implications

The definition of workplace violence that was used within the study was

> "Any incidents of aggression that are physical, verbal or emotional that occurs when HCPs are abused, threatened, or assaulted in circumstances related to their work." (Health and Safety Executive, 2024).

Participants broadly supported this definition, although some wished to amend the definition to include racial violence or more subtle forms of violence like stalking or harassment. This is in line with Stevenson et al. (2015) who noted that definitions of violence are complex and that people have different definitions. Gillespie et al. (2016) suggest that verbal violence is considered so common within healthcare workplaces that it is not conceived as a form of violence. Whilst this study placed more emphasis on physical violence, the definition used included verbal violence. Despite this, only one participant discussed an incident involving verbal workplace violence.

It may be possible to tentatively suggest that the findings of this study challenge models of violence that locate the cause within individual psychopathology (Krakowski et al., 1986). What seems clear from the findings, along with the evidence base in general, is that violence is seen through relational and environmental lenses. It contributes to the theorisation of violence as relational and communicative. Participants frequently described

violence not as random or senseless, but as communicative acts shaped by unmet needs. This aligns with trauma-informed approaches (TIAs) and the use of the power-threat-meaning framework (PTMF). The study may also extend models of sense-making by bolstering the notion that participants actively construct meaning. As suggested by Weick (1995), disruption seemed to trigger retrospective meaning-making in the participants. The themes identified highlight how moral dissonance, relational factors, and environmental or institutional factors play a role in sense-making of violence, perhaps adding weight to narrative models, as participants used storytelling, metaphor, and fragmented dialogue to make sense of violence. The critical realist lens enabled an exploration not only of participants' subjective interpretations, but also of the institutional structures and cultural discourses that shape those interpretations. This has allowed for a richer, more integrated account of violence.

4.3.2 Clinical and Organisational Implications

This study highlights important clinical and organisational implications for addressing violence in inpatient MH settings. Participants attributed violence less to individual psychopathology and more to systemic and relational factors, including staffing levels, ward culture, and ruptures in therapeutic connection. Violence within inpatient services leads to decreased job satisfaction and increased intent to leave the profession (Sofield & Salmond, 2003). Themes of *"navigating organisational failure and institutional betrayal"* and *"the emotional and moral weight of violence*" point to a complex interplay between individual distress and systemic strain. Other research suggests a vicious cycle between these two themes. Violence has been shown to increase the chances of staff leaving the profession (Hampton & Rayens, 2019). Increasing vacancies can lead to more violence (Merrifield, 2017). This cycle highlights the impact of violence on patient care. Additional organisational impacts include nurse absenteeism, more frequent medical errors, more workplace injury claims (Ito et al., 2001; Roche et al., 2010), greater costs due to disability leaves, and

reduced quality of patient care (Campbell et al., 2011; Pai & Lee, 2011). Marshman et al. (2022) suggested that compassion fatigue because of violence can be moderated by protective factors such as culture and leadership, reflection, and clinical supervision. Hilton et al. (2022) suggested that training in the management of violence has been associated with lower levels of hyperarousal. Table 12 highlights possible avenues for intervention.

Table 12

Potential Interventions

Level of Intervention	Implication	Details	Role of Clinical Psychologists (CPs)
Individual	Reflective Practice (RP)	Enhances psychological insight, reduces reactivity and violence. Barriers include staffing and culture (Heneghan et al., 2014).	Facilitate and embed RP sessions; advocate for protected time.
	Post-incident Debriefing	Supports emotional processing and early help-seeking. Often absent. Normalises psychological responses and promotes early help-seeking Regel (2007).	Deliver or supervise structured debriefs; integrate guidance from the Association of Clinical Psychologists (2024)
	Training	Emotion regulation, trauma awareness, and communication skills	Lead training to reduce burnout and improve relational safety (Bekelepi & Martin, 2022).
Relational / Team	Team Formulation (PTMF-based)	Promotes shared understanding of behaviour, reduces restrictive practices (Nikopaschos et al., 2023).	Facilitate PTMF-informed formulations; train teams in trauma-informed approaches.
	Trauma-Informed Approaches (TIAs)	Reduce seclusion/restraint, enhance staff-patient relationships (Muskett, 2014)	Guide the service implementation of TIAs; support culture shift.
Ward / Organisational	Organisational Culture & Leadership	Shapes how violence is understood and managed. Leadership impacts compassion fatigue.	Promote reflective leadership; advise on cultural change.
	Ward-Level Dynamics	Staffing levels, job satisfaction, and moral injury contribute to violence.	Use systemic formulations to advocate for change; support workforce wellbeing.
	Systemic Pressures	Staff shortages and institutional betrayal drive a violence-burnout cycle.	Engage in service-level consultation and reform efforts.
Structural / Policy	Policy and Advocacy	Need to mandate the offer of RP, reduce discrimination, and improve equity in care.	Influence policy through research translation and systemic advocacy.

Level of Intervention	Implication	Details	Role of Clinical Psychologists (CPs)
	Community Psychology Principles	Promote culturally competent, preventative, and relationally informed care.	Apply community psychology in systemic reform and staff empowerment.

TIAs, particularly when paired with PTMF-informed team formulation, offer a compassionate alternative to reactive responses such as seclusion and restraint. Conceptualising violence as a response to threats embedded in relational, institutional, and social dynamics aligns both with the PTMF and the themes identified in the current study. These approaches can significantly reduce violent incidents (Nikopaschos et al., 2023; Saunders et al., 2023). This is supported by Kramarz et al. (2023), who found that it created a safe space for discussing challenges, which in turn improved relationships between staff and patients. CPs, with a high degree of knowledge in formulation and experience in using formulations in teams, are well-placed to support health services in adapting to TIAs and introducing formulations such as the PTMF (Johnstone, 2013). PTMF may be unwieldy; however, selected principles may be practically valuable for making sense of violence within inpatient contexts. TIAs aim to reduce re-traumatisation, promote safety, and shift staff away from punitive or pathologising responses. The use of TIAs alongside PTMF may help teams in understanding violence as embedded in meaning-making processes, not just as a risk behaviour. PTMF could be a resource to aid reflective practice (RP), staff support, and systemic change.

RP emerged as a possible practical avenue for further input. The RCN (2022) has recognised the value of RP and called for protected time to engage in it. Despite these endorsements, RP is still not mandated in key practice standards (Chaplin, 2019; Townsend et al., 2021). These findings underscore the need for organisations to prioritise RP as an essential element of working within MH inpatient services. CPs, with knowledge and skills in

reflection and facilitation of RP, will be able to play a role in embedding RP into wider NHS practices.

Post-incident debriefing is another area where there may be organisational implications. This is supported somewhat by participant accounts, who discuss how they were often left alone with the emotional responses from violence. The HSE (2025) recommends optional debriefing and access to counselling for staff following violent incidents, while NICE (2015) advocates for debriefs that assess both harm and ongoing risk. The opportunity for staff and patients to reflect together may improve relationships (Asikainen et al., 2020), highlighted by participants as an important factor in the development of violence.

Team formulation approaches, especially those grounded in the PTMF or TIA, help multidisciplinary teams contextualise patients' behaviour as communicative rather than purely symptomatic (Kramarz et al., 2023). This can promote more compassionate, less reactive responses to distress. Moreover, improving how rules and treatment plans are communicated to patients may reduce violence by fostering transparency and perceived fairness (Bizzarri et al., 2020).

The current study supports the notion that violence in MH inpatient units is linked to systemic challenges (Curran, 2023; Newell et al., 2016; Payne-Gill et al., 2021). As such, community psychology principles, championed by CPs, may be well-suited to address some of the issues highlighted from the participant accounts. These may reduce discrimination and ensure culturally competent care, which may reduce violence (Cuevas et al., 2017).

Economic and bureaucratic constraints are likely to hinder the implementation of the highlighted suggestions. These factors are unlikely to change quickly; however, opportunities exist for embedding structured choice within existing pathways. Services can increase patient participation without new funding. This may be achieved through co-produced care plans, advanced preferences for de-escalation, and thoughtful procedures around leave and

routines. Changing ward culture can be treated not as an abstract value shift, but as the accumulation of small behaviours. Table 13 highlights low-cost interventions that could be embedded into existing ward structures that may support in interrupting escalation, reducing moral injury, and reinforcing values-congruent practice under current constraints. These are by no means exhaustive.

Table 13

Culture Change Recommendations

Action	Purpose	Responsibility	Frequency	Resource Demand
Safety huddle	Anticipate flashpoints, clarify roles, and agree de-escalation plan	Nurse in charge	Beginning of each shift	10 minutes at handover
Post-incident debrief	Learning, emotional containment	Nurse in charge Senior managers Psychologists	Within 24 hours of incidents	10 minutes Template creation
Protected reflective practice	Re-sensitise moral boundaries, reduce defensive drift	Psychologists	Hourly meeting per month	Existing MDT time
Leadership rounding	Visibility, transparency, removing barriers	Ward managers Matrons	Twice weekly, 20 minutes	Time
Sensory or quiet space and kit	Reducing environmental stress, emotional regulation	Occupational Therapy	Time for designing of space, checking of kit weekly	One room corner, low-cost kit

4.4 Limitations

This study offers important insights into how HCPs make sense of violence in MH inpatient settings. However, several limitations must be acknowledged. First, while the sample size is appropriate for IPA, it limits generalisability. The sample included seven HCPs working or having worked in general adult inpatient services within the past five years. To maintain sample homogeneity, specialists from forensic or mother-and-baby units were excluded. Although this helped reduce confounding variables such as dual roles or long forensic histories, it limits the applicability of findings to specialised settings. Additionally, the range of staff roles was narrow; psychiatrists and occupational therapists were not represented, potentially omitting differing professional perspectives. The sample was also skewed demographically, with most participants being women in the early stages of their careers. While this reflects workforce trends, it may have influenced their narratives. For example, early-career staff may feel less able to challenge institutional norms or more vulnerable in high-risk environments. Though this dynamic is discussed in academic contexts (Dore & Richards, 2024), its relevance for HCPs is under-researched. One participant, Kleo, specifically described how femininity shaped her experience of risk, safety, and authority. My position as an insider researcher brings both strengths and limitations. Familiarity with the setting likely supported rapport and depth of insight, but also introduces the risk of interpretative bias. Efforts to mitigate this included reflexivity, bracketing, supervision, and member checking. Nevertheless, my background may have influenced which narratives were emphasised and how meaning was interpreted. Not all participants were currently employed in NHS MH inpatient services, and some discussed incidents from non-NHS settings, making the sample less homogeneous than expected. Two of seven participants engaged in member checking. This variation might reflect differing availability and sense-making trajectories rather than any error in interpretation. Feedback from these participants confirmed the provisional experiential themes. Had participants disagreed, the

analysis plan was to incorporate the challenges and potentially revise theme labels accordingly, with an emphasis placed on the double hermeneutic of IPA. The limited uptake on member checking appears to be a constraint on corroboration rather than a threat to credibility, given the transparency and rigour of the IPA.

The retrospective nature of the interviews presents limitations. While sense-making is inherently retrospective (Weick, 1995), recall may differ from real-time experiences. IPA's interpretative lens also means findings are co-constructed through a double hermeneutic process, raising questions about whose meaning is truly represented. The critical realist framework supports the exploration of subjective meaning within structural contexts, but it also adds complexity. The tension between lived experience and broader theoretical or policy implications cannot be fully resolved here and should be considered when interpreting the findings. Finally, the role of the questions and my positioning had an impact in relation to the findings. The analytic focus on relational and systemic processes might reflect both the study's aims and my position as an insider researcher. This may have foregrounded staff-patient dynamics. For example, I note that patient-to-patient violence was not discussed throughout. Mitigations to this impact included the use of a semi-structured guide, bracketing, and the use of supervision.

4.5 Recommendations for Future Research

Future research should aim to diversify participant samples. This might include perspectives from more senior staff, psychologists, psychiatrists, occupational therapists, security staff, and non-clinical ward workers. These groups may make sense of violence differently due to differences in power, role expectations, and risk exposure. Examining those with longer clinical experience to determine whether identity, coping, or moral dissonance adapts over time may be helpful. Longitudinal or repeated-interview designs

might be able to explore developmental aspects of violence and sense-making. There is scope to extend this work by examining the intersections of identity and power, including race, gender, class, and professional hierarchy and how these shape the experience and interpretation of violence. Some participants reflected on identity-based harms. Further research dedicated to this could examine these dynamics more systematically, particularly concerning how institutional responses differ depending on who is harmed. Additional research could examine how HCPs process, integrate, or suppress responses to violence. Participatory action research embedded within RP groups could longitudinally explore how sense-making shifts over time. Finally, future research might want to consider a greater degree of co-production with EbEs. This could be with staff and patients. This may help to focus relational and trauma-informed models of care. Exploring patient perspectives on violence, particularly when they have been both perpetrators and victims, could further deepen the understanding of what underpins violence in these settings. Finally, future research may want to purposively sample and probe patient-to-patient incidents to balance the emphasis of this study on patient-to-staff violence.

4.6 Conclusion

This study offers a rich exploration of how HCPs make sense of violence within MH inpatient settings. For the first time, to my knowledge, IPA, situated within a critical realist framework, has revealed participants' accounts of violence to be deeply relational, emotional, and institutional. Sense-making was shown to be shaped by coping, surviving, and the normalisation of violence, as well as navigating organisational failure and institutional betrayal. The emotional and moral weight of violence was also an important factor. Finally, violence was seen as a complex and relational form of communication. This highlights the complex moral and ethical dilemmas HCPs can face in these environments.

The findings reinforce existing models of sense-making and direct models of violence towards more relational and organisational factors. They tentatively challenge the dominant narratives that locate violence within the patient alone and emphasise the co-construction of violence through relational and institutional factors. The study suggests a need for more relationally focused, trauma-informed, and psychologically supportive systems, including RP, training, team formulation, and debriefing that could be delivered by CPs. Ultimately, this study calls for a rethinking, in line with other research, of violence not as an isolated event, but as a phenomenon embedded in the moral, emotional, and institutional fabric of MH care.

4.7 Final Reflections

Conducting this research has been a deeply personal and professionally transformative process. Entering the project as an insider researcher, having witnessed and been victim to violence within inpatient settings, I knew that my history, values, and emotions would inevitably shape how I engaged with people and interpreted their experiences. At times, the accounts I heard mirrored my own experiences so closely that old emotions resurfaced. In contrast, at other times, they challenged my assumptions and invited me to consider violence through different lenses. What stood out most was the emotional and moral complexity of how HCPs make sense of violence. I was struck and awed by the courage, vulnerability, and compassion with which participants shared their stories. This research has strengthened my belief that violence in MH settings must be understood both as a deeply human, and institutional problem, that impacts on staff and patients alike.

