The Dissertation Committee for Cathy Hueske certifies that this is the approved version of the following dissertation:

PERCEPTIONS OF AGGRESSIVE BEHAVIORS IN

MENTAL HEALTH CLIENTS

Committee:

Dr. Kathleen Lucke, PhD, RN, Supervisor

Dr. Carolyn Phillips, PhD, RN

Dr. Elnora Mendias, PhD, RN

Dr. Ruth Levine, MD

Dr. Peggy Landrum, PhD, RN

_____

Dean, Graduate School

PERCEPTIONS OF AGGRESSIVE BEHAVIORS IN MENTAL HEALTH CLIENTS

by

Cathy Hueske, RN, BSN, MSN, CNS P/MH, FNP

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Dedication

To my husband Russell and son Andrew

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PERCEPTIONS OF AGGRESSIVE BEHAVIORS IN MENTAL HEALTH CLIENTS

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Cathy Leigh Hueske, PhD

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Supervisor: Kathleen T. Lucke

Abstract:

In 2005 mental illness accounted for 2.4 million hospitalizations in the United States. During hospitalization some of these clients may become aggressive affecting both clients and caregivers. Identifying factors that generate or escalate aggression in mental health clients including those that exist within the therapeutic alliance is important to providing a safe environment. However, the literature describing the interactions within the caregiver/client relationship that trigger aggression was limited. The purpose of this study was to investigate the interactions that mental health care professionals perceived as triggers of an oncoming aggressive event and how the interactions between the caregiver and client affect the aggressive episode. Two research questions were developed through observations, reviewing the literature and discussions with other mental health professionals. Naturalistic Inquiry was then employed to answer the research questions: 1) What factors do licensed and unlicensed mental health professional workers perceive as triggers of aggressive behavior responses in hospitalized mental health clients and 2) How do licensed and unlicensed mental health workers perceive their actions and behaviors influence the precipitation of the aggressive behaviors among hospitalized mental health clients? A purposeful sample of 15 experienced mental health care workers was necessary to obtain saturation and redundancy. Demographic data was compiled from caregiver participants who represented both nursing and social services

departments. Guided by the theoretical framework of Symbolic Interactionism, interviews of the participants gathered rich descriptions of aggression events. These interviews were recorded and later transcribed. Analysis of the transcripts established categories to answer the research questions. Three major categories that emerged from the data comprise the overarching theme of precipitation and resolution of aggression: 1) recognizing aggression, 2) managing aggression, and 3) processing aggression. Findings of this study show that aggressive events can be mitigated or aggravated by caregivers' experience, attitude, and behaviors. These findings provide a direction for further research involving triggers of aggression in the mentally ill, the influence of caregivers' attitudes and behaviors on the hospitalized mentally ill, and promoting a safe work and healing environment.

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Chapter One: Introduction to the Problem

INTRODUCTION

In 2005 there were 2.4 million hospitalizations for mental disorders in the United States (DeFrances and Hall, 2007). The relationship between caregiver and client is the most important element in providing care for the mentally ill (Townsend, 2006). Interactions with the hospital environment, staff, and other clients have been identified as major influences in the precipitation of aggressive behaviors in the hospitalized mentally ill clients (Bowers et al., 2006; Spokes et al., 2002). Few studies have investigated the dynamic interaction as potentially triggering aggression in a mentally ill client. Effective reduction of aggressive behavior by clients suffering from various mental illnesses requires a clear understanding of the relationship between caregiver and clients. Specifically, understanding of staff's perceptions of their influence on aggressive behaviors in mental health clients is critical to providing safe, effective mental health care.

Most individuals who are hospitalized for treatment of a mental illness do not exhibit aggressive behaviors (Townsend, 2006). However, some clients do have episodes of aggressive behaviors as a symptom of their illness. Episodes of aggression in an individual hospitalized with a mental illness can be a potential threat to the safety of staff and other clients. Client aggressive episodes are managed using a range of interventions from the least intrusive to the most restrictive. When initial interventions are not successful at reducing aggressive behavior and the client becomes a danger to them self

or others, more restrictive measures may be needed such as forced medication, seclusion or restraint. The National Research Institute (2008) reports the use of the most restrictive intervention, restraints, has declined over the last seven years. Restraint use is reported in number of hours per 1000 hours of inpatient hospitalization. In 2000, restraint hours for adults 18 - 24 years of age averaged 3.5 – 4.5 hours/1000 inpatient hours; however by 2007 restraint hours had declined to between 1.8 and 3 hours/1000 inpatient hours. Adults 25 – 44 years of age were restrained 2 – 2.5 hours in 2000 and decreased to an estimated 1 hour in 2007. Adults over 45 years of age were restrained less than 1 hour over the 7 years period, with individual over 65 years of age reporting a consistent average of less than 0.5 hours. Clearly improvements in the management of aggressive client behavior have occurred over the past decade, but further progress in early recognition and intervention may be possible if we gain additional insight into the relationship between the caregiver and mentally ill client with the potential for aggressive behavior.

This chapter presents the background and significance of aggression in the mental healthcare setting, addressing the influence of the hospital environment and healthcare worker, management strategies used by the healthcare worker, and the impact of client aggression within the hospital environment. The purposes and aim of the study, sensitizing framework, working hypothesis, and research questions and design conclude chapter one.

BACKGROUND AND SIGNIFICANCE

Early recognition and management of aggressive behaviors in individuals with mental illness has improved considerably over the past several decades. However, when aggressive episodes occur it remains a major safety concern for caregivers and individuals with mental illness throughout the United States (US) (US General Accounting Office, 1999). In the past, many techniques have been employed by the healthcare team to manage and control aggression associated with mental illness. The psychiatric community has used the techniques of psychosurgery, convulsive therapies, isolation, restraint devices, and medications, as well as cognitive-behavioral therapies, and positive reinforcement in an attempt to control aggressive behavior in individuals with a mental illness (Foucault, 2006). Psychosurgery was performed to control aggression from the 1800s through the 1960s, is now reserved for specific disease processes, and performed infrequently (Mashour et al., 2005). Of the convulsive therapies, only one remains in use. Electroconvulsive therapy, generally used for severe treatment resistant depression, is not intended to manage or control aggression in the mentally ill client. When aggression cannot be de-escalated with verbal interventions, client self-management or oral medication, more restrictive interventions such as seclusion, physical restraints, and injectable medications are techniques that may be implemented by caregivers as a last resort to protect the client and others from harm (Foster et al., 2007).

Aggressive behaviors in mental health clients not managed by conventional behavioral therapies can result in a number of seclusions and restraints every year. As an

aggressive client becomes violent, isolation (seclusion), physical restraints and medications may be implemented with or without the individual's consent. Applying restraints, administering medication or secluding a resistant client requires close physical contact between caregivers and clients. Injuries to caregiver and client can occur during the interaction (Bisconer et al., 2006).

Physical interventions can result in serious injury and death even when correctly implemented. In the United States, where over 2 million people experience mental illness annually (CDC, 2003), 176 deaths and/or injuries of mental health clients due to the application of restraints have been reported to the Joint Commission for 2007 (2007b). Seclusion or restraint applications that do not result in injury or death is not required to be reported in the US, making it impossible to know how many are performed annually (United States General Accounting Office, 1999). New York was the only state where accrediting or licensing agencies required reporting of sentinel events (e.g., death or severe injury of a mental health client) until a seminal *Hartford Courant* (1998) report. The *Hartford Courant*, a Connecticut newspaper, reported the findings of a 50 state survey of mental health and mental retardation facilities and group homes in the US, investigating the deaths of mentally ill clients between 1988 and 1998. Telephone contacts were initially made with public agencies to collect data on restraint deaths, and a retrospective review of federal databases and news archives followed. Survey from that 10-year period indicated that 142 deaths of mentally ill clients were attributed to the application of physical restraints to manage an aggressive client (Weiss, 1998).

Since the publication of the *Hartford Courant* (1998) report, both The Joint Commission (JC) (1998) and the Centers for Medicare and Medicaid Services (CMMS) (2006) began to require reporting of sentinel events, including a root cause analysis. Of the national data reported to the JC between 1995 and 2004, the reported root cause analyses of restraint deaths in mentally ill clients indicate that more than 90% of the deaths were related to deficiencies in the orientation and training of mental health staff (The Joint Commission, 2007a).

While each occurrence of aggression is highly individualized and unique, many identifiable factors contribute to aggression in the mentally ill. Irwin (2006) reviewed multiple studies that addressed aggression in the mental health setting. The review included causal factors, prevention, de-escalation techniques, physical responses, and organizational influences, as well as research that identified the relationship between aggression and multiple factors (such as disease process, ethnicity of the client or caregiver, age of client or caregiver, and power imbalances). Irwin concluded that interactions among the staff, clients, organization, and environment all affect aggression occurring in the mental health hospital setting.

Caregivers' attitudes about client aggression have been studied using a variety of methods. Jansen et al. (2005) reviewed the various methods used by different researchers to explore the attitudes of staff toward client aggression in the health care setting. The most common methods used to gather information on aggression from caregivers were: 1) interviews; 2) self-report surveys and questionnaires; 3) retrospective analysis of aggressive incidents; 4) violence scales; and 5) attitude scales. The majority of the studies

focused on nurses' attitudes toward aggression. The authors concluded that the use of multiple instruments to gather the data made it difficult to compare the findings across studies. Difficulty in comparing the findings across different studies decreases the ability of caregivers to incorporate new information into evidence-based practice.

Additional factors identified as triggers of aggression in the hospitalized mentally ill can be divided into four general themes: 1) interpersonal skills and self awareness of the caregiver (Cowin et al., 2003; Duxbury & Whittington, 2005; Horton-Deutsch & Horton, 2003; Morrison & Lehane, 1995; Spokes et al., 2002); 2) the training of caregivers (educational and hospital preparation) (Clinton et al., 2001; Lowe et al., 2003); 3) staffing levels and mix of personnel on duty (number and gender) (Morrison & Lehane, 1995); and 4) client characteristics (Ehmann et al., 2001; Meehan et al., 2006; Nijman et al., 2005). Factors that trigger aggressive behaviors in mental health clients must be explored. An understanding for the triggers of client aggression may allow the caregiver to intervene earlier and decrease the need for physical control.

Influence of the Hospital Environment and the Healthcare Worker on Aggression

Both the hospital environment and the healthcare worker-client interaction have been studied as potential factors triggering aggression in the hospitalized mental health client. Overcrowding, with a lack of personal space in the hospital setting, has been linked to an increase in aggressive behaviors. The client in an overcrowded environment lacks the ability to retreat to a quiet space that would provide a calming influence and decrease aggression. Other environmental influences include the feeling of tension generated by individuals present on the unit. Environmental tension also may affect the

staff members and influence milieu management strategies (Cowin et al., 2003). As tension escalates, the feelings of anxiety are transmitted from the clients to caregivers. The heightened sense of tension can agitate both caregivers and clients and interfere with the ability of an individual to think critically.

Among the many factors that can influence aggressive behavior in the hospital setting, verbal and non-verbal interaction between the health care provider and an aggressive client has the greatest potential to escalate an unstable situation (Hughes, 2002). Staff behaviors are not only influenced by client behaviors, but also by a combination of increased workloads, burnout, poor staffing, and higher client acuity, as well as caregiver anger, hostility and aggression (Antai-Otong, 2001). These personal feelings may alter the caregiver's perceptions of an event, resulting in a negative response toward an agitated client.

Management of Aggression

Control of aggressive behaviors in the clinical setting requires preserving the lawful rights of the client while maintaining safety of the clients, staff, and others who are on the unit. Selection of the appropriate intervention needed to maintain control of any aggressive situation requires judgment and skill. In mental health care, limit-setting or providing clients with rules that regulate their behavior is a vital part of providing a safe and therapeutic environment. However, Lowe et al.'s (2003) examination of mental health nursing staffs' perceptions of conflict situations found that many violent outbursts by mental health clients were triggered when the staff set behavioral limits. They suggest that mental health training in effectively setting limits on client behaviors could have an

effect on the clinical judgment of the mental health worker, thus influencing the implementation and appropriateness of selected interventions.

The client's response to the interaction affects the caregiver's choice of interventional strategies used to manage aggression. These strategies range from the least restrictive, which are collaborative techniques, such as providing choices, face-to-face processing, and redirection, to more restrictive limits on client behaviors that can include the use of physical restraint and medication.

Impact of Client Aggression upon Mental Healthcare Workers

The job of mental health workers has been reported one of the most dangerous, with some studies reporting employee injury rates of greater than 70% (Abderhalden et al., 2002; Delaney et al., 2001; Duxbury, 2002; Hinsby & Baker, 2004; McKinnon & Cross, 2008; Southcott et al., 2002). Many caregivers' injuries occurred while attempting to control violent and aggressive behaviors in a mentally ill client (United States General Accounting Office, 1999). Human bites, unintentional needle sticks, back and other skeletal injuries, and other injuries have occurred, resulting in the loss of productive workdays, and an increase in lawsuits filed against the hospital, employee injury claims, and permanent disability (Quintal, 2002). Injuries may create economic hardships for caregivers who cannot return to work, affecting their ability to meet financial obligation and responsibilities incurred, thus increasing the cost of aggression and violence.

PURPOSES AND AIM OF THE STUDY

The purposes of this naturalistic inquiry (NI) study were: 1) to explore perceptions of mental health care workers about factors that contribute to aggression; and 2) to describe mental healthcare workers perceptions of the influence of staff behaviors and attitudes on aggression in hospitalized mentally ill clients. The aim of this study is to investigate mental healthcare workers' perceptions of the triggers of aggressive behavioral responses in hospitalized mental health clients. This qualitative investigation was based on tacit knowledge, questions that arose from observations during clinical practice, identified gaps in the literature, and interviews and observations of verbal and non-verbal communication. With an understanding of events associated with aggression in hospitalized mentally ill clients, mental healthcare providers may be able to develop and refine de-escalation techniques.

SENSITIZING FRAMEWORK

Symbolic interactionism (SI) serves as the sensitizing framework for this NI study. Weber and Mead were among the first social researchers to define social interaction as influencing behaviors in human beings (Hewitt, 2006). However, Blumer (1969) was credited with formalizing the SI theory by placing emphasis on human interaction that is based on a person's internal interpretations and extrapolated meanings of the symbols in another individual's words and behaviors, as well as in the environment. Blumer viewed human communication as a process where:

> Human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response" is not made directly to the

> actions of one another but instead is based on the meaning which they attach to such actions (Blumer, 1969, p. 180).

Blumer (1969) identified three premises in SI: 1) the symbolic meaning, 2) the sources of that meaning, and 3) the internal interpretation of those meanings by the individual as they apply to a personal response. According to SI, language is an attempt to standardize a conceptual meaning of those experiences into words for a common understanding. However, words are a small portion of human communication; non-verbal behaviors also are considered to play a role in the interpersonal exchange (Blumer, 1969; Hewitt, 2006). The symbolic meaning applied to events and behaviors has the potential to transform any situation making each interaction unique.

The first premise of the SI framework addresses the response human beings toward objects in the environment. The response is based on the meaning the object holds for the individual. All objects in the person's environment, inanimate and human, are assigned meaning by the individual. Objects can be a single person or thing; however, objects may also be viewed as groups or categories that create a unique individual response to any situation. An individual's behavior may change as new stimuli are introduced (Blumer, 1969).

The second premise for SI, the source of the meaning, stresses that the meaning of the experience does not arise out of the concrete nature of the object nor from the intrinsic knowledge of the individual, but from watching others interact with the object. Blumer (1969) believes "the meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing" (p. 4). Meaning is

developed through social process where the defining activities of other individuals form the meaning as these individuals interact with the object.

The third premise of SI is the interpretive process though which an individual handles and modifies the meaning of objects. Meanings for objects are not simply extrapolated from the human interaction process, but by a far more complex method that Blumer (1969) refers to as the process of interpretation. Initially, the individual identifies the situation, notes the object in the experience, and cues in on the stimuli that have meaning. An internal communication occurs, defining the intended elements of interaction and giving meaning to the experience. The individual then analyzes the situation, compares the internal meanings, reorganizes the data, and selects a direction of action. Meanings are applied through the internal process of self-interaction (Blumer, 1969; Hewitt, 2006).

Symbolic Interactionism supports the use of NI methods to study human behavior. Behavioral manifestations are the interplay of applied meanings, interpretations and the application of the interpretation within the situational context to all defined objects in the environment. When a mental health client interprets caregivers' gestures and/or words as threatening, the client's aggression can escalate into violence and become dangerous. Additionally, responses from the caregiver have the potential to either escalate or defuse a tense situation. The caregivers' perceptions of events and their applied meanings are vital to understanding and managing aggressive behavior in a therapeutic manner.

RESEARCH QUESTIONS AND DESIGN OVERVIEW

To achieve the purposes and aim of this study, NI methods were used to answer the following research questions:

1. What do licensed and unlicensed mental health workers perceive as triggers of aggressive behavioral responses in hospitalized mental health clients?
2. How do licensed and unlicensed mental health workers perceive caregivers' actions and behaviors as influencing the precipitation of aggressive behaviors among hospitalized mental health clients?

Naturalistic inquiry (NI) studies are guided by the assumption that all things are interconnected by an intricate network of interrelationships that result in mutual simultaneous shaping of the problem. Context is a vital component of such a study. The phenomena cannot exist outside its contextual structure. The intricacy of the interrelationships permits applications to interpersonal settings such as in the acute care mental health setting (Erlandson et al., 1993; Lincoln & Guba, 1985).

Tacit knowledge and experience with the phenomena stimulated the researcher's initial interest for this study. Tacit knowledge is information that is gained through experience and training including the researcher's instincts, intuition, anxieties, and experiences (Erlandson et al., 1993). Acknowledging the existence of the researcher's tacit knowledge allows the researcher to identify potential bias. Although a variety of instruments may be used to gather data, the primary instrument of NI remains the researcher. The researcher combines appropriate naturalistic strategies, such as interviews, observations, and an audit trail to gather and analyze data (Lincoln & Guba,

1985). The use of NI methodology as the research design permits exploration of the perceptions mental health workers have for factors that may trigger aggression in mentally ill clients.

Healthcare workers' subjective descriptions of their experiences add to a growing knowledge base about triggers for aggression within the mental health setting. Applications of the findings of this study may likewise provide some direction to healthcare workers dealing with aggressive behaviors in the mental health setting. The study findings also may stimulate further investigation of the interactions between client and caregiver, guiding nursing practice and improving care for the mentally ill.

SUMMARY

This chapter presented the background and significance of aggression to mental health caregivers and clients. Management of aggression has improved as attitudes towards mental illness have changed resulting in a decrease in restraint use and an increase in verbal interventions. Nonetheless, when it occurs aggression continues to be a major concern and threatens the safety of clients and caregivers in mental health. However, instead of psychosurgery or devices that restrict an individual physically, preferred management strategies for aggression must begin with techniques that least restrict the client's freedom and assure safety for all individuals in the mental health environment.

Symbolic Interactionism was the theoretical framework that provided the foundation for this naturalistic inquiry study. The framework addresses the dynamic relationship of the meaning of words, actions, and symbols between human beings and is

appropriate when investigating interactions between caregiver and client. Although SI applies to all human interaction, it is especially appropriate to use when exploring the perceptions of mental healthcare workers.

PLAN FOR THE REMAINING CHAPTERS

Organization for the remainder of this study include: four other chapters, appendices, references, and the researcher's vita. Chapter 2 presents a review of the literature pertaining to triggers of aggression in individuals with mental illness. Naturalistic Inquiry as formulated by Lincoln and Guba will be described, along with the associated scientific rigor implemented and followed throughout this study in Chapter 3. Demographic data for the sample will also be included in Chapter 3. Chapter 4 presents the study findings including the categories with supporting emergent themes, along with the rich descriptions from the participants. Chapter Five discusses the findings in relationship to current literature, implications for professional practice and future research.

Chapter Two: Literature Review

INTRODUCTION

Chapter 2 presents a review and critique of published articles and studies that influenced this study. The chapter includes the impact of aggression on mental health workers; management of aggression; staffing characteristics; therapeutic relationships; and client/caregiver perceptions of aggression. The literature review contributed to defining the study by providing a framework for interpretation of the findings and served as a foundation for constant comparative analysis throughout the research process.

The review of the literature for this study included the years between 1990 and 2005. Current standards of care for mentally ill clients were implemented and refined during the stated period. Some of these standards specifically address appropriate management and treatment of the aggressive client. Supplemental searches of the literature published after 2005 were conducted every six months up to April of 2008 for recent publications to ensure that current relevant literature was included. Search terms used for the literature review included aggression, violence, mental health, mental illness, seclusion, and restraint. Although aggression occurs in many areas of healthcare, the literature review focused on the following: aggression in acute adult inpatient mental health setting, forensic units, and nursing homes since the clients may stay for extended periods in each of these types of facilities.

Aggression in the mental health facility affects both caregiver and client. Both clients and caregivers can be physically injured or die. Though no conclusive data was

found regarding caregiver deaths, some alternative sources have reported caregiver deaths as a result of an aggressive episode in a mental health client (Dunn & Alholm, 2007a; Gendar & Siemaszko, 2008; Kindy et al., 2005; Levin et al., 1998; Scott, 2003). Clients also have died from interventions used while managing an episode of aggression (Hartford Courant, 1998; Joint Commission in Accreditation of Healthcare Organizations, 2003). Not all injuries sustained by caregivers or clients are physical; aggression may leave emotional injuries as well. When caregivers must restrain a client against his or her wishes, the caregiver-client relationship may be damaged and difficult to repair, affecting the therapeutic effectiveness of care. Aggression also has other emotional consequences, such as anger, stress, and depression (Irwin, 2006). Through understanding factors that may trigger or escalate aggression, caregivers can employ early interventional strategies that maintain physical and emotional safety for clients and caregivers.

IMPACT ON MENTAL HEALTH WORKERS

The US Department of Labor estimates that 1.7 million mental healthcare workers have been injured while working in the hospital (Center for Disease Control and Prevention, 2008). In addition, work place violence has become an important issue in healthcare setting (Christmas, 2007; Gallant-Roman, 2008; McPhaul & Lipscomb, 2004; Oostrom & Van Mierlo, 2008; St Pierre & Holmes, 2008). McPhaul and Lipscomb identified four types of workplace violence: 1) criminal intent, 2) customer/client, 3) worker-on-worker, and 4) personal relationship. However, the most common type of workplace violence that caregivers experience is from the consumer/client.

The United States (US) Bureau of Labor Statistics (2006) reported workers in mental health hospitals had one of the highest employee injury rates. Several studies also have reported findings indicating that 70% or more of mental health caregivers have been verbally or physically assaulted at some time in their career (Abderhalden et al., 2002; Delaney et al., 2001; Duxbury, 2002; Hinsby & Baker, 2004; McKinnon & Cross, 2008; Southcott et al., 2002). Injuries to mental health workers occur most often during the process of controlling a violent mentally ill client, accounting for the loss of productive work days, an increase in hospital lawsuits and job injury claims by workers, and even permanent disabilities (Coyne, 2002; Quintal, 2002).

Empirical data related to the impact of aggression on mental healthcare workers is limited. Ray and Subich (1998) used a quantitative approach to investigate US mental health caregivers (n = 78) who were considered to be at high risk of assault from a client. The attitudinal variables investigated were: 1) perceived locus of control staff members feel they have over a situation; 2) staff anxiety and fear in assaults from clients; and 3) authoritarianism of the staff. The instrument employed measured both the internal and the external locus of control. The researchers reported finding that caregivers who were anxious and had a more external locus of control experienced more assaults and injuries. Other researchers (Chaimowitz & Moscovitch, 1991; Winstanley & Whittington, 2002) have reported similar findings.

Delaney et al. (2001) used a survey to investigate the impact of aggression on registered nurses in England (n = 59). Eighty-eight percent (n = 52) of the sample reported being assaulted while on duty. Of the nurses assaulted, 27% (n = 14) reported a

physical injury, 21% (n = 11) reported psychological trauma, 25% (n = 13) suffered both physically and psychologically, 25% (n = 13) reported no apparent trauma, and 2% (n = 1) specified some "other" type of injury.

The most common form of aggression directed at caregivers by mental health clients is generally verbal assaults (Lanza et al., 2006; Lucas & Stevenson, 2006; Maguire & Ryan, 2007; McKinnon & Cross, 2008; US General Accounting Office, 1999). Bilgin and Buzlu (2006) investigated aggression in mental health clients in Turkey and found that 79% (N=162) of participants had experienced a verbal assault from a client or a client's relative at some time in their career. Another study in Sweden found similar results when 50% of the caregiver participants experienced verbal threats or assaults from a client or client's relative (Josefsson et al., 2007).

Maguire and Ryan (2007) reported on the types of violent or aggressive incidents encountered by Irish nurses working in mental health. The Scale of Aggressive and Violent Encounters (SAVE) was sent to 280 nurses; 87 (31%) were returned. No psychometric properties were available for the scale. The findings of Maguire and Ryan's study supported the fact that violence and aggression are common in the mental health setting with an average of 24.4 incidents of aggression or violence for each participant in the preceding month. The majority of aggressive incidents were verbal assaults where 68 of the participants were the recipient of non-threatening or threatening verbal aggression. However, the study supported the fact that a majority of caregivers who are employed in mental health institutions work in volatile environments and are the primary targets of assaults. Further studies are needed to investigate the triggers of aggression. Through

identifying the triggers of aggression, training courses could be developed to incorporate strategies designed to minimize or eliminate those factors.

Reducing conflict and containment of aggressive clients was the focus of a London intervention study conducted by Bowers, Brennan, et al. (2006). Nurses identified by the researchers as clinical experts in managing aggression worked with a team of caregivers from two wards that participated in the study (n = 2 wards) three days a week to change their attitudes toward aggressive hospitalized clients. Even with the study partially completed, the researchers identified a reduction in verbal abuse and physical violence directed at caregivers. Clients also benefited with reductions in self-harm and elopement. Creating a safe work environment for caregivers and clients is important in decreasing injuries from escalating verbal aggression or physical violence. Identifying the factors that may trigger or escalate aggression will provide valuable information in helping to minimize and manage both types of aggressive behaviors in the inpatient mental health setting.

McKinnon and Cross (2008) distributed surveys (n = 90) to nurses in two adult acute care units in an Australian mental health facility; 68 nurses responded (70%). The researchers reported that 100% of male (n = 20) and 83.7% of female nurses who responded to the survey had been assaulted. As with other studies, verbal abuse was the most common type of assault (81%). The impact of the aggressive episode on the caregiver included physical injuries (male = 90% and female = 53.5%). Of the participants injured, 96.8% reported being afraid to return to work and 76.2% felt their safety was compromised. Thirty one (49.2%) of the participants used sick leave to

recover from the assault. In this study, 54 of the participants had received training in preventing and managing aggression. Even though the instrument used in the study was adapted with no available psychometric properties, the study is important because it supports the findings of other studies and demonstrates the importance of decreasing client aggressive episodes in the mental health setting. The study also provides insight into the differences between the assaults on male and female caregivers. One hundred percent of the male participants in the study reported being assaulted with 95% of them sustaining an injury. Comparatively, 83% of the females were assaulted with 53.5% reporting a physical injury. Information such as this should be included into the training of caregivers. Other studies are needed to explore the experiences of caregivers so that aggressive episodes in mental health clients can be minimized and a safer work environment created. The impact of threats on healthcare workers and the economic viability of hospitals are evident.

Levin et al. (1998) conducted a descriptive study that "explored contributing factors, consequences, and solutions to the assault of nurses in US hospital emergency departments" (ED) (p. 249). Twenty-two nurses from 15 hospitals were included in four 90-minute focus groups where notes were taken. Three areas identified by the participants in the study that influenced episodes of aggression in clients were: (a) personal characteristics of caregivers, including their attitude, body language and whether they approached the client with confidence and respect; (b) workplace factors that included the lack of administrative awareness about the existence of aggression, and a lack of training for hospital staff members in the skills necessary to manage aggression;

and (c) environmental and situational factors such as societal changes and the types of clients admitted to the unit. The latter factors were outside of the ED department and not something within personal control of the participant

The effects of aggression included physical, personal, and professional factors (Levin et al., 1998). In this study, encounters with aggressive clients resulted in broken bones and chronic pain in caregivers and clients. The emotional results of aggression were anger and a loss of sleep because of nightmares and flashbacks. Professionally the participants reported they withdrew from care and some left the department. Nurses reported being assaulted by clients and verbally abused by physicians. Some of the nurses were threatened by telephone; others were stalked by clients and threatened with guns and knives. The nurses in the Levin et al. study proposed solutions to control aggression through setting boundaries, keeping a physical distance from an aggressive client, and the need to intervene early to prevent aggression from escalating into violence. Participants recommended that administrators be proactive in creating a safe work environment that incorporates mandatory, ongoing training for staff in aggression management.

Although the Levin et al. (1998) study investigated the perceptions of nurses in the ED, important insights can be gained into the causative factors for aggression, as well as the emotional and physical effects of aggression in the workplace on caregivers. Emergency Department (ED) nurses care for clients who have the potential for aggression and violence. There are similarities in aggressive behaviors in many of the clients seen in the ED and on an acute care mental health unit. Investigating the

perceptions ED nurses have on aggression and strategies that would assist in identifying potential triggers of aggressive behavior, thus creating a safer work environment.

As the shortage of mental healthcare workers, especially nurses, becomes even more critical, safety in the workplace is imperative. Investigating underlying causes of aggression and violence is vital. Providing safe effective care to individuals with mental illness, takes constant vigilance so that early interventions and de-escalation strategies can be implemented.

MANAGEMENT OF AGGRESSION

Mental health caregivers use many strategies to ensure that aggressive episodes are safely managed. Assessment of mental health clients is an important aspect of monitoring and managing aggression. The initial assessment of a mental health client should include screening for a history of aggression or violence, the mode of transport to the hospital, disease process and a violence risk assessment. Effective management strategies for aggressive episodes in mental health clients begin with early interventions that stop the aggression from escalating into violence. These include approaching the client verbally, using learned interviewing (therapeutic) techniques, structuring the milieu, and providing activities that focus the client in another area (Cowin et al., 2003; Davison, 2005; Rocca et al., 2006).

In the previous study by Delaney et al. (2001), focus groups were used to investigate how registered nurses managed aggression in the psychiatric setting. Results of the study indicated that nurses used an ongoing informal assessment that included all team members when monitoring clients for aggression. Individualizing care, establishing

rapport, and intervening early with aggressive clients were effective management strategies. Experienced nurses were valued by other staff members for their leadership and guidance in managing an aggressive episode with a mental health client. The researchers also performed an audit of written accounts for 60 aggressive episodes and found that the initial admission assessment for aggression could be used to identify 75% of the clients who later became aggressive. Although estimates of reliability or validity results for the instruments used in the study were not presented and the setting for this study was in London, important insights can be gained into the importance of appropriate and timely use of de-escalation techniques in the reduction of aggressive acts toward mental health staff. Further studies are needed to investigate the potential triggers for episodes of aggression incorporating intervention strategies into existing training and educational programs for managing aggressive clients.

Managing aggression in the acute mental health setting requires specialized caregiver skills and adequate staffing. Initial strategies caregivers use to manage aggression should focus on encouraging the client to maintain self-control and promote independence. Containment strategies used when aggression escalates and endangers others include application of restraints, seclusion of the client, administration of prescribed medication, and implementation of special individual observation. In some cases, rather than managing the aggressive mental health client with interventions that promote self-control, more invasive and physically limiting techniques have been implemented (Fisher, 2003; Sailas & Wahlbeck, 2006). The US Department of Health and Human Services Centers of Medicaid and Medicare Services (CMMS) regulates the

application of restrictive devices and limits the use of restraints in mental health to clients who become dangerous and threatening while hospitalized (US Department of Health and Human Services Health Resources Centers for Medicare and Medicaid Services, 2006). Failure to initiate the least restrictive techniques required that effectively manage aggression has been attributed to a lack of mental health worker education and training regarding clinical skills, staffing shortages, and high client acuity (US General Accounting Office, 1999).

Restraints and seclusion have been used in some instances as an alternative to adequate staffing and training, as well as a punishment for undesired client behaviors (Fisher, 2003). However, Bowers, Brennan, et al. (2006) indicate that strategy selected to manage aggressive clients are affected by differences in psychiatric nurses' thinking and behaviors. Managing aggression through individualized care planning with consistent interventions for targeted behavior and elimination of identified triggers can decrease the use for restraints. Studies that identify triggers that escalate or precipitate aggression in the inpatient care setting are important in creating the least restrictive environment for healing. Caregivers' perceptions may provide valuable insights into additional aggression management skills needed in the hospital training of personnel, especially during staffing shortages and while working with clients demonstrating high acuity levels of illness.

Lewis (2002) used a case study approach to examine the expertise of mental health staff in the prison systems that had to deal with violent situations. The researcher presented a case study of an aggressive violent client, including the initial assessment that incorporated information on the client's history of aggression and violent interactions in

social and hospital settings. Information from the client's past hospital records, other hospital documents, interviews, and staff observations suggested specific behavioral triggers of aggression. Lewis described implementing multiple interventions that included removing known behavioral triggers, a 'cognitive-oriented' anger management program that focused on relaxation training, as well as social skills training in the treatment plan of an aggressive client. Staff members targeted identified triggers for aggression in the client and implemented specialized communication skills, such as maintaining a low voice tone and elimination of verbal threats, to reduce violent behaviors in the client.

Changing the culture and the philosophy of caregivers from one of control to one of care in the mental health arena has been identified as the first step in using de-escalation and anger management skills as the initial response to a crisis and implementation of no touch interventions (Lewis, 2002; Sullivan et al., 2005). Studies that emphasize the importance of clinical skills, personal characteristics and strong interpersonal skills of the caregiver as important in the prevention of violent behaviors and in the implementation of more favorable behavioral interventions tailored to client specific triggers.

Restraints have been used in many healthcare settings to control problematic aggressive behaviors. Dimant (2003) discussed the use of physical restraints to control difficult behaviors (e.g., various behavioral symptoms, prevention of falls) in the nursing home environment. He found that caregivers most frequently cited safety concerns as the primary reason for using restraints. Identification and assessment of the underlying causes of problematic behavioral symptoms that may include aggression is important in

planning care for a client. A restraint, even when applied correctly for perceived safety reasons, has the potential to agitate and escalate a client into an episode of aggression.

Bisconer et al. (2006) presented a case study of a client in a Virginia hospital demonstrating aggression could effectively be reduced through implementing a cohesive plan of care tailored to known triggers. The researchers developed a plan of care for the staff members to implement while caring for a client who was known to experience episodes of aggression. The plan of care included consistent caregiver responses to specified identified behaviors and ongoing staff training. Episodes of aggression were greatly decreased in the client when the caregivers consistently implemented the plan of care. Even though this is a case study, results indicate that careful assessment and monitoring, individualized care planning, and implementation of nursing interventions designed to manage aggressive behaviors can further reduce the use of restraints. An individualized plan of care with consistent responses to specific targeted behaviors may effectively manage undesirable behaviors and reduce the use of restraints in mental health clients.

A formalized program in anger management was included in the plan of care for aggressive clients and was shown to be valuable in decreasing aggression (Lewis, 2002). However, primary caregivers must understand and support the client as they begin to practice newly acquired skills that lead to behavioral changes. Not all caregivers have the clinical skills, personal characteristics, or education to support and encourage the client to developing the necessary skills to self-manage personal anger. Some caregivers can unintentionally prevent a client's attempt to use newly acquired anger management skills

and interfere with the clients attempts to move to a quieter area. Training caregivers in anger management techniques taught to the client is another important aspect for these programs to be successful and effectively reduce aggression in the mental health setting.

