

Paediatric Mental Health Nurses'
Perceptions of Aggression in Five to Ten Year Old Children

by

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Bachelor of Science in Nursing, University of Victoria, 1996

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

Masters of Nursing
in the School of Nursing

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Abstract

Pediatric mental health nurses, working in an agency in the midst of introducing Trauma Informed Care, were interviewed to examine the factors influencing perceptions of aggression. Relational Inquiry (Hartrick Doane & Varcoe, 2005; 2007) framed the research and Kvale's (1996) Interpretive Methodology informed the interview and analysis. The complexity of relationships impacted the participants' perceptions. Two constructs interwoven throughout the findings: time to develop relationships and knowledge about the individuals with whom the relationships were to be formed. Five themes were identified however the Participant-Colleague relationship was critical to perceptions of aggression. The Participant-Child relationship and the functioning of the system of care were important. The participants recognized reflexivity as critical to the understanding of their perceptions. The participants created a common understanding of aggression. Recommendations include: 1) clinical supervision to explore issues of moral distress and burnout 2) create capacity for nursing research 3) expand research exploring 'safety', 'support' and observational studies.

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Acknowledgements

I would like to thank all those who volunteered their time to participate in this project with me. Their thoughts, feelings and care will contribute towards the advancement of practice in pediatric mental health made this project possible. I would like to thank the department for allowing me the opportunity to conduct this project within their walls. To my colleagues who have supported and encouraged me throughout this endeavor, I could not have done it without them. To friends who have read, edited and offered suggestions, I thank you. My family have supported my need to learn, ask questions, and be me, I thank you. Finally to my husband, who supported me and drove the van to the out of the way places so I could write in peace, I love you and thank you.

INTRODUCTION

The focus of this research study was nurses' perceptions of aggressive behaviour within a pediatric mental health population and how those perceptions affect nursing action. I work as a Clinical Nursing Educator for pediatric mental health nurses in the field of child and adolescent psychiatry; these nurses are my population of interest. "Aggression and its impact have rarely been examined in nurses and other staff working with children and adolescents" (Dean, Gibbon, McDermott, Davidson & Scott, 2010). Yet aggression is one of the primary symptoms in a child or youth that will be brought to the attention of health care providers (Bor, 2004; Samuels, personal communication, 2006; Dean et al., 2010). Mental health care providers are privileged to be in intimate and close contact with clients (patients) and are at increased risk of injury when clients become disoriented, are upset and/or are physically ill. Clients are also at increased risk of physical and psychological injury when attempts are made to control their behaviour in a physical manner (McKenna, 2007).

There is a large and growing body of research on aggression and violence in health care. Nurses are the health care professionals most affected by aggression in the workplace. Statistics in British Columbia indicate that "40% of violence related claims come from healthcare workers who make up 5% of the workforce in BC, the majority of whom are nurses" (Worker's Compensation Board of British Columbia, 2000, 2005). Unfortunately, these numbers do not tell us the context for these injuries and thus limit our understanding and knowledge in relation to the actual aggression or events that occurred. Injury to workers is of significant concern. Local government and union agencies attempt to address these concerns within facilities and governing policies however it is unclear to

what effect. As the body of research in the area of aggression is growing, so are the various categories and influences that affect the understanding of aggression within a health care environment. The focus of my study is to learn about what nurses understand or perceive to be aggression and how those perceptions affect their nursing actions as well as to what factors affect the nurses' perceptions of aggression.

In my experience, the nursing practice of managing aggression has often been one of power, control and containment, such as the use of restraint and seclusion, rather than understanding the precipitants of aggression and thus the prevention of aggression (Quinn, 1993; Allen, 2000; Day, 2002; Rew & Ferns, 2005). This orientation has unfortunately tended to result in further aggression and even injury. In unsolicited comments from colleagues these power and control responses are often generated under the auspices of *safety* concerns related to the unit, child or other staff members. To be able to understand nurses' perceptions of aggression I needed to understand the basis in which nurses come to be in the position of understanding, observing, participating and contributing to issues of aggression in the workplace. My research questions included: a) What do nurses understand or perceive to be aggression and how do those perceptions affect their nursing actions? b) How do nurses decide when behaviour is becoming aggressive? c) Where and what have they learned that informs their assessment or knowledge? d) What factors guide their decisions surrounding interventions?

A primary focus that led me to this area of study is my involvement in the implementation, of a philosophy of care within the pediatric mental health programs, called the Engagement Model © (Murphy & Bennington-Davis 2005, 2006). This model of care

is based on a system of care called *trauma informed* care and has been documented to effect clients, staff and system of care to reduce or eliminate aggression (Abramovitz & Bloom, 2003; Bloom, Bennington-Davis, Farragher, McCorkle, Martini & Wellbank, 2003; Rivard, Bloom, Abramovitz, Pasqualae, Duncan, McCorckle, & Gelman, 2003; Huckshorn, 2005; Murphy & Bennington-Davis, 2005, 2006). Trauma informed care involves the entire organization ensuring the psychological, physical and emotional safety of all through collaboration and cooperation. Within this literature review I explored aspects of trauma informed care models; the impact trauma has on the expression of aggression and frameworks for reducing the confrontational interactions that can occur between staff. Trauma informed care approaches are important for reducing the incidence of aggressive behaviours. Trauma informed care moves the agency away from the traditional approach of hierarchy, power and control. The importance of this literature is that it helps set the context in which the participants of this study practice.

CHAPTER I: LITERATURE REVIEW

In order to explore the phenomenon of aggression I reviewed a range of literature that examined the influences affecting nurses understanding of aggression within healthcare. To be able to understand nurses' perceptions of aggression I needed to understand how aggression was being defined in the health care field and nursing in general as well as within the nursing research literature. I examined nursing literature regarding:

- 1) Perspectives of aggression in healthcare including types of assessment tools used within health care milieus
- 2) Nurses beliefs and attitudes regarding aggression
- 3) The influence of intervention programs utilized within local health care institutions
- 4) Formal and informal nursing education, specifically nursing curricula
- 5) Health care institutions' preparation of nurses to assess and manage aggression
- 6) The influence of trauma informed care policies in relation to assessment, management and intervention of aggression that affects the nurse-client relationship
- 7) Government and institutional polices that direct nursing practice

Phenomenon of Aggression

I reviewed a range of literature to gain an understanding of the current state of research surrounding the phenomenon of aggression in healthcare, specifically within pediatric mental health. Much of the research on aggression does not consider the impact on nurses or nursing practice or the subsequent results to or with clients. I have narrowed my scope of the vast amount of literature in this field to reflect on literature that is relevant

to how a nurse comes to view aggression in health care. The phenomenon of aggression within the health care setting and its influence on nursing practice is multifaceted.

At the time I began this study there was no discernible research literature that focused on aggression and nursing of pediatric mental health populations. The literature I reviewed focused primarily on adolescents or adults in general mental health and in forensic psychiatry. As I reviewed the literature, I became aware of the gaps surrounding pediatric mental health nursing research especially for young children. The health care research in the area of aggression primarily focuses on adults, adult psychiatric and/or forensic populations and minimally on adolescent forensic populations. There has been no discernible research exploring pediatric nurses' perceptions of aggression within pediatric mental health populations.

Defining Aggression

The perception of what constitutes aggression is largely dependent on how nurses understand and define aggression which then leads to how they interpret and experience client behaviour. The current literature on nurses' perceptions of aggression and related interventions lacks clarity regarding what behaviour is being defined as aggression. Clear, concise and descriptive language would assist in a clearer delineation of the research surrounding aggressive and/or violent behaviour and lead to better understanding and supportive management for both the workers and clients alike. In the absence of clear definitions, it is difficult to compare literature from such a vast field (Rippon, 1999). Campbell (1989) articulates the confusion surrounding the perception of aggression and violence by raising the question, as to which of the "200 varied definitions should we

choose” (p.20). According to Petti, Mohr, Somers & Sims, 2001, the term ‘aggressive’ is ambiguous and does not adequately describe the precipitants or the behaviour observed or experienced. The Shorter Oxford Dictionary has three versions of definitions of aggression “1) an unprovoked attack; an assault. 2) the act of beginning a quarrel or war. 3) behaviour intended to injure another person or animal. Self assertion, forcefulness” (2007, p. 42).

The Taber’s Cyclopedic Medical Dictionary defines aggression as “a forceful physical, verbal or symbolic action. It may be appropriate and self-protective, indicating healthy self-assertiveness, or it may be inappropriate. The behaviour may be directed outward toward the environment or inward toward the self” (Venes, 2001, p. 56). The internet provides unlimited access to various definitions of aggression such as Wikipedia, “...Aggression takes a variety of forms among humans and can be physical, mental, or verbal. Aggression exists on a continuum with what is commonly called assertiveness although the terms are often used interchangeably among laypeople, e.g. an aggressive salesperson....” (<http://en.wikipedia.org/wiki/Aggression>, retrieved 10/09/2011).

Campbell provides a list of options however indicates “that an essential element is the intention to harm another either physically or psychologically...” (1989, p. 20). Campbell further differentiates between “hostile aggression” as a response to aversive stimuli, and “instrumental aggression” that is purposeful to achieve “some other reward” (1989, p. 20).

Many agencies or governing bodies include a black or white discernment of aggression or violence within their policy definitions, however there does not appear to be any articulation of the continuum of escalation that is realistic to the human condition. For example, the Worker’s Compensation Board of British Columbia (WCB) only refers to

violence within their documents and policies. Violence is defined by WCB “as the attempted or actual exercise by a person, other than a worker, or any physical force so as to cause injury to a worker,” and includes “any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury” (WCB, 2005, p. 9). These behaviours do not need to be perceived to have *intent* to injure, and are often referred to as ‘aggression’ rather than violence, within health care (WCB, 2005). A report recently released by the WCB, explored nurses’ experience of workplace violence, does not include the term aggression. The extent of the definition of violence in this document spans verbal harassment, sexual assault and bullying amongst other variables (Henderson, 2010). Foster, Bowers & Nijman wrote that aggression “can be expressed in many forms, ranging from a patient raising their voice during an argument to an unprovoked violent attack involving a weapon” (Foster, Bowers & Nijman, 2007, p. 141).

In a paper by Carlsson, Dahlberg, Lutzen & Nystrom (2004), the terms aggression and violence are interchanged throughout the article. Morrison (1993) refers to concepts of ‘dangerousness’ and ‘violence’ however does not articulate definitions for either term specifically. However, they used rating scales that outlined terms to compare various definitions of behaviour. The scales used by Morrison (1993) included verbal and physical violence, violence to self and violence to property. Irwin (2006) articulates parameters surrounding the use of the term aggression “...to describe all verbal or physical assaults ...any form of behaviour that is intended to affect, and can actually cause physical or psychological injury” (Irwin, 2006, p.309). Tremblay, Hartup & Archer state “saying that aggression is “intentional harm doing” or “harm doing for its own sake” may be reasonable

for the ordinary user of the English language, but is fraught with difficulties for scientists who want to describe relevant phenomena with precision. Intentions cannot be observed easily; instigating conditions are difficult to specify from structure of the aggressive act; outcomes are difficult to specify; and we can't always tell whether the act has been aversive to the victim" (2005, p.5). Much of the nursing literature in the area of aggression does not provide clearly articulated definitions (Duxbury, 2002).

Nursing regulatory bodies or associations also add to the confusion because there is lack of consistency in a common understanding or definition that is reflective of aggression versus violence. The Canadian Nurse's Association (CNA) in partnership with the Canadian Federation of Nurses Union (CFNU) define *violence* to "broadly include verbal and emotional abuse, physical violence and sexual harassment" (2005). The College of Registered Nurses of British Columbia (CRNBC) does not have a specific position statement or policy, however have the terms buried within a practice standard under the title "personal danger", which includes "violence, communicable diseases and physical or sexual abuse" (2007, p. 2). The College of Registered Psychiatric Nurses of British Columbia (CRPNBC, 2008) does not have any such position statement or policy however refers to a position statement on physical restraint and seclusion as the "client presents a physical danger to others in the area" (CRPNBC, 2008, p. 2) and "directed aggression/violent behaviours (e.g. pushing, hitting, biting, scratching, throwing... verbal threats of violence or aggression" (CRPNBC, 2008, p. 3). The American Psychiatric Nurses Association has an extensive position statement on workplace violence and define violence within their executive summary to include "broadly defined as any physical

assault, threatening behavior, or verbal abuse occurring in the work setting (Antai-Otong, 2001) or outside the workplace but related to work (Occupational Safety and Health Administration [OSHA], 2002, p. 1)” (2008, p. 5). The variation in definition among the nursing associations and regulatory bodies further confounds nurses’ understanding what is meant by ‘aggression’ or violence’ in healthcare. The examples in the literature regarding definitions of aggression and/or violence demonstrate a wide range of interpretations of behaviour as either aggressive or violent or may not be differentiated or defined at all.

Factors Influencing Aggression in Health Care

As with the variance in definitions, the research surrounding aggression in healthcare is viewed from a number of different perspectives. The determinants or causes of aggression that are described within the research literature are inconsistent, partially due to the variation in definitions and participants’ willingness to participate and/or their understanding of what is aggression (Rippon, 1999; Edens & Douglas, 2006; Irwin, 2006). Researchers who describe the perceptions of aggression within the health care system come from a variety of perspectives. These perspectives vary by agency, program, unit, participants and clients. The nurse is situated in relation to all these entities, and interpretations of client behaviours have influence over practice. Perceptions then guide interventions utilized to assess or respond to the behaviour. Nijman describes the effects of aggression using three models of health care system perspectives including internal, external and contextual or situational models (Nijman, 1999).

The *Internal Model*

The most common frame of reference used to identify the cause of aggression in healthcare is the *internal* model; that independent patient variables cause aggression (Nijman, 1999; Nijman, a` Campo, Ravelli, & Merckelbach 1999; Duxbury, 2002; Duxbury & Whittington, 2005; Ferns, 2007). The factors *internal* to the client include illness, age, gender, race, and socio-economic status. Thus demographical information and internal characteristics are not separated from each other. Many nurses and popular media perceive that mental illness consistent with the internal model is a primary predictor of aggression and violence. One client factor perceived to be more predictive of aggressive behaviour is the use of substances such as alcohol or drugs. Combined with a serious mental illness, intoxication can increase the likelihood of an aggressive episode but is *not absolute* (Resnick, 2005). This finding is supported by two other studies that suggest that in mental health, specific internal factors that *can contribute* to aggression include psychosis combined with drug and/or alcohol use, gender and age, such as young males, under thirty years of age (Needham, Abderhalden, Meer, Dassen, Haug, Halfens, & Fishcer, 2004; Resnick, 2005). However, the research literature has been inconclusive regarding the connections between certain psychiatric illnesses such as bipolar illness or schizophrenia, as being the sole ‘cause’ of aggression and violence. In the context of a pediatric population, different variables would be included, such as developmental factors. As well, how each aspect of the child’s understanding and ability relate to their world would need to be taken into consideration, and their attachment capacity (Blaustein & Kinniburgh, 2010).

There is significant focus on prediction and assessment of aggressive behaviour, within the general research literature. The majority of the tools used for this purpose identify the internal client factors as the sole cause of aggression (Bartel, Forth & Borum, 2003; Grenyer, Ilkiw-Lavalle, Biro; Middleby-Clements, Comminos, Coleman, 2003; Needham, Aberhalden, Dassen, Haug & Fischer, 2004; Monahan, Steadman, Robbins, Applebaum, Banks, Grisson, Heilbrum, Mulvey, Roth & Silver, 2005; Copelan, 2006; Copelan, Messer & Ashley, 2006; Edens, Skeem & Douglas, 2006; Kling, Corbiere, Milord, Morrison, Craib, Yassi, Sidebottom, Kidd, Long, & Saunders, 2006; Nicholls, Brink, Desmarais, Webster, & Martin, 2006; Webster, Nicholls, Martin, Desmarais, & Brink 2006; Blake & Hamrin 2007; Meyers & Schmidt, 2008; Welsh, Schmidt, McKinnon, Chattha & Meyers, 2008). These papers primarily focus on specific populations such as adult forensic or youth forensic groups. Tremblay, Hartup & Archer reflect that “similar measures across age (if not equivalent ones) must be used in many forms of developmental analysis (e.g., specifying developmental trajectories and pathways), and one cannot count on this equivalence” (p.5). The literature review on assessment tools for aggression has not included pediatric populations and thus the findings are not transferrable.

The paediatric research literature does not appear to have as many assessment tools, however there are two that that I have identified, the EARL-20B [Early Assessment Risk List for Boys] and the EARL-21G [Early Assessment Risk List for Girls] (Augimeri, Enebrink, Walsh, & Hang, 2010). These two tools primarily identify the child as the sole or internal focus of aggression. These tools measure “antisocial behaviour as acts that would lead to criminal charges if the child were at the age of criminal liability” (Augimeri

et al., 2010 p. 43). Clinicians who use these tools were advised to be well versed in working with this population and able to discern beyond the tool, risk factors that would lead to suspecting the child would continue to engage in antisocial behaviours (Enebrink, Langstrom & Gumpert, 2006; Augimeri et al., 2010). The developers have attempted to include environmental factors such as socioeconomic and family constellation within the tools. There are a number of tools for rating aggressive behaviour however they remain limited in scope and are lacking in their ability to encompass all factors that influence aggression. At best, most assessment tools used for prediction of aggression are time limited or are missing critical factors outside of the clients' control (Delaney, Cleary, Jordon, & Horsfall, 2001). In previous reviews of the research, prediction of aggression is difficult at best and most assessment tools focus on internal client factors. The independent *internal* model focuses on the client as the primary cause of aggressive behaviour, loses the perspective and overall understanding of environmental as well as relational influences.

The *External Model*

Many of the factors that can contribute to the perception of behaviour as aggressive are outside of the client's control. Nijman (1999) identified a second framework of precipitants that contribute to aggression, the *external* model. The external model emphasizes environmental factors, separate from client factors, as contributing to aggression (Nijman, 1999; Nijman et al., 1999; Duxbury, 2002). Environmental influences known to contribute to aggression are often ignored. These environmental influences include context of the milieu such as ages and genders of the mix of clients; staffing levels;

physical space including noise and crowding (Nijman et al., 1999; Duxbury, 2002; Whittington & Higgins, 2002; Beech & Bowyer, 2004; Needham et al., 2004; Irwin, 2006; Aujoulat, Luminet, & Decceche, 2007). For example, space, privacy, numbers of clients, temperature, staffing levels, time of day such as shift change, food, and noise contribute to client (and possibly staff) aggression often by over stimulating already stressed individuals. These are important factors to be considered in the assessment and prediction of aggression among clients (Nijman & Rector, 1999). The nurse could also be included as a component of the *external* framework. The nurses' variables could include level of education, training, gender, and experience as influencing how a nurse interacts in the environment (Nijman et al., 1999; Duxbury, 2002). Most studies do not examine these factors.

A study by Dean et al., (2010), is one of the only studies that investigated the perceptions of aggression in pediatric mental health. However this study does not focus specifically on nurses. The study was a "quality improvement activity" and part of a larger project documenting aggression and its sequelae in this service (Dean et al., 2010, p. 18). The researchers employed a mixed design including a quantitative survey of short yes/no answers and a qualitative two-question interview of all staff members in this clinical area. The authors of this research indicated primarily a client focus as the causation of aggression with some environmental influences. The authors never address any relational or interactional factors, nor did address types of management strategies being employed. Although it is important research in the field of pediatric mental health, again it does not focus on nursing or relational factors.

In relation to assessment tools, as previously mentioned, the EARL-20B and the EARL-20G include components of internal and environmental assessment factors. Unfortunately these tools focus on the prediction of future antisocial behaviour in children already identified as having a diagnostic label of conduct disorder (Augimeri et al., 2010). These tools move away from the assessment of aggression or even general mental health concerns. They also fail to encompass the interactional or situational factors that constitute aggressive behaviour (Nijman et al., 1999; Duxbury, 2002). Overall, there is expansive literature surrounding external influences contributing to the prevention or exacerbation of aggression in health care, but it is vast and moves away from the focus of this research study at this time.

The *Situational/Contextual Model*

The final framework described is the *situational model*, which is the interaction between *internal* and *external* variables, in relation to the nurse-client relationship and context in which the relationship occurs (Nijman et al., 1999; Duxbury 2002; Duxbury & Whittington, 2005). The situation in which nurses and clients find themselves contributes to the potential for aggressive behaviour. The situational model combines the elements of internal and external variables and reflects on how the *context* of the interaction between nurses and clients affects aggression. However the situation or context does not explain the nuances of the interaction or the inter-relational factors involved. The nature of the nurse-client relationship determines and reflects the power dynamic, and perhaps a perceived power imbalance which can contribute to aggressive outcomes (Irwin, 2006). The interpersonal relationship between the client and nurse is considered the most

uncontroversial factor that influences aggression (Irwin 2006). Researchers in this field suggest that the interaction between staff and client variables, such as internal dynamics, and the contextual environment in which they occur, is considered the most valid predictor of aggression and violence (Forchuk & Reynolds, 2001; Day 2002; Turnbull & Paterson, 1999 in Duxbury, 2002; Bloom et al., 2003; Needham et al., 2004; Huckshorn, 2005; Murphy & Bennington-Davis, 2005, 2006; Irwin, 2006). Communication among staff members and with clients is highlighted in a few of the previous papers, however not clearly articulated as to what aspects need focus (Nijman, 1999; Nijman et al., 1999). The task of examining and thus researching the relational or situational variables such as client-staff, culture and environments is complex and difficult to find in the research literature. The situational model that encompasses the nurse-client relationship and the context in which that relationship occurs further stimulates curiosity in this field of study.

Summary

None of these models alone is sufficient to describe the variables that influence the occurrence of aggression. To fully understand how all the three models interact and effect nurses' perceptions, it is important to include how they interrelate. The relational aspects of all factors, internal to the client, external, including the environment and the nursing staff, and the situational context between nurses and clients, I needed to create a lens from which to interpret all relational factors and how they affected the nurse's perception of aggression. Although Irwin's statement that the nurse-client relationship is critical I believe the nurse exists not only in relation with the client but also the environment, the system of care, which includes policies and practices, and other participants.

Unfortunately, the research in the field of aggression in health care primarily focuses on adult or youth mental health or forensic psychiatric populations. This limited scope makes connection between the focus of this thesis and the research literature difficult and limits the relevance of the literature to pediatric mental health populations of children ages five to ten years.

Nurses' Perceptions of Aggression Affects Attitude and Relationships

As in the literature exploring definitions of aggression, the same could be said for perceptions of aggression by nurses. Much of the literature that corresponds with nurses' perceptions of aggression is complicated by how perception is interpreted and often overlaps with beliefs, attitudes, opinions, or cognition (Jansen, Dassen, & Jebbink, 2005). Included in much of this literature are rates of aggressive episodes; sources of aggression beyond the client, such as visitors or other health care providers, effect on the clients' behaviour; staffing education levels, such as regulated versus unregulated care providers; availability and types of training programs and all affecting the nurse's experience of aggression in health care.

The research literature that explored nurses' perceptions of aggression, often focused on the comparisons between nurses and clients, or nurses and students, or between nurses and other staff members. For example, Morrison (1993) compared nurses' perceptions of aggression and violence between nurses who had extensive psychiatric experience and doctoral students who did not. The study involved rating behaviours, out of context, as to the severity of aggression or dangerousness. Morrison found that the two groups agreed on the most severe and least severe client behaviours as potentially causing

aggression. However, the differences between the two groups were in their perceptions of the seriousness of aggression. Morrison postulates that "...the perceptions of dangerousness may be influenced by individual (*nurses*) factors, such as education and/or clinical experience" (Morrison, 1993, p. 267). In her later research, Morrison examined the effect of "organizational culture" on the perception of aggression (Morrison, 1998, p. 21). Morrison found that staff members, who perceived their work environment as supportive, were more satisfied with the facility, and sought opportunities to be innovative also perceived the clients to be less aggressive. Upon further examination she questioned whether the environment was the sole cause of aggression or whether the perceptions and attitude of the of the staff person also contributed. For example, there was some indication that staff who demonstrated more controlling behaviours, referred to as 'system maintenance' or 'socially restrictive', tended to identify clients as more aggressive. This work further adds to the relational factors that are involved during an interaction with a nurse and client. "Aggressive behaviour rarely takes place in a vacuum....Intolerable environments, ineffectual interactions are far more likely to influence the behaviours than symptomatology alone" (Irwin, 2006, p. 315). The most recent literature in the field of pediatric mental health is Dean et al., 2010, however the focus is not specific to nursing nor does it focus the population either. Overall there appears to be a number of complicating factors that make searching for nurses' *perceptions* of aggression difficult.