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Appendix

Appendix 1: Sample of Reflective Diary Entries

04.08.2023: First MRP Meeting

I've just had my first meeting about the MRP and I have a long to-do list now of activities. We thought about the general research topic of violence within MH inpatient services. I've had some experience with IPA before and given a research question in line with making sense of incidents, IPA seems reasonable? I've got some more reading and research to do and consider pragmatically what I'm able to do. Nevertheless, IPA seems like a good route given I want to think about how HCPs make sense of violence. I'm feeling excited and daunted at the prospect of starting this!

22.09.2023: Decision to apply for NHS Ethics

Another MRP meeting with a long to-do list at the end. I've been thinking about recruitment and whether to start the IRAS process for recruiting within the NHS. I'm a bit anxious about recruitment and some of the struggles that might lie ahead. I don't think I'm particularly strong when it comes to selling myself, so perhaps I should widen the pool by going for the NHS route as well. I thought with my supervisor about other avenues for recruitment, and I do think that NHS ethics and recruitment might be a way to go. I've written an IRAS before and it was an absolute nightmare so I'm not particularly looking forward to this, but at least I've done it before.

20.11.2023: Development of the Supervisory Team

I've managed to speak to two staff members who are going to be part of the supervisory team! I'm really happy about this, as I think they will be able to assist with recruitment, which I think will be the biggest struggle. We managed to get a nurse as well which feels important both to have other HCPs voices heard and because practically, she can assist with the NHS recruitment as well by making sure staff are released from duties to engage in the research. Having this supervisory team means I can focus more on NHS recruitment and less on recruitment from other sources.

02.05.2024: Finalising the Plan for the SLR

I've made the decision of what to focus on for my SLR. Looking around the research, as well as the fact that my study is focusing on staff perspectives, I've decided to do a review on patient or carer perspectives on violence. There's no review on this out there that I can see on PROSPERO. Again, after this supervisory meeting I feel like I have a tonne of stuff to do but it's good to be able to start the SLR having played around with search terms for the last few weeks. I think it's a good idea to get patient views as well, because once I've got views on the staff, I might be able to compare them perhaps?

11.11.2024: Bracketing Before Interviewing

Trying to bracket my own thoughts and feelings about violence on MH inpatient wards and I find myself siding with the patient more often than not. Which is interesting because I definitely never used to think that. I think I place a lot of blame on services and systems for violence and probably do carry a belief that it's the services themselves that perpetuate violence. I think that I think that violence on inpatient wards is a different type of violence to violence outside of these spaces. I can think of a few reasons for this. Mostly, on an inpatient setting I think violence is about communicating a need. Occasionally there might be a patient that just wants to be violent but mostly, I see violence as a communication. I'm also very anti the idea that violence is just "part of the job". I think there is a world in which violence doesn't occur in inpatient services. I think at heart I am a psychiatric abolitionist and that psychiatrists, nurses and HCAs should play a much smaller role in the provision of MH inpatient services. I think that I consider patient perspectives much more since I completed the SLR.

I believe that no one should go to work fearing violence. I also believe that people should be safe from violence in their homes (which is what inpatient units are for the patients).

Hopefully bracketing like this allows me to put my perspectives to one side a little, but I'm sure they'll still come through in the analysis. I'll keep trying to bear my own judgements in mind and IPA is a joint process after all. It makes me feel more glad I've decided to use IPA instead of other approaches. I also think being critically realist for this thesis benefits me too. I'm able to try and link some commonalities between individual stories, whilst appreciating that people are constructing their own sense of what violence is. I can acknowledge the reality of violence and value each HCPs experience at the same time (hopefully!). I feel a bit daunted at the prospect of starting the interviews, and being able to give voice to people's experiences.

04.01.2025: Interview with Maeve

The first interview is done! I feel massively relieved after doing this. I had lots of worries about the interview, that the schedule would be rubbish or it would be short, but none of that was true. The interview was rich, deep, and I think there is plenty to unpack here. I wonder if I stuck to the interview schedule more rigidly than I should have. In future interviews, I'll try and be a bit more flexible. It is only my first one. It felt quite overwhelming seeing all the possible avenues you can go down. Being an interviewer for a research study is quite different to being a clinician, though there are obviously some transferable skills. I'm sure I'll learn more after each interview.

21.03.2025: Interview with Obinze

I've finished another interview. Obinze spoke a fair amount about racism in the interview, and it feels essential to try to give voice to that within the write-up. Even if Obinze is the only one who discusses racism, I think I'll still write a section on it. It wouldn't feel genuine to omit Obinze's reflections given that we were talking about racism and its interactions with violence. This probably speaks to my values. There's something coming up here, but I can't quite make sense of it. Maybe I feel my own social GRACES and privilege coming in.

06.06.2025: Results Discussion

I've just had a chat with my supervisor about my results section and there's a little confusion over two sub-themes. Environmental stress and containment, and the co-construction of violence have a fair bit of overlap. There's a section on environment within the co-construction of violence sub-theme which is confusing me a little. We agreed that they are separate and distinct, but I need to make it really clear in my head (and in the write-up) what the differences are. So… Environmental stress and containment is about the environment itself (like locks, drab paint etc). Co-construction of violence is more about the interaction of the environment and the person. I've gone back through my results and just made this more distinct so hopefully it's clearer.

Appendix 2: Research Advertisement

University of Hertfordshire UH Ethics Committee

HEALTHCARE PROFESSIONALS NEEDED FOR RESEARCH

Have you ever worked in a psychiatric inpatient unit?

Have you been a victim of or witness to violent incidents from patients?

ABOUT THE STUDY

The research will be exploring how you make sense of these incidents.

WHAT WILL HAPPEN?

You will be invited to take part in an interview with me that will run for around 1 to 1.5 hours.

HOW CAN I TAKE PART?

If you wish to participate or have any questions please contact Mitchell Kemp

Email:
m.kemp4@herts.ac.uk

This doctoral research study has been approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

Appendix 3: Contract with Research Consultant

Doctorate in Clinical Psychology

MRP SUPERVISION CONTRACT

Please complete this supervision contract and submit with the MRP proposal.

Please note that **both supervisors and the trainee need to complete and sign the contract.**

This contract is intended to support conversations within the supervisory team to ensure clarity from the outset of your project regarding supervisor roles and responsibilities. **Please modify this document to fit the specific needs of your project.**

Principal Supervisor

Please fill in ALL the details below, as these will be needed to register the MRP on the University's online system RSMS.

Principal Supervisor details	
Title, First name and Surname:	Dr Emma Karwatzki
Work Address:	Health Research Building University of Hertfordshire
Telephone number:	N/A
Email address:	e.karwatzki@herts.ac.uk
Number of current doctoral supervisions. (This includes the current trainee's project.)	7
Number of successful doctoral supervisions. (This refers to how many thesis/ MRP's you've supervised in the past)	6
Number of previous examinations at doctoral level. This may not apply to all- this refers to how many viva's you've held as an examiner.	29
Have you attended University of Hertfordshire Supervisor Training?	Yes

Brief overview of expertise to supervise current project:	Leadership Staff Wellbeing Qualitative Research

	Principal Supervisor role
X	**I agree to have at least six joint meetings across the span of the project as stipulated by the University of Hertfordshire Research Degrees Board**
In addition, I agree to the following: (Please tick the areas that this supervisor has agreed to)	
X	Providing specialist knowledge and advice through regular supervision.
X	Advise on the research proposal and any modifications following review by staff.
X	Provide support to obtain ethical and research governance approval.
X	Help respond to problems that occur in the course of carrying out the study.
	Facilitate access to participants.
X	Help with timetabling and time management.
X	Provide input and clarification on methodology and analyses.
X	Read and provide feedback on each section of the MRP. If specific section only- please list:
X	Help with viva preparation on issues specific to the project.
X	If required, assisting with revision or resubmission.
X	Provide support in disseminating the findings, including:
X	Support preparing a paper for journal submission for the Sept course deadline.
X	If required, support responding to reviewer comments

Secondary Supervisor

Please fill in ALL the details below, as these will be needed to register the MRP on the University's online system RSMS.

Secondary Supervisor details	
Title, First name and Surname:	Dr Rebecca Aloneftis
Work Address:	[redacted]
Telephone number:	[redacted]
Email address:	[redacted]
Number of current doctoral supervisions. (This includes the current trainee's project.)	0
Number of successful doctoral supervisions. (This refers to how many thesis/ MRP's you've supervised in the past)	0
Number of previous examinations at doctoral level. This may not apply to all- this refers to how many viva's you've held as an examiner.	0
Have you attended University of Hertfordshire Supervisor Training?	No
Brief overview of expertise to supervise current project:	Experience of own doctoral research

Please tick the areas that this supervisor has agreed to (typically a secondary supervisor will tick fewer boxes than the principal, but if possible, the two supervisors should cover all the areas outlined between them):

	Secondary Supervisor Role
X	**I agree to have at least six joint meetings across the span of the project as stipulated by the University of Hertfordshire Research Degrees Board**
In addition, I agree to the following: (Please tick the areas that this supervisor has agreed to)	
	Providing specialist knowledge and advice through regular supervision.
	Advise on the research proposal and any modifications following review by staff.
	Provide support to obtain ethical and research governance approval.
	Help respond to problems that occur in the course of carrying out the study.
X	Facilitate access to participants.
	Help with timetabling and time management.
	Provide input and clarification on methodology and analyses.
	Read and provide feedback on each section of the MRP. If specific section only- please list:
	Help with viva preparation on issues specific to the project.
	If required, assisting with revision or resubmission.
	Provide support in disseminating the findings, including:
	Support preparing a paper for journal submission for the Sept course deadline.
	If required, support responding to reviewer comments

Secondary Supervisor

Please fill in ALL the details below, as these will be needed to register the MRP on the University's online system RSMS.

Secondary Supervisor details *NB NUZHAT HAS LEFT THE TRUST AND WILL NO LONGER BE PROVIDING ANY SUPERVISION*	
Title, First name and Surname:	Ms Nuzhat Rahman
Work Address:	N/A
Telephone number:	N/A
Email address:	[redacted]
Number of current doctoral supervisions. (This includes the current trainee's project.)	0
Number of successful doctoral supervisions. (This refers to how many	0

thesis/ MRP's you've supervised in the past)	
Number of previous examinations at doctoral level. This may not apply to all- this refers to how many viva's you've held as an examiner.	0
Have you attended University of Hertfordshire Supervisor Training?	No
Brief overview of expertise to supervise current project:	Knowledge of staff population and HPFT policies and procedures

Please tick the areas that this supervisor has agreed to (typically a secondary supervisor will tick fewer boxes than the principal, but if possible, the two supervisors should cover all the areas outlined between them):

Secondary Supervisor Role ***NB NUZHAT HAS LEFT THE TRUST AND WILL NO LONGER BE PROVIDING ANY SUPERVISION***	
X	**I agree to have at least six joint meetings across the span of the project as stipulated by the University of Hertfordshire Research Degrees Board**
In addition, I agree to the following: (Please tick the areas that this supervisor has agreed to)	
	Providing specialist knowledge and advice through regular supervision.
	Advise on the research proposal and any modifications following review by staff.
	Provide support to obtain ethical and research governance approval.
	Help respond to problems that occur in the course of carrying out the study.
X	Facilitate access to participants.
	Help with timetabling and time management.
	Provide input and clarification on methodology and analyses.
	Read and provide feedback on each section of the MRP. If specific section only- please list:
	Help with viva preparation on issues specific to the project.
	If required, assisting with revision or resubmission.
	Provide support in disseminating the findings, including:
	Support preparing a paper for journal submission for the Sept course deadline.
	If required, support responding to reviewer comments

Trainee Name: Mitchell Kemp

The trainee will need to take responsibility for the following:

• Take the lead for organising supervision meetings.

• Prepare for supervision meetings as guided by the supervisor(s).

• Develop a plan for the MRP with guidance from the supervisor(s).

• Send draft chapters to the supervisor(s) for feedback by agreed deadlines.

• Inform the supervisor(s) within 24 hours (or as soon as possible thereafter) of any ethical issues that arise during the project.

• Develop a dissemination plan with the supervisors and take the lead on writing presentations and publications, unless negotiated otherwise.

• Provide both supervisors with a final electronic copy of the MRP when submitted for marking.

If other actions have been agreed, please enter these below:

Mentoring

If a lead supervisor is new to this role then a second supervisor from the department can provide mentoring. If mentoring is being provided, then please enter details below:

Supervisor being mentored: N/A

Supervisor acting as mentor: N/A

Agreed support that will be provided (e.g., this could include telephone consultation and advice regarding feedback that the lead supervisor provides): N/A

Signatures

We have read the relevant programme guidelines and agree to the respective roles and responsibilities, along with the contents of this contract.

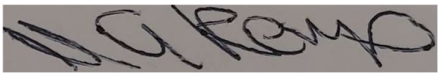
We agree that when this project is submitted for publication or presentation, authorship will be as follows (list surnames as agreed for publication submission):

Kemp, M. G., Karwatzki, E., Aloneftis, R., ~~& Rahman, N.~~

Usually this will be:

Trainee, Principal Supervisor, Second Supervisor.

Since prompt publication of research is of crucial importance, the lead supervisor reserves the option of writing the paper as first author if it has not been accepted for publication within six months of project completion. By signing this form, you agree to abide by this stipulation.

Signature of trainee: 

Date: 20/11/23

Signature of supervisor:

Date: 06/12/23

Signature of supervisor:

Date: 05/12/23

Signature of supervisor:

Date: 05/12/23 *NB NUZHAT HAS LEFT THE TRUST AND WILL NO LONGER BE PROVIDING ANY SUPERVISION*

Please provide a copy of this form to both supervisors and to the Research Lead

Appendix 4: University Ethical Approval

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Mitchell Kemp
CC	Dr Emma Karwatzki
FROM	Dr Rosemary Godbold, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	26/04/2024

Protocol number:	**LMS/PGR/UH/05612**
Title of study:	Healthcare professionals' sense making of patient violence within psychiatric inpatient settings.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Dr Rebecca Alonefti[redacted]

Ms Nuzhat Rahman [redacted]

Recommendations from the Vice-Chair:

- The statement from the information sheet about a contributor release form doesn't seem relevant to this study and could be removed.

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 26/04/2024

To: 30/04/2025

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix 5: NHS HRA Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Emma Karwatzki
Academic Supervisor
University of Hertfordshire
Psychology Department - College Lane Campus
Hatfield
University of Hertfordshire
AL10 9AB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

14 October 2024

Dear Dr Karwatzki

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Healthcare professionals' sense making of patient violence within psychiatric inpatient settings.**
IRAS project ID:	**337316**
Protocol number:	**TBC**
REC reference:	**24/HRA/2908**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The *"After HRA Approval – guidance for sponsors and investigators"* document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **337316**. Please quote this on all correspondence.

