

Introduction

(Re)thinking Violence in Health Care Settings

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Introduction

Several employers are actively working towards creating healthy and safe workplaces, now that a relationship has been established between patient outcomes and the health of the workforce (Shamian and El-Jardali 2007). As much as possible, safe work environments must be free from violence. Unfortunately, violence in the health sector is omnipresent and often subtle. It has been described as complex problem “rooted in social, economic, organizational and cultural factors” (International Labour Office [ILO], International Council of Nurses [ICN], World Health Organisation [WHO], Public Services International [PSI] 2002: 9). Workplace violence in the context of health care is of mounting importance because there has been an escalation in the frequency and numbers of health care professionals reporting such incidents. However, there is a common belief that the very nature of the work performed by health care professionals places them at risk of experiencing workplace violence (Ferns and Chojnacka 2005, Henry and Ginn 2002, Erickson and Williams-Evans 2000). Statement such as this often implicates patients as the main perpetrators of violence.

This collection sets out to challenge such taken-for-granted and preconceived ideas, and explores ideas about violence that are not commonly in circulation in the literature. In effect, the main objective is to come to terms with forms of violence that are rarely discussed in the scientific or popular literature, and to show how violence is *also* exerted by employers and health care providers against both patients and health care providers themselves. Our goal is to (re)think violence in health care settings to make overt the subtleties, nuances and characteristics of its operations in such a workplace so that formerly hidden and silenced forms of violence are opened up for discussion and analysis.

Several guidelines and position statements have already been developed in an attempt to address the ongoing issue of workplace violence (Registered Nurses' Association of Ontario [RNAO] 2008, 2009, Canadian Nurses Association and Canadian Federation of Nurses Unions 2008, New South Wales Department of Health 2005, International Labour Office [ILO] et al. 2002, Workplace Bullying Project 1997). Yet, health care professionals and stakeholders continue to identify

workplace violence as a serious problem (Quality Worklife Quality Healthcare Collaborative [QWQHC] 2007, Shields and Wilkins 2006, Hegney, Plank, and Parker 2003).

Enumerating the Problem: its Prevalence and Categories

While this book's main task is to question the normative approaches to understanding violence in healthcare workplaces, we first want to show the amount of research and effort that has gone into figuring out the dimensions, locations, perpetrators and victims of health workplace violence. As will be seen from the enumeration and prevalence of violence in the healthcare workplace, statistics related to workplace violence are used to confirm the need for action – the need to find solutions to the problem as identified.

For example, a Canadian study of 260 employees (response rate 52 per cent) found that out of 13 occupations studied, nurses were second only to police officers for risk of violence (LeBlanc and Kelloway 2002). Another Canadian study of 8 780 registered nurses by Duncan et al. (2001) found these nurses reporting being the victim of several types of violence including emotional abuse (38 per cent), threat of assault (19 per cent), physical assault (18 per cent), verbal sexual harassment (7.6 per cent), and sexual assault (0.6 per cent). Yet, 70 per cent of these nurses chose not to report the abuse (Duncan et al. 2001). A third Canadian study of about 19,000 regulated nurses by Shields and Wilkins (2006) found that males were more likely than females to experience physical assault (44 per cent compared to 28 per cent respectively) and twice as likely to report such assault, and nurses younger than 45 were more likely to report emotional abuse from a patient (47 per cent) compared to 38 per cent of nurses 55 or older (Shields and Wilkins 2006). In the United States, the Bureau of Labour Statistics reported a rate of 15 injuries from assaults and violent acts per 10,000 workers for those employed in social services and a rate of 25 injuries per 10,000 for nursing and personal care facility workers. These figures compare to an overall injury rate of two per 10,000 workers in private sector industries (Occupational Safety and Health Administration [OSHA] 2004).

