ARTIGO

Aggression towards helping professions: violence as communication, listening as prevention?

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Abstract: The rise in numbers of the episodes of aggression in health and social services arouses concern on how prevention programs can be planned and implemented. There are several forms of violence and the categories verbal/physical, active/passive, direct/indirect help to describe a multidimensional phenomenon involving organizational aspects, psychological and social factors, gender issues, as well as components related to law, architecture and other fields of study. If violence is considered communication, listening is the best form of prevention. The analysis of the organization and the continuous effort toward reflective practice on aggressions are crucial to understand and prevent such acts. This article proposes some tools, in the form of key questions, to support these activities.
Keywords: Violence. Aggression. Social Work. Prevention. Health And Social Services.

Resumo: O aumento no número de episódios de agressão em serviços sociais e de saúde desperta preocupação sobre como a forma como os programas de prevenção pode ser planejados e implementados. Existem várias formas de violência e as categorias verbal / física, ativa / passiva, direta / indireta ajudam a descrever um fenômeno multidimensional que envolve aspectos organizacionais, fatores psicológicos e sociais, questões de gênero, bem como componentes relacionados com a lei, arquitetura e outros campos de estudo. Se a violência é considerada a comunicação, a escuta é a melhor forma de prevenção. A análise da organização e do esforço contínuo em direção à prática reflexiva sobre agressões são cruciais para compreender e prevenir tais atos. Este artigo propõe algumas ferramentas, sob a forma de perguntas-chave para apoiar essas atividades.
Palavras-chave: Violência. Agressão. Serviço Social. Prevenção. Saúde e serviços sociais.

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Introduction

News of violence against professionals in health and social services appear occasionally in newspapers and on TV arousing concern and debates that often are so quick to appear as well as to disappear. On a less limited perspective the few data available on this phenomenon allow us to glimpse the contours of a phenomenon that should not be either underestimated or ignored. Concerning this the two fields of health care and social services share more similarities than differences.

For example, in the U.S.A. in 2000, health service workers overall had an incidence rate of 9.3 (number of events per 10,000 full-time workers) for injuries resulting from assaults and violent acts. The rate for social service workers was even higher, that is 15 (USA, 2004, p. 6).

In the UK in 2003, 3.3% of health and social welfare professionals (including nurses and social workers) had suffered one or more assaults at work during the previous five years (TAYLOR, 2011, p. 14). In Italy in 2005 the reported accidents in hospital services for "violence, aggression" by patients or relatives numbered around 429 (2.3% of the total number of accidents reported in these services, of which 234 are related to nurses, 57 unspecified workers, 30 health auxiliaries / porters, with 31 caregivers, 31 doctors, 7 to 39 other employees (BUCCIARELLI, 2007, p. 2).

In the recent report *Workplace Violence and Harassment: a European picture* of the European Agency for Safety and Health at Work (EUROPEAN AGENCY FOR SAFETY AND HEALTH AT WORK, 2010, p. 56-57) there is a global picture of research showing that aggressions by users are common in sectors of the health and social care in Europe. In particular:

- in Denmark workers most at risk of violence are social educators in residential services and nurses in hospitals and nursing homes;
- in Finland, threats and attacks have been reported mainly against health professionals and social workers, especially women ;
- in Sweden and England , the phenomenon is particularly relevant for nurses and physicians practicing in the psychiatric field ;
- in Sweden as much as 9% of those who work in the health and social services experience violence or threats daily and 67% several times a month ;
- in Poland, the most common form of violence (verbal violence by patients and their relatives) interests 84% of nurses.

A seminal International comparative research presenting case studies from Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and Australia:

> […] has revealed that violence at work against health personnel is an existing and widespread problem in developing and transition countries as well […] for the industrialized world. More than half of the responding health employees have experienced at least one incident of physical or psychological violence in the previous year: 75.8 per cent in Bulgaria; 67.2 per cent in Australia; 61 per cent in South Africa; in Portugal 60 per cent in

> the Health Centre complexes and 37 per cent in the hospitals; 54 per cent in Thailand; 46.7 per cent in Brazil (DI MARTINO, 2002, p. 9-10).

The importance and the complexity of this topic deeply interest both the workers and the service users, since the quality of the services provided is affected by the work environment which in turn is effected by the relationships created amongst users, workers and their organizations.