Yours sincerely,
Rachel Katzenellenbogen
Approvals Specialist

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [None]	1	04 July 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [None]		04 July 2024
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Clinical trials insurance]		12 August 2024
Interview schedules or topic guides for participants [None]	1	04 July 2024
IRAS Application Form [IRAS_Form_09102024]		09 October 2024
Letter from sponsor [None]		04 July 2024
Letters of invitation to participant [None]	1	04 July 2024
Non-validated questionnaire [Participant Screening Questionnaire]	1	18 July 2024
Organisation Information Document [PIC Agreement]	1	09 October 2024
Other [Confirmation the professional indemnity submitted will cover harm to participants from the management, design and conduct of the research.]	1	04 September 2024
Other [IRAS Amendments]	1	09 October 2024
Other [Clinical Trials insurance]	1	04 September 2024
Participant consent form [None]	3	09 October 2024
Participant information sheet (PIS) [None]	3	09 October 2024
Referee's report or other scientific critique report [None]		04 July 2024
Research protocol or project proposal [None]	2	09 October 2024
Summary CV for Chief Investigator (CI) [None]		04 July 2024
Summary CV for student [None]		04 July 2024
Summary, synopsis or diagram (flowchart) of protocol in non technical language [None]	3	09 October 2024

IRAS project ID 337316

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Activities at NHS organisations will involve PIC activity only, including the identification of participants, and discussion with staff teams.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor: * Within 35 days of receipt of the local information pack	The sponsor has provided the appropriate model non-commercial PIC agreement that it intends to use as a contract between themselves and NHS organisations acting as their Participant Identification Centres (PICs).	Study funding arrangements are detailed in A65 of the IRAS form.	The Chief Investigator will be responsible for all study activities performed at PICs.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed).

	* After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National Coordinating Function where the participating NHS organisation is located.				

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 6: Sponsorship Letter

University of Hertfordshire UH

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Professor Wendy Wills
Pro Vice-Chancellor (Research and Enterprise)

Dr Emma Karwatzki
Mitchell Kemp
Department of Psychology, Sports and Geography
School of Life and Medical Sciences

2 January 2025

Dear Dr Emma Karwartzki and Mitchell Kemp

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: Healthcare professionals' sense making of patient violence within psychiatric inpatient settings
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Emma Karwatzki
NAME OF INVESTIGATOR (Student): Mitchell Kemp
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGR/UH/05612
HEALTH RESEARCH AUTHORITY REFERENCE: 337316

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission to the Health Research Authority (HRA) Research Ethics Committee (REC) and I must also be notified of the outcome. It is also essential that evidence of any further NHS Trust or other site permissions is sent as soon as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely,

Professor Wendy Wills
Pro Vice-Chancellor (Research and Enterprise)

Appendix 7: Invitation Letter

Dear Invitee,

My name is Mitchell Kemp and I am a doctoral student at the University of Hertfordshire Clinical Psychology Programme. I am conducting a study titled: “Healthcare professionals’ sense making of patient violence within psychiatric inpatient settings”. Thank you for taking the time to read this letter, I am hoping for your participation in the study.

The aim of this research is to gain an understanding into the sense making of healthcare professionals who have been involved in or witness to violent incidents. Another broad aim is to explore healthcare professionals’ perceptions of workplace violence in psychiatric inpatient settings. Understanding the impact of workplace violence on healthcare professionals’ wellbeing and job satisfaction is also an aim.

The study involves completing a semi-structured interview with me for around 90 minutes. We will be talking through your experiences of patient violence and how you make sense of these experiences. Participation is completely voluntary and you may withdraw from the study at any time up to data collection. This is typically up to 24 hours after we have had the interview. The study is anonymous and does not require you to provide your name or any other identifiable information. If you would like to participate please read the informed consent sheet attached.

Your participation would aid in the understanding of how healthcare professionally make sense of patient violence. The hope would be that this information leads to a greater level of support to healthcare professionals with the prevention and management of these incidents.

Thank you for your time and participation.

Yours sincerely,

Mitchell Kemp

Trainee Clinical Psychologist

Appendix 8: Consent Form

University of Hertfordshire UH Ethics Committee

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')

FORM EC3
CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

.....

hereby freely agree to take part in the study entitled:

Healthcare professionals' sense making of patient violence within psychiatric inpatient settings.

UH Protocol number LMS/PGR/UH/05612

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time up to the point of data collection without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice, video or photo-recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been given information about the risks of my suffering harm or adverse effects

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

6 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Please indicate the following, please note that these are optional (delete as appropriate):
Would you like to receive a copy of your transcript? Yes/No
Do you consent to being contacted about themes identified from your interview? Yes/No

Signature of participant.....Date.....

Signature of (principal) investigator Date.....

Name of (principal) investigator

Form EC3 – 26 May 2021

Appendix 9: Participant Information Form

University of Hertfordshire UH Ethics Committee

UNIVERSITY OF HERTFORDSHIRE
ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS ('ETHICS COMMITTEE')
FORM EC6: PARTICIPANT INFORMATION SHEET

1 Title of study

Healthcare professionals' sense making of patient violence within psychiatric inpatient settings.

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 What is the purpose of this study?

The aim of this research is to gain an understanding into the sense making of healthcare professionals who have been involved in or witness to violent incidents. Another broad aim is to explore healthcare professionals' perceptions of workplace violence in psychiatric inpatient settings. Understanding the impact of workplace violence on healthcare professionals' wellbeing and job satisfaction is also an aim.

4 Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason up to the point of data collection. This is 7 days after the interview has taken place. You can withdraw by emailing the researcher at m.kemp4@herts.ac.uk asking to withdraw.

5 Are there any age or other restrictions that may prevent me from participating?

You will not be able to participate if you are under 18.

6 How long will my part in the study take?

If you decide to take part in this study, you will be asked to sign a consent form and you will be involved in it for 60-90 minutes for the interview. Additional participation beyond this is optional. You may want to be involved in parts of the data analysis. Once the interview has taken place, the researcher will ask if you would like to view your transcript and if you agree we can send this to you to review. We will also ask if you would like to be involved in thinking about the themes from your interview and if so we will make a note and contact you in the future to discuss this.

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7 What will happen to me if I take part?

The first thing to happen will be arranging a suitable time and place for the interview to take place. Interviews can be held online. The interview will be recorded and be expected to last for 60-90 minutes. This will allow time for questions and a debriefing following participation. You will then be asked whether you want to receive a copy of your interview transcript, themes, and an end of study letter.

8 What are the possible disadvantages, risks or side effects of taking part?

It is not anticipated that participants will be exposed to undue distress however, interviews may discuss difficult incidents. If you feel distressed we are able to offer emotional support during the interview process. You are able to contact your occupational health department, employee assistance, or the Samaritans on 116123 if you continue to feel distressed.

9 What are the possible benefits of taking part?

The interview will give an opportunity for you to reflect about your practice and experience. There are several identified benefits of taking part in interviews such as this, including catharsis, self-awareness, and healing (Hutchinson et al., 2014).

10 How will my taking part in this study be kept confidential?

The researcher guarantees anonymity and confidentiality of any collected information. All data will be kept confidential between the participant and the researcher. You will be asked to give written consent for your participation as well as your consent to be audio recorded. Recorded data will be stored on the University of Hertfordshire's secure cloud server which is only accessible by the principal researcher. Anonymised transcriptions will then be created and the recordings will be destroyed. Your consent forms will be stored securely on the university's secure cloud server

11 Audio-visual material

The interview will be recorded and transcribed onto a password protected word document. The recording will be deleted once transcription has taken place. Any information that identifies you, or gives any clues to your identity, will be removed. We are confident that these precautions will ensure that no-one will be able to trace your transcript back to you. You will have the opportunity to review your transcript. At the end of the study, all anonymised transcripts will be kept for 5 years and then destroyed.

You will not be named or otherwise identified in any publication arising from this project. Excerpts of your interview may be published as they form an important part of the project findings. If there is anything you have said that includes identifiable information (for example, where you live, or your name) we will omit or change these details to protect your identity becoming known.

12 What will happen to the data collected within this study?

I will analyse all the data and use this as a basis for writing up a thesis on the topic. The data collected will be stored electronically, in a password-protected environment, for 5 years, after which time it will be destroyed under secure conditions. The data will be anonymised prior to storage.

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The results of the research will be presented in a thesis for the purpose of gaining a qualification in Clinical Psychology. The thesis will be held at the University of Hertfordshire Learning Resource Centre and will be accessible to all interested parties. A summary of the main research findings may be published in written work or articles that project myself or my supervisors write, as well as for the purposes of teaching and conferences. Information originating from the study will only be made public in an unattributable format.

13 How will we use information about you?

We will need to use information from you, shared within the interview, for this research project. This information will include what you have shared throughout the interview, although the information will be anonymised. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

14 What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, up to 7 days after your interview.

15 Where can you find out more about how your information is used?

You can find out more about how we use your information

- **at www.hra.nhs.uk/information-about-patients/**
- **by asking one of the research team**
- **by sending an email to dataprotection@herts.ac.uk.**
- **www.hra.nhs.uk/patientdataandresearch**

16 Who has reviewed this study?

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is LMS/PGR/UH/05612

17 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

18 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: *m.kemp4@herts.ac.uk*

You may wish to discuss the research with the research supervisor. This research is supervised by:
Dr Emma Karwatzki

University of Hertfordshire UH Ethics Committee

e.karwatzki@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix 10: Participant Screening Questionnaire

Screening Questionnaire for Participants

Do you work/have you worked within psychiatric inpatient services in the last 5 years? YES/NO

Have you been witness to/ a victim of physical violence within psychiatric inpatient services? YES/NO

Were these experiences within specialist services such as forensics or mother and baby units? YES/NO

Appendix 11: Distress Protocol

Protocol to follow if participants become distressed during participation (Adapted from Shetty, 2019).

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

Mild distress

Signs to look out for:

1) Tearfulness

2) Voice becomes choked with emotion/ difficulty speaking

3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue

2) Offer them time to pause and compose themselves

3) Remind them they can stop at any time they wish if they become too distressed

Severe distress

Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently

2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack

3) Intrusive thoughts of the specific event

Action to take:

1) The researcher will intervene to terminate the interview

2) The debrief will begin immediately

3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation.

4) If any unresolved issues arise during the interview, acknowledge and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction

5) Details of counselling/therapeutic services available will be offered to participants

Extreme distress

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression

Action to take:

1) Maintain safety of participant and researcher

2) If the researcher believes that either the participant or someone else is in immediate danger, then she will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.

3) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

Appendix 12: Debrief

University of Hertfordshire UH

Contacts for further support

Healthcare professionals' sense making of patient violence within psychiatric inpatient settings.

Thank you for taking part in this study.

Talking about your experiences of patient violence, may have been distressing for you. We hope that the below resources will be helpful should you find yourself needing some extra support.

The professional code of conduct and ethical approval for this study means that the lead researcher Mitchell Kemp cannot personally support individuals with support beyond the remit of the study. This is why we have created this debrief sheet with a list of contact details for further support.

- **GP or local Psychological Therapy Services:** for advice if you are feeling low in mood, anxious or other emotional difficulties.

- **National NHS Helpline:** you can call this service on 0300 131 7000

- **Support via text messages - Shout:** text FRONTLINE to 85258

- **Royal College of Nursing –** can offer support for a range of issues including: with professional practice, bullying, harassment and stress.

https://www.rcn.org.uk/get-help/bullying-harassment-and-stress

- **Cavell Nurses Trust –** Supports those suffering from personal or financial hardship

https://www.cavellnursestrust.org/

- **Samaritans –** A non-judgemental service who will always listen

https://www.samaritans.org/ Call 116 123 free

[redacted]

Appendix 13: Semi-structured Interview Schedule

Primary Questions	Examples of probes
What led to you working within psychiatric in-patient services?	i. Probe for information regarding their role, responsibilities, work/personal experience, context of the workplace ii. What's your motivation for the role?
Provide definition of patient (Service User) violence	i. Provide definition for patient violence that the study utilises. "Any incidents of aggression that are physical, verbal or emotional that occurs when HCPs are abused, threatened, or assaulted in circumstances related to their work", but you might have your own definition…
What are your experiences with patient (Service User) violence?	i. If there is more than one experience ask the participant to discuss the one that stands out the most ii. If there is more than one of these go through each in turn iii. What do you think the causes were leading up to the event? iv. What time of day was it? v. How many staff were around on the ward? vi. What was the person's current situation/care/ward? vii. What happened during the event? viii. How did it end? xi. What were your feelings as it occurred and afterwards? xii. Are there any processes that could have helped to prevent this?
Why do you think some patients act in a violent manner?	i. What do you think the contributing factors are? ii. Is there something about the person? iii. Is there something about the environment?
How do you relate to patients that have displayed violence?	i. Do you treat them any differently in the short term? ii. Do you treat them any differently in the long term?
What do you think it means about a patient	

that they have acted in a violent manner?	
What impact did your experiences have on you personally?	i. What were the immediate impacts? ii. What were the longer term impacts? iii. What are the different impacts of different types of violence? iv. What impact did it have on your job or role identity, or the approach/relationship to the job? v. What impact did it have on relationships (personal/with the service user/with the team)?
What are your experiences of your employers/management of patient violence in the moment?	Seclusion? Support/training/supervision/debrief?
What do you need to help the management of patient violence in the moment?	i. Employers? ii. Colleagues? iii. Patients? iv. Policies/Guidance? v. Environment? vi. New approaches/innovations?
What are your experiences following an incident of patient violence?	Support/training/supervision/debrief?
What do you need from your employers following an incident of patient violence?	i. What support or follow up did you receive? ii. Was there anything that you wished you would have received that you didn't?

*These are indicative questions and there will be some flexibility in line with IPA study design and best practice.