Violence in health care settings is not limited to acute care settings, even if the majority of studies on the topic were conducted in these settings. Many health care professionals, mostly staff nurses, from several different types of units are at risk of becoming victims of violence. For instance, intensive care units, general medicine wards, psychiatric wards and emergency departments were all identified as high risk areas for verbal abuse (Öztunç 2006). However, there is still no agreement on whether emergency departments and intensive care units are actually more at risk for workplace aggression than general wards such as medicine (Landy 2005). Violence is also known to be a significant problem in psychiatric facilities (Privitera et al. 2005, Barlow, Grenyer and Ilkiw-Lavalle 2000). Authors found that staff, rather than patients, were more often the victim of both verbal and

physical aggression from patients (Daffern, Ogloff, and Howells 2003). As well, aggressive incidents were more likely to be preceded by interpersonal or hospital related antecedents, such as staff refusing a request, and managed by physical interventions such as restraint and medications rather than verbal interactions such as counselling (Shepherd and Lavender 1999). It is research such as this that starts to confront some of the assumptions about violence and certain forms of riskier populations or workplaces. We begin to get a glimpse that violence and its solutions may not lie in simply thinking about the problem as having a single source or origin.

The consequences of workplace violence are far-reaching and include absenteeism related to illness, injury and disability, staff turnover (direct cost); decreased productivity and lower quality of service (indirect cost); and decreased satisfaction at work and decreased moral, decreased commitment towards the organization, and damage to the organization's reputation (intangible cost) (Di Martino 2005, Krug et al. 2002). As well, the ramifications of workplace violence are not only felt by employees and employers but can also affect spouses, children and families in general (Courcy and Savoie 2003). As for the financial cost associated with workplace aggression, Henry and Ginn (2002), citing the work of Jossi (1999), have stated that "combined with other costs such as lawsuits, lost productivity, higher insurance cost and workers' compensation claims, the bottom line figure for workplace violence is an estimated \$36 billion U.S. annually" (Henry and Ginn 2002: 481). As such, managing violence in the health sector remains a priority, as seen in the many reports which identify the development of workplace violence prevention programs as organizational priority action strategies for decision-makers and managers to improve quality of worklife for health care professionals as well as quality of care and patient outcomes (Registered Nurses' Association of Ontario [RNAO] 2008, Quality Worklife Quality Healthcare Collaborative [QWQHC] 2007).

The incidence of aggressive acts as well as its management is based on the interaction between: patient (e.g. psychopathology, gender), environment/setting (e.g. size of ward, crowding), interaction/situation (e.g. aversive stimulation, provocation), and staff (e.g. level of education, training in aggression management, attitudes) (Abderhalden et al. 2002). The attitudes and behaviours of staff have been found to be the most important factors affecting patients' aggressive behaviour (Abderhalden et al. 2002). A study exploring differences between patient and staff perceptions of aggression in mental health settings found that staff often perceived patients' illness as the cause of aggression, while patients perceived illness, interpersonal and environmental factors as being equally responsible for their aggression (Ilkiw-Lavalle and Grenyer 2003). As a result, staff believed that change in medication was indicated to deal with the issue, while patients suggested improving staff-patient communication and flexible unit rules to reduce aggression (Ilkiw-Lavalle and Grenyer 2003). As such, strategies identified by staff to respond to acts of patient aggression often included physical interventions

such as restraints, medication and seclusion, while strategies identified by patients included counselling (Shepherd and Lavender 1999).

A cyclical model of violence by psychiatric in-patients suggests that nurses' reaction following an act of aggression may contribute to the risk of further aggression (Whittington and Wykes 1994). In effect, since experiencing assault leads to increased stress, such stress may in turn affect nurses' behaviour toward patients. Coping strategies include such behaviours as becoming "confrontive" by over controlling or verbalizing hostility towards patients; or "escape-avoiding" patients by spending as little time as possible in direct communication with them, thus increasing the risk of further aggression (Whittington and Wykes 1994). Conversely, the issue of intra/inter professional aggression does not appear to be reported nor addressed in the psychiatric literature.

More incidents of workplace aggression are also spreading to general wards (Beck 2008, O'Connell et al. 2000). As a result, several studies explored the issue of workplace aggression towards health care staff in relation to their area of practice. Findings from several studies that compared critical care units such as emergency departments (ED) and intensive care units (ICU) to ward units found that certain types of critical care units appear to have a slightly higher rate of aggression. For example, a study of 2 407 Australian nurses (response rate 38 per cent) found that 76.1 per cent of ED nurses, 68.9 per cent of ICU nurses and 63.8 per cent of operating room/day surgery nurses experienced verbal abuse compared to 72 per cent of medical setting nurses and 64.1 per cent of surgical setting nurses (Farrell, Bobrowski, and Bobrowski 2006). The percentage of nurses experiencing physical abuse was also slightly higher in critical care units with 57.5 per cent of ED nurses and 47.1 per cent ICU nurses reporting physical abuse compared to 44 per cent of medical settings nurses and 35.5 per cent of surgical setting nurses (Farrell et al. 2006). While 74.3 per cent of survey respondents identified patients/clients as the most common perpetrators of verbal abuse, patient/client visitors were identified by 35.3 per cent of survey respondents, nurse colleagues by 28.7 per cent, doctors by 27.1 per cent and nurse managers/supervisors by 15.8 per cent (Farrell et al. 2006).

Notwithstanding the significant amount of data pertaining to workplace violence and aggression, as we can see from the above studies, health workers often fail to report incidences ensuring that statistics and prevalence data is unreliable due to much under-reporting (ICN 1999). Several reasons are cited to explain this phenomenon.

Failure to Capture: the Under-reporting of Violence

In putting together this collection on violence in health care workplaces, we noted that as part of our re-thinking, a critique of current approaches to the problem was a necessary first step. While in the section above we outlined many studies of the prevalence and characteristics of violence in healthcare, it was clear that such

studies while enumerating the breadth and depth of violence, such approaches failed to develop a reliable picture. One of the reasons for this singular failure, are the numbers of justifications for under-reporting workplace aggression. The justifications include but are not limited to: aggression being perceived as an integral “part of the job”; reporting being considered as not worthwhile because historically nothing was done about it; the fear that the victim will be reprimanded, or accused of negligence or inadequate performance, thus provoking the attack; reporting mechanisms that are both cumbersome and time-consuming; and nurses perceiving a conflict of interest between reporting workplace aggression and being a professional caregiver (Ferns and Chojnacka 2005, Hesketh et al. 2003, Gates and Kroeger 2002, McKoy and Smith 2001, O’Connell et al. 2000, Erickson and Williams-Evans 2000). These numerous explanations suggest a vicious cycle resulting in entrenched, structural failures to approach either full understandings of the situation or to show how systems continue to reproduce violence in healthcare systems across the globe.

Cultures of disclosure in organizations operate to reproduce the conditions for violence. For instance, such situations where under-reporting is encouraged by senior decision-makers because, if the actual number of incidents were known, “administrators would have to respond to pressures to determine why there were so many assaults [and] they would be forced to take remedial action to prevent further incidents of aggression” (Rippon 2000: 454), cultures of silence are promoted. On the other hand, senior managers can be unaware of the real extent of the issue because of lack of reporting from front-line staff and front-line and middle-managers. In the context of understanding attitudes towards a patient safety culture, a study of 15 California hospitals by Singer et al. (2003) serves to parallel this last point. The findings suggest a tendency for front-line workers and middle managers to gloss over patient care problems when briefing senior managers, which in turn made it hard for executives to understand the true state of their organization (Singer et al. 2003). As such, under-reporting plays down the seriousness of the issue of workplace aggression to senior management.

According to ICN (1999), only one-fifth of cases of workplace violence/aggression are officially reported, which serves to confirm the notion of a *code of silence* around reporting incidents of violence. Only in the situation of serious violence does silence become broken. This is attributed to such serious workplace injuries requiring medical attention or involving lost time from work that is required by law to be declared to Workplace Compensation Boards (Rippon 2000), or police and court actions are required. However, Andersson and Pearson (1999) found that allowing low intensity deviant behaviours to prevail by not paying attention to such actions in fact increased the incidence of more serious types of aggressive behaviours. Such research calls for organizations to implement better reporting systems and to encourage staff to report all episodes of workplace aggression. Authors of these forms of organizational cultural analyses believe that monitoring incidents of workplace aggression may be the first steps in identifying trends with which to guide future interventions and educational

needs (Clements et al. 2005). Savard (2004) argues that before employees can feel comfortable reporting incidents of workplace aggression, the organization (including the administration) is required to break from the code of silence by taking a clear stance toward violence in the workplace. She suggests, as a first step, the need for a clear policy pertaining to workplace aggression and stresses that management, put simply, do what they say (Savard 2004). What is clear from much of this research into workplace cultures and the reporting of violence is that there are significant barriers to collecting accurate data from merely monitoring violent acts, and that much time is spent on developing strategies that overcome barriers in organizations so that violence no longer goes unreported. However, more concerningly, another important reason for the under-reporting of workplace aggression relates to the lack of a clear definition of the concept.

Naming and Framing: Defining Workplace Violence

The definition of what constitute workplace aggression and violence is contentious to this day. In some instances the terms aggression and violence are used interchangeably, whereas in other instances a clear distinction is made. Current reviews of the terminology suggest that both terms appear to have different meanings whether they are used in English or in French. When used in English, it appears that *aggression* has a broader meaning than violence (Jauvin 2003), with few authors viewing *violence* specifically as the physical expression of aggression (Griffin and Lopez 2005, Mason and Chandley 1999, Newman and Baron 1998). As well, some view the term *violence* as relating more to the area of criminology and criminal justice, and the term *aggression* relating to health care (Chappell and Di Martino 1998). Conversely, when used in French, it is the term “*violence*” that has a broad meaning, while the term “*aggression*” has more of a legal or technical connotation (Jauvin 2003).

Other challenges associated with defining workplace aggression and violence resides in the fact that aggression and violence are often perceived as *emotive topics associated with particular stigma* (Rippon 2000); and as *internal personal constructs with subjective aspects* where the perception of what constitutes violence can vary between groups and cultural settings (O’Connell et al. 2000). A theoretical paper by Waddington, Badger and Bull (2005) reinforces these views and identifies three main reasons as to why the concept of workplace violence is so difficult to define. First, violence can be exhibited in a number of different contexts; in some contexts violence may be acceptable whereas in others it will not be tolerated. Second, participants of a violent episode can give different meanings to their own and others’ actions (i.e., objective actions versus subjective responses to these actions). Third, the relationship between the apparent severity of an act of violence and the impact the act has on the victim is often unclear and very complex. For example, verbal aggression could ultimately be more debilitating than physical attack (Waddington et al. 2005). This last point is also paralleled

by Engel (2004: 45) who states that “there is no correlation between the extent of physical injury and the degree of psychological injury. People do not have to be physically injured to suffer psychological trauma from a violent episode.”

While definitions of workplace aggression and violence may greatly vary in the literature, some factors appear to be consistent, such as: intent on the part of the aggressor, a cognitive process and the behaviour resulting in a physical, psychological or emotional harm (Rippon 2000). However, explicitly including “intent” as part of the definition may create challenges in health care because health care professionals are likely to be the victims of unintentional aggression from patients who are confused, demented or hypoxic (Ferns and Chojnacka 2005) or in physical pain or distress (Ferns 2006), thus making their cognitive process impaired. As well, while factors found in the work environment of employees may potentially elicit aggressive or violent behaviour (ILO et al. 2002), and while common workplace practices (e.g. the measure of time and workload, mandatory overtime) are associated with institutional violence (St-Pierre and Holmes 2008), one would be hard pressed to prove any explicit intention to hurt on the part of the employer (O’Leary-Kelly, Griffin, and Glew 1996), although many definitions of workplace bullying point to the use of high workloads as a form of punishment or harassment by management visited on workers (Workplace Bullying Project 1997). Moreover, as some studies of workplaces have found (Singer et al. 2003, Workplace Bullying Project 1997), how violence in the workplace is defined depends on one’s location in the organization. It is not unknown for management to express or excuse bullying by minimising or reducing the severity of an episode of bullying where the worker perceives the same episode as serious. The complexity of the idea of violence means that currently, there is no agreement on a clear definition of what constitutes workplace aggression and workplace violence. As such, definitions and typologies vary considerably from study to study or are completely omitted, resulting in ambiguity, greatly reducing the ability to make inter-study comparisons. In framing the current collection of chapters on violence in health care, we suggest that violence in its various guises requires other forms of analysis and theorization. Clearly enumerating, capturing through categorising and finding a single definition for violence or aggression in health care has not provided a way into its chameleon-like characteristics – hence our move to re-think violence, and to critique its assumed normativity in health care settings.