As will be better explained in this article, violence is a multidimensional phenomenon influenced by factors from different areas of interests: social, gender, psychological intrapsychic process, communication and relationships, relating to safety at work, concerning the organization of the spaces in the services and others (SICORA, 2013, p. 18 - 19).

1 The complexity of an exploration on a subject still taboo in the social and health services

Before going further, it is useful to recall a couple of definitions and a classification so as better to clarify the topic of this article. Using the words of the European Agency for Safety and Health at Work (EUROPEAN AGENCY FOR SAFETY AND HEALTH AT WORK, 2010, p. 9 – 10), "work-related violence" or "workplace violence" includes "all kinds of violent incidents at work, including third-party violence and harassment (bullying, mobbing) at work. The phrase 'third-party violence' is used to refer to threats, physical violence, and psychological violence (e.g. verbal violence) by third parties such as customers, clients, or patients receiving goods or services". The most obvious manifestation of this violence appears in the form of "aggression", that is "the delivery of an aversive stimulus from one person to another, with intent to harm and with the expectation of causing such harm, when the other person is motivated to escape or avoid the stimulus" (GEEN, 2001, p. 3).

Moreover, on the basis of a three-dimensional physical-verbal, active-passive and direct-indirect model eight types of aggression of the following typologies are identified (BUSS, 1961 cit. MONDS-WATSON, 2011, p. 10):

- physical-active-direct (e.g. physically assaulting someone);
- physical-active-indirect (e.g. getting someone else to assault someone on your behalf);
- physical-passive-direct (e.g. obstructing someone doing something as in a sit-in protest);
- physical-passive-indirect (e.g. refusing to perform necessary acts);
- verbal-active-direct (e.g. insulting or humiliating someone in public);
- verbal-active-indirect (e.g. spreading malicious stories about someone);
- verbal-passive-direct (e.g. ignoring someone);
- verbal-passive-indirect (e.g. deciding not to defend someone falsely accused or unfairly criticized).

The list above shows the great variety of forms taken by the violence against health and social workers. Fortunately, only

rarely do the gravest attacks (physical-active-direct) have tragic outcomes (i.e. death) but this cannot obscure the fact that threats and attacks targeting aid professionals are common in many services. Nevertheless violence has often an ambiguous meaning: the same behavior can be seen as aggression or defense according to the point of view of the people involved. For example, as it will be better explained later in this article, many episodes in the field of child protection illustrate this when different views between social workers and families produce great tension and even violence. Moreover and even if it is not the focus of these pages, it cannot be forgotten that organizations are often settings where abuse of power, mobbing and bullying are common in the everyday interactions between management and employers or amongst the latter ones. Sometimes these kind of acts can even take the form of management mechanisms asking for hyper-performances impossible to reach. These situations are potential hazard to personal wellbeing on the workplace and can even lead to some forms of illness.

It is important to start talking on this issue in order to understand it and to identify useful strategies to prevent violence or at least to minimize the risk faced by social workers, educators, psychologists, nurses and other professionals when dealing with situations that are potentially dangerous. In this regard and often with large national differences, it should also be noted that the difficulty of recovering data and literature on this topic goes hand in hand with the infrequency of training initiatives and shared reflection. These may significantly help to understand what are the useful behaviors and skills in dealing with the aggressiveness of the users.

Sometimes, it is important to note, the fear of the health and social workers can be mitigated or exacerbated on the basis of their perception of their own professional skills, as well as on the protection they can expect from their organization, from their colleagues and, more generally, from their professional community. It should also be noted that the social workers are experiencing a particularly difficult paradox, namely to be those offering help while being, at the same time, the authority against which users sometimes feel anger (SCHULTZ, 1989).

How common is violence against social workers and other professionals working like them in health and social care? What causes physical and verbal aggressions? How can the first signs of risk be understood and how can we prevent the outbreak of violence, or, at least, limit the damage? Can specific training on this topic help? Finally, what support can be provided to victims of aggression?

These are all questions to which it is certainly not possible to give full answers here in the limited space of an article. However, in any case it is useful to outline some paths to explore this area in search of tools for the security, not only of those who are the object of violence, but also in the interest of those who sometimes do violence as a last attempt to oppose what they perceive as a wall of indifference or inadequacy with respect to their requests

and needs. So, it is not always easy to determine who is "victim" and who is "executioner", who is fragile and who is strong and powerful. In fact the outcome, i.e. the violent act, is not the result of a "fault" but rather the consequence of the interactions between users, social workers and organizations (SARKISIAN; PORTWOOD, 2003).