Appendix 14: Example of Analysis for PETs

Experiential Statements (my interpretation of their meaning of the experience)	Data	Exploratory Notes (participant's meaning of the experiences - no researcher interpretation)
Reflecting on the painful contradiction of working in a support role while routinely facing threats and abuse from those he is trying to help. Despite his intention to offer care, encounters violence that feels deeply personal. An emotional struggle of sustaining compassion and commitment in the face of repeated harm, and the difficulty of making sense of violence directed at helpers.	Obinze: 14:44 So The thing is, like I said earlier, we come, is unfortunate when we come, we will you receive… You are abused in different forms, you know, apart from the one of this lady, the other one of a of a guy, this one this time around, the service that was was, it was male and he threatened to smash me and he told me to my face that I would hit you and I'll ensure that you don't get any free medical care, you know. And I was just trying to help. So most times what we do there is not to prevent them from having a good life. We try to support when the place of supporting.	You are abused in different forms There's a sense of inevitability in his statements "I was just trying to help" Something conceptually around helping and being harmed whilst trying to help Triple hermeneutic in Obinze making sense of service users thinking that he is preventing them from having a good life
	Interviewer: 14:55 Mm hmm mm hmm.	
Candidly describes the cumulative emotional toll of enduring physical, verbal, and racial abuse while trying to help others. Repeated attacks on dignity, particularly through racial slurs, have led to feelings of deep sadness, worthlessness, and depression. Despite wishing to leave the role, economic necessity compels him to stay. Emotional burden and moral injury of continuing to work in a context where harm is both expected and normalised.	Obinze: 15:21 You get abused either physically or… racially and the rest of them verbally. How I feel is I feel… Feel sad, I feel… When somebody tells you makes you feel your… You're worthless and you're trying to help someone and the person is attacking you in the process so it and then they call you names and ask you to go back to your country, call you different cons, black monkey. I'm sorry for my language. You know, things like that. So it makes you feel depressed. You're you're depressed. You're feeling. I really don't have words to describe how I feel is really a terrible feeling… It's not a nice feeling at all. Yeah, because you're not looking forward to going to work again, but you need to go to work because you need to. The abuse, you know, so it's an unfortunate situation, but I mean and that's why I did. I said the job is risky. I don't know if I answered your question, but that is how I feel how I feel. I feel depressed. I feel sad. I feel.	Physically, racially, verbally, there is a sense of multiple types of violence all occuring at once Feeling sad - being made to think you're worthless Repetition of trying to help Explicity mentioning racial abuse - and it making him feel depressed (More than sadness earlier?) Terrible feeling - Needing to go to work when you don't want to Repetition again of the job being risky Repetition of feeling depressed and sad Wanting out of the job ***

	I wish I had another option in order to stop doing this job, you know? Yeah.	
	Interviewer: 16:17 Mm hmm. Yeah, yeah. OK. So I mean, it sounds like feeling… Feeling kind of trapped in in the job, in a sense.	
	Obinze: 16:44 Yeah, yeah.	
	Interviewer: 16:47 I'm wondering as well what what goes through your mind when… That incident is playing out.	
Reflects on the intense internal struggle between maintaining professional standards and managing the emotional toll of absorbing physical and verbal abuse without retaliation. Sees caregiving as a moral obligation, even when it results in personal suffering. The emotional burden of repression is likened to a bomb or volcano, suggesting the dangerous accumulation of trauma.	Obinze: 16:58 What goes through my mind is I try to… Struggle with two things. I try to act in a professional manner because I owe the patient duty of care at the same time… I'm trying not to allow my emotions to to… Take the best part of me. So as human, you're someone is punching you and unfortunately you can't do anything. You can't punch back. Someone is insulting you and calling you terrible names, racially abusive towards you when you can't call them back. You can't. You can't challenge them, so you just keep quiet. So when you keep quiet and you're assimilating things, you're receiving things. Is like a bomb, like a volcano is is a lot inside you. So like, there was a day I had to walk away from that environment immediately. And I went into an office.	Struggling with the dichotomy - professional vs emotional Owing the patient - Why owing? Duty of care You can't punch back - double standard? Being insulted and racially abused - and feeling powerless - keeping quiet "Like a bomb, like a volcano inside you" Needing to walk away - Wanting to retaliate
	Interviewer: 17:47 Yeah.	
	Obinze: 17:52	
	To sit down, just to try and er you, to manage myself, my emotions. So I don't know if I answered your question, but that's what goes on in my head.	
	Interviewer: 18:01 Yeah.	
Emotional and professional impossibility of responding to violence in a mental health care setting. Being metaphorically tied and stabbed while being forbidden from speaking or acting. Fear of disproportionate consequences,	Obinze: 18:02 I'm trying not to react… In in a way that is not appropriate, you know, so you try to still maintain the professional conduct. So it's it's, it's a lot like your your your your tied. You're being stabbed at the same time you're not allowed to speak. You're not allowed to act. Because because when	Trying to remain professional Feeling tied Powerful statement of being silenced and made to feel powerless - Not allowed to speak/act paired with quite violent act of stabbing.

including job loss and professional deregistration, enforces this silence capturing the deep moral injury and systemic injustice	you do, when you say anything or when you do anything… The service user goes free and you get into trouble, you're suspended, you lose your job, you lose your PIN. As a case. Maybe. So it's it's tough.	Retaliating results in greater consequences for staff than the initial violence
	Interviewer: 18:41 Yeah, yeah. And I'm wondering as well you you mentioned a few times that about… Like racial abuse and like racial violence, it's it's not in the definition that that that we talked about earlier, but perhaps perhaps it should be. Could you speak to? Yeah, how how it feels for you when racial violence or aggression is used against you?	
Describes the profound emotional and moral injury of experiencing racist abuse while working in a caregiving role. Distinguishing between behaviour arising from mental illness and deliberate racial prejudice, asserting that racism is a conscious and systemic problem. Suggests a compounded harm caused by both interpersonal and institutional racism, revealing a deep sense of injustice, betrayal, and exhaustion within the caregiving profession.	Obinze: 19:12 So… Erm… It's it's… It's unfair. I see it as… Discriminatory because you're here. This they need help. We are here to support. But you are calling me names and you are asking me to go back to my country… Because I am a black monkey… You call different names and then… So it's it's… I think the racism is not just… From the service user, it's also a systemic problem because… Those in the category of BAME suffer a lot, you know, so they you are discriminated. You are not, you lose some favours because of your colour or your race. You know things like that. So it's not just about service users so when services do that it's I see it is as them having capacity is not because they are they are unwell but because it is… What they are aware of it is their nature, their person to do that, because if someone is truly unwell, you will not remember the colour of the other person.	*** Double discrimination Supporting and helping but receiving racist abuse Racism is a systemic problem Thinks that racism is racism regardless of whether someone is unwell or not***
	Interviewer: 20:32 Yeah. Yeah.	
	Obinze: 20:41 You know. Yeah. So you need to have capacity to be able to judge a person standing in front of you to know what to say to the person.	
	Interviewer: 20:49 Yeah. Yeah. OK.	
Further expanding that racist violence can be an attempt to make you feel less human.	Obinze: 20:51 So I don't if I if I answered your question. So for racism it's it's tough because. You you see yourself as human being,	Racist abuse is an attempt to make you feel less human

	you see yourself equal with others, but people want to… Possibly make you feel less human.	
	Interviewer: 21:11 Yeah, yeah.	
	Obinze: 21:12 And that is why under my signature on my e-mail I've changed. I've taken it out now. I used to have something under my e-mail I wrote… Different skin colour, same blood colour… So we have different skin colour but the the colour of the blood is the same.	
	Interviewer: 21:31 And what does? What does that mean for you that phrase?	
Highlights a moment of unexpected solidarity and emotional repair, where a service user's affirmation of shared humanity became a meaningful counterpoint to experiences of racism and discrimination.	Obinze: 21:34 Equality. So, erm, you know, I appreciate the quality, you know, diversity equality is something very beautiful. We are from different backgrounds and we are meant to use that. Difference. So our our diversity to help each other. So but yeah, so we are equal, because what's that phrase means to me why I put it out there? And actually, to even it was a service user that, that, that told me that and I kept in my head…. You know, he said he was he was fighting for me when I was being abused sometime and then he told me, oh, I've got. I've got your back if you need support, let me know what that service user did to you is wrong. This was the service user they are trying to fight for me. And they said, I mean, we are all the same, you know, different colours but same blood colour. So for me that's the that's sentence or that phrase.	Speaking to equality - desiring this Being supported by a service user - and service user giving the phrase "different skin colour, same blood colour"

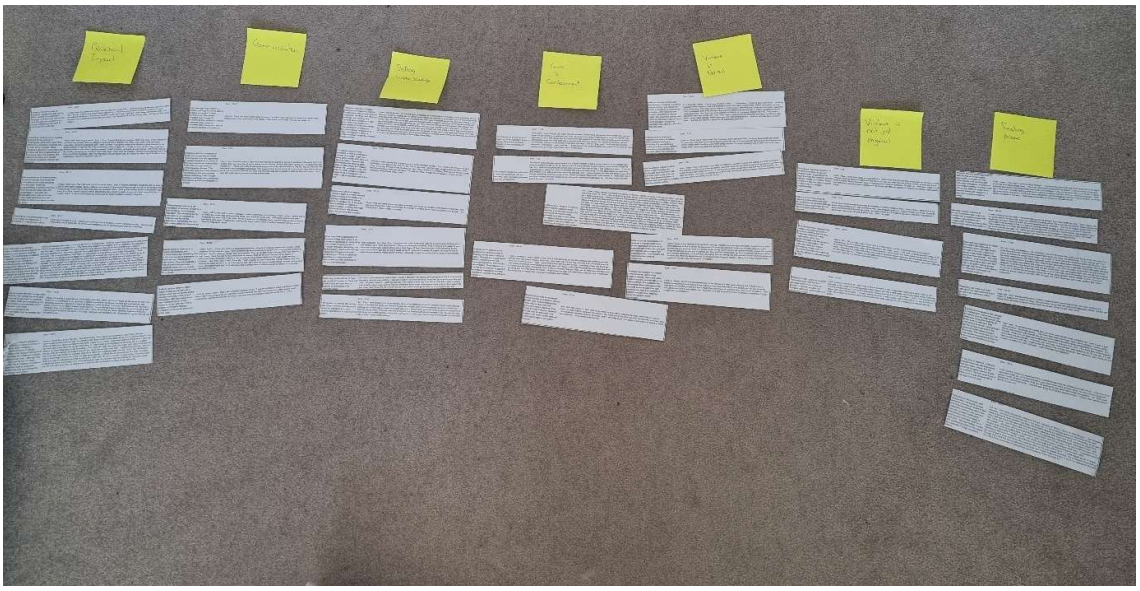
Appendix 15: List of PETs for Each Participant

Participant	PETS (personal experiential themes)	GETS (group experiential themes)	GETS (sub)
Maeve	Senior management need to take it seriously	Navigating organisational failure and institutional betrayal	Systemic invalidations
	Fight or flight and getting out of this day alive	Coping, surviving, and the normalisation of violence	Normalisation and daily survival
	Feeling safe but judged by colleagues	Coping, surviving, and the normalisation of violence	Adaptive strategies
	How do you expect them to get better?	The emotional and moral weight of violence	Moral dissonance and identity conflict
	More information is needed so the person doesn't "become the violence"	Violence as a complex and relational communication	Complexity of causes
	Systems perpetuate and invalidate people	Navigating organisational failure and institutional betrayal	Systemic invalidations
	Using humour as a coping strategy	Coping, surviving, and the normalisation of violence	Adaptive strategies
	Violence is a daily thing	Coping, surviving, and the normalisation of violence	Normalisation and daily survival
Hassan	Aggression is rooted in emotional distress	Violence as a complex and relational communication	Violence as communication
	Loss of control and autonomy	Violence as a complex and relational communication	Co-construction of violence
	Violence as a response to loss of freedom and power	Violence as a complex and relational communication	Co-construction of violence
	Violence is relational: Staff play a role too	Violence as a complex and relational communication	Co-construction of violence
	Violence often isn't personal, but responses to violence can be	Violence as a complex and relational communication	Co-construction of violence
	Working as a HCA feels like policing a ward	Navigating organisational failure and institutional betrayal	Institutional neglect and role burden
Sarah	A sense of camaraderie and togetherness following or during aggression	Coping, surviving, and the normalisation of violence	Adaptive strategies
	Emotional responses to violence	The emotional and moral weight of violence	Emotional responses and isolation
	Personal vs professional	The emotional and moral weight of violence	Moral dissonance and identity conflict
	Post-incident support feels like "ass-covering"	Navigating organisational failure and institutional betrayal	Systemic invalidations

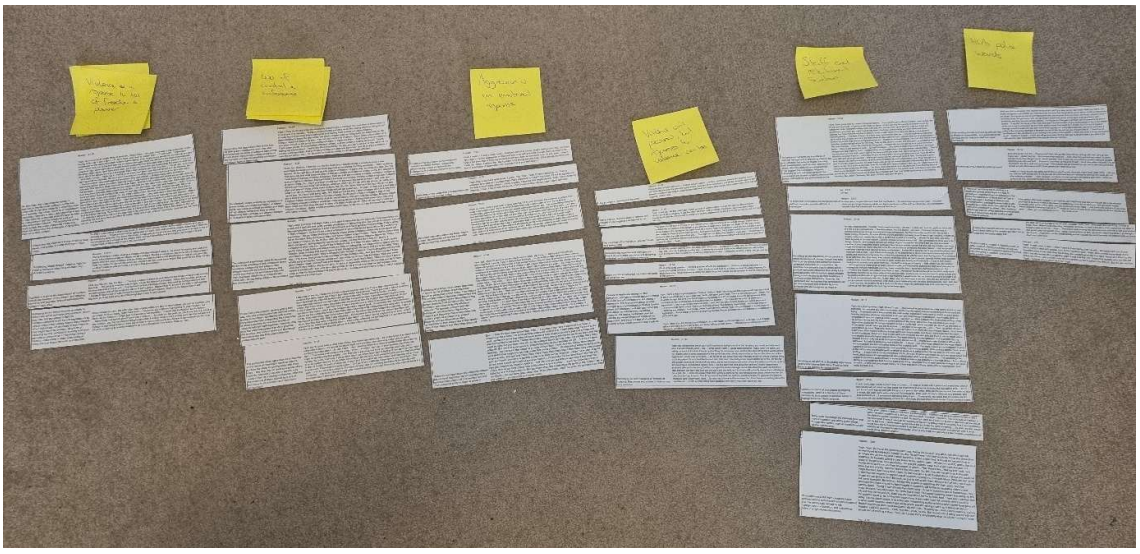
	Staff are responsible for managing violence	Navigating organisational failure and institutional betrayal	Institutional neglect and role burden
	Trauma is a response to violence	The emotional and moral weight of violence	Emotional responses and isolation
	Violence has many causes	Violence as a complex and relational communication	Complexity of causes
	Violence is (sometimes) personal - It depends on the type of violence	Violence as a complex and relational communication	Co-construction of violence
Kleo	Emotional responses to violence	The emotional and moral weight of violence	Emotional responses and isolation
	Gender and violence	The emotional and moral weight of violence	Oppression and identity-based harms
	Moral Outrage at Counter-Violence	The emotional and moral weight of violence	Moral dissonance and identity conflict
	The inpatient environment	Navigating organisational failure and institutional betrayal	Environmental stress and containment
	Violence as a systemic issue	Navigating organisational failure and institutional betrayal	Systemic invalidations
	Violence serves a purpose	Violence as a complex and relational communication	Violence as communication
Obinze	Being abandoned by the institution	Navigating organisational failure and institutional betrayal	Institutional neglect and role burden
	Violence creates conflict within the staff member (conflict conflicts)	The emotional and moral weight of violence	Moral dissonance and identity conflict
	Dehumanised by racist abuse	The emotional and moral weight of violence	Oppression and identity-based harms
	Moral Injury and Obligation	The emotional and moral weight of violence	Moral dissonance and identity conflict
	Multiple contributors to violence	Violence as a complex and relational communication	Complexity of causes
	Violence is normal	Coping, surviving, and the normalisation of violence	Normalisation and daily survival
	Wards are war zones	Coping, surviving, and the normalisation of violence	Normalisation and daily survival
Eren	Care and containment	Navigating organisational failure and institutional betrayal	Environmental stress and containment
	Feeling alone	The emotional and moral weight of violence	Emotional responses and isolation