There are a number of factors that effects a nurse's perception of client behaviours and that includes a sense of efficacy. Efficacy in this context explores the nurse's history of exposure to various levels of aggression and violence, in and out of the workplace.

However, the predominant impact of workplace violence was a history of being assaulted at work and the resulted impact on one's perceived ability to manage the situation (Dunn, Elsom, & Cross, 2007). If a nurse perceives that his/her ability to provide care is compromised in some way either through their capacity or that of others, he or she may over react or disengage with the client. The nurses' engagement or disengagement can escalate or de-escalate the potential for aggression to occur. The staff person's attitude, entering into the interaction with the client, directly affected the outcome, and the staff member's perception of success in managing the situation (Carlsson et al., (2004).

Whittington and Wykes demonstrated a cyclical model of aggression that occurs in connection with a nurse's ability to work with clients who may become aggressive. They found that nurses who had been assaulted, "any physical contact by a patient which the victim perceived as intentionally aggressive" (Whittington & Wykes, 1994a, p.87), demonstrated two kinds of behaviour that tended to increase further aggression. The nurses' behaviours were defined as 'social distancing', such as being unavailable to the client (e.g. remaining in the nurses' station) or "confrontive coping" involved a desire to express anger and take unnecessary risks with clients (Whittington & Wykes, 1994b, p. 609). For example, the more experienced nurses were perceived to not engage in these types of behaviours and engaged in more activities with the clients such as talking with them and spending time on the unit (Whittington & Wykes, 1994a, 1994b; Whittington, 2002). Other research attempts to connect workplace violence with post-traumatic stress disorder on the part of the nurse, however this particular article failed to conduct any pre-assessment measures or define the terms 'violence' and 'assault' (Gates, Gillespie &

Succop, 2010). This literature further demonstrates the importance of the relational factors involved in nurse-client interactions, the need to examine the factors that can affect the context and the resultant potential for aggression to occur.

Duxbury (2002) assessed staff perceptions of aggression and violence using the MAVAS (Management of Aggression and Violence Attitude Scale). The MAVAS is a five point visual analogue scale used to rate aggressive behaviours, and the MSOAS [Modified Staff Observation Aggression Scale], (Yudofsky, Silver, Jackson, Endicott & Williams 1986; Yudofsky, Kopecky, Kunik, Silver & Endicott, 1997; Foster, Bowers & Nijman, 2007). Using the MAVAS, MSOAS and interviews, Duxbury found that staff members identified that aggression triggered by “problematic interactions and restrictive environments” accounted for over 30% of the aggressive incidents and over 20% were reported to be the “direct result of staff-patient interactions” (Duxbury, 2002, p. 331). Although not definitively explained, a restrictive environment typically is depicted by the variables of forced medication, patients being denied requests, and rigid program rules such as clients’ ability to access the outdoors. In the survey portion of the study, the staff members did not identify their own interactions as being problematic. Over 26% of the aggressive incidents reviewed had ‘no cause’ attributed to the incident. The staff members framed most incidents from an internal, client-centred framework indicating that the client’s illness and type of illness as primary contributing factors. The clients however saw the external model as the focal cause for aggression such as the restrictive environment. The situational model was not identified within the MSOAS or MAVAS however was alluded to in the interview portion. The interviews indicated that clients reported feeling

'controlled' by staff whereas the staff members felt they were the 'victims' of client aggression. The question of how the situation affects the nurse-client interaction and outcome remains unanswered yet it is clear that the interaction is important and is not clearly articulated in many areas of research. The literature on nurse's perceptions of aggression is also rife with confusion in definitions, scope and how the interaction between the nurse and client affects the context and situation. As well, the literature in relation to pediatric mental health is limited at best. There is a gap in the literature, specifically qualitative research in pediatric mental health nurses perceptions of aggression.

Education of Nurses about Aggression

Nurses working in pediatric mental health come from a variety of educational backgrounds. Many nurses currently working in this field have not received specific education on how to work with this population. Currently there is only one nursing program in British Columbia that offers a course on paediatric mental health (Douglas College, 2009) and no program that specifies prevention of aggression within this client population. Few nursing education curricula across North America teach anything about the prevention of aggression in health care (Mohr, 2006). For example, education programs for both students and nurses on preventing aggression are limited in scope and primarily focus on management versus prevention (Beech, 1999; Beech & Leather, 2003; Cowin, Davies, Estall, Berlin, Fitzgerald & Hoot, 2003; Duxbury & Paterson, 2005; Needham, Abderhalden, Zeller, Dassen, Haug, Fischer & Halfens, 2005; Hahn, Needham, Abderhalden, Duxbury, & Halfens, 2006; McDonnell, 2006, 2007; M. Crook, September 2008 personal communication & A. Jajic, September 2008, personal communication).

Nurses' understanding and ability to reflect on the causation of aggression contributes to how nurses' prevent and thus manage aggressive behaviour in the clinical setting.

The training guiding health care workers remains reactive rather than preventative in nature. Typically what many nurses and health care staff receive is referred to as response training. In British Columbia, organizations and training groups have limited their perspective of the client as the sole cause of aggression within their teaching frameworks (WCB, 2002, 2005: Management of Aggressive Behaviour (MOAB), 2003; Crisis Prevention Institute Inc., 2008; Non Abusive Psychological and Physical Intervention (NAPPI), 2008; Therapeutic Crisis Intervention, 2008; Provincial Health Service Authority, 2010). The content taught within these programs is varied as well, with some having more focus on verbal skills whereas others on the physical skills of either avoiding or how to best restrain an aggressor. These various agencies that attempt to support health care workers in client safety have not previously identified their findings with current research, especially for the programs that are directed towards nurses. Subsequently these programs appear to use limited if any research to direct or evaluate their training programs. There are some new programs in creation; however my experience of them is that they continue to lack utilization or application of current literature towards the *prevention* of aggression (Paterson, Leadbetter & Miller, 2005; Paterson, Miller, Leadbetter & Bowie, 2008). Overall there are few, if any programs, attempting to provide health care workers with education in this field that reflect current research. There are no programs that provide the developmental and clinical aspects specific to a pediatric mental health population.

Learning from Experiences

Nursing experience learned throughout practice may also have an effect on how nurses perceive and intervene with client behaviour. Morrison's (1993) findings indicated that experience has an effect on perception of seriousness of the level of behaviours observed. This may or may have an impact on the effect to the nurse and/or the client. Holzworth and Wills (1999) found that the longevity of nursing experience resulted in less intrusive interventions used with clients. In my own facility, colleagues have commented that as they get closer to retirement age, they are concerned about getting hurt therefore feel the need to control the situation before it gets out of control. A younger nurse commented that her tolerance for client behaviours decreased as the number of staff reduced in the evenings. She stated she would intervene in a more 'controlling' manner, such as setting limits on behaviours that she would typically ignore or allow the client to settle without intervention, than she would during the day. Nurses' perceptions of aggression may also be affected by their own trauma experience as noted by Whittington & Wykes (1994a, 1994b). As well the nurses' perception of aggression may be directly affected by their education surrounding the topic. Tension during critical events, or past experiences has an effect on the decision making and on the nurses' perceptions of the situation in the moment (Crook, 2001). With such variation in nursing responses to clients' behaviour, there appears to be a disconnection between what is happening for the client in the moment and how the nurse will intervene in a more cooperative and attuned to the client framework, than one of power and control. Although education is a contributing

factor to how nurses perceive behaviour as aggression, overall experience may affect the perception of behaviour as aggressive and the types of interventions used in the moment.

Interventions Addressing Aggression in Health Care

Staff beliefs about client behaviour can have a strong influence on their actions (Hastings & Remington, 1994, Hastings & Brown, 2000 from McDonnell, Waters & Jones, 2002; Kristiansen, Dahl, Asplund, & Hellzen, 2005). The health care provider's attitude toward the client directly affects that the "nature of the interventions that will be implemented to manage the behaviour" (Jansen, Dassen & Jebbink, 2005, p. 3). The nurse's perception of a client's behaviour and the nurse's subsequent response in any given moment directly impacts the interaction or relationship that evolves between the nurse and client. The factors that influence an interaction between a nurse and client encompass the nurse, the client and the relational context in which the interaction occurs. Kristiansen et al., (2005) found that staff members spent less time with clients who displayed less socially engaging behaviour such as psychomotor retardation, social withdrawal or more dependent. The presence of the nurse and his/her attunement to the client's state can affect the outcome of the situation. Nurses' attitudes about perceived aggressive behaviour influences his/her interactions and resultant interventions with the client (O'Connell, Young, Brooks, Hutchings, & Lofthouse, 2000; Needham et al., 2004; Jansen, Dassen, & Jebbink, 2005).

A literature review conducted by Allen (2000) identifies research regarding the use of seclusion and restraint in response to perceived aggressive behaviour. The majority of the research indicates that nurses usually respond to externalizing behaviours, such as

client aggression towards staff, other clients or property damage, with more aggression in the form of restricting privileges, secluding the client or initiating physical or chemical restraints (Quinn, 1993; Allen, 2000; Day, 2002; Sourander, Ellila, Valimaki, & Piha, 2002; Rew & Ferns, 2005). Responses to aggressive behaviour with interventions such as seclusion and restraint are believed by many health care staff to be ‘necessary evils’ in mental health care. However, there is no identified or evidenced therapeutic value to these interventions (McDonnell, 2006; 2007). A concern is the lack of awareness of the impact of these interventions on the client or the nurse themselves.

Mohr & Anderson (2001) provided a review of assumptions care providers make when working with children. Mohr & Anderson also found that staff members’ use of “punitive and isolation behaviors tended to be associated with a significant increase in the likelihood of a child’s subsequent negative behavior and a significant decreases in a child’s positive behavior” (Mohr & Anderson, 2001, p.146). Allen (2000, p. 162) quotes Selekmán and Snyder (1995) that “pediatric psychiatric nurses had the highest perceived need for restraints however were least likely to use alternatives”. Allen (2000, p. 164-65) also refers to work by Morrison (1990) and Goffman (1961), who state that the use of these techniques are based in a culture of ‘toughness’ and organizational control rather than one of understanding and therapeutic need. Further to this, current regulatory agencies, such as the CPRNBC, add to the misconception that seclusion and restraint are therapeutic tools to manage aggressive/violent behaviours with little guidance in their use (CRPNBC, 2008). The use of power and control to manage aggression has been well documented to be unsuccessful in changing behaviour. It may limit behaviours in the moment however,

more often than not perpetuates further aggression and has not been shown to change the behaviours in any way.

Trauma Informed Care

The research literature indicates that programs that adopt a model of *trauma informed care*, that shifts the organizations' bias from power and control to one of collaboration and cooperation, have higher rates of staff retention, less illness, lower injury rates, better outcomes for clients and lower rates of aggression (Lebel & Goldstein, 2005; Gill, Fisher & Bowie, 2002). Organizations whose staff manage through rigid and rule based care mimic the powerless trauma environment experienced by the client. The importance of a collaborative and cooperative organization allows for the creation of client-centred services and acknowledgement of the individual's ability to contribute to their own care needs. Clinical programs and schools that have adopted trauma-informed-care, shift the focus of care to strength focused, collaboration *with* the client and family versus compliance with the agency's directives (Kinniburgh, Blaustein & Spinnazola, 2005; Blaustein & Kinniburgh, 2010). A trauma informed program provides emotional, psychological and physical safety for all. In order to achieve this, programs need to examine how to reduce overt power and control practices that are often present in the health care system such as rules and regulations that work for staff but not clients. A truly *trauma-informed* system of care ranges from the top of the organizational structure through to the lower levels, it encapsulates everyone.

The intimate understanding and practice of trauma-informed care has demonstrated the reduction, and in some cases, the elimination of aggression within a number of health

care programs (Bloom, 1994, 2004; Petti et al., 2001; Gill, Fisher & Bowie, 2002; Sailas & Wahlbeck, 2005; Murphy & Bennington-Davis, 2005; Huckshorn, 2005; Sailas & Fenton, 2006). Prior to this shift in practice, many of these programs primarily functioned from a behaviour based system. Many required clients to adhere to the rules and regulations, without consideration of client factors, such as cognitive functioning or previous experiences. These trauma informed programs have demonstrated a dramatic decrease in aggression amongst clients as well as the reduction or elimination of seclusion and restraint in response to perceived client aggression. These same programs have also demonstrated improvement in staff morale, reduced sick and injury times and improved retention (Bloom, 1994; Bloom et al., 2003; Hodas, 2004; Murphy & Bennington-Davis, 2005; Delaney, 2006; Huckshorn, 2005). “Restraint reduction has been associated with a decrease in staff injuries and time missed from work due to restraint related injuries” (Lebel & Goldstein, 2005 in Curran, 2007, p 47; Lebel & Goldstein, 2005). These programs support staff to improve communication amongst each other as well as work collaboratively with all levels of care. The agency in which this thesis research was conducted has begun working in this direction therefore the nurses’ perceptions may reflect these concepts.

The Affect of Trauma in Relation to Aggression

The influence of a history of trauma within the context of mental health is tremendous and can dramatically influence the emotional, psychological and physical safety of all involved. “Given the complexity of the topic...’trauma’ is not singular, those who experience it are not identical, and the context and cultures within which each of us

lives are as varied as blades of grass in a field” (Blaustein & Kinniburgh, 2010, p vii).

Within the healthcare environment, the research literature surrounding the field of trauma in children and its impact is vast. The program in which this study was conducted has been working towards a philosophy of trauma informed care. I have chosen to explore some aspects of the literature to set the context in which this study was conducted. The concept of trauma-informed care is a philosophy of practice that incorporates the in-depth understanding of the effects on trauma on the neurobiological, emotional and psychological functioning of individuals and systems. A trauma-informed model of care rests on the assumption that the experience of trauma, specifically in childhood, effects the overall growth and development of the individual and impacts the health and well-being even in the face of resilience (Perry, 2004; Blaustein & Kinniburgh, 2010).

Unprocessed trauma has been demonstrated to affect an individual’s response to relationships and their environment, even after the original threat has gone. Therefore the development of relationships, or as in early development, attachment, can be disrupted by the effects of a traumatic background. I will provide a brief overview of: (a) the statistics of children exposed to trauma events; (b) the affect of trauma on the development of the brain in children; and(c) the resultant responses of children within their environment and relationships. As well, briefly introduce the beginning research on how trauma-informed care has demonstrated the prevention or reduction aggression from occurring.

The National Child Traumatic Stress Network (NCTSN) identifies that “one in four children will be exposed to trauma prior to the age of 16 years” (NCTSN, 2003). In the United States child maltreatment affects many children: neglect and emotional

maltreatment 60%; physical maltreatment 25% and sexual maltreatment 15%. The Canadian Incidence Study (CIS) of reported child abuse and neglect indicated that less than 4% of children *are investigated* for maltreatment (Trocme`, Fallon, MacLaurin, Singh, Black, Fast, Felstiner, Helie, Turcotte, Weightman, Douglas, & Holroyd, 2008). The types of maltreatment identified during investigation were 34% neglect; 34% exposure to intimate partner violence; 20% physical abuse; 9% emotional maltreatment and 3% sexual abuse (Trocme` et al., 2008). The majority of children were documented to have received diagnoses other than post traumatic stress disorder or chronic paediatric stress disorder. It therefore raises questions as to whether a trauma diagnosis such as developmental or complex trauma disorder was even considered (Kinniburgh, Blaustein, & Spinazzola, 2005; van der Kolk, 2009).

In British Columbia, the most current document listing the prevalence of mental disorders in children and youth, at a total population of 15%, is from ten years ago (Waddell, 2002). The statistics from ten years ago hardly seem relevant today, however this document continues to be the primary reference in most government documents. Trauma is not factored out from the various diagnoses such as anxiety disorder or conduct disorder; therefore it is difficult, if not impossible to determine the causation of some of the diagnostic labels applied. It has been noted that in research regarding childhood psychiatric disorders that the trauma experience is often an afterthought (Perry, 2004; Brendtro, 2006; van der Kolk, 2009). What the research literature does tell us is that over 95% of adult clients, with mental illness, have a history of trauma (McKenna, 2007). From these research statistics, many individuals develop chronic illnesses, as the result of traumas that

were generated in childhood (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, Marks, 1998; Bynum, Wynkoop, Anda, Edwards, Strine, Liu, McKnight-Eily, Croft, 2010). The importance of recognizing the impact of trauma in children and subsequent long term effects is well established (Bloom, 1994; Felitti et al., 1998). The importance of this literature points to the effects of trauma on the interactions, relationships and possibly the impact of psychiatric hospitalization, on the children when in care.

It has been well documented that early chronic stress on the developing brain affects the how it grows and develops (Center of the Developing Child Harvard University, 2012; van der Kolk, 2009; Perry 2004; Porges, 2004; Gunner & Quevedo, 2007). As a result, individuals with trauma histories potentially live in a state of neurological hyperarousal. Traumatized individuals often do not come out of this hyperaroused state and are “hypervigilant and focused on non-verbal cues” even when they are in a situation that is perceived to be safe (Perry, 2002, p. 6; Mulvihill, 2005). Those individuals with traumatic experiences often have difficulty with verbal interactions or therapy when memories evoke “trauma-related physical sensations and physiological hyper- or hypoarousal, which evoke emotions...” (van der Kolk, 2006, p.284). Loud noises, tone of voice, non-verbal behaviours, gender, the environment and/or some adults’ stances, gender, intonation or touch, and in the case of children, peers, can initiate a hyper arousal response to what appears to be little or no provocation. The reactivity is in the form of automatic fight or flight system, taking the form of overt aggression or internal withdrawal (Perry,

2001, 2002a, 2002b; van der Kolk, 2006; Gunnar & Quevedo, 2007). These responses are referred to as triggers.

Triggers may or may not be perceived at a conscious level to the individual experiencing them, and the response may or may not result in aggression. These triggers reflect the residual effect, or survival skills an individual has developed in order to function within a traumatizing environment. The individual's reactions to these triggers, potentially puts the individual at risk of becoming aggressive for self-protection (Perry, 2004) "Young children often lack words to express themselves, relying instead on a range of adaptive and maladaptive behaviors to communicate their needs, including crying, tantrums, facial expressions, running away , and other demonstrations of urgency or demand" (Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Evans, Andres, Cohen, & Blaustein, 2011, p 42). In this context, an aggressive response could be triggered by any number of relational contacts between the child, staff members, visitors, other children or interactions within their environment including stimulus such as noise or smells. It is these interactions that precipitate the response.

Considering the impact of trauma on the developing brain there are strategies to intervene and alter the trajectory of the child's overall functioning. The neurodevelopment of children exposed to traumatic events effects their cognitive and emotional development (Glaser, 2000; Brendtro 2004, 2009; Hodas, 2004; Perry, 1994, 2004; Porges, 2004; Kinniburgh, Blaustein & Spinazzola, 2005; van der Kolk, 2005, 2006, 2009; McEwen, 2007). "These children may demonstrate hyper-vigilance, intrusive thoughts, nightmares, bed-wetting, excessive clinginess, inconsolable crying, and severe

tantrums” (Arvidson et al., 2011, p. 41). Programs that emphasize the establishment of self regulation strategies, attachment attunement and work towards development or repair of cognitive skills, have shown to shift affected children towards better success and reduced psychopathology (Bloom, 1994; Harris & Morrison, 1995; Abramovitz & Bloom, 2003; Brendtro, 2006; Mulvihill, 2005; Murphy & Bennington-Davis, 2005, 2006; Cook, Blaustein, Spinazzola, van der Kolk, 2005, 2009; Kinniburgh, Blaustein, Spinazzola, 2005; van der Kolk, 2009; Blaustein & Kinniburgh, 2010; Arvidson et al., 2011). For example, the ARC (Attachment, Self-regulation and Competency) Program that works towards teaching both health care provider and parent how to modulate their own emotional responses, attune to the child and assist with their self regulation. “Caregivers and clinicians play an essential role in restoring a sense of safety and security to traumatized children by developing predictable routines and rituals in their lives” (Arvidson et al., 2011, p. 42). Once the child is better able to self regulate, they are more open to learning and experiencing the world from a safer perspective (Blaustein & Kinniburgh, 2010). A trauma informed approach has been shown to benefit children attending inpatient settings and outpatient settings, as well as schools and residential care homes (Arvidson et al., 2011).

Relational factors that contribute to the activation of a fight or flight response can be constant within a mental health care setting. For some clients the interventions often employed in health care such as enforcing a rule, denial of requests or the removal of something (Foster, Bowers & Nijman, 2007; McKenna, 2007) can trigger an aggressive reaction. More often than not, the reactive response on the part of the client is defined as

being internally driven, and often referred to as being ‘uncooperative, attention seeking or demanding’. The understanding of the client by the nurse, or attunement to, and in his/her ability to develop a relationship, contributes to the potential that aggression could be limited or eliminated. The recognition that stress and trauma affects each of us, and our clients differently is important in supporting the client and nurse to respond versus react in a given situation.

The next question becomes the affect of trauma on the nurse, and his/her ability to be in relation for the caring of children. Trauma affects all of us, and for some may be pre-existing prior to becoming a nurse. Specific research literature has not focused as much on the impact of psychological trauma in nursing until most recently. Most nursing literature focus on burnout or moral distress, and in some cases creates confusion with the phenomenon secondary trauma or is could be all of the above (Perry, 2003; Brunero & Stein-Parbury, 2008; Bryant, 2010; Clark, 2010). These areas of research are vast among themselves, and I am unable to go into greater depth as this is not the focus of this current study. Secondary or vicarious trauma relates to the affect of working with traumatized children. “The better we understand how working with traumatized children affects us both personally and professionally the better able we will be to service them” (Perry, 2003, p. 2). Therefore it is important to create an environment that adequately attends to the deleterious effects of trauma.

Some nurses are the direct recipients of overt aggression and violence, leading to long term effects, such as post-traumatic stress disorder. Whittington and Wykes describe how the effects of trauma from assault impact the nurse’s ability to engage in care for

clients. Some nurses withdraw and avoid interacting and others become overt, and provocative, attempting to re-enact their experience (Whittington & Wykes, 1994a & 1994b). Other nurses become conflicted over the use of restraint or seclusion in response to client aggression (Marangos-Frost & Wells, 2000). Nurses feel at a loss to alternatives however also experience ethical conflict when trying to determine the best response to an already difficult situation. Overall nurses may suffer with the same reactions to their environment and relationships as the children do. Therefore it is imperative that nurses have a process for taking care of not only their physical well being, but also their emotional wellbeing. The use of the post event debrief is relevant to the nursing in being able to process the event, learn from it in order to have an ability to effectively move forward (Murphy & Bennington-Davis, 2006; Huckshorn, 2005).

The literature in this field trauma and trauma informed care is vast, and points to a number of factors that put an individual at risk of responding to their environmental context with aggression. It would be reasonable to assume that clinical relationships, with traumatized individuals, need to be approached from a perspective of collaboration and cooperation, and strong relational attunement, in order to reach the most successful outcomes. Therefore, the use of a trauma informed model of care within a child psychiatry program is logical for guiding staff members in the assessment and treatment of these children. It remains unclear to the exact effect a trauma informed care perspective would have on aggression within the overall health care environment. The evidence appears to be pointing towards a less adversarial dynamic between care providers and clients, resulting in less reactivity that may be perceived as aggression.

Government, Regulatory Bodies, and Agencies' Perceptions of Aggression

Governments, regulatory bodies (e.g. nursing or other health professional colleges) and agencies (systems of care) affect nurses' perceptions of aggression by co-creating the contextual environments in which they practice. Policies and regulatory directives attempt to inform and direct nurses on definitions of what is aggression. These same policies and directives attempt to inform nurses about how to respond to or how to intervene when the behaviours of others such as colleagues, clients and visitors, becomes aggressive. Institutional cultures may draw from government policy, general education or from nurses' own personal beliefs or experiences, but may not lay value in best practice of evidenced based information (Duxbury, 1999). Many health care agencies implement policies under government and regulatory body directives have yet to demonstrate effectiveness of these policies as effective in reducing or eliminating aggression.

Government and regulatory bodies, such as the Zero Tolerance initiative in the United Kingdom (Gournay, 2001; Behr, Ruddock, Benn, & Crawford, 2005; Paterson, Leadbetter & Miller, 2005; Gabe & Elston, 2008; Paterson et al., 2008; Beech, 2008) or the Violence Prevention policies from Worker's Compensation Board of British Columbia (WCB, 2000) are often influenced by special interest groups such as unions or insurance agencies. However, many of their policies are not been based on current literature or research. These policies were created to manage workplace violence, in order to keep workers safe, such as those in British Columbia (WCB, 2002; 2005), or the Zero Tolerance Policies of the UK and Australia (Behr, et al., 2005; Paterson et al., 2005; Wand & Coulson, 2006; Paterson et al., 2008) yet they often fail to take into consideration the

circumstances or context in which aggression occurs. There is little evidence that these initiatives or policies demonstrate any effectiveness in reducing or eliminating aggression in the workplace and may even increase its likelihood.