Professional social work contains structural dimensions of social control, the exercise of which can cause many problems on personal, technical, organizational and institutional levels. In particular, it is often very difficult to combine purposes of support, protection, help with implicit goals of social control. But it is very important to keep ones eyes wide open and be sure that social work values and purposes always come first. Social workers are seldom fully aware that the size of the control is a structural component of their professionalism and feel uncomfortable playing this part. So a very common reaction consists in giving the institution where they work and its impersonality full responsibility for the unwelcome part of the professional activities. Sometimes instead, they give the whole "blame" to the user and his/her unreasonableness, without asking themselves if some behaviors could be considered inappropriate and worth changing. Of course, violence against social workers has some different features with regards with the type of service (territorial, residential, etc.) and users (children, elderly, drug addicts, people with disabilities, people with mental health problems, etc.) but some dynamics are everywhere the same.
It has also to be mentioned that the global pressure produced by neoliberalist health and social policies is creating structural changes in existing welfare systems. The "mantra" of productivity, profit and costs reduction is menacing the public provision of services that once were firmly considered as part of the rights of social citizenship (SPOLANDER et al., 2014).

The reduction of professional discretion and autonomy and the transformation of the practitioners in mere services dispenser is creating a growing tension between them and the service users. Some of the so-called "organizational rationalizations" are creating a gap between helping profession and service users and, consequently, the latters often perceive the former as acting against their legitimate interests rather than on their side.

The following are just three voices from a qualitative research involving 20 Italian social workers interviewed on their experience of aggression (TROCINO, 2013):

- At that moment, I cannot describe what I felt. Surely it was not a good thing ... but I was also embarrassed in front of all those people. I did not expect ... then a girl that we have always helped, we have always tried to be close to her in every way (family counseling service);
- During a removal of a child, the father tried to break down the door of the room where I was with the child and threatened to kill us all (municipality);
- I thought that one way to protect ourselves could be to install a camera outside the door with an intercom so I can see and open the door. But this does not fall precisely into the culture and mindset of managers who may prefer to spend a lot of

money on a guard here and not consider other alternatives. (family counseling service).

Key emerging concepts like the frequent removal of the problem, overwhelming emotions and the role of the organization seem common tracts of the phenomenon everywhere.

The last of the above three excerpts of interview recalls some echoes of the managerialistic approach that, in tune with the policy transformation mentioned before, are often unable to provide solutions that are more respectful of the needs of the service users. Social justice, human rights, collective responsibility and respect for diversities and individual needs are often neglected. Instead of being mean to obtain wellbeing and comply people's rights, efficiency becomes the supreme value, also in health and care services.

On a wider perspective it is possible to identify some risk factors in health and social services in order to perform more targeted preventive measures. Among these factors it is important to mention: location in degraded and dangerous areas, user/patient features and previous negative experiences, diseases, prolonged and not adequately treated pain, alcohol or drug abuse, anxiety, inappropriate expectations (frustration can easily lead to aggressiveness), social image of the service and the profession involved (e.g. "social workers steal children"), inadequate service organization (e.g. long waits, crowded spaces, lack of information, difficult communication, uncomfortable opening hours). Some services like emergency unit and psychiatric ones are more at risk than others (ITALIA, 2012, p. 99 - 100).

2 Organizational dimension and violence against social workers

The organizational dimension is an important element in the phenomenon examined here because it greatly affects limits and opportunities of services provided. The organization may be experienced by the user as a depersonalizing "monster" who is deaf and blind to the needs of the people and is formed also by the social worker who is cold and indifferent, too. For this reason also acting on the organizational mechanisms helps to prevent the emergence of violence.

Social Workers at Risk. The prevention and management of violence is one of the first texts written on this issue, in 1986, and sponsored by the *British Association of Social Workers*, but still remains one of the most effective examples of dealing with the issue. In this book there is a checklist to help managers to identify organizational risk factors to be targeted for preventing aggressions. It seems useful to propose here this list of questions from that publication (BROWN; BUTE; FORD, 1986, p. 115-116).

First, concerning the organization of the staff, key questions are:

1. "[…] does the establishment have sufficient staff?is care taken to appoint appropriate staff?
2. are staff given training in the reduction of violence?