	Shifting understandings over time	Coping, surviving, and the normalisation of violence	Adaptive strategies
	The personal impact	The emotional and moral weight of violence	Emotional responses and isolation
	Violence as communication	Violence as a complex and relational communication	Violence as communication
	Violence is more than just physical	Violence as a complex and relational communication	Violence as communication
	Violence is normalised	Coping, surviving, and the normalisation of violence	Normalisation and daily survival
Sana	Relational factors	Violence as a complex and relational communication	Complexity of causes
	Systemic factors impacting on violence	Navigating organisational failure and institutional betrayal	Environmental stress and containment
	The impact of violence on care	The emotional and moral weight of violence	Moral dissonance and identity conflict
	The personal impact of violence	The emotional and moral weight of violence	Emotional responses and isolation
	Understanding violence	Violence as a complex and relational communication	Violence as communication
	Violence is normalised	Coping, surviving, and the normalisation of violence	Normalisation and daily survival

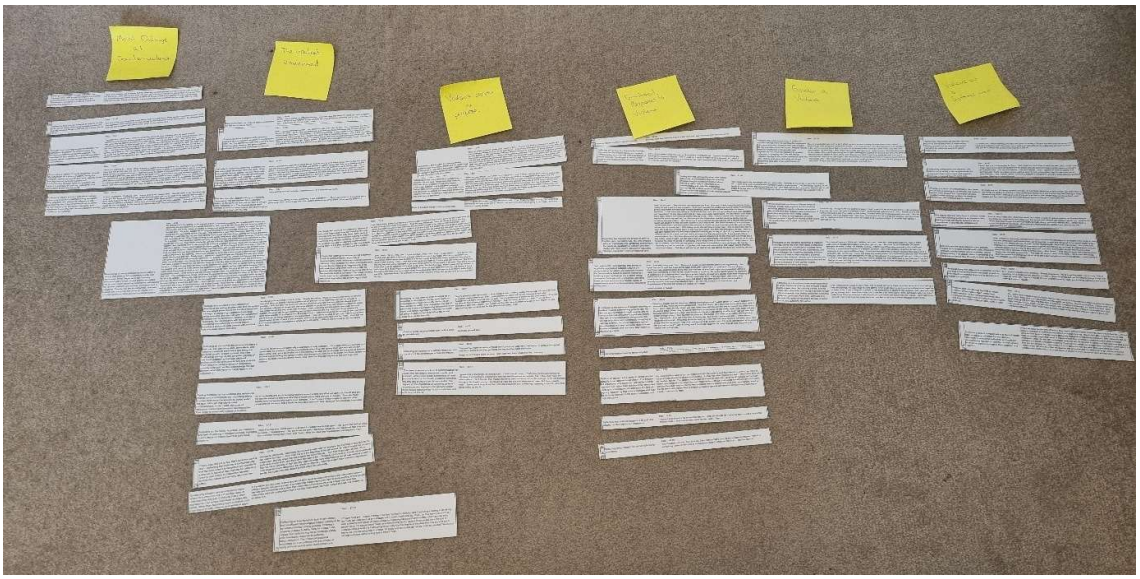
Appendix 16: Analysis Audit Trail



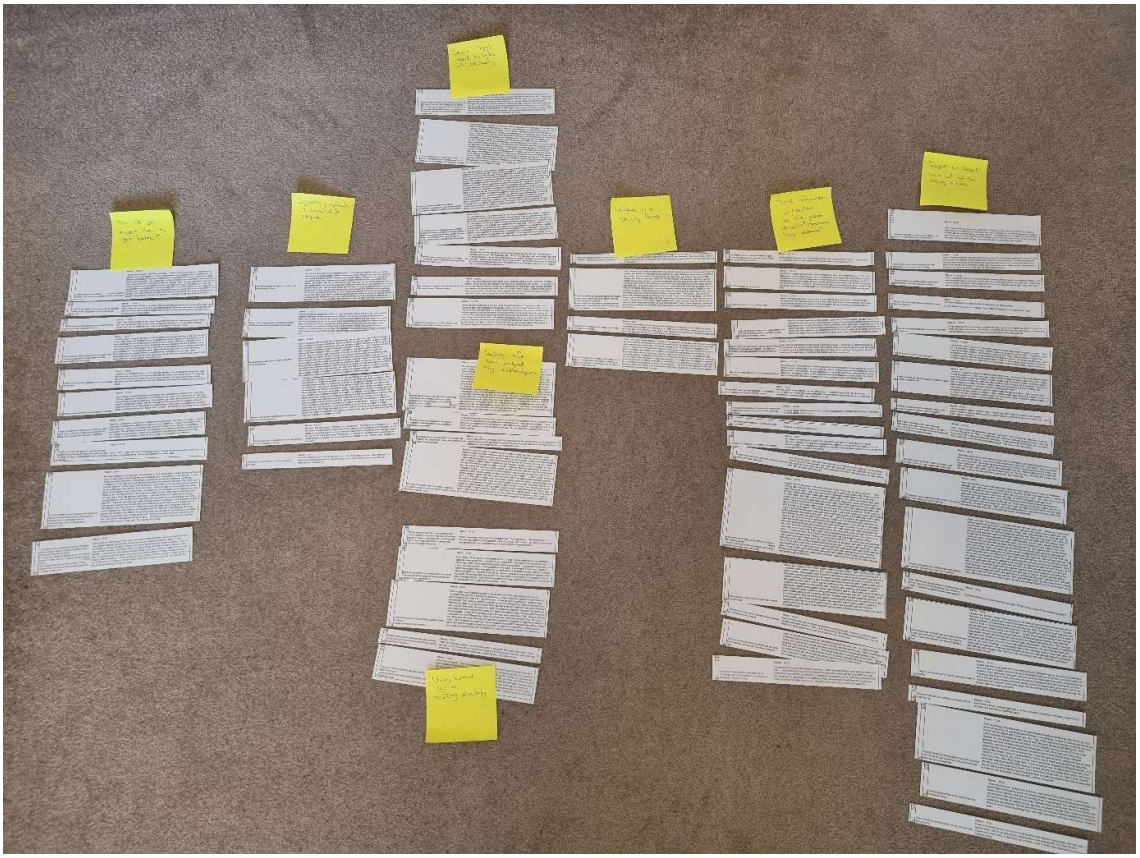
Eren



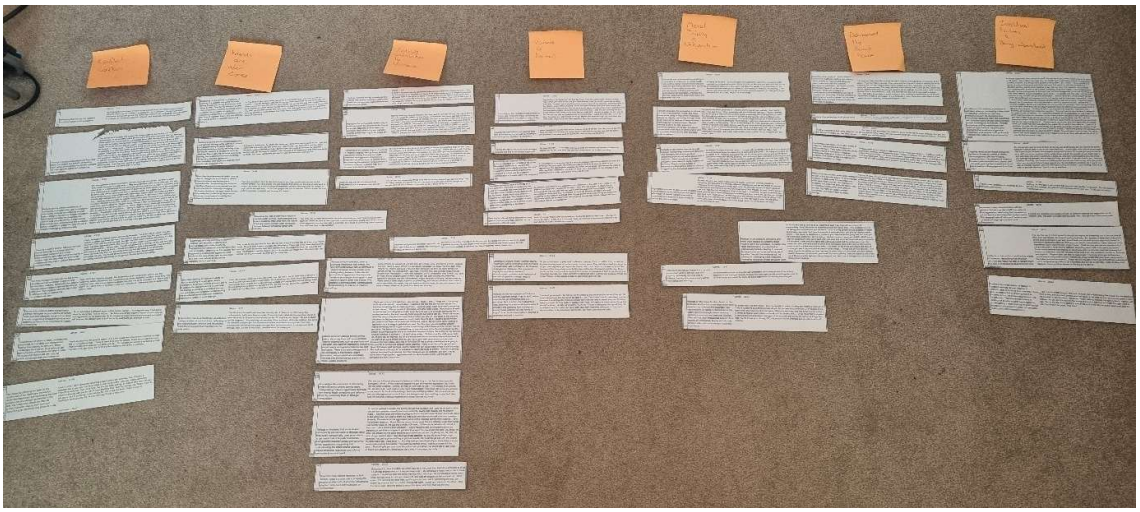
Hassan



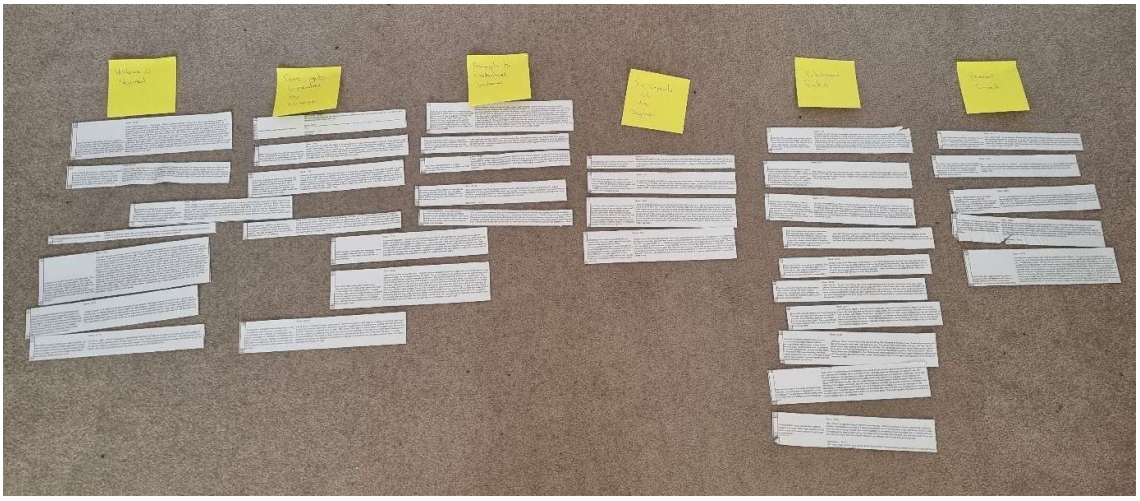
Kleo



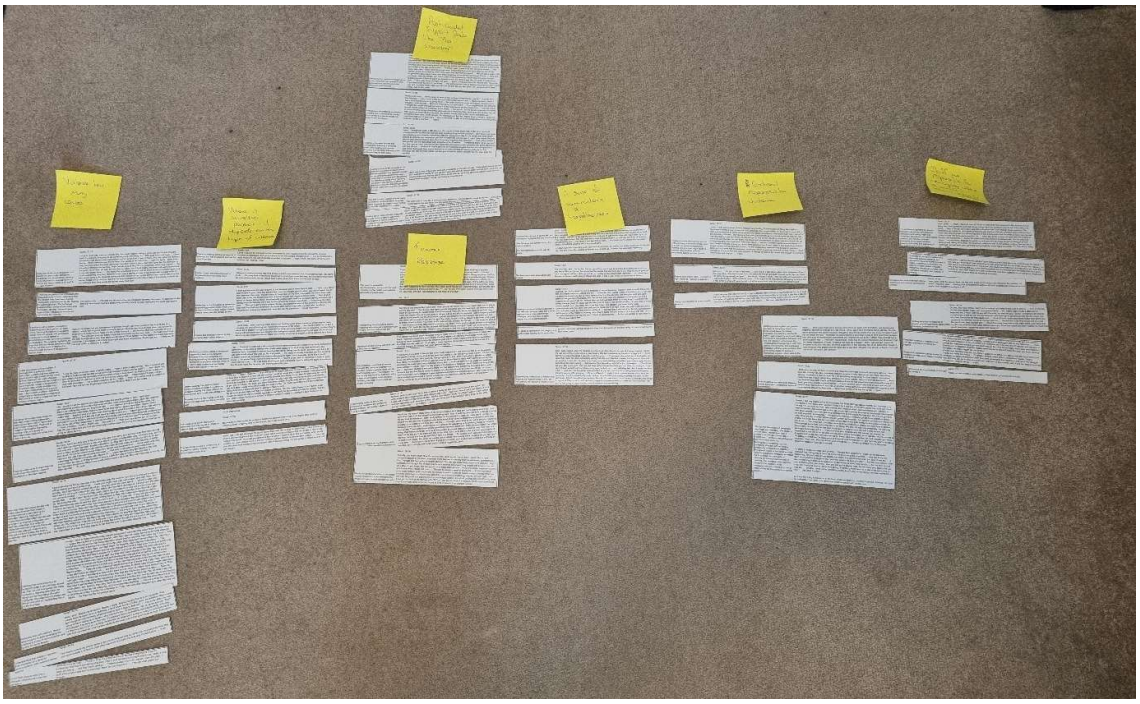
Maeve



Obinze



Sana



Sarah

Appendix 17: Recurrence of Themes and Sub-themes

GETs	Sub-GETs	Maeve	Hassan	Sarah	Kleo	Obinze	Eren	Sana
Coping, Surviving, and the Normalisation of Violence	Normalisation and Daily Survival	X				X	X	X
	Adaptive Strategies	X		X			X	
Navigating Organisational Failure and Institutional Betrayal	Systemic Invalidations	X		X	X			
	Institutional Neglect and Role Burden		X	X		X		
	Environmental Stress and Containment				X		X	X
The Emotional and Moral Weight of Violence	Moral Dissonance and Identity Conflict	X		X	X	X		X
	Emotional Responses and Isolation			X	X		X	X
	Oppression and Identity-Based Harms				X	X		
Violence as a Complex and Relational Communication	Co-construction of Violence		X	X				
	Violence as Communication		X		X		X	X
	Complexity of Causes	X		X		X		X

Appendix 18: SLR Transcript Example

Transcript	Themes
Benseley et al. (1995): RESULTS Patient Interviews At Hospital 1 nine group interviews were conducted, ranging from two to seven patients in size. At Hospital 2 five group interviews were held, ranging from five to nine patients in size. Total participants were 37 and 32 patient volunteers at Hospital 1 and Hospital 2, respectively. Although individual demographic information was not gathered, both genders were represented approximately equally and ages ranged from young adult to geriatric populations. Unfortunately, transcripts of the group discussions contained a number of omissions due to more than one person speaking at once, extraneous noise, etc., and so detailed quantitative results are not available. However, based on the transcripts and interviewer notes, the authors derived counts of the number of wards on which each major topic was recorded as having been discussed. These counts are minimums because of large amounts of missing data. First, two interviewers reviewed the transcripts and notes and identified 31 topics of discussion. Then, a coder who did not serve as interviewer coded transcripts and notes from each ward. Coding identified whether each factor was identified as a problem area by patients in at least one group on that ward. For patients, the major issues believed to contribute to assaults were smoking and access to outdoors, not being treated with respect by staff, excessive use of seclusion and restraint, and not enough explanation of rules. Additional detail is presented in Table 1. On some wards, relatively few patients participated in the interviews. For this reason, results are presented across both hospitals (total eight wards) to maximize patient confidentiality. Factors Influencing Assaults. The top five factors were adequate numbers of personnel, staff clinical and interpersonal skills, staff training in management of potentially assaultive patients, legal penalties against competent assaultive patients, and physical environment. Priorities for Change. The top five priorities were adequate numbers of personnel, staff clinical and interpersonal skills, physical environment, legal penalties against competent assaultive patients, and training in management of potentially assaultive patients.	- Staff factors: Availability, skill (including training - Punishment - Physical environment Wider practices?