(Re)thinking Violence in Health Care

For the purpose of this collection the conceptualization of violence will be broad and be largely influenced by the works of critical theorists, notably Michel Foucault, for whom the nexus between violence and power is an instrumental one: that is, violence is an instrument of power. As a consequence, violence means more than inflicting harm or injury (in all their forms) to individuals. It is also a way of looking and constructing these individuals. Drawing together the latest

research from Australia, Canada, the UK, and the US, this collection engages with the work of critical theorists such as Bourdieu, Butler, Foucault, Goffman, Latour and Žižek, amongst others, to address the issue of violence in health care settings and theorize its workings in creative and controversial ways. Using a broad range of critical approaches in the field of anthropology, cultural studies, gender studies, political philosophy and sociology, it examines violence following three definite yet interrelated streams: institutional violence and managerial violence against health care workers; horizontal violence amongst health care providers and from health care providers (part of the health care apparatus) towards patients; and patients' violence towards health care providers.

The chapters which make up this collection use explicit theories to account for violence they find in health care settings. In using Foucauldian analyses some authors provide insights into how power and violence intersect in the forensic settings where violence is an instrument of power and the knowledge of groups of professionals and experts in such settings. Goffman's analysis of total institutions is thought to have contributed to how Foucault came to view prisons, school and hospitals – where the organization of a total institution governed all aspects of an inmate's life, as well as of those who were to provide care in such a setting. Indeed the idea of the moral career of a patient has as much to say about the government of care providers in health care as it does the mental health patient in forensic settings. Such forms of analysis lead to explorations of the micro-world of mental health and forensic care, yet speak to the societal structures that make such institutions possible.

A further strong aspect of the volume is the use of theorists such as Butler, Bourdieu, Latour and Žižek whose influence on the works in the book is to explore how violence is constituted in the spaces and interstices of health care settings. For authors using such theoretical approaches it is not that violence is always already a part of such settings but that violence is constituted in the actions, performances or symbolic activities of health care, wherever such practices are located. While Butler and Latour would suggest that violence is not inherent in the forensic or health care setting, but performed or brought into view as a part of a forensic or health network of practices, we can see how violence is potential rather than inevitable in such settings. For structuralist approaches such as Žižek or Bourdieu, violence emerges from the structural relationships and the production of social relations as these intersect with power, symbolic or material that constitutes the relationships in health care settings. In using this range of theoretical perspectives the hope is to expose how violence requires more than merely enumerating, categorising and conceptualisation (or naming), that is working out its grids of specification (Foucault 1972) will always be insufficient. Instead analysis of discourses, texts and talk and practices within social relations are needed to expose more nuanced accounts of the complexities of violence in the social spaces of health care. Moreover, in starting this exploration with an analysis of how institutions and organizations contribute to violence, this collection turns its analysis on its head – starting as such explorations do with interpersonal and specific populations

being more problematic than others. Rather, in starting where we do, we suggest the need to look to health care and its organization for how violence is bred in its practices before we turn to explore interpersonal forms of violence in health care.

Part One: Institutional and Managerial Violence

Part one of the collection deals with institutional and managerial violence, that is violence that deploys from various dimensions of institutions, such as administrative rules, policies and procedures, legislative frameworks, their relationship with other institutions, architectural imperatives, and the bureaucratization and *technocratization* of health care work. In the first section of the book, our contributors highlight how organizational and managerial violence are pervasive in health care settings. This collection opens with a most controversial chapter in which Holmes and Murray (the authors) show how behaviour modification programs (BMPs) continue to be in vogue in some “total” institutions, such as psychiatric hospitals, prisons, and penitentiaries. Drawing on the seminal works of Erving Goffman and Michel Foucault, they argue that the continued use of BMPs is not only flawed from a scientific perspective, but constitutes an unethical and violent approach to the management of nursing care for mentally ill offenders. This is followed by Rudge and al.’s contribution looking at the use of migration to address the current deficit in skilled workers in Australia and explore the social relations of difference in health care settings. Using Žižek’s (2009) philosophy of objective and subjective violence as the frame of reference the authors examine how the ideological structure of tolerance operates to produce a ‘multicultural workplace’ that is hostile to skilled migrants. They contend that the ideology of tolerance acts to mask, alienate, and silence those whose daily life is affected by the violence inherent in the smooth running of what is believed to be a multicultural system.

The radical opening chapters of the collection are followed by a sophisticated reflection on blame in nursing and healthcare. Cooke identifies two contrasting narratives which have been used to explain problems in healthcare: “corruption” of care and “bad apple.” These two narratives locate responsibility for problems firmly with individual members of staff. She goes on to examine what this tells us about changes both in the boundaries of professional health work and also in the control of professional health work in an age of managerialism (itself an ideology to obtain the smooth running of the system) while also looking at issues of boundary maintenance and control in more depth. For Cooke, these two dimensions of social life are central if we wish to understand how institutional troubles are explained and put to use. The distribution of blame has played a central role in justifying and bringing about changing boundaries of control in healthcare.

In chapter 4, Powers presents the results of a discourse analysis of hospital policies. Using a Foucauldian approach, she examines discourses regarding hospital violence and identifies dominant discourses that pervade policies as well as resisting/resistance discourses. Her analysis sheds light on the effects

of discourses on power relations in hospital settings. Studies of power relations in hospitals settings have rarely been published in the health care literature but this type of research in the forensic nursing domain settings have been examined extensively by many researchers.

Amongst them, lies the work of Perron and Rudge (in this collection). Their chapter stands as a renewed way to theorize nursing work in forensic psychiatry. In effect, Perron and Rudge invite readers to a theoretical experimentation seeking to introduce the work of French philosopher Bruno Latour in the health sciences, specifically in nursing. Latour's *Actor-Network Theory* is mobilized in this original chapter to critically examine the violence experienced by psychiatric nurses in an Australian forensic hospital.

As Foucault rightly argued, day-to-day life is often dirty and messy. The last chapter of part one deals exactly with this. Hamel and Lauzon show that nursing ethical considerations are not yet fully integrated in the culture of long term facilities. Although professionally responsible for the quality of the care provided in these institutions, nurses do not always act according to their code of ethics when faced with the ethical dilemma of reporting or not reporting abuse against elderly persons. Hamel and Lauzon's research results are of utmost importance in any settings where vulnerable patients come in contact with nursing staff be they long term care facilities, hospitals, or prisons.

Part Two: Horizontal Violence

In this section of the book, we turn to an exploration of horizontal violence. This section of the collection opens with the provocative work of St-Pierre on intra/inter-professional aggression. The purpose of this chapter is to broaden the understanding of how nurse managers respond to intra/inter-professional workplace aggression. Based on the work of Michel Foucault, it describes violence as an instrument of power and explores the role played by power in instances of intra/inter-professional aggression. The chapter also focuses on some aspects of the social/cultural work environment and how it impacts the ability of nurse managers to deal with such forms of aggression.

Following St-Pierre's contribution, Thomas looks at the interrelationship between horizontal and vertical violence at the hospital in chapter 8. She purports that few authors examine the issue of hospital violence from a critical standpoint, and fewer still consider the effects of violence on nursing student education. Therefore, this chapter examines two distinct, yet interrelated, forms of violence in the hospital setting: horizontal violence between registered nurse peers, and vertical violence from staff nurses to student nurses. Thomas' courageous contribution offers a framework to better understand the complex relationships between these two forms of violence, literally silenced in the nursing literature.

In chapter 9, comes an original account of the rise of violence in HIV/AIDS prevention campaigns and its implications. Gagnon and Jacob show that

while mass media prevention campaigns are widely utilised in the field of HIV/AIDS in order to raise awareness of health risks and encourage the uptake of desired (healthy) behaviours, violence has now been introduced to achieve these objectives. Their chapter is the result of a critical discourse analysis aimed at examining three HIV/AIDS prevention campaigns launched in 2009–2010. Gagnon and Jacob's work is followed by Simons and Mawn's research on bullying in the workplace. As the literature clearly shows, bullying in the workplace is associated with negative job satisfaction and retention. It has also been found to have adverse effects on the health of employees. Using a qualitative descriptive design, Simon and Mawn examine the stories of bullying among nurses based on actual or witnessed experiences. Their work echoes some of Thomas' conclusions (chapter 8 in this collection) as they demonstrate the extent to which bullying is experienced firsthand and second-hand by nurses, and particularly by vulnerable, newly graduated nurses.

Commonly, nursing practice is conceptualized as a caring process – a therapeutic undertaking in which nurses facilitate rehabilitation, foster skill development, or undertake life-saving techniques. In chapter 11, O'Byrne and Woodyatt explain that nursing interaction with patients can be violent. In effect, in-depth analyses of the intimate exposures that occur during sexual health assessments reveal that these exchanges can be understood as such. This is particularly true when nursing-based sexual health assessments are analysed using Pierre Bourdieu's concept of symbolic violence. This framework allows the authors to understand sexual health assessments as a form of non-physical, yet powerful violence that examines, evaluates, and normalises patients according to set criteria.

The second part of the collection ends with the contribution of Jackie Cook and Colette Snowden which looks at bullying during interpersonal communicative relations through telephone talk. According to Cook and Snowden, telephone contact enacts the talk-relation as a form of interpersonal "chat": a friendly, conversational exchange, with each participant securely inside the relative comfort of their known domestic or professional environment at the point of exchange. Paradoxically, this very form of interpersonal "privacy" permits the deployment of those work-based practices of manipulative control which have evolved within the hierarchies of power built into professional life. Using analytical techniques developed within the Sacksian tradition of *conversation analysis*, this chapter powerfully works to reveal how seemingly casual talk between two individuals can manipulate existing power relations in ways which appear, at least during their enactment, near-impossible to resist. In using common codes that govern interaction and in forms of threat 'talk' understood by both, Cook and Snowden explicate how bullying is difficult to neutralise, taking place as it does in the back-channels, making its control through policy and procedure elusive. They show how to counter such bullying through the use of conversational, yet subversive gambits that are equally personal resisting the power in the conversation and neutralising its personalising operations.

Part Three: Patients' Violence

In the final section, our contributors focus on the violence manifested by patients toward health care providers. However, this exploration is not about violence itself but how its potential has an impact on the development of therapeutic relationships. In these chapters, the authors show how the need to monitor or be alert to the potential for violence may interfere with practices of therapeutic care. In focusing on risk the ability to empathise or to include or exclude some nurses and not others alters the ethics of care in forensic settings. In other research on violence and the nurse-patient relationships, the affects of violence focus on nurse safety and in this last section, we challenge such a focus instead seeking to explore how the potential for violence may alter the characteristics and operation of this relationship.

The third part of the book opens with an important research contribution from Elizabeth Mason-Whitehead and Tom Mason on risk and the use of special observations in mental health practice. The use of special observations in psychiatric practice may be employed as an alternative to more restrictive methods such as the use of seclusion and restraint. Special observations are used for a complex array of signs and symptoms (and risk behaviours) which include suicidal intent, self-injurious behaviour, hallucinatory experiences, and absconding. This chapter reports on research into the use of special observations in both forensic and non-forensic psychiatric settings. A comparative approach was adopted to establish if the perceived risk factors leading to the adoption of special observations were similar in both settings.

In his intriguing and controversial piece, Dave Mercer reports on a portion of his research conducted in a high-secure setting. His chapter focuses on the management of sexual media in the context of a rehabilitative environment for the treatment of detained sexual offenders with a diagnosis of personality disorder. This is a vexed issue which has attracted professional-political attention, and criticism, in the UK. In contrast to a body of empirical research into a causal relationship between pornography and male sexual violence, with little clinical utility, attention is given to the practical problems and challenges faced by practitioners in forensic environments, where decision-making is always a product of competing debates about care or control. Sympathetic to the idea of forensic nursing as a discursive practice the discussion adopts a constructionist approach and suggest that the accounts of forensic nursing staff and offender-patients permit an exploration of the way that individuals position themselves in relation to dominant institutional, and ideological discourses about sex and sexual offending. Mercer concludes that the performative talk of staff and patients contribute to the cultural texturing of a masculine and sexist world in a way that marginalises female nurses, mediates the otherness of inmates and contradicts therapeutic ideals.

Following Mercer's original work, Stone and McMillan undertake an analysis of swearing in health care. Swearing is ubiquitous in a range of health contexts and is under-reported in health care but the implications of swearing are poorly

understood by both nurses and managers, who therefore do not appreciate its potentially detrimental effect on the quality of the therapeutic relationship, of which empathy is a core component. The taboo nature of swearing means that the particular circumstances of events involving verbal abuse are not always discussed. The strength of nurses' affective response limits both their range and expression of empathy and the extent of therapeutic engagement with the patient. Implications arise for the nature of the partnership between the nurse and his/her patient. Certain characteristics of the patient or nurse have potential to create a therapeutic gap between the two, leading to a sense of otherness and increasing vulnerability for the patient. The authors conclude with a model which promotes responses to the dilemmas involving complex nurse-patient encounters that may include moments of verbal or other forms of violence.

In chapter 16, Walsh looks at threats to caring in the prison context by exploring the nature of caring for patients in the prison environment where the threat of violence and aggression is ever present, and where nursing practice is set against a custodial philosophy. Anticipated or expected violence and aggression towards both staff and other prisoner patients is illustrated by the clear policies and procedures in place to manage it. In line with Holmes and Murray (chapter 1 in this collection), Walsh shows that prison policies and procedures place control at their core, and are therefore in direct conflict with more therapeutic caring practices that are central to nursing. Walsh argues that clinical supervision might have the potential to both manage emotional labour and develop emotional intelligence and thus, counteracts the effects of custody and care tensions.

Following up on the topics of threat, dangerousness and violence, Cary Federman examines the various methods used to determine criminal dangerousness, especially among serial killers. Many serial killers have never been psychologically assessed while alive. But many have been, usually after capture. This of course presents problems in terms of determining motive and the possibility of repeat offences. Equally problematic is the determination of dangerousness, which is made only in part by interviews. In chapter 17, Federman proposes an overview of the meaning of dangerousness in the criminological and psychological literature as well as an evaluation of the criminal profilers that are used to determine levels of dangerousness among serial killers. The overall objective of his approach is to cast a critical eye on these assessments of danger, principally because such assessments come with assumptions about human nature in general and the criminal in particular that may be nothing more than general pronouncements about the behaviour of a particular subgroup rather than quantify dangerousness, *per se*.

Finally, this collection ends with the reflexive work of Jean-Daniel Jacob regarding nursing work in violent environments, in which the penetration of security imperatives into forensic psychiatric nursing practice is problematized. In the concluding chapter, Jacob presents the results obtained from a qualitative research undertaken in a Canadian medium secure forensic psychiatric unit. He

highlights how “security discourses” influence and impede nursing practice, especially the nurse-patient relationship.

Given the content of this collection, we assert that we must (re)think violence in health care settings and continue to find ways to theorise it in alternative and productive ways. Silencing violence, in all its forms will not deter violence or its expression. Furthermore, there is a need to recognize that the multiplication of policies and rules, including those that address issues of violence add further complexity to an already complicated issue; first by making a heavy reporting process even more arduous, and second, by creating new (bureaucratic) technologies that add rigidity to care environments and unintentionally straiten both nurses and patients, thus creating a vicious cycle with the potential to victimize further. The contributors to this collection acknowledge that dealing with issues of workplace aggression and violence in health care is extremely complex and that despite ongoing efforts may be nigh impossible to eradicate. However, the hope is to start a dialogue about these issues and increase awareness, raise debates, theorize ongoing issues, lift prevailing taboos, and recognize the subtle, multiple (and often ignored) forms of violence that pervade institutions that are meant to protect and care for vulnerable populations and the workers who provide their care.

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