3. do all staff feel supported, secure and able to admit fear and report violent incidents?
4. are the provisions of the Health and Safety at Work legislation being complied with?
5. are staff properly insured against the risk of assault? ”

The work environment is another important factor and the following questions help to assess the risk and implement prevention measures:

1. “[…] are reception areas, interviewing rooms and other facilities furnished so as to provide security for all who use them?
2. are there alarm systems, and do staff know how to use them?
3. is there a system of "coded" messages for requesting assistance?
4. is care taken to exclude objects that are potential weapons?”

Finally, on the agency’s task, it is useful to think over these questions:

1. “[…] are all staff kept aware of the dangers of known high-risk procedures? (compulsory admission to care, hospitals, homes).
2. are agency records used systematically to identify those who may become violent?
3. is it the practice that staff are never left alone in the building?
4. in fieldwork settings, is care taken: to allocate work appropriately? to decide whether “paired” home visits or office interviews are necessary? to decide whether police assistance is required? to decide whether standby staff and prearranged interruptions should be organized in office interviews?
5. in residential and day care settings, is care taken: to develop and maintain an ethos that will minimize risk? to facilitate communication between staff and residents? to work [with] staff combinations that will reduce risks of confrontation?
6. after incidents of violence, are staff given proper support? are incidents recorded and reported? is the question of prosecuting the assailant considered?”

It is a checklist that, beyond any consideration regarding its complete applicability to other national contexts, offers interesting ideas. In the first place, it leads us to pay attention to the adequacy of the organizational structure and its staff with respect to the risk of violence. Quantity and quality of the workers have to be appropriate to the performance of the functions of the service. And, between the many, clear guidelines for action, insurance coverage, attitude accepting fears and difficulties encountered by the practitioners, logistical and structural elements of the workplace are all factors that have to be carefully considered, especially in particularly risky operational contexts.

An important role should also be attributed to communication. This is certainly a key element in preventing violence against services to help people, especially when the use of force becomes an extreme attempt to overturn, or at least redefine, relations of subordination perceived by the users. The proposal of the "British Association of Social Workers" is useful

for this purpose as it helps to produce "organizational learning", that is when the knowledge of the few who have been involved as victims of assaults is shared with colleagues and becomes something the whole organization can use to learn and to help implement prevention programs.

On the other side of the Atlantic Ocean, one of the checklists of the document *Promoting Safe Work Environments for Nurses*, published in 2002 by the American Nurses Association represents also an effective tool for this. In fact a good violence prevention program has to implement some good record keeping and evaluation actions and, on this issue, has to provide for (AMERICAN NURSES ASSOCIATION, 2004, p. 38 – 39):

- "[…] records of all incidents involving assault, harassment, aggressive behavior, abuse, and verbal attack with attention to maintaining appropriate confidentiality of the records;
- training records;
- workplace walkthrough and security inspection records;
- keeping records of control measures instituted in response to inspections, complaints, or violent incidents;
- a system for regular evaluation of engineering, administrative, and work practice controls to see if they are working well;
- a system for the regular review of individual reports and trending and analysis of all incidents;
- employee surveys regarding the effectiveness of control measures instituted;
- discussions with employees who are involved in hostile situations to ask about the quality of post-incident treatment they received;
- a provision for an outside audit or consultation of the violence programs for recommendations on improving safety".

The proposals made by Sarkisian and Portwood (2003, p. 56-57) are also of great interest. They suggests five specific recommendations for the protection of social workers:

1. managers must take an active role in promoting the adoption of programs to prevent workplace violence and in providing necessary funds;
2. organization policies on violence from users must be communicated to all workers in a clear way;
3. the role of law makers in developing adequate legislation to protect those who work in social services from being subjected to violence should be explored in depth;
4. the safety of the social workers and the empowerment of the users must be an integral part of social work practice through the promotion of appropriate forms of cooperation in the network of services;
5. better understanding of the environmental factors that lead users to use violence against aid workers has to be promoted also in academic and research institutions.
4. violence as communication, listening as prevention.

As anticipated before, some of the key questions leading to a better understanding of aggression in the work place lay in interconnections between the social workers, users and organization.

If someone is considered violent when he or she uses force to impose his or her will at the expense of the others, are there organizations that subtly evoke violent aggression in those that are not capable of making their voices heard and demand respect for their rights or what they perceive as their rights? How much are dynamics of oppression still hidden within some organizations?

According to Gallino (2000, p. 721), if we include within the concept of violence all forms of control that crush intellectual and practical achievements of men and women below their potential realizations, any organization virtually becomes violent when not specifically structured to make maximum use of the individual and social creativity. It would be too simplistic, however, to draw a perfect equation between power and violence, such as supported by the theory of "structural violence" (STRASSOLDO, 1987, p. 2327).

The problem of coercive measures legitimized by institutions is very complex and a further interesting paradox is the fact that not all forms of physical coercion constitute violence. As a result, the same act described in objective terms (for example, a man who shoots someone in the street) is configured as an act of violence only if the dominant frame defines it so in the light of the wider accepted concept of legality and legitimacy. For example, if the shooter is a cop and his opponent is a robber on the run, the act of shooting is not considered as violence; but it becomes violence if the shooter is the robber and his or her target is another cop or a passerby who hinders the escape (GALLINO, 2000, p. 721).

A similar reversal of perspective is found in the not uncommon situation in child protection services when a minor is abused within his or her family. It could be easily argued that "removing" a child from his or her parents is an act of violence when such an action is made, for example, by a group of people who want money or something else from the parents, but it is not (always?) when those who "kidnap" the child are social workers. The same act of violent resistance is often seen in two very different ways: an aggression in the social workers' perspective, a defense from the parents' point of view. In many similar situations, also the so-called heterogeneous "public opinion" is divided between the ones who think that social workers are stealing children from parents who have the right to keep their children with them and the ones who think they are not if the children are in danger.

Violence is an extreme act full of implications and meaning that is not always easy to fully understand, but it is extremely important to try and carefully observe the dynamics of the interaction with the service users, especially in the most risky situations. So, it could be said that if violence is a form of communication, listening could be the best form of prevention. Listen to whom? Service users, patients and their families but also the professionals themselves. Reflective practice can provide a systematic learning coming from experience and one that is tailor made to the specific characteristic of the service, its users and the practitioners involved. So it is important to sit and think, hopefully together with colleagues and managers, about an experience of aggression and ask

questions like the following (SICORA, 2013, p. 112 - 114):

1. What happened?
2. What was I thinking and feeling?
3. What was good and bad about the experience?
4. What is my/our explanation of how and why violence has broken out? What was my role and the role of the other people involved?
5. If I had the "time machine" and could return to the time when the event happened, what would I do differently?
6. If a similar case happens in the future, what would I/we do in order to:
   - better understand the nature of violence?
   - recognize the potential for violence?
   - prevent violence?
   - face violence when it occurs?
   - obtain/give adequate support after the episode of violence?

Reflecting in depth is the base to learn from any critical incident. Any kind of error (personal, organizational, etc.) is a powerful opportunity for understanding complex realities and improving practitioners and their organizations (SICORA, 2010). As described in the seminal work of Reason (1990), *The human error*, there are two main types of errors: errors in execution ("I thought well, but I did wrong") and errors in planning or in problem solving ("I did well, but I thought wrong"). This distinction is also helpful when aggression against health and social professions is considered, especially when an intervention fails and violence is raised as a consequence of an assessment expressed not in accordance with reality. Another model taken from Reason is the so-called "swiss cheese model" which has proved to be very useful in helping to reconstruct the sequence of events that leads to an erroneous event with the production of damage. When "sentinel events" represented by aggressions from service users are carefully considered, personal and organizational learning is possible and changes can be made for providing better services and leading to a higher degree of wellbeing both of the service users and the practitioners working with and for them.

Before concluding, one last thought from a totally different context. In the novel *A woman in Jerusalem: a passion in three Parts* writer Abraham Yehoshua (2011) imagines that the elderly owner of a large bakery in Jerusalem send his human resources manager to discover what was true in the statements of a journalist who had accused the company of "lack of humanity" because they had not noticed the absence of one of its employees who was killed by a bomb in a market. About halfway through the book, when the investigation seems already well under way, the old man asks "Answer me yes or no. Are we guilty?". And the human resources manager says "Responsible. This is the right word" and receives in reply an additional question: "In what way? ".
This question left open seems to be more than adequate to start a process of reflection involving all the components in a health or social service. Not only because it shifts the focus from "hunt for the guilty" (the user, the whole organization, the practitioner or other people) to an analysis of the dynamics of responsibility that is

more constructive for the prevention of violence against social workers, but also because it leads to a shared search for the deep meaning of the phenomenon under scrutiny. Even the most controversial and worst episodes can help us to learn and bring awareness about things that have to be changed for a better quality of the working conditions and of the help provided to the services users.

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