Hospital Practices Influencing Assaults. The top five hospital practices believed to influence assaults were practices for handling smoking, medication, seclusion and restraint, privacy, and programming (activities scheduled).

Physical Environment. The top five aspects of the physical environment believed to influence assaults were crowding, noise, privacy, food, and temperature levels. In order to measure possible differences between hospitals, the authors conducted four sets of five Wilcoxon signed-ranks tests for the four sets of variables listed above (factors influencing assaults, priorities for change, hospital practices, and physical environment). None of the differences between hospitals achieved significance after applying the Bonferroni correction for multiple feelcomparisons, which required p < .01 to maintain the overall significance level at p c .05 across each set of comparisons.

DISCUSSION

Whereas another study utilized patient and staff interviews to gather information related to specific restraint incidents (Sheridan et al., 1990), our study solicited views from both patients and staff members regarding potential risk factors for patient assaults in more generalized circumstances. Our study included several limitations. First, different methodologies were used to gather information from hospital staff' and patients. Other researchers have noted that it may be difficult to administer standardized questionnaires to psychiatric inpatients because of some patients' grossly psychotic states, inability to attend to or comprehend questions, and short attention spans (Klinge, 1994; cf. Everett & Boydell, 1994). For this reason, staff were given a self-administered written survey, whereas patients were interviewed orally. Also, the questionnaire given to the staff listed a large number of factors potentially associated with patient assaults. Patient interviews focused on hospital practices and physical characteristics of the hospital. Patients' views on other concerns related to staff numbers, skills, and training were not obtained unless participants initiated the topics.. Because of the voluntary and public nature of the participation, it is possible that the patient participants were not representative of hospital patients, or that some important issues were omitted. Patients who participated and made meaningful contributions in interviews may have been representative of a higher-functioning group than the total inpatient population. Smoking and Access to the Outdoors Patients on most wards discussed concerns about smoking and access to outdoors, which are interrelated. In 1992, a no-smoking policy was instituted at both hospitals, in accordance with state laws and regulations prohibiting smoking in state buildings. For patients who require an escort, access to outdoors ranges widely from ward to ward, from every 2 hours to as little as once a week on the study wards. Considerable friction is created during waits for outdoor access or as a result of illegal smoking activity. Patients reported enjoying going outdoors for fresh air, exercise, and a change of pace, as well as for smoking. Patients additionally reported that after an outing with staff members, they would see each other more positively, and tensions would ease. Floor designs were suggested that would allow patients free access to a yard area, and it

Physical environment, particularly comfort

Stigma and discrimination of those in mental health inpatient units

Wider practices

Staff factors, skills, training etc

Omissions?

Smoking

Smoking but also environment? Maybe also boredom or activities?

Activities and enjoyment

More activities and enjoyment but particular – OPEN SPACE

Being treated with respect

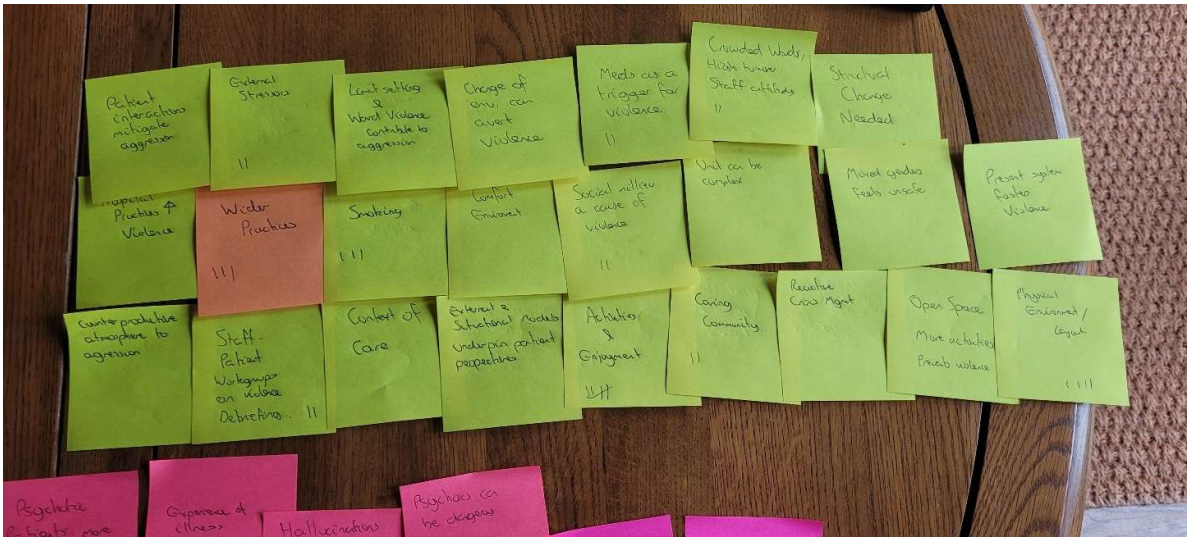
Consistency?

was noted that in some states correctional systems adhere to a “sunshine law,” which mandates at least an hour of fresh air a day.	
Staff Clinical Skills and Respect for Patients A second major theme in the patient interviews was not being treated with respect by staff; i.e., staff were not consistently supportive and responsive.	Seclusion as punishment, punitive It’s complicated
Use of Seclusion and Restraint A third major theme was the excessive use of seclusion and restraint (being placed alone in a room, or in a chair with physical restraints on arms, legs, etc.). Patients believed that seclusion and restraint were used in some cases as a first resort, when verbal interventions might have been effective. Seclusion and restraint procedures typically involve forcibly handling a patient against his or her will and are situations in which injuries classified as assaults frequently occur (Carme1 & Hunter, 1989). However, it is difficult to assess the relationship between assaults and restraint activities because many, if not most, restraint episodes occur in response to assaultive threats or behaviour (Soloff, 1987).Further discussions of the pros and cons of physical restraint are available (e.g., Sclafani, 1986; Stilling, 1992). Patients, but not staff, mentioned inadequate explanation of rules as an important factor influencing assaults. This suggests that some assaults may be avoided by more extensive communication between staff and patients about hospital rules and procedures. In addition to comparisons to other studies measuring patient and staff views, these results can be compared to empirical evidence as to which factors influence the numbers and severity of assaults. Other research has provided empirical evidence that staff training (Carmel & Hunter, 1990) and overcrowding (Palmstierna et al., 1991) influence assaults. Staffing level has not received wide research support as an empirical factor influencing assaults (see Bensley et al., 1993 for a review). However, Bensley et al. (1994) found a relationship between staffing patterns that involved working in isolation from other employees and more serious injuries due to assaults. Staffing patterns may influence assaults indirectly by increasing isolation from other employees, or by reducing the staff’s ability to address patient requests (such as access to outdoors for patients who require a staff escort). Legal penalties for assaultive patients have not been found to deter future assaults in the few studies that are available (e.g., Hoge & Gotheil, 1987). Other factors that received high importance ratings by patients, staff, or both (such as staff clinical skills, smoking policies, and noise levels) have not been scientifically evaluated. The present findings suggest several changes in hospital practices that might reduce assaults. In particular, increased access to outdoors and smoking might relieve daily tensions. Increased communication about rules and more expressions of respect for the patients by hospital staff may also reduce conflict. Increased staffing may allow patients to go outside more often or engage in other activities, and it may allow employees more time to interact with patients and understand their personalities and moods, better enabling them to recognize unusual behaviours. Increased	Inadequately explaining rules – Consistency? Communication? PUNITIVE – Punishment Staff factors – Working in isolation. Punishment is not effective Hospital practices can increase assaults. Physical environment Staff factors

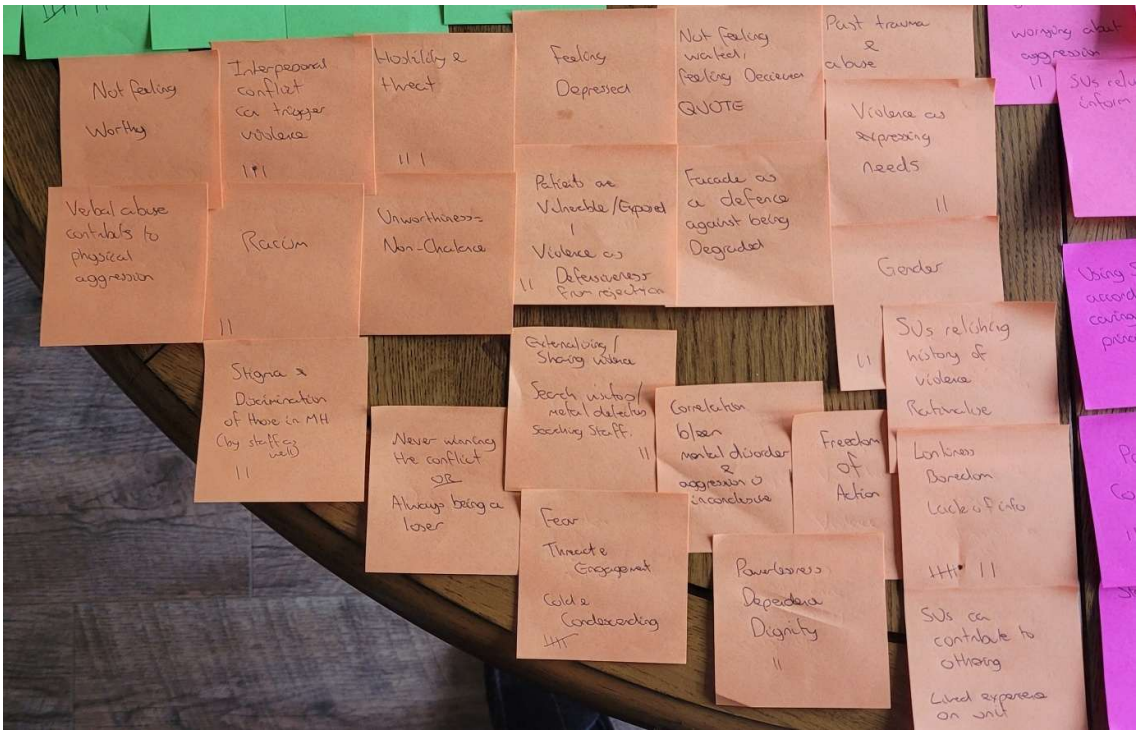
efforts to train staff in recognizing these behaviors and how to deal with them may allow intervention in early stages of aggression, perhaps lessening the likelihood that a violent act will occur, or lessening its severity.	

Appendix 19: SLR: Analysis Audit Trail

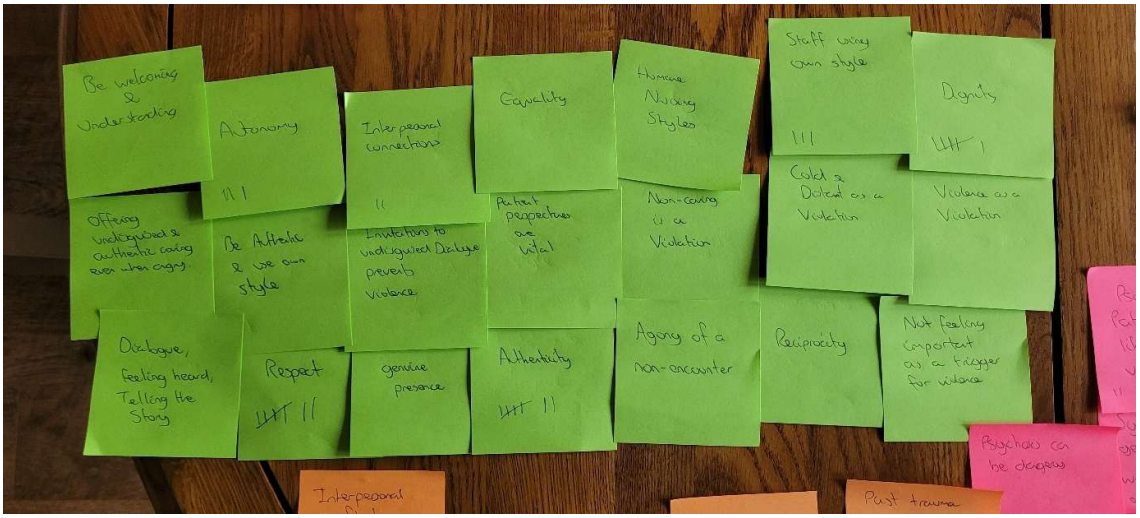
All Themes



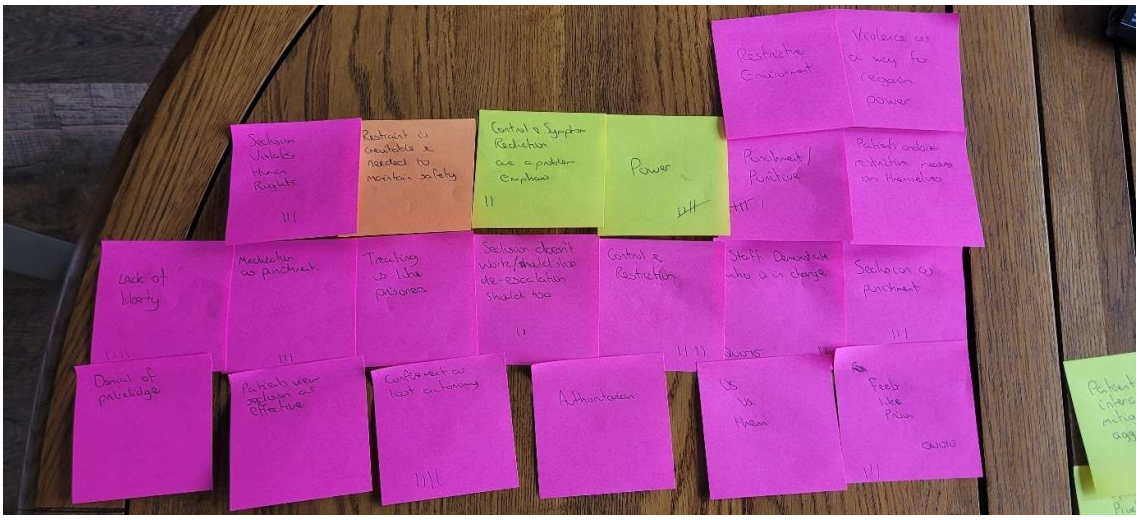
Wider Practices and Physical Environment