Holzworth and Wills (1999) determined that nurses agreed, on paper, with their institution's policy, to use the least intrusive interventions first. However, the question remains, 'what did they actually do in practice?' The focus of almost all these initiatives is on the client as the sole cause of aggressive behaviour and fails to take into account the importance of the relational and interactional and environmental factors. Thus it would seem that the internal model underlies many of the initiatives and policies for managing aggression in health care settings. Given the dominance of the internal model and the gap of research between government regulatory bodies and agencies' policies connecting the various relational constructs involved in aggression, it raises questions about how nurses are expected to interpret this information, specifically in relation with children.

The Workers Compensation Board of British Columbia (WCB) as a regulatory agency has the directive to enable the collaboration between employers and employees "to promote the prevention of workplace illness, injury and disease" (WCB, 2010, website), as well as rehabilitation services, fair compensation and fiscal management. Within this mandate, WCB has created a number of policies in relation to 'violence' in healthcare with few, if any, references in their documents. The policies direct employees to act or behave in response to aggression. However, none appear to assist individuals in identifying preventive awareness or strategies to respond in accordance with current literature. Although the WCB attempts to create definitions, they are not always clear or congruent

with current nursing literature or institutional policies. The WCB Violence Prevention Program (2005) guideline indicates parameters for creating an education program that includes policy development. The WCB published the Five Steps to Violence Prevention in Health Care (WCB, 2000, 2005). Neither of these documents referenced any evidence based practice, research, expectations for reliability, functionality or evaluation of their effectiveness. There is a new curriculum in development with online training modules that focuses the learner to gain knowledge through cognitive processes rather than experiential or relational learning. The program does not take into account how an individual responds emotionally to various behaviours (Provincial Health Services Authority, 2011). It remains that these programs continue to be reactive to specific client behaviour rather than examining the entire context. The focus is on internal client factors rather than a larger view of preventative relational factors.

As identified in the literature review on definitions, the nursing regulatory bodies further reinforce the view of the internal model by melding definitions to be too specific or so vague there is no guidance (CNA, 2002; 2005; CRNBC, 2007; APNA, 2008; CRPNBC, 2008). CNA (2005) directs nurses to follow a zero tolerance policy. The zero tolerance initiative begun by the National Health Service (NHS), 1999, in the United Kingdom, was based on a belief that by limiting even the most minor infraction would reduce further escalation of behaviour into violence. It began to become better known throughout the nursing profession as 'we don't have to take this' (Paterson et al., 2005). The literature from the UK, over the past ten years, indicates that the zero tolerance initiative was not a successful approach to managing aggression and violence in healthcare

(Behr et al., 2005; Gabe & Elston, 2008; Paterson & Leadbetter, 2004; Paterson et al., 2005; Paterson et al., 2008; Whittington & Higgins, 2002). Neither CRNBC (2007) nor CPRNBC (2008) have specific position statements on aggression or violence. However, within the 'Duty to Provide Care' practice standard, nurses are "not obligated to place yourself in situations where care delivery would entail unreasonable danger to your personal safety..." such as in the case of "violence, communicable diseases, and physical or sexual abuse" (CRNBC, 2007, p.2). The American Psychiatric Nurses Association (APNA) position statement is vast and incorporates many aspects of aggression and violence (APNA, 2008). The APNA focuses on the relational aspects of the phenomenon of aggression. Overall, nursing regulatory bodies and associations confuse the issue even further by being overly inclusive. It remains that none of these agencies remotely come close to addressing aggression or violence within from a pediatric population, almost as though it does not exist.

In my own experience as a nurse/educator and as a writer of policies for pediatric mental health populations, I carefully consider here the current literature on best practice in working with children. The client, environment, and the nurse all bring components to the interaction that can contribute to the escalation or de-escalation of any situation (Carlsson et al., 2004). The developmental aspects of children, especially within a pediatric mental health setting, are not limited to the child alone, but also to their attachment needs with adults, interactions with other children, and the child's overall cognitive development. This does not give credence to the internal model as a sole focus of causation. Children are still learning to self-regulate (behaviorally, emotionally, somatically, and cognitively) and

rely heavily on adults in their world to help them to co-regulate. Many government initiatives and policies are often written with the average, calm functioning adults in mind however that does not transfer to the distressed client, family or child who may be developmentally delayed with autistic features or a significant trauma background. The research I reviewed for this thesis includes a focus on how government initiatives, regulatory bodies, and policies are interpreted by pediatric mental health nurses work with children ages five to ten years.

The nurse's understanding of aggression is influenced by governments, regulatory bodies and agencies. Specifically, conflicting policies within or between organizations, affect the nurse's ability to effect care and impact perceptions of aggression. As well, the interpretation of policy is often left to the agency, or culture of the unit as to how aggression or violence is being defined. The nurse, in relation to his/her own personal background, education and training, and the impact of organizational, cultural and environmental factors determines what behaviour is observed to be aggressive.

Summary of Literature Findings

To conduct this study on nurses' perceptions of aggression in five to ten year old children I examined related research literature in the field. There is limited to no research in a pediatric mental health inpatient setting that is specific to five to ten year olds who do not have a diagnosis affiliated with conduct disorder or antisocial personality disorder. The majority of research available for review is focused on adult or adolescent mental health, mainly with forensic populations. The few papers that referenced youth were limited in scope or appeared to be an adjunct to adult research. There is emerging research

in the area of developmental origins of aggression (Sakimura, Dang, Ballard & Hansen, 2008; Tremblay, Hartup, & Archer, 2005; Tremblay, 2008; Centre of Excellence for Early Childhood Development, 2009), unfortunately the content of this is beyond the focus of this study at this time. The ability to generalize this evidence to my population of interest is limited at best. The topics within the research on aggression in health care that I have chosen to include in this literature review relate directly to my research findings.

The literature reviewed begins with how aggression is defined in relation to healthcare literature. The lack of consistency and clear explanation of what is perceived to be aggression makes comparisons of the research literature difficult. Individuals within healthcare systems primarily view aggression from an internal causation standpoint; the client as the sole cause of aggression. There is some emphasis on how external factors, such as the environment, including staff, contribute to the cause of aggressive behaviour. The most salient factor that contributes to aggressive behaviour is the situational or interactional dynamics between the client, external factors (including internal nurse factors) and interactions with clinicians. The research examining nurses' perceptions of aggression in clients is also limited in scope with a primary focus on adult populations. Examples of this research is the work of Morrison (1993), Holtzworth & Wills, (1999), and Duxbury (2002), and Carlsson et al., (2004) and has begun the discussion of nurses' perspectives on aggression in health care however does not include a pediatric population.

It is important to comment that the nurse-client dynamic is affected by the nurse's attitude when engaging with clients. The nurse's general attitude, or experience of the client population, or institution, will have an impact on the nurse's interaction and

engagement with the client. From that relationship derives the reaction or intervention that may or may not be employed based on the nurses' perception or attitude towards the client in question. Programs that employ a *trauma-informed care* perspective utilize interventions that take the relational aspects of the dynamics between clients and nurses as central to reducing the risk or exacerbation of aggressive behaviours. These programs also work towards teaching staff members various prevention strategies such as the effects of trauma on the body and brain; self-regulation (self and client) strategies; attunement strategies (staff and parents) on how to read client cues of dysregulation; and cognitive behavioural strategies for clients (and families) (Blaustein & Kinniburgh, 2010; Arvidson et al., 2011).

Education programs on *violence prevention* for nurses continue to teach reaction management. The majority of programs fail to incorporate concepts of prevention, relational influences, situational factors and overall developmental understanding in mental health with limited focus on aggression. I explored government, regulatory bodies and agencies policies that direct nursing practice in relation to aggression and violence. The realm of policy development is also varied as that of definitions and the inconsistencies amid the myriad goals of competing stakeholders.

There is limited qualitative research focusing on the understanding of the meaning attributed to aggression in healthcare, particularly within pediatric mental health populations. The limited research beginning to appear in relation to pediatric mental health is not specific to nursing and fails to explore the relational aspects of aggression or perceptions thereof (Dean et al., 2010). Most of the literature reviewed for this study has

been quantitative revealing the need for qualitative research. The research surrounding aggression in health care is vast and rife with confusion, partially the result of inconsistent and varied definitions. The frameworks that guide these definitions vary from internal or external frameworks and rarely consider the extent of which relational dynamics affect contribute to the context of the situation (Nijman et al., 1999; Duxbury, 2002; Hartrick Doane & Varcoe 2005). What is needed is a fuller understanding of aggressive behaviour and how it arises and is influenced by a multitude of factors. In particular, research is needed to examine the nurses' perceptions of aggression within pediatric mental health, what influences those perceptions and how those perceptions shape nursing interventions with children. My thesis focused on the realm of pediatric mental health nursing to assess the perceptions of nurses with aggression in five to ten year old children using Relational Inquiry.

CHAPTER II: METHODOLOGY

In the following section, I will discuss the methodology used to guide this study. I will discuss the purpose of the study, the research questions selected, the research design and the research location. I have used Relational Inquiry (Hartrick Doane & Varcoe, 2005) to frame this study. I used Kvale's Interpretive Analysis (Kvale, 1996) to inform the interview process and analysis portion of this qualitative study.

Purpose of the Study

The purpose of this study was to explore the perceptions pediatric mental health nurses have of behaviour of five to ten year old children described as aggressive, and the factors that influence their interpretations and perceptions. The research questions guiding this study included: What do nurses understand or perceive to be aggression and how do those perceptions affect their nursing actions? How do nurses decide when behaviour is becoming aggressive? Where and what have they learned that informs their assessment or knowledge? What factors guides their decisions surrounding interventions?

Research Design

The research design was interpretive inquiry informed by Relational Inquiry (Hartrick Doane & Varcoe, 2005) as the theoretical framework. Kvale's interpretative methodology informed the interview process and the overall analysis (Kvale, 1996).

Relational Inquiry

To understand pediatric mental health nurses' perceptions of aggression, I needed to understand the basis from which the participants came to be in the position of observing, participating and contributing to issues of aggression in their workplace. I selected

Relational Inquiry as the conceptual framework to guide my research as it created a lens from which to view how the participant engaged with and were shaped by relationships with their clients, colleagues, the overarching system of care, and self. As human beings, especially as nurses in health care we are always in relation to the world around us.

“Relational Inquiry involves a reflective process” (Hartrick Doane & Varcoe, 2007, p. 198) that assumes and looks for “how people, situations, contexts, environments and processes are integrally connecting and shaping each other” (Hartrick Doane & Varcoe, 2005, p. 51). Each person has a unique personal socio-historical location that affects and shapes the personal identity, experience and interpretations...people are both shaped by and shape other people’s responses, situations, experiences and contexts” (Hartrick Doane & Varcoe, 2005, p. 198).

The relational experiences of nurses are critical to understanding their perception of what influences and contextual elements affect aggression. From this perspective, I began the research with the assumption that aggressive behaviour arises through the relational interplay between nurses and clients, and is affected by the nurse, the child, other colleagues, other clients, the environment and the overall context in which it occurs. While this construct is similar to the situational model of aggression (Nijman, 1999; Duxbury, 2002) the situational model has only viewed the relationship between the health care personal and the client. Relational inquiry expands the view to consider how a multitude of factors relate to and shape each other and affect the potential of aggression. Using a relational inquiry framework the study was oriented toward illuminating and understanding

the complex interplay of factors and processes that shaped nurses' perception of aggression in five to ten year old children within nursing experiences and relationships.

Kvale's Interpretative Methodology

The study employed a qualitative methodology to expand understanding of participants' experiences and interpretations of aggressive behaviour. The use of qualitative research to explore pediatric mental health nurses' perceptions of aggression in five to ten year olds is "invaluable for this task in particular is that it is an approach designed specifically to give voice to an individual's or group's experiences - a perspective that otherwise might go unnoticed" (Davidson, Ridgeway, Kidd, Topor & Borg, 2008, p.141). The qualitative interview is in itself an inter-relational activity that allows for the researcher and participant to co-create the content. I developed a semi-structured interview that functioned in a conversational manner, which was a more natural and familiar process for the participants, creating a more relaxed atmosphere than a more formalized structured format.

Kvale's interpretive methodology informed my analysis and allowed me to be creative in my approach to the analysis. I used aspects of 'meaning condensation' and 'meaning interpretation' that Kvale refers to as "ad hoc meaning generalization" (Kvale, 1996, p. 203). The ad hoc process incorporated components of the two categories in order to create an interpretive approach that fit with me, and the relational connections within the interviews. Meaning condensation involved listening to the audio-taped interviews as I read through the transcribed text to appreciate the entire experience of the interview. As the reading progressed, "natural meaning units" or themes evolved (Kvale, 1996, p.194). I

then reflected on those themes through the Relational Inquiry lens, back to my original questions for the study. From meaning condensation, I reconstructed the themes in relation to the examples of experiences provided by the participants. I used meaning interpretation to create a deeper understanding as I re-interpreted the interviews as to how they interrelated with each other, and integrated with my original research questions.

Kvale's perspective of the 'interview as conversation' was a good fit for me. The interview process is one of taking information in, processing it in the moment, reflecting it back to the interviewee for clarification and directing the interview from the response to guide the next question. I felt I created a relaxed atmosphere by being in relation with my participants, attending to their verbal and non-verbal cues, thus allowing for a more participant engagement. The participants and researcher are in relation with each other and the data continuously through the interview questions, clarification in the moment, and then through subsequent interviews. The use of Relational Inquiry and Kvale's interpretive analysis required me to continuously be in relation with the data and interpreting the content throughout the process.

Research Location

There are few agencies within the province of British Columbia that provide paediatric mental health, inpatient services for children ages five to ten years old. In order to access sufficient numbers of participants to maintain confidentiality, I accessed one of the larger paediatric mental health centres that serve this client population. I recruited participants, from multiple inpatient units, that have capacity to provide service to this age group. The agency selected has been in the process of implementing a philosophical shift

in care from one of power and control to one of collaboration and cooperation using a *trauma-informed framework* called the Engagement Model © (Murphy & Bennington-Davis, 2005, 2006). Although I have been I have been an active leader in the implementation of this process, I am not a direct supervisor of the participants.

The Engagement Model of Care promotes an environment that is welcoming and supportive of clients and staff. It promotes language of non-violence, intimate knowledge of the interpersonal neurobiology of trauma for both clients and staff members, and allows for more individualized care of clients (Murphy & Bennington-Davis, 2005, 2006). Over the last six years, the majority of staff members within this program have received some form of education on trauma informed care. However, there is variation as to the intensity and extent as to what type of education has been provided and to which staff members. In order to set the context for my research, I needed to understand how the nurse understood the effects of trauma on the client's expression of aggression within healthcare settings. As well, I needed to understand how the understanding of trauma in the client, may influence nurses' perceptions of aggression. The selection of this research location was for the availability of potential participants, the client population being served and the philosophy of trauma-informed care being implemented within the program structure.

Researcher Location

I have worked in the field of child and adolescent psychiatry for over twenty years; adolescent psychiatry inpatient and child, adolescent & adult outpatient psychiatric services. I have observed numerous changes over that time in practice both in myself and within the healthcare system. In relation to the phenomenon of study I have become more

aware and accepting of the expression of aggression in clients based on what I now perceive as normal responses to stressful situations regardless of the precipitant. To achieve this understanding I have used various approaches of self reflection that have included informal and formal processes including individual, internal and group. This has allowed me to examine my responses to various experiences, both personal and professional.

Over my years of practice I have conducted my own internal assessment and reflection of how I respond in situations of aggression and distress as well as having attended courses and workshops on this process. I have learned over the years that when voices are raised or there are sudden loud noises, my body responds with increased heart rate, breathing and I become more attentive to the sounds, tone, words and intent of the exchange occurring. I then consciously make a decision, based on my interpretation of the exchange, such as the sound of increasing distress in one or both parties. If there is a tone of distress, I may go to explore this exchange, if not directly visible to me, or let it play out. If visible I reflect on who is involved, the non-verbal and verbal cues being exchanged and if there appears in my experience an opportunity to offer support at any time. I see aggression as a natural part of human reaction in response to fear or frustration. I have also observed that there are times when an opportunity to alleviate the fear or frustration may have, in fact, averted the potential for an aggressive response. However there may also be times when the expression of frustration and fear in the form of aggression is distressing for those witnessing or bearing the brunt of it, and therefore their own fear and frustration take over. The client's need may be to express their frustration and fear in a manner that

may be viewed as aggression by observers, however may be the most therapeutic form of coping for the client. This balance between the needs of clients and the differing needs of various staff members is an ongoing challenge for me, and I believe the healthcare system. This reflection has allowed me to evaluate how I might alter my responses in the future.

Self-reflection is a process of looking inward and assessing one's own responses to certain situations, people and interactions. In mental health, this is often referred to as transference and counter-transference. However I see it going beyond the verbal exchanges to actually examining those responses at a more indepth level. For this study, I did not explore the participants' thoughts on transference or counter-transference, but wanted to know if they were attuned to their *physical* reactions prior to or during a perceived aggressive exchange. I see the ability of awareness and thoughtfulness of our physical responses, may assist us in effectively responding to the aroused individual, which may include doing nothing, and then talk through their responses in these circumstances. If we are unaware of our own responses, we may react to a situation that may put ourselves and the client at increased risk, rather than in a thoughtful, manner. My assumption is that nurses, especially within a mental health setting have conducted some level of both informal and formal self reflection throughout their career.

Aggression with healthcare, especially psychiatry, is a known experience. As previously noted, the majority of children referred to psychiatry come with a history of what has been labeled as aggressive behavior. My personal assumption of aggression is that it involves verbal or physical acts that situate on a continuum of normal human responses to life stressors. I believe that some 'aggression' can be mitigated, or prevented,

with distraction or by meeting the needs of the individual, however some may also just need to be expressed. That is the juxtaposition of working within healthcare and striving to support clients and families, as well as keep health care professionals free from harm in the process. My assumption entering into this study was the participants would have a similar view, regarding the clients they worked with, based on education received within the last two years about trauma informed care and alternative responses to seclusion and restraint approaches.

The program where this research was conducted has been actively pursuing approaches to reduce aggression in the workplace, as well as the subsequent staff responses to control or contain it, such as seclusion and restraint. The program has been implementing a trauma informed care philosophy in order to understand all of these issues. My observation is that many staff members continue to struggle with understanding how trauma informed care is helpful or how it enables greater safety in practice. As well, staff members appear to struggle with balancing their own responses to aggression, with the developmental and clinical needs of the clients, and expectations of the organization within a tertiary paediatric setting.

As the primary nursing educator for this program I have had the opportunity to be exposed to much more information, both through reading and from attending various conferences with regards to trauma informed care and the approaches that might work best in this environment. In my role, I have provided and facilitated the provision of education to staff members about the effects of trauma on clients and families. Included in the education has also been training on alternative or supportive responses that would assist to

mediate and or alleviate aggressive responses. Part of this education has been to assist staff members with the understanding that aggression is on a continuum of normal human responses to stressors. My frustration in this process is that those in administrative positions have not been as active in the process and have left a few, including myself, struggling to implement a systems approach from the middle out. Complicating these endeavors, there is a zero tolerance approach from political and governing agencies, stating that aggression is not to be tolerated at any cost, regardless of the circumstances.

The program in which this work was conducted is striving towards becoming less punitive of client responses to stressors as well as how staff members respond to those stressors, such as not meeting aggression with more aggression, however the organization still struggles with a no-blame culture. In my role, I assist with debrief sessions and team meetings to examine and understanding the client and families' triggers and finding approaches that work best for them within a complex healthcare system. What has been missing is discussion with staff about their triggers and best approaches for them in the moment. The challenge has been balancing the needs of individual clients, families and staff members, keeping them free from harm, while providing the service mandated.

The education provided, from a larger systems level, has lacked structured planning and evaluation, and unfortunately, has not examined trauma informed care from a staff or organizational perspective. The result is ongoing tension between child or client-centred care and unit programming and staff needs. My ability to translate the information and provide education to colleagues and staff members has been limited by the numbers of staff (over two hundred), and the availability and accessibility of staff due to shift work.

My primary interest in conducting this study was to understand nurses understanding of aggression and whether or not they attributed any of the education regarding trauma informed care as having any influence on their practice.

As a beginning researcher, I struggled to balance my previous clinical work as a counselor with interviewing as a researcher. I also found balancing my knowledge base regarding trauma informed care and developing my research questions was critical to ensuring I accessed the participants' views and balanced my own influence in the process. After each initial interview, I reflected on how the participants responded to the questions with my understanding of the environment both contextually and physically. I worked to ensure I interpreted their ideas, without overt influence of my own. I wanted the participant's to define aggression from their perspective, not mine. I worked towards having the participants direct how they perceived aggression and what other influences (either policy, people, personal or professional) affected their perceptions. I found that due to my dual role, I did not feel it prudent to actively explore the effect of personal trauma experiences, or workplace or secondary trauma of the participant at this time. I felt if they wished to share those experiences, they would have during the interview process. I also realized that as I began the research I had pre-formed perceptions of certain participants' responses only to be found that it not how they answered the questions.

Participant Recruitment

The direct care staffing in this program is a combination of Registered Psychiatric Nurses, Youth & Family Counselors and Registered Nurses making up the majority. Participant sampling for qualitative research was challenging because of the small numbers

of nurses working in the pediatric mental health field and the intensity of the research process involved. Participation was voluntary. I employed a variety of media to contact participants with permission from the health care institution. I used poster and email solicitation to advertise for study participants (Appendix A). I arranged to have posters in a variety of common areas for nurses to see. I spoke directly to nurse leaders and staff members in team meetings to inform them of the research project and to promote clinical research within the department. Interested participants made contact with me either by email, phone or in person.

Participant Selection Criteria

I limited my recruitment to Canadian educated nurses. I focused on Canadian educated nurses because the standards and requirements of education systems in other countries are different from Canadian schools (CRNBC, 2009). In some provinces of Canada, there are education programs that specifically provide education for registered psychiatric nurses (RPN). However, the programs vary in length and academic requirements. Currently, there are a number of nurses coming from the United Kingdom and Australia to work in British Columbia, however their education requirements are also varied. Therefore I did not include Canadian educated RPN's, British or Australian Nurses. The education for Canadian registered nurses includes a component on mental health but the depth of this varies depending on the education program. The majority of nurses working in this particular pediatric mental health program are registered nurses. In order to create a cohort that was consistent in educational program expectations and duration; professional regulation and ethical guidance; and overall work experience; I limited my

scope to Canadian educated registered nurses with a minimum of one year working experience in pediatric mental health inpatient settings.

The criteria for selection included the above educational requirements and recent experience, a minimum of one year working with children between the ages of five and ten years. The criteria also included an ability to commit to attending the two interview sessions. Two nurses, who expressed interest in participating, did not due to an inability to coordinate schedules. One of the two stated she did not know how she could get time away from her shift to participate and did not want to use her time off. One nurse, had signed consent forms, however, ended up withdrawing due to family emergency. I had a total of ten nurses volunteer and seven who participated. The median age of participants was 35 years, with a range of paediatric mental health work experience from two to over twenty years. There were six female and one male participant, which is reflective of the population of staff working in this organization. The participants reflect the population of Registered Nurses working on these units, in relation to age, education, gender and work experience.

Participant Description and Profiles (pseudonyms)

All participants were registered nurses who were working with five to ten year old children within a pediatric inpatient mental health setting at the time of the interviews. There were a total of seven participants, both male and female from a possible cohort of twenty-five who met the selection criteria. All had been in nursing a minimum of five years. Most participants had a minimum of a degree in nursing with the majority having a variety of additional education either directly related to nursing or outside of healthcare

completely. All participants had been working with the selected population within the last year. The participants represent a well-grounded mix of nurses from a selection of culturally and ethnically diverse communities. Most have interests outside of nursing, either artistically or sports related. Most are part of a family constellation or in a single partner relationship. To enable illumination of the importance of the situational aspects of nurse's perceptions, and how those situational aspects influenced perceptions I created pseudonyms for the participants. The pseudonyms used for the participants are: Kaley, Lorne, Jane, Pamela, Julia; Galena; and Josie.

CHAPTER III: ETHICS

The ethics of this study focuses on the dual role of the researcher with the participants; confidentiality and data management including storage. Ethics involves the exploration of my relational connection with the participants in a dual role as an investigator and colleague and my management of that dynamic. Next, I reviewed the participant selection, criteria and issues of confidentiality and consenting process. I describe the risks and benefits of participating in the project as well as an outline of my data management plan, storage duration and location.

Consent Process

Consent in qualitative research is an ongoing process with renegotiation occurring throughout the process. I requested written consent at the beginning of each interview. Full disclosure of the purpose of the research and intended distribution of results and potential impact was made and is essential to the consent process. I discussed the risks and benefits for participation in the research with each participant as well as including it in the consenting document (Appendix B). Each participant was provided with a brief overview of the research process prior to consenting to participate. This allowed the participant to voluntarily determine if the time required of them was feasible and if they were interested in the topic being researched. This initial introduction also allowed me to assess what the concerns other participants may have had regarding time, availability and willingness to share their perceptions of the topic at hand. The consenting process involved most of the participants reading the consent form prior to meeting with me, and then re-reading and signing the form immediately prior to the initial interview itself. A few participants

consented just prior to the first interview occurring due to scheduling challenges between the participants and researcher.

Risk/Benefits

A general benefit from this study is an increase in knowledge of how a select group of pediatric, mental health nurses, perceive aggression in children. This expanded understanding could assist in guiding an education program for those working in the field of pediatric mental health nursing. An additional benefit is to add to the overall research in this field and as mentioned, there is nothing reflective of this population group from a qualitative perspective in the nursing literature I have reviewed to date. Benefits for the participants may be the satisfaction of contributing to the field of research, being part of increasing knowledge and experts in the field of pediatric mental health. Additional benefits may include the process of learning about one's own perceptions and exploring an overall understanding of aggression in a more thoughtful manner.

A potential risk for participants has been a loss of privacy by sharing information. There is potential of being a 'known' participant as the sample size was a relatively small cohesive group of staff members who work within the same facility. I discussed this potential with all participants at the time of consent. It is at their discretion if they choose to inform others of their participation in the study. I asked that they try not to do so and limit commenting on the study with colleagues to limit the alteration of perceptions until after the interpretations were complete.

Another potential risk for participants was that of psychological stress during the discussion of possibly distressing experiences and possibly thereafter. I addressed this risk

in the consenting process and throughout the interviews. I provided information regarding external counselling/support service that is accessible by participants and I encouraged the participants to use the service as they needed (Appendix C). All participants received the counseling brochure. I clarified with each participant that I am not in the role of therapist or counsellor and an external support may be needed at some point after the interviews. The discussion of any experience has the potential to raise emotional, psychological and physical distress, which needed to be attended to in the moment or later if needed. None of the participants asked to stop the interview at any time and all refused the relaxation strategy offered at the end of the interview. As mentioned, the participants reported enjoying the research process and the opportunity to share their perspectives.

Challenges of qualitative research include the processes of maintaining confidentiality and anonymity. Anonymity may not be possible as the population of interest was small, the agency is known to the community and the participants work closely together. My process to ensure further level of confidentiality was possible was to use identification numbers instead of names on transcriptions. The interpretations and potential of quoting participants comments in publications was disclosed to all participants. The use of pseudonyms and fictional histories assisted in creating confidentiality of participants, clients and colleagues as well as the experiences described.

Ethical Considerations-Dual Role

I received ethical approval from the University of Victoria and from the University of British Columbia that is the overseeing ethical board for the tertiary centre where I conducted the research. I have no industry or other identified biases to my knowledge. All

ethical concerns were addressed within the informed consent, identification of a secure location to keep the transcripts, and duration of storage of the data post research.

Confidentiality is very important when the participants are potentially colleagues. To be a known researcher among a group of colleagues presents challenges and benefits of its own; my dual-role possibly influenced recruitment in a positive or negative direction. I am the Clinical Nurse Educator for the program where I conducted my research. In this role, I am responsible for providing various levels of educational support to both nursing and other clinical staff members. Although I am not in a supervisory or managerial position, I am an experienced nurse working as a Nursing Educator with a level of authority that may have encouraged participation or distracted from it. Some of the participants are colleagues I have known for many years and some are new to me. I was not friendly with any of the participants to the point of socializing outside of work. Overall, the participants were receptive to working with a known researcher and did not indicate a perception of any undue bias based on my role in the institution. One participant commented that they were initially hesitant to participate as they felt 'intimidated' by me and my years of experience and education. This participant later commented that they would in future encourage others to participate based on their experience and level of comfort working with me. The dual role had an effect on participant enrollment.

Being in a dual-role influenced my perceptions and relationships with my participants. I realized in the interviews I was making assumptions of meanings from some of the participants and had to remind myself to seek clarification to ensure I was using the participants words not mine. I became aware of these biases and beliefs towards those I

thought I knew fairly well, and in fact did not. I worked to remain cognizant of this perception in order not to cross the boundary into one of overt familiarity as the participant was a known colleague. As the interviewer, I recognized that I was a significant part of the research in creating a space for the participants, to safely share their thoughts and feelings on this subject. The participants often commented on how comfortable they felt during the interview process and enjoyed participating. I remained as supportive and neutral in this process as possible in order to gather the most accurate data. There was a balance of being as 'engaging' as possible and to not pass judgment or assume any attributions to the content, but allow for the participants to define, direct and guide the meaning. Although the dual role may have influenced recruitment in this study, it did not appear to hinder participation.

The work of bracketing is not limited to my knowledge of the topic but is also necessary in my familiarity of some of the participants. Included in this were my assumptions about what nurses perceived to be aggression, knowledge transfer about trauma informed care, and the understanding of the concept and utilization of self reflection. Another consideration in this process was to ensure that the participants were free from exploitation. Exploitation could take the form of a perceived bias on part of my presence having influence on the participants in answering questions either encouraging, or discouraging depending on the level of trust perceived (Polit & Beck, 2004). The challenge as the researcher in this process was to bracket my own beliefs and biases and be open to the words expressed by the participants. Overall, I tried to refrain from leading or directing the comments, even when I was asked more direct questions. I also recognized that my

knowledge of the participants made re-identifying their profiles a challenge to balance content with their experience as practitioners and still maintain confidentiality.

CHAPTER IV: DATA COLLECTION

This study's participant selection was volunteers from a pool of registered nurses working in paediatric mental health. In review of my selection criteria, all volunteers met the requirements. As well, the sample of participants represents the mix of staff in this agency well, with both male and female participants, variable age range and years of work experience. The participants were able to respond to the research questions with depth and knowledge that depicts an understanding of working in a paediatric mental health setting. As well, they were able to articulate the issues surrounding aggression within this population from a relational perspective that will add to the evidence based research in this field.

The participant group was able to provide "information-rich cases that manifest the phenomenon of interest intensely (but not extremely)...one seeks excellent or rich examples of the phenomenon of interest but not highly unusual cases" (Patton, 2002, p. 234). My knowledge and experience in the field of study allowed me to identify those scenarios that could be considered extreme and request the participant to select another example, unless they believed that was the best description of aggressive behaviour for them. I believe I achieved a sample that is representative of the group of nurses working in this field that have the knowledge and experience to provided information that highlights the understanding of perceptions the paediatric mental health nurses have of aggression.

Relational Inquiry Methodology

Relational Inquiry guided the research interview questions developed for this study. I was seeking to develop an understanding of pediatric mental health nurses' perceptions of

behaviour of five to ten year olds that was interpreted as aggressive. I explored the factors that influenced the nurse's interpretation of behaviour described as aggressive. I inquired as to how that interpretation of behaviour informed the nurse's decision about what interventions were employed with the child. I also examined the level of awareness the nurse had of the relational influence his/her presence had with the child involved. The details of my specific research interview questions are found in (Appendix D). The questions evolved in each interview depending on the direction the participant took.

Kvale's Interpretive Method

I used Kvale's Interpretive Method to inform the interview process and data analysis, for this research. I choose this method because it was suggested by research colleagues as a good fit for qualitative research, and my area of interest. I had considered using other methods, such as grounded theory approach or Parse's Human Becoming Theory, however returned to Kvale's interpretive methodology. I have over twenty years of interview experience in both clinical and professional settings. I found Kvale's method worked well with my personal interview/analysis style. Kvale's approach allowed for internal reflection and interpretation throughout the process of interviewing, and the later analysis. This approach allowed for my interpretations to happen in the moment with the participants which provided opportunity for confirmation, clarification and adjustment of the interview data to match the participant's thoughts. Together we co-created the research findings. Kvale describes a variety of analyses, however I referenced an "ad hoc" method combining components of "meaning condensation" and "meaning interpretation" (Kvale,

1996, p. 193) to focus my analysis. I will describe below how I proceeded with this process.

The First Interview

Each interview began with a review of the consent and confidentiality process, the audio-taping process and an explanation of the interview process itself. I discussed with each participant the potential risks and the availability of their Employee Family Assistance Program (EFAP) should they experience any distress post interview (APPENDIX C). I also informed the participants that at any time during the process they wished to stop and discontinue, that would be fine, and up to them if they chose to continue at a future date or not. The first interview was approximately an hour in length, although some ended sooner than others; I did not record specific times for each interview. Most participants requested to meet at the worksite, in my office, at the end of the work day. All participants who made this request stated it was more convenient to do the interviews while they were already at work than trying to find another time on a day off. Two participants made alternate selections, one I met in another office and the other requested to come to my home as it was between the participant's home and the worksite. All participants reported feeling comfortable with me and did not see my dual role as a conflict due to the nature of the research and consenting process. All interviews were audio-taped on a hand held tape recorder; as well I took handwritten notes throughout.

I began each interview by asking the participant to sit comfortably, offered them coffee, tea or water prior to beginning the process. Participants were invited to describe an experience of when working with a child, age five to ten years old that they, the

participant, had perceived the child's behaviour as aggressive. According to Kvale, the participant is invited to provide an example of "their lived world" (Kvale 1996, p.189) in order to situate the researcher. The participant's example of an experience with a child allowed me to begin the process of exploring their perceptions of aggression in this particular population. The interview questions guided this exploration of the participants' perceptions (Appendix D). However, as the interview progressed I clarified and added questions to ensure the flow of thought and content. The interview questions were open ended and the content flowed from the interview conversations.

Throughout each interview I also made handwritten notes to be able to reflect back on certain phrases, expressions, or other participant behaviour. For example, I documented my interpretations of participant's facial expression and voice tone or inflections, in the margin next to the written notes I made during the sessions. I wanted to ensure I had noted a reference as to the tone of the words expressed to ensure I captured as true a meaning as the participant was willing to share. I became attuned to my own emotions and biases during the interviews and worked hard to ensure that I maintained neutrality in the interviews and bracketed my own beliefs and understanding the participants' perceptions of their experience. I clarified and reflected back my initial interpretations of the interview content in collaboration with the participant. The questions evolved through the interview process from the dialogue that ensued.

At the end of each interview, I checked in with each participant to assess for their level of distress, if any, and offered to conduct a relaxation exercise if they needed. After the participant had left the room, I wrote a brief paragraph of my first hand interpretations

then reviewed the notes I had made during the interview. For example, if a participant stopped the conversation or repeated a topic a number of times I indicated to myself that this was to be attended to. I became more attentive during the transcription process for these phrases. It was usually up to a week between the interview and transcription process. I wanted to allow sometime between the interview and transcription to create a space of bracketing in hopes of having a clearer perspective of analysis. After I transcribed the initial interview, I reviewed it with my post interview summary to determine if the interpretations I initially made matched or were different after time; they were the same.

I chose to transcribe the interviews myself as it allowed me the opportunity to relate with the data at a number of levels and explore my own reactions to the data and the process. The interviews were transcribed verbatim, word for word, including repetitions, grammatical errors colloquialisms, pauses and fillers. Each interview transcription took between five to eight hours to type out. Once the interview was transcribed, I reviewed the transcript, while listening to the interview and made additional handwritten notes. As mentioned, I utilized a combination of Kvale's meaning condensation and meaning interpretation to look beyond the themes and create an interpretation of what I saw as the participant's perceptions of aggression as described. I used both individual words and a selective phrase approach to interpret the interview content. Individual words can have such varied meaning, yet a phrase provides more content and context in which to define and explain the meaning provided. The emotions the participants discussed as well as descriptors of the relational dynamics also influenced my interpretations as I worked through the interviews. Emphasis of phrases and specific words as well as the speed of

conversation alerted me to the fact that the participant's emotion had changed. If the participant returned to the same topic repeatedly, I interpreted it as having more emphasis for them.

Interpretive Summaries

For each interview I created an interpretive summary to present to the participant. In this process I used "meaning clarification" to ensure that my interpretation of their statements was accurate as well to determine if there were similarities or differences between the participants' statements. To create the summary I incorporated a combination of my hand written notes, the interview transcription and re-listened to the oral interview. I used the summary to clarify the participants' understanding of the statements they made. I made changes or alterations to my interpretations in order to ensure I reflected the participant's perspective. I then compared the statements to like or related statements made by other participants for validation of concepts that I identified within the ongoing analysis. I met with each participant and reviewed their individual interpretive summary and clarified if findings from participants previously interviewed 'fit' with their perception of aggression. Kvale refers to this process as "clarification of material" (Kvale, 1996, p.190). Almost all the participants were in agreement with my interpretations, except for a few changes. For example, including the term self harm in the definition of aggression, was quickly refuted by all participants, even the one who had originally raised it as a concept. Another example was the use of the term 'trust' to describe the dynamics between colleagues; which was refuted by most of the participants. For each participant I

checked on similar themes and any overt differences to ensure that the consistency and all perspectives were included.

The Second Interview

I arranged for a follow up interview with each participant. However, the coordination within the initial two week window between interviews proved challenging. The length of time to transcribe the interviews, my work schedule and the participant's schedule meant this two week window was not possible, except in one circumstance. Most of the follow up interviews occurred within a month of the initial interview. One participant and I had difficulty coordinating our schedules therefore the follow up interview was about five months post initial interview. The one participant that took numerous attempts to book changed jobs twice very quickly within that five month time frame. The participant remained interested in participating therefore I continued to pursue a time to meet and finally was successful.

The purpose of this second interview was to consult with the participants to review my interpretive summary of the initial interview and to ensure my interpretation reflected his/her meaning. I reviewed the purpose of the second interview with the participants, as well had each participant re-consent. I inquired of the participants whether anything had changed for them since our last meeting. I clarified if the interview had brought up any undue distress or other related thoughts. I audio-taped the sessions and documented any interpretations or changes that were identified. These follow up interviews lasted approximately thirty minutes, however again I did not specifically time the sessions.

I realized after the second interviews and subsequent analysis, I had made assumptions about meanings of some of the participants words, such as 'safety' and 'support'. The terms 'safety' and 'support' were used frequently and I failed to clarify the meaning attributed to the terms in the moment. It was during my final analysis that I realized how frequently these terms were used, and I failed to clarify the meaning with the participants during the interview processes. To ensure the validity of the research, the participant's voice must be maintained, thus the many opportunities to check in and clarify meaning and understanding. I remained reflective throughout this process to acknowledge my own responses to the data. When I was unclear or if I was aware of an aspect of knowledge or understanding that the participant could have been aware of I would ask a clarifying question to confirm that understanding. Based on my own knowledge and experience in this field, I was able to recognize the participants' responses to be genuine, and descriptive of their actual paediatric mental health practice. Immediately after each second interview I documented my first hand interpretations for comparison. I transcribed the second interview to ensure I had not missed any major themes that arose from this process.

Development of the Final Themes

To develop my final themes I listened to each interview again and highlighted common words and phrases. I consolidated these into headings which I wrote onto flip chart paper that I had posted around my home office. While listening to the interviews again, one after the other I again wrote key words or phrases onto sticky notes or directly onto the flipchart paper. I conducted this process over a two day period. As the words

became familiar so did the phrases used to describe their perceptions of aggression. I began to realize that although each participant had their own lived experience, there were common perceptions of experience and language amongst them. If there were words or phrases that did not fit into a pre-identified theme or category I put them aside for further analysis such as the terms 'safety' and 'support'. Throughout this and the interview processes I was attuned to the reality that I was in relation with the participants and could influence the data. Being reflexive during this process is critical and I endeavored to ensure I was using interpretive clarification, and tried not to make too many assumptions however did so anyways. Once I completed this final aspect of analysis, I attempted to organize the data into categories that reflected back to my literature review and could be articulated on paper.

Management of Research Data

I locked all written, typed and audio-recorded material in a secure filing cabinet within my home office. As the participants work in the same institution where the research was conducted, my home office location provides more security for confidentiality. The research material will be stored for five years according to ethics approval and Tri-Council requirements. I have shared the research material with my thesis supervisor and will share this paper with my committee members. I informed all potential participants that I will provide strict confidentiality regarding the recordings, transcriptions access and storage of all research material. There will be no discussion of the specific interview content outside of my thesis committee.

CHAPTER V: RESEARCH FINDINGS

The findings from this research study include paediatric mental health nurses' perceptions of aggression in five to ten year old children that is currently missing in the research literature. I will present my findings using a Relational Inquiry Framework. To guide the reader through my findings, I have structured the findings into five thematic categories: Defining Aggression; the Participant-Child Relationship; the Participant-Colleague Relationship; the Participant-System Relationship; and the Participant-Self Relationship. While I outline distinct categories the categories form an interrelated whole. For example, in pediatric mental health, and in all relationships, how we engage and communicate with each other is ever evolving and dynamic. Participants, colleagues and systems of care would not be in relation with each other, or with the child, had the child not come into the hospital setting. All aspects of the findings overlapped relationally as well as embedded threads that involved both time and knowledge. The participants illustrated their perceptions of aggression through examples of interrelated experiences they encountered within their practice.

Physicality: Construction of Aggression

A central question in this research study was to determine what behaviour pediatric mental health nurses perceive as constituting aggression. Interestingly, when asked for a definition of aggression, the participants attempted to illicit a preconceived definition of aggression from me prior to providing their own. I was unclear if the participants were unaware of how they defined aggression or they lacked confidence in their definitions and wanted direction. That is, they did not seem to have a clear, working definition that

informed their perceptions and/or decisions until we began the conversation through the interview process.

When participants were asked to reflect on their definitions of aggression, all of them struggled to provide an answer. Most participants were not aware of whether personal or professional experience, or education, informed their personal definition of aggression. As the participants worked through creating their definition, I would clarify statements they made to confirm their intention. For example, many participants initially included verbal abuse and self-harm in their definitions. Pamela stated, “she would start by hitting her head and the wall...self harm is aggression...it’s a tough call cause that really was the case in this situation...” Jane observed, “... eventually due to self injury ... it was repetitive and severe. The extent of damage that she would due to herself and how (pause), she was driven to hurt herself.” In determining if self harm was to be included in the definition of aggression, the participants decided it did not fit this context. In my final interpretations, although self-harm was perceived to be aggression towards oneself, the participants did not feel it should be included as part of this definition.

The participants drew from a number of different situations to help make sense of aggression. Kaley drew from her experience as a preceptor, explaining “I teach the theory of that (*aggression*). So trying to help young nurses understand that. But definitely years of practice and years of meeting new clients and thinking about it after self-reflection”. My interpretation is that most nurses shape their understanding of client behaviour from formal learned knowledge but consolidate that awareness through experiences with clients. Pamela stated, “...a mixture of life experience and nursing experience... I’ve been in

situations where my intuition said one thing and I never followed it because objectively things weren't adding up then I got injured. So I think I learned a lot from that." The understanding of what is experience and then later perception is developed through personal self-reflection and engagement with colleagues and the system of care.

The participants described differences in the types of aggression and the developmental phases of it. For example, Galena identified certain cues that helped her differentiate behaviour "...when kids start yelling, I start paying attention. Is it fun yelling or angry yelling?" The participants also distinguished between agitation and aggression. Agitation was described as pacing, running around, or name calling, however aggression was perceived when the child's behaviour shifted to "persistence in an intent to hurt" (Jane). Impulsive or reactive behaviour as well as the diagnosis, or reason for admission, were also seen to be different. Kaley's perception was "if it's an expression of pain, not to hurt others" (pain referring to the emotional effect of the illness process), differentiated the behaviour from aggression. The ability to differentiate illness state from aggression was described as occurring through their professional growth through their lived experience of being with clients who had become aggressive. Kaley explained, "I see aggression as more physical, it doesn't have to be verbal and emotional...but it's the intent to hurt". Galena clarified, "It's the physical stuff I identify as the actual aggression. The other I kinda label as agitation...when they actually physically do something" that is aggression. Julia described the loudness as more disturbing for her however "getting hit was not fun either." Julia also agreed that the when behaviour became physical she perceived it to be aggression. Josie stated, "...if I feel personally threatened...well there's the physical, the

verbal, like intimidation can be aggression.” Each participant was able to discuss various aspects of behaviour that led to their definition of aggression and settled that when behaviour became physical, hitting at them or at others was aggression.

There was a slight difference between the female participants and the male participant. The female participants required a level of ‘intentionality to do harm’ that shifted their perception of the behavior from one of agitation, or illness related behaviour to actual aggression. The intent to do harm was towards the participant or others (other clients or colleagues). Lorne had a slightly different perspective in that he differentiated intentionality from threat. However, he did not think intent needed to be part of the behaviour for it to be aggression. Lorne explained, “People can have aggressive tendencies and be aggressive without the intent to be. For example, if they are psychotic, they may not actually have intent, they may be internally threatened, you know, and they’re, you know, protecting, so they don’t necessarily have the intent to harm, but it can be more or less reactivity. ...With intent there should be an ability to rationalize, in my opinion.” Intentionality was not part of Lorne’s definition.

Overall, the participants defined aggression as having a primary focus of physical expression through behavior although verbal and emotional expression could escalate. There is slight variation between male and female participants that requires further investigation. The female participants shared a common definition of aggression that primarily was physical acting out with a perceived intention to do harm. The male participant did not include intentionality in his definition of aggression. This study did not clarify if this variance was because of gender differences or experiential differences

between the participants. It's an interesting question, though. The participants were consistent in determining that aggression comes in a variety of forms, physical, emotional or verbal, however independently each participant determined that physical behaviour was the foremost aggressive component.

The Factors Influencing the Perception of Aggression

It became evident from the beginning of this research process that the participants' perceptions of aggression were influenced by a number of factors. In considering the elements and the interrelationships I organized the data into four primary thematic categories including: the Participant-Child Relationship; the Participant-Colleague Relationship; the Participant-System Relationship; the Participant-Self Relationship. These themes were categorized using Relational Inquiry and arose from the participants' perceptions that aggression arises in the context of an environment and ultimately within the dynamics of their relationships. Each category reflects the participants' perceptions of the internal, external and situational factors that can contribute to aggression. Overall perceptions of aggression were influenced and shaped by each of the above categories.

Two central threads—time and knowledge— weave through each of these thematic categories. Participants reported that 'time' influenced their ability to develop rapport with children, to be able to identify potential triggers of aggression and be effective in preventative responses. Participants stated that not having enough 'time' affected their ability to gain knowledge and interact with colleagues and the system of care. Time was also identified in the participants' ability to self-reflect and to create space in which to do so. The second thread that affected the participants' perceptions of aggression is that of

knowledge. Participants identified that knowledge of the child's usual behaviours, their potential triggers and interventions that prevented aggression were important. Julia stated, "It was about two weeks after her admission something arrived from her teacher about ...tips for working with her.would have been helpful to have the interventions in her careplan book" (at the beginning). With that knowledge of the child and rapport, they could have planned with the child, the best approach, in that circumstance. The participants also reported that knowledge about collegial work values and their expectations created the work environment and context in which the relationships with children began. Jane reflected, the "knowledge of someone you have worked with for an extended period of time, I mean positively or negatively...is there commonality amongst beliefs and what's important. Knowledge of the processes within the system of care and how it functions also impacted their perceptions. For example, assumptions were often made in relation to whether the administrative staff in the system of care demonstrated concern about the participants' wellbeing. The participants expressed this through examples of how programs were staffed and in ways they related to their managers. Julia observed regarding a portion in her schedule, "that's not good for me, and it's not therapeutic for the kids, it's, I need another day and I don't want to be here". Josie's perception that "I feel there's a mentality that everybody is replaceable..." Together, the categories and central threads highlight the complex, relational process of nurses' perceptions of aggression in children.

The Participant-Child Relationship

All participants identified interrelated circumstances that they felt contributed to changes in the child's behaviour that was considered to be aggressive. These interrelated aspects made the nurse-child relationship a central influence on perceptions of aggression. For example, the importance of developing a relationship with a child and family relies on the connections, or attachments, made in creating rapport. For example, Julia described how she and a colleague unknowingly interrupted the child's obsessive-compulsive ritual causing the child to strike out at them. "I interrupted her ritual cause I had to come in and do something. She got really upset and that started everything and she was really disinhibited as well... as soon as I knew that, I was okay and careful of that." Julia felt that if she and her colleague had more opportunity to develop rapport with the child, they would have had the knowledge of the child's reactions to interruptions. Julia demonstrated her understanding how the relational dynamic between herself, the child, the effects of the child's particular diagnosis in relation to her behavioural patterns, and her colleague, contributed to the child striking out.

Lorne described an example of how the relational dynamics and awareness of the child's trigger points affected his ability to intervene when the child was distressed. Lorne understood that aspects of the child's history affected the context of their relationship and situational factors contributed to the child becoming aggressive. "He walked in and saw two strange men there who were talking to a co-patient about going home to foster care" as the starting point for the child's triggered reaction. There were numerous factors that Lorne felt further contributed to the escalation of the child's response, the "security

ignored me and tried to talk to the patient...she moved in when I asked her not to...(another staff person) jumped in, grabbed him so that was the escalation right there". Lorne's discernment of relational factors and his interpretation of the effects of the child's extensive trauma history, affected his interactions with him in the larger clinical context. He also noted that had he had this information previously, he and the team could have worked with the child and the visiting parent, to find a solution that could have avoided the aggression. The participants' perception of aggression was affected by the interactional influences that affected his knowledge about a child and the effects on behaviour.

Participants further identified how the relationships they established with the child affected their perception of behaviour and thus their ability to provide care for the child. Pamela's states, "...I think you can have a relationship with a patient, and you know their history, you can have a better idea of how to talk to them, how to manage them, how to communicate trust and safety and just a sense of security...." Kaley described how her experiences as a new nurse developed her understanding and perceptions of aggression. Kaley discussed a relationship with a child, in which she became relationally over involved, "...she had such issues with attachment and had so many broken down foster homes...she was such a likeable child that people would be really drawn to her. ...I think the transference with me, and feeling connection, you know; I had worked with her so closely she wanted to terminate before I terminated." Kaley illustrated how this example of this child, who was being discharged, and was making attempts to disengage with her. The child eventually bit Kaley. Kaley's initial response was shock and surprise, however she realized that she was not paying attention to the child's cues of trying to disengage. "I just

remember feeling so assaulted and hurt by it. And I had to, you know, really go deeper inside to realize this wasn't about me". Kaley was able to articulate how over involvement with the child affected the relationship, causing the child to strike out to set a boundary. Kaley stated that had she been more aware of when to disengage and have an understanding of the child's attachment patterns, she would have had a better understanding at the time of her interaction. Kaley stated, "I do remember feeling closure around it. ...we found a really good placement for her and she never returned, which is always a good sign."

Relationships have natural points of ebb and flow, so a nurses' ability to attune to communication cues from a child requires time to reflect and learn their language. Pamela and Kaley's perspectives, about what affects their ability to develop relationships with children, have evolved over time. Kaley's self-reflection about her evolving awareness of relational factors contributes to her evolving perceptions of aggression. Jane was also able to articulate the importance of relational factors in working with children, "the staff that was assigned to the patient that day was not his primary staff, but had a good relationship with him and was successful in using that relationship to attune and support him to calm down repeatedly; but not completely as his arousal level kept going back up. But I observed that they were able to use the relationship as co-regulating and support for the child to quite a successful degree." The interactional factors that evolve through time through knowledge, help define the participant's perceptions of aggression.

Another example of how the dynamics between a participant and child affects the participants' perception of aggression is with Galena. Galena's initial description of her

relationship with a child, focused on the child's developmental history and influence of trauma on the child's responses to interactions with staff. She then altered her frame to focus on one particular experience she had had with the child; "...she has large history of trauma and abuse from her biological family, ... This one singular event I think started when she woke up, the entire day she was agitated and running around the unit...it was Monday morning she just come back from the weekend, and she's being discharged this week, so there's a lot going on." Galena's comment is relevant in that the staff members are not always privy to every influencing factor that can affect the development of the relationship with the child. Essential to creating a relationship with children, the participant relies on learning about the child through interacting, but also through understanding how the influence of the child's history effects the development of relationships, such as the examples given above by Julia, Kaley, Galena and Pamela. The relationship with the child allowed the participant and/or team to plan care more effectively and have more opportunity for understanding the child's triggers and subsequent aggression, therefore developing strategies for prevention of aggression when possible. Aggression is often perceived to be wrong when it causes harm to self, others or the property of the facility. How a participant engages with a child affects the child's response and ultimately the participant's perception of behaviour expressed by the child as aggression.

The participants expressed that developing relationships with clients and families involved attuning to their needs and their particular way of communicating, which often took more time that was available. Jane also comments, "...no one has the time to sit

down with me to talk about what's worked what hasn't worked...I spend a lot of time doing things that aren't child friendly..." There were times when the participants reported they did not have time or the opportunity to engage with the child in a meaningful way to be able to plan the care effectively with the child. This was especially true when the participant was working in an 'on call' or 'casual' basis. Julia talked about when she used to work casual shifts (on call) "I don't mind floating to different units, but I thought it worked better for the kids and us, when we were on one unit for a period of time. We got to know them and they got to know us. We knew what was going to work and what was not." Julia and Pamela both felt that when they had more opportunity to develop relationships with the children, interactions were perceived to result in less aggression. Pamela, "I introduce myself ...you could tell it would take time to develop a relationship with this child...She was there with her mom and brother and really resistant to sort of any other, seemingly new faces. I mean it's overwhelming to be in hospital so I can understand that." In order for these relationships to develop, and for the participants to engage effectively with the child, the participant believed time and knowledge affected that process to respond in a preventative manner. The participants agreed that the interactions within the relationships with the child, ultimately affected their perception of what behaviour was interpreted as aggression.

Since the relationship between the child and nurse influenced the participants' perception of aggression, they used strategies that would enable the development of the relationship. For example, they sought to develop more knowledge of the child so they could relate in an informed way and intervene effectively with the child and family in the

context of care. Whenever possible the participants attempted to learn as much about the child and family at the beginning of the relationship as they could, and often used play to engage with the child to do this, as described by Pamela, "...it's time to take that effort to kinda subtly introduce yourself through play...playing alongside...I could pickup up on that challenge in connecting." The participants did not offer much comment about the impact of parent involvement in the development of relationships. Pamela's example was situated around a child's anxious attachment. She described how the attachment challenges and separation anxiety contributed to the child's escalation in behaviour, however was focused on the child, rather than the parents' contribution. For example, Pamela states, the child was "triggered by mom and brother leaving, separation anxiety...." When asked how her relationship was with the mom and brother in this situation, she responded, "very relational". To me this meant Pamela perceived that she had been able to engage with them much more easily than with the child in this context. I did not focus or question the participants about the family or parents in my interview process, and only one participant raised the interaction with parents in the context of the interview.

The participants articulated the importance of the relationship development between the participant-child and how it contributed to the de-escalation or prevention of aggression. The relationship with the child affected the participants' ability to determine effective interventions. The ability of the participants to develop rapport, have creative options for intervention and thus focus on prevention with the child was hampered in some circumstances by the lack of information or knowledge about the child, services available or the time required to achieve this. Jane expressed concern as to how long it took to

determine a treatment, "...lot of times we can see vast improvement quite quickly and this kid took a long time for any improvement. ... research is showing (*particular treatment*) can be quite successful..." but the team was unaware of it at the time of admission. The participants' also felt that colleagues and the system of care affected their ability to develop relationships with the children. For example, Julia comments about support from colleagues and administration, "I work with a lot of really great people, so basically it was positive, supportive...if the staff feels unsupported they're not going to feel like coming to work."

Participants reflected how their own internal factors, such as how fatigue affected their ability to develop or stay attuned in their relationships with children. For example, Pamela "it was quite exhausting, it lasted for an hour...frustration too, in the sense that eventually chemical restraint was ordered by the doctor cause she wasn't settling after an hour ...I think that was hard to wait a long time cause an hour is a long time". Jane reflected, "she required so much attention and care from the staff constantly with her it was exhausting....if you weren't with this one kid and you were off of her it made it really difficult to give good care to the other patients because you were so tired...I think that after two hours with this kind of kid you'd be a little irritable inside too, you know probably a little harsh at times too." Josie's perception was "when you're in the initial piece of it, you don't sleep well that night cause you're thinking about it...what could I have done differently so that didn't happen".

Overall factors that interfered with relationship building were knowledge about the child, time to gain that knowledge; colleagues' interference; expectations of the system of

care ; and the participant's own experiences, both personal and professionally. The participants' perception of aggression of the Participant-Child Relationship was deeply rooted in the complexity of relationships and the interactional effect of the child-participant dynamic.

The Participant-Colleague Relationship

The situational context of participants' working world is comprised of many relationships including those with colleagues. When asked about what other aspects of their work environment affected their perceptions of aggression, all participants quickly transitioned from discussing the child relationship to the relationships with colleagues. Throughout the study, the participants referenced the connection or lack of connection with colleagues as the most influencing factor affecting their ability to create an environment that supported their relationship with the child. For example, Pamela stated "...a more collaborative effort of communication letting you know that we're here to support you, and just kinda having more of a team effort as opposed to working in isolation". Pamela also commented, "...the way it was managed bothered me...the sense of team working together, communicating better, updating us and what we are going to do..." Josie's comments focused on the workplace, "you know certain people can be bullying in the adult world and it's not that overt but you know when you're coming out of that situation afternoon, and you feel 'wait a second that wasn't right' ...when someone's trying to make you feel bad about yourself."

The participants perceived that colleagues were directly involved in the escalation or reduction of aggression in children. These colleagues were either involved in the

moment, or arrived at some point during the interaction with the child and participant. For example, Julia reflected, “I know other people, and I don’t agree with their approach as much, if I like the way they handle situations, that I guess makes a difference and I view it more positively... I guess it’s better to be alone than have someone come in and trigger a kid...” Galena’s observation of supporting colleagues, “...when she (*patient*) started to yell and name calling the other staff, and I guess it’s even looking at the body language of the other staff as well, you know they kind look on their face of ‘this is not working’ or noticing it’s not working, and another person in the situation might help cause I had rapport with the patient as well.” The dynamics of the relationship between the participant-colleague appeared to affect the participant’s ability to attend to their interactions with children. When the relationships between participants and colleagues were perceived to be incongruent, both within the relational dynamics and also in approach, it resulted in the participant’s feeling the relationship with the child had been intruded upon. The result of which created a context in which the potential for aggression increased.

The participants referenced two terms to describe their relationships with colleagues, ‘walking along side’ and ‘support’. My interpretation of ‘walking along side’ was when colleagues and participants were in agreement on how to approach a child within a particular circumstance. Lorne states, “there are some people I feel good about working alongside with because I know that we are talking the same talk, and there’s other people ...I get more anxious when I am working with because I know they won’t come in and work along-side me. They will take over and create a scenario that diminishes or

disrespects the work I have done prior to them showing up.” Lorne further added, “...it creates a discomfort in that relationship (*with colleague*)...I think it’s that values clash”. Julia’s previous comment regarding “if the staff feels unsupported they’re not going to feel like coming to work...” is important for both colleagues and administration. Kaley stated her experience with colleagues, “I was more validated within my team cause they helped me get through that a little bit...I was safe to say that I didn’t know or that I was feeling upset about a situation, ...it was okay to that could have a discussion...I just felt really supported...it was a safe place to learn.” The term ‘support’ was used interchangeably in connection to colleagues, the system of care, and the administration, however did not appear to carry as much value as ‘walking along side’. Most of the participants preferred the term ‘walking along side’ to describe the relational connection between themselves and their colleagues.

The participants’ perceptions of child’s aggression were directly affected by their relationship with colleagues in their response to the child’s situation. This shared approach of ‘walking along side’ did not always need to be verbalized. Kaley stated, “We just knew to look at each other and just reduce the stimulation, lower the lights...” Walking along side involved a level of knowing, however, most participants did not feel time or longevity of relationships with colleagues was necessary to be able to walk along side. Some of participants determined that to ‘walk along side’ a colleague required a set of shared work values rather than personal values. Lorne was the clearest on this point and felt that personal values were not the same as work values. This differentiation was deemed important by the participants. Although participants were aware that colleagues may have

similar personal values, what they looked for was a shared philosophy of work values. The shared work values led to the understanding that the participant and colleague would work together with the child. Overall this connection was thought to support the relationship with the child.

The interactional dynamics between the participants and colleagues created an environment where the participant felt either supported or detracted from their ability to engage *with* the child. Participants identified that colleagues who took over, rushed in, and interrupted the participant-child interaction was detrimental to the rapport and work done by the participant and was perceived as “disrespectful” (Julia, Lorne, Pamela). Participants commented that these colleagues often intruded on the relationship between the participant and the child. “I had asked for backup and I guess that was interpreted as *help now*. They just rushed in and restrained the kid. I just realized that’s what happened. I guess I will need to talk to them about that” (Lorne). “They just come in and take over and totally undermine you in front of the kid. Leaves you feeling useless” (Julia). The perception of a colleague’s response of “when you ask for help” was viewed positively when the colleague’s response is congruent with the participants, they “agree with the approach” (Pamela); “I like how they handle situations” (Julia).

Working together from the same perspective was viewed by the participants as important to the outcome of the situation, and directly influenced the outcomes for children. Jane states, “knowing someone you have worked with, are there common values in what it is you’re doing, in that when you’re moving into a situation, or working with a particular kid, is there commonality amongst beliefs and what’s important.” The uninvited

intrusions disrupted the relationship the participant had created with the child, was perceived to escalate the child's behaviour, thus contributing to the participant's perceptions that colleagues affect the potential for aggression. Participants reported it took longer to settle a child after a colleague interfered. These examples highlight how the relationship between participants and colleagues affected the participant/child relationship. Galena provided an example of how conflict and communication in the participant-colleague relational dynamics affected the child's behaviour. Her interpretation was that conflict among colleagues escalated the child's behaviour to an intensity she perceived to be aggression. Galena reported that conflict can directly affect the participant's 'feeling safe' and ability to walk along side. "I had to mediate two colleagues who were not communicating well. One thought the other was going to ignore the child's indiscretion however they were allowing the child some time to process. They were arguing outside the room, so I took them aside to clear it up. They eventually listened to each other and got it sorted out". Galena's concern was that the child could over hear the conflict outside and believed this was contributing to the child's increasing aggression. Galena perceived this interaction as being about how the conflict between colleagues was affecting the child and the impact of the outcome for all concerned. Resolution of such conflicts was stated to have long standing impact on future work relationships. The confidence in the collegial relationship contributed to how the participant interpreted their relationship with the child in this interaction.

Further to collegial congruence, was the connection among all members of the clinical team. Communication and shared values was central to the development of team

work. Kaley and Pamela discussed the importance of being able to feel 'safe' or secure to question practice or even disagree was critical to developing communication and knowing amongst a team and between colleagues. For example, Kaley states, "I was open to listening to what they thought was going on, and open to kinda debriefing and discussing it rather than keeping it to myself. I really grew with that team. I think it makes you such a better practitioner to have that safety when something was escalating we just knew to look at each other and just reduce the stimulation." To be able to make mistakes and not be judged by colleagues and/or management was important to the development of knowing and feeling one could 'walk along side' safely. Pamela stated, "I need to know that I could depend on them (*colleagues*) to be supportive and make a decision...When there wasn't a steady flow of information and communication on the other end, it's not that we can actively seek it out (in the case of being directly involved with a child). People have to come to us and ask us for added support. Teamwork and support is important". The participants' perceived communication among colleagues was important in developing the ability to 'walk along side'.

To be able to create an environment of walking alongside, Jane comments about having time for reflective practice, it "creates a non-judgmental environment, it's made to explore thoughts or feelings you are having. ...Some staff have been able to let go of the blame and shame towards patients..." When questioned explicitly, most of the participants determined that the concept they described as 'walking along side' was not equitable to 'trust'. Only Jane agreed that the word 'trust' fit the circumstance. Pamela dismissed the word as being too strong; she clarified "it's more a lack of teamwork and support. I don't

know if I necessarily don't trust them but maybe that's one of the results of the lack of teamwork and support in response to these situations. ...it doesn't necessarily mean I don't trust them...." Pamela, Galena, Julia and Kaley described their perceptions of interactions with colleagues directly affected their perceptions of aggression. Galena stated "it's better to have somebody you are able to communicate with and they can jump in, know the kids..." "There would be a component of anticipation so you can anticipate your co-workers reaction...you have the knowledge that this is how they will respond," Jane. Jane's comment about anticipation indicates that the interactional dynamics between colleagues affects the participant's sense of confidence in the moment and ultimately their confidence in working with the child and their perception of aggression. Relational congruence with colleagues assured the participant's confidence in maintaining a focus on the child. The participants described this dynamic as walking along side and it appeared to involve shared, synonymous practice values. The participant-colleague relationship was described by the participants as having the most impact on their relationship with the child and in effect, their perception of aggression.

The Participant-System Relationship

The participants referred to the system of care as including the context of the larger health institution, administration or management, governing policies, non-direct care colleagues such as physicians. The system or culture in which a nurse works influences his/her perception of aggression. The participants work within a culture that incorporates a philosophy called 'trauma informed care', which in turn effects the environment in which they practice. Clinical practice expectations, structure of the programs, policy integration

impacts the participants' perceptions of aggression. All the participants were able to clearly identify how traumatic experiences affected the child's development and resultant behaviour, demonstrating the integration of the trauma informed care philosophy in their understanding of the child. I did not specifically consider asking the participants about connections between their relationships with colleagues, or to other staff members, such as administration or physicians, in the overall system of care in regard to trauma informed care philosophy or program policies as my focus was on the relationships with the child. Therefore there was not a connection made on how these would or would not contribute to their perceptions of aggression. For example, Julia's statements in regards to scheduling, frequently moving from unit to unit, "I think management is trying to make things better, more cost effective...I think management is trying to do their best for the most part, but sometimes it's frustrating". In a fully trauma informed model, considerations of attachment with children would be a foremost consideration when staffing the units. As well, there would be transparency in the reasoning for the process as it is. Josie's comments regarding how she feels the organization treats staff members, "...there's a mentality that everybody is replaceable so if you don't suck it up then that's fine you can leave and just get someone else to do it. ...it's just another hair on the camel's back about in the organization about what's going on around staffing levels, high turnover rates. The feeling there's no consideration of that, it's just purely numbers so it's more of a big picture type thing." My interpretation of what Josie is experiencing, is referred to in the research literature, as organizational trauma, however she did not specifically indicate that she recognized her feelings or statements as such.

The participants described how the administration of the system of care affected their feelings of being supported in the work environment. I interpreted the term support to be similar to walking along side, relational congruence, as described with colleagues. The participants' interpretation was that the overall structure of the system of care and that the administrative staff needs to share a common set of work values, and demonstrate in some manner concern for the staff. Lorne comments, "...it is an interface between multiple values and I find that really difficult...I don't want to be driven by value stances that don't align with our program...to create a culture that supports a level of psychological, emotional safety for people, for everybody, I mean the kids and the team". Each of the participants raised the concept of system support as affecting their ability to respond within relationships with children, to redirect, avoid or overt behaviour from becoming aggressive. The participants indicated that if the system provided more 'support' it would allow for more opportunities to develop rapport and relationships with the children, and thus impacted the participants' ability to affect the child's behavior. The perception that support comes from the larger system of care that includes administration or physicians was important to the participants' perceived ability to create space to develop relationships with the child or colleagues. Josie's salient comments about her perception that staff are "replaceable" is significant to how others may be feeling, although of the participants she was the one the vocalized this. Lorne commented about feelings of being "coerced" to work a certain way with colleagues and children. Julia, as well expressed comments about how frequent moves between units affected the ability to develop rapport with children, "it's not a comfortable set up for the person coming to work as well cause the don't really

know this kid...I don't feel we are offering the best services that we could because you're putting someone with them that doesn't really know them and so there is the potential to trigger them a lot faster." It was also important to the participants that they be recognized or acknowledged in the work conducted. Therefore, while system support did not necessarily directly shape the nurses' perceptions it did have a mediating influence on how the child was ultimately viewed and treated. For example, by having more time to develop rapport and connect with the child, the child was less likely to act out and/or if negative behavior did occur. The nurses were less likely to perceive behaviour as aggression since they interpreted through their knowing of the child and the empathic connection they had established. It is unclear as to why the participants did not reference any influencing policies or the philosophy of care as having any influence on their perceptions; however I also did not ask them directly.

Communication within the system of care was vital at all levels of the organization. Josie reported feeling frustrated when she did not believe she was being 'supported' by others, "it comes from the leadership". Whereas Kaley stated she felt she was well 'supported' throughout her nursing career; "knowing that I would be supported anytime, whether that would be with other team members from other units or with management or whatever, I always felt supported". Lorne's experience was more reflective of his relationships with physicians when he felt he was not getting the answers he needed, to work with the children, "I feel frustrated because I would like to know what to do or don't know who to ask or how to get the support for this child." Pamela voiced similar thoughts, "You need to have a *go to person* who can answer your questions, without blame or

judgment and support you in the process.” My interpretation of these statements was that the participants’ expected open and direct communication from other practitioners in the system of care, which also included recognition, and acknowledgement of their work. This is relevant as the participant’s perception of their value directly impacts their desire to connect and engage with children in a positive, therapeutic manner. When staff members believe they are appreciated, they are more confident in their work, and relationships.

Some of the participants identified that in some circumstances the management of the system of care, interfered with their ability to develop relationships with the child. The participants stated that ‘staffing issues’ or programming challenges affected their ability to engage with children. Julia focused on scheduling and staffing levels “I mean I think management is trying to do their best for most part but sometimes you’re ..., it’s frustrating”. Julia’s comment reflected back to issues around her particular shift rotation, accommodations of colleagues and feeling exhausted by the work. The perceived lack of support left participants feeling “unbalanced, left on your own” (Julia), this increased when the participant was in the role of being on call and/or having to move from unit to unit. I believe Julia has a belief about staffing levels have an effect on client care. In reality, the issue is likely more about experience, trauma education and colleague interference that than it is actually about staffing levels. The lack of support was perceived to affect both the participant’s ability to *connect* with the team and with the children and families. Julia further explained, “When you are in one place and work with the child, you get to know what works and what doesn’t. You often get assigned the most complex children with

little time to develop rapport or knowledge about their experience. This is not fair to them or me or other staff”.

The term safety was also used to describe ‘support from the system’ however I did not examine that within this study. In terms of safety, Pamela and Galena expressed similar views. However, Galena was clear that she would rather have anybody, experienced or not, than be alone in a difficult situation. Julia reflects on her experiences, “it’s hard to develop rapport it’s to know what works with people because you have to memorize three wards worth of patients...people forget to tell you really significant information that would have helped you.” Although the participants expressed frustration with the system, they stated they felt confident and comfortable in their work environments. Participants identified how the system of care’s treatment of them affected their ability to develop relationships with children, families as well as colleagues. The participants’ perceptions of aggression were influenced by how well they felt the system of care’s administration listened to their needs and beliefs about their practice of client care, and a feeling of ‘support’. The ability to establish relationships at many levels impacted the participants’ perceptions of aggression.

The influence of the system of care was also evident in the types of interventions available to the participants, and when to engage them with a child. The articulation from leadership about the philosophy of trauma informed care, practice guidance and policies, creates a lens from which the nurse learns to perceive the child’s behaviour and intervene accordingly. Emergency interventions, such as seclusion and restraint, are treated as high risk activities and are clearly articulated within this agency’s policies. Staff members are

supported to use various preventative strategies such as Collaborative Problem Solving (Greene, 2009) and strategies from the ARC framework (Blaustein & Kinniburgh, 2010). Depending on the staff member's perception of the degree of behaviour of the child, and the context in which it occurs, can determine the type or level of intervention employed by the direct care providers. The relationship with the child assists the nurse in planning and developing interventions to prevent or divert reactive or aggressive behaviours. The nurse is also responsible for collaborating with the team, child and family to assist the child in learning new strategies of response. The options and variations in which a nurse is able to employ interventions with a child, is dependent on the nurse's engagement with the system of care and integrating the philosophy within his or her practice. For example, Julia "I find they do sometimes give (*casual, on call staff*) the tougher assignments, which is frustrating cause we have the least rapport (*with the child*) ...it's not really fare to them." Jane reported, "...the extent of damage she (*the child*) would do to herself and how...she was driven to hurt herself...so straps to the bed and eventually...restraints when in a chair" to prevent severe self harm. When the participants reported that the intensity of the behaviour increased such that participants were at a loss of what to do, and the child was in danger of hurting themselves or others, they used more restrictive measures such as seclusion or restraint. The use of restraint and seclusion was perceived to be negative. However, the participants did not necessarily feel they had the skills or knowledge to employ other strategies. Jane, Pamela, Julia, and Lorne felt that by having an assortment of interventions in which to engage with a child, affected at what point they perceived behaviour as becoming aggressive. When options seemed limited, participants expressed

emotional and physical fatigue; “day after day with no resolution is exhausting” (Jane); “an hour straight without any direction, or support was too much ...it was both (*physical and mental exhaustion*)” (Pamela). Participants expressed concern that in these circumstances they would disengage or withdraw from their other clients to focus on the child who appeared to be the primary focus in keeping the unit ‘safe’. Jane’s comment reflects the outcome of overburdening staff, “we had a lot of sick calls because people just could not come in again and deal with her.” The participants identified that the administration of the system of care was responsible for providing time to learn new strategies and interventions. The participants interpreted that in order to gain the confidence to practice new things depended on their relationships with colleagues and that of administration within the system of care.

The participants’ ability to develop relationships with the child and family assists them to identify intervention strategies to prevent or engage with the child, should the child’s behaviour become aggressive. The participants reflected that the interventions available to them were not always suitable for the child or the context of the situation. The participants would question their skills, the system of care and other care providers in ability to intervene in a therapeutic manner. For example, Lorne talked about the needing time, space, and creativity to make changes with the children. Lorne’s hopes for more in-depth psychiatric intervention, “work with him (*the child*) around in a neutral way, like with the doctor in the doctor’s office, not in the scenario which I find is difficult and disrespectful [*of the child*].” He expressed a sense of isolation, and struggled with being able to generate *real support* when working with the child. The support Lorne appeared to

be seeking was connected to his relationship with the physician in this example. His inability to engage the physician in the process of care left him frustrated, and at a loss of how to effectively intervene. Again, this returns to the impact of relationships outside the participant-child dynamic and it's the effect on the participant's feelings of confidence and competence. The participants identified that the context of the system of care administration, and relationships with physicians directly affected their perception of aggression in their practice options and interventions for the child.

The Participant-Self Relationship

The interview is a self reflective process for the participants and myself. The participants were all able to draw on memories, interpret their meaning and then reflect them back to the questions. Some of the participants acknowledged having taken time to interpret past experiences and identified how that exploration effected their interpretation of those experiences and the influences on their current perceptions of aggression. I assumed that during the interview process that if participants had specific trauma experiences from their past or through work, they would be in the best position to determine if this was the place they wished to share those thoughts and feelings. I was concerned about the psychological safety of the participants and my dual role in this context, therefore I chose not to ask specifically about how participants' personal trauma experiences may have affected their perceptions of aggression. I did focus on whether the participants were attuned to their physiological responses to aggression, and if there was a connection that may have affected their perceptions of aggression.

There were variations in self-reflection at different stages of the interview process. Many of the participants diverged to tell stories that were unrelated to the research process or to ask unrelated questions. The participants not only reflected on how their perception of aggression was related to children, colleagues and system of care but also internally to themselves. Kaley reflected, "...I remember it being a pivotal part in my nursing that helped me realize that piece of self awareness that I have to be careful of transference and counter-transference...and in, not having me need to be liked as a nurse you know". Kaley stated that her perception of aggression has changed with her ongoing experience in developing relationships with children and learning her role as a nurse.

Perceptions of aggression requires the individual to be able to have an awareness of both verbal and non-verbal communication cues that indicate that behaviour may become aggression. Bodily knowing, or attunement, is the awareness of our own physical responses when we are in relation with others. In many circumstances we have come to ignore the physical sensations. I asked the participants if they could identify within themselves, physically in their body, where they perceived aggression. Pamela identified that the one time she got hurt by a client she had ignored those physical sensations. The physiological responses that the participants identified were varied. Some of the participants were conscious of their bodily knowing prior to or within the context of aggression, such as Lorne, "I become very aware of what is happening in my body. I seem to feel a calm come over me and an inner voice that keeps talking." Some participants reported not having reflected on their physiological or emotional responses to the child's behaviour prior to this study. Galena stated she has not consciously considered how her

body responds during a child's expression of aggression. Galena stated, "I never thought about that, yeah, probably I don't know, I think it's more the tension of the okay I need to be in charge of the situation...like your spidey sense goes off..." Galena reported she had never been reflexive in her experience of aggression with children or with her colleagues.

The participants reported that being mentally present during aggression was both physically and emotionally draining, as commented on by Pamela above. Some of the participants were able to be reflexive for a brief moment with the child however needed to create emotional space to move on to the next child to be able to be present and authentic with them. Conceptually, Galena appeared to gain new insights into how her perception of aggression was enhanced by her increased self awareness about her internal response and towards her colleagues. Josie described her feelings, "...you feel sick in your stomach kinda feeling, but I think for me there is a cognitive piece in that it plays I your head over and over and over again, then you know something's not right...when you can't sleep at night...you're thinking about it..." Most participants had not reflected on their awareness of their physiological changes that occurred prior to or during aggression. The participants' perception of aggression was affected by their awareness of their physical responses that indicated behaviour as aggressive.

Each participant continued to carry a memory and a deep level of compassion for the child and their colleagues. The participants' overarching sense of responsibility towards children and colleagues affected their perception of aggression. Pamela stated, "I just hope that...the child did get some good care, did benefit from the inpatient stay." Kaley stated, "I wish her well, I think of her." This compassion shaped their perception of

aggression by reflecting on their personal need to know. Jane expressed “...there was a treatment out there and we did not know about it. I feel sad for her all the time. Frustrated that I couldn’t even do anything. How much time does it take to get this under control?” Kaley comments, “I felt kinda helpless initially, sorry for her, I just felt she was too young to be experiencing a lot of those feelings.” Julia stated, “I don’t know how much she understands of what she’s doing so I was trying to figure out how to best communicate with her to let her have a smooth day; and let everyone and to keep everyone safe.” Galena felt the need to step in to assist her colleague, “...looking at the body language of the other staff, you know they kinda look on their face of ‘this is not working’ or noticing it’s not working...” The participants’ expressed strong emotions of compassion and caring for the children throughout the interviews; “they touch you and we touch them” (Kaley). Each participant wondered how the child was doing, what was the child’s outcome. Kaley, Jane and Pamela outwardly expressed hope that the children were doing well, that they had made a difference, “did we help?” They demonstrated deep compassion for the clients, families and their colleagues. The knowing of self and to have the time to reflect is essential for the participants to process these experiences, to develop future relationships with children and to understand where they draw their perceptions of aggression from.

To understand their perceptions of aggression, participants recognized the need to be self-reflective. Self-reflection, as a process, was felt to enhance team work and created a safe space to discuss and explore challenges of practice especially when working with children with mental illness.

“I don’t think it diminishes teamwork at all. I think it enhances but I don’t think its necessarily immediate gratification. I think that reflection and reflecting as a team

is a process that takes time and the more safety you develop as a team in doing it the more you will bring forward from it. ...the environment in which you work. The way management responds to i.e. perceived mistakes, learning situations, clinical situations, and then taking those and applying it to the learning and leaders and other staff. ...it's a form of confidentiality of practice and reflection," (Jane).

Although team self-reflection was not identified as clearly as in the situation by Jane, several participants shared that self-reflection was important to the development of their perceptions of aggression both immediately after an event had occurred and again, much later.

Most participants commented that until this research project they had not had an opportunity to reflect on their perceptions of aggression. Although most of the participants described having a post-incident debrief, a more in-depth reflection on each individual's practice or perception of aggression had not occurred. Jane reflected, "...it's interesting going through this. I haven't talked about it (*voice cracks*). Galena's comments about the research interview, and her own self-learning, "It was good, it makes me think, like, what happens in your body, I don't know?" The research interview process allowed the participants to return to that reflexive moment. The participants commented that the research interviews provided them with time to 'discuss openly' in an environment that rarely or never comes to the surface in the context of day to day practice. Josie stated when she was in charge, she would be up at night worrying about whether enough was done to prevent the aggression, and what, if anything could be done to prevent it in the future: "I feel that responsibility a lot more. I do see that as a personal failure of some sort if somebody gets hurt. Did I miss something? Did I ensure adequate staffing? Did I advocate enough for support and resources, so that those kinds of incidents don't occur...?"

Galena had similar reflections that she drew from her experiences in previous leadership roles with colleagues, “I want them to feel supported and I think having casual staff involved in these situations can be hard cause they are not there the next day, and if you have to debrief right away so I think it’s a key aspect.” The participants reflected that their perception of aggression was laden with the emotional responsibility towards the children and their colleagues.

The participants also reflected that their perception of aggression was influenced by their ability to affect change for the child. Within this, the participants expressed concern for the child, and a desire to know the outcome for the child post-discharge. Participants posed the question, did we help them? “I don’t really know the outcome of that so that would be interesting to know. It would add perspective in the sense that knowing that this child did get some good care did benefit from the inpatient stay,” reflected Pamela. All participants reported wanting to know that there was a resolution for the child. Self-reflection was prevalent among the participants. Although much of what occurred in this work environment was reflected upon briefly after the aggression occurred, many did not have the opportunity to speak to someone directly about it. The participants reflected on the importance of having an opportunity to discuss, in depth in a safe environment, how their experiences with children, colleagues and the system of care and contributed to their perceptions of aggression. All the participants were appreciative of the opportunity to explore how they perceived aggression. The depth of compassion disclosed by the participants towards clients and colleagues demonstrated a deep sense of caring, accountability and responsibility. This level of self-reflection indicated to me an

awareness of the interrelatedness of self, and others in the context of clinical care but also in their creation of their perceptions of aggression.

Summary

In summary, the findings stress the importance of the dynamics of relationships affecting the participants' perceptions of aggression. The participant-child relationship was central to understanding nurses' perceptions of aggression. However, the threads of knowledge and time affected the participants' development of those relationships. All participants were able to discern a common definition of aggression with minor differences. The participants' perceptions of aggression were influenced by a number of relational factors. The participants were able to express an understanding of the child's needs and the dynamic relation between each individual and the child, colleagues, others within the system of care, and within themselves. The relationships, between the participants and their colleagues, influenced the participant's confidence in relating with the child effectively. The participants provided information that described their understanding of what factors contributed to aggression and thus reinforced their perceptions. The participants identified multiple sources of contextual or situational contributing factors that potentiated aggression such as the child's clinical presentation, diagnosis (autism, OCD, developmental delay), child's hospitalization history (admitted from emergency, new admission, new staff) and developmental history (abuse by parents; or other trauma experience); genetics; family dynamics; unit environment (small space, noise, multiple children with similar presentations); staffing levels (inexperienced staff, not enough staff) and the related dynamics and ultimately their ability to develop a

relationship with the child. The development of relationships and opportunities to intervene were affected by time and knowledge, however all impacted the perception of aggression with the child. All participants attributed multiple factors to the development of their perceptions of aggression.

CHAPTER VI: DISCUSSION

This qualitative research explored mental health nurses perceptions of aggression and the relational influences that affected those perceptions. The phenomenon of aggression in healthcare is well identified and researched in a variety of contexts. Currently, there is no such research within pediatric mental health, especially in relation to nurses' perceptions of aggression. Connecting the current literature from healthcare to my findings proved to be a challenge. The limited research beginning to appear in pediatric mental health is not specific to nursing, and fails to explore the relational aspects of aggression or perceptions thereof (Dean et al., 2010). There is limited qualitative research focusing on the meaning attributed to aggression within pediatric mental health populations.

My research revealed that although the nurse's relationship with the child was central to the participant's relationships with colleagues were more impactful on the perception of aggression than client factors. The system of care and the self were also identified as relationships that contributed to the nurses' perception of aggression. Evidence of how using Relational Inquiry, expanded the understanding of complex relationships and their effect on perceptions of aggression is explicit in my findings. Relational Inquiry, allowed me to examine the dynamics that influence our relationships within the construct of the healthcare milieu.

The literature review explored the phenomenon of aggression in healthcare, including definitions, assessment tools, education, and government, agency and/or regulatory policies influence on nurses' perceptions of aggression. Specific philosophies

of care were reviewed that demonstrated reduction or elimination of aggression including trauma informed care (Bloom, Bennington-Davis, Farragher, McCorkle, Martini, & Wellbank, 2003; Huckshorn, 2005). Trauma informed care is relevant as the agency where this research was conducted has been working towards implementation of this philosophy (Mulvihill, 2005; Kinniburgh, Blaustein & Spinazzola, 2005; Murphy & Bennington-Davis, 2005, 2006; Blaustein & Kinniburgh, 2010). A fuller understanding of the factors contributing to aggressive behaviour, including how an understanding of trauma affects the care provided and the care-providers was needed to direct further education and support for staff working in this agency.

To understand pediatric mental health nurses' perceptions of aggression, I needed to understand the basis from which the participants came to be in the position of observing, participating and contributing to issues of aggression in their workplace. I used Relational Inquiry as the conceptual framework to guide the research. Relational Inquiry created a lens from which to view how the participant engaged with, and was shaped by, relationships with their clients, colleagues, the overarching system of care, and self. "Relational Inquiry involves a reflective process" (Hartrick Doane & Varcoe, 2007, p. 198) that assumes and looks for "how people, situations, contexts, environments and processes are integrally connecting and shaping each other" (Hartrick Doane & Varcoe, 2005, p. 51). "Each person has a unique personal socio-historical location that affects and shapes the personal identity, experience and interpretations... people are both shaped by and shape other people's responses, situations, experiences and contexts" (Hartrick Doane & Varcoe, 2005, p. 198). While this construct is similar to the situational model described by

Nijman, the situational model is limited to the relationship between the health care personal and the client (Nijman, 1999; Duxbury, 2002). Kvale's Interpretive method was use to inform the interview process and data analysis. The study was, thus, oriented toward illuminating and understanding the complex interplay of relational factors that shaped nurses' perception of aggression in five to ten year old children.

The results of the findings were categorized into five thematic segments: Physicality: Construction of Aggression; the Participant-Child Relationship; the Participant-Colleague Relationship; the Participant-System Relationship; and the Participant-Self Relationship. Interwoven throughout the themes were the concepts of "time" and "knowledge". All aspects of the findings overlapped relationally, as did the embedded threads of time and knowledge. The participants illustrated their perceptions of aggression through examples of interrelated experiences from their practice.

Understanding Physicality: Construction of Aggression

One of my primary topics of inquiry was to identify how the participants defined aggression. The research surrounding aggression is vast and rife with confusion, partially the result of inconsistent and varied definitions. The frameworks that guide these definitions vary between internal or external models, and rarely consider the extent of which relational dynamics contribute to the context of the situation (Nijman, 1999; Nijman, a' Campo, Ravelli, & Merckelback1999; Nijman & Rector, 1999; Duxbury, 2002; Hartrick Doane & Varcoe 2005). The participants' definitions helped me determine what guided their perceptions, and where they drew their understanding. The defining, or categorizing of behaviour, in an affirmed statement, required the participants to reflect, and

internally relate to memories and experiences that influenced their perceptions. Many of the participants stated they found this process of creating a definition challenging. Some of the participants, such as Galena, had a very difficult time. Galena reported never having taken the time to internally reflect on her own physiological responses to aggression. I question whether this lack of internal self reflection had an impact on her ability to define aggression.

The participants did not employ the language of 'violence' as is used in their health authorities' policies, regulatory bodies or other agencies such as WCB. A recent document from the WCB discusses nurses' experience of workplace violence in terms of bullying through to rape (Henderson, 2010). This in turn may have been related to my request for them to define 'aggression', rather than violence. I may have skewed the participant's exploration of other terms, such as interpersonal violence, by focusing the participants to examine children's behaviour in the term aggression. The participants did differentiate between agitation, self harm and aggression, which lead me to believe that perhaps they do not see violence within this population.

The participants initially struggled to determine a definition of aggression. Most participants looked to the researcher to provide guidance regarding the definition. The majority of participants had not considered or reflected on what behaviours they interpreted as aggression. The participants eventually settled on a concise definition. The female participants' perceived that behaviour *became* aggression, when the client demonstrated a physical intention to hurt; the male participant disagreed with intentionality, as a necessary component.

Definitions of aggression within the literature reviewed ranged from terminology that described assertiveness through to overt intentional violence. In comparing the participants' definitions with the literature, the majority were most similar to Campbell's articulation of aggression "that an essential element is the intention to harm another either physically or psychologically..." (Campbell, 1989, p. 20). The male participant's definition fits more with the Taber's Cyclopedic Dictionary of "a forceful physical, verbal or symbolic action" (Venes, 2005, p. 56), however, this definition does not encompass the harm being inward or towards self. Similar findings were identified in the study by Dean et al., (2010), although Dean's research did not sort by gender or professional designation. The differentiation between the male and female definitions may be gender related, however it is difficult to determine without further exploration (Gehart & Lyle, 2001). The participants perceived aggression on a continuum which included agitation. The participants dismissed self harm as part of their definition of aggression, and the term violence was never raised. It is significant that the participants' definitions differed from the literature in that the participants did not support the use of self harm as part of their definition of aggression. Although some participants agreed that self harm could be considered aggression they did not see it fitting within this conceptual framework. The participants acknowledged self harm to be different from aggression, but did not articulate clearly how or why, nor did I explore this at the time. Creating a framework or definition of aggression is important in order to develop a deeper understanding of the phenomenon. Rippon (1999), and Irwin (2006), note the variation in definition leaves health care providers confused, at best, or left on their own to define what aggression or violence is.

The participants were able to come to a similar definition of 'aggression'. Creating a framework of what behaviour the participants defined as aggression was imperative to setting the stage for the research study. Their perception that aggression is relational and required intention left numerous questions for future research. The participants in this research perceived 'aggression', not 'violence' in children, in contrast with the findings in general research literature as a whole and did not include self harm.

The Perception of Aggression in Children

All of the participants demonstrated an understanding of the importance of developing a bond of attachment, or rapport with the child. Connecting with a child was perceived as important to be able to support the child effectively in learning strategies for various clinical issues that arose. The participants were aware of the influence the parental dynamic with the child. For example, Pamela acknowledged the child's reaction to separation anxiety, when the parent attempted to leave, and Pamela was unknown to the child. Pamela's attempted to use play to engage and attune with the child and the parent present. The participants' perceptions were similar to those observed by Brendtro (2004). Brendtro stressed the importance of developing trust by engaging with the child through the use of play or other child means (Brendtro, 2004, 2009). All the participants recognized how their presence and interactions with the child influenced the potential for aggression. This understanding is dramatically different from the majority of the research literature. The majority of health care personnel appear to lack awareness of how interactional factors contribute to aggression (Nijman, 1999; Nijman et al., 1999; Duxbury 2002; Duxbury & Whittington, 2005; Ferns 2007).

The participant-child relationship findings revealed the participants' awareness and ability to reflect on how the child's illness state, lived experience and presence in the hospital contributed to being a risk for aggression. The participants also identified how their interactional role with the child exacerbated or resolved the situation. The potential for aggression is based on the understanding that most aggression is situated in the freeze, flee, and fight response (Perry, 2004). The response of 'freezing' may reflect an internal withdrawal, which is sometimes confused with the child being oppositional (Perry, 2004). The other possibility is the child has dissociated, and may be re-enacting their prior trauma experience, in that moment. For example, Lorne's description of a child's response to security personnel was thought to be a re-enactment of an experience involving the police. The participants continuously supported the construct that multiple factors contributed to the relational dynamics with the child which in turn affected the participants' perception of behaviours as aggression. Pamela and Julia's comments about their ability to develop rapport and relate with the child and family supports the importance of how each party engages and responds with each other. This relational reflection demonstrated insight into the importance of connecting, attuning and attaching relationally in this context (Hodas, 2004; Perry, 2004; Kinniburgh, Blaustein & Spinazzola, 2005; Brendtro, 2009; Blaustein & Kinniburgh, 2010). The ability to develop rapport and trust is dependent on one's opportunities to engage, communicate and be with another.

The participants' efforts to establish rapport with the child were affected by a number of relational variables beyond the participant-child context, including collegial relationships and the system of care. A challenge in the hospital setting is developing

rapport and trust between strangers, such as nurse to child (client) or colleague to colleague, within a relatively short period of time. To create the context in which the relationship can develop the nurse must work towards creating a space in which the child and/or family or colleague perceives there is room for emotional, psychological and physical safety. It can be challenging to create space for relational development, especially with a client population whose ability to trust has been hindered in some way, such as through a traumatic upbringing of abuse, neglect or abandonment. The participants provided several examples of how their ability to connect with the child was affected by colleagues, the system of care or even themselves. For example, Lorne's request of support from a colleague was interpreted as 'help now'. Lorne's perception was that the colleague's interference escalated the situation into aggression. Lorne's reflection was to speak to the colleague, however I wonder if the relationship with the colleague was a factor in the communication. The nurse's own life and work experience contributed to his/her reflexivity to establish and frame communication and relationship development within a safe place. The importance of relationships is prevalent throughout this study. Within a pediatric mental health population where relationships, attachment and attunement are critical to providing care, the types of relationships and how they affect perceptions of and outcomes of aggression are equally paramount.

When children (or adults) are less agitated and aroused, they are better able to engage in activities that allow for the development of relationships (McDonnell, Waters & Jones, 2002). The participants did not state that the environment was ever considered the sole cause of the aggression, however they were able to describe its effect on the child's

state of regulation. For example, Kaley described how importance of having an awareness of the environmental milieu and her ability to respond with changes was critical to influencing the relationships with the children. Kaley talked about adjusting lighting, sound, conversations and activity levels to affect the environmental stimulus to affect the emotional regulation of the child population. Kaley's example is one of how by altering the environmental (e.g. attending to light, sound) she was able to affect responses in the children she was working with. This required Kaley to be attuned to the children and also emphasized the relational awareness between herself and her colleagues to interpret both child and collegial relationships in this context (Nijman, 1999; Nijman et al., 1999; Duxbury, 2002; Whittington & Higgins, 2002; Beech & Bowyer, 2004; Irwin, 2006; Aujoulat et al., 2007).

The participants were clear that how they approached and engaged with the child or their family directly affected the potential for aggression, and felt that the child's triggers could be mitigated (Irwin, 2006). The literature surrounding trauma informed care emphasizes the importance of learning the child's verbal and nonverbal language to be able to work effectively with them, and co-create strategies to assist with self regulation and affect tolerance (Abramovitz & Bloom, 2003; Rivard, Bloom, Abramovitz, Pasqualae, Duncan, McCorcle & Gelman, 2003; Brendtro, 2004; Perry, 2004; Blaustein & Kinniburgh, 2010). The participants readily identified how their relational engagement with the child was, at times, impeded or tested, by the child's trauma history and interaction with the specific illness state. The participants were clear that the child's aggression was created by the various interrelated aspects of their life, being in hospital

and ultimately by interacting with others. The participants' perception of aggression in the child was affected by numerous relationships and interactions that occurred throughout the health care stay. The child or the child's history alone was never deemed to be the sole cause of any aggression, unlike the findings of the research literature reviewed for this study (Nijman, 1999; Nijman et al., 1999; Needham et al., 2004; Resnick, 2005; Duxbury & Whittington, 2005; Ferns, 2007). The relationship with the child was created through engaging with the child, learning about the child's history, antecedent triggers, and responses and incorporating the contextual factors in which they found themselves. The participants felt strongly that interventions available to them were directly connected to the relationship with the child. When the participants were able to engage with the child and learn the child's relational attunement, their ability to prevent aggression increased..

We are constantly 'in relation' with everyone and everything, including ourselves. Nurses work in the privileged position of being *with* people at some of their most challenging times in their lives. Nursing is a long-standing profession that involves the intimate relationship between the care provider (nurse) and the recipient (patient or client). The relationship between a nurse and a child, and potentially his/her family, is critical to the nurse being able to adequately assess and provide comprehensive care, including identifying when they may be becoming overtly stressed. Without that relationship, the nurse would not have an awareness of when changes for the child or family occurred (Benner & Tanner, 1987). To alleviate the potential for anxiety, stress and possibly aggression, trust between the nurse, child and family, must be established (Blaustein & Kinniburgh, 2010;

Hartrick Doane & Varcoe, 2005; Perry, 2004). My findings reinforce that relationships are critical to providing care, within a paediatric mental health setting.

The participants demonstrated how attunement with the child allowed them to plan care for children and thus prevent some aggressive outbursts. The participants were eager to learn strategies of prevention to avert aggression both for the child in question, the other children and themselves. The literature surrounding trauma informed care and engagement of children emphasizes the importance of learning the child's language both verbal and non verbal to be able to work effectively with them and co-create strategies to assist with self regulation and affect tolerance (Rivard et al., 2003; Brendtro, 2004; Perry, 2004; Delaney, 2006; Blaustein & Kinniburgh, 2010). Overall, the participants were able to deconstruct the aggression from an internal child perspective. The participants were able to differentiate the influence of the environmental factors and ultimately emphasize the relational context in which the participant engaged with the child.

Communication

Communication was perceived to impact all relationships identified in this study and was critical to the creation of relationships. Kazdin, Whitley & Marciano (2006), wrote that over a third of therapeutic outcomes were based on the client's perception of trust toward the 'therapist' within the relationship. The participants identified the importance of the relationship with the child and family was situated in their ability to communicate both verbally and non-verbally as in play, as mentioned in Pamela's example. The therapeutic relationship with children and youth "does not imply that the adult engages in psychotherapy with the child, but that the adult responds in ways *of*

therapeutic benefit – developmentally, behaviorally, socially and emotionally – to the child” (Hodas, 2006, p. 39). Creating rapport with children may take more time than with adults depending on the child’s experience and background. All participants commented on how the ability to have time with each child was hindered in some way by the environment in which they engaged with the child. The child’s ability to develop trust and respond in the therapeutic relationship requires that the *adult* create a space where rapport can be established (Cheng, 2008 unpublished). Kinniburgh, Blaustein, & Spinazzola (2005) refer to this process as ‘attunement’. This process requires the caregiver/adult to learn the child’s verbal and non-verbal language, at various levels of interaction.

The Participant-Colleague Relationship

The participants perceived that the relationships with colleagues had the most significant impact on aggression in children. Although the trauma informed care literature discusses the impact of how organizational treatment of staff members effects aggression, it does not explicitly describe anything about the impact of collegial dynamics (Gill, Fisher & Bowie, 2002). Participants felt that colleagues, who interrupted or interfered with the participant-child relationship, affected the dynamics and increased the potential for aggression, similar to a parental relationship. The participants felt de-valued and dismissed by colleagues who interfered. Longevity and years of work experience were not factors in the relational dynamics between colleagues. Communication, respect and shared work values were critical to relationships with colleagues. Participants referred to this collegial dynamic, as ‘walking along side’. If colleagues were unable to ‘walk along side’, and interfered with the participant-child relationship, the child’s behaviour was perceived to

escalate into aggression. My interpretation is that relationships between colleagues affected the participant-child dynamic by reducing anxiety in the participant (and child) and increasing their confidence in working with the child. Participants concluded that if they were able to walk along side a colleague, their perceptions and responses to children's behaviour were less intense, more manageable and less likely to perceive behaviours as aggression.

The participants' concept of 'walking along side' appeared to elicit comfort, and what I interpreted as related feelings of *safety* which had direct impact on how the participant perceived their working relationship with colleagues. Although the participants stated some awareness of their colleagues' personal life experience was helpful, their emphasis was on shared work experience and values. The majority of participants did not attribute 'walking along side' to *trust*, however, at many levels, it was about trust. The participants felt trust was too strong a word and implied something greater. I interpreted walking along side as trust, in relation to the interfering staff member 'not trusting' the participant's ability to attend to the child in a manner like their own. The participants were clear that the dynamic between themselves and colleagues affected the child's behaviour. The participants were also clear that colleagues, who interrupted, interfered or took over their engagement with the child, were detrimental to the participant's relationship with the child (Julia, Cindy, Kaley, & Lorne). The behaviour described by the participants led me to question whether there has been interpretation of trauma informed education beyond the child-participant relationship. I also question whether there is an aspect of horizontal bullying, colleague to colleague (nurse to nurse) bullying, taking place within this

environment even though none of the participant's identified it as such (Center for American Nurses, 2008). A strategy to build confidence among team members is clearly needed, as well as further exploration as to the cause of the interference by some colleagues.

Although, the literature focuses on the relational exchange between staff and clients as the *situational or* contextual model, I believe the relational dynamic between colleagues has significant impact on the relationship with the child, and contributes to the perceptions of aggression (Nijman et al., 1999; Duxbury, 2002; Duxbury & Whittington, 2005). Participants concluded that if they were able to walk along side a colleague when their perceptions and responses to children's behaviour were less likely to be as intense and more manageable. My interpretation is that when colleagues walk along side, the participants' develop an increased sense of confidence, reduced anxiety and thus reduced their perceptions of child behaviour as aggressive.

The Participant-System of Care Relationship

The participants identified that physician staff and administrative management had an impact on their perceptions of aggression in children. A few of the participants reported feeling as that the administration viewed them as 'replaceable' and unvalued. The majority of participants felt content with their work, yet this discrepancy raises the question of whether others are feeling discontented. Lynch, Plant & Ryan (2005) connected job satisfaction and job related stress with staff feeling supported at work, satisfied with their ability to control their work environments, resulted in being less reactive and thus less controlling of clients. Gill, Fisher and Bowie (2002) indicate that the

less supportive organizations are the unhappier its workers are, and thus the more aggressive client behaviours are perceived. Administration and staff members overlook how organizational culture and environmental contexts contribute to aggression. The overall organizational message and leadership presentation affect staff morale and care provided to clients (Paterson, 2006).

The relationships with administration, managers and physicians were identified by the participants as separate from colleagues. The participants' ability to relate to and feel connected with the administration appeared to affect their perceptions of aggression. Josie, reported feeling as if the system of care sees staff members as 'replaceable' and unvalued. Julia's expressed uncertainty about the rationale for many changes, and her assumptions were that management was *trying* to be supportive. Lorne's example of needing physician contribution demonstrated the need for all team members to be present in the care of the child. Whereas Kaley stated, she always felt supported by her management team and felt she was able to communicate effectively with them at any time. The participants did not directly link organizational factors to the causation of aggression. Throughout the interview process there were several comments made by participants that I reflected on as different from my understanding, specifically in relation to the administration. I found it a challenge to not respond to these comments. I likely would have been less reactive if I was not in a dual role as colleague and researcher, having worked closely with both the participants and the management of this institution. I am aware that this agency's management team is very concerned about their staff members and do not see them as

disposable however I question how that is communicated in the context of the participants comments.

Health care providers do not always have time to develop and understand all details of the child or their family, or colleagues, lived experience in this context. Knowing and being present allows the nurse to glean a moment of awareness of how to engage and relate with the child and family. The participants' stated that time affected their ability to connect and know a child and family, and colleagues which affected their perceptions of behaviour as aggressive. The participants did articulate an awareness of how the practice of moving staff from unit to unit affected their ability to conduct their practice in the development of relationships with children. As the staff members' work satisfaction decreases, the ability to be proactive also decreases, resulting in an increase in the perception of a lack of safety (Lynch, Plant & Ryan, 2005).

The concept of safety then becomes one of staff focus, increased rigidity and rule formation. Unfortunately, what often occurs in these circumstances is an increase in staff members' attempts to control and restrict client behaviour. "Pediatric psychiatric nurses had the highest perceived need for restraints however were least likely to use alternatives" (Allen, 2000, p. 162). Although the participants were not explicit in describing responses to aggression as positive or negative, they felt physical interventions, such as restraint or seclusion, were undesirable for use to contain aggression (Holzworth & Wills, 1999; Masters, 2005; Delaney, 2006; Ryan & Bowers, 2006). These approaches are often used under the guise of 'safety', however typically create increased reactivity on the part of the client, often resulting in increased aggression (McDonnell, 2006; 2007; Delaney, 2006;

Huckshorn, 2005). Galena's example of the two colleagues disagreeing about approach in front of a child, demonstrated how the colleague behaviour was increasing the child's potential for aggression. The same would be said for Lorne's example of the colleague who assumed his request for assistance was to intervene with physical restraint. I wonder if the examples given by the participants of their colleagues, who were unable to walk along side were affected by their own trauma experience (Whittington & Wykes 1994a, 1994b; Ryan & Bowers, 2006).

In review, most of the participants expressed feeling content with their work environment, however if there is discrepancy with this small group it begs the question are there others feeling discontented. I did not explore the concept of 'support' unto itself nor what it would look like for the participants. There is clearly variability within the participants group on what they define as support from the administration within this system of care.

The Effect of Trauma Education on Perceptions of Aggression

Many mental health programs throughout the United States (US), United Kingdom (UK), and Canada are implementing a trauma informed care philosophy. In British Columbia, a few child-adolescent mental health programs have also begun implementing this same philosophy; in this institution the philosophy is called *The Engagement Model* © (Murphy & Bennington-Davis, 2006). The shift in philosophy acknowledges a move from a position of power and control, to one of collaboration and cooperation. The philosophy includes an overarching understanding of the influence of trauma on neurobiological development, the impact on interpersonal relationships and overall functioning in clients

and care providers (Perry 2001, 2004; Bloom, et al., 2003; Huckshorn, 2005; Murphy & Bennington-Davis, 2005, 2006; Kinniburgh, Blaustein & Spinazzola, 2005; Stefan, 2006). The rationale for adopting this philosophy of care was to improve child and family outcomes; improve understanding of the trauma effects on children and families with complex mental health challenges; and provide more collaborative and less coercive care. Some of the unexpected outcomes of a trauma informed care approach is the reduction and/or elimination of aggression; reduced or eliminated use of interventions such as restraint and seclusion; improved staff morale; and reduction in staff turn-over and illness. A trauma informed care philosophy encapsulates the 'entire organization' from the president through to the cleaning staff, and reinforces the overall relational affects of interactions for all (Murphy & Bennington-Davis, 2005, 2006; Huckshorn, 2005; Stefan, 2006).

The influence of trauma, on clients and staff members, within mental health can dramatically influence the emotional, psychological and physical safety of all involved. The majority of participants in this study have received some base level education on the topic of trauma informed care as part of their general professional development. There is variation to the degree and extent of trauma informed education provided and received depending on clinical area of work and opportunity for exposure. None of the participants identified any specific aspects of this education, or any other training, as having influence on their perceptions of aggression. Most participants alluded to their work experience as having an impact on their perceptions. The participants' ability to reflect on how aspects of trauma, influenced the potential of aggression in children, indicated to me that

implementation of *trauma informed care* has had *some* influence on their understanding of behaviour. The participants appeared to understand the affects of trauma in relation to the children, however did not discuss how trauma may have affected them personally or professionally, nor did they refer to it in their colleagues. I did not ask the participants directly about personal trauma however it may be a topic for future research consideration or education. The education received did not readily appear to translate to colleagues, the administration, physicians or themselves (Duxbury, 2002; Rivard et al., 2003; Murphy & Bennington-Davis, 2005, 2006; Huckshorn, 2005; Perry 2002c, 2003, 2004).

The understanding of the influence of trauma on the relationship is critical to safety and could contribute to decreasing aggression within a healthcare setting. The participants in my research demonstrated a very clear understanding of how their relationship with the child had a direct impact on the child's responses. They were aware of the integrated nature of the environment, the child's experience, and how relational dynamics contributed to the child's relating in the context. Children or youth, with which the trust bond or attachment process has been hampered, will actively scan the environment watching for danger (Perry, 2001; Biering, 2002; van der Kolk, 2005, 2009; Hodas, 2006). If a child, youth or family is scanning the environment with a constant belief that danger is around every corner, it challenges the ability to establish trusting relationships (Perry, 2004; Mulvihill, 2005). For example, when working with children and youth, Brendtro asks us to engage or connect with children, youth or families in a space where they feel safe both physically and emotionally (Brendtro 2004, 2009). These same children and youth will also make 'bids' to engage with adults they perceive to be safe. Some children and youth

appear to 'know' whom to trust even when their innate system has been damaged or has been ineffective (Brendtro, 2009). "They typically recognize sincerity, and can tell when someone cares as opposed to one who is faking it" (Hodas, 2006, p. 38). Kaley's example of the young girl becoming distraught when the relationship was ending demonstrates Brendtro's comments very well. Adults in therapeutic roles, who are 'in tune' with clients and self, know how to establish safety and are doing so at a level beyond verbal language (Blaustein & Kinniburgh, 2010; Kinniburgh, Blaustein & Spinazzola, 2005; Perry 2002b). In my experience youth have said, 'you looked okay', 'you just hung out with us' or 'you are easy to talk to' in reference to connecting with adults in a therapeutic role. Many of these children or youth display behaviours or problems that are significant, and many adults stigmatize the child or youth. The stigmatization involves the "inaccurate attribution of intentionality" (Hodas, 2006, p. 32). The adults working with these children and youth would benefit from understanding that the behaviours the child or youth is utilizing have been necessary for survival.

An in depth understanding of trauma is needed to work with this population. This understanding would guide staff members to engage in interventions and activities that would create safety for growth (Harris & Morrison, 1995; Murphy & Bennington-Davis, 2005; Delaney, 2006). All the participants were able to articulate the effects of trauma and their therapeutic relationship with the child. Understanding the child or youth's perspective and understanding of relationships or their 'knowing' is imperative to developing relationships and creating safety. The relationship between the nurse and client

(child/youth) ultimately contributes to the overall safety for both the child and staff member working with them.

All participants have received an education session on the use of ‘non-violent communication’ however it did not appear to be recalled within the findings or in relation to any of their relationships (Rosenberg, 2003). The use of language can lead to attributions about behaviour, which can affect perceptions of aggression and impede trust in the development of relationships. The actual language and tone may create disengagement in the interaction, especially with children who have experienced domestic violence or abuse. The use of language within communication is critical to the development of relationships and the creation of safety amongst nurses and children as well as with colleagues. None of the participants referenced any education, formal or otherwise as having an impact on their perceptions. Kaley and Pamela provided examples and described how her perception of aggression changed over time and with experience. However none of the other participants raised this as a factor in their current perceptions of aggression.

The trauma informed philosophy of care employed by this agency has created some understanding that aggression does not stand alone and is the result of interactions and experiences with a number of individuals. The participants varied in their perception of aggression as being the responsibility of the client, as demonstrated in the literature reviewed, to that of interactional and relational dynamics between individuals within healthcare. The philosophy of trauma informed care emphasizes the impact of the health care provider interactions with the client at various levels of the healthcare system. The

nursing relationship develops through interaction, knowledge of and connection amongst all relationships in this context. Overall, the participant group has embraced the trauma informed care concepts in their perceptions of aggression in children.

The Participant-Self Relationship

Relationships are not limited to others; we are also in relation with ourselves.

“Nurses intentionally engage or disengage with people, they are always in relations, and those relational moments are always affecting and shaping the health and healing process to and for others, but equally for oneself” (Hartrick Doane & Varcoe, 2005, p.175). Self reflection is an important and critical nursing skill that most nurses do not always have the time or opportunity to consciously engage in. The participants demonstrated self-reflection throughout the research process. For example, the act of remembering various situations, their role, thoughts and feelings, demonstrates an in-depth level of self-reflection.

A nurse’s self-awareness, perceptions of competence and confidence contribute to the ability to work with clients, colleagues and the organization (Dean et al., 2010). The participants varied in their understanding of their own personal physical and psychological reactions to aggression. Some participants reported having attended to their personal experiences and its effects on their responses, for example Lorne “I become very aware of what is happening in my body. I seem to feel a calm come over me and an inner voice that keeps talking.” Whereas Galena, stated she has not consciously considered how her body responds during a child’s expression of aggression, nor had she considered what was happening for her colleagues. The majority of participants did not report having participated in formal self reflection processes or clinical supervision, however some had

participated in group self reflection discussing and debriefing clinical cases or events. Most did not disclose any other specific experiences. The participants reported that the research process allowed them the chance to reflect on an experience they previously reported not 'having the time' to do. Self-reflection creates an opportunity to consider the various strategies and options to ensure that they, the participants practice from an ethical framework. Ultimately, the participants recognized that self reflection was important to establish an understanding of their role in relational development, with the child and others. These relationships are critical to affecting the dynamics between the staff member and child and the affects and perceptions of behavior as aggression.

Reflexivity is a nursing skill that is acquired with time and unless there is explicit attention drawn to it, is not always recognized. Most experienced nurses will walk into a room and 'know' when something is out of the ordinary for the client. Nurses refer to this awareness or attunement as a 'gut feeling' or 'sixth sense' (Benner & Tanner, 1987). Hartrick Doane and Varcoe, (2005) refer to this aspect of nursing as *embodied knowing*. We know through our senses, life experiences, and contextual surroundings. "Our bodies are a site where many forms of knowing come together" (Hartrick Doane & Varcoe, 2005, p. 160) which is neither subjective nor objective knowledge but perhaps a combination of both (Gendlin, 1992c as cited in Hartrick-Doane & Varcoe, 2005). "Our bodily sense offers a window into the complex and multifaceted aspects of nursing situations including knowledge about the personal, professional, and political elements" (Hartrick Doane & Varcoe, 2005, p. 160). Many mental health nurses' use their awareness of their physical senses to assess the clinical environment. Staff have made statements to the effect, 'I knew

what kind of day we were going to have by who was working' or 'I could feel the tension in the air'. Some participants were not as attuned to their physical responses to aggression, such as with Galena. Galena appeared proud to state that she was getting better at turning it off, at the end of her day when she got home. I wonder if Galena values being able to emotionally disconnect from the work, and that perhaps her feelings and perceptions related to aggression lingered beyond the work day. This may challenge her perceptions or she may still be reacting to the day, and unaware of how to regulate her emotions another way. There is more opportunity for further investigation into this process for nurses and how it affects their practice.

An expansion on this bodily knowing is the understanding that this reflection is used to determine and assess safety, or danger within the environment. This attunement is imperative to assessing and judging what intervention, if any, would be therapeutic in the moment. When the attunement is misread or ignored, the child and nurse struggle to communicate in a healthy and supportive manner. "Human services are delivered in the context of a relationship" (Hodas, 2006, p. 34) and in order for that relationship to develop "trust and safety, rather than being assumed from the beginning, must be earned and demonstrated over time" (Harris & Fallot, 2001 as cited in Hodas, 2006, p. 34). A nurse's knowing may influence his or her ability to engage, communicate and develop trust in a relationship with a child and thus be able to create a space of safety within the environment

Self-reflection includes the ability to recognize how the relationships with others impacts the emotional self and, in essence, the physical self. The ability to be reflexive and in tune with oneself, allows the nurse to evolve his/her practice over time, with each

colleague, with each system of care and ultimately with each client. To be reflexive the nurse learns to attend to “thoughts, emotions and bodily responses one is having at any moment” (Hartrick Doane & Varcoe, 2005 p.162) and considers those responses in order to be more conscious and intentional in his/her responses with clients, families and colleagues. Most of the participants appeared to struggle with reporting on their emotional and physical responses within the interview session. It is unclear if this was due to not wishing to share this information in context of my dual role; or not having verbally shared this experience in the context of an interview before; or just never having considered it. Lorne, Kaley, Jane, Pamela and Josie were the most attuned to their bodily reactions in the moment when working with children. Often there was not the time to create a space of safety among colleagues to participate in group self reflection or even individual reflection. Jane, Galena and Josie commented on the need to be constantly present for all the children, and rarely have time for self. In personal conversations, most nurses report that by the end of their shift they want to move onto self-care and not think about the work day. Galena framed it best in her statement about disconnecting from her work self once at home. It is curious that Galena also had the hardest time being internally reflective of where in her body she experienced aggression, or how she attuned within herself. I am not sure if there is a connection between these abilities, however it may be worth further exploration in the future.

The participants reflected on how their presence with the child was important and also with their colleagues. “Presence is the quality of being open, receptive, ready and available for the experience of another person through a reciprocal, interpersonal

encounter. A caregiver who exists in an authentic way masters a special caring presence that comes from within the caregiver will do well, and is expressed as an honest desire to be with, be attentive to and support the patient” (Carlsson et al., 2004, p. 207). Many of the participants described their ability to be present with the child was challenged when colleagues interfered with the relational dynamic. Julia, Pamela and Lorne perceived their relationships with the children as being undermined by colleagues who interrupted or interfered. Taking time with the child provides opportunity for the child to be heard, alleviating aspects of stress and fear, and articulating the relational aspect of nursing care (Doane, 2003; Hartrick Doane and Varcoe, 2007). Carlsson et al., (2004) and Hartrick Doane & Varcoe (2007) demonstrated the importance of the nurse’s presence *with* the client influenced the outcome of the encounter. The attunement of the nurse with the client can determine the outcome of the interaction. As mentioned, this was well articulated by the participants and demonstrated in their comments about interactions with children, as well as colleagues.

All participants commented on the limitations of individual self-reflection in relation to a lack of opportunity to clarify ideas outside of one’s own. Reflection with colleagues was determined by the ability to walk along side that colleague in a safe manner without the situation becoming venting. To be reflexive, with a knowledgeable and supportive associate, allows the individual to become aware of his/her biases and clarify issues of transference or counter transference experiences outside of the traditional ‘counsellor or therapist’ relationship. All the participants shared an appreciation for the opportunity to share and question their stories with a safe professional in the context of the

research interview. However, each participant stated that this rarely occurs in their day to day work environment. Each participant provided an unsolicited story, question or experience unrelated to the research itself. My interpretation of this was an attempt by the participants to relate with me, in some way, separate from the research. It is unclear as to the purpose of this, as I did not question it at the time. Perhaps it was in effort to establish a relationship and to identify themselves as individuals separate from the work.

Self Care

An aspect of self-reflection is recognition for the need and ability to provide one's own self care, both at work and at home. The ability of the nurse to be present with the client can have significant influence on the outcome of the situation. The nurse being able to 'be in the moment with' the client is critical to the client believing that the caregiver is an active participant in their care. Participants were able to recognize how fatigue affected their ability to be present for the stated child or other children on the unit. Jane, Pamela, Julia and Josie discussed the level of emotional and physical exhaustion that occurs in circumstances where aggression has occurred. The response reported by the participants was to withdraw from other children, the child in question and colleagues. The recognition that stress and trauma affects each of us, and our clients is important in supporting the client and nurse to respond versus react in a given situation. Galena's strategy was to leave the unit or offer colleagues the opportunity to leave the unit to 'take a break' prior to re-engaging with the child. For staff members who experience trauma in the workplace, there may also be negative repercussions. The participants acknowledged that fatigue affected their engagement with the child that was the source of frequent intervention, but

impacted their ability to work with the other children. This reflection was not to the extreme as in Whittington and Wilkes studies (1994 a, b) of “confrontive coping” or total withdrawal, but it does demonstrate the effects of frequent exposure to complex and exhausting work.

The participants identified their self-care strategies employed to remain present and grounded within their roles as a pediatric mental health nurses. The importance of self-care is often forgotten in the busy day to day shift work in health care (Kravits & Grant, 2010). Many health care providers have busy lives outside the work environment that does not always allow for the type of care needed to re-energize and prevent exhaustion or burn out. All participants were able to identify the importance of self care in coping with the intensity of the work they do. Jane spoke of exercise and getting to the gym. Exercise as a stress reliever was often spoken of by the participants. Julia felt that shift work often interfered with a regular exercise routine. All spent time with family and friends outside of the workplace as re-energizers. A few used meditation, spirituality and prayer for solace from the challenges faced in the day to day work. Some also engaged in various forms of the arts as a source of relaxation. The use of self care is important for overall health and is especially important when working in an emotionally and physically stressful environment. Unfortunately, not enough time was spent on this topic and is an important concept to be explored within future research.

Conclusion

The research identifies that participants perceive aggression on a continuum of behaviour. Perceptions of aggression are directly influenced by the relational dynamics

between participants, colleagues and feelings of job satisfaction, and confidence in the workplace. The participants' compassion for the children and each other is impressive. All participants desire the opportunity for self reflection in a supportive and safe environment. It would benefit this agency, and others, to create a process of allowing staff, such as nurses, time away from their day to day work to participate in self reflection. It would also benefit the participants and the agency to engage in active research. There is good evidence that self-reflection, mindful communication, including clinical supervision, reduces burnout and moral distress (Brunero & Stein-Parbury, 2008; Bryant, 2010; Clark, 2010). The participant's ability to self-reflect illustrated a personal awareness, confidence and understanding of how they respond to children's behaviour, and recognizing the potential for aggression. From the findings of this research there are a number of recommendations that affect the staff directly and the overall organization.

The results of this research inform the research literature on aggression, specifically about pediatric mental health nurses' perceptions, of aggression in five to ten year old children. At the time this research was conducted, the findings contributed new research in the field of nursing and aggression literature. The participants' defined aggression has as primarily physical behaviour intended to do harm. The participants perceived aggression to be on a continuum of responses that did not include violence or self harm in this discussion. The relational attributes involved in the practice of paediatric mental health nursing are complex and involve the child, colleagues, various staff within the system of care and the self. Communication, languaging and education contributed to the participants perceptions of aggression. The participants demonstrated a unique awareness

of their relational contribution to the potential of aggression in children, as well as that of colleagues with the participant-child relationship. The participants also demonstrated an unusual level of understanding of the effects of trauma on the child's potential for aggression, as described within the trauma informed care literature. Unfortunately, these understandings did not extrapolate to the relationships with colleagues or others within the system of care. As mentioned, I did not explore the participants own historical trauma, and the impact on the understanding of trauma on the self.

CHAPTER VII: LIMITATIONS

The nature of qualitative research allows for an in depth exploration of the phenomenon at hand, and is “essential to evidence based practice” (Sandelowski & Barroso, 2007, p. 4). Until this study, there has been no qualitative research specifically exploring paediatric mental health nurses perceptions of aggression in children. Although the content of this research is ground breaking, there are limitations. Limitations to this study include a) only registered nurses working in paediatric mental health were invited to be interviewed; b) my position of being both researcher and colleague; c) self report versus observational study and d) lack of dedicated time for myself to conduct research and for the potential participants. The seven participants embodied the lived experience of nurses working in the clinical area both from a contextual and relational perspective. Seven is considered an acceptable capacity for conducting qualitative research, and I perceived I reached saturation of information at five participants. The information gained from the participants allowed me to develop an understanding of similarities and differences, between nurses working within pediatric mental health. Overall the both the participant group and information regarding the target phenomenon will provide significant learning on the topic of aggression, in health care and specifically paediatric mental health (Sandelowski, 1995).

Conducting research requires time and opportunity for reflection. The time management limitations involved my current work schedule and ongoing demands that did not include research as a component. Challenges that occurred were the coordination of schedules between participants and me. This resulted in the time difference between the

first and second interviews ranging from two weeks to five months, in one instance. This time lag, could have affected the participants' memory and emotional connection to the event in discussion. My attempt to continue to work full time during this process, impacted my ability to complete aspects of writing in a timely manner. As well, I attribute my inexperience with the qualitative research process as having contributed to some of the time delays.

Conducting research within one's own work environment creates challenges unto itself. Working in the same environment as my participants, was both a benefit and a limitation. Participants reported that the availability of time to be able to participate in the study was a limiting factor for at least two potential participants. Neither of these potential participants were willing to use time off nor did they perceive they had the ability to arrange time from their shift and client care to participate. All but one participant chose to conduct the interviews at the workplace. In future, I would ensure that research is part of my work portfolio, and be diligent in dedicating time to doing this work.

My dual role may also have affected the participants' willingness to share completely of their experiences and observations. My position, as being affiliated with the administrative team and as a leader in the trauma informed care initiative, may have limited the participants' the disclosure of experience and interpretations, especially while being tape recorded. Only one participant disclosed their apprehension about participating in the research, however the question remains as to whether it limited others to participate. My dual role also limited *my* willingness to question participants about their personal histories and the impact that may have had on their perceptions. I would need to conduct

further personal self reflection and reconciliation of the balance of researcher, colleague and clinician if I was to conduct further research in my area of work.

The content of the research focused on perceptions of aggression rather than observed actions. This limits the reality of what occurs in practice versus what was discussed in the safety and quiet of an interview setting. Maintaining a cohort of registered nurses, with a minimum year of work in paediatric mental health limited the accessibility to other health care clinicians who may also have had perceptions to contribute to this research. As well, there were gaps in my exploration of language used by participants. I made assumptions regarding the meaning of words that I did not explore. For example, the terms “safety” and “support” were used frequently and I did not realize this until I was conducting my analysis. To me this is a direct effect of my dual role, and hearing the words daily without truly understanding how they are being used. Although there have been limitations, the content of this research contributes to the nature of the phenomenon of aggression and adds to the evidence as a whole.

Chapter VIII – RECOMMENDATIONS & FUTURE RESEARCH

Recommendations

The recommendations from this research are primarily directed to the leaders and staff of this organization, where it was conducted, and to health care facilities in general. There is a gap in the ability for nurses to participate in research that is conducted outside of the regular work hours or is unpaid. It would be of benefit to develop capacity for direct health care providers, such as nurses, to participate in clinical research. One potential participant commented she would have liked to participate, however did not know where she would find the time and did not want to meet on her days off. I would suggest the organization look at a process for building capacity for opportunities to allow nurses or others to participate in research. The gap in the literature in the area of pediatric mental health nursing demonstrates the need for further research in the area.

Professional dialogue, ‘clinical supervision’, that involves self reflection, either on an individual or group basis, has demonstrated improvements in job satisfaction, clinical competency, client care and reductions in moral distress and burnout (Landmark, Hansen, Bjones & Bohler, 2003; Brunero & Stein-Parbury, 2008; Krasner et al., 2009; Buus, Angel, Traynor, Gonge, 2010; Bryant, 2010). Mental health nurses from the United Kingdom and Australia are provided with ‘clinical supervision’ within their clinical schedule, and meet with a senior nurse or other professional to conduct this work. Clinical supervision is currently provided or accessed as part of professional competence within the fields of psychology, family therapy, social work and clinical counseling. I would strongly recommend the introduction of clinical supervision to all staff either in individual or group

formats in order to create opportunities for self-reflection in a safe and *supportive* environment.

My primary recommendation would involve scheduled time with a senior nurse or other, not the direct supervisor, either individually and/or as a group, to have time for self reflection and professional development (Fowler, 1996; Landmark, Hansen, Bjones, & Bohler, 2003). The evidence is clear that by creating a place to share and discuss practice concerns, issues of burnout, moral distress, and possibly collegial conflict would be greatly reduced. I would suppose that this approach may also assist with overall transparency of communication within the organization. I believe that by engaging in group self reflection, such as clinical supervision, that the ‘walking along side’ of colleagues would identify and allow opportunities for colleagues to discuss these issues, and perhaps improve teamwork.

The concept of professional dialogue or ‘clinical supervision’ is not new, however might be an option for participants to consider outside of the research process. Clinical supervision, is “a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations” (Fowler, 1996, p. 478). In a literature review by Brunero and Stein-Parbury (2008) the majority of the literature supports clinical supervision in “three domains: normative – professional accountability; formative – skill and knowledge development and restorative – colleague and social support”. There is growing evidence that clinical supervision, especially in psychiatric care, improves staff job satisfaction, clinical

competency, client care and reduces moral distress and burnout (Brunero & Stein-Parbury, 2008; Bryant, 2010).

Several strategies would need to be employed to allow nurses to access clinical supervision that suits their needs at the time. Nurses could volunteer to attend education about what clinical supervision entails, and the roles and responsibilities of those interested in supervising and those being supervised. Clinical supervision requires confidentiality, however that would be need to be determined how that process would be conducted. Once trained, the organization could provide a list of potential supervisors to the nursing staff from who they could select. The organization would need to commit to ensure that those interested in participating are allowed time off the unit in which to do so, whenever possible. Currently this process is available for those who have identified issues with their clinical competency, either with the clinical educator, nursing director or nursing supervisor.

Clinical supervision would need to be available to those conducting supervision as well. One unit has been conducting guided group self reflection, with the nursing supervisor creating space during the day shift for the clinical team to meet and discuss how they are experiencing the clinical environment. The challenge is being able to provide this support daily, as it misses the night shift staff; the time to develop trust between colleagues; and determining how the conversations would be perceived and reflected on by the participants' direct supervisor.

The participants demonstrated an in-depth level of compassion towards the children and their colleagues. They are well aware of the need for opportunities in which to self-

reflect and articulated the appreciation for that opportunity within this research framework. The relational aspect of connection is communicated at all levels of connection within the participants' information and intertwined among the connections that participants have both in work and during the research process. Clinical supervision would be a relational methodology to support the staff in their ability to articulate and process their experiences in working with children and colleagues amidst a complex system of care.

The value of sharing and storytelling amongst nursing is a well known and documented phenomenon. Most recently it has been demonstrated to decrease burn out in other health care professions such as physician groups (Krasner, Epstein, Beckman, Suchman, Chapman, Mooney, & Quill, 2009). I believe that clinical supervision would benefit nursing by increasing job satisfaction, reducing morale distress, decreasing sick time, improve confidence in working with clients, and improving overall the quality of client care. Ultimately, I believe that clinical supervision would alter the perceptions of participants regarding aggression as well as the ability to identify opportunities for prevention, with children, colleagues and others within the health care system.

I also recommend that trauma informed care be evaluated from a systems perspective at this organization, and determine next steps for educational opportunities. The organization would benefit from examining the extent and consistency of education provided, regarding trauma informed care (Rivard et al., 2003). Based on my findings there is a lack of, or disconnect, of the trauma informed model of care purported, and the participants understanding. The participants did not connect their relational interactions with their colleagues or others within the system of care, as being a part of the trauma

informed care framework. The participants were well adept at identifying their role with the child and the child's trauma history however they did not demonstrate knowledge in the relation of connecting the rest of the team, the agency and trauma informed care. My belief is that if this program was truly trauma informed, the perceived interference by colleagues would not exist, and the 'support' that the participants were looking for would. There was also known discrepancies in the types and level of trauma informed education the participants received. Although I did not go into detail in this area, it would be benefit the organization to explore the type of education provided and the evaluation process for uptake and competency development.

As the lead educator in this program, I am working with others to assess our current education regarding trauma informed care. As well, to connect various other initiatives to a culture of trauma informed care. The other aspect of this initiative is to review the current clinical competency assessments and rewrite them to reflect a culture of trauma informed care. I intend to invite participation from the various units and levels of nursing clinicians. I will also invite clinicians to review our orientation package and work with them to update the content to reflect trauma informed care. I will also work to develop an evaluation of learning to be conducted at various points during the nurse's orientation process to determine if knowledge transfer has taken place.

There also appears to be a lack of general assessment and treatment planning from a trauma informed care perspective. It would benefit this organization tremendously to determine a process for which a common approach or assessment of trauma is conducted within the client population and their families. Currently there is no formal process for

making these assessments. Many children arrive at the organization with multiple diagnostic labels, with a known history of trauma exposure, and no formal assessment or treatment trajectory to work towards. For this organization to be truly trauma informed, there are a number of opportunities to do this. As the educator in this facility I am able to work with nursing staff to develop care pathways that would reflect a trauma informed care approach with both clients and families. Finally, there are a number of variables that are left to explore beyond this research that I will discuss in the chapter on Future Research.

Future Research

Qualitative research leads to understanding at a deeper level and lays the groundwork for further research (Davidson et al., 2008). Qualitative research raises ideas of how individuals are thinking and experiencing their practice. The outcomes of this research suggest further exploration of care initiatives and education with the goal to preventing aggression in healthcare, as well as stimulate further research in the area of pediatric mental health. Specific research suggestions would include: examining experiences of other health care providers, such as the meaning attributed by registered psychiatric nurses, youth and family counselors (or other unregulated care providers), other allied health providers (social workers, occupational therapists) and physicians. It would be interesting to determine if there are specific differences between genders in relation to staff perceptions of behaviour in children, or others, specifically in regards to aggression. It would be curious to determine if there is commonality among professions as to the definition of aggression in this population.

The participants in this study frequently referred to two terms 'safety' and 'support'. Support was referenced in relation to each other, various aspects within the system of care, and management. Understanding the participants' perceptions of what support entails is an important concept that I did not develop fully within this study. The definition or framework from which the participants drew this concept was not investigated during this research. It would be of benefit to conduct further exploration into the meaning of the term support for this population. The term safety was used interchangeably at times with the term support. To feel safe one needed to be supported to

support you need to be safe. The participants used the term safety as a verb and a noun, however did not elaborate on what that would entail nor was it investigated at this time. Clarification as to what ‘safety’ means to pediatric mental health nurses and others would also be an area for future research.

The trauma informed education provided in this organization would also lend itself to future research opportunities to determine what affect it is having on practice, as well as perceptions of children, colleagues and the outside community. It would be of benefit to compare various trauma informed care education programs, from Canada or other countries. As well to compare current state of nursing curriculum in relation to prevention strategies and overall understanding of the causes of stress, trauma and aggression. In my experience many nurses do not connect that their experience of stress is physically and psychologically, the same as their clients and families, however the triggers may differ.

The literature is clear ‘managing’ aggression or controlling aggression only leads to more aggression, we need to take several steps back and examine how to prevent it from occurring in the first place. As the research indicates zero tolerance is not a solution to the issue of aggression in healthcare, as care providers we need knowledge and awareness of precipitants and prevention strategies. I would suggest exploring entry level education for nurses regarding prevention of aggression across the lifespan using a health promotion model of care from primary to tertiary interventions. As well, expanding the trauma informed education to include experienced nurses at all levels of care.

Particular to this current research, I would follow up with exploration of the meaning of the terms ‘safety’ and ‘support’. How these terms are used, what is their

meaning, the embodied experience of feeling ‘safe’ or ‘supported’? In connection to research surrounding concepts of safety and support, would also be an exploration of ‘self care’. Questions surrounding specifics of how nurses engage in self care; what interferes with or encourages nurses; how do nurses cope with stress within a paediatric mental health setting or other health care venues? Further to this, I would explore the use of clinical supervision with pediatric mental health staff, or other health care professionals, and measure pre-experience levels of job satisfaction, moral distress and burnout and post experience effects. Included in this exploration would be the examination of any changes in perceptions of aggression in clients. Does the use of clinical supervision affect the experience of aggression for both client and nurse? Finally, does the level or quality of education contribute to the overall understanding and experience of these concepts?

There is substantial opportunity for observational studies to be conducted in the area of pediatric mental health. Similar to Whittington and Wykes (1994a) use of the Direct Observational Scale in measuring nurses interactions with clients to ascertain the measure between practice and stated practice. Other observation studies could be conducted on milieu management. For example, the use of outdoor activity or other self-regulation practices to ameliorate aggressive behaviour specific to developmental levels of children and with staff members themselves. Current research indicates that self regulation practices and strategies to “stay steady in the moment” (Hornstein, 2011), are impactful and preventative both for the client and the staff member (Perry, 2004; van der Kolk, 2009; Blaustein & Kinniburgh, 2010). Inclusive with self regulation and self reflection exploration would also include further assessment of the depth of self care and

whether it affects clinical perceptions of staff members and overall clinical functioning (Kravits & Grant, 2010).

Overall, the richness of qualitative data lends itself to expanding the potential for improved health care outcomes and staff learning within pediatric mental health programs. In conclusion, I have been able to contribute to the overall field of nursing research and work towards creating future research opportunities and educational frameworks based on this information.

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APPENDIX A

Interview framework/script:

I will invite the participant to think of situation where they perceived a child's behaviour to be aggression. Prior to beginning to describe the situation, I will ask the participant to identify any feelings that the memory evokes.

QUESTIONS: "I would like you to think of a situation or event you saw as a child being aggressive. Before you answer, what emotions are coming up for you as I ask this question? Please describe the event you are thinking of remembering to choose a pseudonym for the child's name".

I will request that the participant refrain from disclosing specific client information however, the event in question will need description in context. I will ask the participant to use a pseudonym in place of the client's name and refrain for using any other identifying data such as community of origin, parent names or service agency.

QUESTIONS: "When describing the event, please refrain from using real names and provide as much detail as you remember.

I will ask the participant to begin by focusing on the event itself and to describe it in detail as best they can remember. As the participant describes the situation, he/she will be asked to describe what he or she was thinking and feeling at different points during the event.

QUESTIONS: "I would like you to think of the event you are about to describe. What feelings or emotions are coming up for you at this time? Where is feeling sitting in your

body?” (I will prompt if needed e.g. stomach, head). I will observe their breathing and facial response. I will ask them to take some deep breaths prior to beginning to speak.

I will further explore what has led the participant to determine that the behaviour they are observing is aggressive.

QUESTIONS: “What led you to perceive the child’s behaviour as aggressive? How do you distinguish aggressive behaviour from other behaviour—e.g. what elements, characteristics lead up to you labeling behaviour aggressive? At what point during the event did it become aggressive. In the situation you described, what factors influenced or contributed to the child behaving in this manner?”

I will then invite the participant to reflect on what he/she thought lead up to the event at the time and what he or she thinks now about it, if different from the time it occurred.

QUESTIONS: “In reflection, what do you think led up to the event in question? Has anything changed for you or your interpretation of that event since it occurred? If so, what do you believe that to be? What are you feeling right now?”

I will then explore the roles and responsibilities the participant undertook during the event e.g. active participant or observer and what influenced that role e.g. unit culture, personal understanding of the child/situation and/or understanding of effective interventions. I will ask the participant from where they drew the knowledge or expertise in invoking the intervention described.

QUESTIONS: “What was your role during this event? What interventions were utilized if any? What led to the decision making of intervening or not during the event? Where do you draw that knowledge from?”

I will then ask the participant to reflect on his/her feelings about the intervention.

QUESTIONS: “What emotions come up for you at this now that we have discussed this scenario? How would you respond if a similar scenario occurred today?”

To finish the interview I will check in with the participant about emotions and ask about where they are in their body. I will do a short visualization exercise to reground the participant in the here and now. I will also remind him/her to utilize the employee counselling services as needed.

QUESTIONS: “Where are you in your body right now? I would like to do a short grounding exercise to return us to the here and now: First, I would like you to stand up and stretch to the sky as you breathe in. The return bending over to touch your toes, breathe out. We will do this three times. I would like you to sit back down, close your eyes, and take a few slow deep breaths with me (3). I would like you to think of a favourite place you like to go to relax – can you tell me where you are? Can you describe what the air feels, like, smells, sounds? I would like you to think of being at _____; take a few more deep breaths. I would like you to start to resettle into your body. Feel your feet....., your legs....., your torso – back.....-front....., your upper body....., arms.....,

hands....., neck and..... head. Think of your relaxing place and take a few more deep breaths. How are you feeling?"

"Before you leave to go let's book a follow up interview." We will than book our follow up interpretation interview.

APPENDIX B

Informed Consent for Research Project: Perceptions of Aggression

You are invited to participate in a study entitled **Perceptions of Aggression** that is being conducted by Lorelei Faulkner-Gibson, Primary Investigator.

Lorelei Faulkner-Gibson is a University of Victoria, Advanced Nursing Practice Graduate Student in the department of NURSING at the University of Victoria. You may contact her directly if you have further questions by calling (xxx) xxx-xxxx) or via email *personal/university email* or.

As a graduate student, I am required to conduct research as part of the requirements for a degree in Advanced Practice Nursing Leadership, Master's Degree Program. The research is being conducted under the supervision of Dr. Gweneth Doane. You may contact my supervisor at 250-721-6191 or gdoane@uvic.ca.

There is no funding for the research.

Disclosure (Researcher's Relationship with Participants)

Please note that the investigator, Lorelei Faulkner-Gibson holds the position of Clinical Nursing Educator for the Mental Health Programs. Should you feel uncomfortable in participating in her study, please know that you do not have to do so. Your participation is entirely voluntary and the investigator will ensure to follow the highest ethical standards in the conduct of this study, as per appropriate standards and guidelines. The investigator will keep your participation at any time clearly separated from your working relationship. Please read carefully this consent form and do not hesitate to ask for clarification as needed.

Purpose and Objectives

The purpose of this research study is to gain an understanding of the meaning pediatric mental health nurses ascribe to aggressive behaviour in the workplace. This study aims to inform how aggressive behaviour is understood, and how aggression effects and affects the nurse and his/her decision making. It is hoped that based on this research education can be created that matches and supports the needs of student nurses and registered nurses to work safely in these situations.

Importance of this Research

Research of this type is important because aggression in health care is a concern for all health care professionals and clients alike. Nurses' are more frequently exposed to aggression and violence than any other health care provider. Nurses' approach towards aggression has been identified as mediating the choice of nursing interventions. The relationship between the nurse and child influences perceptions and interventions used. By understanding when nurses' perceive behaviour as aggressive and the relationship he/she has with the child, it is hoped that a better understanding of what influences the event will be gained. This project will also look the nurses' lived experience working with aggressive children. This project will lead to future research, education and support that can be directed towards therapeutic practice built upon this knowledge.

Participants Selection

You are being invited to participate in this voluntary study because as a registered nurse working in pediatric mental health inpatient setting, you are frequently exposed to children and families in crisis. Participants included will be Canadian trained registered nurses; either male or female; who have in the last 12 months or are currently working within a pediatric inpatient setting with five to ten year old children. The purpose of this study is to explore how registered nurses identify and understand aggressive behaviour in 5-10 year old children with mental health concerns from an inpatient setting.

What is involved?

If you agree to voluntarily, participate in this research, your participation will include two to three sessions: one initial consenting meeting of about thirty minutes in duration; the initial interview of approximately one to two hours in duration regarding your perception of an aggressive event and a follow up interview to review the themes that gathered from the interviews of all participants. All interviews will be audio-recorded. Written consent will be requested at each interview session. All interviews are voluntary.

Inconvenience and Risks

Participation in this study may cause some inconvenience in regards to time as it will take a total of about 3 hours. Interviews will be conducted away from the work site and not during working hours at a location of your choosing. As the potential participant numbers is small, there is a risk of loss of confidentiality.

There are some potential risks in participating in this research that may include being emotionally or physically triggered by the memories of the event you choose to describe. To prevent or attend to these potential risks the following steps will be taken: if you become upset or uncomfortable at any point during the interview process, the interview will stop, an opportunity for a break will be given and the interview will only continue if you choose. You will be provided with contact information of the facility Employee Family Assistance Program (included as part of employee benefit package) and you will be encouraged to attend the service post interview as needed. If you choose, a relaxation exercise will be conducted at the end of the interview session.

Benefits

The potential benefits of your participation in this research include participating in a local project that will provide us with an understanding of how pediatric mental health nurses perceive aggression. This study will contribute to the larger body of research that is growing in this field; currently there is no research in pediatric mental health nursing in this area.

Reimbursement

There will be no reimbursement of any kind provided for participating in this study.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time either by phone or email notification. You do not have to providing any reasons for withdrawing. There will be no consequences or any explanation required for withdrawing from this study. If you do withdraw from the study, you will be asked permission to use any data gathered to this point, if you choose not to allow the data to be used, your data will be destroyed. The only indication of withdrawal in the study documentation will be a number of withdrawn candidates.

On-going Consent

Your consent will be sought at the beginning of every session. All interviews and participation in this study is voluntary.

Anonymity

In terms of protecting your anonymity, your name will not be used and a number will be inserted in its place. Only the primary investigator will have access to this information. There are limits to complete anonymity as the participant group is small. The investigator will work with you to change circumstances of the event you describe in order to ensure as much confidentiality as possible. The investigator will arrange to meet you outside of regular working hours at a location of your choice, preferably off facility grounds in a quiet, location. If you choose to tell others of your participation in this research, that is your decision alone.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by use of a random identification number. Data will be cleaned (reviewed) to eliminate any possible identifying information. Direct quotes will be used however individuals will not be identified in any manner in this process. As there are a small number of potential participants (25), the investigator will work with you to adapt the circumstances of the event you describe in order to ensure as much confidentiality as possible. The data and all identifying information will be stored in a locked filing cabinet in my home office, offsite. At no time will this interview or content of the research be discussed with anyone outside the researcher's advisory committee. The data will be password protected on a private computer and general communication will be conducted through a private email and private cell phone so that facility email conversations cannot be tracked. The transcriptionist does not live in the city nor does the individual have any connection with healthcare in anyway. The transcriptionist will sign a confidentiality form and identification of all interviews will be by random identification number only. The transcriptionist and primary investigator will only discuss aspects of the interview in relation to clarification of recordings and transcripts.

Dissemination of Results

The findings of this research will be shared with participants by way of executive summary in order to protect confidentiality. The research analysis will be shared at the investigator's Thesis Dissertation session. Scholarly presentations or publications will be made using the basis of the executive summary and research analysis. The research location will not disclosed in which the research was conducted or specifics of participants in any way.

Disposal of Data

The data will be stored in accordance with ethical and Tri-Council mandates. All data will be shredded and burned and all electronic data, including audiotape recordings will be erased five years after publication.

Legal Rights

Participation in this research study does not waive any legal rights by signing this consent form. Signing this consent form in no way limits your legal rights against the investigators or anyone else involved in the conduct of this study.

Contacts

Individuals that you may contact regarding this study include Lorelei Faulkner-Gibson, Principal Investigator; Dr. Gweneth Doane, Thesis Supervisor (gdoane@uvic.ca); Dr. Bernadette Pauly, Thesis Advisory Committee (bpaul@uvic.ca) and Ms. Yvonne Haist (yhaist@uvic.ca), Thesis Advisory Committee. In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca) or Research Subject Information Line in the UBC Office of Research Services, 604-822-8598; Toll Free Number 1-877-822-8598 or email RSIL@ors.ubc.ca

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researchers. A signed and dated copy will be given to you for your own records.

 Print name

 Signature

 Date

Future Research

If you are interested in participating in future projects involving this data, please sign and date in the sections below

Print name

Signature

Date

APPENDIX C**AGGRESSION****AT****WORK!****NURSES**

Are you exposed to 'aggression' in your
workplace?

Do you work with 5- 10-year-old children in
a mental health inpatient setting?

Will you participate in nursing research?

Please contact
(XXX) xxx-xxxx or
email address:

university address/personal address

UVIC Advanced Practice in Nursing, Master's student