Other effective management strategies used to de-escalate a client's aggressive behavior identified in an Australian study by MacKay et al. (2005) included six techniques. The techniques identified were: 1) Monitoring and taking action when early signs of aggression appear; 2) Maintaining the safety of the individuals within the environment; 3) Familiarity with known client triggers and client history; 4) Ongoing risk assessment; 5) Communication techniques (e.g., giving information, interacting, and explaining); and 6) Psychotherapy. Establishing trust and a good rapport with the client is particularly important when working with an aggressive client. The use of a risk assessment instrument has been reported by other researchers in identifying and managing the potential for an aggressive episode in a mental health client (Crowe & Carlyle, 2003).

Developing clinical skills to manage aggression and establishing a trusting relationship with interventions that promote self-control in clients with a mental illness maximize the therapeutic effect of hospitalization (MacKay et al., 2005). Caregivers can develop skills to manage aggressive episodes in mental health clients. CMMS makes annual training in aggression management and skill development mandatory. Part of skill development is choosing the appropriate intervention at the right time (US Department of Health and Human Services Health Resources Centers for Medicare and Medicaid Services, 2006). Gilje and Klose (2000) studied the decision-making process of US

psychiatric nurses as part of a research project initiated in Finland. The researchers had identified five domains of decision-making in Finish nurses: a) intuitive knowing [intuition], b) self-confidence, c) interpretive [interpretation], d) collected information, and e) analytic processing. The authors suggest that US nurses also use a multi-dimensional decision-making process. However, the translated instrument indicated that the US nurses used only the domains of intuitive knowing and self-confidence. The instrument used in this study was translated into English and there was no indication that the instrument measured the same concepts in a culturally different population.

Although the Gilje and Klose (2000) study offered important insights into the decision making process used by US nurses, findings are limited by the use of a foreign instrument that may not have measured the same concepts in both cultures. Understanding the process that US nurses use to make clinical decisions is important when investigating triggers for aggression in American clients.

Lowe et al. (2003) examined how nurses choose to manage a conflict situation. Five nurses, recognized as experts in defusing aggression, identified three dimensions of nursing judgment: support/control, communication, and face-saving/personal control. Findings of this study indicated that participants perceived setting limits and structure as important strategies when minimizing conflict situations with clients. The researchers suggested that management strategies should be used in conjunction with other interventions, since setting limits on client behaviors can trigger violent outbursts. The researchers concluded that the complexity of crises requires multiple interconnected interventions. Although the study is limited by a small sample size, its lack of

information about participants' credentials, and a European setting where health care is managed differently, the findings suggest that mental health training could affect clinical judgment of mental health workers and influence the appropriateness of selected interventions increasing the potential for an aggressive episode to occur.

Johnson and Hauser (2001) used a phenomenological approach to study nurses identified by peers and supervisors as experts in managing aggression by successfully incorporating de-escalation techniques. Four themes of nursing expertise emerged from the study: 1) the ability to identify where the client on a continuum of escalating behaviors, 2) interpreting the meaning of the client's behaviors, 3) identifying client needs during an aggressive event, and 4) the ability to connect and stay connected with the client while implementing the appropriate de-escalation technique. The researchers described the practice of the expert nurses as incorporating skills that include: 1) high levels of self-awareness, and 2) general traditional non-specific de-escalation interventions for aggressive behavior, such as separating the client from peers, calming strategies, listening attentively, allowing verbalization of feelings, setting limits, and being empathic.

Although the generalizability of the study by Johnson and Hauser is limited, the results provide insight into the skills needed to manage aggression and promote safety within the hospital environment. The skills described, when used to manage aggression, allow the caregiver to accompany the client to a calmer space and defuse aggression. Experience in early recognition of escalating behaviors with implementation of interventions based on the individual and the nurse's understanding of the situation as it

evolves is a basic component in reducing aggressive behavior. The calming strategies identified by Johnson and Hauser support the need for the nurse or caregiver to develop self-awareness. The latter allows the caregivers to identify the influence of their own attitudes and behaviors on an aggressive client. Further studies are needed to help the caregiver identify how their behaviors and attitudes influence aggression.

Horton-Deutsch and Horton (2003) used grounded theory methodology to study the caregivers' ability to manage difficult conflict situations and respond in ways that promote the client's personal growth and /or resolution of aggression within the workplace. Based on their research, Horton-Deutsch and Horton proposed that mindfulness could be developed in three phases that include developing awareness of self and others, accepting reality, and regaining equilibrium. Mindfulness was defined these researchers as a continual process of evaluation and creation of new information, enabling responses based thoughtfully within the context of the situation instead of a mindless reactive response. The researchers suggested that through developing and using mindfulness in everyday lives, caregivers' reaction to conflict could be more thoughtful, less emotional, and more appropriate to the situation.

Although the study by Horton-Deutsch and Horton (2003) was not applied to a mental health setting, the research identified important internal resources for all caregivers (including mental health workers) to use when dealing with an aggressive client. Development of mindfulness in the awareness of self and others, accurate identification of difficult conflict situations, and regaining equilibrium could enable the caregiver to better resolve conflict in an unpredictable situation. Clinical skills play an

important role in managing aggression. Developing a state of mindfulness as a clinical skill could help mental health caregivers to intervene and manage aggression differently by changing their individual behaviors and attitudes.

Clinical assessment skills are vital to managing aggression. Assessment of a mental health client begins with admission to the hospital and is a continuous ongoing process. The client's initial assessment should include individual characteristics that may predispose a client to aggressive and violent behavior. Crowner et al. (2005) used a naturalistic design to investigate antecedents of aggressive episodes in mental health clients at an adult inpatient psychiatric center in Manhattan, New York. One hundred and fifteen clients were admitted to the hospital unit during the 3-year study period; more than half (59) were the victim, the assailant, or both in the 155 assaults that occurred. Some of the study's participants were both victim and assailant in different episodes of client aggression; although the actual number of clients who were both victim and assailant was unclear. Characteristics of the client assailants were reported that the clients were predominantly non-white males with a mean age of 42.6 and a diagnosis of schizophrenia (33 out of 50 clients) or bipolar disorder (18 out of 35 clients). The findings related to the client characteristics and disease processes in this study were similar to other studies (Hodgins et al., 2007; Saverimuttu & Lowe, 2000; Walsh et al., 2002). The results of the study indicated that female clients show fewer cues prior to an aggressive episode and the behaviors that lead most often to an assault were intrusive, including physical touch or encroachment into another client's personal space. Sixty percent of the assaults reported in the study were predictable by monitoring clients' cues

of aggression. A continuous ongoing client assessment that includes identifying cues of aggression allows the caregiver to implement early management strategies averting a potentially dangerous situation and preventing an assault.

Hospital training for caregivers has been investigated as a means to reduce aggression in mental health clients. Identifying the type of training caregivers need is an ongoing process as federal and state laws change. Credentialing and licensing guidelines for accrediting agencies, Joint Commission (JC) and CMMS, change with the laws to reflect the recent legislative mandates. JC and CMMS credential and monitor hospitals for compliance of the rules and regulations that govern care for hospitalized individuals with mental illness and reporting events where a client is harmed (The Joint Commission, 2003; US Department of Health and Human Services Health Resources Centers for Medicare and Medicaid Services, 2006). Caregivers working in mental health facilities in the US are required to attend annual hospital training on client's rights and aggression management that incorporate recent changes in rules and regulations. Training caregivers to manage aggression safely and to comply with current guidelines nonetheless remains the responsibility of the hospitals.

Forester et al. (2000) investigated the application and documentation of physical restraints used on clients and the effects of a training program. The most commonly cited reasons for using restraints included confusion and client safety. After the hospital where the study took place revised the restraint and seclusion policy and implemented staff development, a follow up study conducted one-year later reported the following: 1) a decrease in the use of restraints, 2) increased use (60.4%) of alternative verbal and non-

verbal interventions to defuse aggression, and 3) improved restraint documentation (143%). It was unclear whether the program or hospital policy changes influenced the pattern of restraint and seclusion. Although the study site was an urban acute care facility that did not include psychiatric clients, the results of the study illustrate the importance of staff training when restraints are used in healthcare settings to maintain client safety.

Clinton et al. (2001) surveyed a convenience sample of 59 participants who worked in a psychiatric intensive care unit (PICU) in London to determine the education and training needs of mental health caregivers. Seventy-one percent of the respondents identified management of aggression and violence as essential course content and as a fundamental practice issue. The participants likewise identified the need for a course that incorporates de-escalation techniques, the proper use of restraint and seclusion, and psychological therapies, as well as anger management strategies. The cultural, philosophical, and legal differences in mental health should be taken into consideration when evaluating the findings of studies conducted outside the US. Although a major limitation of the Clinton et al. study was the lack of information available to evaluate the data collection instrument, the study results are important because identifying strategies that can potentially decrease an aggressive episode in a mental health client promotes safety and healing. Staff members who are uncertain in managing aggression may hesitate in responding or unintentionally trigger escalation of aggression in a client. Learning activities that focus on de-escalation and alternative, less invasive management strategies prove to be beneficial to both staff and clients.

Hahn et al. (2006) investigated the effects of training on mental health nurses' attitudes regarding the causes of client aggression. The study sample consisted of a control group (n = 34) and a study group (n = 29) of volunteer German nurses practicing in Switzerland. Comparing data from the pre- and post- tests, no significant change was noted in the attitude of the nurses who received training (p = 0.01). Although there are limitations that include cultural, healthcare delivery, and legal differences between Switzerland and the US as well as non-random sampling, this study demonstrated the importance of identifying the attitudes and behaviors which lead to escalation of aggression. Further studies are needed to identify the triggers of aggression of mental health clients in the US. Such studies potentially could lead to specific educational programs can be designed to help the caregivers change or at least minimize the effects of their attitudes on aggression. The perceptions caregivers have about the influence of their behaviors and attitudes on client aggression, as well as training in the management of aggression must be studied. Training should include the triggers for aggression so that caregivers can respond to aggressive behavior as well as to limit the effects o aggressive behavior on clients.

STAFFING CHARACTERISTICS

Staffing characteristics have been suggested as a potential trigger of aggressive episodes in mental health clients. Morrison and Lehane (1995) used official reports of seclusions and staffing assignments to investigate staffing patterns, and the gender and experience of mental health caregivers as determinants of seclusion over a two year period in one locked mental health 17-bed unit in a Wales hospital. Most (54%)

seclusions occurred when the least number of staff members were scheduled to work on the unit. As the number of staff members increased, the number of seclusions fell. Additionally, gender of the staff appeared to have an influence on aggression and the use of seclusion. More seclusion occurred (198 or 88%) at times when only 1-2 female caregivers were scheduled to staff the unit, as opposed to when the same number of male caregivers were scheduled (100 or 44.4%). Moreover, as the number of male caregivers increased to three or four, the number of seclusions also increased (108 or 48%); the opposite phenomenon was seen when the same number of female caregivers were scheduled (23 or 10.2%). However, when five or more caregivers, regardless of gender, were scheduled, the number of client seclusions decreased.

Another finding in Morrison and Lehane's study (1995) was the effect of having an experienced nurse in charge (such as a charge nurse or supervisor) on the rate of seclusion. The majority (225 or 70.2%) of seclusions occurred when no charge nurse was scheduled on duty and were initiated by caregivers who were not in charge. Interpreting the effect of the staffing information presented on the number of seclusions is difficult without knowing the acuity of clients and the staffing ratios for the unit. However, the study demonstrates the importance of an experienced charge nurse who provides leadership and guidance for staff interaction with aggressive clients. The current and projected shortage of healthcare workers may make it more difficult for hospitals to staff their mental health units and balance gender and experience with acuity of the clients. As the shortage of healthcare workers continues, further studies are needed to evaluate how staffing issues influence aggression among acutely ill mental health clients.

Hospital units frequently have professional students on the units interacting with clients. Bowers, Jeffery, et al. (2006) conducted a retrospective study in the United Kingdom (UK) that reviewed official records of adverse events and professional student placement on 14 inpatient mental health units and 3 PICUs were reviewed. Physical aggression decreased on the days when students were present on the units, but no change was reported in verbal aggression, property damage, or self-harm. Although physical aggression decreased when students were present, the phenomenon occurred after the first week with nursing students and after the third week with medical students. Mental health caregivers must consider how student presence on hospital units influences the episodes of client aggression. Further studies are needed to explore the impact of students on influencing aggressive episodes in mental health clients.

THERAPEUTIC RELATIONSHIP

Interaction between a client and a caregiver is dynamic and fluid. Each participant in the communication process interprets spoken and unspoken messages and responds accordingly based on the interpreted meaning. Spokes et al. (2002) used a qualitative approach to study 108 professional and non-professional caregivers from inpatient mental health units in England. One aspect of the study evaluated the complex relationship between mental healthcare staff and clients. The researchers report that nearly all of the participants (105) had been involved in a violent incident while working. The most commonly reported precipitating event for violence in an aggressive client was the administration of medications.

All study participants identified personal strengths and clinical skills that enabled them to deal with violent clients; however, 80% reported they had weaknesses in the clinical skills need to effectively manage violent clients. Participants identified strong interpersonal skills as a personal strength in peers who were skilled in dealing with violence. One group of participants in the study, when asked to describe the action of caregivers that may have contributed to a violent incident, identified challenging behaviors in caregivers that prevented clients from goal attainment, the other group reported some caregivers as being confrontational. Challenging and confrontational behaviors appeared to stimulate aggression in mental health clients. The strength of the Spokes et al. study is the large sample size. The study results identify the potential impact staff behaviors and skills may have on the occurrence of violence in a mentally ill client.

Carlsson, Dahlberg, and Drew (2000) used a phenomenological approach to investigate the therapeutic relationship as a resource to manage aggression, exploring the tacit knowledge occurring in the interaction between caregiver and an aggressive client. Five participants, two nurses and three nursing assistants, provided a narrative of successful or positive interactions with aggressive clients. The essential meaning for the encounter was described as embodiment of the moment. Seven themes were identified: 1) respecting one's fear and respecting the client, 2) touch, 3) dialogue, 4) situated knowledge, 5) stability, 6) mutual regard, and 7) pliability. Each theme had a positive outcome for both client and caregiver. Experienced caregivers, both nurses and nursing assistants, were able to acknowledge the fear of client and caregiver, as well as the danger in the situation, enabling them to manage the fear, frequently resulting in positive

outcomes. Caregivers approached aggressive encounters with openness and complete engagement of the client. Carlsson, Dahlberg, and Drew reported that psychological and physical needs of the client were foremost in the caregivers' thoughts. The astute caregiver was able to accommodate the client's need for space with sensitivity and compassion. Caregivers who approached the aggressive client in a non-threatening, open, non-judgmental manner promoted more positive outcomes. Experienced caregivers were better able to apply a variety of techniques to ensure better outcomes for those involved in an aggressive event. Study findings support the importance of the caregiver-client relationship as an integral aspect of providing care for the mentally ill client. Relationships between caregiver and client may also be a source for triggering aggression. Therefore, it is important to investigate aspects of the relationship, as well as the interrelationship of the environment, philosophy of the institution, and level and mix of caregivers, that may serve as a source for triggering aggression in the mental health setting.

The chief executive officer for the Colombia Behavioral Health System in South Carolina reviewed charts of aggressive mental health clients and reported that more than 50% of seclusion and restraint episodes were directly related to the interaction between the caregiver and client (Hughes, 2002). Unfortunately, no descriptive information other than the percentage for seclusion and restraint of a client with mental illness was reported. Anecdotal statements that relate the interactions between caregiver and client to seclusion and restraint use add to the importance of investigating this dynamic relationship. After a goal was set to eliminate coercive measures of controlling

aggression in mental health clients, Hughes reported on the effects of "…creat[ing] an environment where employees were valued and empowered and where consumers would be treated with the same courtesy and respect" (p. 17). Staff and clients were included in debriefing meetings when restraints had been used. Staff members were given the responsibility and accountability for managing the unit. The hospital staff members attended sensitivity training to gain an understanding of how clients felt when 'taken-down' and restrained. The South Carolina mental healthcare system reduced the hours clients spent in seclusion were reduced from 695 hours in 1993 to 70 hours in 2000; restraint hours also decreased from 24 in 1992 to 2 in 2000. These findings suggest that restructuring and changing the manner in which care is provided to individuals with mental illness can significantly reduce aggressive episodes and coercive containment interventions. Therefore, it is important to investigate alternative methods for providing care to individuals with mental illness that support independence and minimize the chance of injury.

As noted previously, only one study explored the role of caregivers as an antecedent to aggression. No United States (US) studies were found that explore this issue. Thus, a need exists to explore the perceptions of healthcare workers about how their behaviors influence aggression as an important aspect of identifying the triggers for and the management of aggression in a mentally ill client.

CLIENT/CAREGIVER PERCEPTIONS OF AGGRESSION

Perceptions of clients and caregivers in mental health facilities, as they experience the events that surround an aggressive episode, are important in providing safe competent care.

Carlsson, Dahlberg, Lützen, et al. (2004) used a phenomenological approach to study five "positive" and seven "negative" violent encounters between mental health care workers and clients. The researchers described a positive encounter as one in which the caregiver managed to control his/her inner fear while interacting to meet specific needs of an aggressive mental health client. A negative encounter was described as being one in which the caregiver was emotionally or psychologically absent and fear predominated the interaction between caregiver and client, resulting in the client being treated as an object by the caregiver. The findings of the study indicated that the desire of caregivers to promote a positive outcome was guided by an inner dialogue that enabled them to manage the fear elicited by a violent client encounter. Successfully promoting a positive outcome depended upon the caregivers' ability to embody and present sensitivity and compassion rather than a controlling forceful attitude. Compassion and empathy guided the caregivers though the process. Nonetheless, when the inner fear of the caregiver predominated, a dangerous situation resulted.

Carlsson, Dahlberg, Lützen, et al.'s (2004) study is important because it explores the caregivers' emotions in a violent aggressive situation. The study highlights the fact that caregiver emotions can influence decisions that must be made quickly in an aggressive episode, affecting the outcomes. Successful management of aggression

depends on the caregiver remaining emotionally available when tensions begin to rise. Caregivers who were emotionally and psychologically calm approached these situations in an empathetic manner and are better able to care for the client in the safest, least restrictive manner possible.

Knowing what consumers perceive during a psychiatric emergency or crisis is part of understanding the dynamics of the aggressive episode. Allen et al. (2003) surveyed 59 mentally ill clients who had been restrained or secluded for purposes of identifying the reasons for seeking emergency care, which the researchers did not define. Participants reported their most common reason for seeking emergency care, included feelings of being out of control or being very afraid; problems with relationships, medications, school or work; and suicidal thoughts or attempts. The participants reported dissatisfaction with the manner in which psychiatric emergencies had been managed and described perceptions of being disrespected (63%), not being seen in a timely manner (65%), the sense of not being heard (68%), the sense of not being adequately cared for (77%), having problems inadequately addressed (80%), and receiving no explanation of risk, benefits or alternatives (82%). Fourteen percent of the participants perceived restraint application as a punishment and 20% reported being refused bathroom privileges. These findings support the fact that many clients perceived that they were inadequately cared for during a psychiatric emergency and might have suffered emotionally and physically, suggesting a need to investigate how best to intervene in a psychiatric emergency while still providing support, maintaining the client's autonomy, and preserving human dignity. Evaluating the perceptions of those involved and

identifying common themes in aggressive episodes may reveal changes that should be implemented to prevent violence from re-occurring.

Outlaw and Lowery (1994) investigated "the causes clients and nurses gave for implementing seclusion and restraint, the relationship between client and nurse causes, and the relationship of situational variables to the causes given" (p. 71). Although 83% of the participants were able to identify a cause for restraint application, nurses and clients disagreed about the reason. Nurses attributed the cause for most restraints to be internally driven and controllable by the client, as well as unstable factors within the client psyche. Clients, however, perceived the cause of the restraints to be external factors, uncontrollable, and influenced by other factors unrelated to the client's behaviors such as staffing issues. Although the nurses and clients in this study reported opposite views on the factors that caused the application of restraints, the impact could have an effect on the outcomes of the aggressive episode.

The client's perceptions of being restrained are also important because an experience perceived as traumatic can affect how the individual responds in another situation when restraints are employed. Johnson (1998) used a phenomenological approach to interview clients who had been restrained with leather cuffs. Prevalent themes of caregiver power, separation, and a sense of powerlessness surfaced. The client did not always perceive restraints to be therapeutic; restraints were viewed more often as a consequence for violating unit rules. While in restraints, clients were more likely to feel frightened and vulnerable. Though a small sample size limits the generalizability of Johnson's study, caregiver understanding of the clients' perception while restrained may

facilitate maintenance of the therapeutic intention and minimize the potential damage to the therapeutic relationship. Investigating the perceptions of clients who have been restrained may provide caregivers with valuable insights into a client's aggressive behavioral responses facilitating better evidence-based care.

Marangos-Frost and Wells (2000) used an ethnographic approach to examine Canadian mental health nurses' perceptions of restraint application during a client aggressive episode. The researchers reported that emotional responses by the staff might contribute to the use of restraints when dealing with a potentially violent client. Participants reported that the decision to restrain a client was difficult and framed the decision for restraints within the context of protecting the client or others in the environment. The study participants described searching for alternatives to restraints when less restrictive management strategies were unsuccessful. Conditions surrounding the application of restraints, including the acuity and diagnosis of the clients and the impact of restraint application, also were discussed. Nurses in the study reported policies requiring constant care (1-to-1 care) for restrained clients that necessitated staff reassignment and sometimes increased the number of staff needed to provide adequate care on the unit. Nurses perceived that both physicians and management minimized the volatility and danger of the work environment. When client aggression escalated into violence, staffing needs quickly changed and clinical decisions were unsupported by hospital management. Nurses generally have mixed feeling about the use of restraints in mental health clients. Nurses in this study who had to make the decision to apply restraints experienced conflicted emotions because of having to choose between two

equally unpleasant alternatives, either endangering others or restraining a client. Although the sample size consisted of six Canadian nurses, the study is important because it identifies the fact that using restraints on clients who become violent remains a difficult choice for nurses. A need exists to further explore the perceptions of nurses to define how their behavior and decisions affect aggressive episodes in mental health clients and the use of restraints.

Kindy et al. (2005) also studied nurses' perceptions of aggression and violence in a qualitative study using interpretive phenomenology. Ten nurses were interviewed "to give a voice to registered nurses who work in environments where there is a high risk of assault" (2005, p. 170). The findings included four categories designations: 1) safety fortification (personal preparation such as training in managing and preventing aggression); 2) catalysts for violence (increased the risk of violence); 3) perplexing aftermath (being hypervigilant, distrustful, and fearful resulting in poor morale); and 4) pervasive invasive sequelae (pervasive emotional burdens like stress). The participants of the study attended training sessions and were taught to develop interpersonal communication skills designed to manage aggressive episodes in dealing with mental health clients. Nonetheless, subsequent to the training, nurses perceived many factors that stimulated aggression in clients that resulting in a violent encounter, such as staff members, clients, administrators, and health care environment. The nurse participants reported that the encounter left them questioning their personal safety at work. They also felt that some of the interventions used, while managing aggression conflicted with core personal and professional values produced role conflict and emotional dissociation.

Studies such as this are important because they identify that violence in the health care arena has far reaching implications and can affect nurses both in the home and work environment. Larger studies of this type are needed in order to define and identify potential strategies to minimize the outcomes of aggression on the healthcare worker.

Hinsby and Baker (2004) used grounded theory methodology to explore perceptions of 4 male nurses and 4 male clients relative to violence in a forensic setting. The core category of control was identified; nurses and clients both struggled to exert control over the client's behaviors. Caregivers and clients perceived that aggression was caused by a complex web of factors that interact with one another. Nurses who participated in the study described aggressive episodes as unpreventable with the view that the behavior needed to be controlled; management or de-escalation strategies that addressed the initial trigger for the aggressive behavior were not reported. Participant clients identified themselves as being responsible, rational adults possessing free will and experienced the interventions as a means of punishment. Although the sample size was small, it does reveal the differences in perception of events between clients and caregivers. These are important differences and can influence the caregiver-client relationship. Restraints and seclusion should not be viewed as punishment by caregiver or client. Strategies to reduce or eliminate interventions perceived to be coercive need to be conducted. Likewise, studies are needed to examine how caregivers can best manage an aggressive client most effectively while maintaining the therapeutic intent and safety.

SUMMARY

Areas of investigation for aggressive episodes in mental health clients found in the literature included the impact on mental health workers, strategies caregivers use when managing aggression, the role staffing characteristics and the therapeutic relationship had in triggering aggressive episodes, and client/caregiver perceptions of seclusion and restraints. Although many studies have investigated different aspects of aggressive episodes in mental health clients, only one study, Spokes et al. (2002), was found which investigated the triggers of client aggressive episodes that arise from the client-caregiver interaction. Other researchers identified caregiver characteristics that generated positive outcomes for an aggressive episode, such as strong interpersonal and clinical skills, a focus on the psychological and physical needs of the client, and the ability of the caregiver to respect the client. The lack of studies that investigate the caregivers' perceptions of interactions as a trigger for aggression indicates a need for this study. Future research studies must identify triggers for aggressive client behavior including the contributing behaviors and attitudes of staff, to serve as a basis for developing interventions that are more effective and that promote the healing process in the mentally ill client. The purposes of this study are to explore perceptions mental health care workers have regarding factors that contribute to aggression and to describe the influence that staff behaviors and attitudes have on aggression in hospitalized adult mentally ill clients. This study will assist caregivers in better assessing, monitoring, and managing episodes of aggression in mental health clients. The study results also may provide information that can assist in the development of hospital training programs with

the focus on how caregiver's behavior may influence the care of an aggressive mentally ill client. Caregivers then can incorporate management strategies that may prevent episodes of aggressive client behaviors from escalating into violent situations requiring more stringent and intrusive measures such as the application of restraints, measures that can result in injury or death.

Chapter Three: Methodology

INTRODUCTION

The research design, including a description of Naturalistic Inquiry (NI), and the methods used to answer the research questions are presented in this chapter. Procedures used to recruit participants, the sample demographic data, and data collection and analysis techniques are discussed. The standards for maintaining scientific rigor, measures designed to protect human subjects and limitations are likewise included in the chapter.

The purposes of this study were to explore perceptions mental healthcare workers have on factors that contribute to aggression as well as to describe the influence staff behaviors and attitudes have on aggression in the hospitalized mentally ill. The aim of this study was to investigate perceptions mental healthcare workers had about triggers for aggressive behavioral responses in the hospitalized mental health client. Approval for the study was obtained prior to beginning data collection from the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB). The approval letter, the approved subject consent form and recruitment flyer are in Appendices A-C.

RESEARCH DESIGN AND QUESTIONS

The focus of this study evolved from observations in the clinical setting of aggressive episodes by mental health clients. Some clients appeared to react more aggressively when in the presence of certain caregivers, but less aggressively when in the

presence of others. Moreover, some personnel appeared more likely to be associated with aggressive episodes in mental health clients. Curiosity about this observation led to exploration of the literature for factors that were associated with mental health client aggression. However, as noted in chapter 2, only one study (Spokes et al., 2002) addressed the influence of caregiver behavior on client aggression. The need to investigate the dynamic client-caregiver relationship and the role of the caregiver in mental health client aggression was identified as the focus of this dissertation study. The literature did not provide enough information about the influence of the client-caregiver relationship on aggressive episodes in mental health clients; the decision was made to begin with the perceptions of the caregivers themselves. Naturalistic Inquiry (NI) as described by Lincoln and Guba (1985) was selected as the appropriate method to investigate the study questions.

The following research questions guided this study.

1. What do licensed and unlicensed mental health workers perceive as triggers of aggressive behavior responses in hospitalized mental health clients?
2. How do licensed and unlicensed mental health workers perceive their actions and behaviors to influence the precipitation of aggressive behaviors among hospitalized mental health clients?

NATURALISTIC INQUIRY

Naturalistic Inquiry (NI), developed by Lincoln and Guba in 1985, was chosen to answer the study's questions since this paradigm lends itself to exploring a phenomenon

where limited investigation has been done. The NI paradigm allows for interaction between the investigator and the participants in order to reach a more complete understanding of the phenomenon of interest. This interaction between the investigator and participant is essential to the collection of a full description of events that surround the phenomenon (Erlandson et al., 1993).

Understanding the perceptions caregivers have about aggressive episodes in mental health clients is essential since the actions and behaviors of the caregivers cannot be isolated from the events and phenomena within the mental health setting. Moreover, the researcher's reality alone cannot fully explain the complexities of the phenomenon of interest. Naturalistic inquiry (NI) acknowledges the strong influence that the researcher and study participants have upon one another. Naturalistic inquiry methodology leads the investigator to discover a common understanding and meaning of the phenomenon through immersion in the rich descriptions of the participants' responses (Erlandson et al., 1993).

The focus of NI is the participant's reality and what that reality adds to the understanding of the phenomenon being investigated. Naturalistic Inquiry views the phenomenon within the context of the participant's experience and understanding since multiple realities and meanings of the same phenomena are assumed to exist.

Naturalistic Inquiry acknowledges the researcher's role throughout the research process. The researcher's knowledge, as well as the researcher's intuitions and feelings, serve as a guide for communication and facilitate the interpretations of non-verbal cues. The researcher and respondent become partners in the process of exploring the

phenomenon of interest. The dialogue between the researcher and participant leads to a mutual understanding of the phenomenon. Categories evolved from the complex web of communication between researcher and participant, leading to an understanding of the participants' experiences (Erlandson et al., 1993; Lincoln & Guba, 1985).

SAMPLE AND SETTING

Purposive sampling was employed to recruit mental health caregivers for this study. Participants with a minimum of five years work experience and currently employed in direct care with hospitalized mentally ill clients were eligible to take part in the study. The goal was to obtain a representative sample of healthcare workers who provide direct care to mental health clients. Exclusions from the sample included anyone with less than five years of experience and those employed in hospital settings with no direct care responsibilities to clients. Mental health workers from different educational and training backgrounds, with and without professional licensure, were recruited for this study. Efforts were made by the researcher to include the different levels of caregivers that provide direct care to clients with a mental illness to enhance the richness of the data.

Participants were recruited from multiple inpatient settings in a large southwestern metropolitan area. Potential participants were recruited using an IRB- and hospital- approved flyer (Appendix C) that was posted in the mental health facilities, as well as announcements at professional meetings and word-of-mouth. Participation in the study was voluntary and written informed consent was obtained from the participants before the interview began (Appendix B).

Demographic Data

Fifteen participants were interviewed for the study. Demographic data such as age, educational preparation, years of experience, and position were gathered using a form developed by the researcher (Appendix D). Participants included 5 Registered Nurses (RN), 2 Licensed Vocational Nurses (LVN), and 5 Psychiatric Technicians (PCT), as well as 1 Licensed Master Social Worker (LMSW), 1 Licensed Professional Counselor (LPC), and 1 Licensed Chemical Dependency Counselor (LCDC). Physicians were approached by the researcher and asked to participate in the study, but declined. The age range of study participants was 34 to 63 years with a mean of 49.33 (Table 1).

Table 1: *Summary of Demographics for the Sample (n = 15)*

Characteristics	**Male N = 4 (26.67%)**	**Female N = 11 (73.33%)**	**Years of Experience (Mean = 15.9)**	**Total Sample N = 15**
Age (mean) (range 34-63)	43.33 years (range 34-52)	53 years (range 40- 63)		49.33 years
RN	0	5	Range: 5-33 Mean = 13.6	5
LVN	0	2	Range: 5-15 Mean = 11	2
PCT	3	2	Range: 5-33 Mean = 16	5
LMSW	0	1	15	1
LPC	0	1	18	1
LCDC	1	0	33	1

Participants had worked with mental health clients from 5 to 36 years with a mean of 15.9 years. Four (27.1%) of the participants were men and 11 (73.3%) were female.

Participants self-identified their racial/ethnic heritage. The sample included 6 African Americans (40%), 1 Hispanic (6.67%), and 8 Caucasians (46.67%).

In summary, the age demographics of the study group were similar to the available data for nursing and social service personnel (US Department of Health and Human Services Health Resources & Services Administration Bureau of Health Professions, 2006). There was a two-year difference in the mean age of the nursing service personnel in the sample (48.9 years) and that reported for US nurses (46.8 years). Limited data were reported for social service personnel, however the mean age for social workers in the US is 49 (US Department of Health and Human Services Health Resources & Services Administration Bureau of Health Professions, 2006).

The educational preparation of the participants ranged from a high school diploma to a master's degree. Registered nurse participants represented three types of educational preparation for licensure: a diploma (3 years generally hospital based), an Associate Degree (2 years in a college setting), and Bachelor of Science in Nursing (4 year college degree program). The LVNs had at least one year of training at community colleges. Four of the PCTs had at least two years of college and one held an Associate of Arts degree. Other credentials held by the PCTs included nursing assistant certification, PCT certification, and completion of an LVN program (Table 2).

Table 2: *Summary of Education and Ethnicity (n = 15)*

Education		**Ethnicity**		
RN		White	African American	Hispanic
Diploma	2	3	2	0
ADN	2			
BSN	1			
LVN	LVN program (18 months)	2	0	0
PCT	Range: High School to 2 years of college; 1 Associate's Degree	0	4	1
LMSW	Bachelor's and Master's Degrees	1	0	0
LPC	Bachelor's and Master's Degree	1	0	0
LCDC	LCDC program-1 ½ years of college	1	0	0
	Totals	**8 (53.33%)**	**6 (40%)**	**1 (6.67%)**
	Sample Total	**15**		

Setting

The setting for individual interviews varied because each participant selected a convenient time and location for the interview. Settings included living areas of the participants' personal homes, professional offices, and quiet cafés away from other patrons.

Study participants worked in facilities that represented the various types of hospital settings that care for acute mentally ill clients. Six hospitals located in a large southwestern metropolitan area were represented. Four of the hospitals were freestanding psychiatric hospitals. Two hospitals provided a wide range of services in addition to units

for mental health. Two of the freestanding hospitals were private, not-for-profit facilities. Two of the private hospitals were for-profit; one of these facilities also provided medical/surgical care. A county and a government facility also were represented. All hospital units had 10 to 15 double occupancy rooms with capacity for 20-30 beds.

All participants had worked in several area hospitals. As a result, some of the descriptions in the study interview may have included situations that occurred in facilities other than their current employing facility.

INSTRUMENTATION

Data were collected using a semi-structured interview guide (Appendix E) and a demographic data sheet (Appendix D). The investigator created both the demographic data sheet and interview guide specifically for the purpose of the study.

Semi-Structured Interview

A focused exploration using a semi-structured interview technique was employed with each participant to obtain the participants' perceptions about the influence the health care provider's actions and behaviors have on hospitalized mentally ill clients who become increasingly verbally or physically threatening to others (Appendix E). Participants agreed to a second interview or follow up telephone call, if needed, to clarify information.

The semi-structured interview guide (Appendix E) was used to provide the topics and general sequence for the first interview with the participants. The interview questions were designed to elicit perspectives that addressed the research questions of the study.

Each participant was asked the same general questions (Erlandson et al., 1993; Lincoln & Guba, 1985). The participants were encouraged to provide a full expression of their thoughts, feelings, perceptions, and experiences related to the interview questions. The aim of the interview questions was to elicit spontaneous descriptions, rather than speculative information (Kvale, 1996).

Three types of questions were used to elicit full, exhaustive descriptions of the participant's perceptions and experiences. Introductory questions allowed participants to become acquainted with the researcher and initiated the topic for discovery. These were broad in nature and provided direction without rigidly limiting the participant's description. The investigator used follow-up questions and verbal prompts (such as, "Go on" or non-verbal behaviors) to clarify or encourage a deeper exploration of meaning. The researcher also used probing questions during the interview to obtain more in-depth descriptions about the experience.

Demographic Data Form

The demographic data form (Appendix D) was designed to gather general information about the participants, such as age and gender. The participants were also asked to provide information about their role as a mental healthcare worker (e.g., social worker, nurse), their years working in mental healthcare settings, and whether those settings were inpatient/outpatient or day treatment units.

DATA COLLECTION

Mental health caregivers who were interested in participating in the study were

asked to contact the investigator. During the initial contact with the potential participant, the investigator determined whether the individual met the study inclusion criteria. The investigator also described the study procedures. If the potential participant met the study criteria and voiced interest, the investigator set up a time, date, and location that was convenient for the first interview.

Prior to beginning the interview, the researcher explained all study procedures and answered any questions the participant might have. The participant signed two copies of the informed consent (Appendix B). The participant retained one copy and the investigator retained a second copy. Once the participant provided signed consent, the participant was asked to complete the demographic data sheet.

The principal investigator (PI), an Advanced Practice Nurse in mental health, conducted all of the interviews. Participants were asked to meet with the PI at least once for no more than 90 minutes. All efforts were made to minimize fatigue by providing a break if needed. The interviews with each participant were face-to-face in a setting of the participant's choosing. All interviews took place away from the care setting to ensure confidentiality and privacy of the participant. The participants appeared relaxed while being interviewed. The interviews ranged from 45 to 90 minutes and lasted an average of 60 minutes. A digital voice recorder was used to record the interviews.

At the end of each interview, the investigator summarized the obvious themes of the interview with the participant. The participant's comments, clarifications or amendments also were recorded and transcribed as part of the data. As part of the validation process, the findings were reviewed with a limited number of the participants

during a member check activity. The investigator met with 10 of the participants a second time in order to validate the meanings and promote clarification of the findings of the study. Some new information emerged during the second contact with the participants; this information was recorded in the investigator's field notes (Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985).

Field Notes and Reflective Journaling

Field notes and the investigator's reflective journal also were part of the data collected for the study. Field notes recorded the investigator's thoughts and observations about the participant, the interview setting, and events that may have occurred during the interview. A digital voice recorder (DVR) was used to record the field notes immediately after the interview.

Entries were made in the reflective journal a minimum of twice weekly. The journal included thoughts and insights about the various phases of the research project.

The DVR recordings of the field notes and reflective journal were transcribed and stored on a password-protected external drive. Hard copies of the field notes and reflective journal were placed in a locked file drawer in the researcher's office. The DVR recordings were erased after being typed and verified for accuracy.

DATA MANAGEMENT

A well-planned and executed study includes well-defined data management techniques. The digital voice-recording of each interview was transcribed either by a professional transcriptionist who had been trained by the researcher to format the

transcripts for the study, or the investigator. Each participant was assigned a numerical code that was placed on all the participant's documents to maintain confidentiality. Any information that identified a particular participant, patient, or location was removed or masked in the transcribed data. The researcher reviewed all transcribed interviews for accuracy by listening to the recorded interview and comparing the audiotape with the transcript. Incomplete or inaccurate information was corrected.

The recordings and transcripts were separated from the codebooks that were developed during data analysis. The recordings and transcripts were stored in a locked file cabinet in the researcher's locked office. The codebooks were stored on a small accessory drive that was disconnected daily from the computer and secured with an encryption code requiring a password known only to the investigator. The researcher had sole access to the small accessory drive.

Ethical Considerations

The phenomenon of interest in this research study was of a very sensitive nature. The study had the potential to uncover information that might violate regulations pertaining to care of individuals with mental illness, potentially affecting the caregiver's licensure. The subject consent form included a statement notifying the participant of the legal responsibility of the researcher should the participant reveal information about an event that was a clear violation of the law.

Protecting the participants' anonymity is important in any research study. Coding techniques were used to maintain the confidentiality of the participant. Where possible, findings were reported as aggregate data to ensure that no participant could be identified

and confidentiality maintained. Descriptions and quotes provided by the participants were identified with a subject number and line number in the transcript. These identifiers were further masked by a four-layer rotation of the code numbers. In addition, any information that might give clues to the identity of a participant, a patient, or a facility were masked or removed from the quotations.

DATA ANALYSIS

NI data analysis relies heavily on the grounded theory (GT) strategy of constant comparative analysis (CCA) (Glaser & Strauss, 1999; Lincoln & Guba, 1985). Glaser and Strauss (1999) described CCA as "a continuously growing process . . .where earlier stages remain in operation throughout the analysis and each provides continuous development to its successive stage until the analysis is terminated" (p. 105). Hodson (1991) describes the CCA method of analysis as: "the most recent responses are compared with previous responses in the search for consistency, discrepancies, anomalies and negative cases" (p. 51). CCA is used in every aspect of data analysis. Four points are included within the data analysis process where CCA is particularly important. The first point is comparing items of raw data to each other for similarities and differences. Categories are constantly being refined as the data are analyzed. The category properties are tentatively identified and tested during the second point of CCA. During the third stage of CCA, categories are further refined, better defined, and more clearly articulated; some categories may collapse or be assimilated into other categories. When no further information emerges from the data, the categories are considered saturated, and the study

ends (Charmaz, 2003; Glaser & Strauss, 1999; Lincoln & Guba, 1985; Strauss & Corbin, 1998)

Lincoln and Guba (1985) identify four NI data collection elements: 1) unitizing the data; 2) categorizing; 3) extending (moving from known to unknown), bridging (identifying connections), and surfacing (suggesting new categories); and 4) negative case analysis (Erlandson et al., 1993). Data analysis in the present study began with the initial unitizing of the data. Unitizing, or disaggregating, the data began with a line-by-line analysis of the data, using constant comparison techniques, and was the foundation for tentative categories and themes during the second reading of the transcripts. Narratives or interview transcripts were divided into units of data and placed in envelopes which had rudimentary category designations based on the general meaning and common wordings.

Extending, bridging, and surfacing of data are interrelated rather than sequential elements. Extending the data occurs when a category appears viable but may need to be explored further (Lincoln & Guba, 1985). Initially, the envelopes served to cluster similar data items and refine the boundaries of the clusters. Extending the data occurred in this study as category one began to develop and one theme held little information. This theme was thought to be important and the investigator employed purposive sampling to pursue potential participants who would be the most likely to possess the experiences. As further transcripts were analyzed, items of data were reviewed for similarity to previously-clustered data items.

Bridging is the process of identifying emergent category designations. Categories in the study evolved as the data were sorted by similarities in wording and conceptual meaning. Similar concepts were grouped and themes identified. The reading of the transcripts continued, with each piece of data placed into the appropriate category designation (Lincoln & Guba, 1985).

Surfacing is the process of defining the categories. The data clusters were placed into a concept grid that assisted in exploring the conceptual fit among emerging categories. The categories were examined to define their essential meanings. Category titles were then developed to reflect meanings. The conceptual grid assisted in refining, collapsing, and determining appropriate labels for each of the categories (Erlandson et al., 1993; Lincoln & Guba, 1985).

Along with the transcripts, other information contributed to the study data. The researcher's field notes and journal entries also were analyzed for themes and compared to other unitized data. Additionally, the audio-record of the interview was reviewed for nuances in the participant's voice tone, emphasis on words, pauses or stammering when answering questions, and other pertinent information that may have an effect on the analysis of the data.

The member checking process included sharing the initial findings with 10 participants. Each of the 10 participants reviewed the researcher's findings to check for factual and interpretational accuracy. Data gathered from the participants during the member check process was compared and included with the study findings. Placement of

data into a particular category was based primarily on similarities to other unitized data and the contextual meaning that emerged within category.

The final analysis began after all unitized data were categorized. The step included the process of rereading the unitized data to ascertain whether the content was appropriate for the assigned category. Rereading the unitized data lead to clarification and evolution of the categories (Erlandson et al., 1993).

Part of the process of data analysis in NI is allowing for the possibility for negative cases to emerge. This process "involves addressing and considering alternative interpretations of data, particularly noting pieces of data that would tend to refute the researcher's reconstruction of reality" (Lincoln & Guba, 1985, p. 121). No negative cases were identified within the data. However, during the member check process some of the participants provided additional information that affected the initial data analysis and interpretations. The participants' clarifications were added to the initial interpretation.

Methodological Notes

Methodological notes also were kept throughout the study. The information included the researcher's notes about the data, concept grids where themes and categories began to emerge, evolving codebooks, and other data coding information. Methodologic notes also provided part of the audit trail (Guba & Lincoln, 1989; Lincoln & Guba, 1985).

TRUSTWORTHINESS

Trustworthiness in naturalistic inquiry is established through the techniques of providing *credibility* or truth-value, *transferability* or applicability, *dependability* or consistency, and *confirmability* or neutrality and replicability. Various activities were used to maintain the scientific integrity and establish trustworthiness throughout the study (Erlandson et al., 1993; Guba & Lincoln, 1989; Tobin & Begley, 2004).

Credibility

Credibility, the 'truth value' of the study, is comparable to internal validity in a quantitative study. Strategies used in this study to establish credibility included prolonged engagement, triangulation, peer debriefing, and member checks. Prolonged engagement was accomplished by the initial 90-minute interview and the member checking process, by the prolonged immersion in the data and the extant literature pertaining to the phenomenon of interest (Erlandson et al., 1993; Guba & Lincoln, 1989).

There are several different forms of triangulation. The present study used investigator triangulation. Two experienced qualitative researchers independently evaluated the study data for themes and category designations then met with the researcher and compared their interpretations with those of the researcher. Ultimately, a consensus was achieved about the interpretation of the data.

Peer debriefing helps the investigator to identify thoughts, feelings, and biases that may affect the findings. The process of peer debriefing occurred throughout the study and assisted with identifying emerging conceptualizations and clarification of emerging

themes. Two committee members with PhDs, who are experts in qualitative methods and research, served as debriefers for the investigator.

Transferability

Transferability is the extent to which the findings can be applied in other contexts or with different participants (Erlandson et al., 1993; Lincoln & Guba, 1985). Transferability is comparable to external validity in quantitative research. Transferability is the applicability of the study findings. Transferability in naturalistic studies is limited because the findings are contextually based to a specific population or problem. Application of study findings, therefore, rests with the individual whose intent is to apply them to another setting.

Strategies that increase the transferability of a naturalistic study include the thick descriptions, the study reports, purposive sampling, and a reflexive journal. Transferability in the present study was established through the exhaustive descriptions, purposive sampling, and reflexive journaling. Thick descriptions of the phenomena provided a rich source of contextually based data to support interpretations of the data. Purposive sampling was employed to include multiple disciplines, ethnicities, and both genders into the study. Reflexive journaling documented the investigator's thoughts, feelings, insights and decisions throughout the study process (Erlandson et al., 1993).

Dependability

Lincoln and Guba (1985) describe dependability as how well the study can be replicated with the same or similar respondents and achieve similar findings. The

dependability in NI mirrors the reliability estimates for quantitative research. Strategies used in the present study to establish dependability included an audit trail and reflexive journaling. The audit trail included the raw data; data reduction and analysis products such as the initial unitized data clusters and data grids; data reconstruction and synthesis products, such as code books and methodologic notes; and process notes, materials related to intentions and dispositions, such as journal and peer debriefing notes (Erlandson et al., 1993, p. 149; Lincoln & Guba, 1985, p. 316-318). Creating footprints or a visible audit trail allows another investigator to replicate the study.

Confirmability

Guba and Lincoln (1989) describe confirmability as the degree to which the findings "can be tracked to their sources and the logic used to assemble the interpretations into structurally coherent and corroborating wholes is both explicit and implicit" (p. 243). Confirmability differs from dependability in that confirmability deals with the interpretation of data while dependability is how well the study lends itself to replication and reflects the objectivity of the qualitative researcher. The audit trail, peer debriefing, and reflexive journaling were used in this study to establish confirmability (Erlandson et al., 1993). Confirmability was established by an audit trail that included evaluation of field-notes, personal journal, and expert evaluation of the verbatim transcriptions of the interviews (Creswell, 1998; Erlandson et al., 1993; Guba & Lincoln, 1989; Lincoln & Guba, 1985).

SUMMARY

Naturalistic Inquiry (NI) was utilized to investigate the perceptions of mental health personnel regarding triggers of aggressive behavior in hospitalized mentally ill clients and the caregivers' perceptions of whether caregivers' behaviors and attitudes influence aggression in hospitalized mentally ill clients. A semi-structured interview guide that included questions and subsequent probes was used to gather rich descriptions of caregiver's perceptions of factors that trigger aggression.

The NI method emphasizes the collaborative effort between participant and investigator in deriving common understanding to the phenomenon of interest. The present study utilized the NI strategies of unitizing, extending, bridging, and surfacing, as well as the constant comparison method developed by Glaser and Strauss (1999) (Lincoln & Guba, 1985).

Several techniques were used to establish trustworthiness and increase the rigor of the study. Prolonged engagement, persistent observations, triangulation, peer debriefing, and member checks were techniques used to establish credibility. Transferability was established through the thick rich descriptions of the participants, purposive sampling, and reflexive journaling. The dependability of the study was formulated on the techniques of the dependability audit and the reflexive journal. The final aspect of trustworthiness was the confirmability audit and the reflexive journal (Erlandson et al., 1993; Guba & Lincoln, 1989). The audit trail was maintained throughout the study to preserve the trustworthiness and scientific rigor. The audit trail allows for the steps in the study to be followed and scrutinized by other scientists.

Chapter Four: Findings

INTRODUCTION

This study explores perceptions held by mental healthcare workers of factors that contribute to the escalation of aggression and the influence of staff behaviors and attitudes on hospitalized mentally ill clients. This chapter includes a presentation of the influence of Symbolic Interactionism (SI) and a report of the findings of the study with interpretation of the emergent categories and themes that answer the research questions of this naturalistic inquiry study.

SYMBOLIC INTERACTIONISM

Symbolic Interactionism (SI), as described by Blumer (1969), provided a context for guiding the analysis and interpretation of the data obtained in this study. Human beings communicate through words and actions that define symbolic concepts existing within the environment. Communication, or symbolic meaning, requires a person and environmental stimuli to convey conceptual symbols to another individual. The conceptual symbol is received and the recipient applies meaning to the symbol. A feedback loop of behavioral responses occurs when the receiving individual uses the meaning of the interpreted symbols. The individual bases behavioral responses on object identification and interpretation, and on the applied meaning of the initial symbol. The source of the meaning for the symbols is learned through exposure to the object and observation of other individuals as they respond to the object. Evaluating the behavioral

responses to the communicated symbols allows the person who conveyed the message to know if the desired message was received and properly understood. The process with verbal and non-verbal conceptualizations repeats continually throughout the interaction (Blumer, 1969). Applying the principles of SI assists the investigator to understand the actions and reactions of caregivers and clients.

Symbolic Interactionism was the conceptual framework used to assist in identifying the major categories contained within the perceptions of the participants as they described their experiences of personal interactions with aggressive clients in the mental health care setting. Participants in the study described how they identified aggression in mentally ill clients and how they perceived caregiver-client interactions affecting clients' aggressive behaviors.

Mental health caregivers work in an environment where an episode of aggression by a mental health client is an ever-present threat. Symbolic Interactionism provided a deeper understanding of the perceptions held by the caregivers. The perspective of SI allowed for a better understanding and interpretation of behavioral responses between the caregiver and client.

Study findings presented in this chapter describe how mental healthcare workers recognize, manage, and process aggression in the hospitalized mentally ill client. The perceptions mental healthcare workers have about the precipitants and outcomes of aggression for both client and caregiver also are reported. The findings suggest that many factors contribute to the precipitation and escalation of aggression that includes the interaction between client and caregiver. An overarching construct woven throughout this

research study was the precipitation and resolution of aggression. The caregivers who participated in this study described a continuum of behaviors that could precipitate or resolve an episode of aggression in a client with a mental illness.

CENTRAL FINDINGS

The central findings of this study included three categories that emerged from recurrent themes and data clusters present in the rich descriptions of aggressive episodes provided by the participants. The major categories were: 1) Recognizing aggression, 2) Managing aggression, and 3) Processing aggression. Additionally, several themes supported the categories. Table 3 presents a summary of the categories and themes.

Table 3: *Categories and Themes*

Category 1: Recognizing Aggression
A) Client Cues
B) Self: Intuitive Knowing
C) Characteristics of Other Staff
D) Mental Health Unit Characteristics

Category II: Managing Aggression
A) Communication
B) Building a Relationship
C) Milieu Management

Category III: Processing Aggression
A) Reporting Outcomes of Aggressive Episodes
B) De-briefing Aggressive Episodes

Data collection interviews began by asking each participant to identify aggressive episodes in mental health clients in order to determine whether in fact they had been involved in such episodes. The participants described a variety of behaviors indicating aggressive episodes. The clients were aggressive when they exhibited verbal or physical behaviors that threatened or caused harm to the environment, themselves, or other people. Examples of escalating verbal aggression provided by the participants include:

> …she was very upset, acting out. Very loud verbally. (S2 L16-17)
>
> Well he gets louder and louder and closer and closer and gathers an audience and every other word is "fuck"…we realized he was very labile and it would be every so many hours he would cycle into this. Umm…It was the louder voice. . .he cursing. . . (S8 L211-216)
>
> Every time she would see me she would curse me out. . . (S12 L23-25)
>
> . . .she came in and she was really anxious. . . screaming and yelling and crying and fighting. (S3 L104-107)
>
> And he said 'F-U-C-K" you and when he said that I said "uh oh." He has changed. . .He never said anything like that to me before or acted like that. (S9 L94-97)
>
> He was yelling obscenities to the doctor and saying a lot of really nasty things to him and calling him all kinds of names. (S7 L38-40)
>
> Loud voice, threatening behavior, by being intrusive to personal boundaries, getting up into people's face. The words he used, saying "I'm gonna break the doors" and "I'm gonna be hurting some people if I don't get out of here." (S4 L20-25)
>
> He was verbally abusive, threatening, intimidating. Rolling his face. . .and banging on the table. . .very demanding. . .and entitled. . .and using profanity. Threatening me personally. He was very threatening by facial expression. . .movement of his body. . .and words he was using profanity.' (S1 L27-37)

The participants provided the following examples of increasing physical behaviors indicating escalating aggression. These behaviors included throwing objects, pushing or hitting others, running or jumping, and self-mutilation:

> She starts throwing chairs and throwing different items. (S15 L60-61)
>
> Throw things. . .she didn't like me much. (S12 L25-26)
>
> . . .threw his coffee. (S15 L464)
>
> She was pushing on me. (S2 L61)
>
> This guy punched me in the stomach. (S5 L232)
>
> . . .some of those kids are running around. . . hitting each other. (S14 L22-24)
>
> He came up to the medication cart and he was banging his hand. (S1 L51-54)
>
> They were yelling in group and they jumped up and charged toward another client. (S4 L79-81)
>
> He [client] actually went over the counter after the doctor. (S7 L32-33)
>
> . . . nice one minute talking to me one minute, I could kind of trust her, then she would snap and start try to do stuff to herself like trying to cut herself, hitting her head against the wall, or trying to bust a window. You know she couldn't break it, trying to break a window and. . .she would sit down and try to talk with you for a little while, then try to grab your ink pen and cut herself with it. Try to grab your badge and cut herself with it. (S12 L 74-87)

Participants believed the primary issue surrounding aggressive episodes was to prevent aggressive episodes from occurring or escalating, so recognizing factors that could indicate the potential for or escalation of aggression was important. The participants had to manage episodes of aggression that could not be prevented or de-

escalated; after the episode, they processed the episode by identifying the outcomes and contributing factors.

The following sections of this chapter addresses each the categories and subcategories. Conceptual models developed from participants' perceptions of factors leading to aggressive episodes and management strategies for aggressive episodes are included in this chapter as well. The participant's code number and the corresponding lines from the transcript identify data items illustrating particular categories.

CATEGORY I: RECOGNIZING AGGRESSION

The primary goal of the present study is to examine factors mental health workers perceive as stimulating aggressive episodes in clients. The participants were able to describe clues they used to identify clients at risk for actual or impending aggressive episodes. They also reported reactions within themselves, other people, or the hospital environment that could indicate impending or potential aggressive episodes among their clients.

Recognizing aggression included being alert to client predispositions and behavioral manifestations that might initiate an aggressive event. These included the client's diagnosis and history of aggression, the client's responses to hospitalization, and characteristics unique to the client. The participants also described behavioral responses that alerted them that the client was escalating toward aggression.

Client Cues

The study participants utilized information about the client that might indicate the client's risk for aggression including the client's disease process and whether the client had a history of aggression. The participants reported that the client's disease process could predispose the client to aggression. Participants identified clients' psychotic conditions, including dementia and drug-induced psychosis, as clues that the clients may be at risk for aggressive episodes. Statements taken from participant responses demonstrating the use of a client's past history of aggression include: "It really depends on how psychotic the patient is at the time" (S7 L147-148) and "Unless they are too psychotic to hear you" (S3 L428). The participants also were aware that when the client was hallucinating or delusional the client was at risk for aggression: "Some cases the patient is psychotic and may be hearing voices" (S1 L209-210); "He had a psych problem too" (S1 L191); "I think it was dementia as well" (S10 L313); "Client came in to be admitted to the hospital . . .was impaired with drugs" (S4 L14-16); and "Let's see, the patient who was diagnosed with schizophrenia. . ." (S2 15-16). Participants also used nonspecific general statements about disease process in the descriptions of aggressive episodes in mental health clients: "But also it depends on their disease process and where they're at. . .what they are cycling to" (S8 L795-798). The participants perceived clients who were severely psychotic, hallucinatory, or delusional as more likely to become aggressive.

History

A client's history of aggression influenced the participants' perceptions of the client's potential for additional aggressive episodes by such statements as: "He had a history [of becoming aggressive and assaulting caregivers]" (S7 L95); "I had already had known he was aggressive" (S3 L137). Statements such as these indicate the participants used their prior knowledge of the client's aggressive behavior to recognize the need for increased vigilance for potential aggressive episodes.

Participants reported that at times they were unaware, or had not been informed, that they were caring for an aggressive client until violence erupted. According to the participants had they been given the information prior to interacting with the clients, they would have been prepared and planned early strategies to intervene or prevent aggression. One participant volunteered this description: ". . . [The client] had actually gotten through admitting with a record. . . past [of attacking a caregiver at another hospital], that had that been brought to light probably wouldn't have been let in" (S8 L83-84). Another participant told of being unaware that the client she was admitting had a history of aggression. The client later assaulted her: ". . . [He] hit me, because he has a history of that" (S3 L90). She perceived that, had she been aware of the client's potential for violence, she would have been more alert to the risk for aggression.

The participants identified the importance of communicating the client's potential for aggression. One participant who had been assaulted by a client stated "Needless to say a lot of hair came out at that point. . .but if there had been better communication between the hospitals and transferring information to the nursing staff. . .that would have

never happened" (S6 L296-300). Another participant reported, ". . . later I found out that she was in our care because of beating her husband" (S5 L392-394). Personal safety and that of the unit were compromised when staff members are not given adequate information.

Lack of Control

Participants reported that clients exhibited characteristics that could indicate their risk for increased aggression. Many such characteristics dealt with the client's reaction to loss of autonomy and independence as part of hospitalization in an inpatient mental health setting. The participants identified their clients' reactions to the loss of personal freedoms resulting in a lack of control of their lives, being reminded of someone, and not wanting to be in the hospital as increasing the risk for aggressive episodes.

Several of the participants saw the client's response to lack of control as a potential trigger for aggression. The initial assessment in most acute care mental health facilities is completed behind a locked door, and then the client is placed on a locked unit. Cigarettes and other personal objects must be surrendered; some personal items must be requested from the staff members. One participant described the experience as, "They feel like nothing is in their control. . .Especially in a locked facility. They feel like they have no control" (S14 L554-555). Participants believed clients could become aggressive when they felt a lack of control or power as they struggled to take control over their lives: ". . .any sense of control that they feel the staff has over them. . .really makes them escalate. . ." (S8 L806-808).

Client aggression and the link to the client's sense of lack of control in the hospital environment were mentioned by several participants. One participant described a client's attempt to control the environment so that he could have "just one more [cigarette]." Another participant described a situation when clients "revolted" to gain more control:

> And at 11:10 [pm] approximately 11 to 13 of them decided to revolt and "We're going to go outside by hook or by crook." So we tried reasoning with them. . .security was called. . .nursing supervisor was called. The children chose to light up cigarettes in our front lounge of our. . .unit. . .and still nothing was unlocked. (S8 L23-30)

As the interview continued, this participant returned to the "revolt" several times as if she was reliving the event. Her description included how the aggressive episode affected the unit. The episode escalated as additional clients were recruited:

> So they start stomping, and yelling, and screaming, and you know walk around the unit, I don't know if they are necessarily trying to rile people up, but usually they try to get support from others. You know "What's this so and so is doing to me. Did they do this to you?" like trying to rally the troops. (S4 L209-215)

The issue over smoking and who controlled when and where clients smoked came up repeatedly in the data as potential triggers for aggressive episodes. Clients struggled against the hospital rules about smoking:

> I just really thought it was silly for him to act out that way about a cigarette, because I wasn't gonna, really wasn't going to do anything. He had been there for a while, so this wasn't something new to him. (S7 L158-162)

Another participant observed an incident that began when "This patient wanted to smoke and . . .there are rules and the tech tried to tell him. . .to go on back to his room. And he didn't want to go. . .and they got into it" (S1 L169-172).

Included in the theme of lack of control was that clients "don't want to follow the rules" (S3 L5). One participant perceived it as simply "Controls [rules] some people [clients] don't like" (S1 L190-191).

> Patients don't like controlled [by rules]. . .and if you're [clients] sick, they [clients] don't understand that in every environment there are rules. And they don't want to follow the rules and they don't want anyone to tell them. . .let's say in the case of adolescents they get in trouble with a cop because they have problem listening to people. . .following rules. . .so when they get in their controlled environment. . .even though. . .you try to be nice with them…they still resist. (S1 L220-228)

Resistance to rules that limited the client's choices could increase aggression. A participant described multiple instances when clients had rebelled against the rules and detailed how the episodes were managed:

> Well a patient's gonna be aggressive. . .whenever they are told no. And I find that you have a lot of homeless patients that come in, that feel entitled. . . "You gotta do this for me. . ." but sometimes the answer is "No. I mean. . .if it's not time for smoke break. You can't go out and smoke. There's nothing I can do. I can't override a doctor." . . . Sometimes the answers are out of my power. Patients get mad. Sometimes the patient is on a certain diet; they can't have a regular snack. I told them all the time, "Ma'am I will accommodate you as much as possible within reason, but I can't override your doctor. You know what. . .the best I can do is tomorrow when you doctor comes in talk to your doctor. . .maybe write a doctor order because I can't override doctor's orders." So that makes a lot of patients mad. . . "You can't smoke." or "You're on an 1800 calorie a day diet." Set limit[s] on just regular behavior. On regular behavior. . .or "You can't have, you know. . .you're use to abusing Adderall or you were abusing Demerol. . .or. . .Haldol or whatever. But the doctor has taken you off all that because you were abusing it. Now you want. . .this. . ." and then "What do you mean you can't give me this?" (S5 L646-683)

One participant described the importance of rules to clients who were smoking on the unit, "We said actually it's not that. . .fire alarms are gonna go off that you're standing here lighting cigarettes. . .you know you're breaking the rules. . .just making sure everything safe for every patient here. That's all" (S8 L197-198). Rules are important in

structuring and providing a safe and healthy environment in any hospital setting. However, rules can become a focal point for control issues between caregivers and clients in the inpatient mental health care setting.

Reminding the Client of Someone

Another theme that emerged as a client characteristic that could trigger aggression was that a staff member could remind the client of someone, a phenomenon referred to as transference. Participants were aware that aggressive episodes could occur when clients responded to another staff member as if they were the other person. The client's behavioral response could become even more aggressive when the staff member reminded the client of an individual that they did not like. One participant who had been hit by a client remarked, "I guess I must have looked. . .later I found out I must look like him [client's disliked person]" (S5 L394-395).

Four other participants described similar events. Even the use of therapeutic techniques did not always compensate when a client responded towards a caregiver with aggressive behaviors because he or she reminded the client of someone else. One participant noted ". . .sometimes you can approach a patient appropriately but they. . .or you may remind them of somebody" (S1 L211-213). Two of the participants reported that they had reminded clients of relatives they did not like. One of these participants said, "Sometimes they just don't like me because I look like their mother or something" (S14 L367- 368).

Violence can erupt when transference issues arise. One participant was attacked because ". . .someone thought that I was. . .their aunt or some family member that they

didn't like" (S1 L213-216). A fourth participant who identified transference as a trigger for aggression described her assault as, "She was just real violent, especially to me. She thought I was someone else that she didn't like on the outside" (S12 L21-23). One of the participants viewed transference as more a basic human issue when she stated:

> Not everybody like[s] everybody. You know sometimes the patients. . .you remind them of someone or someone have done something to them similar; or whatever I don't know. Whatever is going on in that patient's mind. Because sometimes a patient, will pick. . .will pick a staff that they don't like for whatever reason. And it's like with us students we don't like everybody. So you can't expect everybody to like everybody. You know even in the work place. Even if you work with clients, you just have to try your best to be therapeutic. (S15 L339-352)

Clients did not always like caregivers for many reasons. Whatever the reason given for not liking someone, their dislike could trigger aggression and staff members were often the victims.

Wanting to Leave the Hospital

The final client characteristic that participants believed could precipitate an aggressive episode was that of clients desiring to leave the hospital. In some cases, wanting to leave appeared to be a progression from the client feeling a lack of control, not wanting to follow the rules, and not liking staff members. Participants' comments consistently identified many aggressive episodes that had occurred when a mental health client decided the hospital was not the place to be. Participants' descriptions ranged from "[The client] didn't want to come in [to the hospital] in the first place" (S11 L162) to "She wanted to go home" (S11 L85). Another participant had to intervene when "He [client] didn't want to go to the unit. He wanted to deal with everything right there" (S14

L175-177). Clients with mental illnesses are often brought to the hospital against their will. One participant described a client who had been brought in to the mental health facility by force, "they brought him in very, very angry. . .very, very. . .at his mother 'cause she brought him in" (S14 L237-239). Another participant felt that some of the clients were ". . .just mad for already having to be there" (S7 L354). Locked doors, restrictions of personal freedoms (i.e., making telephone calls, eating, watching television, smoking), and limited choices could trigger aggression in many clients.

Client characteristics

The participants also described characteristics unique to the client that they considered triggers for aggression. The characteristics identified by the participants were those of gender, intolerance of others, a client's attitude, and personal issues. One participant believed that his own gender might be threatening to the client:

> I personally got out of his sight so he wouldn't see a male threat but stayed close enough so that if he did get aggressive, I would be able to intervene. (S6 L69-71)

The participants identified the client's intolerance of another individual's personal characteristics, such as race, sex, and age as a potential trigger for aggression. A participant described a client that ". . .was very blatantly racist, sexist, ageist everything you possibly could be" (S8 L78-80). ". . . racist comments. . .sexist ageist all kinds of comments going on [that] wreaked havoc on the unit" (S8 L90-101).

Participants also identified clients who had aggressive tendencies related to the client's own characteristics:

> . . .a lot [of aggression] with males. . . particularly African American or Caucasian males where they're. . .pretty much are aggressive. Or also. . .ironically. . . found

> there is a rise in Oriental…especially Oriental patients coming into our facility because their culture don't believe in mental health. They believe in that you have a problem talk to Big Momma or talk to such and such. But you don't. . ."How dare you go to some public and let them know you have problems." So when they do come in to our facility you already know from. . . experience you already know that they are pretty much gone. That they have that aggressive part. . .tendency to . . . that tendency to react. (S5 L150-166)

Participants identified personal issues of clients as potential triggers of aggressive episodes. One participant identified ". . .most times it is not the staff. Most times it is the patient himself that is struggling with issues" (S1 260-263). Clients' mental health issues can manifest themselves as aggression on the units. One participant reported that sometimes clients have ". . .asked a staff member a question and. . .didn't like the answer" (S4 L207-209), and thus have precipitated an aggressive episode. Other characteristics the participants perceived as a triggers for aggression were demanding clients who ". . .would come up. . .and demand. . .or want something" (S6 L227-229). Another participant perceived this type of aggressive behavior differently and referred to a client as "attention seeking and med seeking" (S8 L368).

Not only were the participants aware of clients at risk for aggressive episodes, they also monitored changes in clients' responses that could indicate increasing aggression. Clients exhibited changes in their breathing, facial expression, increasing physical/behavioral activities, and verbal escalation that alerted the participants their clients were escalating into an aggressive episode. For example, one participant reported: ". . .breathing, usually they are breathing heavy" (S4 L54) and ". . .her breathing had changed. . . to like it was getting more rapid. . .instead of like slower like a normal. . .like a normal person would when they're breathing" (S15 L179-180).

Physical Signs of Aggression

The participants monitored the facial expression of their clients as an indicator for the potential for aggression: "He was very threatening by facial expression" (S1 L27) and "The facial expressions, there were angry facial expressions" (S10 L25-26). A third participant simply noted ". . .the look on the face" (S8 L217). A fourth participant described how a client's facial expression ". . .was looking more disgusted and more distant [as the client became more upset]" (S15 L182-183).

Participants reported that a client's behaviors intensified as the client's potential for aggression escalated. Constant monitoring for changing physical behaviors was important when providing care for an individual with a mental illness. One participant shared:

> You can always . . .You always look for red flags. . like always they give you a sign. . . they're gonna give you that warning sign that. . .they're not gonna just. . .you know I've rarely seen cases where patient would jump out with aggression. It's a gradual thing . . .that happens and stuff. (S5 L55 and 74-77)

Behavior was a key feature in recognizing escalating aggression in a client. The most commonly described incremental behaviors were forms of movement such as walking and pacing. One participant described the following scenario in which the client's walking behavior indicated impending aggression: "She was walking the hall and she was saying all kinds of things. And I could see, I said 'Aw, something's going on here.' She was just walking the hall" (S9 L688-691). Another participant reported: ". . .He was pacing" (S3 L52). Other participants described pacing as well as a combination of physical behaviors that indicated a client was becoming aggressive:

> . . .that was the build-up of it though. But he started being very, very anxious, pacing, sitting but not able to sit still. Moving. . .moving his legs, moving his hands around. . .just interfering with the group. Not being able to sit quietly and listen to group. (S3 L58-64)

> . . .pacing, talking to self, fumbling with their hands. . .that's my way of knowing. . .the body language. . .you gotta to be able to read body language to know they are aggressive. Because if I see a patient pacing or talking to themselves. . .9 times out of 10 something is gonna happen. He is gonna react. . .he's gonna act. . .we need to see. . .what's going on with this patient. And. . .to keep aware of it. . .Sometimes. . .it may be nothing. . .but sometimes. . . (S5 L 56-73)

Subtle changes in client behaviors also could indicate the potential for an aggressive episode. One participant reported noticing subtle changes in a client's behaviors:

> I didn't know exactly what was going on because she hadn't been talking that much. And all the sudden she just. . .you know. . .after she got to pacing she began to escalate" (S15 L166-169).

Even though the participant reported, "not knowing exactly," the client's change in behavior was recognized as a potential for an aggressive episode.

The participants identified that clients' verbal behaviors reflected their escalating aggression. One participant reported, "She [a client] was verbally abusive, and did not want to listen to staff, throwing chairs around" (S1 L135-136). The participants often mentioned loud verbal tones of clients:

> He was yelling. He was. . .He was yelling. . .He was cursing at us. . .calling us names. . . racial slurs. . .things like that. (S3 L169-172)

> He got louder and started screaming about being stupid. . .he didn't respond at all. All he could do was just focused on that. He couldn't hear anything else he was saying. (S3 L220-225)

> He was yelling at us that he was going to go home that day and he meant it. (S3 L53-54)

> This patient was just pacing and yelling and. . .getting worse the more we talked to him. (S3 L151-152)

Other participants described subtle changes in the affective environment of the unit to describe community behaviors that might indicate that aggression was escalating. Through monitoring the physical behaviors of several clients this participant recognized anxiety among the unit population:

> Because all of them [clients] were nervous and antsy that day. And the anxiety, the other nurse even mentioned that . . .that it hadn't been like that the day before because he noticed that they were more anxious than general days usually are. (S3 36-41)

Although a client's breathing patterns, facial expression, verbal and physical behaviors might indicate the client might be escalating into an aggressive episode, such behaviors were not in themselves triggers of aggression. Recognizing the risks for and indicators of escalating aggression could allow the participants to intervene before an aggressive outburst, thereby promoting a safe, healing environment. If the participants had not been able to recognize such cues in mental health clients, aggression could have escalated or been triggered.

Self: Intuitive Knowing

Some study participants reported that even without overt physical or behavioral manifestations by their clients, they sensed an aggressive episode was a possibility: "I intuitively knew that this patient was dangerous to the rest of the patients, myself, and others" (S5 L 251-256). A second participant sounded as if she was surprised when describing her intuitive way of knowing: "Oh my gosh! It's that psych intuition, nursing intuition. . .but I know that's not. . .able to be measured. Not measurable because. . .[It's]

hard [define]. There was just a feeling of brewing this past week" (S11 L71-75). Another participant summed up this type of knowing: "That's psych. . .You just know" (S8 L103-204). The participants frequently used their own intuitive knowing to monitor a client or the unit for the possibility of aggressive episodes.

Characteristics of Other Staff

The participants identified characteristics or behaviors in other staff members that might precipitate aggression in mental health clients. Many situations that could precipitate aggression in a mental health client were not under the staff member's control. The participants also described other staff members' behaviors that could precipitate aggression in clients. These types of behaviors appeared to reflect choice on the part of the staff member.

Culture

Aspects that were not under the control of the staff member included cultural differences, gender, and physical size. Cultural differences will always exist in the healthcare setting. The various social groups have accepted behavioral norms and communication styles. These norms and communication styles vary between cultures. Cultural differences in social settings may go unnoticed, but in the mental healthcare setting, cultural differences can become problematic:

> You have different cultures, in nursing industry. . .I have find that a lot of African cultures have a lot of aggression in their speech. . .which they don't mean that they're. . .they don't mean to be that way. . .that's the way their culture is. . .and as a person that comes from a different culture. . .as American or whatever. . .they take their offense to that and I find that aggression can kinda happen that way and stuff. It's like…I can say something and you can say something and another

> person can say something…and there's a lot of dialect for a lot of aggression in the way they speak. It's only natural for someone to respond aggressively. (S5 L111-127)

Another participant recounted the following incident:

> Because we were getting the client frustrated because they couldn't understand the dialect and what they were saying. . .the nurse is getting frustrated because she is having to repeat herself. . .what she is not saying is. . .the word that these people can understand and stuff…"are you having. . .did you ever have surgery?" But it came out. . .like. . .you ever have an orgy". . .that's what he heard. He's looking at her like. . .did I ever have an orgy. I said "Whoa, no sir, she meant did you ever have surgery." That's what she was trying to say, but the dialect. . .that is the make and break (S7 L540-574)

One participant described the following incident involving a coworker: "She has an accent and sometimes they have an accent and they talk to the patients . . .Patients don't understand them. . .Patients think they're. . .making fun of them or something like that" (S9 L563-567). As the interview progressed this participant noted another coworker ". . .unknowingly escalates them because she has this accent and they always thinking that she is saying something about them" (S9 L751-753).

One participant reported an event in which the client's aggression escalated because he could not understand the English-speaking staff: ". . .part of the problem with him [client] though, was a language barrier" (S3 L181). The event continued to escalate as "He [the client] was.. .going off in Viet. . .Vietnamese. . ." (S3 L 250-253). The client could not understand the English-speaking staff and the staff could not understand the client, although there was a partial understanding of certain words. The outcome was that the client's agitation increased.

Cultural differences that participants perceived to trigger aggression were not confined to foreign-born workers. Healthcare workers carried with them cultural

characteristics that became problematic because they came from a different locality than the client. One participant told of a problematic cultural encounter between a locally-born client and a nurse from another state and socio-economic class:

> A nurse who's. . .PRN. . .who's worked in many facilities. . .who said she spoke with the boy that was detoxing and said "you're acting like an asshole. . .and he said "are you calling me an asshole . .you called me an asshole." And she said "No, I said you were acting like one." I was shocked, believe me. (S8 L409-420)

The participant, who was from the same locality as the client, continued:

> And I see. . .some. . .what could pass for a language barrier. . .sorts of aggression. Things that come out of their [staff from other localities] mouths that are. . .the culture here in [a state]. . . sort of horrendous. What's the word I want. . .it would make me angry. If someone. . .spoke to me in that manner. . .or said what they are saying or they are trying to use an analogy. (S8 L430-441)

The participants perceived language and cultural differences as potential triggers of aggressive episodes. Such differences went beyond those of people born in different countries to include people born in the same country but from different localities and social-economic groups.

Gender, Size and Age of the Caregiver

Participants identified gender and size as personal characteristics that could affect clients who were potentially aggressive. Male caregivers, especially those with strong physiques, are relied upon in psychiatric units to physically control episodes of violence among mental health clients. Participants observed that coworkers who were physically much larger than their clients could make the client feel intimidated and respond aggressively. A participant who was describing an aggressive episode involving a staff member commented: "Perhaps his [staff member's] size, the fact that he is a large male"

(S10 L280). One participant believed his own of physical size intimidated clients: ". . .somebody's gotta regulate. Of course when it's me, because of my size and stuff, they think I just being a bully, when all I'm just trying to do my job. It just a misperception" (S7 L107-119).

Other participants identified instances where either gender of the caregiver or physical size could increase tension between caregiver and client: "And these are staff that are bigger than the patients, male/female it doesn't matter" (S6 L559-561). The participants reported that clients could be intimidated by the caregiver's size or body language: "2 male techs raced. . .I mean raced into the group room. . .Slapped on a pair of latex gloves. . .and kinda stood there like 'I'm techman'" (her voice changes to be like a comic book character) (S8 124-128).

Only one participant identified age as a staff characteristic that could be a stimulus for aggression. The participant felt that the age of a caregiver affected certain professional behaviors such as boundaries, professionalism, education, inappropriate self-disclosure, and therapeutic interaction. The participant's description included:

> You know the socialization. . .getting to their level. . .you have problems, you can smile. . .you can have a conversation. . .you know. . .not be regimental. The kids seem to like when you redirect them. And set limits on their behavior. But when you try to get too friendly with them they have no control. . .no control. (S1 L329-334)

Caregiver Behaviors

The participants identified staff member's behaviors that they perceived could trigger aggression and could have been controlled by the caregiver. These behaviors reflected a disrespectful, demeaning, or irritating attitude toward the client. For example,

participants had observed that clients who felt the staff did not hear or were not listening to them frequently responded aggressively. One participant commented that an aggressive client complained that he was ". . .not being heard" (S8 L221). Another participant described an event this way:

> There was a patient that came up. . .and he said he needed to have an inhaler. . .That he had to have his inhaler. And she [the medication nurse] said there was none ordered and that he needed to wait. That he didn't. . .and. . .So he went away, he was very angry. . .very upset into his room, slamming the door and cussing and cussing. . .I mean he [client] was okay right at that moment but I didn't know how long he would be that way because of his anxiety. And yelling and saying how he needed the inhaler and she [caregiver] wasn't listening to him." (S3 L307-331)

Later in the interview, the participant returned to the event to emphasize how not listening further escalates aggression in clients explaining: ". . .if you try to get them to quit that [asking for something like the inhaler], it's gonna get them to escalate further, because you're not listening to them" (S13 L376-379). Another participant clearly felt that not listening played an important role in triggering aggression:

> Not listening to them. Not listening to them and blowing them off. Because really a lot of times they just want to be heard. And at times they know you can't really do anything about what they're angry about, but they want someone to hear them. But they just really want to be heard. (S4 L283-289)

Voice Tone

One participant identified the effects of his personal voice tone when interacting with a client and stated, "The mistake I made was raising my voice and that increased. . . escalated her" (S1 L132-133). The participants viewed tone of voice as important when interacting with clients: ". . .the psych unit. . .you got to watch your tone. . .you gotta

watch the way to talk to them and stuff. . .cause basically it can get ugly if you don't watch. . .watch yourself" (S5 L571-576).

The following descriptions illustrate how voice tone can convey different meanings to clients: "If you demand that they do something. If you give them orders. If you speak in authoritative, loud tones to them" (S3 L392-393) and "Not necessarily yell at them, but talk not very nice to them, talk demeaning to them" (S4 L270-272). Another participant commented: ". . .because we have first a female tech who is very loud and puts the patients down" (S1 L369-370). One of the participants described how voice tone could be a trigger for aggression: "If you raise it [your voice] and then you're putting somebody down and they're already there because probably all your life you've been down" (S1 L398-400). Tone of voice included not only amplitude but also the caregiver's perceived intent.

Participants reported that some caregivers matched the aggressive tone of an aggressive client while interacting with the client. One participant described this type behavior by a caregiver ". . .because she [client] was getting louder and he [caregiver] was getting louder. And they were both getting louder and he was walking closer toward her. And he was escalating with her" (S14 L421-424). Some caregivers used their voices in an attempt to control episodes of aggression in mental health clients, as one participant verbalized: "I guess they think that coming down to their level with shouting to control them" (S1 L396-397).

Participants also reported that they had heard other caregivers using profanity when interacting with clients:

> Saying negative things. And I think then they take things personally. And take it negatively. . .the patient of course gets worse. Starts using profane language and back and forth, because I've heard [staff] use profanity too. (S1 L391-396)

The participants believed that the staff member's negative statements and profanity could trigger aggression in clients with mental illness. One participant described how a caregiver's voice could exhibit disrespect, inflexibility, and a sense of power and control over a client:

> We had a couple of people who worked there who wouldn't talk to people in a respectful manner. It's not even the words they used, but how they said it. And that's the way it is with a lot of people. It's the way you present things that really matter. It's not the words that comes out of your mouth. (S7 L334-352)

Another participant also identified that some caregivers forget that their clients are mentally ill. The participant described:

> You know. . .that they forget that they are psych patients. And umm, and I've seen a lot of people get in trouble behind that. You know. . .either being mean. . .(S11 715-719)

Forgetting that Individuals are Clients

The participants recognized that maintaining a therapeutic relationship with clients who have a mental illness can make a difference in managing aggression. Caregivers who forget that the individuals in the hospital are clients do not interact in a therapeutic manner. The relationship and the communication techniques become more social and less therapeutic. The participants clearly identified disrespectful and demeaning communications and attitudes as having the potential to trigger aggressive episodes.

Caregiver Emotion

Participants also observed a staff member's fear of the client as a potential trigger. As aggression escalated on one unit and a physical altercation became imminent, a participant thought fear in a third staff member could have generated even more aggression and commented ". . .the tech did kinda show that she was fearful" (S9 L506). One participant related her concerns about a client whose behavior escalated during the shift change:

> I had one tech, but what had happened is the evening tech walked in. Both of them was females. And I can see that one of them was pregnant. I didn't want her to be in the way. And the other, my tech was fearful. I could see she was fearful and so I had to just keep talking. (S9 L555-561)

This participant recognized that she was dealing with a complex situation. She recognized that the client was beginning to escalate into aggression, and she had two staff members who might not be able to assist because one was pregnant and the other was becoming fearful.

Caregivers are responsible for making certain that clients adhere to the unit's rules and regulations. Although clients may become upset about certain rules, as discussed earlier, staff member who displayed an overbearing, overly controlling, or demeaning attitude as part of enforcing the rules risked precipitating aggressive episodes in their clients. Twelve of the 15 participants mentioned other caregivers' authoritarian behaviors as potential triggers of aggressive episodes in clients. One participant commented:

> Some staff members try to control them like they were their children and not treat them as fellow adults. I guess staff members do have authority over the clients, but they still need to treat them with respect and dignity of an adult. (S4 L257-262)

Another participant commented: “Staff who feel like they are in charge and that patients don’t really matter. . .that they, I think have a lack of respect frequently for the patient and don’t see the patient as a person but that they see the patient as an object and treat them that way” (S9 L164-170). A different participant recognized that some caregivers had difficulty accepting mental health clients as ‘equals,’ potentially contributing to the problem: “They [staff] had a tough time going, ‘I have to treat this person as an equal because they are an equal human being.’ Okay. . .so. . .I watched that cause a lot of problems” (S1 L260-263). A different participant described her perceptions when actions of caregivers could trigger aggressive behavior: “They’re [the clients] just sensitive to anything that you might say that is derogatory” (S6 L363-364).

One participant described: “. . .meaning that you know the staff member says you need to do this. . .And the client says, ‘No, I’m not going to [be]cause I’m not doing anything wrong.’ And it’s a show of force between who will win. It’s a power play” (S8 L291-295). Two participants simply stated, “. . .Power struggle” (S9 L142) and “It was more of a power play,” (S8 L289) as they described the issue underlying a client’s aggressive episode. Another of the participants described: “It was a power situation. . .That’s the last way you want to speak to the person. That’s not going to get you the result you want. You know” (S1 L336, 346-348).

The same participant shared another event charged with tension and aggression stimulated by a caregiver’s controlling behavior. The nurse and client argued and the situation continued to escalate:

> She was, pardon my language, she is in a pissing contest with this client. And there is, you know, and I didn't know if I was gonna have to do some work with the nurse to get her calmed down to allow this client to go outside. (S1 L133-137)

Another participant identified power struggles as triggering of aggression: "It was kind of a power struggle. A different participant related an event where, "A staff member gave a patient a directive. She challenged it and he immediately engaged in a power struggle. . .with this client. . .She was escalating and it was ridiculous" (S13 L379-383). A fourth participant reported, "You know I think that power over the patient was definitely a part of what was going on with that [staff member] when she held his leg next to the side rail [causing the client discomfort]" (S4 L456-459).

Power and Control

The participants repeatedly described what they perceived to be co-workers trying to exert power over the clients and risking an aggressive episode. The words "control" and "in charge" were prevalent throughout the participants' narratives describing staff members' behaviors the participants believed contributed to client aggressive episodes. These words resonated; not only did participants see control issues as a staff characteristic, but also as issues that interfered with the interpersonal relationship between client and caregiver and posing a risk for an aggressive episode. The participants used the words "control" and "in charge" to describe an underlying issue between staff members and clients when one person, the staff member, exerted absolute authority over another, the client, without regard to basic rights. One participant voiced concern over this type of conduct:

> It's all about control. . .you know it's all about control. . .you know. . .Because they're [clients] scared. They're confined. I mean. . .somebody. . .to do treatment. (S11 L164-166)

Other participants expressed similar perceptions. The idea of the staff having control or being 'in charge' was reflected when another participant indicated:

> Staff who feel like they are in charge and that patients don't really matter. . .their needs. . .Staff that feel like they are right, that they don't have to discuss options with patients. Umm. . .that they, I think have a lack of respect frequently for the patient and don't see the patient as a person but that the they see the patient as an object and treat them that way. (S9 L164-170)

Several participants discussed other staff member who wanted or needed to be the most powerful person in the setting:

> I think it was the staff trying to prove who's in charge, from the lowest level of staff to the charge nurse. You know there are a lot of charge nurses, although they do have the authority, they are still trying to prove their authority and are verbally aggressive to the patients and the staff. (S15 L526-530)

The participant identified other caregivers who had the same mind set as the charge nurse: ". . .sometimes counselors or nurses wants to take charge. And they don't have the patience you should have" (S15 L199-201). The participant later added: ". . .sometimes the psych techs want to take over. They [psychiatric technicians] wanna be in charge. Well, they don't have any skills to do that" (S15 L486-488).

All types of caregivers were identified as having power or control issues. One participant expressed "There are a lot of aggressive nurses and a lot of aggressive staff that can prevent these things if they want to" (S6 L509-511). Another participant described the mind set as a:

> . . .kind of attitude but also kind of an agenda. I mean. . .We all bring. . .We like to think of ourselves as. . .you know. . .I'm coming to help others. . .you know. . .all this altruistic stuff. . .Well, we bring our own stuff to it. Uhh, I have worked

> with people who. . .you know they're bringing their own agenda. . .whether it's a counselor that's a big book thumper or. . .you know. . .a hard core AA guy. . .you know. . .that's there to preach the word of AA. I've worked with people who have a lot of control issues and who are bringing those to the unit. And their interactions with the client. . .what they are really acting on. . .They are not dealing with the client; they are trying to extend their own control units to those. . .or control issues to those around them on the unit. Uhh, you know, and when you have that. . .I worked in one hospital where we were doing three codes a day on the unit, three or four codes a day. (S1 L201-218)

Another participant described an incident when a client interrupted a staff member by asking a question. The staff member responded aggressively:

> I want to say she wasn't aware of her behavior; she was just stressed at the time. I'd had worked with her for a time. I think that maybe that's just how she was. That she had to be in an authoritative position or she does this on the unit. I don't know what the patients knew. She did this to the patients she was in charge and she [client] wasn't. So it was a power/control type of thing. (S12 L377-387)

Participants from each of the disciplines identified the need for power and control as an issue that influenced caregivers' actions and behaviors that consequently precipitated aggression in hospitalized mentally ill clients.

Additional characteristics of other staff that appeared to induce episodes of aggression in mental health clients were the "challenging behavior of some staff" (S2 L161) and "attitude" (S4 L231). The participants reported that staff members who "had a bad attitude" could provoke aggression:

> She must have just came to work with an attitude and took it off on the woman for some reason. Yeah, she had to, because there wasn't a reason for her to snap like that. At least I didn't see a reason anyway. (S12 L318-329)

> . . .staff member approaches the patient with the attitude. . .You're crazy you don't know what you're talking about. Doesn't take the time to at least listen to them and let them know or hear what they have to say. Because fighting with the delusional person or psychotic person, you can't get anywhere 'cause they're out of reality." (S11 L320-330)

Disrespectful Demeanor

Some of the participants described the demeanor of caregivers as conveying an attitude of disrespect that could precipitate an aggressive episode in a mental health client. One participant described an episode of aggression in a mental health client when the caregiver's tone and demeanor may have had an influence, the coworker showed "[a] lack of respect toward clients" (S5 L763). One participant provided this explanation when asked to describe what was meant by "attitude:"

> The attitude. It means that they talk down to the client. He was just talking to the client like he was a child. You know, "you need to get over there and sit down and do what I told you to do." And the client said "I don't think so, you don't tell me what to do." (S4 L231-245)

A different participant identified a staff member's punitive attitude as a potential trigger for aggression: "You can be very punitive to them. And that's generally what starts the fights and there will be staff fighting against patients. The patient always loses" (S6 L545-549). Another participant described a caregiver's response to ". . .violent behavior demonstrated by a patient the staff member reacts to it in an aggressive manner. Then to top it off to have the patient called. . .use racial slurs. . .really ignited him [caregiver]" (S10 L266-271).

The participants recognized characteristics in their colleagues that could precipitate aggressive episode in mental health clients. Staff members who were disrespectful, controlling, and intolerant towards their clients potentiated their clients' agitation and risked escalation in to a violent episode. In such episodes, as quoted earlier, "the patient always loses" (S6 L549).

The participants reported other staff characteristics that could trigger aggression. For example, one participant observed that some caregivers appeared not to be able to disengage from a client's verbal aggression and continued with the interaction: ". . .unfortunately people will not back down from a patient. They're not therapeutic at that point whatsoever" (S6 L243-245). Another participant described the following interaction between a client and a nurse: ". . .immovable object meets an irresistible force. . .so they are both at it and they keep going back and forth. . .this woman keeps escalating. . .escalating. . .escalating" (S13 L105-113).

Caregivers who become too familiar with the clients can set up a situation that could lead to aggression and violence. One participant observed:

> and then you have the male tech who wants to socialize with them, and that's a bad combination. (S1 L370-372)

> . . .the next week I come back, I hear. . .everyone gets shots [sedation] and all that. (S1 364-366)

Disliking a client was another staff characteristic the participants perceived could escalate aggression. One participant noted:

> We had a male patient one time that one of the male techs just couldn't stand. I don't know he just couldn't stand him. He would look at him and get mad. So anything this male patient would do, this staff would pick with him, just pick with him. Just really pick with him. He wanted him to do something so he could do a takedown. That was his whole thing. So he would pick with this guy. (S12 L371-399)

Participants reported that clients would tell a trusted staff member how another caregiver sometimes treated them. One participant described an incident where a client's aggression appeared to be triggered by the actions of another staff member and provided this account:

> The patient told me [participant] that the staff had been picking on him. And was messing with him. And tell him [client] that he [client] had spit on him [staff member] before and was egging him [client] on to do it again. And he [client] tried to ignore the staff member and felt like he [client] couldn't anymore and turned around and threw his [client] coffee and he attacked the staff member. And later on I found out from a couple of other staff members that the patient was telling the truth and the patient had gotten. . .Instead of them [staff members] being honest and telling what happened. . .the true story what happened. They lied on the patient. (S15 L460-471)

Appearing distress while relating this story, the participant's head repeatedly shook back and forth as if in disbelief with the staff member's behaviors.

The participants identified that lying was another staff characteristic that could trigger an episode of aggression. In addition to lying about what actually had precipitated an aggressive action, some staff members also provided clients with false information regarding their treatment. One participant gave an example of false statements made to clients to garner cooperation and defuse aggression in the milieu. However, this strategy proved to be temporary; the participant described the outcome:

> "Oh you'll be going home tomorrow. If you don't fight you can go home this day here." And they want to go home. So even though the nurses don't have that say so. . .They've been told this by a nurse or a tech. And they say if "I'll be good I can go home." See that's the whole thing. They want them to be good, be quiet, be still. . .That's true they gotta be good to go home, but that's leaving it open. But when you say "If you be good today you can go home tomorrow," then they don't get to go home. Then they are gonna act a fool. What are they gonna say. First thing they are going to say is "I wanna go home, you said I was going to go home, or Mr., Miss So-and-So said I could go home if I be good and I was good." (S12 L467-493)

One participant believed that not keeping a promise could stimulate aggression. The participant described a situation in which a physician did not visit the client. The client became upset and aggressive when the physician did not show up and did not call with an explanation:

> A lot of it also is when a physician says they are gonna see this patient at a certain time and doesn't come by. Now they are upset because they can't talk to the physician. It's Friday and they know they won't see him until Monday. Now they are angry and that will cause them to get upset at the staff. (S10 L350-357)

It is important to clients that caregivers follow through with promises. Making false statements and promises erodes the caregiver-client relationship and can trigger aggression in an agitated client.

The participants' discussion of staff members' behaviors that triggered aggressive episodes also included situations where the staff member appeared intentionally to provoke the client's aggressive response. Staff behaviors that trigger aggression were difficult for these participants to discuss. The participants appeared uncomfortable when recounting events where a caregiver triggered an aggressive episode in a mental health client: "Well, that's not a very popular thing to talk about in psych" (S8 L405-406). Nine participants voiced concern when discussing these issues and requested that taping cease. They reviewed the confidentiality portions of the consent form with the investigator and appeared relieved, their body posture changed and eye contact improved; they then indicated that the tape could be restarted and resumed their stories. The participants' comments included: "I don't want to get anyone in trouble" and "I don't want to lose my job."

The following participants' stories reflect incidents where other staff members' behaviors had provoked client aggression:

> He [staff member] wanted him to do something so he could do a takedown. That was his whole thing. So he would pick with this guy and one day he [client] was sitting down . . . eating lunch and he had ask me if he could have another tray. And the tech I was working with already knew he had one tray but he didn't ask me if I had told him he could have another tray. I mean this is a grown man, that

> little food they give you wouldn't do nothing. So he went up there to get that other tray and he [staff member] took it out of his [client] hands and he [staff member] just swung it. And when the patient went to hit him. . .of course he [client] went to hit him he [staff member] took his food out of his hands. So when the patient went to hit him he did a takedown. And he was yelling he was trying to take these trays and da da da da and all that craziness. I said I told him he could have another tray. It wasn't for nobody. I didn't figure it would be no harm in him taking another tray. We were going throw it away anyway. But that was his reason just to do a take down on that man. (S12 L376-399)

> And the nurse would do things like come in with a syringe in one hand and a thing with pills in the other. . .and they taught them to do this at times. . .is offer them a choice right. . ."You can have the syringe or the pills, which is it going to be?" . . .and about that tone of voice (a stern voice tone was used as an illustration). Well you know the minute she says that…you're dealing with adolescents and . . .you know. . .the adolescents will look at her and go "It's gonna be neither ma'am. Up yours and the horse you rode in on." You know. . .and when we start taking a look at something like that. . .you know. . .and that was what caused it. (S1 L220-249)

The same participant added: "You know every time she did that, you know it set the patients off . . .I watched her do it. That's the last way you want to speak to the person" (S1 L337-345).

> I've seen him [staff member] be aggressive. . .At one point, there was another patient, kind of feeble male patient, and he was making a lot of noise. . .loud noises. Pretty much acting like a two-year-old. And he [staff member] just wanted him to stop and instead of going around the nurse's station, there is a little nurse's station window. He [the staff member] jumped through the window. As if to intimidate him, to let him know, that no matter where you are I can get to you very quickly. And so the patient was startled, but then he continued to make louder noises. At which time he [staff member] came from behind and picked him [client] up and carried him to another area of the unit. (S10 L281-298)

Unfortunately, these participants perceived that some healthcare workers did not respond therapeutically to their clients. Rather, the participants saw the healthcare worker's behaviors as being most non-therapeutic and provocative. According to the participants' descriptions, such behaviors directly triggered or escalated client aggression.

Team Work

The participants also observed that aggression could surface when the caregivers had difficulty working as a team. One participant viewed the danger of flawed teamwork as:

> . . .the biggest problem that I can see in working in the psych business with everybody not working on the same page, following getting together and working as a team and not showing favoritism or anything. Treating everybody the same across the board and let's all decide on what we are gonna do and stick to it. (S7 187-194)

The same participant later verbalized: "I have to say that because I. . .as part of a team. . .I feel like I have to trust and believe in the entire team's mission and theories of care" (S8 L407-409). A second participant noted ". . .and staff splitting and people not being on the same page causes those kind of problems" (S7 L164-167). Another participant complained that when caregivers did not function well as a team while managing a physically aggressive client, aggression could escalate. The participant recalled one episode: "I didn't think it was being handled appropriately because none of the staff wasn't working as a team" (S6 L480-483). Teamwork has always been critical in providing care to all clients. The participants knew that if all staff members were not consistent and worked as a team when providing care for clients, they risked inciting client aggressive episodes. A cohesive team has the potential to neutralize an aggressive event, while a lack of teamwork has the potential to trigger or escalate aggression. The safety of everyone in the vicinity is jeopardized when staff members cannot work together to subdue or de-escalate an agitated client.

Participants were aware that certain staff member characteristics could trigger aggression in mental health clients. Some conditions were under the staff member's control and some were not. The participants identified the importance of the staff member's self-awareness regarding those aspects that could be perceived as threatening by their clients. The participants identified behaviors of other staff members that clearly were a matter of choice and potentially inflammatory to an agitated client.

Mental Health Unit Characteristics

Participants identified two characteristics of the unit that could trigger aggression. These were the milieu itself and staffing issues.

Milieu Management

Milieu management in mental health facility includes monitoring for stimuli that have the potential to escalate aggressive behaviors in clients. Loud noises, for example, can agitate clients and escalate behaviors. A participant reported ". . . upbeat modern music. . .seems to increase the anxiety" (S1 L305-307) on the unit. The participants also identified television programs as a trigger for aggression. A client watching a reality show on addiction became agitated. The participant, who witnessed the event, noted: "I think that was going on too last night. A girl who was totally craving [drugs]. . .while she was watching the show *Intervention.* She was demanding Xanax, Clonapine, Camprel. . .or Ativan immediately" (S8 L319-323). One client's aggression can become contagious, influencing other clients to become aggressive. A participant commented that when aggression occurs in the milieu other clients, ". . .notice[ed] that something was going

down" (S11 L111-113). Caregivers should continuously monitor the environment for noises, distractions, and disruptions that can trigger aggression. Anxiety, agitation, and aggression are contagious and can affect other individuals in the milieu.

Staffing Issues

The number of staff members assigned to provide care to hospitalized individuals with a mental illness is an important aspect of the mental health unit. Participants from all but one of the facilities perceived that the number of staff was inadequate to care safely for their acutely mentally ill clients. One participant commented, "Bad situation" when answering a question about staffing in the hospital, saying:

> One RN, one LVN, and a couple of psych techs to possibly 20 patients, which is. . .Acute patients. . .very acute. A lot of them on suicide precautions. . .a lot of them on 15 minute checks. . .So it is really a bad situation. (S6 L259-264)

Participants identified the client-staff ratios from memory and were not verified for accuracy. The impact of inadequate staffing creates an environment where aggression could occur. Another participant described the experience of working on a poorly staffed unit:

> It was me, the supervisor and the charge nurse . . .and 20 patients. I have to say it was a very dangerous situation. I have to say that. . .It could have been. . .you know. . .through the Grace of God. . .staffing has gotten better since. . .there are now two staff. On those times. . .through the Grace of God nothing seriously every happened. (S5 L201-213)

Other participants described similar situations. One participant noted: "Hopefully, no one else will follow behind that person [aggressive client]. . .and follow their lead as to acting up because there wasn't no staff" (S15 L276-278). A third participant described similar conditions: "On that day. . .that wasn't very good staffing. That was probably, one RN,

one LVN and three techs. . .to 12—13 patients and. . .that doesn't sound like very many patients, but when they are all acute and anything can happen" (S6 L208-214).

One participant described the assignment for the day was to care for an aggressive client on 1-to-1 monitoring and how the staffing numbers affected the assignment:

> Aw man, usually it would be two techs on the floor and me and this girl on this 1-to-1. No, and umm it was so bad with her and I had to take her in the day room where they had a lot of stuff she could get a hold of. When one of the other techs would leave and bring the other kids to school, and one of them had to stay down there in the school, I would have to bring her in the day room with the other tech to watch the other girls. So that was a mess. They were making me do double duty. (S12 L94-105)

Caring for potentially dangerous clients is demanding work that requires constant monitoring. Inadequate staffing of a unit has the potential to become unsafe especially in situations requiring the caregivers to provide 1-to-1 monitoring for a specific client, as well as provide care to other clients on the unit.

Participants perceived that staffing was inadequate in most cases when there had been an aggressive episode. Caregivers must subdue the client to maintain the safety of everyone in the vicinity when a client's aggression erupts into violence. Controlling a violent client can require many caregivers, decreasing the number of caregivers available to manage other clients so they too will not become aggressive.

The number of staff members scheduled to work on an acute care unit is important. So, too, is the gender of the staff member. One participant described the following experience of having only female staff member on a unit with an aggressive client: "But I recall that was a very dangerous situation there, because. . .there was no

other tech on the unit, when actually we need a male tech there. We don't have no male tech, just female techs" (S9 L731-734).

A participant believed that the staffing numbers on her unit were adequate. However, she also identified that frequently the staffing consisted of a combination of staff members employed by the hospital and by different staffing or PRN agencies.

> And our unit is particularly one of that has the highest PRN use. . .and on the weekends. . .every other weekend, I have to be charge nurse and. . .I. . .will work with me as regular staff and maybe one of the shifts on Sunday a regular staff and the rest are PRNs. That is. . .you really have to know what you're doing and who you're working with and their strengths. And. . .yeah. . .so definitely staffing plays a major role in what goes on the unit." (S8 L251-259)

In summary, recognizing impending aggression included more than objective assessment of the client. The caregivers also used their own intuition, as well as knowledge about the client's history, disease process, and client behaviors to help them recognize impending aggression. Participants were aware of other factors, such as staff characteristics, the impact of milieu management, staffing issues, and hospital communication, which could become triggers of aggressive episodes in mental health clients. Participants often identified that many of these factors could occur simultaneously, intensifying the risk of aggressive episodes among their mental health clients. Participants in the study considered every client a human being deserving individual respect. Treating clients with respect and understanding creates a healing environment and complies with the basic rights for mental health clients as outlined in the Federal Register (2006).

CATEGORY II: MANAGING AGGRESSION

The participants' narratives emphasized the importance of identifying the potential for or the escalation of aggression in their mental health clients. However, the participants went on to describe situations where they had been called upon to intervene when a client became aggressive. Managing aggression, the second category, arose from of the participants' descriptions of the interventions utilized to defuse or de-escalate aggression among mental health clients. The participants managed aggression in mental health clients using strategies that defused or de-escalated client behaviors. Such strategies included verbal and nonverbal communication techniques, rapport-building, and milieu management.

Communication Strategies

Communication skills are the essence of providing quality care to the mentally ill. The participants identified communication techniques as crucial strategies for managing aggression among their clients. Participants further described how talking and listening to clients defused or de-escalated the aggressive episodes.

Talking

The participants recognized that merely talking in a calm and soothing manner could defuse an agitated client: ". . .there are situations where you can actually talk people down from being aggressive. . ." (S13 L545-546). In another situation the participant described how simply talking was used successfully as an intervention with an agitated client, ". . .and I went to her and just started talking quietly to her and she sat on

the floor. She was still crying and screaming. I even sat down with her and faced her" (S10 L104-110). Still another participant reported: "I kept talking to her, talking to her. . .[be]cause I'm trying to keep her calmed down. . ." (S11 L526-528). The participants used calm verbal strategies to contain and defuse a potentially volatile situation, thus support a more appropriate response in an aggressive client. .

Participants indicated that other verbal characteristics were important when talking to an aggressive client. Soft subtle vocal tones were identified as most effective in defusing aggression: "It works much better if you use low tones and ask them if they can use a tone the same as yours or lower. And sometimes that shocks them into hearing you" (S10 L410-413). Another participant used a different technique, choosing to use the same words as the client who was escalating because she wanted to smoke. This participant described how, as the client switched topics, the participant switched as well: "I want to keep talking about smoking but she's still talking about the doctor. She changed on me. So I say "Okay. You will see a doctor. I can't tell you what time you're gonna see a doctor" (S11 L517-521). The participant's vocal tone became softer and lower and reflected a great deal of intensity as though she were talking to the client during the description of the incident.

Participants also provided information to aggressive clients as a way of defusing aggression. Several described how they explained or they provided information to aggressive clients to help them regain self-control. For example, one participant described a situation when an aggressive client wanted to leave the hospital and began escalating: ". . .[I] sat down and talked with him. . .and tried to explain to him that he

couldn't go, that the doctor would be the one to discharge him or the court" (S10 L68-71). Another regularly cared for agitated and potentially aggressive clients who had been brought to the hospital by law enforcement personnel:

> You explain the situation, what's going on, because a lot of times when that happens it's that person's first psychiatric experience, so that person isn't used to being on a locked unit and not being able to do what they want to do. . . Smoke when he wants and all of that. If you would take the time to explain to them they will usually respond a little more, instead of saying: "No you can't do it." That will usually work and calm them down some. And they'll say "thank you". . . Just give them a sense of comfort. So it's not all brand new and everything is like up in the air. And they're not taken by surprise. The fact that they were brought in by the constables, that was surprise enough. They feel violated. (S1 L425-547)

The participants in this study considered verbal communication as one of the first management techniques caregivers employed to de-escalate aggression in clients with mental illness. Caregivers who skillfully employed talking as a technique with aggressive clients were able to successfully calm and defuse a potentially dangerous situation.

Listening

Participants identified listening as another basic technique for managing aggression in mental health clients. One participant simply stated, "Listening to them is very important" (S6 L383-386). Another participant who successfully calmed an aggressive client described the event: ". . .she felt I was listening to her and trying to give her positive feedback" (S7 L113-114). Listening was not simply hearing the client's words, but a complex interaction that included understanding, interpreting, and appropriate feedback. One participant described the process of listening to a client who

was becoming aggressive, along with an observation that such techniques might not be effective in every situation:

> 1-to-1 intervention, where you will allow the patient to vent his feelings. And. . .listen intently and show you understand when there is. . .it is understandable. . .and allow the patient to talk until the patient is completed and then you can give your feedback about what you saw and umm. . .suggest to the patient: "Don't you think this would have been a better way to deal with it. . .what do you think about that?" You know just throw it back. . .throw back the question. And usually that will help. . .you know de-escalate them. . .sometimes. Other times they throw you out of the room. (S7 L271-282)

Another participant successfully used listening to calm a client who was escalating toward aggression:

> I walked over and just said "Can I sit down and talk to you for a second?" And I sat down and let her go through what was going on with her. . .let her say. . .you know. . .the nurse is being this and that. . .never disagreed with a word that she said. (S13 L105-118)

This participant talked, but also listened and was attentive to the client's needs. Using the combination of techniques had an additive effect helping the client become calmer.

One participant described an intervention with a client who was aggressively demanding a change in medication. The participant emphasized the importance that clients ". . . communicate their needs. . .And that you're [the caregiver] hearing them. . .And understanding . . .And that you are going to work on that. And that you're hearing what they're saying and what their needs are" (S9 L419-423). The intervention was successful and the client's agitation was defused; the client was able to wait calmly for the medication he needed.

Another participant emphasized attentive listening, ". . .you need to stop and listen and give your 100 % attention to them [to defuse an agitated client]" (S5 289-290). One participant described using attentive listening to defuse an aggressive client:

> And so he was far from me about 15 feet away, so that I wouldn't intimidate him. And so I said "I'm just gonna lean back here against the wall I'm gonna slide down real easy. Why don't you just go ahead and do the same and we're just gonna talk about what's going on. Just tell me what happening." He did the same. He slid down, got on the floor and started talking a little bit. (S6 L85-90)

The participants talked about the many facets of communication used when managing client aggression. Communication included both verbal and non-verbal features. Words and tone were important, but non-verbal behaviors were equally important when defusing aggression.

The participants also were alert to the dynamics of personal and psychological space when interacting with their clients. Care was taken to manage aggression by maintaining spatial boundaries between clients and caregivers. One participant described a progression of talking and listening techniques as well as space to defuse a client:

> We tried to talk him down first to de-escalate the behavior. And the nurse also tried to comply with him, what his demands were which were to back off. We all backed off. (S6 L63-69)

The client was continually monitored for any further warning signs of intensifying aggression. The client eventually quieted.

The participants also cited non-verbal communication as an effective strategy to defuse and manage aggression. Many described their approach to an aggressive client attempting to defuse the situation. One participant described the approach:

> You deal with aggression. . .it's verbal. . .it's the way you walk up to a person. . .it's the way you give them eye contact. . .if a person knows you're scared they're

> gonna be more aggressive and try to intimidate you. You got to go there calmly, firm but fair. . .and that's it. (S3 L127-135)

Good communication skills were identified as an essential aspect of managing aggression in clients with mental illness. The narratives of the participants repeatedly demonstrated the utilization of communication skills, particularly talking and listening, as well as their physical being in space.

Building a Relationship

The participants identified the importance of relationships with mental health clients in defusing or de-escalating aggression. They emphasized the importance of the clients perceiving caregivers as trustworthy, someone with whom the client could develop rapport, and one who would treat the client with respect. Building the relationship between caregiver and client was perceived to be based on the interplay among trust, rapport, and respect.

Trust

Trust was perceived by the participants as the basic of these elements. The participants described trust as an essential element of their relationship with their clients. The participants believed their clients could trust them when the clients had the sense that the caregiver was available to work in his or her best interests. One participant described the importance of trust when discussing a situation with a client who was: ". . .paranoid, real paranoid" and becoming aggressive. The participant perceived the intervention was successful because "I got him to calm down because he trusted me. I was one of the first people he met. I was always nice to him and stuff. So I . . . got him to calm down" (S12

L158-159). The same client decompensated while away from the unit. The participant relied on trust to defuse the situation:

> I said "Don't you trust me, are we friends? Are we friends?" He said "Yes, I trust you." I said "You got to get from under the table, with all these people around here." He said "they want to get me." He kept saying that over and over and over again. I said "I promise I won't let them touch you, just calm down. First you gotta give me the knife." He said "You sure? Promise you won't let them touch me." I said "Look at me. Have I ever lied to you since you've been here?" He said "No." I said "I keep my word." (S2 167-179)

The frightened aggressive client handed the participant the knife and was taken back to the unit without further incidence. The same participant discussed trust as a foundation for building a relationship with a client:

> If you have an aggressive patient, it is trust. It is trust because they want to know that they can trust you. . .If you talk to them in a calm voice and don't be lying to them and passing them off on the next person and just talking crazy to them. (S2 462-467)

One participant emphasized trust as an early intervention strategy for clients whose aggression was expressed as self-mutilation. The participant described the importance of having ". . .staff members on each shift that they can interface with that they trust and feel comfortable with" (S4 L587-591). The participant believed establishing trust was central in the plan of care as a way of breaking the client's self-mutilation cycle. Establishing trust was essential in the participants' relationships with their clients. Caregivers who were able to establish trust with clients could develop an interpersonal relationship and use that relationship to defuse aggression.

Rapport

The participants' descriptions identified rapport with their clients as another important aspect in the management of aggression. One participant used rapport with the client as a way of being able to meet the client's needs and manage his aggression:

> The same patient, admitted again several days later after he was discharged. Again same behavior [aggressive], but this time he was in the hallway, and so by this time I had a rapport with him from the last visit and so I asked him to go ahead and sit down. [I said] "I'm sitting down with you." (S6 L75-85)

While describing the event, the participant said, "I felt confidence that it was working that he was responding to the rapport that I had established with him" (S6 L105-107).

Another participant used the term "partnering" to describe the same concept. The participant described partnering as a ". . .calmness, individualized attention, non-threatening behavior toward the patient . . .Trying to partner with the patient and trying to meet [their] needs to best of your ability" (S14 L175-179).

Every participant had a story of how they rapport had been used to de-escalate or defuse aggression. Rapport had to be quickly established when a newly-admitted or unfamiliar client became aggressive. One of the participants described one techniques used quickly to establish rapport with a new client who was becoming aggressive. The participant recognized similarities in their backgrounds and used those similarities to develop a connection with the client:

> That the client was from [area]. . .and I'm from [the same area] and stuff. . .so it really helped that out a lot that I knew. . .the patient. . .you know. . .kinda relate to the patient a little bit better. Everybody else couldn't relate to the patient but I could have. . . [be]cause what the patient was real aggressive and wasn't listening. . .you don't know I was a [natural disaster] victim and all this stuff. And I knew right away I started to talk to the patient. "I'm like okay where are you from? . . .I'm from [area]. . ." "Oh! Yea what you say" . . .it was a female patient. . .you

> know a female patient I remember. "I went to [school]".. . .she says "Oh I went to [that school]. . ." . . .So we right there. . .she had a connection. . .like okay wait a minute. . .he's safe. . .she looked at me as safe. . .but she found me as a safe person to talk to. So it was. . .I used that to. . .My experience and my geographic location from where I was born to my. . .for my advantage. . .to basically de-escalate the situation. (S3 L321-348)

The participant created a bond by sharing some personal information with the client. The caregiver verbalized shared experiences, then personalized the situation enabling the client to identify similarities and establish a viable bond that could serve as a foundation for a therapeutic relationship.

Respect

A respectful attitude was identified as another essential aspect of building the relationship with the client, enabling the caregiver to better manage or de-escalate aggression. One of the participants explained ". . .you need to give them an option and respect. I give them respect like the adults they are" (S5 L274-280). Another participant also defused aggression by displaying a respectful attitude toward the client:

> If you treat that person with respect and the way you want to be treated and try to find the root of what's going on before you just rush in and put your hands on somebody. And try to talk to them and see what's going on. [Be]cause sometimes they will answer and you don't have. . .sometimes they just need someone to listen. . .just to hear me. And that will make them feel a lot better. (S12 L551-559)

The participant believed that demonstrating respect for the client was crucial in managing and preventing escalation of aggression in the mental health client. Another participant approached the client with ". . . [an]attitude of respect towards him even though he was aggressive towards me in the beginning. I think that made a big difference" (S6 L111-114). A third participant discussed the role of respect in the management of a group of

aggressive adolescents: “We were dealing with a lot of gang kids. And they [staff] just really weren’t prepared for those kids. If you came back with respect toward them they would be okay” (S9 L252-255). The participant used a reflective voice tone when describing this group of clients. Even though the participant was describing clients who were rebelling against the rules, respect featured prominently in managing the aggressive event:

> And they should be approached with respect and dignity no matter what they do. Even when they are dangerous and then yes we need to have them transferred to acute facility. . .And based on. . .since I have worked on all the different units. . .based on their age I think there is a way to approach that also. (S4 L539-547)

Another participant gave a similar explanation:

> If you, but if you treat people like you would want to be treated then you shouldn’t need to be protected. I’ve heard that word a lot, “protected.” If you treat them like you want to be treated, you shouldn’t need a reason for protecting. (S2 L449-452)

One of the participants used the term, “customer service,” to convey an attitude of respect toward clients:

> . . .when you think of customer service you think of like pizza places, restaurants, hotel stays. . .customer service is everything. Customer service is golden. And my thing is. . .I believe. . .you have to be polite and nice to people. (S3 L408-412)

Participants identified establishing a therapeutic relationship between caregiver and client as an important element in managing an aggressive episode in a client with mental illness. Many of the participants believed that building a therapeutic relationship began with establishing a trusting bond between caregiver and client. Interventions that participants perceived as successful in building the therapeutic relationship included caregivers who generated an attitude of respect towards their clients. Participants viewed

respect and dignity as a basic human right and essential in providing care for a client with a mental illness.

Milieu Management

The participants identified how they managed aggression by controlling the environment around the aggressive client by maneuvering people and objects in the environment. They also recognized the importance of other staff members being available to assist in managing client aggression. The participants reported how they or other staff members managed client aggression by isolating the aggressive client, moving other clients away from the aggressive client and, as a last resort, "coding." The participants also used these strategies to help the client learn responses that were more appropriate.

Isolating the Client

Isolating an aggressive client is an accepted management practice in mental health and is not the same as secluding that individual. A participant described a situation when a client's behavior in a common area of the unit began escalating into aggression. The staff ". . .isolate[d] that patient away from the rest of the other patients. So we let him have his temper tantrum and get it out of his system so it doesn't affect the rest of the group" (S5 L218-222). The participant recognized that the aggression was contagious and could result in more clients escalating. Moving the aggressive client also helped lower the tension level in the environment thus protecting other clients.

Offering Choices

The participants offered clients who were acting out choices of where they could be alone while they were working out their anger and frustration. For example, one participant described how offering choices to a client who was threatening to injure herself:

> "You know it's okay if you sit there. And it's okay if you don't like this. You can go to your room if you want. That's just really just okay. Umm, but if you start to hurt yourself, you know. . . we're just gonna have to get some help." And I said "I really don't want you to hurt yourself." Well then. . .he got. . .he was okay for a few minutes. (S8 L342-350)

All acute care mental health hospitals have a variety of options available to clients who are agitated, angry, or frustrated. One technique participants described was that of moving an aggressive client to a quieter area to provide the client time to calm down. The participant limited access to an area with the intent to "Seclude the area so it was just her and I" (S15 L118). Each mental health unit has a seclusion room that can be used as a quiet room, or the agitated client can go to his or her assigned room. Isolating the client did not mean leaving a client alone: "[I] had quiet time in there with her and nobody was yelling. . .the unit was calmer at that time" (S10 L123-125). Those participants who moved clients to a quieter area did so to control aggression and used the time to talk with the client.

In addition, all of the participants' hospitals provided a space where clients could engage in some type of physical exercise to defuse their aggression. One participant described how the hospital's facilities were made available to an aggressive client:

> What we do is offer them the quiet room of their own volition. . .to be able to go in there bring their own. . .to be able to go in there bring their own iPOD. . .hang-

> out. . .kick a ball. We really don't use the quiet room for anything else. We have never really used it. So that worked out. . .all the primary clinician and all staff had worked out a deal with him. That if he needed to be removed from the. . .he needed to remove himself. . .he had the choice of the quiet room. . .he was given trail privileges so he could run. . .because he is so hyperactive all the time. . .until the meds started working. (S8 L 173-185)

The client was encouraged to make appropriate choices when he felt he was becoming agitated and aggressive and learn responses that were more appropriate than acting out. Another participant described a similar strategy: ". . .we tried to basically have him walk away from the other patients" (S6 L39-41).

Participants provided opportunities for clients to learn to manage their own feelings of frustration and aggression in more socially acceptable ways. One participant described the importance of defusing an aggressive client without physical force and promoting the client's self-management, ". . .it is so degrading to have to physically pick up the patient. . .It [a code] took away a lot of their [client] power. And try to let her really keep the power that she has" (S5 L109-112).

Structured Environment

Structure and rules are important in the acute care mental health environment. Nonetheless, promoting independence and helping clients find ways to gain control over their environment is part of providing care for individuals with mental illness. One participant identified the importance of helping the clients focus on what they could control rather than what they could not: "If we can show them what they have control over. . .because I think that's what they are fighting [struggling] for" (S14 L508-553).

Allowing clients to control their care as much as possible may help to defuse some of the aggression.

Other clients were moved out of an area when it was not possible to move an aggressive client. One participant described an incident with a client who was escalating but would not move to another area: "I knew . . .I had to try and move the rest of the group out" (S8 L357-361). Another participant, whose aggressive client would not move to a quieter area, ". . . had all the other boys go to their rooms. [One client responded] 'Well, I don't want to go.' I said 'I know you don't but we would really appreciate it. Sometimes everybody just has a bad day' " (S7 L285-289). Other clients were not exposed when a client became violent; distracting stimuli and the effects of aggression were minimized by moving other clients out of the area. Another participant would ". . .ask the tech to take them [the clients] out[side]. . .especially the 3-11 shift. . .and where they can play some basketball or play some music or subdued music" (S7 L289-290).

Acute care mental health units have a designated room available to manage threatening or dangerous client behaviors. These rooms, referred to as the quiet room or the seclusion room, provide a minimally stimulating environment to help the client regain control. Agitated clients are given the opportunity to be escorted to the quiet room willingly. If the client resists, staff are required to use more forceful strategies to control the client's aggression: ". . .we had taken her into our quiet room" (S9 L122-123). One participant described how the quiet room was used to control client aggression:

> We take them forcefully to a quiet room. Umm. . .It's not forcefully as far as hurting anybody. It's forcefully in as far as …so they won't hurt themselves. Okay, let's see, in the quiet room sitting there, with the door shut and a nurse at their side. . .every. . .What it's called a 1-to-1. (S12 L111-114)

Several participants described using the seclusion room to manage an aggressive client ". . .[the client's behavior] escalated. . .where it was required to put that patient in seclusion" (S8 L156-157). Seclusion occurred when the client was placed in a room with the door shut and/or a caregiver blocked egress. A participant described placing a client in seclusion:

> I knew it was going to end up we were going to having to seclude him. Meaning I was going to have sit there and watch him in the bubble room and he was going to do a lot of unnecessary stuff and that he still wasn't going to get out. (S13 L86-92)

Caregivers use a behavioral "code" or "take down" to manage clients who become combative and are uncontrollable by less restrictive strategies. Participants refer to this procedure using words such as, "He had to be taken down" (S2 L173). Behavioral codes include physical force that limits the client's movements. The use of such force is a "restraint." Restraining the aggressive client can involve either personal or mechanical restraints. Personal restraint involves the client being physically restrained by another person's hands or body; mechanical restraint involves the use of leather cuffs and belts to restrict the client's movements. Restraints can be applied to all four extremities and is referred to as a four-point restraint. All of the study participants had participated in episodes of client aggression that required a behavioral code to manage them:

> ". . . [the staff] had to intervene again, and bring in a mattress and put him down in restraints in the quiet room." (S12 L193-195)

> So we had to call a code. . .Which is to get some more help. . .so a lot of guys come down there. And then he was on. . .they had to put him down on the floor in four point restraint. And so one of the guys talked, talked. . .we talked to him I had to give him some medication. (S14 L131-136)

> There are times that we do interventions…and the talking doesn't work. . .and we have what's called. . .it's not a take. . .I hate to call it a takedown method, but that's basically what it is. It's to not to injure them but to hold them until we can get them on their bed…on their back. . .and with the straps on their ankles and wrist. (S12 L147-154)

Participants in this study described strategies for managing episodes of aggression in mental health clients. The participants' management strategies ranged from promoting options where the client could self-manage and control aggressive impulses through "coding" or forcibly isolating, subduing, and restraining aggressive clients.

Three participants described situations when managing aggression could have escalated further because of staffing inadequacies. One participant reported monitoring a client for an aggressive episode and realized the only psychiatric care technician (PCT) scheduled to work with her was not on the unit as the client's aggression began to escalate:

> That day he [client] hit that tech in the eye. . .I didn't have a tech. . .my tech was gone somewhere. I don't know where the tech was. So I had . . .a young lady sitting at the desk. Who use to be a unit clerk but now she was doing other things for the hospital. (S9 L253-257)

She asked the former unit clerk to call another unit for staffing support. However, by the time a PCT arrived from another unit the client was highly aggressive and inflicted an injury to the caregiver. The same participant described another situation in which she was alone with a client who began acting out and went into an area where dangerous equipment was stored. Although two other staff members were scheduled on the unit, they were off the unit with other clients. In one incident, the participant describes a feeling of abandonment when a client was experiencing a rapidly developing aggressive episode. The participant could not leave the client to call for assistance because of the

client's increasing aggression and safety concerns. The participant described feelings of relief when assistance arrives:

> "I'm by myself." (S9 L692-693) . . . the doctor was coming to see another patient. The doctor showed up. The doctor and 2 of our aides came. I said Oh. . .Thank God they are here. They're here. So that way I hurried up and called the code." (S9 L718-722)

The arrival of other caregiver gave the participant time to call other staff members for help to manage the client. Had the physician and other caregivers not arrived, it may have been impossible for the participant to manage the aggression. The participant also could have been injured.

One participant reported that when a client repeatedly shoved him and a code was called the other caregivers disappeared from the area instead of responding. The participant described his feelings when he realizing that no other staff members were available to manage the escalating aggression:

> . . .being extremely vulnerable with this kid on the floor. Because I was on the floor holding somebody completely vulnerable, if they [the clients standing around] didn't like me I would have been completely dead meat on the floor. . .They [the other staff members] were all behind the nurse's station. (S13 L278-298)

Another participant reported a similar experience when a staff member was not paying attention when she called for help: "Getting physically. . . I'm saying let me call for some back up. So I did. My tech still wasn't paying attention much" (S9 L500-502). A second participant had experienced a similar situation:

> The part that was kinda scary was I am facing off against this kid going. . .this kid could go off and I have no back up here. Okay I am vulnerable. . .I am halfway through a door. . .I'm vulnerable. . .I have no back up. . .it's gonna be him and me(S7 L40-45)

Participants found themselves in vulnerable positions when other staff members were not available or unwilling to assist in managing aggressive clients.

State and federal laws (Department of Health and Human Services, 2006; Texas Department of State Health Services, 2004) require that only staff members who are trained to monitor the client's physiologic status manage behavioral codes and restraint application; in acute care mental health facilities, this is the responsibility of the registered nurse. Sometimes this does not happen, as one participant reported. The participant recalled that upon arriving in the admissions area where the RN had called the code, he found:

> . . .quite a few people in intake but when they [RNs] call a code they [RNs] all disappear. In fact, last time. . .I went to one. . .it's like. . .you know. . .what do you need? If you're standing around. . .it would be real helpful. . .what do you need? Because once they [RNs] call the code, they [RNs] are not involved in the code. They tell you what the problem is. . .but. . .I told somebody, "You need someone to direct us." But they call it, then they go in their offices. All she [RN] did was point to him and said . . ."He won't go, he refuses to go up to the unit." And then she walked back into her office. She didn't say talk to him. . .She didn't say or do anything. (S14 L250-270)

The nurse did not fulfill the statutory responsibility related to managing an unruly client. As a result, an unqualified person had to step forward to manage the client's aggression and prevent further escalation or harm to the client or others.

One participant had found himself in a dangerous situation and another staff member did nothing to assist him:

> I got chased by a kid with a pool cue one time. . .as I am running away I ran past one staff member. And her solution to the problem was she [staff member] moved out of the way. And the kid keeps coming by with the pool stick and she just keeps leaning back. Lets it go by. (S7 L301-309)

Fortunately, the participant was not injured. However, the unwillingness of his colleague to help him was a chilling experience.

A participant described the following dilemma when a nurse did not want to take an aggressive client brought from a less-secure unit. The client had already assaulted the only male caregiver in the hospital. The nurse appeared unsure how to manage a combative client. The participant was neither credentialed nor legally qualified to make such decisions; nevertheless, the participant was forced to make the decision and take actions that were the RN's responsibility. The participant described the situation:

> We brought him to unit one and I had a nurse who. . .[said] "Well why do you want to put him here?" [the nurse refused the aggressive client being brought to the unit]. . .I say "No"…It caused me to basically take charge. Basically, like "Look we better put him in the quiet room." I gotta make legitimate decisions…I'm gonna make an executive decision. I am gonna take over the unit per se to make a decision… "No (name of staff member) listen to me". . .sorry to use the words. . ."You listen to me I am gonna put this patient on the other PICU." (S5 L245-260)

Managing aggression requires structuring the environment when client behaviors are escalating and becoming aggressive. Staff members must be present on the unit and attentive when client aggression begins; as well as willing to fulfill their responsibilities.

The participants recognized that more experienced staff members could manage aggression more effectively. One participant cited experience as a factor and related that a nursing supervisor seeing an event develop, took charge of the event, making critical decisions needed to defuse a client's aggression:

> [The nurse was a] very, very, very good nursing supervisor. Who's no longer there, but who was very. . .who has been in the field for. . .experience is golden in a psych field. You got to have experience. And I have been in the psych field for awhile so I knew how to handle myself. She also knew how to handle it. (S3 L179-184)

The participant identified the importance of experience in effectively managing aggression.

Another participant thought that most PCTs did not have sufficient experience, education, or training to manage aggressive clients, ". . .a psych tech, which doesn't have a whole lot of training. There is no college experience for psych tech" (S6 L235-237).

Two participants reported aspects of milieu management that could not be categorized. These aspects of milieu management will be reported because they reflect important management strategies. One participant believed that choice of music could affect the incidence of aggression on the unit: "That's what I have noticed. When you play all this modern music. . .you know a lot of drums and stuff they [clients] escalate [become agitated]" (S7 L289-291).

On this unit, music that was played in the common area served as a management strategy in a milieu arranged to be quiet and soothing.

The second participant described how the staff had effectively defused escalating aggression over the course of the evening when the client population was becoming bored and acting out. Initially the staff member responded by:

> . . .organizing games that night too. . .a full staff was out on the floor, rather than in the Nursing station. . .pulling out games and. . .we were playing Pictionary, charades and checkers. . .I mean everybody had a Friday night feel. . .that we were out there and we need to be visible and entertaining, [be]cause it's kind of boring on a Friday night, there's no activity. (S4 L121-139)

The clients continued escalating throughout the evening and into the shift change. The staff members used other strategies to contain the aggression including increasing the number of staff to manage the milieu and maintain stability. Staff members volunteered

to ". . .hang around and make sure that the people stayed safe" (S4 L44-46). The participant and the other staff members were, ". . .more. . .vigilant. . .now the 11-to-7 staff was in. . .who was thinking we were going to walk out. . .There was no way we were gonna walk out. I have stayed whole other shifts when things like this happen" (S4 705-711). The client population continued to escalate ". . .and 3 hours later the front doors had not been unlocked. . .they [clients] have not been allowed to go out. Everyone. . .had been called in" (S4 L30-31). The staff managed the milieu by providing activities and calling extra personnel; this combination of interventions kept the incident from escalating into a physically violent altercation. Ultimately, the clients became calmer and the incident was defused without physical confrontation. The key to successful resolution of the episode was adequately trained staff members working together.

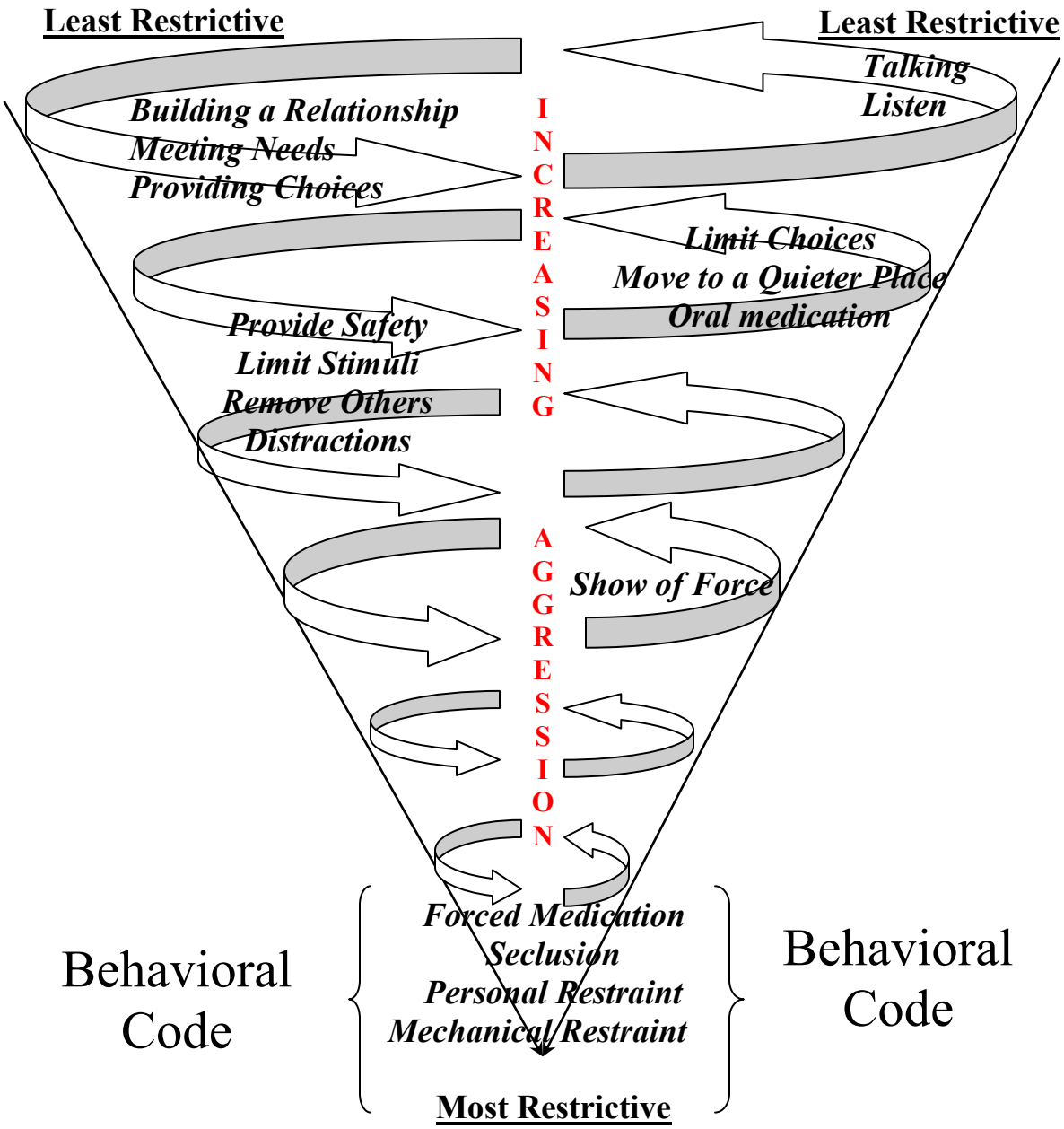
In summary, the participants believed managing aggression involves personal and professional skills in communication, relationships, and managing the milieu. The caregivers described the importance of trust, building a relationship, and respect in managing an aggressive client. De-escalation strategies began with techniques that allowed the client to respond and calm down without physical interventions, techniques based on the caregiver talking and listening to the client in order to meet specific needs. Implementing techniques to de-escalate aggression in mental health clients began with strategies that provided the client with maximal personal freedom while maintaining safety of the client and others. Participants selected management strategies based on the client's ability to collaborate in the process. Clients whose aggression could not be de-escalated through verbal interventions had to be managed using more physically

restrictive strategies. Mental health caregivers not only must be experienced in managing aggressive episodes in their clients, they also must be adequate in number, appropriately trained, attentive, and willing to fulfill their responsibilities.

Client aggression poses a danger to the client and others in the environment. Aggression management techniques must prevent injury and harm while allowing maximum personal freedom of the client. As client aggressive behavior increases, more restrictive management strategies are utilized. Management techniques, when used appropriately, afford the client the opportunity to regain control without physical contact from the caregiver. However, these skills require time, experience, and training to development.

Figure 1 presents a model inductively derived from the data that represents the strategies used by the study participants to manage aggression by mental health caregivers. Strategies the participants described using when managing an episode of aggression began with the less restrictive interventions of talking, listening, and building a relationship. The participants believed the most restrict intervention should be implemented when all other strategies do not work and the behaviors become violent.

Figure 1*: Management Strategies*



CATEGORY III: PROCESSING AGGRESSION

The participants' stories included rich descriptions of episodes of initiation, precipitants, management and resolution of client aggression. The category of processing aggression evolved as participants recalled the events as the aggressive episode unfolded specifically when they: 1) related outcomes of aggressive episodes for clients and staff in a volatile environment; and 2) reflected on circumstances that fostered an aggressive environment.

Reporting Outcomes of Aggressive Episodes

The natural flow of the participants' stories relating aggressive episodes required an ending; without an ending, their stories would have been incomplete. Participants concluded their stories by reporting what had happened to the clients or to themselves following the aggressive event. Not all endings were positive. The primary goal was that the client would calm down, the aggressive episode would be averted, and everyone would be safe. That did not always happen. The participants reported that both the client and they themselves had experienced both positive and negative outcomes of client aggressive episodes.

Positive Outcomes for the Client

The participants reported that when the aggressive episode was defused, clients were ". . . able to get a grip on themselves and calm down" (S9 L414-415). Clients did not have to be medicated or given intramuscular injections (IM): ". . . the patient. .

.started calming herself down and we did not have to give her an injection" (S9 L110-112) and ". . .[she] was able to calm down and she didn't even have [an]. . .IM injection. She was able to take something orally" (S5 L95-98). A participant who had defused a client's aggression commented, ". . .[She was] able to get herself together and be focused, and apologize. And talk about what was bothering her why she was acting out" (S5 L99-101). The participants perceived that allowing a client to regain control without force actually supported the healing process and that it was important ". . .to make sure the patient stays calms. If he stays calm, then he's able to recuperate faster because then he is not disrupted by more medication which is going to put him back further in his treatment" (S1 L412-416). Another participant shared that by allowing clients to calm down, they are able to:

> ". . .sit down and talk. They are still upset, but they're not aggressive; they're in control of the situation and their environment. And they are able to get somewhere and sit down with the staff and talk. And works it out" (S5 L301-305).

Negative Outcomes for the Client

Aggressive episodes that could not be de-escalated resulted in the client becoming a danger to self or others and required more restrictive management strategies. All of the participants had experienced episodes of client aggression that resulted in less-than-optimal outcomes for the client. The outcomes for the clients in such situations involved implementation of a behavioral code. The client might have needed to be restrained or medicated: "She ended up giving him. . .an IM" (S4 L303). Another participant stated, ". . .he was. . .assisted to the floor. Yes, they assisted him to the floor and I gave an

injection to help him calm down" (S11 L137-140). A third participant described a different outcome for an aggressive client:

> . . .the patient became very aggressive. . .you know. . .toward the nurses and stuff. . .[we] escorting him to the quiet room. Where he. . .where he stayed until. . .we phoned the doctor to go ahead and give. . .[an] IM. . .once we did that he was okay. (S10 L40-47)

Clients also could suffer an injury: "That girl had also punched a wall. . .last week. . .and has an injured hand" (S15 L369-370). Another participant reported "He ended up with some bruises (S4 L607). Clients might injure themselves, "She [a client] has outwardly aggressive. . .as far as cutting herself" (S12 L45-46). A different participant story ended with the statement that the aggressive client had been injured during a behavioral code: "[She] hit her head on the glass as she was taken down." Some of these client injuries required medical attention: "I've seen them [client] have to go to the emergency room afterwards" (S12 L521).

Some clients can become so physically violent that caregivers are unable to de-escalate and calm them; as a result, these clients can be incarcerated. One participant described a situation in when a client attacked a staff member. The caregiver filed legal charges against the client: "The patient was locked up [in jail]" (S5 L477).

Two different participants described incidents of client aggression in which healthcare workers had choked the client during a behavioral code. One of these individuals was a staff member and another was a physician. A participant hesitantly described what she had witnessed: ". . .I have seen it where the [physician]. . .grabbed the patient in a choke hold one time. . .and they had to hold him [client] in a choke hold"

(S10 L873-877). The other participant recalled: ". . .[the staff member] grabbed him by the neck and pushed him down and held him there for several seconds" (S1 L195-198).

Positive Outcomes for the Caregiver

Participants also reported that, like their clients, they also experienced both positive and negative outcomes from aggressive episodes involving their clients. Participants who had been successful in defusing client aggression reported:

> It feels really good. It makes you feel really good inside that you are actually stopping your day to help that patient through a very real crisis. So it feels very rewarding. It's really fun too. . .help them and not hurt them. (S12 L137-142)

> I really like and enjoy it. . .I love working with psych patients. . .I want to make a difference. . .I feel good. . .doing my part. . .giving back to humanity. (S10 L844-849)

Successfully defusing client aggression encouraged the participants learn to be more effective. One participant commented ". . .you know we are human. . .that we can learn from that and do better next time" (S4 L624-626). Another participant had not reacted therapeutically to a client and was reprimanded by a trusted superior. In addition to the reprimand the supervising RN also: ". . .got me a book on borderlines. And after reading the book, it made me understand a little bit more and I knew what I was doing. I didn't take it personally" (S13 L462-464).

Participants who had successfully defused an aggressive event described a senses of self-efficacy: ". . .[I had a] feeling that it wouldn't be difficult to calm him down. I was pretty capable of the job. I wasn't really stressed" (S9 L39-41). A different participant explained that ". . .my purpose was to de-escalate her and I felt as if I had accomplished what I set out to do" (S8 L121-121). Another participant remarked: "I never thought of

myself as very victorious. . .because I consider of myself as one of the best. . .one of the best. . .there is on the [my] shift. Because I'm not one to always be aggressive toward the patient. . .I want to de-escalate the situation verbally" (S10 L361-367). One participant also expressed confidence in the healthcare team: ". . .[I had] concern for myself, the rest of the staff, and the other clients on the unit, but calm also, because I knew we could handle the situation before it gets out of control" (S2 L62-65).

Two participants did not verbalize that they had felt calm; rather, they expressed an absence of fear as an outcome of dealing with the aggressive client. A participant who had dealt with a unit in turmoil described his response: "I don't feel scared and I didn't feel scared last night," (S7 L193-194). Another participant intervened with an aggressive client and indicated that, "I wasn't really fearful of him because I knew him and I knew generally how what his reaction would be" (S9 L35-37).

Some of the participants had received recognition from their superiors as an outcome of their ability to de-escalate aggressive clients. One participant had been rewarded for consistently having positive outcomes with aggressive clients. This participant remarked,

> "I'm very proud of that. . .I have [the award] to show my customer service and all that kind of stuff. My facility has that stuff that gives us [the award]. It is. . .basically some kind of merit. . .how well you do." (S10 L477-488)

Even more important to a second participant was simple recognition from another caregiver after defusing an aggressive client. This participant stated, "Dr. . . .said, 'I'm proud of you, I don't believe you did that'" (S6 L192-193).

Participants who had successfully defused aggressive clients had positive feelings about themselves. They felt calm and proud of their accomplishment; they also experienced personal growth, and in some instances, received acknowledgement from others.

Negative Outcomes for the Caregiver

Client aggressive episodes also resulted in trauma to staff members as well as clients. Staff members suffered both physical and psychological trauma from aggressive events. They were threatened with bodily harm by their clients: ". . .[He] verbally threatened me, that he was going to kill me just as soon as they let him go (S11 L142-145)." Another participant reported that a client threw a lit cigarette at her. The participant relates: "It went down my shirt and then I had to get her away from. . .I didn't get burned (S6 L43-44)."

Other participants also experienced physical injuries. One participant described an event when he ". . .had to restrain this guy. . .This guy punched me in the stomach" (S10 L231-232). Another participant recalled, "She grabbed me and basically she started hitting on me" (S5 L395-397). A third participant described being physically assaulted while admitting a client:

> She seems very calm. She reaches across the nurse's station. . .grabs me by the back of the head. . .and starts pulling. . .But the fight ended up. . .not the fight. . .but the problem ended up between me and four or five other people. . . trying to get her hand off my hair. (S12 L288-294)

Participants also reported witnessing other caregivers being attacked by aggressive clients. In one instance a participant told of a client ". . .actually struck the

doctor and the doctor left" (S13 L32). Several such incidents resulted in injury that required medical care. "And the staff member went to the doctor" (S5 L476). Another participant witnessed an incident between a staff member and client: ". . .the patient had thrown coffee in a staff member's face and hit him in the face. . .scratching his eye and stuff" (S5 L457-460). Physical assault happened quickly and unexpectedly: ". . .and when he raised back up this young 18-year-old had that quick jumped up and hit him in the eye. And hit him hard. And the tussle was on" (S14 L124-126). The participant continued: "But he [client] hit this guy [staff] so hard that the guy did have to go to the. . .to see the doctor" (S14 L140-142). One participant described more severe consequences she had witnessed as a result of an aggressive episode:

> Necklaces gets broke, eyeglasses broke, hit in the head, hair pulled. I've seen a necklace broke and hit in the head. . .We had a male patient that had, that went, that flipped out for some reason. So one of the male techs got hit in the head and he had his glasses on when he hit his head. From the pressure, I guess, cut his eye. He needed surgery. He had to have surgery on that eye. Yes, he had to have surgery on that eye. Because he already had bad eyes, so when it hit it messed up something up. So they took him to the hospital and he had to have surgery. (S6 L225-243)

Staff members can experience physical injury as an outcome of client aggressive episodes. They also experience psychological reactions to the aggressive episodes, including anxiety or fear, anger, and regret. One participant described feeling ". . .Anxious. . .Nervous. . .because I didn't want the situation to get worse" (S3 L203-204). In the beginning stage of an aggressive episode, a participant reported that she had "felt anxious because he [client] was loud and disrupting the unit" (S6 L247-248). As the aggression continued to escalate in a different situation, another participant described, "feeling anxious and I was feeling like it was not going to work. That you know we

would try to talk. . .we would try to redirect but that it probably would not work" (S6 L162-165). Even when an aggressive client was contained but remained aggressive and threatening one participant felt ". . .a little scared, but I knew the techs had him under control at the time so he couldn't get up and get me" Another participant responded with fear for her client who had a knife: "[I was] scared. Because at any moment she could slit her throat" (S8 L76-77).

Aggression could sometimes result in physical confrontations. A participant indicated that when such an event occurred that, ". . .it did scare me a lot. It was kinda scary [be]cause of all this [physical] stuff" (S11 L304-305). One participant described the feeling not as fear but ". . .vulnerable . . .Okay. . .I am halfway through a door. . .I'm vulnerable. . .I have no back up. . .it's gonna be him and me" (S1 L42-47).

One participant feared working on a unit he believed was particularly dangerous. He admitted when he was assigned to work the unit he was always fearful:

> I don't like working unit. . . but I had to work it. And I am always pretty much am scared. . .that hey what if it does get to a point where I'm gonna get a guy that is gonna over power me. . .hurt me. . .I have kids. . .you know. . .but that was a dangerous situation. . .because you know. . .there is. . .it could have been a situation where I could have got overpowered. . .and. . .hurt. Get hit in the head. . .or dead or even be a psych patient myself. . .Psych is. . .anyone can be a psych patient. Just take one hit in the head or somewhere. (S11 L290-302)

Two participants reported they had felt angry as a result of an aggressive episode. One participant described an encounter with an aggressive client who was demanding medication. Her first response was anger: "First, . . .Oh, I was angry" (S3 L63). A second participant experienced anger, although his anger was in response to fear:

> I was trying to reason with him [client], explain with him, having patience with him but then he hit. . .I said the wrong thing. . .he was intimidating me so that's why I felt angry. . .I really felt angry. (S3 L65-68)

Participants also felt regretful and had empathy toward the client who was going through an aggressive episode. A participant who had witnessed a client being wrestled to the floor by the mental health staff verbalized: "I felt so sorry for him [client] that was such a nice little man. I liked him" (S12 L399-400). Another participant simply stated, "I felt kinda bad for her" (S14 L165). A participant recalled an incident that had occurred, prefacing the description of the event with: "it still bothers me" (S4 L592). Participants who had experienced aggressive episodes in clients with a mental illness were unable to remain aloof and objective about some of the events that occurred while other caregivers attempted to manage the aggression. They became upset with some of the techniques employed by other caregivers to control the client during the episode and were left with emotional responses stemming from the episode.

Coping with client aggressive episodes took a physical as well as psychological toll on the participants. Even participants who had not been assaulted had physical sequelae. A participant who had worked directly with an agitated client for a16 hour shift explained:

> I couldn't wait until it was time to go home. Tired, mentally drained. You know when you are watching someone and trying to keep them from hurting themselves, it is worse than trying to keep them from hurting other people. That's just way more work. WAY MORE WORK [The participant's emphasis]. (S10 L128-134)

Another participant indicated the effect of dealing with a client who had been aggressive for several hours commented, "I wish he [client] would get off [sic] my face. Because I

was really tired because I was trying to reason with him, explain with him. . .” (S3 L64-68). Participants expended a great deal of emotional and physical energy managing aggression.

In summary, participants processed aggressive episodes in mental health clients through identification of outcomes for clients and staff. Aggressive episodes resulted in an array of outcomes that ranged from satisfying individual experiences of growth and learning, to unpleasant social, psychological and physical trauma for both clients and caregivers.

Debriefing Aggressive Episodes

The participants processed aggressive episodes in mental health clients through de-briefing themselves, which included reflecting upon events, circumstances and responses surrounding each event. The participants' primary goal was to promote safety in a volatile environment. Evaluations of the adequacy and appropriateness of staff responses to aggressive episodes and staff influences on aggression in their clients, as well as their own ability to impact responses of both clients and other staff in the acute care mental health environment followed.

Thinking

Participants began their debriefing process began by first revisiting their own thinking surrounding the aggressive episode. Their first goal was prevention: “. . .[I was] thinking let me control this before something breaks loose, before the patient is harmed

or any of the staff members are harmed" (S8 L134-136). Another participant described as a client became agitated:

> So you pretty much got to make sure you're safe, first and foremost that. . .you're know. . .you're safe, the nurse is safe and everybody else. . .the patient. . .and the rest of the patients are safe. So patient is being aggressive you kinda make sure you have the proper people to help you before you approach to restrain that person and stuff. . .because you don't want to get hurt. (S11 L91-100)

This participant first checked to see that other individuals in the area were safe. He then began to plan strategies to contain the client's increasing agitation, thereby maintaining the safety of the client and everyone else. Another participant described the mental process of thinking as a client exploded: ". . .[I was] thinking that we needed to get the rest of the clients out of the area and to protect the rest of the patients' safety, but to also protect our safety" (S2 L65-70). Client aggressive episodes are a crisis, requiring caregivers must respond quickly and definitively. A different participant explained, ". . .you do have to think fast or you can get hurt or somebody else can get hurt" (S5 L548-549).

Safety was always a primary consideration for the participants. Clients that chose to use a weapon in an aggressive situation generated a great deal of concern. One participant remembered ". . .thinking that we have to remove that weapon from her. Because she will do harm to herself or she will do harm to staff" (S8 L71-73). This participant later described safety as the objective when multiple clients were aggressive:

> People [other clients] who were in this out of curiosity. Because there were lit cigarettes at each point in this. . .We wanted to make. . .and that's against fire codes but we knew we couldn't stop it right then. We wanted to make sure that what was attended to and safe. (S8 L687-692)

Safety

Caregivers in an acute care mental health environment are responsible for maintaining safety. They are responsible for their clients' wellbeing as well as that of their co-workers, other clients, and themselves. Caregivers must maintain a constant vigilance for impending threats to safety on the unit, then plan controls for any threat that arises.

Participant reflected on qualities that had promoted safety during episodes of client aggression. One participant reported that she had successfully intervened with an agitated client because the client trusted her. The client lost control in a hospital cafeteria and grabbed a knife. The participant approached the client and reminded him of their relationship:

> Then he gave the knife and took my hand. He was squeezing the life out of my hand. But I got him to walk with me upstairs and get on the elevators. . .and they were asking "You want me to ride the elevator with you?" I said "No, it will be alright. He's not going to do anything to me" and he didn't, because he trusted me. So I got up there and walked him to his room. I sat with him in his room for a little while and talked with him and stuff like that. He laid down there and the nurse came and gave him his medicine. He did pretty good. I was glad. (S6 L171-191)

The participant recognized that the relationship established with the client was what made the difference in the outcome. The relationship enabled the participant to de-escalate and calm the aggressive, frightened client so he could cooperate and move to a more secure unit without any physical force diminishing the chance of injuries.

Feelings of Caregivers

A participant had successfully de-escalated an aggressive client by projecting calmness and talking with the client: "I verbally de-escalated him; he calmed down. Didn't have to lay hands on him or anything" (S2 L28-30). A different participant also identified a calm demeanor as defusing aggression in an adolescent: "Nobody had to lay a hand on this kid" (S4 L241-243).

Participants recognized that they had been successful defusing an aggressive episode by listening and responding to their clients. One participant intervened when a client was becoming agitated because the medication nurse would not give him a medication. This participant intervened by contacting the physician, got an order for the inhaler, and told the client she had the order:

> . . .and he calmed down and he was able to talk to me and it did work out. I [went] to the resident and said "He needs [the medication] now." And she said, "Fine." She put the order in and I called the pharmacy and got the [medication]. And after that he was a happy camper. It calmed the whole day down. (S9 L341-346)

The participant's intervention calmed the client and helped meet his needs.

The participants, who reflected on aggressive episodes with their clients, realized that their first concern was the safety: the safety of the client, other clients, other staff, and themselves. The participants recognized that personalizing their relationship with their clients had been a fundamental influence in defusing what were potentially aggressive episodes. The participants' relationships with their clients promoted safety; they also supported the client's recovery.

Reflections of Aggressive Episodes

The participants processed aggressive episodes by reflecting on situations when safety was compromised because the client's agitation escalated into violence. All the participants identified staff behaviors and system problems as major contributors to the volatility of the situation. The participants appeared distressed while talking about the appropriateness of some staff behaviors. There were several instances where the participants clearly identified some staff behaviors as inappropriate and sometimes illegal:

> It was totally illegal, . . .he was trying to escape and they had to hold him in a choke hold. (S10 L874-877)
>
> You know all of them turned out okay. But the fact is they did not need that level of restraint. (S12 L522-524)
>
> Well he didn't need that type of force, you could have held [the client's leg] down against the bed, but not against the rail. [She was] obviously letting him know, I'm gonna hurt you if you try to hurt me. That wasn't necessary. (S1 L315-319)
>
> But she [a PCT] wasn't told to do a code, the nurse hadn't called it. So she [PCT] turned around and threw the little lady down. Just had her braced on the floor. She kept telling me "You have to help. You have to help" I said "Oh no, a nurse didn't tell me or call a code and I was told the nurse is supposed to call the code. The nurse didn't call the code so I'm not touching her" She said "Well she tried to hit me" I said "I'm standing right here, she didn't try to hit you. She was talking like she usually does. She didn't raise her hand up" It was a big old mess. I ended up having to write some stuff up. And I told them exactly what I'm saying now "She [client] didn't try to hit her" She was just talking mess, but she didn't try to hit her. This woman was like in her late 60s. I say how can you do a code on someone that. . .I mean it was uncalled for. When you're doing a code on someone that age and they. . .hit the wall. (S6 L268-291)

The participants struggled to understand why their colleagues had behaved so inappropriately. Two participants identified impatience as a problem:

> Impatience, the staff member just doesn't have the patience to put up with irregular behavior and is unwilling to work with the patient. (S4 L302-305)
>
> Impatient. . .She was impatient. She was not patient with that particular client. It seems like every time a patient tries to act violent they take it personal and respond as if it were a normal individual out on the street, so they respond aggressively in return, instead of realizing where they are. (S6 L329-333)

A third participant also attributed the staff member's behavior to feelings of anger: "The staff member. . .was holding some kind of anger, instead of realizing that these are patients and things happen" (S14 L482-484).

Other participants believed that offensive staff members were responding to internal, personal stress when they had responded inappropriately to an aggressive client. One participant explained:

> It's very stressful. And some people. . .staff when they get stressed. . .they don't handle it any different than the patients do unfortunately. Nurses are taught to be patient, but not to. . .how to handle the stress. Because nurses have their own stress in their own lives, and then they have the stress of their patients on top of that. So it can be very. . .Some people can't handle it as well. (S15 L388-396)

Stress can change an individual's perceptions of events. High levels of stress often affect judgment and decision-making. One participant shared thoughts on how stress can affect a staff member's ability to provide care to an aggressive client: ". . .It gets very tedious. . .time consuming and that's when you have to really push yourself to keep doing what you know is the right thing. Basically. . .it is very stressful." (S5 L69-75).

A combination of personal and work environment stress can affect the way a caregiver responds to aggression. A participant identified workload as adding to the stress

of staff members. This participant observed an incident when a co-worker snapped at a client who had asked her a question; the client then became agitated:

> It was a busy day and she [staff member] was stressed. . .She was just stressed out that day and having a bad day. . . But at that time she was just irritated because of the whole unit itself, what was going on. (S12 L357-374)

A different participant felt that sometimes caregivers bring their personal issues into the workplace. Amid nervous chuckles, this participant described: "But, you know some people can't separate their issues from home from their issues at work. I see it a lot" (S10 L329-331). The long hours that caregivers work can add to the stress of an acute care mental health facility. A participant described:

> The staff can get drained very quickly. Okay that can be one. Number two if they feel that they are under staffed. . .okay. . .that. . .the patients. . .not the patients. . .but the caregiver's patience runs thin. . .okay. . .let's see, just if they are busy. . .if it has been a hectic day…umm…Oh, I think sometimes people work double shifts. I think that can. . .(bring on fatigue). I know it would be for me. If I worked a double. . .I'm sure I wouldn't be as nice as I am, you know, refreshed in the morning. (S13 L480-492)

Caring for acute mentally ill clients can be physically and mentally taxing. A participant described an incident when, because of fatigue, a caregiver had responded inappropriately to a client who was acting out:

> . . .she [client] is a pain to deal with. . .you know. . .and the nurse had just. . .didn't want to have to deal with her. Honest to god. . .that's a sad thing to say. . .the nurse is sitting there going "I've gotten tired of you. You're just have to do whatever you need to do, but you're gonna have to calm yourself [client] down" . . .you know. . .that was it. That's sad to say…but some people come to work with a great attitude and some people come to work really wanting and will go the extra mile. But some people come. . ."I'm here to do my job and I will work this far and that's it." (S1 L181-197)

Three participants believed a staff member's individual personality could make a difference when dealing with an aggressive client. One participant who was describing an

aggressive episode between a staff member and client who became aggressive reflected on the staff member's behavior: "The attitude" (S12 L231). A second participant described what he perceived to be a major influence on a client's behavioral response to a caregiver: "I think it all comes down to personality" (S15 L384-385). A third participant summarized: ". . .unfortunately just because you are a professional that doesn't mean that you have a personality that can deal with other people" (S5 L348-350).

The data collection interview included a question asking participants whether they had observed incidents when a client responded aggressively to something a caregiver did. Not only had each participant observed such incidents, but they all provided several examples of caregivers' deliberately provoking clients into aggression: "Actually, there are a lot of cases like that" (S5 L225); "I know there is lots" (S8 L321); "[Begins to laugh] Which time?" (S14 L378); and "I have several of those" (S15 L107).

Data gathered during member checking activities revealed that many of the participants felt that caregivers knew when they were being aggressive with clients. One participant perceived many of the aggressive caregivers, ". . .have no license so they don't care. It all falls back on the nurse." This participant also believed that the staff members are aware they are stimulating aggression (S11). Another participant also thought that, "staff members who stimulate aggression know they are doing it. There may be times when the staff member is unaware but that is not very often" (S2). A third participant perceived that staff members who triggered an aggressive event in a mental health client were aware of their behaviors that stimulated the aggressive client, but that ". . .they know they can get away with it" (S3).

Participants described how they dealt with other caregivers who provoked clients into an aggressive episode. Their choice or strategies to deal with other caregivers' inappropriate or illegal behavior seemed to reflect a personal appraisal of how safe they felt within the system of their work environment. Some of the participants had attempted to intervene while others hesitated, fearing retaliation or ostracism.

The participants described their attempts to intervene between the provoking staff member and the client when the episode began to escalate. The participants' stories included their interventions as well as their feelings. A participant had intervened when a co-worker was holding an aggressive client in a chokehold:

> . . .so the patient used several derogatory terms [towards the staff member] and so at that moment I told him [staff member] "Let him go; it's not worth it." I could see that the terms he [client] used offended and ignited him [staff] even further. I could see his [staff] hand getting a little more tense around the neck [of the client]. I said "It's not worth it." At which time he [the staff] did let go. (S1 L198-205)

A participant reflected upon an episode when another staff member was angry and lost patience with a client. The caregiver and client were responding to each other's agitation with increased aggression. The participant offered:

> . . .that the employee was angry and if another employee stepped in at that time. . .who was calmer. . .If someone else [who was calmer became] involved. . .and de-escalated the patient. . .he [client] probably would have understood and gone back to his room. (S3 L178-184)

A different participant verbalized during the member check that she tried to talk with staff members who evoked aggression in a mental health client and expressed, "Sometimes it works, sometimes it doesn't" (S4). Another participant discussed how she

handled aggressive episodes when other caregivers were escalating an episode of aggression in a mental health client:

> Depending on the staff member, I try to talk with the client separately. I try to defuse the situation. I let the staff member know, I'll take care of it. Or if I know them well enough, I try to take them off to the side and say "Maybe we could have handled it a little differently." Usually you can handle it one-on-one. Just take care of it that way. (S2 L312-318)

The participant preferred to try to defuse such incidents personally rather than reporting the coworkers to the supervisory personnel. A second participant recalled the personal dilemma of attempting to intervene with staff members who were antagonizing a client who had been placed in seclusion because of aggressive behaviors:

> I was torn between "Do I let them?' Of course I couldn't let them do what they were doing; they were antagonizing the patient, knocking on the window, encouraging the aggressive behavior. The charge nurse is not doing anything and the nurse manager is nowhere around. (S15 L499-504)

Once the participant decided to intervene by telling the staff members to stop, the staff members accused her of trying to "take over." Later the participant was told she was not allowed to work on that unit again.

Some participants avoided reporting other caregivers who had provoked or reacted inappropriately toward their clients because they feared the consequences. One participant described the result of talking to a supervisor, "I believe she [supervisor] talked to him [staff], because he [staff] and his friends [other caregivers] started looking at me so I didn't say anything more, you know" (S8 L375-377). This participant might have been concerned because the unit always had aggressive clients. If the other members of the team remained angry at her, they might not fully assist or help her manage

aggressive clients. Safety of all individuals in the environment thereby would be jeopardized.

A second participant had reported another staff member to the supervisory personnel and believed she had experience retaliation shared: "They moved me [to other units]. Yeah, but I work all over anyway so I didn't really care. I was used to working everywhere" (S14 L300-310). The participant spoke in a strong and defiant voice. She continued to talk after the taped interview had ended, commenting that after she had reported the other caregiver the administration had tried several times to "fire me." The participant responded to those threats from the administrative personnel with, "Go ahead, but you better have a better reason than that, [be]cause you'll be talking with my lawyer" (S14).

Some participants hesitated to report other caregivers because the offending caregivers had some sort of connection or relationship that would protect them. One participant had not reported her coworker:

> . . .because this was one of her [supervisor's] favorites. He was a big guy and like she said, he protects us. So that was one of her favorites. . .Yeah, oh yes. You know some of the nurses have their favorites. . .But, yes, especially when it comes to most of the male techs. Because the male tech have to protect them from these patients like on the adult units and sometimes the adolescent unit. [The researcher requested clarification. "So is it that they may feel that if they don't protect the tech or let them act like that, then so when it comes time on the unit, they may not be protected?"] Yes. I'm thinking so. If you, but if you treat people like you would want to be treated then you shouldn't need to be protected. I've heard that word a lot, "Protected." (S13 L437-461)

A different participant attempted to rationalize not reporting an offending staff member:

> That staff member had been in that hospital for many years. . .he works a lot of over time; they count on him quite a bit. That staff member is an LVN. And so I

> think I waited and said, "well he does a lot more good than bad" considering they are really short staffed on that unit. (S10 L222-228)

A third participant summarized the dilemma:

> I wouldn't know who to report that to. . .Exactly. . .who do you report. . .I need my job you know. . .you just be quiet. . .You shut your mouth and move on you know. So. . .I hated to say that but I wanted to say the truth and to say what needs to be said and give you part of my knowledge. (S13 L886-892)

All of the participants had observed inappropriate behavior by other caregivers. They knew the behavior was wrong and increased the risk of violence in and toward the client. Some participants could defuse other staff members' inappropriate responses toward the clients; others became victims of retaliation by other caregivers and the supervisory personnel. The participants were troubled by other staff members' behaviors that were illegal or compromised safety in their acute care mental health units. Although some of the participants had intervened, most of them contributed to a continuation of the problem because they were afraid of becoming victims of retaliation or ostracism by other staff members or by hospital supervisory personnel.

In summary, the participants processed aggression by reporting outcomes of de-escalation or escalation of aggressive episodes for the client and staff members; they also debriefed following aggressive episodes. The participants identified positive and negative outcomes related to an aggressive episode for clients and caregivers. The participants debriefed after aggressive episodes by reflecting on their ability to promote safety in a volatile environment; identifying qualities that promoted or compromised safety in the acute care mental health environment, and processed by describing characteristics of other caregivers that compromised safety by stimulating an aggressive episode in a client or compromised the client's safety. Their reflections included their emotional dilemma

when witnessing other staff members provoke aggressive responses in clients with mental illness and their attempts to intervene and redirect the staff members who were escalating aggression in a client. The participants identified their own quandary when faced with other caregivers' inappropriate or illegal behavior: Standing up for what they believed was right placed participants at risk for retaliation from their coworkers, their superiors, or both.

SUMMARY OF FINDINGS

The present study was undertaken to investigate the phenomena of aggression among acutely ill mental health clients. A variety of mental health professionals including registered nurses, licensed vocational nurses, psychiatric care technicians, licensed social workers, licensed psychological counselors, and licensed chemical dependency counselors were interviewed in order to answer the following research questions:

1. What do licensed and unlicensed mental health workers perceive as triggers of aggressive behavior responses in hospitalized mental health clients?
2. How do licensed and unlicensed mental health workers perceive their actions and behaviors influence the precipitation of aggressive behaviors in hospitalized mental health clients?

The participants recognized triggers and precursors of aggressive responses in their clients as well as manifestations of escalating aggression. Participants first identified cues in a client's condition, history, and individual responses that increased the client's

risk of becoming aggressive. The participants described what they perceived as triggers for client aggression. These triggers included staff characteristics and behaviors, such as culture, age, gender, and physical size, as well as disrespectful and demeaning staff attitudes. Triggers of aggression in clients with mental illness included characteristics of the mental health unit, such as noise and staffing issues. The participants identified their own ability to sense or "just know" when aggression was impending in a client. In addition, the participants were acutely sensitive to client behaviors indicating escalation into aggression.

Interestingly, the data contained only one example of a participant who perceived that his actions had contributed to aggressive behaviors in a client. However, the participants did identify numerous instances where another caregiver had influenced or precipitated aggressive behaviors in hospitalized mental health clients.

The findings of category I, Recognizing Aggression, essentially answered the research questions. Category II, Managing Aggression, and category III, Processing Aggression, emerged as the participants discussed the events surrounding client aggressive episodes. Data in categories II and III included descriptions of the natural progression for an episode of client aggression. Participants discussed therapeutic and nontherapeutic interventions that had been observed while caring for an acute mentally ill client. The descriptions of caregiver behaviors provided to the researcher by the participants ranged from nurturing and supportive to hostile and aggressive. Insights gained from the perceptions of the caregivers who participated in this study provide

important insights that contribute to what is already known about the topic and will provide direction for future research.

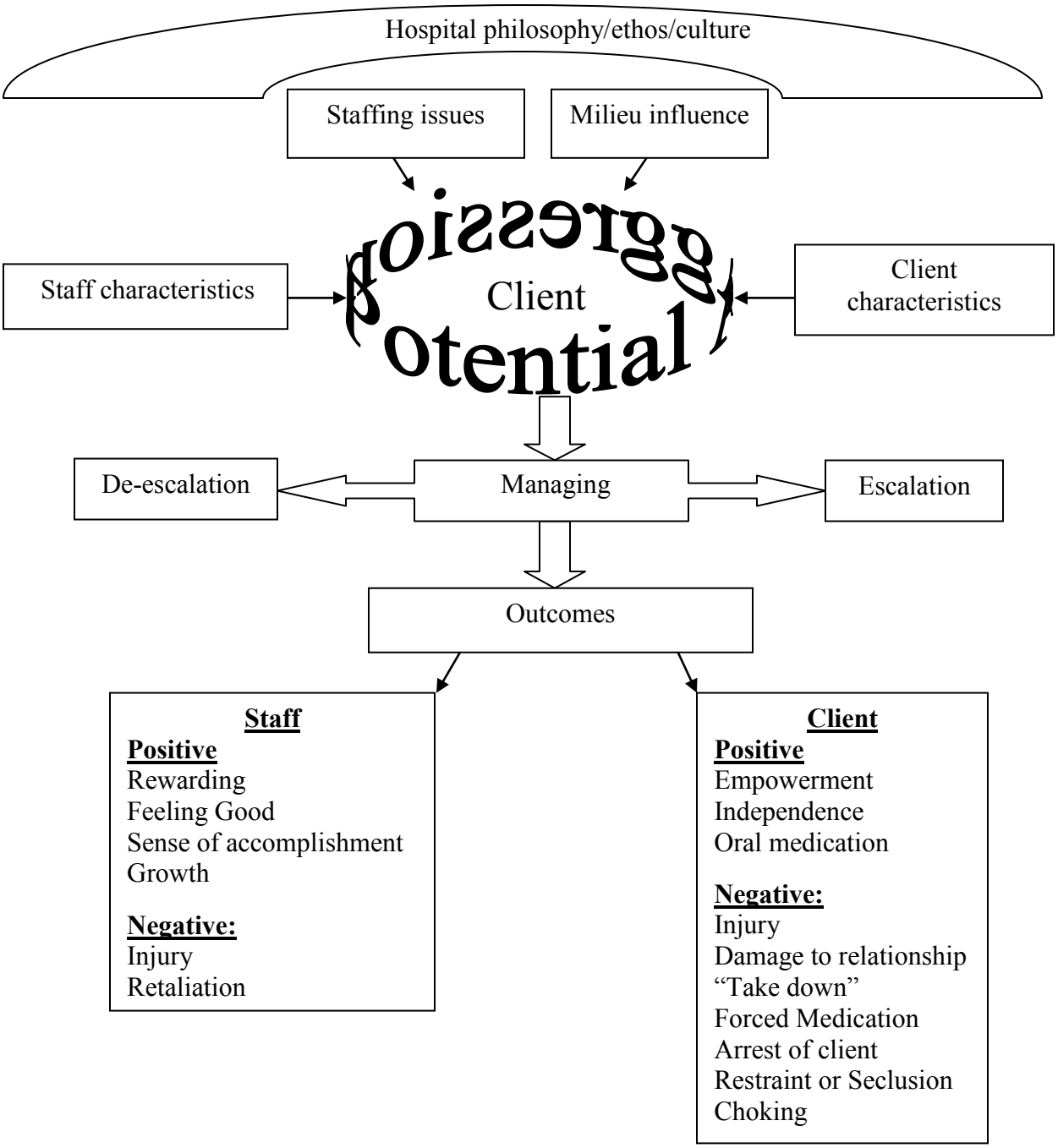
The participants' preferred techniques for managing client aggression were based on their interpersonal relationships with their clients. They stressed the importance of using good communication techniques and developing a therapeutic relationship based on trust, rapport, and respect, with their clients. Nevertheless, not all episodes of client aggression could be defused, so more restrictive management techniques were necessary to maintain the safety of the client, other people, and the environment.

Processing aggression occurred as the participants looked back upon a client aggressive episode. The participants reflected on what happened and what did and did not work. They also reflected on their own responses to the event and the people involved. Their first concern was the safety of their clients and other people. They also were concerned for their own welfare and many hesitated to intervene when other caregivers acted inappropriately or illegally because they feared retaliation in some form.

Figure 2 summarizes the findings of this study. The mentally ill client with the potential for aggression is at the heart of the model. The client brings a personal history and potentiality into the acute care mental health setting. The client enters the mental health setting that reflects the philosophy and culture of the hospital, transmitted overtly or tacitly through the actions and behaviors from supervisory personnel through caregivers, creating the care-giving environment. The number and characteristics of staff members, as well as practices within the physical and affective milieu influence the care-giving environment. Any or all of these factors potentially can lead to a client becoming

aggressive, which can be managed and defused or can escalate to a violent encounter (Please refer to the model of Management techniques depicted in Figure 1). Both the staff and the client are affected by episode of client aggression. Positive outcomes lead to learning and growth for the staff members and healing for the clients. Likewise, staff members and clients can suffer psychological and physical harm as result of a negative resolution to an aggressive episode. The model, depicted in Figure 2, illustrates the complex web of interactions surrounding aggression in hospitalized mental health clients culminating in various outcomes. Both illustrations were developed using actual statements from participant responses.

Figure 2: *Concept model: Precipitation and Resolution of Aggression*



Chapter Five: Discussion and Conclusions

INTRODUCTION

This chapter presents a brief summary of the study, overview of the problem, discussion of study limitations, and compares study findings to the literature. Included likewise are important conclusions drawn from the participants' interviews and implications for action, as well as recommendations for future research.

SUMMARY OF THE STUDY

Acute care mental health caregivers work in an environment where the potential for client aggression is great. The outcome of aggression can be devastating to both healthcare workers and clients, as well as costly to healthcare facilities. This study examined the perceptions of 15 mental healthcare workers from nursing and social service departments regarding factors that trigger aggression in their clients. Symbolic Interactionism was used as the theoretical foundation for this study. Naturalistic Inquiry, as described by Lincoln and Guba (1985), guided the research process and provided rigor to the investigation. The findings included an overarching process of precipitation and resolution of aggression. Through bridging, extending, and surfacing of data, the three major categories identified were: a) recognizing the continuum of aggression, b) managing aggression, and c) processing aggression. Several subcategories and themes supported the major categories.

Participants were asked to describe how they knew a client was becoming aggressive and were able to identify escalating aggression through verbal and nonverbal

behaviors of the client, as well as perceived factors intrinsic and extrinsic to the client as influencing aggression. These factors included the clients' disease process, communication characteristics of clients and caregivers, staffing patterns, and hospital communication.

The participants managed escalating aggression by using de-escalation strategies that incorporated communication such as talking and listening, meeting client needs, and milieu management following an aggressive episode. An aggressive episode either de-escalated or continued to escalate into violence, which required caregivers to employ interventions that were more restrictive. The participants shared their perceptions of processing aggression through identification of positive and negative outcomes. Positive outcomes were perceived as rewarding and were identified when the aggressive episode was defused and the client's behavior calmed in response the caregiver's intervention. Participants' perceptions of negative outcomes included restraining and medicating clients and injuries to caregivers or clients. Processing aggression also included thoughts for the safety of all individuals in the immediate area of the aggressive episode and feelings of anxiety and fear within the caregiver. Finally, participants processed their perceptions of the aggressive events adding that issues of power and control as well as caregiver stress and personal attitudes appeared to be present within the caregiver-client relationship influencing the potential for aggression. Participants perceived that some caregivers forgot that they were caring for mentally ill clients, acting intentionally to trigger aggression in clients. Attempting to change the situation by reporting offending caregivers to administrative personnel, the participants experienced or feared undesirable

consequences from the offending staff member because they seemed to rely on a "buddy system" with administrative personnel to protect their actions.

OVERVIEW OF THE PROBLEM

The acute care mental health environment can be volatile; without the vigilance of skilled mental health care workers aggression can escalate into violence rapidly. Nijman et al. (2005) investigated the experiences of mental health nurse with episodes of aggression. Seventy-six percent of the respondents in the study reported being a victim of client aggressive behaviors but sustained no physical injuries; slightly more that 1 of every 5 nurses reported missing work as a result of the violence. Spokes et al. (2002) explored the perceptions of nursing service personnel for factors that could potentially trigger aggression in a mental health client. Identifying factors that might precipitate a client aggressive episode is an important aspect of promoting a safe environment. The safety of all individuals within the mental health unit depends on the ability of the healthcare workers to recognize aggression in the early stages and to intervene appropriately. Aggression in the mental healthcare setting is a complex issue making identification of potential triggers for aggression essential.

PURPOSE STATEMENT AND RESEARCH QUESTIONS

The purposes of this study were to explore the perceptions held by mental healthcare workers about the factors that contribute to client aggression, then to describe the influence that healthcare workers' behaviors and attitudes have on aggression of

hospitalized mentally ill clients. Research questions serving as the basis for the study were:

1. What do licensed and unlicensed mental health workers perceive as triggers of aggressive behavioral responses in hospitalized mental health clients?
2. How do licensed and unlicensed mental health workers perceive their actions and behaviors influence the precipitation of aggressive behaviors in hospitalized mental health clients?

REVIEW OF THE METHODOLOGY

Naturalistic Inquiry (NI) (Lincoln and Guba, 1985) was used to explore the perceptions of 15 mental healthcare workers who provided care to hospitalized mentally ill clients in a large metropolitan city in the southwestern United States. Once data patterns developed into definite categories and the new data fell into the established categories, recruitment of participants stopped. The use of open-ended questions and follow-up probes encouraged the participants to provide full in-depth descriptions of the phenomena of interest.

Personal interviews were used to collect data for this study. These interviews were conducted at a time and place chosen by the participant. The digital voice-recorded interviews were transcribed and reviewed for accuracy. The constant comparative technique (Glaser & Strauss, 1999) was used throughout each phase of data analysis. Trustworthiness of the study processes and findings was assured using techniques described by Lincoln and Guba (1985) to achieve credibility, transferability, dependability, and confirmability. These techniques included an audit trail that consisted

of field and methodological notes, a reflective journal, transcript notes, peer debriefing, and member checks.

LIMITATIONS OF THE RESEARCH

Limitations to this research are those that exist with most qualitative studies. Purposeful sampling and the small sample size of 15 limits the findings of the study. Participants volunteered to take part in this study. The self-selection process has the potential to introduce bias into the study findings. Transferability of the findings is an additional potential limitation. Transferability of the findings in naturalistic studies lies in the thick rich descriptions of the participants. Lincoln and Guba (1985) noted that the transferability is determined by the applicability and the ability of other researchers to use tentative judgments regarding the findings. Whether this will occur will be determined with the dissemination of the findings.

The process of data collection could likewise be seen as a limitation. Semi-structured interviews with open-ended questions were used to collect data. The interviews and quality of data are dependent on upon the comfort level of the participant during the interview, truthfulness of the participant's answers, and the accuracy of the interpretations by the investigator. Potential for participants to falsify information during the interview existed. This study investigated a phenomenon that could have moral, ethical, and legal ramifications; participants may have encountered stress during the episode of aggression that may have altered the perception of events and the subsequent description. The researcher did not attempt to validate any of the descriptions provided by the participants and offered no rewards or incentives for participation.

The researcher as the primary instrument can be a limitation in qualitative research. Bias can occur in an investigation undetected by the researcher. Strong investigative rigor and adherence to methodological standards were followed to minimize researcher bias and establish trustworthiness in the study. However, the potential for bias still exists because of the innate nature of qualitative research where there will always be a human element.

Another limitation of this study could be the time frame of the participants' stories. Although 12 of the 15 participants indicated many of the recalled descriptions occurred within the last 5 years, it is not possible to know if all the stories were current. While caregiver behaviors described in this study may not be common in all institutions, episodes of client aggression may be more prevalent in some institutions than others.

Study data were collected in one geographic location, which also may limit the transferability of the findings. Laws that address the care of individuals with mental illness vary from state-to-state. Cultural and legal differences among various geographic locations may affect the manner in which mental health care is provided to individuals with mental illness.

FINDINGS RELATED TO THE LITERATURE

The following discussion will present the study findings of the categories and themes as they relate to the current literature. The researcher structured the study in order to explore perceptions of triggers for aggressive episodes in mental health client; the participants responded to the questions with their own ideas and perceptions. The

overarching construct was the precipitation and resolution of aggression. Categories developed from the data were:

1) Recognizing Aggression
2) Managing Aggression
3) Processing Aggression

The participants' rich descriptions provided a rich source of information giving rise to the remaining categories, managing aggression and processing aggression. There seemed to be a cyclic relationship among the three categories; the participants dealt with potential or actual episodes of aggression by constantly being aware of potential triggers, managing and defusing episodes of aggression and processing the experience in order to function more effectively in the future.

Category one, recognizing aggression, described how the participants identified aggression in their clients. The participants described multiple ways that were used to recognize the imminent potential of a client who was at risk for or beginning to escalate into an aggressive episode. Participants noted physiologic and behavioral changes in the clients. As aggression escalated in their clients, so did these behaviors. Johnson and Hauser (2001) identified the same continuum of escalating behaviors and the ability of the expert nurse to identify those behaviors as the participants in this study. The participants in the present study also noted a continuum of behaviors indicating escalation of aggression in clients. Additionally, they described caregiver-client interactions that resulted in de-escalation or escalation of the aggressive behavior.

Gilje and Klose (2000) identified that nurses used intuitive knowing when making clinical decisions while assessing and implementing care for clients. Participants in the present study represented licensed vocational nurses, psychiatric care technicians, licensed social workers, licensed professional counselors, and licensed chemical dependency counselors as well as registered nurses. The only participants in the present study who identified intuitive knowing as a method of recognizing aggression in a client with mental illness were the nursing personnel. They reported they "just knew" intuitively when a client could become aggressive. Participants indicated their intuition helped them monitor clients more closely allowing them to institute early management strategies. Gilje and Klose found nurses routinely used intuition when making decisions about caring for specific mental health clients. Another study by Carlsson, Dahlberg, and Drew (2000) found that mental health caregivers based their decisions on "inner knowledge" especially when dealing with unfamiliar situations. Although each aggressive event is unique, basing care and interventions on intuitive feelings is common among caregivers.

Participants used knowledge of the mental illness disease processes to gather information about a client's potential for aggression. Study participants most often identified psychotic states as indicators of potential violence. Rocca et al. (2006) commented that aggression potential varies among mental disorders. The authors found that only 8% of clients with schizophrenia became violent; however, when schizophrenia was combined with substance abuse the percentage increased to 30%. Any client with mental illness has a chance of at least one violent lifetime episode. Rocca et al. (2006)

also noted that clients were likely to become aggressive during their first occurrence of psychosis, exacerbation of chronic schizophrenia, mood disorders, personality disorders, panic disorders, other anxiety disorders and post-traumatic stress disorder. Dunn and Alhom (2007a) indicate that clients who are intoxicated or under the influence of drugs have the potential to become aggressive. Caregivers in the present study included the disease process as part of their assessment to predict a client's potential for aggression.

Participants also reviewed the client's history for the risks of potential aggression. Delaney et al. (2001) state that addressing the client's risk of aggression within the first week helps to decrease violent outbursts about 75% of the time. Clients who previously had assaulted another individual were monitored more cautiously. Morrison (1992) and Dunn and Alholm (2007a) identified the client's past history of aggression or violence as the most reliable predictor of aggression in a mental health client. In an environment where aggression is an ever-present threat, knowledge of a client's past history is necessary, allowing caregivers to be even more alert and readily implement intervention strategies that can prevent or quickly defuse an aggressive episode in a mental health client.

Certain staff characteristics also were identified by participants in the present study as potential triggers for aggression in mental health clients. Hughes (2002) estimated that at least 50% of aggressive incidents were directly related to the interaction between the caregiver and client. By eliminating staff behaviors and characteristics that can trigger aggression in their clients, the number of aggressive events could be reduced by half. Reduction of aggressive events would create a healthier environment and

promote healing through improving the quality of care for clients and the safety of all individuals in the mental health care setting.

Participants in this study reported that some staff members responded aggressively to clients and treated them with disrespect. Lewis (2002) found that disrespectful and demeaning caregiver behaviors could cause clients to respond more aggressively. Caregivers may inadvertently respond to a client as if the client was someone else familiar to the caregiver (Townsend, 2006). This phenomenon is known as countertransference. Although no participant identified countertransference by the staff members as a trigger for an aggressive event, they did comment that some caregivers "forget that these are clients." Interacting in a social, rather than therapeutic, manner can alter the dynamic between caregiver and client. Countertransference issues are sometimes difficult to identify and caregivers may be unaware when this phenomenon occurs, potentially responding inappropriately and unknowingly triggering aggression in a client with mental illness.

Staffing in most hospitals is a constant concern. Morrison and Lehane (1995) reported that staffing issues can influence the decision to use restraints. Most of the participants in the present study reported understaffed facilities. Only one of the 15 participants in this study described the unit as having adequate numbers of staff to provide safe care to the clients with mental illness. This hospital maintained the staffing levels by using staff from temporary agencies. Recruiting and maintaining adequate numbers of staff to care for clients will continue to be an issue as the demand for mental

healthcare workers continues to increase (US Bureau of Labor Statistics, 2005; US General Accounting Office, 1999)

Gender of the staff assigned to a given unit also surfaced as a precipitant of aggression in the study. The study participants perceived that at least one male staff member is needed on each unit to decrease and manage episodes of client aggression. However, Morrison and Lehane (1995) reported the presence of one or two male staff members actually result in more aggression. Staffing ratios, acuity of clients, and gender are important considerations when assigning caregivers to mental health units. Female caregivers are by nature not physically as strong as their male counterparts making it important to have an appropriate mix of female and male staff members present to safely manage the unit.

The culture of a caregiver was sometimes perceived to be a trigger for an aggressive episode by the participants in this study. Although Irwin (2006) did not specifically identify culture as a factor in escalating aggression, interpersonal variables were identified as influencing aggression. Many interpersonal behaviors are culturally based and learned responses from living as part of a community. Personal factors determine caregivers' attitudes, behaviors, and responses toward episodes of aggression (Whittington, 1997).

Another characteristic that was perceived by the participants to trigger aggression was the large physical size of a caregiver. The Bowers (2005) identified power and dominance as a key element in conflict situations such as aggressive episodes. A physically large caregiver who is following and implementing the unit rules may be

perceived as intimidating or restricting a client's personal freedom. One participant who identified himself as large perceived aggressive episodes in clients were triggered as he enforced the hospital rules, especially when those rules limited the client's personal freedoms.

Participants in this study also reported that some aggressive episodes were triggered by routine restrictions and daily care of the hospitalized client. The participants reported aggression being triggered by enforcement of unit restrictions and while performing routine care that required the staff members to touch a client. Episodes of aggression triggered by caregivers performing routine care have been reported in the literature (Flannery, 2005; Lowe et al., 2003).

Staff behaviors have been cited in the literature as stimulating aggression in mental health clients. Spokes et al. (2002) reported staff characteristics, including clinical skills, personal characteristics and interpersonal skills, could contribute to escalating aggression in a client. Participants in the present study perceived that behaviors of other staff members, such as voice tone, lack of respect, aggressive attempts to control the client, and cultural differences triggered aggression in mental health clients. Verbal communications, specifically a forceful or raised voice tone of a caregiver, were reported by the participants to escalate aggression. Another characteristic mentioned by Spokes et al. was listening skills. The authors believed, as did the participants in the present study, listening and basing responses on client's comments is important in preventing and managing aggression. Caregivers who demonstrated that they had heard what the client had to say and responded appropriately were more successful in defusing escalating

aggressive episodes. Caregivers who did not respond to what the client said encountered more episodes of aggression in clients with a mental illness. These findings are very similar to the descriptions provided by the participants of this current study where the communication skills of the caregiver could escalate or defuse aggression.

Research studies that include the perspectives of caregivers and clients identified many of the same staff behaviors that can defuse or stimulate aggression as those identified by the participants in the present study. These characteristics included personality factors, abrasive words, staff abuse of authority, disputes between the staff and clients and staff enforcing limits on clients (Davison, 2005; Fagan-Pryor et al., 2003). Personality and the individual's interpersonal skills are an important aspects of the caregiver's effectiveness mastering and using clinical skills effectively (Dunn & Alholm, 2007a; Lowe et al., 2003; Spokes et al., 2002; Townsend, 2006). De-escalation techniques are more effective when caregivers can use themselves therapeutically and can be fully present in the moment with the client (Johnson & Hauser, 2001). Therapeutic use of self is taught in all medical, nursing and social service professional programs before students are allowed in the clinical setting. This skill is extremely important when establishing a therapeutic relationship and rapport with any client, becoming even more important when dealing with the mentally ill. The participants in this study discussed the importance of a caregiver using self to build rapport and the therapeutic alliance with clients. All of the participants provided examples of a time when they themselves used these techniques to de-escalate an episode of client aggression.

Addressing characteristics of the caregivers and clients that may trigger aggression is important because it is part of providing a safe environment for the mentally ill. Individuals with a mental illness are hospitalized because they require stabilization. The care-giving environment should be safe for caregivers and clients (Runy, 2007). It is imperative to identify factors that jeopardize the safety of clients and caregivers. Future research studies on violence in mental health must address the influence of caregivers' behaviors on their clients.

The Health Care Sciences (HCS) and the Institute of Medicine (IOM) (2004) advocated that all hospitals, including mental health facilities, begin to develop a culture of safety as a future goal. The HCS and the IOM have developed a plan to assist each hospital to create an environment of safety for clients and caregivers. The plan includes a commitment to safety beginning at the highest levels of the management team. For such a plan to be successful, resource allocation and a commitment to client safety must begin with the administrative staff of the hospital. Unsafe practices in healthcare settings should include identifying and managing caregivers who either intentionally or unintentionally escalate aggression in clients (Health Care Sciences & Institute of Medicine, 2004).

Aggressive episodes in the acute care mental health setting, affect caregivers and clients. Assaults on caregivers by clients are considered an occupational hazard worldwide (Flannery et al. 2007). Six of the 15 participants in this study reported they had been assaulted or physically injured by a client at some time in their career.

This finding is less that other studies where more than 70% of caregivers reported being assaulted (Hinsby & Baker, 2004; McKinnon & Cross, 2008). The US Bureau of

Labor Statistics (2007) reported injuries to healthcare workers in mental health facilities for 2006 that averaged 9.2 reportable injuries per 100 workers (about 8500 injuries). Injured caregivers missed an average of 3.9 days of work (US Bureau of Labor Statistics, 2007). None of participants in the present study reported missing work from injuries sustained during an aggressive episode. However, the participants acknowledged that other staff members, as well as some clients, had been hospitalized as a result of injuries sustained during a violent encounter. Many authors believe assaults and injuries sustained by caregivers are under-reported (Abderhalden et al., 2002; Anderson, 2001; Bowers, 2006; Cowin et al., 2003; Duxbury, 1999; Flannery et al., 2007; Grassi et al., 2001; Lanza et al., 2006; Morrison et al., 2002; Nijman et al., 2005; Ray & Subich, 1998; Rocca et al., 2006; Saverimuttu & Lowe, 2000; Spokes et al. 2002; Walker, 2000; Whittington, 2000). Future research is essential to investigate the incidence of assaults and injuries to staff and clients that are sustained during violent encounters. Investigating assaults and injuries to caregivers and clients could provide valuable insights into the root cause or trigger of client aggressive episode.

Lewis (2002) and Lanza et al. (2006) reported that clients tend to respond to "take downs" and restraints with anger, aggression, and sense of hopelessness. Situations in which a person is forcibly restrained move that individual into a primal survival mode where there is limited processing of events because of the narrowing of perception (Stuart & Laira, 2004). The person feels threatened, striking back out of a basic survival instinct, sometimes injuring a caregiver or themselves (US General Accounting Office, 1999).

Mental health clients (Hartford Courant, 1998; Weiss, 1998) and caregivers (Lichfield, 2004; Scott, 2003) may die as a result of aggression in the mental health unit. Mental health clients are often restrained when their aggression cannot be defused. A report by the Joint Commission (JACHO) (2007b) indicates that one hundred seventy six (176) deaths of mental health clients were attributed to restraints during 2007. The JACHO web site identifies communication and client assessment as the most common root causes linked to restraint deaths in clients in mental health facilities for 2005 (The Joint Commission, 2007a). It is imperative to continue to investigate the triggers of aggression and implement strategies that incorporate early identification and intervention to defuse aggressive behaviors in mental health clients in order to minimize or eliminate use of restraints, thereby reducing the risk of death or injury to mental health clients and staff.

The study participants identified fear and anxiety as their primary affective responses to aggressive episodes in the mental healthcare setting. Carlsson, Dahlberg, Lützen, et al. (2004) report that initial anxiety and fear are common in aggressive events involving mental health clients. Carlsson, Dahlberg, Lützen, et al. also noted that during the aggressive event the feelings began to subside once the caregivers recognized the feelings. Fear and anxiety are normal responses to a dangerous situation causing individuals to react instinctively. Future research should address strategies to help mental health caregivers manage the emotions they experience while managing an aggressive episode in a mental health client. Feelings of anxiety and fear naturally narrow perceptual fields influencing critical clinical judgments and decision-making. Techniques to manage

the inner fear experienced by caregivers should be incorporated into hospital training programs.

Participants in the present study stressed the importance of protecting other individuals in the environment. Marangos-Frost and Wells (2000) described similar considerations by caregivers who restrained aggressive mental health clients to ensure the safety of all individuals in the immediate area of the aggressive event including the client. Protecting clients, other staff members, and visitors was identified by the participants in this study as one of their first considerations and influenced the choice of intervention to defuse the impending episode of aggression.

Restraint use has decreased dramatically in the United States over the last 7 years (NRI Performance Management system, 2008). The World Health Organization (2005) views excessive use of restraint as a human rights violation, believing restraints should be used only when there is imminent harm to the client or others in the mental health environment. Nevertheless, some authors discuss restraints being used as a punishment or to compensate for the lack of staff in acute care mental health units (Altimari, 1998; Fagan-Pryor et al., 2003; Fisher, 1994; Lucas & Stevenson, 2006; US General Accounting Office, 1999). None of the participants in this study described restraints being used to punish the client or to compensate for lack of staff.

The participants of the study identified staff and client triggers for aggression and how these interrelated. They also identified the effects of caregivers' behaviors and attitudes on aggression among their clients. Many of the triggers of aggression identified

by the participants in this study as well as intervention that contribute to the resolution of aggression are supported by the literature.

UNEXPECTED FINDINGS

Several unexpected findings not previously reported in the literature emerged during the course of this investigation. All were related to the fact that the participants firmly believed that behaviors and attitudes of a limited number of mental health staff clearly contributed to clients' becoming violent. All participants' interviews included at least one description of caregiver aggression. Dawes et al. (2005) point out that human beings are predisposed to meet aggression with aggression and the outcomes can be disastrous. The participants in this study perceived that the offending caregivers' verbal and nonverbal communication appeared to be a key component in escalating aggression in their clients. A client who interprets a caregiver's behavior as threatening can respond defensively, which may grow into violence.

A second related finding surfaced during the member checks. One participant realized after the fact that he had provoked a client into an aggressive episode. However, the participants in this study believed that offending caregivers were aware of their behaviors often knowing that their behaviors elicited client aggression. No literature was available that specifically described mental health clients as being intentionally provoked by caregivers; however, Chou et al. (2002) and Fagan-Pryor (2003) addressed personality and interpersonal skills as triggers for aggression. Self-awareness in caregivers has been identified as important by several authors as an aspect of preventing aggression in mental health clients (Blakemore & Frith, 2003; Eckroth-Bucher, 2001; Kantcheva, 2002).

Caregivers who develop self-awareness potentially could identify their personal behaviors and attitudes that may trigger an aggressive episode in a mental health client. Teaching caregivers to develop self-awareness can aid the caregiver to alter personal strategies and behavioral patterns that could trigger an aggressive episode.

The last unexpected but related finding was the role of hospital supervisory personnel in the perpetuation of aggression on the units. Participants believed that aggressive behaviors and attitudes of some staff members went unchallenged by supervisory personnel, while staff reporting the events risked negative consequences. Although none of the literature reviewed specifically addressed supervisory personnel overlooking the behaviors of aggressive caregivers, the IOM recommendations for developing a culture of safety include accountability of supervisors, developing clear protocols for assessment of employees and the ability for other caregivers to report offending employees without fear of retaliation (Health Care Sciences & Institute of Medicine, 2004).

The potential for aggressive episodes in mental health clients can be identified early in many cases (Ehmann et al., 2001; Flannery et al., 2006). These authors also have identified the potential for other caregivers' behaviors and attitudes to influence aggression among mental health clients. Many facilities perform background checks when hiring personnel. However, the background check only identifies individuals with a criminal past. Facilities that care for vulnerable populations should enhance their screening of potential employees to help identify those who pose a risk to clients. In

addition, observations during the initial orientation period might be used to identify individuals at risk for potentiating aggression in clients.

There are multiple reasons why some caregivers may stimulate aggression in a mentally ill client. Many of these reasons can include personal attributes, such as gender, size and culture. A fearful caregiver also may unintentionally trigger an aggressive episode. One underlying theme that emerged from the present study was the need for power and control over others. These types of personal issues can and must be addressed in order to decrease aggression and improve safety and healing in the mental health facilities. It is important that caregivers and administrative personnel become aware of the influence their behaviors and attitudes have on mental health clients in order for aggressive episodes to be prevented or managed more effectively.

The information provided to the researcher throughout this study had the potential to be inflammatory and posed many personal risks for the participants. Some of the participants appeared to need an outlet for what they had witnessed. One participant remarked, "I hated to say that, but I wanted to say the truth and say what needs to be said and give you part of my knowledge." Two of the participants said that they had asked about the researcher's reliability before they called to set up an appointment for the first interview. The participants may not have shared such sensitive descriptions with a person who was not known to be trustworthy. The participants seemed to have a real sense of relief regarding being able to share some aspects of their experiences with a trusted person.

CONCLUSIONS

There have been many positive changes in the care of individuals with a mental illness to ensure clients are treated humanely. The majority of caregivers in mental health are capable, compassionate, and kind. Caregivers, such as the participants in this study, understand the importance of managing and defusing aggression. Most client aggression can be managed, but it does take training, commitment, time, and patience. There are still areas in which improvements are needed.

Some hospital administrative systems seem to foster the aggressive behavior of some staff members, allowing inappropriate behavior to continue. Administrators and supervisory personnel who protect aggressive staff members perpetuate the problem, increasing the likelihood of clients becoming aggressive and violent in the mental health setting. The participants commented that the offending staff members "had been there a long time," one for as long as 15 years, without being required to change behaviors. Conversely, those participants who chose to report aggressive caregivers risked or suffered harsh consequences from the administrative staff or peers. An editorial by Mason (2004) discusses a "code of silence" existing in many institutions that protects offending caregivers from the consequences of their actions. Clients are injured and die as a result of this "code." Mason says that the decision not to report colleagues and peers who provoke or escalate aggression may be due in part, to the fear of being ostracized, scrutinized, and criticized by administrators. Several nurses responded to Mason's editorial. Many of these nurses also had maintained a code of silence resulting in situations where clients suffered, and in some cases, died (Adeyinka, 2004; Allen, 2004;

Johnson, 2004; King, 2004; Name withheld, 2004; Ramos, 2004; Roti, 2004). Everyone in the mental health setting is potentially at risk by behaviors that provoke aggression because the action may foster a hostile environment that inhibits healing risking injury to clients and caregivers.

IMPLICATIONS

The findings of this study have implications for mental health practice and administration; suggestions regarding ethical implications and future research are also included. Although educating caregivers is costly and time consuming, it is the responsibility of the hospitals to provide that education, and as often as needed. There are many barriers to developing, implementing, and enforcing an effective educational program in the acute care mental health setting. Requiring all caregivers to attend mandatory education may create staffing problems. Most hospitals have aggression management programs because federal law requires it; however, implementation of those programs and training of staff is left to the discretion of hospital.

Training mental health caregivers in identifying the risk for aggression and managing aggressive client behaviors can decrease the incidence of aggression (Bisconer et al., 2006). Knowing the mental health client's potential for aggression allows caregivers to remain constantly alert, ready to implement early management strategies to neutralize specific triggers that stimulate or escalate aggression in mental health clients. Risk factors should be included in training programs just as verbal de-escalation techniques are taught in managing aggressive clients. Mental health caregivers need and

desire the support of hospitals in providing training for the care of acutely ill mental health clients.

Training of mental health care providers should include hospital policies and procedures that detail proper techniques the staff members are to follow when managing aggressive clients. Several study results have indicated that the mental health staff would like to review policies and procedures that guide the management of aggressive clients prior to providing care to clients (Jones & Lowe, 2003; Martin & Daffern, 2006; Southcott et al., 2002). Violence and client aggression can be greatly reduced by such support as well as a comprehensive program that includes the attitude of a safe workplace (Dunn & Alholm, 2007b; Needham et al., 2005).

Southcott et al. (2002) demonstrated that teaching verbal skills to caregivers has been beneficial in de-escalating an aggressive client. De-escalation strategies include not only what is said, but tone and personal demeanor as well. However, as the present study suggests, the attitudes indicated by vocalizations, voice tone, and demeanor of some caregivers accelerate aggression in clients. Needham et al. (2006) reported that changing the attitudes of caregivers through training in de-escalation techniques alone was not effective. Training courses provided without changes in institutional organization values has little impact on caregiver attitudes. A comprehensive training program designed to create a culture of safety that incorporates positive values and promotes professionalism throughout the organization is necessary (Health Care Sciences & Institute of Medicine, 2004).

Many mental health caregivers hold professional licensure from credentialing agencies that set standards for their behavior. Since such standards are based on state and federal laws, some of the behaviors identified by the study participants are considered illegal and need to be reported. Staff members should be empowered to report the offending individuals to supervisors without fear of retaliation (Health Care Sciences & Institute of Medicine, 2004). Reports made anonymously to credentialing organizations may be misleading or include minimal information of the incident, making an investigation difficult. A reported incident, where aggressive behaviors were triggered in a client, may become one person's word against another (Fudin, 2007).

Reporting another caregiver's actions can be especially difficult when the offending caregiver has a personal relationship with the supervisory personnel. The federal government and all states have some form of whistleblower protection laws for employees who perceive they have been wrongfully terminated. Termination of an employee for reporting an offending caregiver is not usually identified by hospitals as the basis for dismissing the employee, because in most instances that would be considered illegal (US Department of Labor Occupational Safety and Health Administration, 2007). However, performance appraisals of employee work may suddenly become negative, so workers are dismissed based on unsatisfactory evaluations. While whistleblower protections are in place for many caregivers, unethical treatment can be difficult to prove. For example, one study participant spoke up when an elderly client was pushed against a window and "taken down" roughly. Administrative managers reassigned the participant to another unit thought to be an undesirable environment to the caregiver. When the

strategy did not result in the caregiver resigning and the participant was given another undesirable work alternative. The participant declined the assignment, the hospital supervisory personnel retaliated and reprimanded the participant. The reprimand was written up and placed in the employee's file.

Hospital administrations or supervisory personnel who protect aggressive personnel perpetuate violence in the workplace. The American Nurses Association has taken a stance against workplace violence stating that it "threatens the delivery of safe quality care, and violates individual rights to dignity and integrity" (American Nurses Association, 2004, p. 2). McPhaul and Lipscomb (2006) state: "Don't let anyone tell you workplace violence is part of a nurse's job" (p. 53). This statement should include all levels and the multiple disciplines of caregivers not only the nursing profession.

Episodes of aggression in clients with a mental illness can be managed, defused, and often prevented. The caregiver first must identify a client's potential for aggression. and then implement appropriate techniques to manage the client's behaviors. Risks for aggression include not only identifying a client's tendency but also those of other caregivers who interact with the client. Hospital supervisory personnel should counsel and correct caregivers who trigger or escalate aggression in a mental health client. A proactive administrative management committed to a philosophy of non-violence and safety is necessary to change the attitudes of caregivers in the current mental health care environment (Dunn & Alholm, 2007b; McPhaul & Lipscomb, 2006). The IOM (2004) believes that leadership must be commitment to a culture of safety if this type of program is to succeed within an organization. One measure the IOM supports is "facility-wide

patient safety policies and procedures that delineate clear plans for supervisor responsibility and accountability and enable each employee to explain how his or her performance affects patient safety" (Health Care Sciences & Institute of Medicine, 2004, p. 288).

RECOMMENDATIONS FOR FUTURE RESEARCH

Further research is essential that can contribute to developing hospital strategies and implementation of a plan that addresses the influence of caregivers' behaviors and attitudes on client safety. Clearly, holding management, supervisors, and employees accountable for their behaviors would be instrumental in creating a culture of safety (Dunn & Alholm, 2007b; Health Care Sciences & Institute of Medicine, 2004).

Additional studies are needed to identify interventional strategies and programs contributing to improvement of caregivers' interpersonal skills. Studies that evaluate how acute care mental health hospitals implement training and certify the qualifications of trainers also may provide information that might help design stronger aggression prevention and management programs. Such programs could decrease health care costs associated with emotional and physical injuries and improve the overall well-being of mental health clients and caregivers. Additionally, studies should be directed at identifying and developing screening strategies to be used during the hospital orientation period to identify individuals who may have the potential to trigger aggressive episodes.

Staffing for all areas of healthcare, including mental health, will be a focus over the next ten years as the "baby boom" generation ages out of the workforce (Garrett & Martini, 2007). The shortage caused by caregivers leaving the workforce will affect the

care of individuals with a mental illness, including those with dementia. Staffing levels will continue to be stressed as the shortage of mental healthcare givers continues to grow. Understaffing affects the ability of caregivers to manage aggression and can increase anxiety and stress when there are aggressive clients in the milieu.

Caregivers, both male and female, who work in any healthcare setting in the US, come from a variety of cultural backgrounds. Future studies are needed to explore the relationship of cultural and gender differences and aggressive behaviors in mental health clients. Studies also are needed to identify the optimal level and mix of staffing and their effects on aggressive events and client outcomes.

Currently, a great deal of attention is directed at creating a safe workplace. McPhaul and Lipscomb (2006) identified the most common type of violence that occurs in the workplace is "assault by a client, patient, or student served by the facility" (p. 53). The IOM specifically addresses "creating and sustaining a culture of safety" in the hospital setting (Health Care Sciences & Institute of Medicine, 2004, p. 286). Strategies for implementing a culture of safety in the mental health setting is an important area that should be examined in future studies. A culture of safety requires that all individuals at every level of an institution examine their role in promoting a safe environment. Qualitative studies designed to help caregivers examine the effects of their behavior on precipitating or escalating aggression in mental health clients would be useful in implementing such a program. Newhouse (2007) says that to ignore the IOM recommendations is a failure of the system to meet safe client-centered care, putting clients and caregivers at risk for physical and psychological injury.

CONCLUDING REMARKS

This study was designed to explore and describe the perceptions of mental healthcare workers concerning the triggers of aggression and the perceptions of the participants on the influence of an individual's behavior and attitude on mental health clients. The findings of the study, as well as the review of the literature, have revealed the necessity for further exploration of how staff attitudes and behaviors may influence aggression and how such problems can be prevented or managed. Additionally, it is important to investigate the role of administrative personnel involved in establishing an environment of respect and safety, managing aggressive episodes, and in dealing with staff members who intentionally and continually trigger aggressive episodes in mental health clients. Quantitative and qualitative studies are needed to expand the understanding of the influence mental health caregivers and supervisory personnel have in triggering aggressive episodes in a mental health client. Additional research should continue to facilitate the development and evaluation of alternative strategies for the management of aggression using insights gained from this study. Research may also provide a vehicle for staff members wishing to voice experiences and observations of individuals triggering aggression without fear of repercussions. Individuals who care for the mentally ill have a challenging job. Although most caregivers provide and promote quality mental health care, some do not. Through a rigorous exploration of what caregivers believe stimulates or escalates aggression in their clients, new strategies may be revealed that will contribute to a safer and more healing environment for both mentally ill clients and their caregivers.

The use of metaphors can help to clarify tacit meanings and feelings embedded in qualitative research that otherwise may not be fully realized (Charmaz, 2003). Mental health units and freight trains have much in common. It takes a team to manage both successfully. The locomotive is powerful, allowing it to carry tremendous amounts of freight, as does a mental health client. A well-trained team of individuals with special knowledge and commitment is necessary to manage the train safely and effectively in order for it to arrive at the specified destination. Mental health care also requires a team of educated members that support the mentally ill client to attain goals and maximize functioning.

The engineer, much like the physician, guides the train, monitoring for changes that could indicate problems, while the rest of the team attends to other functions. Equally important is the brakeman who collaborates with the engineer to calculate speed, course, and braking distance, taking into consideration, the number of engines and cars, the weight of the freight and existing conditions within the environment. The nurse is like the brakeman. The nurse manages care, monitors progress and applies collaborative interventions that propel the client safely forward.

The flagman stands present at the crossing to keep others safe by warning as the train approaches. The psychiatric technician stands vigilant in the milieu monitoring for warning signs that may indicate and create an unsafe healing environment.

The switchman's responsibility is to move the train over to the appropriate track and guide the transitions that occur during the switch. The social worker or counselor encourages and guides the mentally ill client through life-changing transitions.

The gandy dancer maintains the track by replacing damaged rails and timber. Maintenance functions of the hospital are provided by housekeeping, plant operations, central supply, and pharmacy departments. Without these vital departments, the hospital and care environment would cease to function effectively.

Finally, a dispatcher's job is to make the most efficient use of the resources available by scheduling trains so that they can use the same rail line without colliding. Hospital executives and department administrators include in their plans the optimal number of employee needed to provide safe, quality care to the mentally ill.

The train arrives safely at its final destination because of the proper dedication, commitment, education, and experience of the entire railroad crew. Failure of one or more of the systems to operate efficiently can result in derailed twisted wreckage or run-away train. The results of a run-away train can be disastrous; individuals can be killed and property can be damaged beyond repair. Prevention begins with a company united to achieve a common goal. Management strategies that incorporate a philosophy of safety and caring and a productive working environment result in the train safely reaching its destination. The same can be said about providing care to the mentally ill. When the team of dedicated caregivers and administrators provides and manages care in the most effective manner, client outcome measures also improve and the client's "train" has a better chance of a safe journey through his or her mental illness, returning the client to a productive life.

SUMMARY

Workplace violence has become a topic of interest over the past several years (American Nurses Association, 2004; Bilgin and Buzlu, 2006; Bowers, Brennan, et al., 2006; Bureau of Labor Statistics, 2007; Dawes et al., 2005; Health Care Sciences & Institute of Medicine, 2004; McKinnon & Cross, 2008). Episodes of aggression in mental health clients appear to be multifaceted and have been investigated extensively in an effort to reduce workplace violence. However, a paucity of studies addressed the role of caregiver-client interaction in the precipitation of client aggressive behavior. In the present study, 15 caregiver participants perceived multiple factors influenced the diffusion or precipitation of client aggressive episodes. Episodes of client aggression were perceived by the participants to be on a continuum ranging from threatening vocalizations to overt physical violence. One overarching construct and 3 major categories that described the continuum of behaviors emerged from the participants perceptions of aggressive episodes.

The participants perceived that clients and caregivers could both trigger an episode of aggression. Client factors that influenced aggression included disease process, history, and a desire for independence. Participants perceived that mental health caregivers also had an impact on aggression and could trigger aggression, as well as manage an escalating episode of aggression. Caregivers were perceived to use multiple strategies to defuse client aggressive behaviors. De-escalation strategies began with the least physically intrusive measures such as communication and building a rapport with the client. When an aggressive episode could not be managed using least restrictive

methods, caregivers were seen to limit environmental stimuli and move the client away from others. In cases where the episode of aggression began to jeopardize the safety of the client or others, caregivers would employ interventions that were more physically restrictive.

Behaviors of some caregivers also were perceived by the participants in this study to trigger episodes of aggression in a client. These behaviors included inappropriate vocalization such as loud voice tone, social rather than therapeutic interactions, and a challenging demeanor. The participants also perceived that some caregiver responded to their clients with a lack of respect. Many of the findings of this study were similar to those discussed in the extant literature.

Mental health is a challenging specialty. Aggression and violence is a constant potential threat in the mental health setting; therefore, it is important to identify all factors that can trigger or escalate aggressive clients, even when those triggers involve the caregivers themselves. Caregivers who work with the mentally ill must always be diligent in assessing and providing early intervention strategies with aggressive clients. The early identification of a potential volatile situation and implementation of safe intervention strategies can help to secure optimum care for the mental health client.

APPENDICES

APPENDIX A

IRB Approval Letter

November 22, 2006

MEMORANDUM

TO: Kathleen Lucke, PhD, RN/Cathy L. Hueske, RN, CNS, P/MH, FNP
School of Nursing 1132

FROM: Wayne R. Patterson, PhD
Senior Assistant Vice President for Research
Institutional Review Board 0158

SUBJECT: Expedited Review, Human Subjects

Project Director: Kathleen Lucke, PhD, RN/Cathy L. Hueske, RN, CNS, P/MH, FNP IRB #06-377
Project Title: Perceptions of Aggressive Behaviors in Mental Health Clients

Under the Institutional Review Board's policies and procedures for reviewing protocols by an expedited review process, your project referenced above was approved on November 22, 2006. The Board Action was:

Status: Approval with Stipulations **(See Comments):**

Project Directors of approved projects are responsible for reporting to the Institutional Review Board any unanticipated adverse reactions observed during the conduct of the project as well as any severe or serious side effects whether anticipated or unanticipated. If the adverse reactions were unanticipated or death has occurred, the adverse reactions must be reported to the IRB within 24 hours.

Should your project require modification which alters the risk to the subject or the method of obtaining informed consent (if applicable), the project must be reevaluated by the Institutional Review Board before the modification is initiated.

If applicable to the study, completed subject consent forms should be maintained in the designated place for at least three years after the termination of the project. In order to be in compliance with the requirements of the FDA regulations, 21 CFR 56.27a, a copy of the completed consent document must be provided to the subject.

Comments: 1) SUBJECT CONSENT FORM CHANGES: a) Please remove "Appendix A" from the top of the first page. Please also remove "Aggressive Behaviors" and the page number located at the top of each page. b) Please change the header entitled "Number of Subjects Participating" to "Number of Subjects Participating and the Duration of Your Participation". In addition, please include the length of time of participation anticipated for the subject. c) Please remove the paragraph which states, "Study records that identify you...file in Ms. Hueske's office" from the "Use and Disclosure of Your Health Information" section. d) Please change the "Required Clauses" header to read "Additional Information". Please also replace the language under this section to include the most recent verbiage, which can be found on the "Sample Subject Consent Form" located on the IRB website. e) Please remove "Appendix B" and the "Interview Guide" from the last page of the consent form. 2) OTHER CHANGES: a) Cathy Hueske must complete the "Protection of Human Research Participants" online training course prior to her participation in any research activities. Please provide the IRB with a copy of her certificate of completion.

When written documentation has been submitted to this office responding to the above stated stipulations, final approval will be forwarded to you. This project should not be implemented until final approval has been obtained. Please contact this office (409-266-9475) if you have any questions or need assistance.

Please be advised if you do not respond to this stipulation **within 60 days**, this project will be **administratively deferred**.

WRP/mls

APPENDIX B

IRB Subject Consent Form

IRB APPROVED DEC 8 2006

FORM VALID THROUGH OCT 3 1 2007

SUBJECT CONSENT FORM

You are being asked to participate as a subject in the research project entitled, "Perceptions of Aggressive Behaviors in Mental Health Clients" by Cathy Hueske, a doctoral student working under the direction of Dr. Kathleen Lucke, Ph.D., RN, Associate Professor in the School of Nursing at UTMB.

PURPOSE OF THE STUDY

The purpose of this qualitative study is to employ naturalistic inquiry interviews to describe the mental health staff's perceptions of factors that affect aggressive behavior in clients. Effectively reducing the risks of harm for the mental health worker and client requires a clear understanding of factors that trigger aggressive behaviors and how those factors can be diminished and eliminated from the environment.

You are being asked to participate because you have identified yourself to the researcher as a mental health care provider who currently works with the mentally ill in an in-patient setting. Information will be collected using an interview process. Locations of the interview session are selected with your input to provide privacy. The questions will ask you to discuss your perspective on what your perceptions are of prevention, management and precipitation of aggressive behavior in mentally ill clients. Ms. Hueske will also ask you specific questions about your age, race, employment status, years of employment, years of education completed, and hours worked per week.

PROCEDURES

1. You will be interviewed by Ms. Cathy Hueske at a time and place convenient to you. You will be interviewed at least once but not more than twice for a period of no longer than 90 minutes. You also may be contacted by telephone for clarification of information. The interviews will be audio-taped and later transcribed verbatim so that the researcher can analyze and interpret your responses along with the responses of all the other participants in the study. If for any reason you become unable to safely and comfortably participate in or complete any interview session, it will be stopped. You may refuse to participate in this project at any time without prejudice.

2. Ms. Hueske also will ask you to complete a questionnaire asking you your age, race, employment status, marital status, years of education completed, years of employment, years of education completed, and hours worked per week.

3. The questionnaire and the interview guide, notes, and audiotapes will be coded so that none of the aforementioned study materials contain information that could identify you.

4. The audiotapes, transcripts of the interviews, and responses to the questionnaires will be kept in a locked file cabinet in the researcher's office. One copy of the coding scheme that allows only the researcher to identify you will be kept in a locked file separate from the one where the interview tapes, transcripts, and questionnaire responses are stored. Verbatim

transcripts are needed because Ms. Hueske will be examining what you and all participants in the study say about what happens while caring for an aggressive mental health client.

5. Following any and all of the interview sessions, Ms. Hueske may be contacting you by e-mail, postal service, or telephone to clarify any information that she has questions about. This is because it is important for her to have an accurate understanding of the answers you provided.

6. Each participant will be given information gained in this study that could benefit you in your role providing care to an aggressive mental health client will be made available to you at the conclusion of the study.

RISKS OF PARTICIPATION

The potential risks from participation in the study include the potential loss of confidentiality. To minimize these risks all data will be coded and locked in a file in the Principal Investigator's (PI) office. The interview process may elicit an unexpected emotional response. Participants who express discomfort caused by the interview will be referred to an appropriate support service for counseling at their own expense. As an advanced practice nurse in Mental Health, the PI will attend to any of the participant's discomfort, stop the interview, allow the participant to regain composure, if necessary will reschedule the interview and /or refer the individual. The participant may become fatigued during the interview. All attempts will be made to minimize fatigue, included allowing for breaks if needed.

Additional risks of participation includes revealing information that would indicate abuse of mental health clients. The investigator is required by law to report information that indicates abuse or violation of the mental health to the proper authorities.

NUMBER OF SUBJECTS PARTICIPATING AND THE DURATION OF YOUR PARTICIPATION

The anticipated number of participants involved in the study will be 20 mental health care workers currently employed in an inpatient mental health facility. They may be licensed or unlicensed. The length of time for participation is no longer than 3 hours over a period of 11 months.

BENEFITS TO THE SUBJECT

You may not benefit from your participation in the research project.

ALTERNATIVE TREATMENT

The alternative is not to participate in the study.

REIMBURSEMENT FOR EXPENSES

There is no reimbursement for your participation in this study.

COSTS OF PARTICIPATION

There will be no cost other than gasoline and parking to participant in this study.

REASONS FOR THE STUDY INVESTIGATOR TO STOP YOUR PARTICIPATION

The interview may be stopped by the investigator if you become distraught or emotionally unable to continue with the interview. If necessary, the participant would be referred to a counselor at their own expense.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Health information will not be collected as a part of this study.

All of the interview and questionnaire information collected from you during this study are collected only because you are in this study. The study results will be shared with you in summary form and will be published only as aggregate data, without identifying you in any way, in professional journals. Data collected may be reviewed in order to meet federal or state regulations. Reviewers may include, for example, representatives of the UTMB Institutional Review Board. This authorization for the use and disclosure of your information as described above expires upon the conclusion of the research study.

ADDITIONAL INFORMATION

1. An offer has been made to answer any questions that you may have about these procedures. If you have any questions before, during or after the study, or if you need to report a research related injury or adverse reaction (bad side effect), you should immediately contact Ms. Cathy Hueske at (713) 854-0549 at any time, or if after normal office hours, at (713) 217-2020 (pager) or Dr. Kathleen Lucke at 1-409-772-8205.
2. Your participation in this study is completely voluntary and you have been told that you may refuse to participate or stop your participation in this project at any time without penalty or loss of benefits and without jeopardizing your medical care at UTMB. If you decide to stop your participation in this project and revoke your authorization for the use and disclosure of your health information, UTMB may continue to use and disclose your health information in some instances. This would include any health information that was used or disclosed prior to your decision to stop participation and needed in order to maintain the integrity of the research study. If we get any information that might change your mind about participating, we will give you the information and allow you to reconsider whether or not to continue.
3. If you have any questions regarding your rights as a subject participating in this study, you may contact Dr. Wayne R. Patterson, Senior Assistant Vice President for Research, Institutional Review Board, at (409) 266-9475.

The purpose of this study, procedures to be followed, risks and benefits have been explained to you. You have been allowed to ask questions and your questions have been answered to your satisfaction. You have been told who to contact if you have additional questions. You have read this consent form and voluntarily agree to participate as a subject in this study. You are free to withdraw your consent, including your authorization for the use and disclosure of your health

information, at any time. You may withdraw your consent by notifying Ms. Cathy Hueske at (281) 499-1579 or Dr. Kathleen Lucke at 1-409-772-8205. You will be given a copy of the consent form you have signed.

Date	Signature of Subject
Signature of Witness	Signature of Authorized Representative *(if applicable)*

Description of Representative's Authority to Act for Subject *(if applicable)*

Using language that is understandable and appropriate, I have discussed this project and the items listed above with the subject and/or his/her authorized representatives.

Date	Signature of Person Obtaining Consent

APPENDIX C

IRB Approved Flyer

Volunteers Needed

to participate in a study related to aggression in hospitalized mentally ill clients.

To qualify for this study all volunteers must:
1) hold one of the following credentials:
MD, RN, LVN, PT, LMSW, LPC, RT, OT
2) currently work in inpatient mental health care setting
3) have a minimum of 5 years of inpatient experience

If interested please call:

Cathy Hueske, R.N., CNS P/MH, FNP-BC
PhD-candidate University of Texas-Galveston

APPENDIX D

Demographic Data Form

Demographic Information

Id # _____

Gender: M F Age: _____

Ethnicity:_____Nationality:_____

Please circle one

SSW LPC LCDC RT OT

Other:_____

Basic Education: _____

Highest level of college completed:_____

Degree/s:_____

Professional Certification:_____Advanced Certification:_____

Current Position:_____

Please indicate the number of years:_____

Type of Mental Health Experience:
Please indicate the **Number of Years** in each setting

_____ Inpatient _____ Outpatient

_____ Partial Hospitalization/Day Treatment

_____ Other:_____

Total Years of Mental Health Experience including current work setting:_____

APPENDIX E

Interview Guide

Interview Guide

Hello, my name is Cathy Hueske. I am a graduate student with the University of Texas-Medical Branch in Galveston. I am currently doing a study called "Perceptions of Aggressive Behaviors in Mental Health Clients" in which you have volunteered to participate. Your honest responses to the questions asked would help to add to what is already know about the topic.

1. Tell me about the most recent time when you were assigned to give direct care to a client who was displaying aggressive or threatening behaviors.
   Probe for:
   - Describe the unit at that particular time.
     - About how many clients were on the unit?
     - What was the ratio of staff to clients?
     - How many RN, LVN, PT, other staff including MDs.
     - Were there other clients who were aggressive or threatening on the unit?
   - Tell me about his/her behavior?
   - Did you do anything differently in response to his/her behaviors?
   - How did the client respond?
   - Describe what you were thinking at the time.
   - How were you feeling?

2. Describe a time when a client who was displaying aggressive or threatening behavior calmed down after something you did.
   Probe for:
   - Describe what was happening on the unit.
   - How did you know he/she was aggressive?
   - What you were feeling and what was your response to the aggression?
     - What did you do?
     - Tell me what happened next.
     - What behaviors seemed to make a difference?
   - Describe what you were thinking at the time.

3. Describe a time when a client's aggression or threatening behavior increased after something that you did. Tell me what happened.
   Probe for:
   - Describe what was happening on the unit.
   - What were you thinking/feeling and what was your response to the aggression?
   - Think about a time when you saw a client aggression or threatening behavior decreased after something another staff member did. What happened?

- Think about a time when you saw a client aggression or threatening behavior increased after something another staff member did. What happened?

4. Tell me about a time when you've seen a client with aggressive or threatening behavior escalate in response to another staff members intervention.
   Probe for:
   - Describe what was happening on the unit.
     - About how many clients were on the unit?
     - What was the ratio of staff to clients?
     - How many RN, LVN, PT, other staff including MDs.
     - Were there other clients who were aggressive or threatening on the unit?
   - Tell me about the client's behavior.
   - What about the incident led you to that belief?

5. Tell me about a time when you thought an aggressive client should have been approached differently.
   Probe for:
   - Describe what was happening on the unit.
     - About how many clients were on the unit?
     - What was the ratio of staff to clients?
     - How many RN, LVN, PT, other staff including MDs.
     - Were there other clients who were aggressive or threatening on the unit?
   - Tell me about the client's behavior.
   - What about the incident led you to that belief?

6. What do you believe encourages clients with aggressive or threatening behaviors to escalate?
   - Can you give me an example?

7. What do you think calms clients with aggressive or threatening behaviors?
   - Can you give me an example?

Conclusion:
Thank you for your participation in this study. I appreciate the time you have spent and the information you have provided to me. While analyzing the data I may contact you to clarify any questions I may have about your answers. At the end of this study I will provide you with the generalized findings. If you have any questions or comments you would like for me to know please call me.

APPENDIX F

Abbreviated Codebooks

Initial Category Destination:
Started February 10, 2007

Signs of aggression

Knowledge about aggression

- Intuition
- Physical

Staff behaviors/Precipitating aggression

Constant vigil

Inattention

Inconsistencies with rules and limits

Environmental issues

Staffing

De-escalation techniques: talking

De-escalation techniques: partnering

De-escalation techniques: general

Client consequences

Perceptions of what's going on

Thinking of self

Thinking of clients

Feeling of self, anxious

Client causes of aggression

Staff injury

Hospital communication

Protection

Preliminary Code Book 1:
Started February 15, 2007

I. Assessment

a. Signs of Aggression

Took off on her own
Tearing up things
Yelling/shouting/Threatening/Loud/Cursing
Throwing/Pushing/Shoving/Hitting/swinging/fighting/combative/attacking
Angry/agitated/antsy
Gotta knife (weapon)
Hurting himself or someone (cutting, hitting, punching)

b. Constant vigil

Couldn't keep my eyes off her
I'm listening I got this critical thinking going on at the same time
I looked at the patient's face and I knew
I noticed…
You don't want to …leave a patient alone..when they are angry…you don't know what steps they'll take next

c. Intuition

I knew then
Something insider her made her call
I don't know I just sensed
Something inside me told me so
I always know in the back of my mind

d. Disease Process

Psychosis and drugs/Hearing things in his head (Psychosis)/Hallucinating
Drug addict
Delusional
On a 1:1
Suffering from drugs
They can be hallucinating, detoxing,…or in pain

II. Precipitation of Aggression

a. Staff behaviors

i. Overt Physical & verbal

Shouting/talking loud
Negative way in her tone
Approaching the patient with attitude
Show …you don't believe what they are saying
Don't have the patience you should have

ii. Inattention

The staff wasn't paying attention
The tech wasn't paying much attention
My tech didn't see it…didn't see what was going on…She was not clicking to it

iii. Inconsistency of staff with rules & limits

Everybody else had been bring food up from the cafeteria..they're not supposed to
Cause you did it for one and not for the other

b. Client behaviors

Gave us this finger that goes up (obscene gestures)
They do what they want to do
…do what they want to do and they don't understand the reason & rationale
Don't want to do what is asked

III. Environmental/milieu

It can become very dangerous
I didn't know anyone..the charge nurse barely spoke to me
Kept talking to her under my breath , but she still was getting it (milieu management?)

IV. **Staffing** (So far only one has reported a MD there when it began to escalate)

a. Number

Other than that I'd have been all by my self
Short staffed
I didn't have a tech, I don't know where the tech was
Couldn't go back out front cause there was nobody out there

b. Gender

Both of them (techs) were female
Had to call a male tech (from another unit)
I can see one of them was pregnant…I didn't want her to be involved
We actually needed a male tech there…just female techs

V. De-escalation of aggression

a. Talking

I tried to talk to her to see what was going on
Try to talk to a patient
Communication

b. Partnering

I just want you to tell me
I asked her if there was anything I could do for her
You have to go with it…talk to them later

c. General

Moved out of the way
Basically how you would treat your mother
Body language…eye contact
Lower my voice to them an pay attention

VI. Consequences of aggression

a. Pt. consequence

Coding (calling a code green, white, mont, show of force)
Pressed charges for assault
Injection
Sent to the hospital

b. Staff consequence

i. **Injury**
Hit/punched/scratched
Coffee thrown at …face

ii. **Positive**
It's really fun too…help them and not hurt them
Rewarding

VII. Perceptions of behavior

They (staff) wanna be in charge..take over
Prove their authority
Fear of bucking the system
It's a power play/I think it's more of a power play
Communication problem/lack of understanding
Accent and cultural difference

VIII. Thinking

I was thinking let me control this…before the patient is harmed or any of the staff members are harmed
Thinking about her safety
Thinking I have to do something

IX. Feeling

Really good inside...very rewarding
Scared ….because at any moment she could slit her throat
I was concerned…
I wasn't frightened…I really had a lot of concerns

X. Hospital Communication

If there had been better communication between hospital

XI. Protection

I tried to use my authority to tell the psych techs to leave the room…I wanted to help the patient
You have to think fast or you can get hurt or somebody else can get hurt

Code Book 2:
Started March 7, 2007

Knowing Aggression: How a caregiver assessed for increasing aggression through observation, intuitive feelings and disease process potential about the client. (Collapse of I a and b)

Saying all kinds of things
Escalating
Yelling/shouting/Threatening/Loud/Cursing
Something inside me told me so
Hearing things in his head (Psychosis)
Delusional
Suffering from drugs
Schizophrenia

***Managing aggression*:** Methods caregivers used to modify or de-escalated aggression. (Collapse of V a, b, and c)

Moved out of the way
Basically how you would treat your mother
You have to be aware of your tone of voice…what can we do to help
Non-threatening behavior
Trying to meet those needs to the best of your ability
Just listen
Respect (to the individual)

Precipitating factors for aggression: Factors identified by the participants as cause for increasing aggression. (Collapses II, III, IV and X)

Staff behaviors

Overt Physical & verbal

Shouting/talking loud
They're not therapeutic…and the aggressor
Show …you don't believe what they are saying
Making fun of

Client behaviors

Gave us this finger that goes up (obscene gestures)
They do what they want to do
Attention seeking/anything they can to get your attention
Didn't want to be there

Environmental/milieu

It can become very dangerous
Turn off the TV..don't lay down on the sofa
No telephone

Staffing

Number

Other than that I'd have been all by my self
I didn't have a tech, I don't know where the tech was
Couldn't go back out front cause there was nobody out there

Gender

Both of them (techs) were female
Had to call a male tech (from another unit)
I can see one of them was pregnant…I didn't want her to be involved
We actually needed a male tech there…just female techs

Hospital Communication

If there had been better communication between hospital

***Outcomes of aggression*:** Descriptions of clinical outcomes of aggression. (Collapse of VI)

Pressed charges for assault
Restraint/seclusion/quiet room/hold
Sent to the hospital
Changes in behavior

Injury

Hit/punched/scratched the staff member
Coffee thrown at the staff members face

Positive

It's really fun too…help them and not hurt them
Rewarding

***Perceptions of the behavior that precipitated aggression*:** What the caregivers perceived to be happening between staff members who stimulated aggression. (Collapse of VII)

They (staff) wanna be in charge..take over
They just don't understand what's really going on (with the patient)
Fear of bucking the system
Accent and cultural difference
Get into a power struggle

***Processing aggression*:** What the caregivers remembered thinking and feeling during the event of escalating aggression. (Collapse of VIII, IX, and XI)

Thinking

I was thinking let me control this…before the patient is harmed or any of the staff members are harmed
Thinking I have to do something
What was going on with the patient…what was bothering

Feeling

Really good inside...very rewarding
Scared ….because at any moment she could slit her throat
Really stressful...very trying...tedious…push yourself to keep doing what you're doing
I wasn't frightened…I really had a lot of concerns

Protection

I tried to use my authority to tell the psych techs to leave the room…I wanted to help the patient
You have to think fast or you can get hurt or somebody else can get hurt

Final Code Book

Bridging, Extending, and Surfacing of the Data with Emergent Category Designations

Major Construct: Precipitation and resolution of aggression

Category I: Recognizing Aggression*:* Statements that included methods and cues used by the caregiver to assess aggression in mental health clients.

Major Themes:

A) *Client Cues*

a. Disease Process:
"It really depends on how psychotic the patient is at the time"

"Some cases the patient is psychotic and may be hearing voices"

"Let's see, the patient who was diagnosed with schizophrenia. . ."

"But also it depends on their disease process and where they're at. . .what they are cycling to."

b. History:

"He had a history"

"I had already had known he was aggressive."

". . . [The client] had actually gotten through admitting with a record. . . past [of attacking a caregiver at another hospital], that had that been brought to light probably wouldn't have been let in."

". . . [He] hit me, because he has a history of that."

c. Lack of control:

"They feel like nothing is in their control. . .Especially in a locked facility. They feel like they have no control."

". . .any sense of control that they feel the staff has over them. . .really makes them escalate. . ."

"I just really thought it was silly for him to act out that way about a cigarette, because I wasn't gonna, really wasn't going to do anything. He had been there for a while, so this wasn't something new to him."

"This patient wanted to smoke and . . .there are rules and the tech tried to tell him. . .to go on back to his room. And he didn't want to go. . .and they got into it."

"don't want to follow the rules"

"Controls [rules] some people don't like."

"you want. . .this. . ." and then "What do you mean you can't give me this?"

"We said actually it's not that. . .fire alarms are gonna go off that you're standing here lighting cigarettes. . .you know you're breaking the rules. . .just making sure everything safe for every patient here. That's all."

d. Remind the client of someone else:

"I guess I must have looked. . .later I found out I must look like him."

". . .sometimes you can approach a patient appropriately but they. . .or you may remind them of somebody."

"Sometimes they just don't like me because I look like their mother or something."

e. Wanting to leave:

"[The client] didn't want to come in [to the hospital] in the first place."

"She wanted to go home."

"He [client] didn't want to go to the unit. He wanted to deal with everything right there."

"they brought him in very, very angry. . .very, very. . .at his mother 'cause she brought him in."

". . .just mad for already having to be there."

f. Client's personal characteristics:

". . .was very blatantly racist, sexist, ageist everything you possibly could be"

". . . racist comments. . .sexist ageist all kinds of comments going on [that] wreaked havoc on the unit."

". . .most times it is not the staff. Most times it is the patient himself that is struggling with issues."

". . .asked a staff member a question and. . .didn't like the answer"

". . .would come up. . .and demand. . .or want something."

". . .attention seeking and med seeking."

g. Physical/behavioral changes

"…she was very upset, acting out. Very loud verbally.

"Every time she would see me she would curse me out. . ."

"…she came in and she was really anxious. . . screaming and yelling and crying and fighting."

"And he said 'FUCK" you. And when he said that I said "uh oh." He has changed. . .He never said anything like that to me before or acted like that."

"He was yelling obscenities to the doctor and saying a lot of really nasty things to him and calling him all kinds of names."

"The facial expressions, there were angry facial expressions."

"She was walking the hall and she was saying all kinds of things. And I could see, I said 'Aw, something's going on here.' She was just walking the hall."

". . .He was pacing."

"He was yelling at us that he was going to go home that day and he meant it."

"Throw things. . .she didn't like me much."

". . .threw his coffee."

"They were yelling in group and they jumped up and charged toward another client."

"He actually went over the counter after the doctor."

"… nice one minute talking to me one minute, I could kind of trust her, then she would snap and start try to do stuff to herself like trying to cut herself, hitting her head against the wall, or trying to bust a window. You know she couldn't break it, trying to break a window and… she would sit down and try to talk with you for a

little while, then try to grab your ink pen and cut herself with it. Try to grab your badge and cut herself with it."

"Because all of them [clients] were nervous and antsy that day. And the anxiety, the other nurse even mentioned that . . .that it hadn't been like that the day before because he noticed that they were more anxious than general days usually are."

B) Self: Intuitive Knowing

"I intuitively knew that this patient was dangerous to the rest of the patients, myself, and others."

"Oh my gosh! It's that psych intuition, nursing intuition. . .but I know that's not. . .able to be measured. Not measurable because. . .hard. There was just a feeling of brewing this past week."

"That's psych. . .You just know."

C) *Characteristics of Other Staff*

a. Culture of the caregiver:

"You have different cultures, in nursing industry. . .I have find that a lot of African cultures have a lot of aggression in their speech. . .which they don't mean that they're. . .they don't mean to be that way. . .that's the way their culture is. . .and as a person that comes from a different culture. . .as American or whatever. . .they take their offense to that and I find that aggression can kinda happen that way and stuff. It's like…I can say something and you can say something and another person can say something…and there's a lot of dialect for a lot of aggression in the way they speak. It's only natural for someone to respond aggressively."

"She has an accent and sometimes they have an accent and they talk to the patients . . .Patients don't understand them. . .Patients think they're. . .making fun of them or something like that."

". . .unknowingly escalates them because she has this accent and they always thinking that she is saying something about them."

b. Personal characteristics of the caregiver:

"And these are staff that are bigger than the patients, male/female it doesn't matter."
"The mistake I made was raising my voice and that increased. . . escalated her."

"If you demand that they do something. If you give them orders. If you speak in authoritative, loud tones to them."

"Not necessarily yell at them, but talk not very nice to them, talk demeaning to them."

"If you raise it [your voice] and then you're putting somebody down and they're already there because probably all your life you've been down."

"I had one tech, but what had happened is the evening tech walked in. Both of them was females. And I can see that one of them was pregnant. I didn't want her to be in the way. And the other, my tech was fearful. I could see she was fearful and so I had to just keep talking."

"I think. . .see the patient as an object and treat them that way."

". . .Power struggle."

"challenging behavior of some staff."

". . .staff member approaches the patient with the attitude. . .You're crazy you don't know what you're talking about. Doesn't take the time to at least listen to them and let them know or hear what they have to say. Because fighting with the delusional person or psychotic person, you can't get anywhere 'cause they're out of reality."

c. Disliking a client

"We had a male patient one time that one of the male techs just couldn't stand. I don't know he just couldn't stand him. He would look at him and get mad. So anything this male patient would do, this staff would pick with him, just pick with him. Just really pick with him. He wanted him to do something so he could do a takedown. That was his whole thing. So he would pick with this guy."

"And the nurse would do things like come in with a syringe in one hand and a thing with pills in the other. . .and they taught them to do this at times. . .is offer them a choice right. . ."You can have the syringe or the pills, which is it going to be?" . . .and about that tone of voice (a stern voice tone was used as an illustration). Well you know the minute she says that…you're dealing with adolescents and . . .you know. . .the adolescents will look at her and go "It's gonna be neither ma'am. Up yours and the horse you rode in on." You know. . .and when we start taking a look at something like that. . .you know. . .and that was what caused it."

. . .the biggest problem that I can see in working in the psych business with everybody not working on the same page, following getting together and working

as a team and not showing favoritism or anything. Treating everybody the same across the board and let's all decide on what we are gonna do and stick to it.

D) Mental Health Unit Characteristics

". . . upbeat modern music. . .seems to increase the anxiety"

"I think that was going on too last night. A girl who was totally craving [drugs]…while she was watching the show *Intervention.* She was demanding Xanax, Clonapine, Camprel. . .or Ativan immediately."

"One RN, one LVN, and a couple of psych techs to possibly 20 patients, which is. . .Acute patients. . .very acute. A lot of them on suicide precautions. . .a lot of them on 15 minute checks. . .So it is really a bad situation."

"It was me, the supervisor and the charge nurse . . .and 20 patients. I have to say it was a very dangerous situation. I have to say that. . .It could have been. . .you know. . .through the Grace of God. . .staffing has gotten better since. . .there are now two staff. On those times. . .through the Grace of God nothing seriously every happened."

"Hopefully, no one else will follow behind that person. . .and follow their lead as to acting up because there wasn't no staff."

"And our unit is particularly one of that has the highest PRN use…and on the weekends. . .every other weekend, I have to be charge nurse and. . .I. . .will work with me as regular staff and maybe one of the shifts on Sunday a regular staff and the rest are PRNs. That is…you really have to know what you're doing and who you're working with and their strengths. And. . .yeah. . .so definitely staffing plays a major role in what goes on the unit."

Category II: Managing aggression: Methods caregivers used to modify or de-escalated aggression.

Major Themes:

A) *Communication Strategies*

". . .there are situations where you can actually talk people down from being aggressive"
". . .and I went to her and just started talking quietly to her and she sat on the floor. She was still crying and screaming. I even sat down with her and faced her."

"I kept talking to her, talking to her. . .[be]cause I'm trying to keep her calmed down. . ."

"It works much better if you use low tones. And ask them if they can use a tone the same as yours or lower. And sometimes that shocks them into hearing you."

"I want to keep talking about smoking but she's still talking about the doctor. She changed on me. So I say 'Okay. You will see a doctor. I can't tell you what time you're gonna see a doctor'."

". . .[I] sat down and talked with him. . .and tried to explain to him that he couldn't go, that the doctor would be the one to discharge him or the court."

"Listening to them is very important."

". . .she felt I was listening to her and trying to give her positive feedback."

". . .you need to stop and listen and give your 100 % attention to them."

B) *Building a Relationship*

"I felt confidence that it was working that he was responding to the rapport that I had established with him."

"If you have an aggressive patient, it is trust. It is trust because they want to know that they can trust you…If you talk to them in a calm voice and don't be lying to them and passing them off on the next person and just talking crazy to them."

"I got him to calm down because he trusted me. I was one of the first people he met. I was always nice to him and stuff. So I . . . got him to calm down."

". . .staff members on each shift that they can interface with that they trust and feel comfortable with."

". . .calmness, individualized attention, non-threatening behavior toward the patient . . .Trying to partner with the patient and trying to meet needs to best of your ability."

". . .you need to give them an option and respect. I give them respect like the adults they are."

". . . attitude of respect towards him even though he was aggressive towards me in the beginning. I think that made a big difference."

"And they should be approached with respect and dignity no matter what they do. Even when they are dangerous and then yes we need to have them transferred to acute facility. . .And based on. . .since I have worked on all the different units. . .based on their age I think there is a way to approach that also."

"If you, but if you treat people like you would want to be treated then you shouldn't need to be protected. I've heard that word a lot, "protected." If you treat them like you want to be treated, you shouldn't need a reason for protecting." (S2 L449-452)

C) *Milieu Management*

". . . isolate that patient away from the rest of the other patients. So we let him have his temper tantrum and get it out of his system so it doesn't affect the rest of the group."

"You know it's okay if you sit there. And it's okay if you don't like this. You can go to your room if you want. That's just really just okay. Umm, but if you start to hurt yourself, you know. . . we're just gonna have to get some help." And I said "I really don't want you to hurt yourself." Well then. . .he got. . .he was okay for a few minutes."

"Seclude the area so it was just her and I."

"I knew . . .I had to try and move the rest of the group out"

"There are times that we do interventions…and the talking doesn't work. . .and we have what's called. . .it's not a take. . .I hate to call it a takedown method, but that's basically what it is. It to not to injure them but to hold them until we can get them on their bed…on their back. . .and with the straps on their ankles and wrist."

"Getting physically. . . I'm saying let me call for some back up. So I did. My tech still wasn't paying attention much."

". . .organizing games that night too. . .a full staff was out on the floor, rather than in the Nursing station. . .pulling out games and. . .we were playing Pictionary, charades and checkers. . .I mean everybody had a Friday night feel. . .that we were out there and we need to be visible and entertaining. 'cause it's kind of boring on a Friday night, there's no activity."

Category III: Processing Aggression: Descriptions of clinical outcomes of aggression and debriefing of aggressive episodes in clients.

Major themes:

A) *Reporting Outcomes of Aggressive Episodes*

". . . able to get a grip on themselves and calm down"

". . .started calming herself down and we did not have to give her an injection."

". . was able to calm down and she didn't even have to have IV. . .IM injection. She was able to take something orally."

". . .able to get herself together and be focused, and apologize. And talk about what was bothering her why she was acting out."

". . .the patient became very aggressive. . .you know. . .toward the nurses and stuff. . . escorting him to the quiet room. Where he. . .where he stayed until. . .umm. . .we phoned the doctor to go ahead and give. . .IM. . .and. . .once we did that he was okay."

"That girl had also punched a wall…last week…and has an injured hand."

"The patient was locked up."

". . .I have seen it where the [physician]. . .grabbed the patient in a choke hold one time. . .and they had to hold him in a choke hold."

"I really like and enjoy it. . .I love working with psych patients. . .I want to make a difference. . .I feel good. . .doing my part. . .giving back to humanity."

". . .you know we are human. . .that we can learn from that and do better next time."

". . .concern for myself, the rest of the staff, and the other clients on the unit, but calm also, because I knew we could handle the situation before it gets out of control."

"I don't feel scared and I didn't feel scared last night."

"I felt so sorry for him that was such a nice little man. I liked him."

"it still bothers me." (S4 L592).

B) *Debriefing Aggressive Episodes*

". . .thinking let me control this before something breaks loose, before the patient is harmed or any of the staff members are harmed."

"It was totally illegal. . .and he was trying to escape and they had to hold him in a choke hold."

"It was a busy day and she was stressed. . .She was just stressed out that day and having a bad day. She could have just, she really couldn't get away at that time. But at that time she was just irritated because of the whole unit itself, what was going on."

"I think it all comes down to personality."

". . .unfortunately just because you are a professional that doesn't mean that you have a personality that can deal with other people."

Which time? (laughing)"

"Actually, there are a lot of cases like that."

". . .they know they can get away with it."

"I wouldn't know who to report that to. . .Exactly. . .who do you report. . .I need my job you know. . .you just be quiet. . .You shut your mouth and move on you know. So. . .I hated to say that but I wanted to say the truth and to say what needs to be said and give you part of my knowledge."

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VITA

Cathy Hueske was born in Texas, the third daughter of Alexander and Emily. She resides in the Houston area with her husband, Russell and son, Andrew. She began work in 1977 as a staff nurse in the Pediatric Intensive Care at Ben Taub General Hospital in Houston, Texas. After working as a staff nurse and then an assistant nurse manager in the PICU, she moved on to teach at a magnet high school in the Houston Independent School District in 1980. She taught at Houston Baptist University from 1990 to 1996 as an Instructor. In 1991 she became an Assistant Professor at Houston Baptist University. She worked at IntraCare Hospital in Houston, Texas from 1997-2002. She has had a small private practice providing consulting and counseling services since 1995. In 2003 she began working at Texas Woman's University as an Associate Professor teaching Mental Health Nursing.

Education

After completing high school, she entered college. She moved to Houston, Texas and entered the nursing program at University of St. Thomas, where she specialized in pediatric nursing. She continued her education at the University of Texas Health Science Center's School of Nursing in Houston, Texas where she graduated with a Master's in Psychiatric Mental Health Nursing in 1990 were she was inducted into Sigma Theta Tau-Zeta Phi. She received her advance practice certification as a Clinical Nurse Specialist in Psychiatric Mental Health in 1995. Continuing her education, she attended a postmaster's certification program at the University of Texas Health Science Center finishing in 1998. In September 2002, she enrolled at the University of Texas Medical Branch in the Graduate School of Biomedical Sciences in Galveston, Texas to pursue her doctorate in nursing.

A.A, May 1974, Del Mar College, Corpus Christi, Texas
B.S.N. May 1977, University of St. Thomas, Houston, Texas
M.S.N. May 1990, University of Texas Health Science Center, Houston, Texas
Post-Master's FNP, May 1998, University of Texas Health Science Center, Houston, Texas
Ph.D., June 2008, University of Texas Medical Branch, Galveston, Texas

Summary of Dissertation

Aggression is part of the mental health care setting. Individuals who provide care to the mentally ill are assaulted while working more than any other profession including police officers. While there is an abundance of studies investigating the external causes of aggression and the outcomes of aggressive behavior, few discuss the dynamics that occur between client and caregiver within the interpersonal relationship. Understanding the perceptions of the caregivers experience with aggressive or threatening mental health clients is essential in developing alternate strategies to manage this behavior more affectively and safely.

The purposes of this naturalistic inquiry study were to: 1) describe the perceptions mental health workers have of the causes of aggressive responses in hospitalized mental health clients, and 2) what mental health workers perceive the influence their actions and behaviors have on the precipitation of aggressive behaviors among hospitalized mental health clients. A purposive sample of 15 healthcare workers was necessary to obtain saturation and redundancy. Demographic data were collected to describe the sample. Participants were interviewed and tape recorded to gather rich thick descriptions of the phenomena understudy. The audiotapes of the interview were later transcribed and used for data analysis. Constant comparison of the data was used develop the emergent themes and categories that answered the following research questions: 1) What do licensed and unlicensed mental health workers perceive as triggers of aggressive behavior responses in hospitalized mental health clients? and 2) How do licensed and unlicensed mental health workers perceive the influence their actions and behaviors have upon the precipitation of aggressive behaviors among hospitalized mental health clients?

Guided by the theoretical framework of Symbolic Interactionism, the overarching concept of precipitation and resolution of aggression as process emerged from the participants' descriptions. The categories recognizing, managing, and processing aggression emerged from several subcategories and themes.

The findings of this study, although limited by design and sample size, provided direction for further research involving triggers of aggression and the influence of caregivers' behaviors and attitudes on clients with mentally illness. Research on aggressive episodes can provide caregivers the opportunity to incorporate valuable knowledge into evidence-based practice.

Email address: chueske@aol.com

This dissertation was typed by: Cathy Hueske