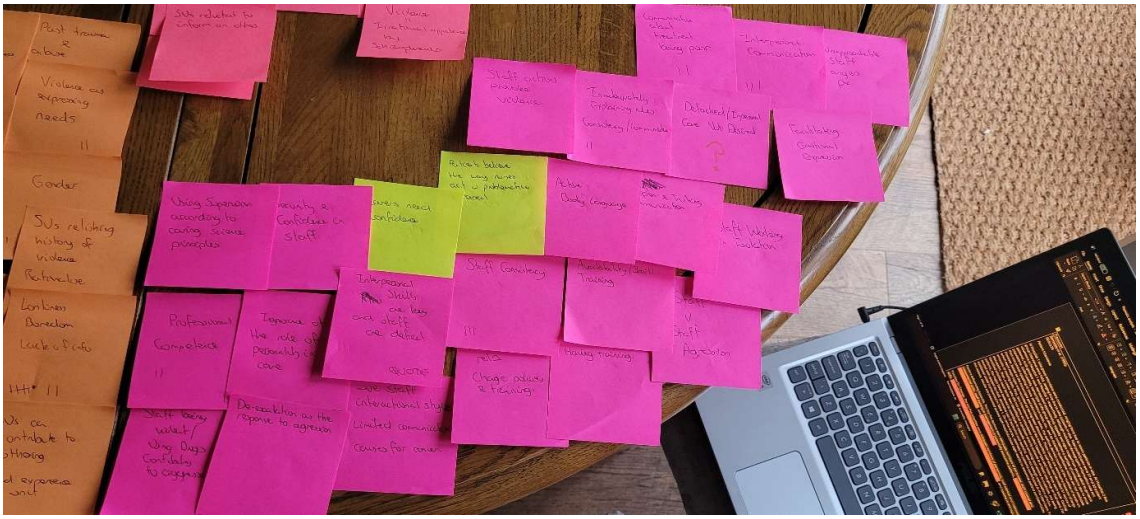
Patient Lifeworld



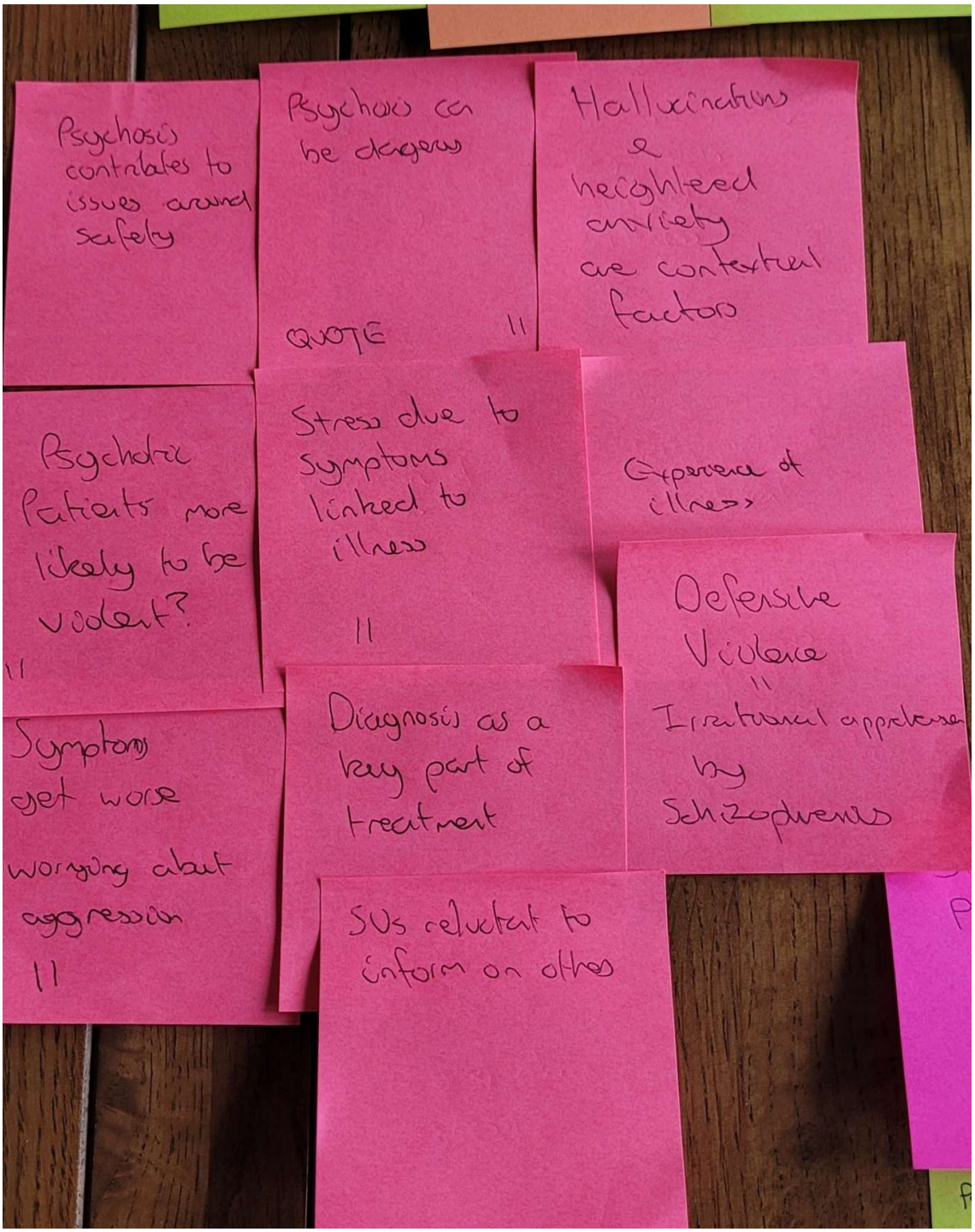
The Agony of a Non-encounter



Control and Restriction



Staff factors



”Psychosis is dangerous”

Appendix 20: SLR: Recurrence of Sub-themes Across Studies

Theme	Sub-Theme	Jenkin et al. (2022)	Välimäki, Lam et al. (2022)	Carlsson et al. (2006)	Lamanna et al. (2016)	Vermeulen et al. (2019)	Kumar et al. (2001)	Nolan et al. (2009)	Kontio et al. (2014)	Bensley et al. (1995)	Omérov et al. (2004)	Duxbury et al. (2005)	Välimäki, Lantta, et al. (2022)	Lenk-Adusoo et al. (2022)	Gillig et al. (1998)	Duxbury (2002)
Control and restriction	Seclusion as punishment	X		X				X	X	X	X	X		X	X	X
	Reactive crisis management			X								X				X
	Lack of Autonomy and control	X		X	X	X					X	X			X	X
Agony of a non-encounter	Impersonal care			X												
	Power imbalances	X		X							X		X		X	
	Violation of dignity			X		X			X		X					
	Emotional consequences of no interaction			X					X				X			
	Violation of respect			X		X	X			X	X	X				
	Authenticity			X		X			X				X			
Patient Lifeworld	Vulnerability and emotional exposure			X					X		X					

	Boredom and its role in aggression	X		X	X	X			X	X			X			
	Powerlessness				X				X							
Wider practices and physical environment	Punitive practices	X								X					X	X
	Poor environment	X							X	X						X
	Need for a therapeutic environment		X	X	X											
	Stigma and discrimination	X								X						
“Psychosis is dangerous”	Frustration with symptoms	X			X						X				X	
	Dangerous dynamics	X						X			X				X	
Staff factors	Inconsistent staff behaviours	X			X				X							
	Communication			X	X	X				X		X				
	Training and supervision									X		X				X

Appendix 21: SLR: PROSPERO Registration

NIHR | National Institute for Health and Care Research

PROSPERO
International prospective register of systematic reviews

What are the attitudes of service users, carers and the public on violence in mental health inpatient settings?

Mitchell Kemp, Shaniah Kothari, Emma Karwatzki, Rebecca Aloneftis

Review methods were amended after registration. Please see the revision notes and previous versions for detail.

Citation 1 change
Mitchell Kemp, Shaniah Kothari, Emma Karwatzki, Rebecca Aloneftis. What are the attitudes of service users, carers and the public on violence in mental health inpatient settings?. PROSPERO 2024 CRD42024571030. Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD42024571030.

REVIEW TITLE AND BASIC DETAILS

Review title
What are the attitudes of service users, carers and the public on violence in mental health inpatient settings?

Review objectives
What are the attitudes of service users, carers and the public on violence in mental health inpatient settings?

Keywords
attitudes, carers, mental health inpatient, public, service users, violence

SEARCHING AND SCREENING

Searches
PubMed, CINAHL Plus, Scopus, PSYCArticles, Google Scholar
All sources searched on: 11/07/24
Search Dates: All
Restrictions: English language only
Searches will also be run prior to final analysis.

Study design
Exclusion Criteria:
Literature Reviews
Commentaries
Editorials
Violence in other settings
Studies focusing only on staff attitudes
Studies only in forensic settings
Child or adolescent participants
Physical health settings
Inclusion Criteria:
Qualitative design
Quantitive design
Mixed-methods design
Reference to violence in mental health settings
Information on patient, carer, or public views
Studies written in English
Published in peer-reviewed journals
Adult participants

ELIGIBILITY CRITERIA

Condition or domain being studied
Patient violence in mental health inpatient settings

Population
Inclusion: Adults with experiences of or attitudes towards violence within mental health inpatient settings
Exclusion: Children (anyone 18 and under)

Intervention(s) or exposure(s)
There are no exposures or interventions to be reviewed. Instead the review will focus on exploration of attitudes of services users, carers, or the public. This may be conducted via interviews or questionnaires.

Comparator(s) or control(s)
Not applicable

OUTCOMES TO BE ANALYSED

Main outcomes
Gathering views of service users, carers, and the public in attitudes of mental health inpatient violence to better understand and prevent these incidents.

Additional outcomes

Not applicable

DATA COLLECTION PROCESS

Data extraction (selection and coding)

Two reviewers will use a data extraction tool within covidence. One reviewer will extract the data and the other will check. Conflicts will be resolved via discussion to form consensus. This will be recorded via covidence.

The participants, location, intervention/analysis, outcome, and results, will collected as part of data extraction

Risk of bias (quality) assessment

Qualitative and Quantitative appraisal tool designed by CASP will be used, at the study level. A ROBINS tool will be used.

PLANNED DATA SYNTHESIS

Strategy for data synthesis

The minimum number of studies required will be 5. The data will be qualitative in nature and data will be synthesised using a narrative synthesis.

Studies will be group based on recurring themes or patterns relating to patient violence in mental health inpatient settings. For example: Type of violence (verbal, physical), affected parties (service users, staff members). We may also consider contextual factors such as geographical location. Finally, methodological approaches will also be considered (interviews, focus groups) to determine if different methodologies influence findings.

Heterogeneity across the study will use comparative analysis to identify variations in results for themes, conclusions, or experiences. Subgroups will also be examined as below.

The CASP framework will be used to evaluate the quality of the included studies, and potential for bias and the review process will be discussed, including discussion around limitations in study design, sample size and researcher perspectives.

Data will be presented using both narrative summaries, thematic tables, and illustrative quotes.

Analysis of subgroups or subsets

The subgroups to be analysed will be the public, service users, and carers. This will be synthesised using a narrative synthesis.

REVIEW AFFILIATION, FUNDING AND PEER REVIEW

Review team members

- Mr Mitchell Kemp, University of Hertfordshire
- Ms Shaniah Kothari, [redacted]
- Dr Emma Karwatzki, University of Hertfordshire
- Dr Rebecca Aloneftis, [redacted]

Review affiliation
University of Hertfordshire

Funding source
University of Hertfordshire

Named contact
Mitchell Kemp. University of Hertfordshire, College Ln, Hatfield AL10 9AB
m.kemp4@herts.ac.uk

TIMELINE OF THE REVIEW

Review timeline
Start date: 19 July 2024. End date: 06 June 2025

Date of first submission to PROSPERO 1 change
25 July 2024

Date of registration in PROSPERO 1 change
01 October 2024

CURRENT REVIEW STAGE

Publication of review results
The intention is to publish the review once completed. The review will be published in English

Stage of the review at this submission 1 change

Review stage	Started	Completed
Pilot work	✓	✓
Formal searching/study identification	✓	✓
Screening search results against inclusion criteria	✓	✓
Data extraction or receipt of IPD	✓	✓
Risk of bias/quality assessment	✓	✓
Data synthesis	✓	✓

Review status
The review is completed.

ADDITIONAL INFORMATION

Additional information
The decision to amend the review to focus on mental health inpatient services has been made to help to focus the review on a more homogenous experience.

PROSPERO version history 1 change

- Version 1.3, published 14 Jun 2025
- Version 1.2, published 14 Nov 2024
- Version 1.1, published 17 Oct 2024
- Version 1.0, published 01 Oct 2024

Review conflict of interest
None known

Country
England

Medical Subject Headings
Caregivers; Health Personnel; Humans; Inpatients; Mental Health; Violence

Revision note 1 change
Skipped "availability of full protocol" step.

Disclaimer 1 change
The content of this record displays the information provided by the review team. PROSPERO does not peer review registration records or endorse their content.

PROSPERO accepts and posts the information provided in good faith; responsibility for record content rests with the review team. The guarantor for this record has affirmed that the information provided is truthful and that they understand that deliberate provision of inaccurate information may be construed as scientific misconduct.

PROSPERO does not accept any liability for the content provided in this record or for its use. Readers use the information provided in this record at their own risk.

Any enquiries about the record should be referred to the named review contact

Appendix 22: SLR: Critical Appraisal Checklist – Cross Sectional

CASP Checklist:

For Descriptive/Cross-Sectional Studies

Paper Title:	
Appraisal Date:	

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A: Are the results valid?	
1. Did the study address a clearly focused issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: *A question can be 'focused' in terms of* • *the population studied* • *the risk factors studied* • *is it clear whether the study tried to detect a beneficial or harmful effect* • *the outcomes considered*	
2. Did the authors use an appropriate method to answer their question?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *Is a descriptive/cross-sectional study an appropriate way of answering the question* • *did it address the study question*	
3. Were the subjects recruited in an acceptable way?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: *We are looking for selection bias which might compromise the generalisability of the findings:* • *Was the sample representative of a defined population* • *Was everybody included who should have been included*	
4. Were the measures accurately measured to reduce bias?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: *Look for measurement or classification bias:* • *did they use subjective or objective measurements* • *do the measurements truly reflect what you want them to (have they been validated)*	
5. Were the data collected in a way that addressed the research issue?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the setting for data collection was justified*	

• *if it is clear how data were collected (e.g., interview, questionnaire, chart review)* • *if the researcher has justified the methods chosen* • *if the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted?)*	
6. Did the study have enough participants to minimise the play of chance?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the result is precise enough to make a decision* • *if there is a power calculation. This will estimate how many subjects are needed to produce a reliable estimate of the measure(s) of interest.*	
7. How are the results presented and what is the main result?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if, for example, the results are presented as a proportion of people experiencing an outcome, such as risks, or as a measurement, such as mean or median differences, or as survival curves and hazards* • *how large this size of result is and how meaningful it is* • *how you would sum up the bottom-line result of the trial in one sentence*	
8. Was the data analysis sufficiently rigorous?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if there is an in-depth description of the analysis process* • *if sufficient data are presented to support the findings*	
9. Is there a clear statement of findings?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the findings are explicit* • *if there is adequate discussion of the evidence both for and against the researchers' arguments* • *if the researchers have discussed the credibility of their findings* • *if the findings are discussed in relation to the original research questions*	
10. Can the results be applied to the local population?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *the subjects covered in the study could be sufficiently different from your population to cause concern.*	

• *your local setting is likely to differ much from that of the study*	
11.How valuable is the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *one descriptive/cross-sectional study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making* • *if the researcher discusses the contribution the study makes to existing knowledge (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature?)* • *if the researchers have discussed whether or how the findings can be transferred to other populations*	

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*

Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**

Referencing recommendation:

CASP recommends using the Harvard style referencing, which is an author/date method. Sources are cited within the body of your assignment by giving the name of the author(s) followed by the date of publication. All other details about the publication are given in the list of references or bibliography at the end.

Example:

Critical Appraisal Skills Programme (2024). CASP (insert name of checklist i.e. cross sectional Checklist.) [online] Available at: insert URL. Accessed: insert date accessed.

Appendix 23: SLR: Critical Appraisal Checklist – Qualitative

CASP Checklist:

For Qualitative Research

Paper Title:	
Appraisal Date:	

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?

12. Was there a clear statement of the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
13. Is a qualitative methodology appropriate?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
14. Was the research design appropriate to address the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
15. Was the recruitment strategy appropriate to the aims of the research?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
16. Was the data collected in a way that addressed the research issue?	☐ Yes ☐ No ☐ Can't Tell

CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
17. Has the relationship between researcher and participants been adequately considered?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
18. Have ethical issues been taken into consideration?	☐ Yes ☐ No ☐ Can't Tell
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
19. Was the data analysis sufficiently rigorous?	☐ Yes ☐ No ☐ Can't Tell

CONSIDER:
- *If there is an in-depth description of the analysis process*
- *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data*
- *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process*
- *If sufficient data are presented to support the findings*
- *To what extent contradictory data are taken into account*
- *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*

20.Is there a clear statement of findings?	☐ Yes ☐ No ☐ Can't Tell

CONSIDER:
- *If the findings are explicit*
- *If there is adequate discussion of the evidence both for and against the researcher's arguments*
- *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)*
- *If the findings are discussed in relation to the original research question*

Section C: Will the results help locally?

21. How valuable is the research?	☐ Yes ☐ No ☐ Can't Tell

CONSIDER:
- *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature*
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*

Positive/Methodologically sound	Negative/Relatively poor methodology	Unknowns

Referencing recommendation:

CASP recommends using the Harvard style referencing, which is an author/date method. Sources are cited within the body of your assignment by giving the name of the author(s) followed by the date of publication. All other details about the publication are given in the list of references or bibliography at the end.

Example:

Critical Appraisal Skills Programme (2024). CASP (insert name of checklist i.e. systematic reviews with meta-analysis of randomised controlled trials (RCTs) Checklist.) [online] Available at: insert URL. Accessed: insert date accessed.

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Appendix 24: SLR: Critical Appraisal Checklist – Mixed Methods

Mixed Methods Appraisal Tool (Pluye et al., 2011)

Types of mixed methods study components or primary studies	**Methodological quality criteria (see tutorial for definitions and examples) Responses**	**Response (Yes/No)**
Screening questions (for all types)	Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?	
	Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question	
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?	
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?	
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?	
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?	
	2.3. Are there complete outcome data (80% or above)?	
	2.4. Is there low withdrawal/drop-out (below 20%)?	
3. Quantitative nonrandomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?	
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?	

	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?	
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?	
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	
	4.2. Is the sample representative of the population understudy?	
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?	
	4.4. Is there an acceptable response rate (60% or above)?	
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?	
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied	

Appendix 25: SLR: Protocol

Background		
Research Question		What are the attitudes of service users, carers and the public on violence in healthcare settings?
Method	Search Strategy	- Using bibliographic databases (Pubmed, CINAHL Plus, Scopus, PSYCArticles) - Google Scholar
	Inclusion/Exclusion Criteria	Exclusion Criteria: - Literature reviews - Commentaries - Editorials - Studies on violence not in a healthcare setting - Studies only focusing on staff attitudes - Studies focusing only on forensic settings Inclusion Criteria: - Qualitative or quantitative design - Direct reference to violence in healthcare settings - Physical or mental health settings - Patient, carer, or public views included
	Screening and Selection	Search terms will be applied and title and abstract screening will be used to identify papers. These will be saved using the function on the databases. Once all search terms have been applied, the inclusion and exclusion criteria will be applied.
	Data Extraction	A data extraction table will be used for each paper taken from Farley et al. (2022).

	Quality Assessment	Qualitative and Quantitative appraisal tool designed by CASP will be used. Survey Appraisal from Crombie (1996).
Data Analysis		The review is narrative in nature, so the data extracted from the studies will be used to describe and evaluate findings and make recommendations.
Patient and Public Involvement		There will be no patient or public involvement due to the nature of the topic.
Dissemination Plan		The review will be considered for publication submission. The review will be presented to the NHS trust sponsoring the other aspect of the thesis research. The review will be disseminated in research presentation days. The review will be available on the university repository for theses.
Time Frame		To be completed by June 2025.

Scoping Search (Using University Library Search)	
Search Terms	Results
violence AND healthcare	24,843
violence	371,717
healthcare	2,039,509
violence AND health care OR healthcare	371,717
Violence OR aggression AND “health care” OR healthcare	118,199
Service User AND Violence AND healthcare	110.694
Service User AND Attitudes AND Violence AND healthcare AND	112
ALL	19,979
Carers	153
Public	9259
Combined search terms	42597

Combined Search Phrases

1. **Violence or Aggression + Context + Population + Attitudes or Exploratory**

(PHENOMENA OF INTEREST) ("violence in healthcare" OR "aggressive behavior" OR "aggressive behaviour" OR "aggressiveness" OR "attack" OR "hostility" OR "patient violence" OR "physical violence" OR "violence" OR "violent" OR "workplace violence" OR "physical harm")

(PHENONEMA OF INTEREST) AND ("hospital" OR "healthcare" OR "health care" OR "A&E" OR "A and E" OR "accident and emergenc*" OR "inpatient" OR "in-patient" OR "psychiatric" OR "ward" OR "mental health" OR "primary care" OR "secondary care" OR "health services" OR "acute mental health wards")

(EVALUATION) AND ("attitudes" OR "exploratory" OR "exploration" OR "qualitative" OR "feedback")

(SAMPLE) AND ("service user" OR "carer" OR "public" OR "user-led" OR "patient" OR "patients" OR "service users" OR "carers")

Synonyms and Related Terms

1. **Violence or Aggression**

"violence" OR "aggression" OR "aggressive behavior" OR "aggressive behaviour" OR "aggressiveness" OR "attack" OR "attack behavior" OR "attack behaviour" OR "homophobia" OR "hostility" OR "microaggression" OR "patient violence" OR "physical violence" OR "racism" OR "sexual violence" OR "threat" OR "transphobia" OR "verbal abuse" OR "violent" OR "workplace violence" OR "restraint" OR "physical harm" OR "psychological harm" OR "incident" OR "neglect" OR "safety"

2. **Context**

"hospital" OR "healthcare" OR "health care" OR "A&E" OR "A and E" OR "accident and emergenc*" OR "inpatient" OR "in-patient" OR "psychiatric" OR "ward" OR "mental health" OR "primary care" OR "secondary care" OR "health services" OR "acute mental health wards" OR "psychiatric"

3. **Population**

"service user" OR "SU" OR "carer" OR "public" OR "user-led" OR "patient" OR "patients" OR "service users" OR "carers"

4. **Attitudes or Exploratory**

"attitudes" OR "exploratory" OR "exploration" OR "qualitative" OR "feedback"

Within covidence:

- Gun, intimate, heart, commentary, epilepsy, domestic, stroke, migraine, diabetes, cancer, chemotherapy, HIV, asthma, asthmatic, child, cardiovascular, vaccine, community

Appendix 26: SLR: Data Extraction Table Example

Title	Places of safety? Fear and violence in acute mental health facilities: A large qualitative study of staff and service user perspectives
Lead Author	Jenkin, G., Quigg, S., Paap, H., Cooney, E., Peterson, D., & Every-Palmer, S.
Full Reference	Jenkin, G., Quigg, S., Paap, H., Cooney, E., Peterson, D., & Every-Palmer, S. (2022). Places of safety? Fear and violence in acute mental health facilities: A large qualitative study of staff and service user perspectives. *PLOS ONE*, *17*(5), e0266935. https://doi.org/10.1371/journal.pone.0266935
Year of Publication	2022
Journal	PLOS ONE
Study Design	Qualitative – Semi structured interviews
Country	New Zealand
Inclusion/Exclusion Criteria	Inclusion: • Adults • Staff (all range of occupations in acute mental health inpatient units in New Zealand • Service users in acute mental health inpatient units in New Zealand Exclusion: • Those unable to consent
Participants (Type, N, demographics)	Type: Staff and Service Users of acute mental health inpatient units N = 85 (42 staff, 43 service users) Service Users: 34.9% Maori 51% Female Staff: 16.7% Maori 64% Female Nurse or nurse managers (n=20) Social workers (n=5) Psychiatrists (n=4) Cultural or consumer advisors (n=4) Occupational Therapists (n=4) Pharmacists (n=2) Doctor, cleaner, music therapist (n=1)
Intervention or comparator	Comparison of staff and service user perspectives
Type of analysis	Thematic Analysis
Outcomes	Causes of violence themes: • Individual service user factors:

	○ Staff: ▪ Illness/psychosis ▪ Disinhibition ▪ Service user histories ▪ Goal achievement (instrumental) ○ Service users: ▪ Illness/psychosis ▪ Self-perception (top-dog) • Built environment: ○ Staff: ▪ Confined spaces ▪ Blind spots ▪ Proximity between certain areas ▪ Access to alarms ▪ Insufficient exits ▪ Lack of visibility ▪ Temperature and ventilation ○ Service Users: ▪ Confined spaces ▪ Nurses' station design • Organisational factors: ○ Staff: ▪ Smoking and rules ▪ Staffing (adequacy, skills and experience, gender mix) ○ Service Users: ▪ Smoking and rules ▪ Staffing • Social milieu: ○ Staff: ▪ Complexities (diverse service user illness/needs)

	○ Service Users: ▪ Locked unit ▪ Paternalistic atmosphere ▪ Boredom ▪ Restraint, seclusion, and medication • Meta-themes: ○ Interpretations of behaviour ○ Othering Consequences of violence: • Staff: ○ Normalisation – Violence is “part of the job” ○ Unsupported by management ○ Self-perpetuating problem (retention and recruitment difficulties, comprised training) ○ Injuries ○ Time off work ○ Mental health issues • Service users: ○ Fear ○ Impeded recovery ○ Stigma
Conclusion	• Codesigned mental health units may reduce violence or at least some factors contributing to it (noting that one newer built unit codesigned had fever concerns about safety). • Environmental and systemic issues being addressed may have the most benefit • Experiences show staff and service users find inpatient mental health units volatile spaces punctuated by biolence • Staff experience chronic safety issues, which heavily impact their well-being. • Service users include scared, disempowered individuals, those with psychotic symptoms, and some who openly discuss their use of violence.

	• When these diverse groups are housed together, the environment becomes combustible, often leading to violence from all parties involved. • The findings question whether these units are truly places of healing or merely custodial settings. • Violence undermines the therapeutic goals of acute mental health units. • Challenges include inadequate resources, poor design, coercive frameworks, and lack of service user input in care models and facility design. • Solutions must be integrative, involving collaboration between management, staff, service users, and families. • Suggestions include giving staff and service users more say in funding allocation, management spending more time on the ground, and staff gaining insight by experiencing life as a service user. • Redesigning units to better serve their purpose is a critical need.
Strengths and Limitations	Strengths: • Twin focus on staff and service user views • Diversity of opinion for staff including different specialities • Inclusion of multiple sites and large numbers of participants (expanding generalisability) • Interviews conducted by experienced social scientist • Interviewer perceived position as an outsider was a powerful tool • Mixed ages, genders, disciplines within the team Limitations: • Staff participants self-selected • Service users were screened by staff after self-selecting • Contradictory answers • Some service users were unwell during interview • Service users may not have been able to talk candidly about their experience given the interviews were conducted in the inpatient unit

Study sponsorship or conflicts	Marsden Fast Start from the Royal Society of New Zealand (UOO1623) No conflicts

Appendix 27: Plagiarism Check

Turnitin Plagiarism Check Score: