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Workplace Violence: Schools and Hospitals

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Abstract

This thesis is a sociological exploration of violence at work. It is concerned with examining doctors', nurses' and teachers' experiences of violence at work in the institutional setting of schools and hospitals. It argues that media representations of this phenomenon, while having been helpful in raising awareness of violent incidents towards staff as mainly inter-personal and neglecting the institutional context of violence, have been unhelpful in extending knowledge and understanding. Thus it is argued that there are significant gaps in understanding of the nature and extent of violence in these contexts.

The thesis aims to extend the current theoretical and empirical understanding of violence at work through the perceptions and experiences of these institutional actors and to examine how the institutional setting – physically and structurally – affects them in their professional roles in public sector schools and hospitals. Qualitative and quantitative data were gathered from two local authority areas in west central Scotland.

Bourdieu's concepts of field, habitus and capital are used to examine the complex inter-relations of institutions, institutionalism and professional/client interactions that create a particular set of conditions which are challenged through the use of violence. 'Fields' represent the political and organisational structure of public sector health and education services whilst the 'habitus' forms the site of delivery for these services and the particular institutional cultural dispositions associated with them. The

concept of 'capital' is used to examine the *inter-personnel* relationships, and the *inter-personal* relationships between client groups, in the work habitus.

It concludes that the need for an integrated approach to understanding violence in the context of institutions is crucial if effective interventions are to be made and appropriate policies developed.

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Chapter 1

Introduction

1. Aims of the thesis

This thesis is a critical sociological examination of the phenomenon of violence at work through the perceptions and experiences of doctors, nurses and teachers working in the public sector institutional settings of schools and hospitals. Theoretically a Bourdieusian framework has been adopted to explore and critically analyse professionals' experiences of violence contextualised in the working institution and the effect these have on inter-personal relations with their client groups. This form of violence is felt to be a pressing issue as Johnson & Indvik (1996) report that 'our workplace relationships have taken a new and deadly turn'; and the contention is that there is more to understanding the experiences of violence – causes and effects - in these institutions than analysing them as the interpersonal violent actions of clients towards institutional professionals.

This study is therefore concerned with exploring both the content of the violence and the context in which it occurs. The challenge is not only to understand how these professionals perceive, experience and define violence in the context of their workplace but also to explore the relationship between institutional structures, practices and the occurrence of workplace inter-personal violence. As Leather (2002) has argued 'real progress' will only be made in relation to workplace violence when an 'integrated organisational approach' is adopted. It seeks to challenge the views as discussed in the following chapter that workplace violence is the product of 'bad' or

'pathological' pupils and patients irrationally challenging and attacking doctors, nurses and teachers in the workplace.

Bourdieu's concepts of 'fields' and 'habitus' are found to provide a useful model for analysing the complex relationships between the organising structure – the field of education or health - of these public service institutions and the particular cultural dispositions (practices) that are evident within the habitus – schools and hospitals - in delivery of their services. 'Capital' is also found helpful in analysis of the negotiations and interactions between fields and habitus at both the structural level between institutions and between institutions and professionals; at the inter-personal level, between professionals themselves; and between professionals and their respective clientele in service delivery.

Such an analytic frame, it is argued, effectively facilitates exploration of the links between the cultural sensitivities of the habitus - institutional working, structures and practices - and the actual experiences of violence. It will develop a deeply contextualised, culturally sensitive understanding of violence in these institutions and therefore contribute to a wider and more complex debate on violence in these workplace settings than has hitherto taken place. It will extend current analysis of workplace issues beyond the interpersonal and provide a more integrative analysis of the interpersonal actions within the institutional context.

Empirically a number of questions are asked and in particular the need to understand violence at work from the professional gaze is highlighted: what are the experiences of doctors, nurses and teachers? The institutional setting

- public sector schools and NHS hospitals - is also explored both spatially and in its regulation – the control of the workplace, access to services, and acceptance of expected patterns of behaviour - to ascertain how it affects the working environment:

- how established and maintained patterns of practices – regulated timetables, allocation and organisation of the delivery of services - affect service delivery;
- how this affects practitioner definitions of workplace violence from experience – understanding the types and meanings of the behaviours they experience as violent; and
- how institutional administrators understand and interpret violent experiences reported to them.

In understanding this phenomenon the media, or social, construction of it as a 'new' and 'increasing' inter-personal problem is challenged. Media representations as discussed below are found to have been central in bringing it into the public domain. Arway (2002) tells us that 'every form of media has carried stories of violence in the workplace (in Gill et al 2002:41). It is argued here that they are limited in analysis and thus highlight the need for a sociological/criminological understanding. Being mindful of the media's ability to stereotype victims and perpetrators the thesis asks: can we really commit to an understanding of violence that limits its definition to that of inter-personal violent relations; focusing almost exclusively on the interaction of the perpetrator, victim and physicality of the act, to the exclusion of other institutional and social factors?

Capturing the fullness of doctors', nurses' and teachers' experiences is surely more important and since it is recognised that violence can be experienced physically, verbally, psychologically and emotionally (O'Beirne et al 2003, Leather 2002), it is important to understanding to know what criteria are applied in defining violent acts: how prevalent is it in the workplace; how does it affect the ability to work; how/where is it experienced; what, if any, factors expose one set of professionals more to the risk of, or possibility of, violence than others; and what factors are identified as contributing to reducing these risks? The effects violence has on the work environment and practice and whether or not victims feel adequately supported while at work are also explored.

Research on violence has identified differences in experience of it by gender, class and race which, given the nature of these institutions, may also be salient factors here. While violence in schools and hospitals has been attracting considerable media attention there was little academic literature on the topic. Therefore a deeply contextualised analysis of the workplace experiences of violence will contribute to our sociological and criminological understanding of violence generally and to our understanding of institutions.

1.2 Schools and hospitals

The rationale for choosing these two institutions is that 'violence' challenges the more common perception of them as sites of instruction and caring. Secondly, as is discussed below, the media have identified them as sites for concern because of the levels and types of violence experienced by their professional employees. Thirdly, they are the institutions most of us are

likely to have contact with: education is compulsory between the ages of 5 and 16 and so, whether in the private or public sector, we all have contact as pupils and again if we are parents or guardians of children; and few of us are likely to get through our lives without at some point having contact with hospitals whether as a visitor, patient or employee. Fourthly, violence challenges the power and control of these institutions as it is more commonly associated with 'chaotic' than highly regulated activity (Ray, 2000, Thornton 1995). Fifthly, violence in schools and hospitals is also of concern at the policy level as is evidenced in the Scottish Executive's high profile Zero Tolerance campaign.

The media discussions and existing knowledge of the structure of these institutional practices begged the question, 'What role does the institution have in the occurrences of violence?' The commonly held perception is that violence is not the norm in schools and hospitals but something that occurs occasionally and unexpectedly, whereas the relatively recent media attention suggests that what these professionals are currently facing is significantly different, and therefore if not new, certainly a growing problem.

While these institutions deliver distinctly different services both are public service utilities and therefore have a complex mix of agents – client groups and professionals. Historically they are embedded in our political and social culture, are valued as important institutions, have clearly defined functions and, while they differ in service delivery, are broadly similar in their structural organisation and functioning. Both are publicly funded bodies, both have politically defined remits, and both in their implementation of policy are perceived as highly autonomous and regulated. Therefore the

context of the institution is important if we are to understand violence therein. What are the experiences of violence of schools and hospitals? What actions have been taken by the institution in relation to prevention and/or sanctions in response to violence? Are there lessons that could be learnt from each other?

1.3 Bourdieu

Bourdieu's theory was adopted because his concepts of fields, habitus, and capital along with the possibility of combining qualitative and quantitative methodologies would provide a flexible but strong methodology and theoretical frame for analysis. Fields, habitus and capital provide a suitable framework to explore the inter-personal and structural intricacies of class, age, and gender within the context of political and institutional culture, practice and service delivery.

He was concerned about breaking down the dichotomy of subjectivism and objectivism, and most importantly about letting the voices of those in the 'frame' be heard: to make possible both a 'reflexive return to the subjective experience of the world and also the objectification of the objective conditions of that experience' (Bourdieu 1990:25). He argued for the need to combine the methods advocated by humanists and positivists 'to move beyond couples of oppositions, which are expressed by concepts ending in "-ism" (Bourdieu, Chamboredon & Passeron (1991: 251) in order to bridge the division between theory and practice which he advocates should not be separated but should create a dialectic process in research.

This is in some ways redolent of grounded theory; for example, both theories

are insistent that the researcher be both challenging of him/herself and reflexive in the research process. Neither divorces itself from methodology but each insists that methods and theory form a reciprocal process – one cannot be divorced from the other; one informs the other and if it does not fit then something needs to be revisited to explain why. The one crucial difference between them is that grounded theory as advanced by Glaser and Strauss (1967) requires the researcher to follow through on all relevant material as it emerges which makes it extremely difficult to define time and set parameters for a research project, one of the main criticisms of grounded theory (Silverman 1993). Bourdieu's theory is more accommodating; permitting the setting of parameters to a study is not problematic so long as they are clearly defined in the process of the research.

This study is only concerned with the perspectives of doctors, nurses and teachers on violence within the institutional setting and the analysis of that. It does not address the views or motivations of the perpetrators of these incidents – essentially it is offering a professional's view of violence at work. True grounded theory can be an extremely lengthy process and would really have required involvement of perpetrators. Access, as discussed in Chapter Four, was difficult enough and would only have been exacerbated by inclusion of the service user population. Adopting Bourdieu's theory was therefore more prudent and provided a more integrative way of analysing violence at work. It was also found to be supportive of the 'grounded approach' adopted in the early stages of the study.

Traditionally research on violence in institutions has been in relation to specific practices – suggesting that racial and sexual harassment are embedded in the system and are a reflection of the wider social ethos and/or

the activities of corporations – selection processes - that divorce themselves from the actions of individuals. Interpersonal violence has focused on the intentions of the perpetrators or on the actions of the victims. Violence is then seen as a residual category to other issues, such as that of race, or gender for example. While violence at work is often experienced as interpersonal violence the explanation and understanding of that violence is complex as it is not just an individual but an institutional representative that is the recipient of these attacks. Consequently to ignore the effect of the institution would be to compromise the analysis.

Such a neglect would, Bourdieu argues, create bias and 'the most insidious source of bias ...... is the fact that, to study society, the sociologist necessarily assumes a contemplative or scholastic stance that causes her to (mis)construe the social world as an interpretive puzzle to be resolved, rather than a mesh of practical tasks to be accomplished in real time and space – which is what it is for social agents' (Stones 1998:226). There is a lack of acknowledgement of the *mesh* of practices, expectations, rights and tolerances that is institutional working. This *mesh* needs to be understood if effective interventions are to be made. It is important to understand what the underlying issues are and the complex interaction/s between structural procedures, client expectations, and inter-personal client/professional relations. A restricted analysis is not likely to assist in clarifying how violence is defined nor to enhance understanding of the types of behaviour associated with it; nor is it likely to stimulate an informed debate of all the issues as identified by professionals, but rather it will misinform effective interventions or protective policies. The debate needs to move beyond a media analysis based on 'bite-sized' reporting of such events; to allow for the inclusion of the influences of

power, politics, gender and other social issues that impact on the institutions, and on the interrelations of staff and clients.

The need to advance the analysis of this type of institutional workplace violence beyond a one-dimensional "them and us" is evident. Institutions are complex hierarchical social settings of regulations, rules and practices, personnel, and client groups that are, particularly in the case of hospitals, often negotiated in a highly emotional state. Because of this a flexible framework is necessary to analyse the complex issues involved. These theoretical issues are discussed more fully in Chapter Three and the methodological process in Chapter Four.

1.4 Background to the study

This study was undertaken in the aftermath of two particularly violent incidents: that at Dunblane Primary School which occurred on 13/3/96, when 16 primary school children and one of their teachers were shot dead; and later that year the fatal stabbing of Head Teacher Philip Lawrence just outside the London Comprehensive School where he worked. Following these incidents the media reporting of violent incidents in schools and hospitals increased (Hearn & Parkin, 2001:67), particularly in the printed press, but also in TV news reports and documentaries and the subject has featured in or been the theme of drama and other television programmes. The media interest in and concern with violence in schools has reported:

> 'a growing and complex series of events connecting violence, responses from staff and responses to these responses from management. In schools and institutions there have been reports

> of violence by teachers, disruptive pupils, attacks by 'boys' on women teachers, teachers' responses to exclude violent children, safety of school children ... inquiries into schools and other institutions, the carrying and use of weapons of school children.... There is also growing concern with young men's violence, often drink-related, in college fraternities in the USA and elsewhere. (Hearn & Parkin, 2001:67).

It is argued, therefore, that the media are significant in bringing the issue of violence to our attention; that they have been influential in the social construction of violence in the workplace as problematic; and that their reporting of it, while opening up the debate, has not always been helpful (Chibnall, 1977). For example, Gill et al (1998:435) noted in their study of violence in schools that '[j]ust over 70 percent of respondents felt that violence in schools was exaggerated by the media.'

The initial incidents were exceptional events; their reporting marked the beginning of a wider and more intense reporting of violence, raising general awareness and influencing public perceptions of it, but rarely examining the context - the complex social and institutional constructs – in which the violence occurred. Hitherto media reporting of violence has tended to focus on specific categories - Sexual, Racial, Domestic, Gang - which has fragmented understanding and accorded a higher profile to some categories - such as rape and assault - than to others; and as Croall (1998) rightly remarks, until relatively recently a category that was often neglected is Violence at Work. Catley (2003b:3) extends on this by pointing out that there is an over reliance on self-evident or obvious physical violence in discussions

of workplace violence which erases, normalises or marginalises other instances of it.

Media reporting of violence at work has firstly brought the issue into the public arena, secondly, has informed public perceptions and general understanding of it, and thirdly, has increased awareness of it through the production and presentation process; on the other hand it has brought about some public misunderstanding (see for example Jempson, 2001) and shares many similarities with previous research on the role of the media. As Reiner (1997:190) points out, they '...manufactured the news (Cohen and Young, 1973), created moral panics about folk devils (Cohen, 1972), stigmatized outsiders (Becker, 1964), and amplified their deviance (Young, 1971), thus legitimising the drift to a law and order society (Hall, 1979) and a more authoritarian style of policing the crisis (Hall et al, 1978).'

Media reporting of violence has revolved around 'moral panic' and the way in which it informs public understanding, fear and reactions to the extent that Hunt (1977) argues some reports even go as far as telling us we are in the *midst* of a *moral panic*. For example, the *News of the World's* 'naming and shaming campaign against paedophiles ... led to mass hysteria in parts of the country' (Levenson, 2001) and media attention on 'race, ethnicity and crime vilifies young black men as a group' (Roberts, 2001). Consequently, Ericson (1991:74) argues that the 'news media are as much an agency of policing as the law-enforcement agencies whose activities and classifications are reported on and Reiner (2002:406) goes so far as to state they 'reproduce order in the process of representing it' and are therefore 'better seen as bureaucrats than as buccaneers' (Curran & Seaton, 1994:265).

The media disproportionately represent crimes of violence 'compared to their incidence in official crime statistics or victim surveys' (Reiner, 1997:199 & 2001:4). The commercial nature and manufacturing of the news means that the media are more 'concerned with grabbing the attention of prospective audiences by making an "impact"' (Chibnall, 1977:25) and therefore 'journalists are better at reporting the fact than the matter of protest' (Whale, 1971:48) but their interest in blame can on occasion be turned to good effect in calling the powerful to account' (Sparks, 2001). Consequently their reporting is very descriptive of the nature of violent incidents but less concerned with why the violence occurred or indeed what factors may have contributed to it.

Clearly the media are a significant influence on public perceptions; as Reiner states, they 'disproportionately present[s] the most serious and violent crime as the product of individual choice and free-floating evil, diverting attention from any links to social structure or culture' (Reiner, 1997:224). 'Crime news stories increasingly orchestrate a kind of virtual vigilantism, in which a proxy audience is constructed to celebrate vengeance against the perpetrators of unmitigated evil' (Reiner, 2001: 5).

Workplace violence as reported by the media has all the hallmarks of a media-manufactured or socially constructed problem. Reporting, as can be seen below, has focused on the sensational headline, is very incident-orientated, highly descriptive and suggestive that violence in schools and hospitals is problematic for doctors, nurses and teachers, and a new and increasing problem:

'Violence in schools is "not being tackled."' (*The Guardian* 1/9/1997)

'Patients face stricter rules.' (*The Herald* 9/10/1997)

'11-year-old has spent only 16 months at school' because 'Boy is too wild to teach'. (*Evening Times* 2/1/1998)

'Incident Response Team' to be set up in one of Glasgow's Hospitals to deal with violence and aggressive patients and visitors. (*Evening Times* 17/6/1998)

'If you think armed guards at school is something that could only happen in America, watch this space.....' (*The Scotsman* (10/2/1999)

'Staff at city hospital demand more protection from violent patients'. 'Nurses want round the clock policing'. (*Evening Times* 22/11/2000)

Such reporting has been maintained through the period of this study and indeed, as shown below is still evident although there would appear to have been developments in the experiences of teachers at the time of writing:

Mum 'smashed teacher's head against the wall'. (Daily Express, 16/12/2005)

In a few hours, the NHS will be overcome by drunken violence and abuse. It's Friday night in casualty. (The Scotsman, 16/12/2005

Security experts called in after violent multiple attack on school grounds could lead to costly litigation, and US-style school fortresses. (The Herald/Society, 18/4/06)

Horror as violence is all in a day's work. (Evening Times, 3/4/07) and,

as reported by the BBC[1], inter-personal violence is not the only way in which teachers' authority is being violated:

Teachers 'are being bullied'.

Teachers have spoken about their experiences of being bullied, which is causing many to leave the profession.

Websites 'must act on bullies'

Teachers are urging websites like YouTube to help clamp down on cyberspace bullying.

Union debates cyber bullying

Members of the teachers' union, the NASUWT, will be discussing the issue of cyber bullying at their annual conference in Belfast.

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[1] The stories and headlines above and below were reported on BB1, 6 o'clock News programme on the 10th April, 2007. Accessed from http://search.bbc.co.uk/cgi-bin/search/results.pl?scope=all&edition=d&q=Teachers+being+bullied on the 10th April,2007.

Concerns over inter-personal violence in schools and hospitals are re-affirmed time and again in headlines, sub-headings and the content of numerous – several hundred - news articles I have collected and read over the period of the study and since formal data collection ended. While there was no systematic analysis of their content, they were read and informed the research process. For example, The Evening Times has called for the need to 'beat hospital thugs' (19/8/97) as 'Scots Nurses are "most at risk" of work attacks (4/10/98) and therefore there is a need to 'ban violent patients'. One director of an Accident and Emergency Department is quoted as stating,

> 'the celebrated position of violence in society has become a public health issue. ..... Violence must be regarded as a disease such as Aids or cancer'. (Daily Mail, 25/8/2001)

Whilst this particular media expose' is about the number of victims of violence ('Hospitals Swamped By An Epidemic of Violence') that are passing through accident and emergency departments - a 10-fold increase in the last 2 years - it also states that this 'growing strain on hospitals comes on the heels of worrying evidence of unprecedented violence within A&E departments.' Similarly, The Herald (18/11/97) reported that teachers were being taught how to defend themselves; The Evening Times that a boy was too wild to teach (2/1/98) and in another article that a child was suspended from school at the age of 6 because of an incident that was in the Head Teacher's opinion 'the ..... most violent in 20 years' of teaching (14/1/98); which cumulatively led to a demand for zero tolerance of violence in schools as reported in The Herald (6/5/2000).

The content of these news articles has been supported by comments from professional bodies and unions (Waddington et al, 2006:7) who share their concerns over the levels and types of violence experienced by staff in schools and hospitals: for example, The Royal College of Nursing are quoted as stating that '34 per cent of nurses directly experience violent incidents at work every year' (Daily Mail, 25/8/2001) and the Scottish Executive (2004) statistics recorded almost 7,000 incidents of violence in schools in 2002/03. On average that is around 1 incident per Primary School and 5 per Secondary School per year. Most recently a BBC1 documentary Panorama: GBH on the NHS (26/2/07) reported that there is a violent attack on staff in the NHS every 7 minutes. So while the media have been instrumental in bringing the issue of violence into the public arena they have focused on the content of inter-personal violent relations at the expense of deep, reflective analysis on why it is that these institutions are experiencing allegedly increasing levels of violence. A classic example of this sensationalised and inflammatory reporting that clearly labels is taken from the Leader in the Daily Mail (25/7/2001), and headed '**Violence needs a tough stance**'.

> '.... The damage done to the health service is not restricted to the financial cost. While young thugs are being given emergency treatment, other patients, including the elderly, are forced to wait longer for attention. ..... It is intolerable that members of our most caring professions ... should be subjected to violence and abuse. Besides increasing security at hospitals, staff should be permitted to refuse treatment to incorrigibly violent patients and exemplary sentences should be passed on those convicted of assaulting hospital staff. ..... The cause of violent crime is the

uncontrolled behaviour of vicious thugs ... and it is time our criminal justice system began to acknowledge that ..... It is time to return to a policy of realism, by locking up young thugs and throwing away the key.'

Printed media reports have been reinforced in TV news reporting and given rise to documentary coverage of violence as experienced at work by doctors, nurses and teachers. The example used here is of violence in an Accident and Emergency department but is indicative of the content of many documentary programmes on violence in schools and hospitals. 'What's the Story', screened on 27/1/98, opens with images of: Liverpool's elite armed response team sealing off the city's only accident and emergency department; with body armour and automatic weapons to protect a man with gun shot wounds; this accompanied with dialogue from the presenter: 'ER, GBH, how casualty is becoming a battle ground with violence directed against staff', and the images continue to show young males being escorted into the Accident and Emergency department by police/security personnel. The second programme in this series, screened on 3/2/98, opens with the same footage and goes on to explain: 'Being in the centre of Liverpool we have had a spate in recent years of gun shot injuries. Whenever the victim of a gun shot injury is brought in, because there's the chance that whoever it was who shot the person is going to come back and try and finish the job off, the police tend to arrive en masse wearing flak jackets and carrying sub machine guns' (What's the Story transcript 3/2/98). The programme then goes on to report that the police have been called to the A & E department of the hospital 'to handle over two hundred and sixty violent or disruptive incidents' and the hospital security staff were called to the department 1,700

times. However, while this seems a huge 'problem', without knowing how many casualties pass through A&E and also what the nature of these incidents were, we cannot determine whether this constitutes higher, lower or the same levels of violence as might be expected by those working in this area.

What was given less prominent coverage at the top of the programme was the way in which structural working practices can contribute to some of the violence experienced in the workplace. For example a consultant in the A&E department explained that:

> 'Triage is to sort. And patients are seen in order of clinical priority, not necessarily in order of the time of arrival. If someone arrives with a relatively trivial problem they are always going to be at the back of a queue which consists of people who are more seriously ill or injured than they are...... some patients are forced to wait several hours. And it's that sort of person who's going to become frustrated and act in an aggressive or violent manner. '

This is backed up by one of his colleagues who comments that,

> 'Waiting times have got a lot to do with it....' and that 'anger over waiting time is made all the worse by potentially aggressive or disruptive patients who may automatically go to the front of the queue – like those on drugs or those who are drunk'.

Essentially what is being reported is that violence gets attention as well as causing disruption and can also as a consequence of that disruption lead to more violence; an example of how violence can be experienced and perpetuated through time. Similarities can be found here with how violence is also being addressed in schools: disruptive and violent pupils get the attention at the expense of the rest of the class in an attempt to restore order to the class.

Furthermore, due to the development of technology, we hear of and are exposed to incidents of violence from around the globe within hours of them occurring (Jewkes, 2004; Boyle, 2005). Technology has also increased our exposure to violence through film, drama, and cartoons. Thus our understanding and experiences of violence are informed by these multi-media images to which we are constantly exposed. TV programmes 'continue to present far more violent crimes than occur in real life' (Lichter et al, 1991;) - Messiah, Midsomer Murders, Inspector Morse, Silent Witness, Waking the Dead, Taggart and Cracker to name but a few (Carter & Weaver, 2003, Boyle, 2005; Jewkes, 2004). For example, Messiah[2] depicts the story of a serial killer and the violent deaths of 6-9 individuals. Also there has been in recent years an increase in TV drama, especially in relation to the health service, (for example ER, Holby City, Accident and Emergency, Casualty) and to a lesser extent to education (Teachers, Grange Hill and Hope and Glory) which have contained scenes of violence against doctors, nurses and teachers. Waddington et al (2006:6) argue that 'fictional portrayals of hospital life ... emphasise violence, no doubt because of its dramatic appeal'.

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[2] Messiah – BBC1 3 episodes running after 9pm on Sunday 28/08/05 to Tuesday 30/08/05.

In their text, *Criminology*, Carrabine et al (2004:333) argue that 'in public opinion the overwhelming view is that there is a direct causal link between media violence and real violence.' Violence portrayed as entertainment in film and television dramas often exaggerates the occurrence of violence - it is seldom one murder or crime that is being investigated - but it is often a sub-text/theme, which can be minimalised, trivialised or even glamorised by the presentation format as it is the detective or investigator who is the real star and the violence the vehicle which allows them to shine. This combination of images on violence – fictional and non-fictional - means 'that maintaining a distinction between 'fact' and 'fiction' is becoming increasingly difficult' (Carrabine et al, 2004) and cumulatively multi-media reporting creates 'moral panic' (Cohen, 1972; Brown, 2003; Carter & Weaver, 2003; Critcher, 2003; Jewkes, 2004) over the levels of violence being experienced by doctors, nurses and teachers. What we are less mindful of is the editorial selection we are presented with. For example, the Scottish Executive (2004) statistics on violence in schools indicate that it is rising but they also stress in the report that this finding <u>is not necessarily valid</u> (original emphasis) and there are a number of reasons for this. Real increases are difficult to establish as improved reporting and recording procedures, along with other initiatives, lead to more incidents being recorded than previously: it does not necessarily mean that the number of incidents is actually increasing but that more experiences of violence are being caught by more effective data collection systems. Institutional responses to recording violence have not been consistent and therefore it is difficult to determine if violence is on the increase. The Royal College of Nursing have identified the need for more research claiming that 'there has been no dedicated survey of the wider effect ... street violence has on ... hospital services' (Daily Mail 25/8/2001). Indeed

the BBC1 Panorama programme mentioned above raised similar concerns and the programme's content mirrored the concerns raised in the programme 'What's the Story' of almost a decade earlier.

That teachers, doctors and nurses are the victims or targets of violent incidents is not in dispute but the contention is that reporting is problematic and does not enhance our understanding of the phenomenon. What it has done is draw attention to violence and associate it with a particular group, namely youths, and the implication is that they bring the violence of the streets into the Accident and Emergency department or school and visit it upon staff.

What has been outlined here is not intended to be a detailed discourse or content analysis of media representations of the phenomenon in question but a more general critique of how it has been problematised in the printed press, TV news, and documentary programmes[3]. The contention is that production process has inhibited a reflexive critique and produced a debate restricted to the elements of *'bad people'*, *'thugs'*, the *'poor quality of care and education'*: incompetent staff delivering a poor quality service; or at the political level, *'too many policy changes without the necessary resources'*: public expectation of service provision has been raised beyond the ability of the institutions to deliver. The media have also raised public awareness of individual rights and what they can expect from the introduction of parents/patients charters. This type of reporting has created a confusing and conflicting picture for the public, produced a fragmented analysis of violence by focusing on a particular point of view at a given moment in time (Carter

[3] The programmes referred to above were: Dispatches screened on Channel 4; Classroom Wars and Frontline Scotland screened on BBC1; and What's the Story? screened on Channel 5.

& Weaver, 2003), and subordinates the debate on violence at the political and institutional level by focusing on the interactions between individuals – doctors, nurses, teachers, patients and pupils.

What is evident is that violence in these two social institutions is newsworthy, increases our concerns and anxieties about violence, draws our attention to victims and perpetrators and has restricted the debate to that of social control. Hallsworth (2005:100) argues that 'any comprehensive explanation of [violence] must draw upon the insights of many theories, rather than find truth in the application of one theory alone'; or alternatively it could be argued that we need a new approach altogether.

For this reason it is necessary, in order to examine violent experiences in the context of work, to include the relationships of the victims with the institutional organisation in order to move analysis beyond the media report of *bad people, social mores, or cultural values* that are brought into the institutional setting; but to understand why these particular institutions are vulnerable.

1.5 The problem defined

The 'problem' of workplace violence lies in fully understanding what 'it' is. Gabe et al (2001) found that there is 'very limited current empirical evidence to assess such claims' as have been reported in the media. And Waddintgon et al (2006:8) report that there are also contradictions to be found 'between the BCS[4] and the picture painted by the generality of discussion on workplace violence' and that work-related violence is neither as prevalent

[4] BCS - The British Crime Survey (Budd, 1999 & 2001; Upson, 2004).

nor increasing as many commentators would have us believe'. Current reporting and recording mechanisms for workplace violence have been criticised by Leather (2002), Tombs & Whyte (2007), and Gill et al (2002) for example.

This study aims to explore and better define 'what is gong on?' and to extend current media led understanding of workplace violence by examining 'the nature, extent and perceptions' of doctors', nurses' and teachers' experiences of violence in the institutional setting of hospitals and schools . It critically examines:

- how these employees define incidents as violent;
- the relationship between this type of violence and other types of violence;
- the inter-subjective nature of workplace violence: the relationship between violence and organisational structures, policy and delivery of services; and
- the interactions within classrooms, hospital wards, and accident and emergency rooms which form the context in which this violence occurs.

It is primarily concerned with violence that is perpetrated by client groups against staff in these institutions. It seeks to understand from the victims' experiences how they perceive and define violent incidents. This raises a number of important questions that need to be addressed:

- What is actually happening?

- How is violence experienced by employees working in hospitals and schools?
- How do they define violence?
- Is it new or is it newly discovered by the media?
- If not new, has the experience of violence in these institutions changed?
- Who are the perpetrators?
- Does it affect their ability to work effectively?
- Are there particular work areas where they are more at risk of violence?
- What is the inter-subjective nature of violence in these institutional settings?
- Have changes in policy had an influence on the experience of violence?
- How can we analyse violence in these institutions in order to extend our theoretical understanding of it?

It is important to differentiate between other forms of violence in institutions and the type of violence in institutions that is being analysed here. Academic and professional research looking at workplace violence has identified three basic categories. For example,

- Goffman's 1961 work *Asylums* has indicated that the bureaucratic process of living within institutionalised settings – psychiatric hospitals or prisons, for example - is so regulated that it isolates individuals from normal daily routines.

- Corporate violence, which is largely in the domain of the HSE and is concerned with the exploitation of workers' rights within organisations, for example violations of health and safety regulations and/or bullying from other colleagues or line managers; and
- Inter-personal violence whereby the workplace setting perpetuates discriminatory practices against particular groups of individuals - for example, racial or sexual discrimination and/or abuse.

This study as is discussed in the following chapter, Chapter Two, is concerned firstly with violence that is brought into the institution: violent patients, pupils, parents/guardians, and visitors who commit violent acts against those working within the institutional setting. It does not explore the motivations or intentions for violence as time and space as an individual researcher precluded me from doing this. This is not to be judgemental, nor dismissive of the role that institutions may or may not play in the incidence of violence. It is firstly to examine the interaction between those who perceive themselves as victims; and then to examine the responses to that within the context of the institution - how they interpret, react and respond to violent incidents against their employees .

1.6 The structure of the thesis

The following chapter, Chapter Two, examines the existing literature – academic and professional – on violence and violence at work. It is initially concerned with critiquing current definitions, forms and categorisations of violence and the importance of looking at institutions in relation to violence

at work. It seeks to show how current conceptualisations of violence within institutions encourages a fragmented rather than an integrated analysis and argues the case for a new approach to contextualise experiences of violence in the context of working institutions.

Chapter Three presents an alternative frame for analysis and introduces the concepts of Bourdieu. It is argued that his concepts of Fields, Habitus and Capital provide a theoretical framework that contextualises the habitus of the school and hospital in the political and institutional fields that shape and define the form of services delivered in the habitus. Capital it is argued is a useful concept for theorising violence in the negotiations that take place between fields, within fields, between fields and habitus and the interactions between professionals and the general public.

Chapter Four outlines the mixed methodological approach - qualitative and quantitative – and the various research tools designed for data collection. The research design also follows a Bourdieusian perspective as his theory implies that methods cannot be divorced from theory. This chapter also provides a commentary on the research process: the main problems encountered; reflections on that process; and a brief summary of the sample group.

Chapter Five provides a contextualised view of the two research sites and draws from the research findings to examine their experiences of violence in the institutional workplace. Statistical and qualitative data from the questionnaires, focus groups, and interviews are used to define violence from the institutional professionals' perspective. It also examines the main

findings from the data on the effects of institutional working practices and institutional definitions of violence on their experiences. The following four chapters are concerned with analysis of this data.

In Chapters Six, Seven and Eight the concepts of Fields, Habitus and Capital are used to explore three key areas emerging from the data. In Chapter Six the way in which the institutional working procedures for reporting and recording violent incidents expose these professionals to the possibility of increased risks or repeated victimisation from violent attacks is examined. In Chapter Seven, the relationship between mental ill health and violence is explored in relation to the perceptions and experiences of violence of these professionals and Chapter Eight examines the gendered dynamics of social and institutional culture in relation to the experiences of violence and the gendered nature of these two workforces.

A summary of the main findings and conclusions from the study can be found in Chapter Nine. This chapter analytically draws from the data to show that understanding the context of violence can yield more meaningful explanations of violence for service delivery.

Chapter 2

Contested Definitions of Violence

2. Introduction

Chapter One has outlined how the media have problematised workplace violence in schools and hospitals as inter-personal violence but this only provides a partial and incomplete picture which is problematic for understanding of this phenomenon. This chapter will examine the existing literature – academic and professional – on how historical, political and legal discourses have informed our cultural and social construction of definitions of violence. Specifically it is concerned with how contemporary social and cultural constructions of violence and their focus on the criminality of it have influenced how it is understood and defined in these institutions and how this is important for analysis and future policy interventions.

It will critique definitions, forms and categorisation of violence and examine how current conceptualisations of it in institutions have encouraged a fragmented rather than an integrated analysis of violence at work - fragmented in that analyses of violence thus far have been concerned with understanding and explaining it in discrete categories – racial, domestic, and inter-personal for example. While current conceptualisations locate it within the institutional site they have not integrated analysis into the institutional organisation and working practices.

Contemporary studies identify that there is not a standard fixed definition of violence (Jones, 2000; Levi & Maguire, 2002; Stanko, 2003; Catley, 2003a), and the multiplicity of issues raised (Hearn & Parkin, 2001) in attempting to

define it, along with the fact that its 'scope and meaning change through time and from space to space' (Keane, 1996:65) highlight its complex and contentious nature (Budd, 1999): violence is an issue that clearly needs to be addressed. However, definitions of violence are strongly linked with the criminality of interpersonal violence and are therefore more concerned with bringing perpetrators to justice and imposing sanctions upon them for committing the offence than on understanding how the events also affect the victims, whether physically, psychologically or emotionally (O'Beirne et al, 2003; Leather, 2002).

In recent times there has been increased concern about workplace violence the significance of which is demonstrated by its recognition at the political level: '[s]ome politicians, public commentators and some educators currently focus on a perceived increase in violence to the person within and around schools' (Watkins et al, 2007:61). For example, concern about violence, including violence in the workplace, is reflected in the support for the Zero Tolerance campaign given by The Scottish Executive. Andy Kerr MSP (then Minister for Finance and Public Services) states that:

> 'No one should ever have to face violence and abuse as part of their work. Yet there is mounting evidence that many of those serving the public risk being physically assaulted and verbally attacked at their work. Every day, public service workers are confronted with hostility, aggression and even violence from their 'customers' as a matter of course. That cannot be allowed to continue.' (Scottish Executive 2004: Ministerial Foreword)

Indeed the then First Minister, Jack McConnell MSP, has been variously quoted in the printed press, news bulletins and political documentaries to the effect that those working in the health and education sectors in particular should not be subjected to violence in the course of their work. In particular the British Crime Surveys (1999, 2001, 2004) consistently show that both health workers and teachers along with prison and police officers are in the category of 'at risk' from violence at work.

The literature suggests that there is more to be understood about experiences of violence and in particular about violence in hospitals and schools than the interactions between professionals and their client groups. Institutional practices also need to be explored if we are to succeed in implementing effective interventions to reduce and/or prevent the exposure of doctors, nurses and teachers to violent attacks at work. Workplace violence is not simply a matter of criminal behaviour, but one of understanding schools and hospitals as institutions of contested meanings, where there is also likely to be misunderstanding and misinterpretation. Institutional professionals have dual identity as civilians and as professional doctors, nurses or teachers. For example, their institutional roles are inscribed with meanings that define what they do, but also accord them a social status (Bourdieu, 1977; Jenkins, 1996; Goffman, (1961); Hearn & Parkin, 2001). How these boundaries – between the social and institutional - are negotiated in service delivery is also important for understanding violence in the workplace. The social identity or experiences of institutional personnel are likely to have bearing on how incidents in the workplace are viewed, interpreted, experienced and ultimately defined (Bourdieu 1990; Jenkins, 1996; Hearn & Parkin, 2001).

Schools and hospitals as institutions are recognised as a 'nexus' of contested meanings – cultural, political, institutional, union and personal - regarding practices, resources and the professional/client interface. 'Many organisations are definitively in the business of allocating resources or penalties to non-members; they organise the social world' (Jenkins, 1996:157) and therefore create boundaries: insiders and outsiders who have to negotiate institutional structures from different perspectives. Therefore violence in institutions is more than a matter for the police and criminal justice system where once the sentence has been conferred on the perpetrator that is usually the end of the interest in official and legal discourses. How such distinct boundaries have been constructed is, as remarked above, a product of the historical and cultural process of defining violence, which is examined in the following sections.

2.1 Defining violence: cultural, social and legal constructions

This section will explore historical perspectives and how these have informed views on legitimate and illegitimate violence which have become established in the dominant political and cultural understandings in defining it. Society generally has tussled with meanings and definitions of violence; historically it is associated with disruption within and between societies. There is no consensus on how violence is defined and understood (Stanko, 2003: Jones, 2000): definitions vary over time and between cultures and 'depend on the specific cultural and situational context in which it is manifested' (cited in van der Knaap et al, 2006:19). Understanding how violence has become defined and understood in form and type is embedded in our historical and cultural definitions, and re-definitions of it are reflected in the social mores of institutions. The state through legal and political

processes has the power and authority to determine legitimacy and inform institutional definitions of violence; social perceptions are often informed by media representations which in turn are surely affected directly or indirectly by powerful definitions. Therefore, criminal violence and the sanctions that it carries are state defined in our legal system. The same system, the 'civilised' state, also has the power to legitimise the use of violence.

2.1(i) The macro context

Harris (1980) argues that violence is associated with decay and symbolically at least reviled by governments, but when it has to be confronted 'unprecedented' resources are deployed - for example, the war in Iraq and more recently the events that have followed the alleged 'terrorist' attacks that occurred on the London Underground on 7/7/05. Essentially it is argued that all societies are violent (Ray, 2000 & Harris, 1980) and that 'violent images' permeate all life from the beginning (Jones, 2000). Significantly, irrespective of the site or the scale of it, violence is generally perceived as something that disrupts normal patterns of social behaviour and includes many different forms of behaviour (Ray, 2000 & Thornton, 1995); and we all know when we feel violated.

Theoretical and historical perspectives have focused on the transitions from pre-existing, precarious, barbaric societies to modern or 'civilised' societies; depicting the changing attitudes towards social relations and the acceptance of and compliance with the regulation of the exercise of power. Elias argues that civilisation 'develops through "inter-group tensions and rivalries", that is in the "formation of group identities, world-views and personality structures among particular social classes within the country and between

..... nations"' (cited in Fletcher, 1997:7). Civilised society is then identified by its lack of overt violence: defined and codified by the state and its legal processes which Ray (2000) argues has effectively made violence a sub-category of power. Violence in the process has shifted from overt to more sophisticated, less visible, forms that are embedded in our legal and criminal justice system. For example, as argued previously in Chapter One, violence has become obscured behind other terms such as assault, battery or murder.

It is inscribed in the political structure of cultures. This Bourdieu refers to as '"symbolic power" (or, in some cases where it is thought to be unjustly oppressive, as "symbolic violence")', symbolic in that 'in the routine flow of day-to-day life, power is seldom exercised as overt physical force: instead it is transmuted into a symbolic form, and thereby endowed with a kind of legitimacy that it would not otherwise have' (Bourdieu, 1991:23). The political and institutional organisation of society is an example of this symbolic power. Stanko (1994:xiv) states that 'Symbolically, violence is used as a barometer of how civilised a society is'. Therefore as social relations between, and conditions within, countries have stabilised the occurrence of overt violence has declined, has become symbolic in nature and been codified in particular ways between legitimate and illegitimate or criminal violence; but it has not disappeared.

2.1(ii) Violence - legitimate and illegitimate

Legitimate violence, associated with the protection or maintenance of the 'democratic state' or 'capitalist economy', is likely to be justified through the language function which effectively excludes the state from the sanctions faced by illegitimate 'terrorist' or 'partisan' violence (Nardin, 1971; Jones,

2000). Nardin (op cit) argues that 'violence' appears in a variety of contexts and exploits a variety of language functions. For example, language is not only used to report it but it also has the capacity to moderate – by tone and expression – the severity of it.

Violence legitimised by the state also has many forms (Connell, 1977), including sports (boxing) and policing, and under the 'common law rule' parents are permitted to use reasonable corporal punishment on their children (Jones, 2000) and '[t]here is also growing concern with the relation of sports violence, peer group support and sexual violence' (Crosset, 2000; Steinberger, 2001; DeKeseredy, 1990. cited in Hearn & Parkin, 2001:67). Consequently, there are many examples of legitimised violence to be found in contemporary societies, where use passes without question – it is an accepted practice and not defined as violence.

Through the formation and stabilisation of the state, violence has become contextualised within the discourse of law and criminal justice systems which has focused on illegitimate violence. However, violence is not simply explained as legitimate, state-sanctioned and illegitimate/criminalised violence. Ray (2000) argues that the most destructive form of violence is that of legitimised or state organised and sanctioned violence. Military violence is one such example, a form of legitimised violence which is disassociated from individual violence and is legitimised through political or governmental processes whereby violence is justified by competing groups - in modern day society usually political factions or governments - as being necessary. However, it also is evident through our cultural institutions, most notably the police and prison services and more subtly, or symbolically, in

our other institutions of health, education, social work, and housing for example.

2.1(iii) Dominant values

Violence has become the 'theme of evolution; psychologically the corollary of human nature; educationally, the enemy of learning; socially, the wrong road to change' (Toch, 1969 cited in Harris 1980). It is strongly linked with the concept of 'power', and inscribed in the power of the organised state; the powerful not only have the opportunity to define but also the power to implement. Therefore the state is 'that agency within society which possesses the monopoly of legitimate violence' (Max Weber cited by Gellner in Giddens, 1992:132). Bourdieu argues that exercising and perpetuating such power and control is more complex, as '[a]ll symbolic domination presupposes, on the part of those who submit to it, a form of complicity which is neither passive submission to external constraint nor free adherence to values' (Bourdieu, 1991:51). Violence involves participation in the form of resistance – making a stand in opposition to the dominant discourse of power (Hearn, 1998).

Violence or violation is for Hearn and Parkin (2001) more than an institutional or state attempt to gain control or enforce compliance with a particular political view but it is 'forms of power, domination and oppression in themselves that structure organisations' (op cit, 2001:19). While definitions vary on what violence is, it is more commonly linked with interpersonal, physical and verbal forms of it whereas 'violence as violation' refers to 'structured oppression, harassment, bullying and violences, and mundane, everyday violences within organisational worlds' (op cit, 2001:18).

Kimmell (2000) argues that the military also has a much wider influence on how violence is perceived and defined: not only is it a legitimised form of violence - so embedded in our culture that its uses and abuses are commonly accepted if not entirely agreed with - but it has gender implications as well; military images and euphemisms create particular forms of masculinity. Enloe (1987) also argues that this is as a result of political choice and can be seen in the 'maleness' of the state, its institutions and organised violence. Hearn and Parkin argue that 'most organisations are doubly gendered' (2001:9), firstly because being in the public domain they dominate over the private and secondly because they themselves are gendered; organisational working is gendered in distribution of men and women and in the roles men and women perform.

Institutions control access to and use of the services provided by them; there may be equity in access to them but other social, cultural and economic factors impact on the ability of individuals to utilise these services. Thus exercising power is only part of a more complex and interactive process. Institutions sit at the centre of that process; they are the public face of the political state in which they are located; they are imbued with institutional practices that are a reflection of the prevailing political ethos; which are socially interpreted. As Ruggiero (2006/7:26) states '[c]lassical criminology, for instance, focuses on institutional violence and warns that this violence may be replicated by oppressed people in the form of violent anti-institutional outbursts. Excessive authorised violence, according to Cesare Beccaria, provokes unauthorised responses in kind…'. This however, while recognised and understood at state levels – coup or revolutions – is less

obviously accepted as a possibility in the internal relations of relatively stable countries.

2.1(iv) Definitional issues

Some forms of violence are criminalised within the legal system but other forms are not. Hearn and Parkin (2001:68) point out that '[t]he definition of physical violence is thus closely bound to legal and criminal justice definitions and their distinctions between different kinds of assaults and worse'. Croall also points out that 'official categories of violent crime include offences of homicide, grievous bodily harm, wounding or actual bodily harm' but that not all crime statistics include 'sexual offences, such as rape and sexual assault, and robbery as violent, or contact crime' (1998:175). Crime statistics are also problematic in that they only reflect reported, prosecuted and convicted offences and so obscure the full extent and range of experiences of violence. There are numerous reasons why it is felt violent crimes go unreported (Owen, 1998; Peterson et al, 1999; Beale, 1999; Jones, 2000) which is discussed in 2.3 below.

However, Hearn (1998) points out that there is also the need for the social experiences of violence to be taken into account; he argues that the *doing* of violence is integral to the *construction of its definition* and furthermore that the more violence we are exposed to, and the greater the intensity of it, the more likely it is that it will be taken for granted. However, the greater the awareness of violence is, the more likely it is to be identified. These two statements may seem contradictory, but apply equally to this study for different reasons: 1) it is the taken-for-granted component of the violence being experienced that is being contested; and 2) increased awareness that

there may be a problem has impacted on institutional procedures which has resulted in evidence/data now being collected on incidents of violence. This data has been used to suggest that violence in the workplace is something new, something that is increasing when in fact we have no *hard* evidence to support this contention.

2.1(v) Context specific

Changes in cultural practices and beliefs inevitably impact on how violence is defined; as Nardin (1971) indicates, interpretations of violence are very subjective as even within societies we do not all share the same experiences - consequently some actions that are acceptable within one context may be read as bizarre, incomprehensible or illegal in another. Therefore different understandings of what is violent exist but few things evoke more concern (Harris, 1980). This also means that actions and behaviours may have different meaning for those who become defined as perpetrators or victims. Social class, age and gender all shape our understanding and experiences of violence and highlight the possibility of misinterpretation or misunderstanding.

Institutions Catley (2003a) points out 'are 'sites of violence of a rich and varied hue' (Westwood, 2003:275). Yet despite these sorts of claims, violence remains marginalised as an analytic perspective in mainstream and critical approaches to management and organisation studies' (Hearn, 2003; Hearn & Parkin, 2001). They also note that statistics on workplace violence are not reported in a unified manner. They are mostly 'surveys of incidence, safety and/or risk in specific work sectors' (Cardy, 1992 cited in Hearn & Parkin, 2001:68). Challenging these issues in relation to organisations working it is

argued will 'draw attention to omissions in understandings, challenge 'common sense' or question deterministic accounts of management and organisations' (Catley, 2003a). At an interpersonal level experiences of violence can create fear - fear of future violence. How this concern is articulated is integral to our understanding of definitions of violence. Consequently, what we have is not a single discourse on violence but a multiplicity of discourses which has resulted in definitions of violence becoming context specific. The following section will examine contemporary debates on definitions of violence.

2.2 Current debates – academic, methodological and policy

This section will examine the contemporary academic and policy literature on violence and methodological considerations for researching violence. Perceptions and meanings of violence are an evolving process, built on historical and cultural definitions (Messerschmidt, 1997; Walby, 1997). More generally the use of the term 'violence' is taken to imply 'that a problem exists: that something is seen as unacceptable or threatening...' (Hearn & Parkin, 2001:17). The types of behaviour defined as violent irrespective of where they are encountered depends upon them being recognised by the 'dominant political, social and legal constructions of violence' by which, Whyte & Tombs (2007) argue, they are overwhelmingly influenced. Differing definitions are more likely to be marginalised by the dominant discourse.

2.2(i) Contemporary definitions

In recent years there has been increased interest in violence. Violence in a variety of social and workplace settings has become the focus of researchers.

However while this has expanded knowledge on the breadth of experiences of violence as discussed below, Tombs and Whyte (2007) argue that definitions 'fall within certain limits, upon a fairly narrow terrain'. It is clear from the 'historical analysis of the changing recognition of what counts as (forms of) violence (Hearn & Parkin, 2001:17)': legitimate and illegitimate forms of violence, symbolic violence, gendered violence, criminal violence, racial violence and institutional violence that definitions of it have been subjected to re-definition over time - what was once acceptable, for example capital punishment is now no longer acceptable in Scotland - and they vary between cultures - capital punishment is still acceptable in other countries around the world.

Forms of legitimate violence can become illegitimate or criminal as social attitudes and values change; for example, corporal punishment, once commonly used in schools to punish or maintain discipline and control, is no longer allowed within our education system (Jones, 2000). Similarly other behaviours that had no recognition in law have become criminalised; Yar (2006:126) argues that the 'rise of stalking as a criminal category can be seen to owe much to shifting perceptions about just what kinds of behaviour constitute a social problem and public concern.'

Definitions of violence have been restricted to the inter-personal, physical, random to the exclusion of other experiences of violence and are strongly associated with forms of masculinity (Hearn, 2001; Kimmell, 2000; Bowker, 1998; Messerschmidt, 1997, 2004; Connell, 1995). For example, Neilson (2002) found that the experience of insults delivered by strangers in public places left victims feeling fearful, intimidated and threatened. From this

perspective, insults are themselves forms of injury, with effects every bit as real as those resulting from acts of physical violence (cited in Yar, 2006:101). Cultural, class and gender relations, for example, also affect our experiences and understanding of what is and what is not violence – we do not all define violence in the same way. Edgar & Martin (2000), Messerschmidt (1997), Batchelor et al (2001), Richardson & May (1999), Stanko (2000), Waddington et al (2006) amongst others have all argued the importance of understanding the meanings of violence: 'the meanings of violence are multiple, complex and often contradictory' (Stanko, 2003:4).

The changing meanings and perceptions of violence have been extended by the ESRC Violence Programme which examined '...settings where violence took place or was mediated by its environment (in prison; in the night-time economy; in children's residential homes, in schools, in settings of prostitution, in neighbourhoods, in professional settings such as health or the church)...' (Stanko, 2006/07:32). There has also been research on women's and girls' involvement in violence (Burman et al, 2001; Batchelor et al, 2001; Morrisay, 2003; Chesney-Lind, 2004; Alder & Worrall, 2004) where it is argued that understanding of girls' involvement been reduced to that of 'troublesome' when in fact as Burman (2004) states, young girls themselves 'interpreted *violence* (original emphasis) much more widely and loosely: they 'talked about a much broader array of diverse behaviours and incidents, including stalking, boxing, sex-racial harassment, self-harm, offensive name calling, bullying, and intimidation as well as vandalism, fire-raising, and cruelty to animals' (Burman, 2004, in Alder & Worrall, 2004:84). These 'definitions' of violence have contributed to the demands for it to be

understood in its widest terms and indicate that meanings and experiences of violence mean different things for different groups of people.

2.2(ii) Definitional issues

It is not only how a problem is presented but also how we come to identify it and its association with violence in our society, and how that affects our understanding of this 'problem', that also has to be examined. Narrow definitions of violence reduce understanding and meanings of it to that of the 'troublemaker' - usually the 'outsider' - who causes trouble. Yet, de Becker (1997:15) argues, '[t]he human violence we abhor and fear the most, that which we call random and senseless, is neither. It always has purpose ... and as long as we label it senseless, we'll not make sense of it.' Therefore this reliance on the physical and perpetrator-motivated violence perspective is drawing from a limited range of variables that prohibit rather than illuminate the possible causes of violence.

Other definitions of violence range from those which only include physical assaults to broader definitions which also include threats, intimidation, verbal abuse, and emotional or psychological abuse. However, it is much more difficult to establish or quantify levels of non-physical violence as the effects are not visible and are dependent on the victim reporting their experiences as violent through some mechanism where they would be recorded. For example, depression may be a result of domestic abuse but unless this is identified as the source by the victim or patient the doctor may not pick this up. Regardless of the scope of the definition of violence applied, there are likely to be problems – too narrow, and many experiences

of violence are excluded; but too wide is also problematic as Elston et al (2002:581) observe:

> '[b]roadening the definition of violence beyond actual physical assaults, especially if accompanied by the adoption of more systematic and comprehensive incident–reporting schemes, is likely to lead to an artefactual increase in the reported incidence rate'.

This 'artefactual' increase should not be an issue of concern, as collecting more data on violence can only enhance knowledge and understanding of it. Ryder (1994) states that violence can be divided into two fundamental categories – individually motivated and culturally caused – and that there are four types: emotional, such as in reaction to fear, anger or frustration; pathological, either through the use of drugs or drink and in some cases as a result of a physical abnormality in the brain; instrumental, to gain rewards, power or control over others; and culturally–determined, as a result of membership of a sub-culture and a desire to conform to that culture's norms. This indicates the need for a wider understanding; one that includes verbal and psychological forms which Flannery at al (1995) argue is now becoming more common. Understanding violence in its broadest terms is supported by Hearn (1998) who contends that it should not be viewed as a 'thing'; it is a 'a word, a shorthand, that refers to a mass of different experiences in people's lives (op cit, 1998:15).

However, Stanko (2006/07) argues that interpretation is often linked to the context, in which violence occurs and this is where the necessary information

to understand and react to violence is to be found. 'It is this context riddled with information of how the structures and spaces of inequalities sustain violence and abuse that enables us to devise protective factors to minimise the harm – and the sustenance – acts of violence take from the situation/environment within which they take place. For example, racist violence may be exacerbated by housing policies, school policies or prison policies' (op cit, 32). The context of violence is all-important for devising preventative and interventionist procedures. She argues that we must 'continue to ask why the contexts of violence are invisible ... and demand that the context of violence is known as much as possible' (op cit, 32). Narrow definitions, as McCreadie (2000) observes, inhibit understanding of violence in the wider context as it can only be interpreted in relation to its definition.

2.2(iii) Definitions and context

More recently there has been increased research interest in the meanings and experiences of violence in a variety of social settings. Definitions 'depend on the specific cultural and situational context in which it is manifested' (cited in van der Knaap et al, 2006:19). Understanding and defining experiences of violence in organisations is dependent upon understanding the relationship between organisations and their members. Any definition of violence has to take account of the experiences of those who are affected by its occurrence which makes it very problematic because as Leadbetter (1993) argues if the victim experiences it as violence, it should be treated as such; however we don't all share the same interpretation. There is an over-emphasis on the physical; it 'takes precedence of the psychological injury' (Featherstone & Trinder, 1997).

And as Catley (2003b:6) points out there is a lack of curiosity about violence which has 'left us with a very familiar concept of violence ...[as] interpersonal, physical and illegitimate' which reduces understanding of violence to 'a technically rational set of "procedural issues" (Mullen, 1997:22). This she argues means that the relevant points are obscured and consequently important questions about the working of institutions are never asked. For example, have the new policies introduced in recent years in both institutions of Education and Health changed or altered forms of management and organisational working practices? Established workplace practices may have been destabilised by these new forms of management.

Institutionally understanding violence in the workplace is important as it has specific costs for them as well as the individual. It is not simply an issue of violence against an individual but against the organisation and it has implications for workers, clients, services and institutions. Cooper et al (2003) and Hogh et al (2003) also found that the costs can affect 'recruitment, retention, absenteeism and ... work performance' (cited in Waddington 2006:5) which has a damaging effect for both the individual and the organisation (Leather, 2002).

2.2(iv) Categorising violence

The over-reliance on an understanding of violence as a physical act has fostered a scenario where other forms of violence are being subjectively defined. For example, Deeney and O'Beirne (2003:61) found that amongst probation officers for example, '[v]erbal abuse had to a large extent become a normalised form of occupational hazard', whereas Catley comments on how '[w]ords can, in the act of their saying, inflict harm. Words wound.

...[C]hildren know, words are powerful weapons to be wielded in the classroom and the playground.' (2003b:10/11). There are some cases and instances when to say something is to do something' (Austin, 1975:12). This highlights the importance of understanding experiences of violence from the victim's perspective and in the context in which it occurs. Communication is central to the effective delivery of services in schools and hospitals and therefore the potential harm to employees and the institution as a whole from unrecognised violence is enormous.

As Baines (2005) states, at the interpersonal level, workplace violence also includes, 'punching, gouging, kicking, pinching, hair pulling, biting, wrenching, choking, verbal abuse, or threats against staff members, their families or property' (op cit, 2005:132). Furthermore the issues faced in schools and hospitals are complex and varied and include 'assault, theft, vandalism, robbery and breaking into the school', that would in everyday life be deemed acts that break the law but are often treated by the schools without 'intervention of outside agencies' (Boxford, 2006:31).

2.3 Violence in the workplace

This section examines the literature on workplace violence and explores how the issues raised are challenging existing conceptualisations of violence. Workplace violence is a global issue and has many forms (Chappell & Di Martino, 1998; Waddington et al, 2006), for example, 'the landmines and 'booby traps' facing international peacekeepers, the ill treatment and abuse of migrant workers, racial and sexual discrimination at work, as well as the more 'local' problems of aggression and antisocial behaviour faced by the

teacher, nurse, police officer, bar tender or sales assistant in the course of their normal daily round' (cited in Leather, 2002)

Waddington et al (2006:xi) argue that since the 1980's there has been a 'burgeoning of workplace violence' interest - for example, Gill et al (2002), Bowie et al (2005), Waddington et al (2006), Wells & Bowers (2002), Paterson & Leadbetter (1999), and O'Beirne et al (2001). However, Williams (1994) states 'the issue of workplace violence becomes a response or reaction to an unexpected, unexplained, unwarranted change in a policy, procedure or practice that creates trauma among employees and in the organisation itself' (cited in Gill et al, 2002:13). For example, Einarsen (2000) found that distressed victims can react in a number of ways and may 'violate expectations, annoy others, perform less competently and even violate social norms describing polite and friendly interactions and hence elicit aggressive behaviour in others' (cited in Bowie et al, 2005:238).

2.3(i) Definitions of workplace violence

Establishing the extent and diversity of experiences of violence in the workplace highlights the difficulty of understanding and defining it. Waddington et al (2006) remark on how 'researchers, campaigners and official bodies' have advocated the inclusion of a wide spectrum of behaviours to be included in any definition of violence beyond that of the 'physical'. And Catley (2003a) argues the way in which workplace violence has been problematised as a 'new' problem, [also] makes apparent the close association of violence to the history of organising work and work organisation'.

For example, as Harvey et al (2002:42) state:

> 'Historically, workplace violence was narrowly defined to include only physical assault or homicide that occurred at the workplace. The general tendency now is for definitions to widen the scope over time in parallel with the greater public and professional awareness of the problem. Thus in some circumstances the understanding of what constitutes work-related violence has been expanded to encompass forms of aggression such as verbal threats, abuse, harassment, any assault or threat that cultivates psychological harm, personal or motor vehicle theft and self-directed harm.'

Yet, 'violence is rarely seen as a public health problem (Shepherd and Farrington, 1993 cited by Stone in Bradby, 1996:14); despite that it can have emotional effects that are present long after the initial incident - for example, fear of future or recurring violent incidents. O'Beirne et al (2004:115) found that fear of violence is heightened amongst some groups of workers and is related to the types of jobs they do, the context of what they do and with whom they come into contact. 'Even in severe cases the injuries are more often emotional than physical, difficult to define precisely and many manifest as stress-related illnesses' (Chappell and De Martino, 1998). These experiences are compounded by feelings that the law provides insufficient protection (Gill et al, 1998).

2.3(ii) Risks from violence

Institutions as complex social organisations as Bowie (1998) argues, by 'knowingly placing their workers or clients in dangerous or violent situations [are] allowing a climate of abuse, bullying or harassment to thrive in the

workplace (cited in Gill et al, 2002:12). Institutional practices and roles often carry high levels of risk, especially when they involve working with the public. Experience it was found is often the best indicator of when situations are liable to turn to violence (Baines, 2005). As Denney and O'Beirne (2003:58) point out being aware of such information, or indeed even knowing who the potentially violent clients are is not the same as being able to choose not to work with them.

The caring and public service professions – health and education – are perceived as professions where staff are at a higher than average risk of violence in the workplace (Waddington, 2006; Baines, 2005; Brockman & McClean, 2000; Bowie et al, 2005; Gill et al, 2002; Denney & O'Beirne, 2003; Gill & Hearnshaw, 1997; Elston et al, 2002; Leyden, 1999). Although Waddington et al (2006:39) report that 'the experience of overt physical assault was relatively uncommon' they noted that 'A&E staff were vulnerable to overwrought and often intoxicated patients' (op cit, 40), and Boxford (2006:29) states that '...present[ly] in the UK, schools operate in a particularly challenging environment'.

2.3(iii) Nature of workplace

Bowie et al (2005) argue that a number of key issues are emerging from the growing body of research that deserve special attention in order to address the issue of violence in the workplace. The following points are of particular interest to this study:

- the recognition of both physical and psychological violence and their intrinsic inter-relationship at work

- the recognition of the gender dimension of workplace violence, affecting both men and women
- the recognition of the special impact of violence on vulnerable workers
- the recognition that only part of workplace violence is disclosed and that a large part of it is still undisclosed
- the recognition that some workplace situations are especially vulnerable to the risk of violence
- the recognition that workplace violence is an inter-personal, organizational and environmental issue.

(adapted from Bowie et al, 2005:31/2).

Violence from clients in the workplace is the unexpected, but as Kenny (in Gill et al, 2002) argues it 'has become too common, too dangerous for us to be surprised and unprepared' (op cit, 76). Previous research has found that workplace violence 'is most often a result of an outsider preying upon an employee' (Arway in Gill et al, 2002:41) and that 'most violent clients are male and have a history of deliberately using aggression and violence to gain control over people (Newhill, 1996; Morrison, 1992; Schwartz and Greenfield, 1978) but in some cases the violence was not directed towards the worker as an individual, but as a representative of the institution. Violence is then being contextualised as a workplace 'risk practice'; accepted as part of the job and is being dealt with within the institutional context and not recognised as severe enough to involve outside agencies such as the police, which has implications for determining the scale of the 'problem'.

2.3(iv) Concerns over violence in schools and hospitals

The various unions and professional organisations who represent teachers, doctors, and nurses strongly identify the interpersonal nature of violence in schools and hospitals. Their concern is with employment safety and risk management/assessment to protect staff from further violent assault. They are supporters of, and partners in, the Scottish Executive Zero Tolerance campaign against the use of violence. Their concern is with how to control or exclude those who offend and in particular with addressing the criminality of these attacks. The unions then are mainly concerned with challenging the view of violence as 'part of the job' and they emphasise the need for more involvement from law enforcement agencies in dealing with violent incidents. This highlights the tensions between the perspectives of the employee and the employer as the evidence from the growing literature on the experiences of workplace violence in a variety of contexts has indicated the need for staff training in prevention and de-escalation of violent incidents; as Waddington et al point out there is 'no shortage of advice for staff ...; training manuals abound ... but ... whilst [they] may contain valuable lessons, they grossly over-estimate the extent to which it is practically possible to avoid difficult encounters' (2006:177). As Lewis & Rayner (2003) point out 'the presence of policies and procedures is no guarantee against bullying and abusive behaviours per se' (cited in Bowie et al, 2005:243). Jacobson and Gottman (2001) found that workplace violence is independent of the worker's behaviour.

While any attempt to reduce violence against staff is laudable in principle, there have also been some worrying consequences of the policies and procedures adopted thus far. The emphasis on prevention and de-escalation

it is argued has left staff feeling further victimised by the process of reporting, recording and investigation of violent incidents.

2.3(v) Reporting and recording issues of workplace violence

Establishing 'the true figure' of workplace violence the Scottish Executive have identified as problematic and they note that 'it is difficult to estimate the true figure' because 'many people regard verbal abuse as 'part of the job' and others feel unable or unwilling to report all but the most serious of incidents' (2004:8). Even where there are policies and guidelines in place inconsistency is to be found in the level of reporting to the employer and to the police, in part because the perception amongst workers is that recording procedures are often 'laborious, time consuming and considered to be not worth the effort by those who have come to regard WRV[5] as part of the job' (Scottish Executive, 2004:37); some argue that it challenges their professionalism (McLean et al, 1999; O'Beirne et al, 2004; Wesely, 2006). It also challenges the principles of existing H&SE safety at work regulations.

Another worrying trend identified by Bowie at al (2005:17) is that under-reporting 'seems to be the norm rather than the exception'. Serantes & Suárez (2006:230) report that between 1996 and 2000 physical violence and harassment at work rose by one-third on its previous rate and that there is gross under-reporting of violent incidents in the workplace. They cite the work of Bulman & Wortman (1977) who found that up to 50% of victims of workplace violence blame themselves for the mishap. More recent studies, including Turnbull and Paterson (1999), Barling (1996) and Warshaw and Messite (1996), for example, found that 'reasons for non-reporting vary and

[5] WRV - Work Related Violence.

can include embarrassment, the influence of organisational culture, toleration of minor incidents with reporting of only major attacks, and staff may ignore inappropriate behaviours if they are fearful of being blamed for the incident. One widely accepted estimate is that, at best, 1 in 5 incidents are reported' (cited in Gill et al, 2002:22). Thus non-reporting is a complex issue of reactions to procedures and interpretation of definitions.

There are numerous reasons why it is felt violent crimes go unreported (Owen, 1998; Paterson et al, 1999; Beale, 1999; Jones, 2000). Under-reporting leaves unasked 'other critical questions about the organisational work and the work organisation' (Catley, 2003b:6). It also creates the situation in which '[i]t is possible that apparently mundane and unnewsworthy incidents of harassment and verbal abuse are much more frequent and [can] have a much more insidious impact' (Gabe et al, 2001:460) and are denied or not counted. Without a more rounded analysis of violence in the context of institutions, resources are not necessarily being used most appropriately in tackling violence, nor will we know what the contributing factors are. The question of whether or not violence in institutions is personal or institutional or a combination of both factors is rarely addressed. Even where there are policies and guidelines in place inconsistency is to be found in the level of reporting to the employer and to the police - if only a minority of cases are being reported to the police, only a minority of cases are going to appear in crime statistics of violence. This may be in part because of the nature of reporting and recording systems which is discussed in Chapter Six. This section has highlighted the complexities of understanding violence in the workplace.

2.4 Violence in the institutional context

This section examines the relationships between institutions and violence. 'Indeed contestations over the definitions (in particular what is included and excluded) are especially intense in the case of violence, and are central in the social construction, social experience and social reproduction of violence in and around organisations' (Hearn & Parkin, 2001:17). Clearly there is the need for a shared interpretation of the meanings of violence in the workplace; one which encompasses more than the cultural, gender, and class experiences which tend to hold sway. For in addition to these there are differences between institutional and job experiences of violence. Denney and O'Beirne (2003:56) state that interpretation is 'context-dependent' and that the extent to which violent actions impact on the 'professional's emotions and practices will vary in line with how they are interpreted.' Hierarchical structures in organisations produce 'sub- and super-ordination of power and authority.

2.4(i) Institutions and fields

The perception of institutions as large, powerful, autonomous organisations presented by Jenkins (1996), Hearn & Parkin (2001), Goffman (1961) and others is akin to Pierre Bourdieu's concept of the 'field'. Bourdieu and Passeron (1977) are particularly concerned with understanding how social structures such as class and power are legitimised and perpetuated and Goffman (1961) who shared their interest in institutions is concerned with understanding the extent to which institutions control and regulate individuals physically and emotionally. That is, institutions are organising bodies; schools of thought and institutions in the form of schools or hospitals,

or prisons, etc. are the physical aspects of the symbolic institution - the state, the process of governance - of which they are part.

'[S]ocial relations between individuals in organisations as elsewhere, are part of a broader system of relations between unequal social groups, based on gender and/or class and/or race' (Halford & Leonard, 1001:13) and these divisions are a reflection of the power invested in the dominant field; structured in such a way as to perpetuate their continuance. However as Goffman (1961:305) states, if 'participants decline in some way to accept the official view of what they should be putting into and getting out of the organisation', what we are likely to find is that ... '[w]here enthusiasm is expected, there will be apathy; where loyalty, there will be disaffection; where attendance, absenteeism, where robustness, some kind of illness; where deeds are to be done, varieties of inactivity.'

2.4(ii) Institutions defined

History and established functions place institutions in a particular position in society which is unquestioned, accepted but also visible 'in the *public* [original emphasis] eye:

- in buildings, artefacts and public symbols; in the organisations of time (timetables, the working day, the prison sentence, visiting time, opening hours, etc.); and
- in the wearing of uniform or other visible identifications by members' (Jenkins, 1996:156).

They are distinguished by particular characteristics:

- members combine in the pursuit of explicit objectives, which serve to identify the organisation;
- there are criteria for identifying and processes for recruiting members;
- there is a division of labour in the specification of the specialised tasks and functions performed by the individual members;
- there is a recognised pattern of decision-making and task allocation (adapted from Jenkins, 1996:136/7; Hearn & Parkin, 2001).

They are embedded in our culture and are best understood as 'networks of people', doctors, nurses or teachers, and their respective clients. Organisational practice or institutionalism is more than just the sum of the personalities (Lea, 2000; Jenkins, 1996; Hearn & Parkin, 2001): 'organisations deal with a range of people wider than their membership - customers, victims, clients and so on (Jenkins, 1996:155) - but are a reflection of the ethos of the cultural/political institution and can have both positive and negative impact on relations between 'insiders' and 'outsiders' (Elias & Scotson, 1965). However, they are dependent on all parties – employees and clients - 'following coordinated procedures', working together in 'inter-related and institutional' ways (Jenkins, 1996:139).

He (1996:129) argues 'The social world that we encounter as axiomatic in the course of socialisation is a world of institutionalised practices. As the products of history, we encounter them 'objectively', not to be questioned, and we seem to move in and out of their shadows. ... This is how institutions 'hang together'. ... Institutions order social life, provide

predictability .... Provide templates of how things should be done. .... But they do require legitimation in order to be presented successfully to each new generation..... Legitimation is bound up with the production and reproduction of "symbolic universes".'

Understanding of institutional organisation, hierarchically and structurally, in its formation, continuation, in the control and regulation of work practice, including how institutions address, challenge and define deviant or violent behaviour, is central to understanding workplace violence. Attitudes towards violence including violence in the workplace have changed due to social concern as is evidenced in new regulations, management approaches and changes in working practice (Catley, 2003a). This concern and the need for change has, as reported above, been recognised and supported by the Scottish Executive through their Zero Tolerance approach to violence and, in the case of schools, the mechanisms put in place for the recording of violent incidents.

Institutional organisation and operation are performed as much by habit as anything else (Berger & Luckmann, 1967). These *habits* are established on historical and cultural values which are embedded in the regulations and enacted as routine by employees. To be successful they are dependent on social and political belief in their worth and the collective acceptance of these practices – by workers and clients alike. Without this acceptance there would be no regulation and control, but conflict. Established, successful institutions are perceived as autonomous, powerful constructs highly regulated by rules and practices.

2.4(iii) Institutional practices

The historical, the political and cultural landscapes, are all inscribed in the formation and maintenance, structure and processes of working institutions, including the protection and safety of employees. Institutions are not, although they may appear to be, autonomous independent constructs, but are collectivities of people, and therefore reflect a wide range of social and institutional views. Furthermore, 'they harbour their own struggles, and tensions, not least between policy formulation, implementation and agency practice' (Hearn & Parkin, 2001:45). In operation these institutions have to negotiate the delivery of services that are politically defined and culturally desired but with finite resources which create internal tensions and competition.

Institutions are sites of contested meanings, actions and interactions but also sites of negotiated identities. Personnel have dual identities; an institutional identity linked to the job they do – doctor, nurse, teacher, plumber, etc - and an individual or social identity – woman, father, hill-walker, gardener, etc. Regardless of their occupation, individuals 'have histories, upbringings and backgrounds, they go home at the end of the day and they read newspapers, they talk to their friends. They live lives which are more than 'organisational' (Jenkins, 1996:165; Goffman, 1961[6]).

Consequently, in the workplace there is a complex mix of individual interpretations of the 'shared' beliefs in the institutional services. Hearn & Parkin (2001:17) note '... organisations are both *social places* of organising and

[6] Goffman's work on Institutions shares a similar, but stronger view. In his work on asylums he talks of the loss of personal identity, due to the intensively institutionalised experience of working and being a patient in such mental health institutions.

social settings of social relations, whose interactions are historically dynamic ... [and] organisations always occur in the context of pre-existing *organisational* social relations.' Therefore institutions are part of a wider social and political 'organising' that is our culture and are founded on established procedures which are recognised and accepted as being , 'the way things are done' (Jenkins, 1996); they 'persist through unspoken forces' (Hearn & Parkin, 2001:xi) and 'exist in history'(op cit, 22). Typically they create divisions which determine access to and exclusion from the institutional setting.

The organisational framework establishes legitimacy and illegitimacy of practices and behaviours within the working practices of organisations. Organisational collectivity is, in fact, the source of legitimacy without which authority carries no weight' (Jenkins, 1996:140). Any analysis of violence within organisations needs to include the organising and institutional control on defining what it regards as violent practice. For as Bowie (2002:11) argues, 'responses to workplace violence by employers [can] deflect attention from a potential key contributor to workplace violence' - themselves. Where there is a breakdown in power relations it is important for all agents involved to be included in consultations to effect the best outcomes (O'Malley and Palmer, 1996).

Systemic violence, according to Catley and Jones (2002), is embedded in daily patterns of work. Organisations are founded and maintained on trust and obedience between the workforce and management (Catley, 2003a); violence against staff that is neither recognised nor supported by management undermines that trust. Patterns of working that violate workers' rights and

well-being are equally likely to weaken the structure of the institution or organisation that employs them (Catley, 2003a). Unjust victimisation and the inability to control or negotiate the workplace is a violation of the employees' rights to safety at work; employers have a duty to inform staff of potential violence from client groups; and to ensure that staff are adequately trained and that there are appropriate staff levels deployed.

In other words, working practices can and do place some individuals at higher risk from violence than others and specific work practices can also increase the risks. For example, nurses who work in Accident and Emergency departments are often the first contact with patients, some of whom may have come into the hospital in a highly agitated and aggressive state. Triage has been found to be a particularly high risk duty. Therefore it is not just status, or gender (the majority of the nurses are women), but the role that is performed within these hierarchical structures that increases 'risks' of violence for some.

Some employers, however, seem to work on the assumption that '[s]kills and knowledge are ....intuitive, rather than learned' (Baines, 2005:144). Thus it is not only institutional policies that are likely to impact on definitions and support systems for violence, but also how they are interpreted in each institutional site. Therefore it is possible that schools and hospitals will vary in their experiences of violence. Some schools or hospitals for a variety of different reasons may be more or less supportive than others towards staff who experience violence in the workplace.

In organisational working Leather and Beale (2002) found that 'differences in line manager support are related both to the consequences of exposure to violent incidents as well as adopted means of trying to deal with the circumstances that often give rise to it.' Violence and reactions to it are not universal in form and there is still much to be learned about what supports are needed, for those who are facing this perceived 'new' and 'increasing' problem of violence at work.

2.4(iv) Understanding violence in institutions

Catley (2003a) argues that workplace violence 'is cast as a problem for organisations rather than a problem of organisations'. It thereby excludes the possibility of such forms of violence as harassment and bullying and draws attention to the sensational violence that is brought into organisations: the young drunk or drug crazed youth who is out of control. Taft & Ross state that 'physical acts of violence in the workplace, far from being 'new', were deeply implicated in obtaining desirable work habits and managerial control over the labour process' (cited in Catley, 2003a).

Violence thus creates a paradox in that it challenges the power, authority and control with which they (institutions) are more commonly associated (Bourdieu, 1990a, 1990b, 1990c, 1988; Foucault, 1977; Giddens, 1992; Goffman, 1961; Jenkins, 1996). Institutions in service delivery assume acceptance of what they do, how they do it and any challenges to that would traditionally be perceived as exceptional, unexpected.

Indeed, what is expected from it is more likely to be based on individual want and need than on an understanding of the objective of resource

allocation; and consensus on the need for a service is not the same as consensus on what is expected from it. Institutions present an idealised picture of service provision at the practical level. However, it is unlikely that all personnel and clients will interpret institutional meanings similarly. Equally so, institutional personnel and clients are unlikely to define violence in the same way, as exposure to and experiences of violence affect how individuals define, interpret and handle it (Denney & O'Beirne, 2003). Institutions, life and cultural experiences all vary and impact on how situational violence is defined (Hearn & Parkin, 2001; Jenkins, 1996).

Competition is an integral part of the interactions between institutional personnel and between institutional personnel and client groups. Internally there is competition for status, and in client interaction there is competition between what is being demanded and what can be delivered. However, institutional personnel are always liable to be at an advantage in client interactions due to their *institutional capital* - in the form of skills and knowledge.

A further integrated issue for understanding violence in the institutional setting is that of its definition. If it is defined in broad but vague terms, which are understood by management as being 'inclusive' of the types of violence faced by employees, it becomes highly subjective in interpretation. The broadness of it makes it non-specific and open to question on what actually is violent and what is not. Furthermore, organisations and employers generally need to be much more supportive to staff - 'simply recording violent incidents is not sufficient but should be backed up by actions which support the member of staff affected'; and they need to make it

clear to all – pupils, patients, members of the public - that violent offences on staff, whether verbal or physical, are unacceptable forms of behaviour (Denney and O'Beirne, 2003:62).

2.4(v) Institutions and people

Within institutional organisations, roles – professional and managerial – acquire status and responsibilities, 'rights and duties' (Linton, 1936:113 cited in Jenkins, 1996:134), but these responsibilities and duties are independent of the individual employees - the position they fill is more than that performed by the individual employee. Institutional positions remain irrespective of whether or by whom they are filled. Rights and duties are the definers of roles, 'they are definitive of institutional identity' and 'status' which symbolically distance the professionals from their clientele. They also set the boundaries of 'rights ... what I expect of others, [and] duties... what can be expected of me' (Jenkins, 1996:135; Bourdieu & Passeron, 1977; Goffman, 1961).

Individuality in the institutional setting therefore creates the potential for misunderstanding and misinterpretation of meanings in professional/client interactions. Differing experiences and understandings of behaviours have, as Hearn and Parkin (2001:49) found, caused '... problems in clearly separating harassment, bullying and physical violence, with physical violence often being a feature of harassment and bullying'.

Furthermore, in the case of health workers workplace violence was 'in effect, remade as a private issue to be dealt with by each individual worker (Baines, 2005:143) ...which remove[d] the spotlight from the structures of work and

the role of violence in society' (op cit, 145). Essentially workplace violence was contextualised in some failing on the part of the employee.

Baines (2005) argues that in the case of workplace violence; workers are more likely to blame it on under-funding, organisational agendas and governments than on their immediate line managers. However, why this is the case is less clear. Thus quantifying violence in and around organisations is problematic as is quantifying violence and crime which is the focus of the following section.

2.4(vi) Reporting and recording issues

Under-reporting of violent incidents occurs for a variety of reasons including: fear of the negative impact on vulnerable clients (Hesketh et.al., 2003; Morrison, 1992) and blame from management (Duncan et al, 2001; Macdonald and Sirotech, 2001; Lanza and Carifis, 1991). A number of factors impact on the reporting and recording of violent incidents and the growing body of research to show the diverse effects of violence at work. For example, Kleber & van der Velden (1996), Leather et al, (1997), Leather et al, (1998), and Wynne & Clarkin (1995) have identified that 'verbal abuse and threat alone can be extremely damaging and distressing in their consequences' (Leather 2002). The austere structure of organisational working, the lack of perceived support from management, and a lack of understanding or recognition of incidents as violent, Macdonald & Sirotech (2001) and Lion et al (1981) report, are contributing factors in the under-reporting of violent attacks on staff. Distance - symbolic and physical - from violent incidents impacts on the interpretation of events which are not always recognised in the institutional structure.

Likewise the lack of recognition is redolent of experiences elsewhere; for example, violence within families and racial violence are two examples of the tensions that exist between 'violence' that is recognised in the legal process and the violence that doesn't fit neatly into legal categories. Pateman (1988) argues that these forms of violence were viewed by the legal profession with some ambivalence. Until relatively recently both types of violence were not recognised in law and therefore the extent of the problem was unclear. It is still argued that only a small percentage of these types of violence appear in the official statistics. Violence at work is another example.

There is confusion and inconsistency over what constitutes a reportable incident (Leather, 2002). Even where management structures were supportive of staff who have been the victim of violence, Beale (2002) found that when increases in reports of violence take place staff members are questioned and challenged on why the violent incident occurred. In these circumstances employees or victims would be dealt with by 'hard questions' about 'what was going on' and what the worker 'needed to change'.

Leather (2002) reports that 'policy makers, managers and organisations continue to underestimate the damage done ..... by forms of violence perpetrated by customers and clients'. However, this raises two interesting points. Firstly, is it a question of underestimating due to a lack of information? Alternatively is it due to a lack of acceptance of reported incidents within institutional structures which results in them being re-classified as non-violent? Such possibilities mean there is the potential for institutions to lose information vital to understanding the violence their

employees have to deal with. Despite the introduction of new reporting and recording measures, the media have nevertheless created the perception that violence in schools is increasing. However, the executive has warned that the lack of previous statistics for comparison, taken with the fact that the new procedures are not guaranteed foolproof means that this perception must be treated with caution.

The costs of violence are not fully understood; they are more than economic, they are also emotional and personal and these costs are often not fully recognised. Cumulatively they are considerable both to the individual and the institution. Individual experiences include stress, ill health, absences from work, poor job satisfaction and for some the intention to leave the post or profession altogether. Institutionally costs include loss of expertise, extra training for new employees, extra staffing costs to cover absenteeism, and generally a low morale which can impact on the efficiency of the services delivered. Institutions need to be aware of the full extent of the costs of violence which can affect them, their personnel and clients alike. However some organisations do not have this awareness.

2.5 Conclusions

This chapter has examined how social and cultural constructions of violence as defined in the historical and political context have influenced contemporary definitions of violence in the institutional setting. It shares the view of Leather (2002) that 'work-related violence affects the individual, the organisation and society alike.' Historical perspectives have legitimised violence within the 'civilised' state which has strongly influenced how it is understood in a variety of different contexts, including workplace violence.

Examining institutional structures and working practices has identified hitherto obscured factors and exposed the need for 'good' practice in protecting and supporting staff against violence in the workplace. Understanding violence demands understanding organisations because '[o]rganisations are open to and are part of their social environments. Their boundaries may be permeable and osmotic; it isn't always easy to see where they are drawn' (Jenkins, 1996:140). Institutional responses to violence are somewhat paradoxical because on the one hand they advocate the need for violence to be understood and defined in the widest of contexts, but on the other hand, due to their subjective interpretation of what is and what is not violent, it would appear they are instrumental in exclusion of valuable information on the nature and extent of it. This suggests that the institutional perspective has some way to go in embracing the fullness of a wider definition.

Current definitions and understandings are context specific and have extended understanding of the meanings of violence but are also influenced by the social and cultural definitions and while they have identified gender, class, and race differences there is still an over-reliance on understanding violence in the content of its physicality and criminality. Other forms of violence, such as verbal, psychological, and emotional, are more readily denied in interpretation of violence reports. Therefore understanding content is as important for understanding as context.

The following chapter discusses the theoretical implications for researching this type of violence and the rationale for an integrated and methodological approach.

Chapter 3

Theoretical Deliberations

3. Introduction

The preceding chapters exposed the need for a strong research methodology and theoretical frame for analysing workplace violence. The immediately preceding chapter, in reviewing the academic literature on violence, especially workplace violence, has challenged the simpler view of it presented by the media. Chapter One highlighted how the media have problematised violence in schools and hospitals, sensationalising and creating moral panic over the apparent victimisation of their employees. However, while reporting has raised awareness of the problem it also has to be treated with caution as they are both selective and subjected to editorial policy in what they report (Macdonald & Tipton, 1993). Concern about violence in the workplace has also been expressed at the political level by the Scottish Executive and the unions and professional bodies which represent doctors, nurses and teachers; their concerns are also shared by the academic community where increased research activity is evident.

Chapter Two examined the academic literature and discussed how violence and institutions have become defined in our society, embedded in historical and political discourses that informed and shaped the services provided by our social institutions. It also identified the difficulty in defining violence, as it varies by form, type and context. The academic literature has, as media constructions have also done, focused on inter-personal violence. While some studies did identify the need to include the role of the institution in analysis, they have been more concerned with the 'situational' than the 'structural' aspects of violence in the institution. Current knowledge of

violence in schools or hospitals has as yet not fully embraced the role of the institution - its organisation and regulation.

One of the most prominent criticisms of research and theories of violence is that they have produced a fragmented analysis. This situation has arisen for two main reasons which are contingent: firstly, the lack of a universally agreed definition of it - some definitions are narrow and focus on the physicality or criminality of violence whereas other definitions are very broad and include many forms from name calling to physical attack; and secondly, the strong arguments for it to be defined as context-specific. This latter point is paradoxical in that the need to understand the context has in turn led to discrete categorisation of violences, which has affected our ability to quantify violence per se. On the other hand it has provided a deeper and more contextualised understanding of these categories. Reporting and recording systems for violence are also fragmented and share a similar imprecision to that of crime statistics. This issue will be discussed in Chapter Five where these workplaces are contextualised.

This research, while adopting a context-specific approach, also takes cognizance of the need to extend hitherto descriptive analyses of violence in the workplace to encompass why and in what ways the *place* affects experience, meaning and understanding. Bourdieu asserts that 'one can break with misleading appearances and with the errors inscribed in substantialist thought about place only through a rigorous analysis of the relations between the structures of social space and those of physical space'. (Bourdieu, 1999:123)

Contextualisation of the problem currently locates it in the work*place,* and while some studies have examined client motivations others have been largely descriptive of the types of violence experienced therein; a few have looked at support systems for victims of violent attacks and others have examined violence statistics and the reporting and recording procedures. (Gill et al, 2002; O'Bierne et al, 2003; Tombs & Whyte, 2007; Klein, 2006) However, there has been little research that has attempted to pull all these factors into a single frame for analysis to examine the inter-related effects of violence in the context of institutional working. Lack of understanding of the effects of institutionalism is not confined to violence but has been noted, for example by Lea (2000) when examining racism within the police.

This thesis aims to explore these connections in the experiences of inter-personal violence in the working institutions: the institutional site of schools or hospitals in the delivery of their services. There are four main areas where a clear need for research is identified: firstly, the identification of what constitutes a violent incident for doctors, nurses and teachers and how they are defining it; secondly, the quantification of the extent of the problem, and whether or not it is a new and increasing problem as the media would have us believe; thirdly, the identification of the victims in terms of age, gender and class and whether or not there are particular work practices or positions that increase staff 'risks' from violence; and fourthly, the examination of the context of institutional working - does it increase or decrease feelings of violation amongst staff who have experienced violence at work.

Methodological issues are considered in detail in the following chapter. This chapter examines the theoretical implications for such research and discusses

the rationale for using a Bourdieusian frame. His concepts of Fields, Habitus and Capital are adopted for analysis on the premise that they will elicit a deeper understanding of the meanings and experiences of workplace violence.

3.1 Theoretical considerations

Where to begin and how to begin was in itself daunting. That there was a need for the research was never in doubt. Initial enquiries were driven by the principles of grounded theory, on understanding the area of study from the informant's point of view (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Lack of consistency between the information coming from the media and the limited academic literature[7] created a confused and confusing picture of workplace violence. Initially a grounded approach seemed appropriate to develop understanding of the research area.

Grounded theory according to Glaser & Strauss (1967) is a general methodology for generating theory while doing research rather than a specific theory in itself. They advocate generating theory from data, while mindful of the need for the researcher to be open-minded in analysis; but most importantly they claim that doing research in this way, allowing categories to emerge from the data produces theory that both 'fits' and 'works'. Validity is then achieved through category 'saturation'- that is when the analysed data is adding nothing new to understanding of that category - and if it does not fit or work in this way then it indicates that either the data has been wrongly assigned to that category, a new category is emerging or

[7] For example only two references were identified in my initial search of the university library: DHSS (1988) Advisory Committee Report on Violence to Staff. London: HMSO, and Levi, M. (1977) Violent Crime in Maguire, M., Morgan, R. & Reiner, R. (1997) The Oxford Handbook of Criminology (2nd Edition). Oxford: Clarendon Press.

indeed more research is needed to fully explain that category. Advocates contend that 'grounded theorists differ in orientation, ... [and that] the principle of theory emanating from data as opposed to the logical testing of hypotheses has led to the generation of important knowledge', (Jones, A. in Humphries, B., 2000:40); and Reissman (1994:2) states that it is a 'systematic, phenomenologically based method'; whilst Silverman (1993:47) comments that grounded theory at its best is creative theory-building from data.

Critics have questioned whether theory construction is intimately linked to field research (Rose, 1982) and Silverman (1993:47) has observed that 'grounded theory has been criticised for its failure to acknowledge implicit theories which guide work at an early stage.' When used unintelligently, Bryman (1988:83-87) argues 'it can degenerate into a fairly empty building of categories ... or into a mere smokescreen used to legitimate purely empiricist research'. Furthermore, as Burgess (1984) points out some researchers are less concerned with theory building and more with theory testing, while Coffey & Atkinson (1996) argue that categorising leads to a broken narrative.

However, the principle of sensitisation of the researcher to the research area through engagement with primary and secondary data goes some way to addressing the criticism expressed above. Researchers are active and not as passive as a first reading of 'grounded theory' might suggest. Far from categories emerging haphazardly or randomly from the data it is the researcher who in actively scrutinising the data identifies which categories are salient to the research area.

While initially the idea of letting the data speak for itself appealed, it became

apparent that 'grounded theory' was not the most effective way to advance this study. How a grounded theory approach was to be achieved was problematic given the reality of the time constraints set for doing the research (Bryman, 2001:396) which meant that it was unlikely to be achievable.

3.2 Rationale for a Bourdieusian frame

The preliminary work carried out in reviewing the literature, in speaking to various personnel involved in the provision of heath and education services, along with a theoretical exploration of violence, opened up the possibility of adopting a Bourdieusian frame. He advocates that 'without doubt ... the relationship between methods and epistemology is purely contingent' (Inglis et al, 2000) and that combining methodologies bridges the divisions between humanists and positivists and between theory and practice; incorporating a reflexive approach produces a robust model within which to apply his concepts in order to develop a deeper analysis. Combining data sources and research tools creates a dialectical relationship, within which theory and practice can be modified; data collection and analysis can be informed; and limited data analysis questioned. Reflexivity, Bourdieu argues, makes for a robust model with which to question data against theoretical concepts and the researcher's role in that process (Bourdieu & Wacquant, 1992)

So there are similarities to be found in Bourdieu's theory with that of grounded theory. Bourdieu (1999:625) argues that sociologists, 'cannot be unaware that the specific characteristic of their point of view is to be a point of view'. It is only the privileged position of the researcher that enables them to access and analyse the various viewpoints of respondents, 'that is, to

understand that if they were in their shoes they would doubtless be and think just like them' (Bourdieu, 1999:626).

Thus adopting a Bourdieusian frame seemed both appropriate and better for 3 main reasons:

1. his insistence on the need for cognizance of the historical and political structures which underpin and give credence to our social institutions;

2. his concepts of fields, habitus and capital offered a framework for analysis similar to that of grounded theory – the dialectical process of doing research between methods and theory and the need for reflexivity. Using his concepts to develop a frame in which 'relationships' between institutions, policies, people, procedures and violence can be dynamically analysed was appropriate for this study; and

3. theoretically the robustness of these concepts could be tested, and any inconsistencies in the data analysis reflectively re-examined.

As Silva (2006:1171) states, '[t]he methodological canon of the early 21st century encompasses much of Bourdieu's transgressive research methods of the late 1960s. Yet the discussion of the kind of knowledge that different methods create, as well as the implications of mixing methods, remains an important concern for contemporary social scientists, and for a critical engagement with Bourdieu's work.'

Bourdieu advocates that in modern societies, understanding issues is a

complex process and therefore needs a dynamic model, which embraces the use of as many methodologies as appropriate for the research question in hand. He argues that one methodology is unlikely to provide an adequate frame for analysis in contemporary society, and embraces the use of both qualitative and quantitative methodologies in addressing modern day phenomena. He recommends a more eclectic approach to research to bridge the divisions between theory and practice. Grenfell & Kelly (1999:15) state that Bourdieu ...'repeatedly emphasises the pragmatic nature of his thought.' His model is less of a rigid theoretical approach: it draws as appropriate from numerous authors in this field: this he deems a 'conceptual realpolitic' (Bourdieu, 1990:28) for undertaking social research.

James (1999:248/248) argues that using such a research practice as Bourdieu outlines 'overcomes the shortcoming of interactionism by conceiving these events as social practices which can be understood dynamically and relationally'. It is argued that the concepts of habitus, field and capital when utilised effectively produce deeper analysis of social actions and when combined with a reflexive approach create a dialogue between theory and practice, producing a framework within which both theory and practice can be modified. Eick argues that Bourdieu 'claims to fashion conceptual tools rather than "grand narrative" or theory *pure et dure,* and that the empirical or scientific methods of sociology are employed not as the only valid way to produce truth but in a spirit of 'bricolage' (1999:88).

He argues that to be confined by either a particular methodology or theoretical framework often only leads to what he terms a surface analysis and does not seek to understand the deeper social structures which underpin

the phenomenon being researched. Therefore the 'key' to doing research is not in defining a prescriptive method. The 'key' is practice. Since we cannot know the outcome when we begin our research, we can hardly be prescriptive on what our actions will be during the research process. What 'he is centrally concerned with [is] how the various practical projects of different people, the struggles in which they engage and the relations of power which push and pull on them, nonetheless reproduce the field of relations of which they are a part' (Calhoun, 1995:142). We all have internalised social structures 'because we have learned from the experience of previous actions a practical mastery of how to do things that takes objective constraints into account' (op cit, 259/260).

Adopting a model based on Bourdieu's principles for understanding the social world in terms of fields and habitus, which are negotiated by strategies based on the acquisition of forms of capital - that is, embodied knowledge and/or skills - will facilitate a critical analysis of the inter-connections of institutional structures, doctors', nurses' and teachers' experiences, the fragmented reports in the mass media, and the academic literature on violence at work. Understanding the operation of fields in their formation and re-formation will allow us to contextualise the experiences of violence in the habitus of schools and hospitals.

3.3 Bourdieu's fields – institutions

Bourdieu encourages us to think of society as a culturally defined field within which smaller fields, or 'force fields' as he calls them, compete for their share of resources, economic or symbolic, and differentiate on the basis of expertise and class relations. These fields are similar to Weber's 'life

orders' (*Lebensordnungen*) and are likened to the operation of the market place where they develop what Weber called a certain *Eigengesetzlichkeit* (self-legislation) (Lash, 1990). They are dynamic institutions that are both created and creative in their existence. They are in Bourdieu's terms forces of negotiation and networking: 'a configuration of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose on their occupants, agents or institutions, by their ... distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions (domination, subordination, homology, etc.)' (Bourdieu and Wacquant, 1992:97). Forms of capital are central for controlling this space: not only does it create the ability to separate and distinguish between different sets or groups, but it also creates the symbolic space that permits us to differentiate between classes or hierarchical positions within institutions. Capital in its application within the field and habitus is discussed more fully below in 3.5.

However, fields or institutions exist mainly in symbolic space as opposed to their physical manifestations - the habitus (defined in 3.4 below as the working institutions of buildings, schools and hospitals) - and social interactions that are the practice of service delivery which exist in real space. The concept of symbolic space is to distinguish between differing social groups, each group having a particular set of practices and mannerisms that are peculiar to them.

Symbolic space in measuring differences, is actually measuring similarities or differences in tastes, not physical distance; the more similarity, the more

homegeneity within groups. He argues that the notion of symbolic space contains, in itself, the principle of a relational understanding of the social world (Bourdieu, 1988) in which the theoretical and empirical are inseparable.

This includes the use of multi-methods 'for the purpose of studying an object well defined in space and time' (Robbins, 2000:3). This is important because all actions Bourdieu argues have a peculiar history to them. Bourdieu (1998:10) argues that '[t]o construct social space, this invisible reality that cannot be shown but which organizes agents' practices and representations, is at the same time to create the possibility of constructing theoretical classes that are as homogeneous as possible from the point of view of the two major determinants of practices and of all their attendant properties'.

Society in its historical and political existence, Bourdieu argues, is structured by fields on which it has conferred their roles. Therefore fields – as institutions – will have shared meanings but also their own structure, rules, regulations, strategies and systems of differentiation. Consequently, as Bourdieu & Wacquant (1992) argue there are tensions between 'fields' as they vie with each other for their share of limited resources. So they are separate and distinct from each other symbolically and substantially. Difference also creates hierarchies both within and between them, so competition is also inherent in their existence. Each field has its own preferences – knowledge and skills or tastes - which also differentiate between them symbolically and substantively through another of Bourdieu's concepts, 'capital', which is discussed below in 3.5.

Fields in their operation as institutions establish particular roles which are performed as habit in an established pattern of service. These roles are also inscribed with rights and responsibilities (Linton, 1936 cited in Jenkins, 1996).

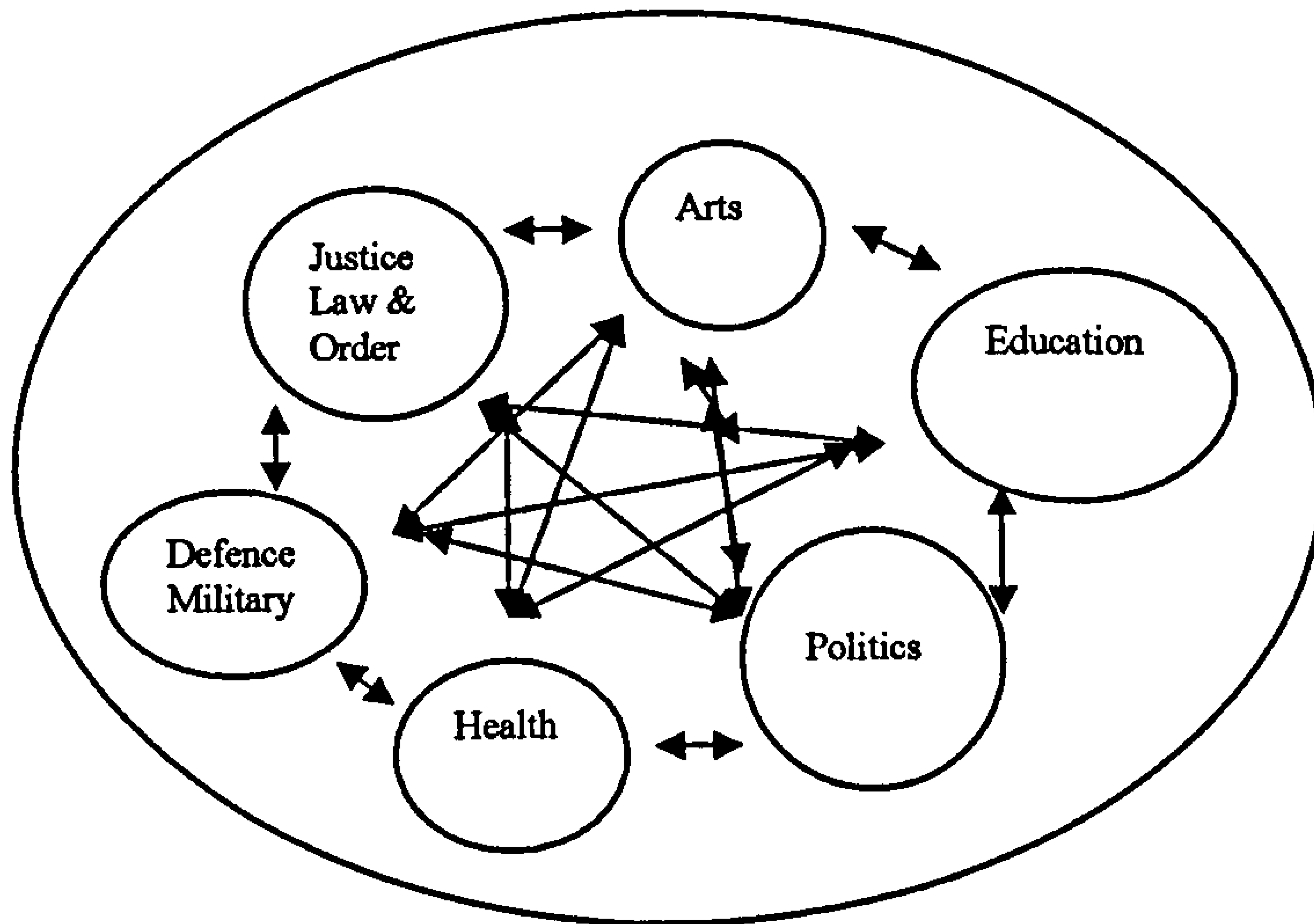


Fig. 1 – Force fields: The interplay between *'fields'* in society

In the diagram above (Figure 1) I illustrate the dynamics of competition between fields; irrespective of size they are all in competition to maintain or acquire a greater share of the resources that are available within the larger structure of the society or nation state. Bourdieu's (1990) preferred terminology *'force' fields,* is illustrative of their competitive nature. Competition, however, also fosters change; for example in line with the reigning political ethos which at any one period in time will have particular preferences. This will be reflected in the political support, and perhaps increased resources available to that particular field; symbolically in recognition, substantively in more, or better, resources to enhance service delivery.

Essentially, fields are sources of power (Bourdieu, 1990). No one field is totally independent of the others, but some are in a more powerful position than others. Highest ranking in our society is the political field, but this does not make it *all powerful*; it is dependent on the support of all other fields for maintaining this position. Challenge is ever present and in its worst manifestations can be seen in Civil War. So power in the field is always vulnerable, but is established in the history of its existence – the way things are done. The dominant field, being accorded this status arbitrarily, is then in the position to define the role and status of all other fields. Fields such as Education and Health will then reflect in their practice not only their history but also the prevailing political ethos at any given period in time.

All fields have a history, are not static, and evolve through time with social change; challenges to and changes in the fundamental structure of the fields are unexpected – governments may change but the overall configuration of the field is relatively stable. This is likely to remain so as long as political power is exercised within the established contexts of the other fields – too much change and resistance is a distinct possibility.

Consequently, the political will be present and seen in all fields and institutional settings – from the process of resource allocation through to service delivery in the habitus of schools or hospitals. Support from the political field has historically been invested in Health and Education which are publicly perceived to be two of our most powerful and autonomous social fields.

Understanding how the field informs and defines institutions is central to

understanding the working institution. The political field defines the sub-field of health or education and all other fields. The sub-field is then assigned the duty of defining, organising and regulating the institutional role within the parameters set politically. Thus it is not just the history on which the institutions were built that is important for understanding of institutions but also the prevailing political ethos. Consequently all fields will have shared and individual meanings specific to the particular service they are providing.

Public institutions, such as health and education, are conceived in the political field, as they are publicly funded bodies (Bourdieu, 1991). They are therefore subjected to constraints in their operation by the political field, underlining the position of domination that this is accorded in society - for example, in target setting in health, defining the curriculum in education, and defining the role of policing in maintaining law and order. Bourdieu (1998) argues that this domination is symbolic and could even be perceived as symbolic violence, as it allows the state to dominate in the relations between fields, habitus and capital in a given society.

In Figure 2 below I illustrate how the political is interlinked into the formation of all institutions.

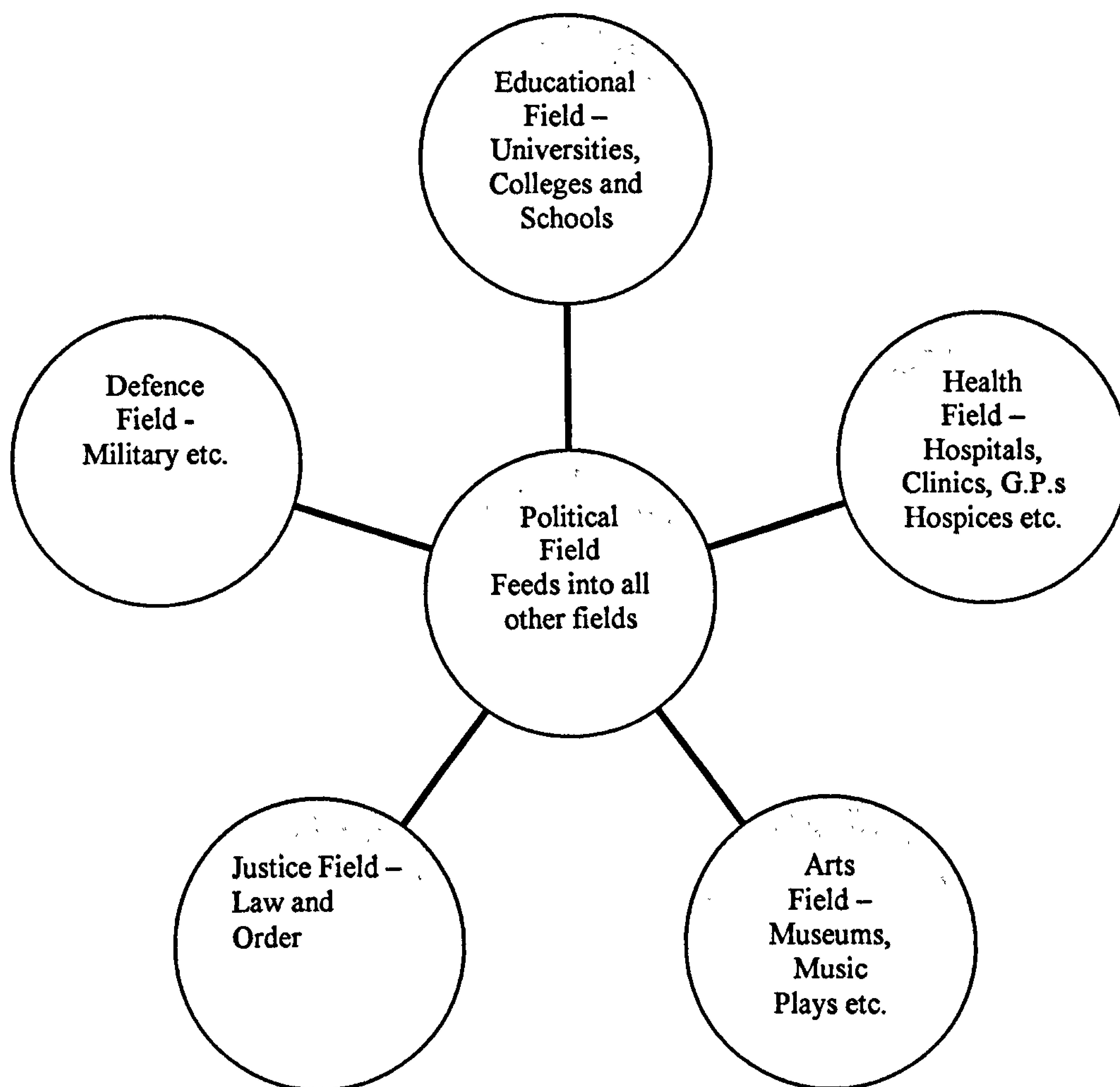


Fig. 2: Structural connections in the formation of institutions

Realistically in their functioning institutions have much more overlap than the above diagram suggests (see Figure 3 below), but it clearly shows how the political influence feeds into all the social fields. Such strong links mean that it is highly likely that the ethos of the political will be reflected in the constitution of all other fields. However, since all institutions are collectivities of individuals and memberships of fields are not always mutually exclusive a more realistic model is likely to be similar to that shown below. For example, it is possible to be a medical doctor and be a member of the police or armed forces at the same time. Furthermore since all

institutions are located within the one society, social mores are also going to contribute to shared values and beliefs.

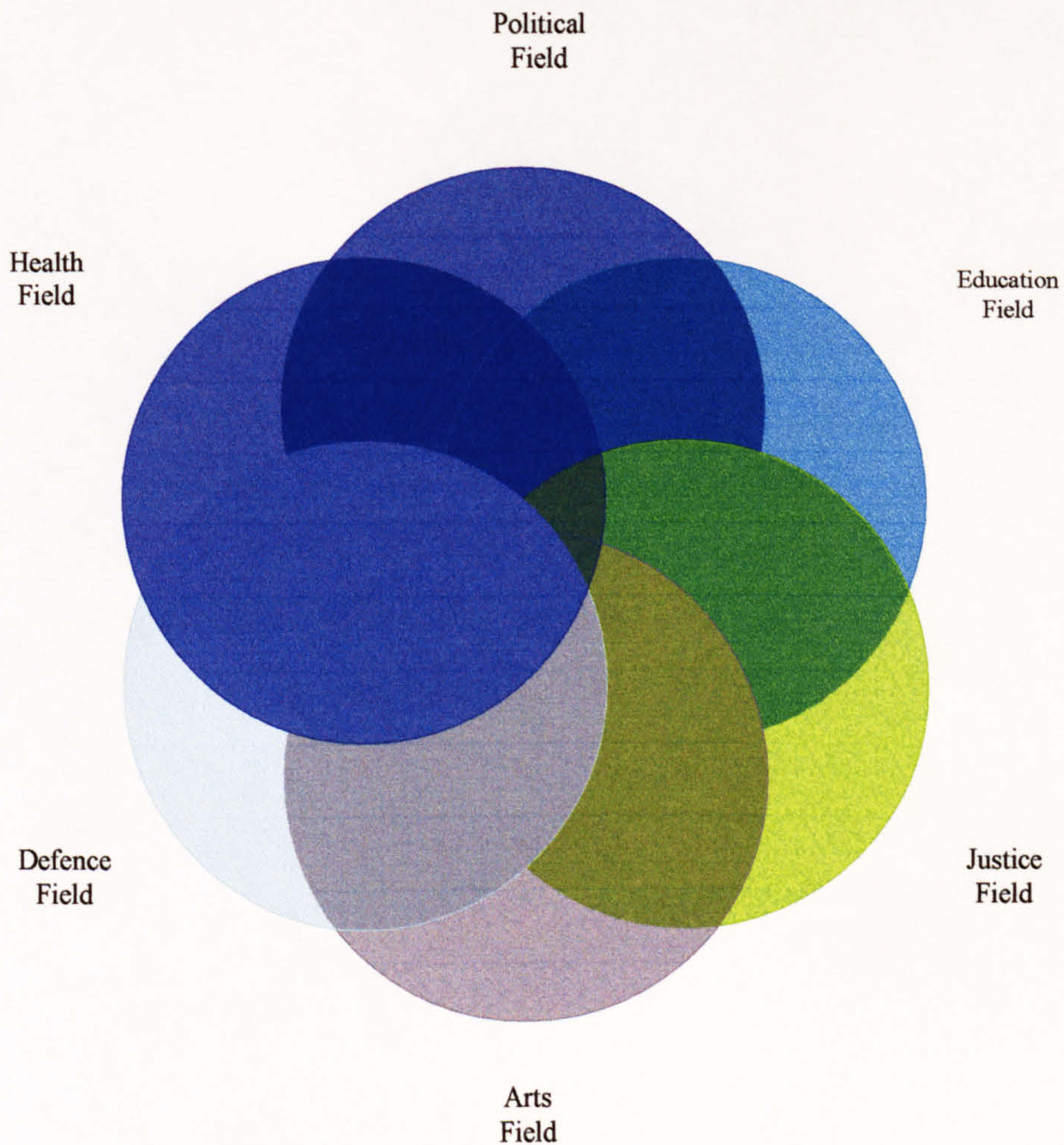


Fig. 3: Institutions as inter-connected and complex constructs

It is clearer from my diagram above the extent to which there is cross over of ethos and ideas with all institutions, not just the political. It also clearly illustrates that attempting to understand them as large, autonomous, stand-alone organisations is inappropriate. They are, collectively and individually, part of a bigger picture, providing discrete services in particular institutional

ways. They are institutions in space and time and as Bourdieu (1999:126) argues 'because social space is inscribed at once in spatial structures and in the mental structures that are partly produced by the incorporation of these structures, space is one of the sites where power is asserted and exercised, and, no doubt in subtlest form, as symbolic violence that goes unperceived as violence.' For example, the violation of individual rights in conforming to the rules and regulations of the institutional working practices - that is, in performing roles within institutions, agents are subliminally reinforcing these structures – accepting and recreating them in institutional practice. Furthermore, in doing so, in conforming to powerful and authoritarian rules and regulations, they may also unwittingly be perpetrators or victims of violations that go uncontested and are often hidden. Therefore in the execution of their roles institutions are best understood as multi-layered. The layers should not be thought of as being entirely separate, but as being units within units.

The institution or field then is in the position to define workplace violence and shape the institutional policy for dealing with it, including questioning the validity of reported violent incidents (Bourdieu, 1990). Violence disrupts the smooth delivery of services and challenges the authority of both institution and institutional professionals. But to what extent, and why, has so far not been critically examined. What has been identified thus far is the need to explore how the structures, interpersonal relations, gender, policy, resources, management and personality all contribute to doctors', nurses' and teachers' experiences of violence at work.

Institutions as the manifestations of fields (Bourdieu & Passeron, 1990), in the

configurations of services, place teachers, doctors and nurses in vulnerable positions, through their organising of the workplace and the nature of the services they deliver. For those individuals who experience violence it is awful. But its recognition as violence is dependent on the institution and the field accepting that it is violence. A further complication is that recognising it as being violence does not necessarily mean that it will be defined or acted upon as violence by the institution or the field.

Political and legal discourses will prevail in how the field understands violence and will be reflected by institutions in their definitions. In the workplace, the legal field determines working practices including reporting, recording and responses to violence. The practicality of this is discussed in Chapter Five where the two working institutions are contextualised in the experiences of the professionals who work in these two fields. Violence if it were severe enough would threaten the structure and existence of these institutions; as it is at present it is the individuals who work in these institutions who it would appear are the victims.

However, I would argue that to define symbolic/social space only as a means of distinction or separation would be to deny the importance of the embodied nature of violence and how it is recognised in both the real and symbolic space of institutions. I would contest that difference and distinction as utilised in symbolic/social space should best be understood as a *classification* system rather than merely a separation of the classes. For example, as is discussed more fully in this and the following chapters, the dynamics of the field and habitus include more than just class: they include

capital values, gender, age, and institutional rules and regulations. All need to be included if a critical analysis of these fields is to be achieved.

3.4 Habitus – schools and hospitals

The habitus is defined here as the working institution where practices are performed, actors carry out duties, and interact with client groups in delivering their services. They are – schools and hospitals - smaller organising bodies than that of the symbolic institution or field. In the Bourdieusian context of the *'habitus'* schools and hospitals are the classifications that group individuals together who have shared interests. The habitus, Bourdieu argues, is best understood as:

> 'the conditionings associated with a particular class of conditions of existence ..., systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organise practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operation necessary in order to attain them.' (Bourdieu, 1990:53)

Habitus, schools and hospitals, as institutional sites are structured by rules and practices that are typically imbued with, but negotiated by, forms of capital in their functioning. It is the active part, or the working institution of the field; where the distribution or delivery of services to the public takes place. They are thriving, evolving sites of convergence that are imbued with the history of their existence from the social and political fields, and with the

continuing recognition and authority that this gives them in service delivery. They are, however, complex and contested sites, and always have been,

Krais (in Calhoun et al, 1993) states that 'it is by habitus that the meaning objectified in institutions is reactivated, that institutions are kept alive, but only by imposing the revisions and transformations that are counterpart and conditions of the reactivation: "The habitus......is what makes it possible to inhabit institutions, to appropriate them practically, and so to keep them in activity, continuously pulling them from the state of dead letters, reviving the scene deposited in them, but at the same time imposing the revisions and transformations that reactivism entails" (Bourdieu, 1990).' So the habitus is not only the site of a set of dispositions (institutional practices and procedures) but also the site of transformations (putting these practices and procedures into practice), which can become the site of disruptions (challenges to the authority of the institution), and it is these disruptions which this study aims to identify and analyse.

The dynamics of the habitus, while reflecting the ethos of the political field also create their own micro-structure for delivery of its service to the public. All institutional or ritualised work, Knorr-Cetina & Cicourel (1981:309) argue, 'contains a history, espouses his [Bourdieu's] function, i.e. a history, a tradition which he has only ever seen incarnated in bodies, or rather, in those habits 'inhabited' by a certain habitus'. Institutions are individually structured sites (habitus) of authority and control that collectively in their similarity create the symbolic field. This places schools and hospitals in unenviable positions: being highly regulated, controlled and authoritarian in

their operation and the site of contact with the public places them at an increased risk from any challenges.

The habitus organises agents in relation to their relative capital values for the particular duties they are assigned and in doing so creates hierarchies within and places particular groups of agents at the front line of the client/institutional interface. It is these frontline workers who are most likely to be exposed to any increased risk of violence in the workplace.

Vulnerability to violence is in part due to the way practices within the habitus are assimilated so that they are virtually 'naturalised': they are not consciously learned, they are unconsciously accepted. In this sense they have an externality in that they exist in a virtual state; independent of agents, but perpetuated in language and communication systems, bodily dispositions. They are examples of 'symbolic universe[s]' in which we are all complicit in their creation and reproduction. We are all culturally socialised and so subconsciously or unknowingly the rules and strategies which operate within that cultural milieu have been embodied. Violence and violent action disrupt this and are also unexpected because of the regulated order of these sites. This is why as Taylor argues, Bourdieu has a preference for the terms 'strategies, habitus and dispositions' (1999:47) rather than rules because rules have to be defined and codified, whereas our actions are a formulation of the rules, that is a 'knowing how to act in each particular situation' (1999:41): learned by association/assimilation rather than consciously taught.

The habitus of these institutions are discrete sites of social interactions –

doctors and nurses or teachers and diverse client groups all of whom will not necessarily share, understand or accept the institutional regulations. Class, politics, race and gender are defining and separating concepts, creating separate habitus, yet when we enter the fields of education and health these boundaries, evident in virtually all other aspects of social life, are breached in an unparalleled way and added to by cultural differences and social problems.

For example, social class is defined as a set of social practices, preference and taste, including bodily dispositions which Bourdieu corresponds to a class of habitus which is 'produced by the social conditioning associated with the corresponding condition and, through the mediation of the habitus and its generative capability, a systematic set of goods and properties, which are united by an affinity of style.' (Robbins, 2000:8). Bourdieu argues that 'Denying the existence of classes, ... means in the final analysis denying the existence of differences and of principles of differentiation' (1998:11-12).

Thus within the habitus there are two groups, the professionals who as institutional representatives are culturally sensitised to the practices and operations of their institution; on the other hand there are client groups drawn from diverse backgrounds who, while culturally sensitised to the services, are not institutionally aware, and will interpret institutional regulation from their own experience and need. Role setting creates divides, in that the institution has in its organisation and functioning established ritualised practices which are known intimately by their personnel. However, the client groups - patients or pupils - are unaware of this intimate knowledge and have only a tacit understanding of what they can expect

and/or indeed want from these services. These notions in the public are likely to be formed from a limited and perhaps skewed viewpoint. Therefore, symbolic distance in the social world creates the possibility of contested meanings and values in the institutional site.

Institutions create their own classification systems, within their own structures based on capital values expressed through knowledge and skill. Those with the most desirable forms of capital are rewarded most; they benefit economically and by status, being in positions of authority, and are often those who are in positions where they are least likely to be the locus of a violent attack.

Differences, Rupp and de Lange (2000:140-141) argue, 'in class habitus are explained by differences in conditions of existence. These are characterised as different degrees of 'distance from economic necessity' on the one hand and 'distance from the centre(s) of cultural values (concentrations of intelligentsia) and cultural facilities ' on the other'. Control in the habitus is dependent on the exercise of 'capital' through the term preferred by Bourdieu, 'bodily hexis' - that is the assimilations and display of bodily dispositions that denote role, position and status within the context of the institution. Therefore the role of the habitus is more than just a set of differentiated positions. It is also generative; in that it is part of the process of differentiation. The generative principles of the habitus produce distinctive principles and practices for the agents within: what to eat, how we eat it, what sport we take part in, our political opinions, ways of walking and talking, what we define as good or bad, right or wrong, distinguished or vulgar and this will vary with each habitus. It also defines the roles and their

functioning within the institutional setting: in schools and hospitals it defines the working role of the doctors, nurses and teachers; it defines the role expected of the patients, pupils and visitors.

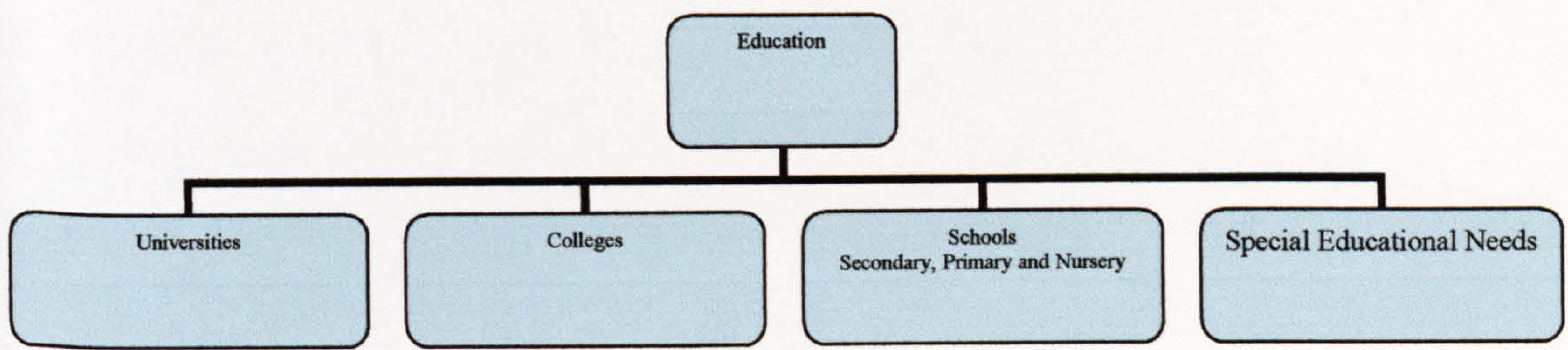
Butler states that 'the *habitus* that the body *is* is generated by the tacit normativity that governs the social game in which the embodied subject acts.' (1999:115). Therefore, what she is arguing is similar to the understanding that Taylor (1999) has given on rules. Rules are enacted bodily functions but are not codified and defined in a static form, they are by their very nature instinctive actions - we know what to do; they may not have been consciously determined or even consciously carried out but they did occur, and within a given set of relations will have value and meaning.

Institutions by their process of reproduction become almost trapped in a hermeneutic cycle whereby they are defensive of their position and therefore reaction to challenge is resistance (Bourdieu, 1990). They automatically assume that violent challenges are to be resisted and that policy measures are needed to control, contain and/or exclude those who challenge in this way. Resistance to the system is typically the: rejection of the established rules and regulations of operation of these institutional sites. The ability to analyse the situation from the voyeur's gaze, and so analyse changes across the boundaries of the institution, is slow if indeed it is ever mobilised.

Bourdieu argues 'It is necessary to write a structural history which finds in each state of the structure both the product of previous struggles to transform or conserve the structure, and, through the contradictions, tensions and power relations that constitute that structure, the source of its

subsequent transformations' (1990:42). In the definition of violence, the history of violence is more important than the history of the institution but the history of the institution and the strategies it deploys to reinforce and maintain its authority converge with how it defines violence. The institutional rhetoric is for 'inclusion' which staff identify as placing them at increased risk of violence, which they do not necessarily have the requisite skills to handle; while the definition and policy to deal with violence is entrenched in that other institution of law and order.

However, at the point of delivery, the schools or hospitals, there are regional variations, because not all schools and hospitals have the same demand for services or the ability to offer all services. Therefore, the configuration of service delivery will vary from school to school and hospital to hospital but the institutional ethos will be shared. For example, geographical location of the school creates different learning environments and demand for subjects often aligned with social class: educationally more academic demands from the upper classes and less from the working classes, but socially often very low demand from the upper classes and high demand from the working classes who have many social problems which de-motivate them from learning. In the case of hospitals geographical location may affect demands based on the effects from environmental factors, such as pollution or climatic conditions – for example, the wet and windy west coast of Scotland is related to the high incidence of chest related illnesses. See Figure 4 below.



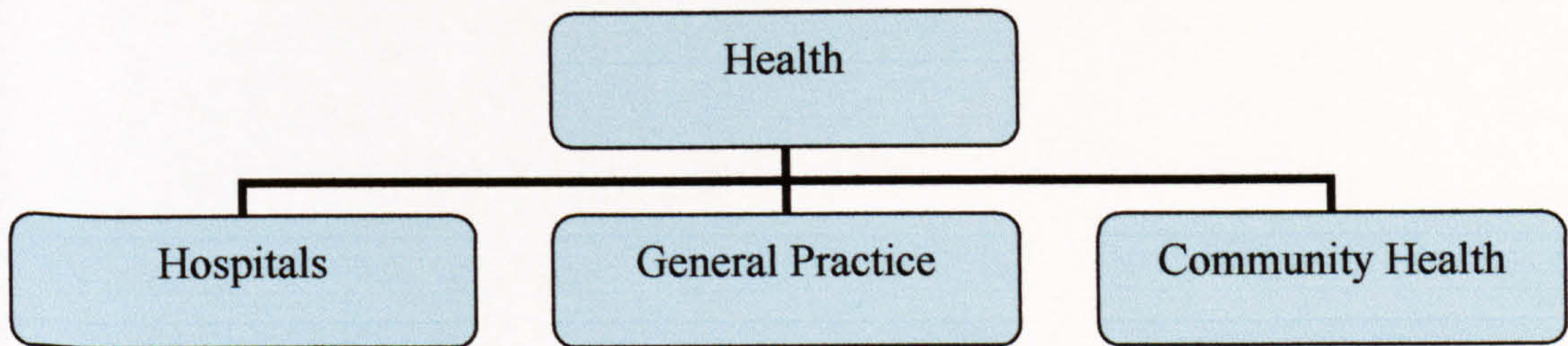


Fig. 4: Service structure

In Figure 4 above I show that these institutions are responsible for a number of discrete services, each of which creates its own habitus; although they all share the institutional ethos all are involved in delivering services to the general public but all vary in the configuration of their services. Furthermore those who work within these fields will be drawn from a variety of different backgrounds - age, gender, social class, race, etc. Those who use the service will be drawn from equally diverse backgrounds. This highlights the dynamic of contested values and meanings that are working institutions. Furthermore, how challenges and violence within are addressed is dependent on the successful exercise of capital and on how violence in the institutional context is defined and supported.

Definitions of violence in the institutional setting are inscribed in the language of legal and political discourse[8]. In the workplace responsibility for safety is enforced by health and safety regulations to ensure that employees are provided with safe working environments. However, the focus on illegitimate and inter-personal forms of violence has restricted discussions on how to deal with it - to the exclusion of other possible explanations or factors – to victim and punishment, protection and exclusion; subsequent proposed policy changes are reflective of how large social institutions and the criminal justice system are structured: discipline and control of known offenders. Central to understanding how these contested meanings are negotiated in the institutional interactions is the concept of capital and this is discussed in the following section.

3.5 Capital – negotiations and hierarchies

Capital is a form of exchange in service delivery between client groups and institutional personnel and is pivotal in understanding relationships of power and inequality: institutional hierarchical relations and institutional personnel/client relationships including those of gender, race and class. It inscribes individuals within the habitus with value relative to their position. It is fundamental to Bourdieu's account of the reproduction of power – those with the most institutionally desirable capital are also those in the most powerful positions.

Client groups in both schools and hospitals belong to social groups which 'possess, or are restricted from access to, material resources, a situation that places them in an unequal social relation to other groups' (Messerschmidt,

[8] The issues with defining violence were discussed more fully in Chapter 2. Violence is and always has been contested and is both historically and culturally specific in its definition.

1997:7). This then places all client groups in a position of subordination within the institutional setting regardless of other common social classifications such as class, race or gender. Ultimately institutional personnel are in a 'unique' position which enables them to reorganise normal social order for their client groups as 'those with power can organise those who are less powerful according to their own ends' (Segal, 1990:261).

Bourdieu argues that there are many types of capital, not just economic, although he does not deny the importance of this: capital in its symbolic sense can be virtually anything - cultural capital, physical capital, social capital, religious capital, legal capital etc. It follows then that capital is available to all in society but in different ways: that is it is symbolic, it acts as an indicator of not just monetary wealth but of the whole package of practices like power and authority, and the strategies we use in our lives. Therefore, in the institutional setting, doctors', nurses' and teachers' positions might not accord with their position in society at large. Having particular skills within the institutional setting – a particular expertise – will accord more capital and consequently greater ability to access and assert power than some others. Forms of capital are used in order to establish and negotiate positions within a particular habitus, although capital worth will vary within different habitus.

Symbolic capital, Bourdieu argues, is a sign of status and creates the identity of self within society. This symbolic value can be acquired in a variety of ways, as cultural capital gained by academic knowledge and learning, or by the development of other skills as in the traditional trades of joinery, bricklaying etc. Capital acts as a negotiating tool in accessing privilege and in

creating hierarchies and distinctions between groups and individuals. Some of the forms of capital will inevitably be transferable but can also have differing values in different locations or habitus within society. Other forms of capital are quite specific and so are of restricted value. Capital is not a static concept as it may be added to or may diminish in response to the dominant culture and our ability to assimilate new or increased capital especially when faced with change. It follows, then, that capital also has an embodied element as well as a physical element. Having desirable capital assets will enable one to access higher status and power within any given society. Bourdieu (1998:7) argues that '..... agents are distributed in the first dimension according to the overall volume of the different kinds of capital they possess, and in the second dimension according to the structure of their capital, that is according to the relative weight of the different kinds of capital, economic and cultural, in the total volume of their capital.'

In our society the political field as discussed above has the most capital. In the habitus those with the most desirable forms of capital are at the top of the hierarchical structure and those with lesser amounts of desirable capital at the bottom. Client groups will have even less access to the desired forms of capital in the field. See Figure 5 below.

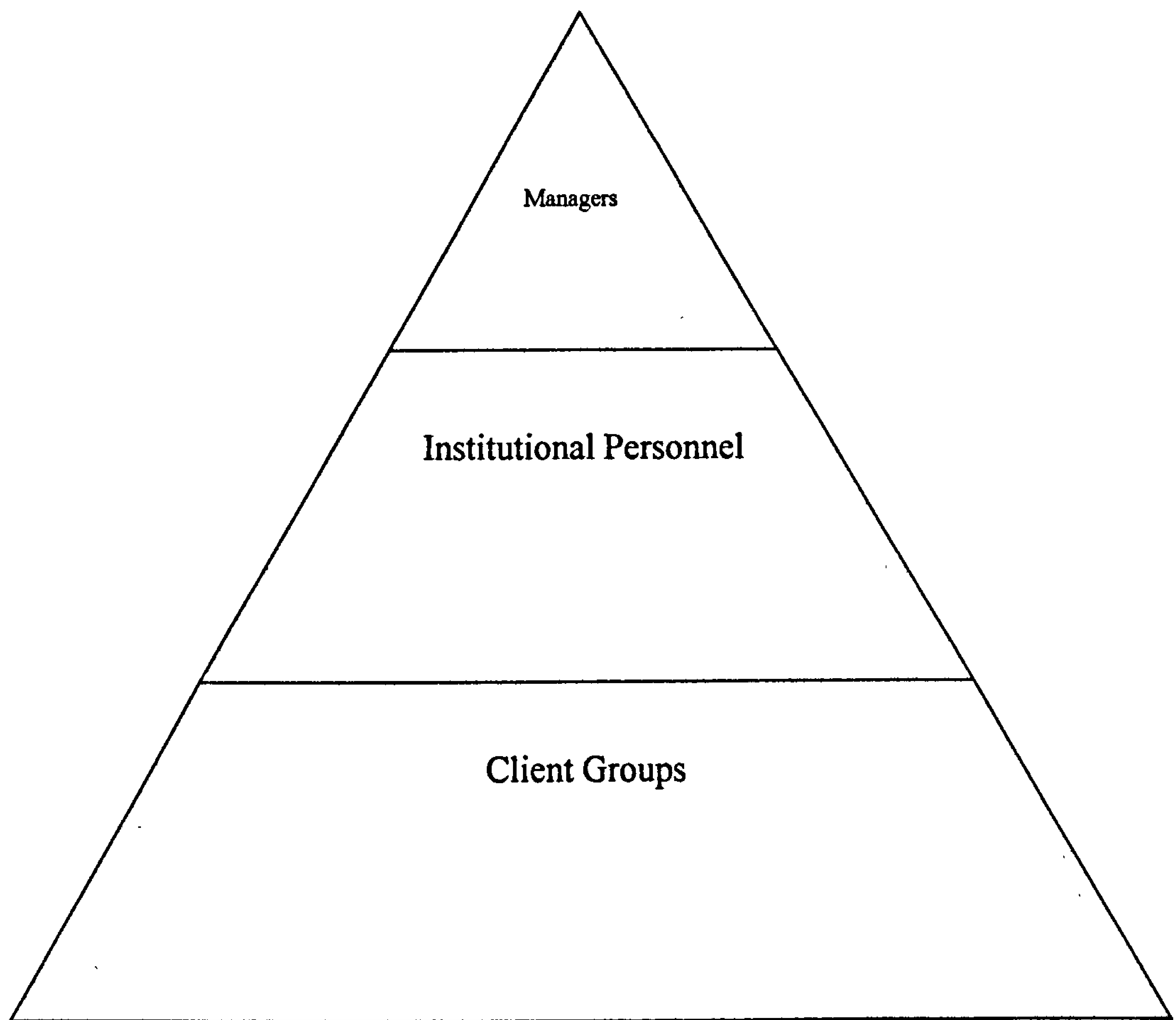


Fig. 5: Top-down model of institutional structure

In this diagram I clearly show the distribution of power and capital in the health and education systems. At the top of the hierarchy is the management structure, comprising senior civil servants and government ministers who define the institutional role; responsibility is then devolved to the local health authorities and chief executives in each of the institutions. This group are responsible for setting targets, defining roles and allocating resources. The service delivery is then carried out by institutional personnel - in the case of health, doctors and nurses. Again we find that there is a hierarchy of skills

reinforced by the remuneration and status conferred on professionals within the institution which also transcends boundaries into the social world. There are also fewer places higher up the hierarchy; hence the competition between agents within the institution to fill these posts. Generally doctors, and those with skills in the most demanded specialist fields, are those who will be found towards the top of the hierarchical structure. Nurses - whose skills are less valued within the institutional system – are towards the bottom of the institutional hierarchy, but still in a position superior to that of the client group. Nurses as a group also have a hierarchical scale in relation to speciality, experience and position filled. Furthermore there are more nurses and therefore competition at the lower end of the scale is less intense than it is at the top where there are fewer positions. A similar situation is also present in the education system.

But Rupp and de Lange (2000) state that different groups access forms of capital and power in different ways and that process determines what is valuable capital and what is not. They argue that '[t]he cultural domain is the scene of permanent manifestations and shifts in power.' What then becomes important is not so much monetary wealth, as the ability to access the seats of power. Those with power are in a position both to determine what in the symbolic world is 'important' which puts them in a position of considerably more power than other social groups. It is not merely holding particular packages of capital but the ability to utilise those packages in a way that perpetuates and maintains the value of the capital that is significant. Understanding power struggles is dependent on understanding position in the institution - those with the greatest capital value are in a position to determine policy but do not necessarily have medical or

pedagogical skills. They may never have experienced service delivery yet they are in a position to determine policy, including definitions of violence in the workplace. Since capital is a differentiating and distinguishing attribute, using it within an analytical frame of fields, habitus will allow for identification of how and where misunderstanding or misinterpretation occur in understanding experiences of violent interactions.

Inevitably this means struggle on two fronts - one within the social group to maintain it, and the other with outside social groups to maintain the difference and symbolic distance between them. Power is 'negotiated via both symbolic and material force and does so by putting across the naturalness of the prevailing order as "legitimizing practices".' (Rupp and de Lange, 2000:140). Bourdieu sees 'the construction of and disposal of "means for the legitimization of economic, cultural and social capital as another form of symbolic capital"' (Brubaker, 1985). In his own words 'the state is the cumulation of a process of concentration of different species of capital: capital of physical force or instruments of coercion (army, police), economic capital, cultural or (better) informational capital, and symbolic capital' (Bourdieu, 1998:41).

Robbins (2000) argues that the concept of 'cultural capital' has often been misinterpreted. The degree of cultural capital possessed has often been taken to be a direct expression of class position, which he believes is not so. Bourdieu identified three forms of cultural capital: incorporated, objectified and institutional forms (Bourdieu, 1986). He explores these forms of capital and their associated roles more fully: 'cultural capital can exist in three forms: in an incorporated state, that is to say in the form of the durable dispositions

of the organism; in an objectivated state, in the form of cultural goods, pictures, books, dictionaries, instruments, machines, which are the marks either of realised theories or of criticisms of these theories, of problems, etc.; and finally in an institutionalised state, a form of objectivation which must be kept separate since, as can be seen in relation to scholastic titles, it confers on cultural capital the supposed capacity to guarantee completely original properties' (Robbins, 2000:33-35).

Incorporated cultural capital then becomes inseparable from the habitus: it becomes inherent in the concept of habitus itself, and therefore, Robbins argues, Bourdieu is indicating that cultural practices should not be viewed only as 'artificial constructs' but that there is a form of 'biological transmission', an almost organic element to the acquisition of cultural capital and associated behaviours. For example, within health care the role of the consultant automatically carries and signifies a particular status whether or not that role is actually filled.

Objectivated cultural capital is best understood in terms of being separated from individuals; it is something to be acquired through one's life. It is the product of desirability and something that has both a historical and present meaning to it. In terms of cultural capital it can be a pre-determined or new set of practices or things - for example, what are defined as 'great' works of art (Bourdieu, 1990). Hence it becomes more than just our ability to acquire, but also our ability to distinguish and differentiate between - to critique aspects of our culture in particular ways. This has a historical context to it, as previous objectives will be adopted and assimilated by later generations, but it is always vulnerable to change because it is dependent on consensus for its

continuity. Within the education system, the ability of the teacher to adapt previous knowledge and skills to new developments in the delivery of education increases their capital value in the workplace.

The third distinction made in the forms of cultural capital is that of 'institutionalised cultural capital', which is instrumental and objective. Institutions are cohesive social groups but not in the class sense; they usually form a unity around the institution and usually involve many from differing classes. What they do however is create micro systems of difference and distinction, where power and prestige are conferred on some more than others. Bourdieu (1990) himself refers to schools as such sites of 'embodied value system'. For example job title creates differences and differentiates between social agents in the school as indeed it also does in hospitals.

However, it is suggested that whilst objective capital is open to fluctuation depending on the consensus for that particular form of capital, institutional capital on the other hand, is fixed - static, a rigid structure (Jenkins, 1996). This is one of the contentious points - if institutions are fixed in how they confer value and practice, then in a world of social change the inevitable outcome is going to be conflict: social agents outwith will change as will the social agents within, yet the structures remain relatively rigid. What then happens is that change becomes retrospective from the institutional standpoint - in response to conflict - but is likely to be slow and appear unresponsive.

Social Capital, a different type of capital, can best be expressed in terms of the networks one is linked to, and the grace and favour that these links can

bring. Cultural Capital, on the other hand, is something that is more closely linked to one's artistic, religious and educational, or professional status. This is not so much exclusion from a particular group or an example of 'social closure' but of how the inherent practices (structures and rules) within a given habitus encourage reproduction of the status quo, a set of self-perpetuating practices rather than practices which project from one class to the other. It is this self-reproduction Bourdieu argues that creates and distinguishes or defines gaps between classes - in other words the embodied practices and preferences of differentiated forms of capital that create symbolic space. This is evident in the hierarchical structures of job specifications within the fields of health and education: in health we have a hierarchy with clinical directors at the top and enrolled nurses at the bottom of the professional scales whereas in the schools we have head teachers at the top and teaching assistants at the bottom.

However, I would contest that the relationship between capital and violence at the interpersonal level has not been fully explored. Violent individuals are also imbued with capital by their use of violence to hurt, humiliate and intimidate their victims. However it is, I contend, for the most part relatively short lived but its effects on others' capital can be in the longer term. Bourdieu's work focuses more on symbolic forms, in that power and symbolic distance between agents are created through capital acquisition, which enables those with the most desirable forms to dominate - exercise force (violence) symbolically - over those with less desirable forms of capital. However, those who are oppressed are always likely to resist and if all other barriers are blocked (actually or symbolically) then there is always the

possibility that they might resort to violence in pursuit of their beliefs, aims, or aspirations.

Therefore capital value associated with the execution of interpersonal violence as mentioned above is for the most part illusionary. This I argue for two reasons: one, that it is in most cases relatively short lived, episodic and not experienced in quite the same way as domestic or racial violence where the threat can be ever present; and two, that the consequences of it for the perpetrators are likely to out-weigh any advantages/benefits. The perpetrator may have had and indeed exercised power over the victim in enacting the violence -physically or psychologically by injuring or inducing fear - but in the type of violence discussed it is time limited and usually brought to a conclusion fairly quickly. The outcome for the perpetrator is normally the imposition of sanctions: either by denial of treatment, removal from the premises, some form of disciplinary action or in the most severe cases legal action and charges. However, the literature review and media representations are suggesting that this 'normal' course of events appears to be becoming the exception rather than the rule, that violence is on the increase, but whether or not it carries any greater symbolic value is still disputed. Current views from schools and hospitals indicate that they feel the need for more effective sanctions, which is reflected in their comments:

> *'Immediate and effective action should be taken. Suspension is an unacceptable punishment and conveys the wrong message to other pupils. Violent pupils seem aware that they can act violently without serious consequence.'* (E25b92) and

> *'I don't know how you can stop violent situations from happening, but when they do they are never dealt with appropriately. People get away with it, if there was a deterrent ie "we always prosecute acts of violence against staff" and meant it – possibly this would stop some of the incidents from occurring.'* (H25b20)

The victims on the other hand may suffer in the long term. While the action of violence may only last a few minutes, the emotional and in some cases physical injury can last much longer. Hence the capital value of the victim can be depleted by their experiences of violence physically and emotionally. Physically they may be unable to work as efficiently immediately following the incident, and emotionally, it may leave them fearful of another attack, which may have a long term effect on their mental health. In extreme cases the effects of a violent attack may permanently prevent them from continuing to do their job.

Violent acts in the institutional setting are more than inter-personal acts. They are also acts against the institution because they have an impact on it. For example, they disrupt the delivery of services; reduce efficiency; and impact economically both in the short and longer term. Some victims will be relatively unaffected and therefore return to normal working practices very quickly, whereas others more severely affected may be unable to work for some considerable time, if at all. Consequently, the costs for the individual and the institution can be considerable: the individual may lose their job; and the institution may lose a trained employee.

3.6 Conclusions

Adopting a Bourdieusian model for doing this research it is argued allows for the disaggregation of events in order to analyse them within the context of institutions. Examining the victim's perspective in such a frame is to facilitate the identification of difference in experience by gender and role in the institutional setting. Furthermore, locating the analysis within the institution enables the identification of any particular practices, spatial or organisational, that contribute to the experiences of violence reported by the respondents.

Combining this analysis with a reflexive methodology as advocated by Bourdieu and as discussed in the following chapter creates a flexible research design for understanding meanings of violence both synchronically – at a point in time - and diachronically – over the course of time.

Chapter 4
Methodology

4. Introduction

This chapter details the research process and explains the organic way in which the research design has evolved. Chapter One examined how the media have problematised violence in schools and hospitals and the need for caution in accepting their representations as they have to be tempered by the 'selectivity that they display' in their reporting (Macdonald & Tipton, 1993). Chapter Two reviewed the growing body of literature on violence and in particular workplace violence. This review has raised questions and identified the need for a strong theoretical frame for analysis. A Bourdieusian approach was adopted, although the initial interviews were guided by the principles of grounded theory (Glaser & Strauss, 1967). Since, as discussed in the previous chapter, Bourdieu intimately links theory with practice, this has also informed the research design.

The neglect on the institutional context of workplace violence has clouded rather than illuminated what was emerging as a complex issue for institutions. The relative paucity of literature with which to balance the media reports initially meant that there was limited information with which to inform the research design. This highlighted the need for an explorative approach to doing the research. Research design drew from both qualitative and quantitative methods which are discussed in detail below but the basic design consisted of: unstructured interviews (Appendix 1) followed by semi-structured focus groups (Appendix 2) with personnel working in health and education to obtain their perceptions of what was going on and why. The

analysis of these interviews along with the data trawled from other sources – unions, professional organisations, official statistics and the on-going review of new literature – was crucial in the development of the study. The significance of this data in conjunction with the media reports in developing the study and in particular the format of my questionnaire (Appendix 3) is explained below. Finally post-questionnaire semi-structured focus groups (Appendix 4) were carried out to investigate any anomalies in the data and to clarify the issues.

The literature had identified gender as a significant issue in the experiences of violence (Hearn, 1987; Messerschmidt, 1997; Connell, 1995) but this was not really addressed in the media reports. Institutional procedures were also identified as another area for examination which was being raised in the growing body of research literature on workplace violence (O'Beirne et al, 2003; Elston et al, 2002; Hearn and Parkin, 2001). There were also suggestions that general social relations, experiences of and exposure to violence affected experiences and interpretations of what is and what is not violent. A questionnaire was drawn up to gather both quantitative and qualitative data. This method was selected due to the difficulties of negotiating access for observations as will be explained below and also in order to target a wider sample. This formed the main core of data collection for this study and was run in one local education authority and two NHS Trusts between December, 1998 and June, 2000 in west central Scotland. There were four sections to the questionnaire to provide data on:

- demographic information on the respondent population;
- how respondents defined violence;

- factors contributing to their experiences of violence;
- levels of violence which respondents were experiencing.

A comments sheet was included and an invitation for anyone who was interested in taking part in a focus group to complete and return separately to maintain their confidentiality.

My main interest was in exploring how doctors, nurses and teachers understand violence at work: how they define it, how they experience it, and whether they perceive it as a new/increasing problem. Furthermore, it was important to extend analysis to include their perceptions on what role, if any, the institutional setting itself – physically and structurally - has on their experiences. Media reporting and academic literature as identified in Chapters One and Two almost exclusively focused on inter-personal relations with scant regard to the institutional settings which as discussed in the previous chapter are identified by Bourdieu and Jenkins as sites of convergence: hierarchies of power, control, rules, regulations, responsibilities, practices, members, clients, cultures, social class and gender.

To understand violence in the workplace it is necessary to understand it from the viewpoint of the institutional personnel (doctors, nurses and teachers) and to ensure a research design in which 'relationships between professionals, their organisations and their clients will [not] become oversimplified and polarised and effectively silenced' (O'Beirne et al, 2003:191).

4.1 Rationale

Enhanced understanding Bourdieu argues is the overall aim of the process of social research: to facilitate discussion of an aspect of social life that advances the use of theory, to inform policy or social change, to help the layman understand the problem, and not just to provide 'verification' of whether or not some phenomenon exists. What was going on? What were their experiences? The picture emerging from the media and the limited amount of existing literature was unclear. In addition, as the unions, employees, employers, and policy makers joined the debate and academic interest in the area grew, the need for a systematic, critical analysis, which for Pierre Bourdieu is the role of the social researcher, was evident. This data was then triangulated with that from documents and the media to assist in framing the research project. Advancing the research in this way facilitated category building from the victim's perspective.

This type of approach is an increasing feature of research methodologies (Bourdieu, 1992; Denzin, 1970; Silverman, 1985; King, 2000; King & Wincup, 2000; May, 2001; Jupp, 2001; Noaks & Wincup, 2004;) in order to address the complexity of current social issues. Violence and understanding it is one area where it is important that any definition of it – in this case workplace violence – is built on one's understanding of, and 'deep involvement in, the subject's world of experience' (Denzin, 1997:35); that is, to identify or uncover from the data patterns of behaviour, or procedures – interpersonal or structural - in their experiences that enhance our understanding (Glaser & Strauss, 1967; Maykut & Morehouse, 1994) of what violence is for them. Adopting a combined/triangulated methodology would assist understanding of their meanings of violence based on their experiences: quantitative data on

definitions and experiences, which quantifies the extent of the problem they face is contextualised by the qualitative data which explores what violence means to them and how it affects them in their professional roles.

Defining violence per se is problematic because as previously discussed in chapter 2 there is no universal standard fixed definition (Jones, 2000; Stanko, 2003) and violence in the workplace is no different. Another anomaly that contributed towards the confusing picture was the terminology used in discussions of violence. 'Bullying', 'harassment', 'difficult', and 'disruptive' were all being used quite arbitrarily in place of 'violence/violent' in the press and other literature. Definitions, therefore, became central to understanding and explaining this particular type of violence. However, I was mindful not to impose, but to allow the data to inform, a definition. It was important to listen to, and understand from the point of view of, the respondents. Their candidness in talking of their experiences, their openness and sometimes emotional discussions were unambiguous.

Burgess (1982, 1984) believes that conducting interviews early in the research process helps to develop it from an understanding of the research population's - the lay person's - point of view. Carrying out field studies in a variety of ways leads to interaction at different levels between the researcher and the participants and between the participants, in both observational, person to person, and person to group situations. 'What can be discovered by qualitative research are not sweeping generalisations but conceptual findings' (Maykut & Morehouse, 1994:21). Qualitative research revolves around the researchers' ability to transcend their own known world into the unknown world of the research area, whilst remaining as open and

unbiased as possible. Mayne (1990:8 cited in Denzin, 1997:47) states that '... researchers... must learn to look at themselves from both sides of the voyeur's keyhole'.

Combining methodologies, qualitative and quantitative, using primary and secondary data as appropriate to examine a phenomenon creates a dialectical relationship, within which theory and practice can be modified; data collection and analysis can be informed; and limited data analysis questioned.

Pinto argues that Bourdieu's theory 'is ... a working method founded on reflexivity' (Shusterman, 1999:1090) which it has been argued 'is "the most significant product of [his] whole undertaking" (op cit) and as Calhoun et al (2002:259) argue '[i]t is crucial not just to see both sides of the issue, but also to see how they are inseparably related'. Being reflexive, Bourdieu insists, creates a solid foundation and a robust model with which to question data against theoretical concepts and the researcher's role in that process. It is more than acknowledging one's 'own social positions in terms of a series of co-ordinates (class, gender, ethnicity etc.) [because] it embraces not just the social position of the researcher, but also the specific location of that individual within the space of the field of social research' (Bourdieu & Wacquant, 1992:40).

Therefore the researcher is active, not only in reporting their findings but also in challenging why they have identified particular issues as important and how they made these decisions in the research process. That is a 'social science based on the study of the doings of actors who always have some

practical knowledge about their world, even if they cannot articulate that knowledge. In other words, social structure is internalised by each of us because we have learned from the experience of previous actions a practical mastery of how to do things that takes objective constraints into account' (op.cit, 259/260). This is particularly relevant to this study in that institutions and their employees create quite separate 'habitus' from the wider social habitus, with its own set of practices, rules and regulations that become known intimately to the employees but are only tacitly known and understood by their client groups.

As discussed in the previous chapter, Bourdieu stresses the importance of the researcher's awareness that 'their point of view is to be a point of view' (1999:625). It is only the privileged position of the researcher that enables them to access and analyse the various viewpoints of respondents, 'that is, to understand that if they were in their shoes they would doubtless be and think just like them.' (Bourdieu, 1999:626). 'Objectivity' is important in analysis but not at the expense of ignoring or denying the role of the researcher in that process.

Bourdieu's standpoint is quite independent in that he argues that previously held traditions of research only serve to limit enquiry. What 'he is centrally concerned with [is] how the various practical projects of different people, the struggles in which they engage and the relations of power which push and pull on them, nonetheless reproduce the field of relations of which they are a part' (Calhoun, 1995:142). This particularly applies to this study as early interviews had highlighted that there was a need to include the role of the institution in the experiences of violence of its employees. Institutions are

also strongly associated with hierarchies of power and control, creating their own working habitus which it is likely all employees will have intimate knowledge of compared to those groups who use these services.

Therefore, adopting a mixed methodology approach as advocated by Bourdieu who is concerned with explaining what is going on, not what ought to go on, or as Glaser (1978:14) puts it telling 'it like it is', is for this particular study an apposite approach. See Appendix 5 which outlines the research process.

4.2 Research process

Data collection began almost immediately as I took advantage of every opportunity to speak with health care workers and teachers whenever the situation presented itself. Initial contacts were derived from personal friends, colleagues and neighbours who work in the Health and Education sectors. However, I was extremely unhappy about including information gleaned from these discussions because they were not undertaken in the spirit of researcher/respondent relations; however I recognised that they were part of the process of sensitisation to the research area. The personal dynamics between me the researcher and friends, their knowledge of what I was doing and my knowledge of what they did were liable to create bias in the interpretation of the data. I am, however, grateful to those who contributed to these discussions round the dinner table, over a cup of coffee, as it was very interesting to hear the differing perspectives being discussed within and between groups of teachers and health care professionals. 'Snowballing' from these informal ad hoc discussions with doctors, nurses and teachers resulted in contact being made with 9 key individuals. Two

face-to-face interviews and 3 telephone interviews were carried out, 3 others were contacted by post and 1 by e-mail. All of them had a particular interest in or expertise in violence in schools or hospitals. These contacts were thought-provoking in that they raised issues not immediately obvious to the 'outsider': for example, the significance of 'triage' in Accident and Emergency departments and the perceived risks from mobile phones in classroom situations. These interviews were also extremely valuable in helping me to focus my thoughts and better understand the significance of the information in the media reports and existing literature. They also identified the need for violence in the workplace to be explored in relation to 'experience' as context is equally as important as 'content' when understanding violence in the workplace.

This information was very useful in the development of the research tools, interview schedule and questionnaire design: a mixed method approach which it was felt would develop a robust methodology that would facilitate an understanding of 'another way of life from the natives' point of view' (Spradley, 1979).

It also highlighted the need to be specific about who was being researched. Therefore, for the purposes of this study those referred to hereafter as professionals (unless specifically identified) are doctors, and nurses working in NHS hospitals and teachers working in local authority schools. Client groups are members of the general public, patients and their families and friends who may visit them in hospital, and in schools, pupils and their parents or guardians who may have occasion to visit the schools for whatever reason.

4.3 Interviews

Unstructured interviews, one of the 'main methods of data collection' (Legard et al, 2003 cited in Ritchie and Lewis, 2003:138), were the preferred form of data collection in the early stages of this study as it was a listening exercise. Such interviewing techniques are particularly useful where it is important to 'find out what aspects of an issue are uppermost in the respondent's mind'(Moser & Kalton, 1971:342); and 'to obtain as full and unbiased an account as possible of the participant's perspective' (Richie & Lewis, 2003:158); and the need for the researcher to understand the matter under research from the respondent's perspective is emphasised by Winlow et al (2001).

I was eager to hear respondents' experiences and to see if they were concerned about the same issues that had been raised in the media. Did they perceive a change in the working environments of hospitals and schools and if so, what kind of change? Loftland (1971) suggests that the 'essence of the research interview is that of a "guided conversation"..... the objective of the non-standardised format [is] to elicit rich, detailed materials ... to find out what kinds of things are happening' (op cit, 1971:76) and interviewees were encouraged to be explicit in their discussions. Later in the research process interviews were semi-structured as they were more concerned with clarifying issues raised earlier and in the data collected by other means. Adopting such interview techniques encourages the interviewee to be as open and candid in their responses as possible, the aim being to create the illusion of a 'conversation with a purpose' (Webb & Webb, 1932:130 cited in Richie and Lewis, 2003:138). Non-standardised interviews also allowed me to 'fine tune' the interview process in order to reduce any misinterpretation

or ambiguity in the questions asked (Fielding, 1993). The initial interviews with key informants were less emotionally charged than later discussions in the focus groups. As key informants in health and education, as opposed to frontline professionals, they were in most cases removed from the sites of violence. However, there was a 'real' sense of concern from them for those who were subjected to violence in their daily employment. Significantly, they raised concerns about reporting and recording and definitions of violence more than actual accounts of incidents.

4.4 Informants' concerns

Some similarity with the media reports was evident from these interviews as all were expressing concern with the situation and calling for more research. The unions and professional bodies representing doctors, nurses and teachers, over the period of this study, were particularly strong in public utterances on this point and indeed two of them had already carried out a piece of in-house research, but only one of them had published their findings. However, two of the unions in particular were extremely difficult to deal with: letters of enquiry and phone calls were seldom answered, and when they were it was to state that violence in schools was 'not really a problem'. Yet, the same unions were repeatedly reported in the press and on TV news reports as being concerned about violent attacks on teachers. Why they were so reticent to be involved in this study was never clear. No formal interviews ever took place with anyone from the Unions but there were several telephone conversations with numerous members from the 5 main representative bodies: EIS, SSTA, NASUWT, PAT and UNISON. One of the professional bodies was eager to be involved – The Professional Association of Teachers – and offered assistance in distributing the questionnaire but

since they were the minority organisation it was felt this would be unrepresentative of the teaching profession.

From the start issues were being raised by interviewees at all levels in the health and education sector and union *materials* that were less prominent in the media reports; in particular the official procedures for reporting, recording and responding to violent incidents and definitions of violence were questioned. There were repeated comments, such as 'I don't know whether or not you would call that violence ...'; 'I am not sure what violence is...'; what is violence...' etc. Concerns were expressed by some that they were not getting the information about violence they needed in order to address it through policy, while others were suggesting that some incidents were not being recognised as violent. This confirmed the need to examine institutional procedures in the experience of violence. Violence was no longer just an issue of inter-personal relations, but a more complex problem that had to be contextualised in the institutional setting. Information and communication systems are all meaningful parts of professionals' working lives and central to understanding their experiences in the workplace.

The inference from the interviewees was that institutional procedures were lengthy, intimidatory and highly formal processes which inhibited some victims from reporting violent incidents. The consequence of this was likely to be under-reporting of violence in these institutions. Furthermore as O'Beirne et al (2003) point out it leaves employees feeling unsupported and 'let down' by their employers. One interviewee, commenting on an internal survey carried out over a 3-month period in the A&E department where he worked, recalled that when a less formal system of reporting, recording and

responding to violent incidents was adopted 61 reports were filed for his department as compared to only 3 formal reports for the entire hospital. These interviews were very insightful, and reinforced the need to understand the complex nature of the institutions themselves and contextualise the inter-personal violence within that frame.

Increasingly violence in hospitals, especially Accident and Emergency departments (A&E), and schools was becoming a much debated topic and the focus of television documentaries as discussed in Chapter One. For example, it was reported, by health professionals that while A&E had always been a violent place to work it was getting worse both in the types of violence experienced and in the incidence of it. Similar views were being expressed by teachers. What was needed was a systematic analysis of the violence which doctors, nurses and teachers were experiencing to enhance understanding and critically evaluate the phenomenon by:

- exploring their perceptions of what violence at work is;
- examining institutional procedures associated with violence at work;
- reporting the victims' perspective on the interpersonal relations between themselves, institutions and violent clients; and
- analysing the role of the media in influencing their perceptions of workplace violence.

4.5 Focus groups

Four focus groups were arranged early on in the data collection process to assist in clarifying the validity of the issues emerging from the interviews:

where some of the issues and concerns raised were similar and where some were stressed more than others; and the discrepancies were probed to identify whether it was differences in experiences or in interpretation of events. This data was also used to inform the design and scope of my questionnaire (Lee, 1999:53). Morgan (1997:2) suggests that 'the hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group'. That is, by lively and directed discussion they encourage people to speak out about incidents which they might not otherwise recall to the researcher. In the initial stages they are extremely useful: especially as my motivation was a 'desire to listen and learn'; to be willing to take the responsibility for deciding the topics to be discussed; and to focus the discussion in this area without needing 'to be too controlling' (Morgan, 1977). You have to be willing to allow the group dynamic to function because 'it is *your* focus but *their* group' (Morgan, 1997). Whilst being extremely useful, they were also extremely difficult. Arranging these groups was a trial – problems with access had dogged this project in the early stages as is discussed more in 4.7. Schools in particular were very difficult: several of them agreed in principle to facilitating focus groups, but actually tying them down to a date and time was nigh on impossible. Eventually they took place and were very useful in opening up the debate and helping to shape the questionnaire. They also clarified how institutional procedures were perhaps obscuring the true levels of violence experienced by staff and how normal working relations within these two institutions put particular groups of workers at greater risk of experiencing violence than others.

In the later stages, focus groups were also used to clarify the findings and to

add detail to the comments made in the questionnaires. They were equally as useful here as in the initial stages and did 'enhance and enrich the data collection' (Lee, 1999:54); that is, they were used to examine any ambiguities found in the data collection process. However, significantly in these groups in which the respondents self-elected the atmosphere was very much more emotionally charged. One woman in particular appeared very stressed if not actually distressed and others displayed such emotions as anger and frustration and they reported that for some of their colleagues fear was a significant factor (Gabe et al, 2001). Emotionality in researching experiences of violence is ever present as 'an interview about a past offence [for example] can revive painful emotions and produce unhappiness' (Ray et al, 2003:224).

4.6 Questionnaire

The questionnaire (Appendix 3) design was informed by the findings from the above process and was selected to target a wider sample group. It was piloted twice before the final version was settled upon, using contacts known to me. The first section gathered statistical data to provide a respondent profile. The subsequent sections all included both qualitative and quantitative questions: the second section on definitions also included a set of Likert type questions. These questions involve 'providing people with statements and asking them to indicate how strongly they agree or disagree' (de Vaus, 1996:88), thereby allowing one to test the strength or weakness of response; but they are also extremely useful in allowing for one to 'pool ... items that appear to be related to or important to the issue' (Robson, 1993:257). It is also possible to build in check questions to such a set, whereby specific issues can be tested by asking the same question in a different format, to reduce any respondent error in the data. In this instance they were

used to both clarify the types of behaviours and test the strength of agreement on what was being defined as violent. However, they were perhaps less useful than they might have been had there been discrepancies in the data but in fact they all confirmed the need for a wide definition of violence with agreement of statements in the 75% plus range for almost all categories. Section three was concerned with who the perpetrators were and where violence occurred most frequently in schools and hospitals and section four with levels, and institutional processing, of incidents of violence. Returned questionnaires were coded and the quantitative data loaded onto SPSS. See Appendix 6 for coding details for the qualitative data. Quantitative data was analysed and categorised in relation to the statistical analysis to enhance or explain the experiences of violence. These findings are reported in detail in the following chapter.

4.7 Access

Formal access was applied for from the local NHS Board and the Education Department who both expressed strong interest in and support for this piece of work. Both granted permission in principle and directed me to contact individual NHS Trusts or Hospitals and individual local authority schools to negotiate access. However, at the individual school/hospital level negotiations were more difficult and indeed it was a combination of serendipity and dogged determination that won the day in the end. Negotiating access is invariably difficult and time consuming. Seldom do things go according to plan - 'trouble awaits those unwary souls who believe that research flows smoothly and naturally from questions to answers via a well organised data collection system' (Hodgson & Rollnick, 1989:3). A myriad of potential problems could compromise any study; so much so that

Hakim (1987:Chapter 10) offers a useful discussion on ways of 'trading down to a cheaper design' in order to respond to time lost through blocked access to resources etc. This study was no different and met a variety of problems which led to the need for 'trading down': for example, none of the schools or hospitals were willing to allow me to do any observations, mainly due to concerns for safety. This was a real disappointment, as I had hoped that it would provide that extra 'something' (Burgess, 1984) which helps the researcher to understand more intimately what the experiences in the field are for the respondents. However, despite this limitation in the research process it is felt that it has not reduced the significance or validity of the study.

There was broad similarity in the problems faced in negotiating access to the two sites but difference in how they were resolved. Consequently, I have outlined the process for each site below. Access within education was gained through snowballing from known contacts. Schools were in principle interested and supportive of the study but less willing to be part of it, despite the support shown by their employers. However, one local authority which granted permission for schools to be contacted also suggested a few named individuals at authority level whom I might want to include. This proved to be an extremely profitable course of action; not only were they willing to be interviewed but in the course of the interview offered access to behavioural records held by the local authority and assistance with the distribution of my questionnaire.

These interviews helped to clarify the organisational position on violence against its employees; providing another perspective on the phenomenon.

Furthermore, I was invited to include in my analysis some 47 of the above-mentioned internally held behavioural records. Behavioural records are filed with the education department when a serious (although not always violent) situation/incident occurs, and the school requires input from or referral to other educational support services, or in some cases the police. Two other respondents to the questionnaires also included anonymised copies of behavioural reports from their own schools.

However, accessing teachers directly to form focus groups was a lengthy process. This was in part due to the nature and the pressures of modern day teaching including extra-curricular activities. It also brought to the fore internal organisational practices as my request to schools had been for any teachers interested in, or who had had experience of, violence in their schools to attend. It transpired in the process of conducting these focused discussions that individuals in one school had been selected to attend:

> ***The head teacher informed me on arrival at the school that she had 'invited 2 union reps and herself along with a representative from the office staff to form a focus group – "you only need 4 people for a focus group"' she said.*** (SAHHT)

My invitation had never been extended to all the staff in the school as I had hoped it would. This focus group was very difficult; it felt very controlled and it took all my efforts to get the group talking. In fact before the group had formally started one of the participants stated to a colleague that it wouldn't last long - 10-15 minutes. I had suggested an hour. It did in fact last 75 minutes, but it took the best part of half-an-hour to get the group

talking. What was behind all the reticence I don't know, but the gentleman who had stated it wouldn't last long left early and discussions improved after that. In another school the head teacher had requested an advert/notice type request to teachers. He was going to include this in the school bulletin, but asked for permission to edit it as space was limited. It emerged at the focus group that his editing altered emphasis of the invitation, to teachers 'who had been violently attacked' as opposed to any teachers who had 'experiences of violence'. Consequently, this group claimed, several other teachers had excluded themselves from attending when they would have probably liked to attend. However, I had not had access to this bulletin and the opportunity to pursue this matter did not arise. The data gathered was insightful and I don't believe it was compromised by the selection process.

While negotiating these focus groups the time was filled by reviewing literature on bullying and harassment in schools that the initial focus on violence had not uncovered. This new body of literature brought to the fore the way in which 'violence', 'bullying' and 'harassment' were being used as virtually synonymous with each other in some cases and as quite distinct terms in others. However, reviewing this literature also identified that while there was a lack of clarity regarding what was violent and what was bullying, for example, much of the literature was to do with pupil-on-pupil or teacher-on-pupil issues that are outside the scope of this study.

Questionnaire distribution went well, with the support and assistance of the local authority who distributed them to all mainstream Primary and Secondary schools. A 10% sample of teaching staff in the local authority was targeted.

Similarly, access was difficult to negotiate at the individual hospital level and was eventually achieved by serendipity as much as anything else. A new Secretary for Health was appointed in the Scottish Executive and I had contacted her by post for her views on the issue of violence in hospitals. While the letter itself did not get a response it transpired that she had forwarded my request to others in the NHS and this resulted in an invitation by one of the large NHS Trusts to attend a 'Violence Committee Meeting' to outline my study. This was a very positive meeting and resulted in their agreeing to distribute my questionnaire to 10% of their staff throughout the entire Trust: in return I was to provide them with a report of my findings from their trust. The time schedule for completing this was very tight, but accomplished and the report received positive feedback from the Trust, who used it to highlight the problem of violence; it was referred to in an article in the Herald newspaper on violence in hospitals (Herald, 5/10/2000 pg4).

Employees were to be selected on a random basis through their employees' data base and the questionnaires distributed by their internal mailing system. Completed questionnaires were to be returned directly to the university. This meeting also identified a contact in another Local NHS Trust - the Press Officer: she took my request to the management committee who granted permission for the questionnaire to be distributed to staff in the Accident and Emergency Department of their Hospitals only. However this did not work as well as response rates were almost negligible. Questionnaires were delivered to the relevant A&E departments; however instead of the respondents posting them to me at the university in the stamped addressed envelopes provided, these two departments, for whatever reasons, collected

the completed questionnaires. I then had to go and collect them and in one department only 2 questionnaires were returned.

4.8 Research problems

Access and the effect that has on 'time' both in pursuing and implementing of the study as outlined above were by far the biggest problems encountered. Access to individual schools and hospitals took some 15 months. This also slightly affected the design of this study as I would have liked to be able to include a 'case study' in each of these institutions, but without access for observations and time constantly being compromised the decision was made to target a wider population with the use of a questionnaire. However, one of the most frustrating issues to arise in the data is the comments made by respondents suggesting that I should come along and see – observe – what they have to deal with – I only wish I could have!

Another issue was that a number of respondents had indicated that they were willing to take part in focus groups, but the details they gave were incorrect, or they had moved to other schools, wards, or hospitals and so I could not contact them. To have tried to do so would have been to compromise their confidentiality.

Two final points which both concern the questionnaire: firstly, that a number of respondents commented that it was too long and this may have lowered the response rate; and secondly, that the information on past violent attacks has not been reported as clearly as it could have been. The question had asked respondents to state the number of incidents they had been involved in and to give detailed information regarding when it occurred, who had

been the perpetrator etc. However, a number of respondents have not given the details requested concerning the number of attacks, but merely reported 'many' or 'various' or 'too many to count' and they have been equally inaccurate in time scales – instead of in the past 6 months, 2 years or whatever, they have reported over a 20-year career, or over the last 10 years etc. This response is similar in effect to that of 'telescoping'[9] as reported by the British Crime Survey whereby there is confusion on the part of the respondent about when particular events actually occurred. This however has not seriously affected the quality of the information on the incidents themselves – it just makes it difficult to analyse in concrete terms.

4.9 Conclusion

This chapter has outlined the methodological approach taken by this study, described the research design and discussed the research process. The main concern is to understand the victims' perspectives on what violence at work means, what is occurring and how to move the debate beyond the surface analysis presented in the media. Therefore, this study has used both qualitative and quantitative methods in order to obtain data on experiences of violence and to address the issues of definition and levels of violence in schools and hospitals. Initially the grounded approach helped to open up the discussions and identified hitherto unreported issues in interviews and focus group discussions. The analysis of this detailed information was used to inform the design of the questionnaire which included a mixture of qualitative - open-ended - and quantitative - structured questions.

[9] Evidence from previous studies suggests that when respondents are asked to recall events that have happened in the past, there is a certain element of 'telescoping'. This is where respondents report events as being within a given reference period when in fact they took place outside the reference period. Telescoping can work in both directions so that respondents may remember incidents as happening more recently than they really did (forward telescoping) or they may remember incidents as happening longer ago than they really did (backward telescoping). (Kershaw et al, 2001).

Furthermore, selecting Pierre Bourdieu's approach to social research facilitates a multi-layered analysis of the data. Developing a reciprocal relationship between methods and theory and in particular using his concepts of fields, habitus and capital allows for 'violence in the workplace' to be positioned within the social and cultural environment of which the institution is part. Consequently, the complex nature and inter-related mix of social, cultural, institutional and interpersonal can be understood in a more holistic way, explaining the complex strategies of negotiation between 'fields' and 'habitus' through the use of 'capital'.

The evidence presented in the findings shows this to be a valid piece of work that has allowed 'violence in the workplace' to be re-contextualised within a theoretical model that demands it be understood in a more dynamic way than was presented in the media reports that aroused interest in the first instance. It has also highlighted the need for a more complex and proactive as opposed to reactive response as this type of response rarely addresses the underlying issues and may only obscure or move the problem from one site to another. A number of other issues have been identified and are reported on, where apposite, that this study was unable to examine or pursue but that are worthy of research in the future to add to and extend our current knowledge in the areas of violence and institutionalism.

The following chapter contextualises the research sample in the working habitus of the school and hospital, and examines current definitions and the reporting and recording procedures for violence at work that apply in these sites.

Chapter 5

Contextualising Experiences of Violence in the Workplace

5. Introduction

This chapter will contextualise the experiences of violence in the institutional workplaces of schools and hospitals. As seen in earlier chapters, health and education are publicly perceived to be two of our most autonomous fields and have a long history of power vested in them, by dint of the specialised forms of capital and support they have from the political field. Institutions are almost insular to the wider social world, creating their own micro-existence – as part of but separate from the real world. Power is also vested in the professionals who deliver their services in the institutional settings but violence in these settings was still perceived as particularly problematic.

For example, managers at local government level reported to the researcher that:

> '*the figures quoted in the press "sound horrendous ... they create a kind of frenzy"*. They question these reports acknowledging that *"there are some genuine assaults and serious cases"* but they challenge the *"degree of the problem"*.'
> (HER)

The official line from one local authority was that they:

'are confident that the extent of incidents are not high', and that *'it is for the employee to consider when they might feel under threat, so your tolerance and mine may be slightly – may be different; I could, somebody might curse and shout at me and I would just brush it off whereas another individual might find that offensive ... So there are these inconsistencies, it is not a blanket approach across the entire authority, but there are norms. ... It is a difficult area, it is a serious matter when it occurs but again you don't want to give the impression to the wider world that staff are routinely and regularly being assaulted, verbally abused, physically abused....'* (PSM)

However, these judgements are made at some distance, symbolically, from the experience of those who deliver services, and furthermore are formulated on *'hearsay'* rather than experience.

Firstly, this chapter discusses the sample group and provides a respondent profile for each of the two workplaces, then examines what issues their supporting unions are most concerned with. Secondly, respondent perspectives and institutional definitions of workplace violence are examined along with experiences of violence in each of the two institutional sites. Emerging issues are identified for further discussion in the following chapters.

5.1 The sample

The sample group, who either took part in focus groups or were formally interviewed, comprised twenty-eight individuals – 17 males and 11 females; a further 10 were in attendance at a Violence Committee Meeting I attended, plus the 318 respondents who returned the self-completion questionnaires.

Further to this many ad hoc situations presented themselves over the course of the study and while this information was not formally recorded, notes were made which were of value in helping to develop my understanding of the work experiences of doctors, nurses and teachers (Burgess, 1984).

The sample population was drawn from two NHS Trusts and the Education Department of one Local Authority in West Central Scotland. Response rates of around 30% were achieved, which although low is typical for this type of method (de Vaus, 1996; Moser & Kalton, 1971; Robson, 1993).

5.2 Respondent profiles

Two hundred and twenty-five self-completion questionnaires were returned from the NHS Trust hospitals and ninety-three from mainstream primary and secondary schools. Overall the gender split of the sample group was approximately 1 male (19.8%) to 4 females (76.7%) and the majority of respondents (91.2%) were between the ages of 30 and 60. This is broadly in line with the gender divisions in health and education

employment where there is approximately a 1 in 3 ratio in education, and a 1 in 5 ratio in health, of men to women.

5.2(i) Schools

Of the 93 returns from the teachers, 29 (31%) were male and 63 (68%) were female. There was a broad dispersion of age within this group:

Age Range	No. (%) of Respondents
Under 30	3 (3%)
30-40	9 (10%)
40-50	49 (53%)
50-60	30 (32%)
Over 60	2 (2%)

Table 1: Age range of teachers in the sample group

As the table above shows the majority of this sample were in the middle range of ages, just over 80% in the over 40 years of age group. The sample consisted of teachers from a number of different positions within the schools, but there is an over-representation of headteachers. This may be due to the system of distribution adopted by the local authority[10].

Returns were received from 58 (62%) primary, 33 (36%) secondary schools and a further 2 (2%) teachers have indicated that they have a remit for the delivery of Special Educational Needs. Respondents are drawn from a

[10] Questionnaires were delivered to the Local Authority with an attached postage paid reply envelope. The local authority distributed the questionnaires to the individual schools – equivalent to 10% of staff in each school – requesting they be filled in. The request was sent to headteachers, who it would appear from returns were more eager than some other staff to fill them in.

variety of hierarchical positions within the schools as can be seen in the table below.

Position	Primary School	Secondary School	Special Educational Needs
Headteacher	45 (5M[11]) (40F)	6 (4M) (2F)	2 (1M) (1F)
Depute Headteacher	5 (1M) (4F)	4 (4M)	
Assistant Headteacher	3 (2F)	1 (1M)	
Principal Teacher (Secondary Schools only)		9 (7M) (2F)	
Assistant Principal Teacher (Secondary Schools Only)		2 (1M) (1F)	
Senior Teacher	2 (2F)	2 (1M) (1F)	
Teacher	7 (1M) (6F)	4 (2M) (2F)	

Table 2: Positions held within schools by gender of respondents

While it is clear from the table above that there is a high representation of headteachers[12], the rest of the respondents provide a broad view of the various teaching positions within schools. The gender split is interesting in that there is a very obvious difference between primary schools which have a mostly female representation and secondary schools which are predominantly male. Although the sample group for secondary schools is

[11] Figures in brackets give the number and gender of respondents in each of the categories. M–Male and F-Female.

[12] This bias in the respondent group has already been discussed in the methods section. It was thought to be a reflection of the distribution methods used.

quite small, and it would be wrong to make sweeping statements on this group alone, it is suggestive of a male hierarchy which is in direct contrast to that of the primary school.

The table below shows the dispersion in relation to the age groups and subject areas taught by the respondents in this sample group.

School Remit	No. of Respondents
Whole School Responsibility: Headteacher	50
P2	1
P4	1
P5	3
P6	1
P7	3

Table 3: Teaching responsibility of primary school teachers

The majority of Primary Teachers in this sample are represented by headteachers although there is representation from a broad range of primary classes. In secondary schools there is also a broad range of subjects represented in the sample group as can be seen in the table below:

School Remit	No. of Respondents
Whole School Responsibility SMT	7
English	6
Maths	4
Science	3
Technical/Computing	2
Physical Education	1
Social Subjects	4
Religious Education & Social/Vocational Education	2
Learning Support	3

Table 4: Teaching responsibility of secondary school teachers

Over half (65) of the respondent population in this group have been in the teaching profession for more than 20 years, a further 22 between 10-20 years, and 6 under 5 years. All respondents worked for the same Local Authority and the majority (51) have indicated that they work in schools with a mixed catchment area; 25 in schools in either working class or deprived areas; and 12 in middle class areas.

5.2(ii) Hospitals

In Health, 225 returns were from 21 male doctors, 16 female doctors, 13 male nurses and 164 female nurses. The age dispersion of these groups is quite broad and as can be seen from the table below most are over 30 years of age.

Age Group	Doctors	Nurses
Under 30	4	4
30-40	1	58
40-50	13	56
50-60	17	56
60+	2	8

Table 5: Age dispersion of respondents by profession

These health care respondents worked in a variety of different types of hospitals including large teaching hospitals (197), respite care (2), general non-teaching hospitals (9), maternity hospitals (5) and a further 12 who didn't specify what kind of hospital they worked in. The respondents were drawn from a variety of different specialist areas within hospitals.

Table 6:

Departments within the hospital and respondent numbers working within these departments

Department	Respondent Numbers
Accident & Emergency	29[13]
Ambulance Room	1
Anaesthesia	3
ARU	1
Bio-Chem Laboratory	1
Cardiology	1
Care of the Elderly	6
Continuing Care	1
Dermatology	1
DME	1
ENT	1
2nd Floor Clinic	1
HDU	1
INS	1
Labour Ward	1
Maternity Unit	5
Mearnskirk House	1
Medical	16
Medical Directorate	1
Medicine for the Elderly	8
Neo-natal Unit	1
Neurological Sciences	14
Nutrition Team	1
Obstetrics/Gynaecology & Paediatrics	10
Orthopaedic	15
Out-patients	1
Practice Development	1
PDRU	1
Radiology	2
Rehabilitation	1
Resuscitation	1
Surgical	11
Surgical Theatre Suite	9
SIU	3
Urology	2
Special nursing remit - throughout the hospital	1
No department identified	70

This group is also relatively representative of the structures and gender split of staff in hospitals as the table below clearly shows:

[13] There may be a slight over-representation from the Accident and Emergency department as this questionnaire was only run in that department in two city hospitals. This was discussed in detail in the previous chapter.

Professional Title	No. of males	No. of females
Consultants	16	11
Senior Doctors	2	1
Junior Doctors	1	
State Registered Nurses	12	127
Enrolled or Auxiliary Nurses	1	40

Table 7: Gender split in professional positions held

The table below shows the differing gender experience of the length of time they have been in the profession and the length of time they have held their current position.

Length of time in Profession	No. of Males	No. of Females	Length of time in current post	No. of Males	No. of Females
Under 5 years	-	12	Under 5 years	1	31
5-10 years	1	5	5-10 years	7	53
10-20 years	7	57	10-20 years	11	54
20 Years plus	26	107	20 Years plus	15	43

Table 8: Number of years in profession and current post by gender

The majority of these respondents have indicated that they work mostly on wards (128), 39 that they only work in A&E, and a further 56 who work in both out-patient clinics and on the wards. All respondents worked within one Health Board Area.

Therefore the respondents in this study do provide a broad range of perspectives from within the working institutions, in relation to the breadth of services provided in health and education. It is also representative of gender, age and professional life span in institutional hierarchies.

5.3 Union concerns

While the media initially highlighted the issue of violence in the workplace as being problematic, the literature reviewed in Chapter Two supported this along with the need for further investigation. However, the union bodies representing these professionals had not been well represented or considered beyond what the media have chosen to report.

This section will consider the unions' perspective on violence in schools and hospitals and review the research reports provided by the NASUWT, EIS and UNISON along with the other data gathered from telephone and e-mail communications as reported in the previous chapter, before moving on in the rest of the chapter to examine the respondents' perceptions and experiences of violence in schools and hospitals. That violent incidents occur is not in dispute, but that the media coverage is a full and accurate representation of what is occurring is questioned.

While the union reports highlight similar types of incidents as were raised by the media, there is a difference in where they locate the need for change. Both the unions and the press use statistics in quite particular ways to highlight the 'problem', but the discussion presented by the unions moves the debate from the largely descriptive reports of violent

interaction found in the press to looking more critically at employment policy and employers' practice that inadequately protect workers from violent attack.

Labour Research (1998) reported in their review of statistical evidence from the HSE's first annual statistics and the BCS that 4,679 workers were seriously injured and 2 killed while at work in the year to March '97; that the greatest number of violent incidents occurred in hospitals: 956 hospital workers were injured - 100 of which are classed as major incidents under the RIDDOR[14] definition – in the year 1/4/96 to 31/3/97; that hospital workers are 4 times more at risk from work-related violence than the general population and that as a discrete category nurses are 5 times more at risk from it. So while violence in institutions is an issue generally, this report has highlighted that nurses are in a profession which is in a particularly high 'at risk' category of violence.

The concern is that violence in the workplace 'could be even worse than the figures suggest' as 'some employers were having difficulties in filling in report forms correctly'. This concern is also voiced by unions including the EIS, SSTA, and the RCN[15], who point out that under-reporting also occurs amongst employees. The 'Criminal Injuries Compensation Authority (CICA) suggest that ... - around 8,000 of its cases each year arise from workplace violence' (Labour Research, 1998). This report also questions whether employers are adequately addressing the risks that staff face: '[r]ecent surveys carried out in the education sector, where

[14] RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, the Health and Safety Executive's (HSE's) regulation for the recording of violent incidents in the workplace. This is more fully discussed in the following Chapter.

[15] EIS – Educational Institute for Scotland; SSTA – Scottish Secondary Teachers' Association; RCN- Royal College of Nursing.

almost 200 people sustained serious injuries as a result of violent incidents at work, have revealed complacency among some employers'; furthermore, 'between a third and a half of all schools had no procedures for reporting and recording violent incidents'. More recently the SSTA (2006), have issued this advice to their members:

- report incidents through normal channels
- insist that the appropriate violent incident reporting form is completed and forwarded to the local authority claiming it is 'amazing how often this is forgotten in the heat of battle', so to speak
- don't contribute to under-reporting, as
- unless the true extent of the problem is quantified, it will not be solved.

The NASUWT[16] urge teachers to report all violent incidents to the police (NASUWT web page accessed May, 2007). Under-reporting, it would appear, is still a significant and complex issue. It is not just a case of incidents not being reported, but the fact that even incidents that have been reported are not necessarily reflected in official figures. The Health and Safety Executive (HSE), it is reported, perceive a lack of action from employers which can be witnessed in their concentration on issuing guidance to them.

The significance is made clear by the Deputy General Secretary of UNISON:

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[16] NASUWT – National Association of Schoolmasters/Union of Women Teachers.

> 'Violence at work is completely unacceptable and not just something which just goes with the job. Employers have a duty of care to their employees and much of the risk of violence is foreseeable and therefore it can be assessed and prevented.' And he added, 'For too long this legal responsibility has been ignored or minimised by employers and some employees have died; others suffered injury and many face a daily dose of violent behaviour' (Labour Research, 1998:14).

Clearly recording of violent incidents involves a complex mix of people, employment practices, and employees' vulnerability.

UNISON reflect the sentiments of the Scottish Executive's Zero Tolerance campaign discussed in Chapter Two: 'Violence at work is not something which has to be accepted as part of a contract of employment. ... Neither is it just a law and order issue. ... [t]he risk of violence is work-related. It arises directly out of the jobs people are asked to do and the circumstances in which they have to work. However violence at work appears to be one of the work-related risks which employees are expected to cope with alone.'

They identify the need for 'risk assessment and coherent overall preventative policy' because '[p]iecemeal arrangements made in response to an incident are no longer sufficient'. They further place the reluctance to report violent incidents firmly in the domain of management styles,

observing that people will not report incidents if they do not believe they will be acted upon; nor if, as they suspect, management styles are liable to interpret their involvement in a violent incident as failure or incompetence on their part.

Consequently then it is not just employment policy, but the attitudes of employers towards violence: their perceptions of reported events, inadequate risk assessment of working practices, inefficient recording procedures, ineffective preventative measures.

The NASUWT change the focus slightly by pointing out that violence in schools is not new and is relatively rare in comparison with disruptive behaviour. They also link the problem to the wider social context and to the general diminishing of '[p]ublic respect for the standing of clergymen, parents, police and teachers.' Nevertheless the issue is real and while the social context is acknowledged, their focus is on protection of staff, responsibility for which they place firmly in the lap of the local authorities, claiming that:

> 'Local education authorities and schools that permit a minority of pupils to undermine the efficiency of schools are arguably in direct contravention of their statutory obligations'. And that ' ... Education Authorities must support teachers in the use of immediate and effective sanctions to deal with anti-social behaviour. If such sanctions are ineffective for a small minority then that minority must become the responsibility of the Education Authorities which must provide a suitable alternative opportunity for education.'

Alongside this debate, bullying is also identified as causing concern. It is defined as 'the unjust exercise of power of one individual over another by the use of means intended to humiliate, frighten, denigrate or injure the victim' (NASUWT, 1996a). It is worth remarking here that this definition of bullying shows close correlation with definitions of violence. This oscillation in terminology between bullying and violence highlights the difficulty in accurately assessing levels of workplace violence. It is estimated that 'between 30% and 50% of all work-related stress illnesses in the workforce as a whole is caused by workplace bullying'.

Two issues are emerging here: that within the schools the bullies are also being identified within the profession - headteachers, depute headteachers, and heads of department etc.; but also that they themselves can be the victims of bullies, and they quote the following comment made by a primary school headteacher:

> 'I believe that the biggest bullies are outside the school. I blame the pressure put on all staff (including the Head) by Government, OFSTED and LMS. These are the real culprits.' (op cit)

The unions and professional bodies representing doctors, nurses and teachers differ in focus in that while the press are more concerned with bringing the perpetrators to justice, the professional bodies move the debate to employment law, workplace practices and the social environment of the institutions and their client groups.

Examining the union's perspective has moved the debate from that of physical inter-personal violence portrayed in the media to demand that analysis of workplace violence must include the issues of working practices and procedures. In recent years changes in institutional organisation have seen the introduction of the principles of the marketplace to schools and hospitals which has impacted on resource allocation, and also on staff management relations where it has, in the opinion of the unions, aggravated levels of bullying and increased stress on the workforce.

5.4 Defining violence in institutions

Our understanding of workplace violence is built on historical and cultural definitions, and how it is politically and legally defined in contemporary society has a direct influence on whether the violence faced in the institutional setting is recognised as violent. Responsibility for safety at work lies with the HSE including the need to protect employees from violence and is regulated by RIDDOR. Both employers and employees have to recognise violence in the context in which it occurs which has led UNISON to stress that any definition has to be inclusive of a variety of forms of it. However, irrespective of its definition, the lack of shared meaning in interpreting it, as previously discussed in Chapter One and Two, is not addressed and it remains a 'mutable' concept (Jones, 2000; Stanko, 2003). As a spokesperson from one local authority commented they were trying to define more clearly what is meant by the Scottish Office when their definition referred to

'anything which makes one feel violated' (PSM)

In other words the perception of large social institutions as immutable acts as a barrier to protest, those who are aggrieved don't perceive an effective avenue for protest and consequently that protest can be enacted through violence.

There is an ambiguity in how violence is interpreted in the institutional setting, despite the realisation of some that violence has to be understood from the victim's perspective:

> *'the important thing is how the individual perceives it ... if the person who was abused felt abused ... that is what the problem is – it is against staff'* (GRC)

and another commented that:

> *'It is for the employee to consider when they might feel under threat, so your tolerance and mine may be ... different'* (PSM)

How violence is defined in the 'field' has implications for how it is understood in particular contexts; for example, as previously highlighted in Chapter Two, violence within families and racial violence are two examples of the tensions that exist between 'violence' that is recognised in the legal process and the violence that doesn't fit neatly into these legal categories. Violence at work is, I contend, another example. The evidence from the unions has shown that employees are not only facing violence in

the workplace but they are also facing resistance from their employers in recognising their experience as violent.

While the cultural field defines the legal position on violence through the HSE - who define it as:

> 'Any incident in which a person is abused, threatened, or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks.' (HSE, 2004)

- each of the fields of health and education has their own working definitions of violence in the workplace. For example, the DHSS (1988) definition reads:

> 'the application of force, severe threat or serious abuse, by members of the public towards people arising out of the course of their work whether or not they are on duty; and includes severe verbal abuse or threat where this is judged likely to turn into actual violence; serious or persistent harassment (including racial or sexual harassment); threat with a weapon; major or minor injury; fatalities.'

The Education Service Advisory Committee (1997) definition reads:

> 'any incident in which an employee is abused, threatened or assaulted by a student, pupil or member of the public in circumstances arising out of the course of his/her employment'.

However in practice the inclusiveness of these definitions also compromises their effectiveness. For example, the health definition which seems quite specific has two particularly significant points worth noting. Firstly, while it appears to be accepting of non—physical forms of violence the phrase 'where this is judged likely to turn into actual violence' is quite telling and would appear to be suggesting that its definition is only relevant to those incidents where something more than verbal abuse or threat are apparent. This view is consistent with that from the press who as discussed in Chapter One have focused on the physicality and inter-personal nature of workplace violence, brought into the institution by the public they serve. Secondly, both the health and education definitions echo the view from the press as they quite specifically identify violence as being perpetrated by non-institutional personnel. It is quite clearly defined as a problem that is brought into the institution by the public they serve. This perception of violence being a problem brought into the workplace setting is as identified by O'Bierne et al (2003) one of the issues that still needs to be adequately addressed. They argue it is a failure in the institution to recognise its own position in the relationship between professionals and clients. This latter point is also evident in the definition of workplace violence in the education sector. Their definition, while much less specific than that of the health one, is equally as problematic. In being non-specific it, in practice, raises questions on exactly what

behaviours it refers to. Hence both definitions are highly subjective in their application.

5.5 Respondents' definitions

Therefore the victims' definitions of violence from experience of it are central to developing a deeper understanding of what workplace violence is. If the media and employment definitions are as problematic in application as the unions are suggesting then a victim-led definition may bring clarity to the meaning of it for employees. The respondents have also defined violence in broad terms, which supports the unions' calls for an inclusive definition. Violence is defined in each of these institutional sites below.

Definitions of Violence	**Teachers**	**Doctors & Nurses**
Verbal Abuse	84%	88%
Physical Abuse	100%	99%
Threat to the person	93%	82%
Threat to property	81%	69%
Mental Abuse	61%	62%
Group Threat	55%	54%
Other	10%	3%

Table 9: Percentages of professionals in agreement with categories as violent

The respondents both conflated and qualified their responses to defining what types of behaviour they considered to be violent by indicating that the following practices were examples of the above types of violence.

Verbal abuse, the majority of respondents agreed, included name calling, threat of violence and threat of future violence, and being addressed in an aggressive manner. Respondents were ambivalent over the effects of verbal abuse in that in some instances it was perceived to be as violent as physical acts and in others it was only upsetting.

> *'Verbal abuse can lead to mental abuse if it is repeated over and over again by the same person. Depends on other evidence of whether this is a statement made by someone who is known for this or not.'* (E10a4)

and on other occasions

> *"Patient becomes verbally aggressive and using threatening behaviour. Then assaults either patients or staff and vandalises equipment and fixtures.'* (H10a 195)

This highlights the subjective nature of violence and indicates that these professionals are discretionary in their use of the term 'violent' in relation to the variety of behaviours they face in the workplace. Similarly, the use of bad language was not always felt to constitute a violent act as it would appear that other factors have to be taken into consideration in making this judgement. Talking in class however, was not felt to be violent, but disruptive. Verbal abuse is more than merely the spoken word/s; sometimes it is combined with physical violence but in any event it is inseparable from the effects it has on the victims of it, emotionally or

psychologically. Furthermore constant disruption and indiscipline experienced on a continuum is also defined as a form of violence.

> *'Pupils with violent tendencies are like volcanoes waiting to erupt and you often have to gauge their mood and try to avoid confrontation. This underlying threat of violent behaviour is stressful.'* (E10a92)

Physical violence involving the use of a weapon is defined as an extremely violent act. It can also be experienced by being deliberately jostled, having objects thrown at you, being pushed or slapped, by being subjected to the use of aggressive body language, intervening in brawls or facing overtly physically behaviours. However, there is ambivalence over whether or not classroom indiscipline, witnessing a violent act against another or feeling fearful can be classified as violent amongst teachers. Similarly disruptive behaviour is not always non-violent and again it is suggestive of teachers being able to apply the term appropriately to the whole event rather than a specific behaviour.

While there is a strong similarity in how doctors and nurses define violence they would appear to be slightly more tolerant of name calling and the use of bad language than teachers. In general doctors and nurses would appear to be more willing than teachers to define disruptive behaviours as non-violent, and they are slightly more ambivalent over the violence as experienced on a continuum and on aspects of verbal abuse such as name calling.

'Several years ago I nursed a patient who had no use of upper or lower limbs. This patient – a known drug dealer – constantly threatened nursing staff. The threat being, as he could do nothing to harm himself was to get his family to "get us" outside. We were all intimidated and frightened by this as we knew he was capable of seeing it was carried out. I perceive this as a violent incident.' (H10a18).

Respondents' definitions and examples of violence experienced in the course of their daily work challenge the focus on the physicality of official definitions of workplace violence. It is clear from the examples here that it is the context in which it occurs and the experiences of it that distinguish for the professionals the violent act from the disruptive act.

5.6 Institutions, rights and responsibilities

Institutions are a complex mix of actors, clients and various viewpoints in a highly regulated policy-orientated environment. The institutions - schools or hospitals - are the habitus which Bourdieu (1990:53) argues are best understood as:

'...the conditionings associated with a particular class of conditions of existence ..., systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organise practices and representations that can be objectively adapted to their outcomes without presupposing a conscious

aiming at ends or an express mastery of the operation necessary in order to attain them.'

The institutional habitus, then, organises agents in relation to their relative capital values for the particular duties they are assigned and in doing so places particular groups of agents at the frontline of the client/institutional interface. Role setting creates divides, in that the institution has in its organisation and functioning established ritualised practices which are known intimately by their personnel. They understand and are able to rationalise virtually automatically through habit and knowledge the operation and delivery of the services they provide. However, the client groups - patients or pupils - are unaware of this intimate knowledge and have only a tacit understanding of what they can expect and/or indeed want from these services.

Governmental policy has radically changed especially in relation to funding and the operational functioning of these public institutions. Marketplace theory was brought to the fore and the emphasis was placed on openness of governance: transparency and accountability being the key concepts in the delivery of services. Furthermore the introduction of the Patients' and Parents' Charters in 1991 was to highlight rights: the Patients' Charter set out what patients could expect in relation to their treatment and care while the Parents' Charter set out the rights and responsibilities of parents in relation to their child's education, in particular 'The right to know' and 'The right to choose'. It is the frontline workers who are most likely to be exposed to these changes and any

increased risk of violence in the workplace. For example, the experience from hospitals is that:

> *'Since the Patients' Charter the public are more aware and concerned about care given to themselves/relatives. Resources from Health Boards can dictate what care is given – nurses are in the front line – no matter who/which department complaints are about. Medical, physio, OT, social workers are not seen every day, whereas nurses are constantly around at ward level, near at hand.'* (H14b9)

The issue of 'rights' and 'responsibilities' is frequently referred to in the discussions of the respondents. 'Rights' from the institutional perspective is interpreted in terms of rights to know: that is, patients, pupils and guardians or visitors have the right to receive information about their condition and what is likely to happen. However, they report in their experiences of violence that this 'right' is interpreted by the public as a right to demand services.

> *'Parents feel they have the right to tell the school what to do. Unfortunately many parents are unable to express themselves in a reasonable manner. ... Parents think they know their rights and try to use them to get their own way'* (E14b14)

and

> *'...parents are full of their rights but are not aware of their responsibilities and are aggressive in demanding their rights'.* (E14b31)

Similar attitudes are also reported by doctors and nurses:

> *'Patients and visitors demand their 'rights'. ... Staff have no rights – according to them.'* (H14b19)

and

> *'Since the patients charter was introduced a certain section of the public almost seem to feel obliged to make unreasonable demands and complaints.'* (H14b17)

These examples are indicative of the views expressed by the sample groups. They are expressing a lack of understanding in the interpretation and intentions of what these charters' aims were by their respective client groups. However it also highlights how want and need can be interpreted and rationalised from more than one viewpoint and there is nothing to suggest that either is wrong until they come against each other. Since the introduction of the Patients' and Parents' Charters in 1991 doctors, nurses and teachers have linked them with increasing violence they are facing at work. Violence is:

> *'a reflection of society, and society's attitude to problems of violence have changed. However, although we understood better how society operates, we seem to know what we want to do, we do not have equal amounts of resources. Schools provide a well publicised area to see all this.'* (E14b4)

and

'Because of the patients charter patients and relatives think they have every right to demand for the attention and treatment they want. If this is not in agreement with the hospital statement then they become upset, violent and abusive. Staff members fear litigation.' (H14b58)

The implication of these remarks is that some people, when faced with barriers to their perceived rights will resort to the use of violence, verbal and/or physical, in their attempt to achieve what they want. Different perspectives and expectations are likely between the institution and client groups and therefore likely to create tensions between those who are providing services and the infinite demands of the public. For example, medical staff report:

'...people's expectations of care are high and they feel very let down if this is not so and demand answers and information.' (H14b68)

"People have tremendous expectations of what the NHS can offer – expect to see a doctor when it suits them, drugs to be available when they are ready to go home, ambulance at a convenient time. When this does not happen, some people become very frustrated and verbally aggressive.' (H14b6)

Therefore, the concept of habitus does not just identify distinctions of social class but can and indeed should be utilised in understanding how the differing perspectives, experiences and indeed forms of capital held by

client groups and institutional personnel impact on the principles and practices of large social institutions.

Management changes have highlighted how tensions develop in habitus through changes to policy conceived in the field. The relationships in the habitus have been altered and the client groups endowed with increased rights, with higher capital value with which to protest. This protest it seems is being exercised at times as forms of violence which the staff directly link to the introduction of the charters. These changes in management structure and clients' rights have been commented upon by union bodies and reported in the press as a major source of unease and tension in the interpersonal relations between teachers, doctors, nurses and pupils and patients. And the institutional site, the school or the hospital, is also a factor in experiences of violence; the physical space – structure and layout of the buildings – classrooms and wards or cubicles create discrete units which are closed to surveillance and observation.

5.7 Experiences of violence in schools

Sixty-three respondents report having personal experience of a violent incident in the workplace and as the table below shows some more than once.

Number of incidents	Experienced by Males	Experienced by Females
1 Violent incident	3	8
2 Violent incidents	4	5
3 Violent incidents	2	6
5 Violent incidents	1	2
6 Violent incidents	—	1
10 Violent incidents	1	—
Various incidents[17]	10	18

Table 10: Number of violent incident experienced by gender

Typically these incidents include verbal abuse in the form of accusations, shouting, swearing and issuing threats. Physical abuse is mostly experienced as hitting, kicking and the throwing of objects in the classroom. The following are examples of some of the respondents' experiences of violent attacks.

> *'Usually by the same pupil who has extreme behavioural problems. Pupil lost control after a minor reprimand. Hit and kicked me and had to be restrained. After a period of calm, erupted in my office throwing things around the room. Picked up scissors within the room which I managed to prise from his fingers. Other two incidents were more verbal – shouting, name calling, body language etc. but following on from the major incident were viewed as potentially violent incidents. The pupil*

[17] Various refers to where respondents have indicated more than one incident but been non-specific about exactly how many.

was an 8-9 year old child and [this] occurred within the school day after the interval.' (E18b36)

'Perpetrator – male pupil aged 15 years – recently pupil punched staff member who was denying him access to cupboard.' (E18b15)

'About 20 years ago I had to break up a fight between two 4th year boys during lunch time. It turned out one was carrying a knife – fortunately he ran away – this has remained at the back of my mind ever since.' (E18b93)

However, as the report below shows these incidents are not confined to west central Scotland, but have been experienced by teachers who have worked in other parts of the United Kingdom.

'A sample only: hit over head with bottle by violent ex-pupil (boy), this in London some years ago. Car scratched deeply with keys – perpetrator unknown. Broke up a fight, originator male 14, carrying a scalpel. This in London some years ago. Boy 13, had air-gun in another teacher's class – effect on staff obvious. 11 year old boy found with knife in recorder case. 16 year old girl towered over me, next to me, and told me she refused to accept my authority. Low level violence eg answering back, swearing under breath etc. daily. Both genders, all ages.' (W18b85)

The effects of some of these incidents can be felt long after their occurrence. Some 30 respondents report that it has affected their health in both the short and long term. These effects include physical injury (7) and feeling more nervous (22) or indeed a combination of both. Two female respondents report being unable to work following a violent attack , one for a period of 5 months; however one-third of respondents who have experienced violence in the workplace also report that it has left them feeling fearful of 'violence' and has an effect on their ability to teach. The unions argue that effective policy changes are needed because '[t]he view of most teachers today is that, if anything, the problems of disruptive, and indeed violent pupils, are much worse that they were ten, twenty or thirty years ago'. There has been, they assert, 'A worrying trend ... in recent times of violence or the threat of violence being directed against teachers'.

For example, teacher comments show how complex the problem is. It is not so simple to assign incidents to categories as the above definitions might suggest. Violence is often experienced in complex ways such as:

> *'"Attacker" close to the teacher, loud voice, personal comments, (implied or explicit) of physical violence.'* (E10b9)

The above could be interpreted by another as non-violent, that of a youth resisting the authority and control of the school, failing to recognise that the closeness of the attacker can make what on paper appears to be non-violent a very threatening and frightening experience. Similarly, some of the issues that teachers have to deal with, which in some cases can lead to a violent incident are not always educational problems; for example:

'Last year I had a boy in my P4-7 class who was very disturbed due to recent revelations of his sexual abuse. He paced around the class when asked to do anything he didn't want to. All the normal strategies for defusing the situation failed and the result was he was throwing things at children violently and upturning anything to hand. He started lashing out at me so I took his arm and pulled him away from the class. He was then pushing and kicking me violently and I had to restrain him with another teacher. He was screaming violently and using a lot of sexual language and only calmed down when I phoned the teacher from the behaviour support school – she spoke to him.' (E10b33)

This example serves to highlight a number of complex inter-related issues that cumulatively are being defined as violent in the school setting. That the above incident is violent and distressing is not the only issue; the child is himself a victim of violence and it is in the analysis of the situation that we begin to see how both institutional and cultural capital of both the teacher and pupil are compromised in the institutional setting. The boy is obviously in need of support that main-stream education cannot provide and the teacher who has to teach is not trained and would not normally be expected to deal with such situations. Similar situations to this are to be found in doctors' and nurses' experiences and are discussed in more detail in Chapter Seven.

In other situations teachers identify as violent incidents where their involvement is not as a *victim* but as an arbitrator:

'As I enjoy a warm rapport with most pupils most violence results from tensions between pupils. I once had to physically separate two pupils which left me very shaken. This is the most typical kind of violent incident I have experienced'. (E10b92)

Despite the evidence from schools the unions state that 'Some local authorities have been causing extreme problems for schools by returning excluded pupils, often without even interview of the parents, by the Director of Education to the schools from which they have been "permanently" excluded.' Similarly the abolition of corporal punishment was a directive from the political field and it is argued by middle management in the education system for example, that this has left a void in dealing with disruptive and violent behaviour in schools. One headteacher highlights how discipline in the habitus of the school is affected from two sides – policy and the client group they serve:

'... fear about the sanctions have gone, and the sanctions are so ineffectual. ... I think there is a general deterioration of behaviour. ... In an area like this[18], when you tease out some of the pressures and some of the families, poverty, there is less parental input than you might hope there would be and again standards of behaviour. .... That kind of behaviour and that kind of language and that kind of attitude to aggression that you see in the way they talk to people, the language they use,

[18] This interview was carried out with the Headteacher in one of the poorer peripheral housing schemes in the outskirts of Glasgow.

they are learning that in the home. So, they cannot be learning it anywhere else ... it is through society. ... It becomes established as aggression ... people turn round and shout at you or in the shouts there is swearing as well, it is quite aggressive. And they are aggressive to each other, they don't see it that way, it has almost become the kind of norm.' (HTCH)

There is a general feeling (83%) that violence in school is increasing even although it has always been a feature of school life (69%) and therefore it is not a new problem. Forty-seven of the respondents have personal knowledge of violent attacks on other teachers. Three-quarters (75%) of them firmly reject suggestions that it is has only been raised in their perceptions by media coverage of it.

One of the points at issue is the distinction between disruptive and violent behaviour. Over half of all the respondents from the education sector have reported that it is possible to clearly make this differentiation, while just under a third have indicated that in some instances the one – disruptive – can lead to the other – violent – behaviour. For example one teacher reports that:

'Disruptive pupils may not exhibit violent behaviour. It can be managed within class and with support, where this behaviour becomes threatening is when it becomes unpredictable or where the pupil(s) are in control or able to manipulate the class, teacher and/or situation. Disruptive pupils should be a whole

school and authority issue, where class teachers are and feel supported by management and their colleagues.' (E11b1)

'Not all disruptive pupils are violent – but all violent pupils cause disruptions.' (E11b6)

'Constant disruption is of course extremely stressful and unpleasant but for a pupil to actually physically attack a teacher or threaten to do so must be treated promptly and must be seen to be unacceptable in any school. I think there is no difference in low level continuous disruption but there appears to be more in the way of major incidents. This could be because children perhaps don't see enough in the way of sanctions being imposed.' (E11b45)

'Disruption always carries the potential for violence. The fear of potential violence can have a major effect – whether a violent act transpires or not. It is the vulnerability which counts.' (E11b86)

While teachers from their experiences in the classroom feel they can clearly differentiate between these two behaviours, to the layperson removed from the situation it is more difficult to understand precisely what this difference is. There are from the evidence above clear links between the two behaviours which makes clear the subjective nature of defining and understanding violence.

Eighty-three percent of all teachers feel that violence in schools is increasing and 58% report that while violence can be experienced from pupils, ex-pupils and visitors to the schools – parents or guardians – most of their concern is with those between the ages of 7-9 (67%) and 18 year olds (69%) and with male pupils in particular. They comment on their various experiences of teaching pupils and dealing with parents:

'Children much more aware of 'their rights'. Increasingly likely to challenge teachers or refuse to accept discipline. Low level discipline is also increasing. Growing number of parents less willing to support teachers/school disciplinary action.' (E14b70)

'Attitude of pupils. Can't count to 10. Say what they think instantly. Aggressive replies. Less parental support to teacher.' (E14b8)

'There is a feeling that little can be done to control disruption, bad behaviour and even violence. Parents often cannot or will not control or discipline their children so the problem grows. Schools often feel ineffective in dealing with difficult children and often feel that they have to be 'contained' in school when they will continue to disrupt the education of the majority – exclusion is frowned upon.' (E14b16)

'In the past, teachers have been reluctant to admit a lack of discipline and that there were violent pupils, as that could be

construed as an admission of failure. Lack of sanctions means that pupils can behave badly with impunity.' (E14b45)

'Perhaps because more incidents are reported in the press and pupils are generally more disruptive in school there is less respect for authority.' (E14b55)

'They feel that children see incidents in school and feel that others are "getting away with it" and then others feel that they can try out various acts themselves. Usually teachers have had one or two violent children in class either year – although they are usually violent to each other not in class.' (E14b57)

'The incidents have increased in numbers over the years and are probably more likely to be officially reported.' (E14b60)

These comments show that teachers are concerned with pupils, parents, employers and social values generally. More specifically they are also concerned with the increased challenges from pupils and parents, as well as the increases they face in indiscipline which is exacerbated by the lack/loss of status and support for the teacher in their role as educator in the classroom. They also feel that the current sanctions are ineffective in dealing with cases of violence in the school. Therefore, their professional status is being undermined but so also is their institutional and individual capital – fear of being seen as failures undermines their self-esteem.

Generally teachers report that their concerns about violence in schools are

listened to by the line managers (85%[19]) in the school and their union representatives (66%). However they are ambivalent over whether their local authority listens - 42% believe they do but 39% believe they don't - and only 5% of this group believe that central government is listening to them. While the majority also report being satisfied with support and protection procedures adopted by their schools their comments suggest that it is more complex in practice. For example, the following comments are indicative:

'Back up is required from LEA when incidents occur so that staff don't feel so isolated' (E25b3)

'more psychological service personnel needed' (E25b6)

'The system supports parents by ensuring that their children are kept in school no matter their behaviour. It is not teacher friendly.' (E25b27)

'Violent pupils and their parents have too many rights and are given too much consideration. The rights and feelings of the victims – whether teachers or other children – are dismissed, ignored or not taken seriously.' (E25b80)

'Violent pupils seem aware that they can act violently without serious consequences.'(E25b92)

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[19] This finding may be slightly skewed as there are a disproportionately high number of Headteachers in this cohort.

They repeatedly refer to the need for back up and support from Local Authorities and Central Government, which implies that while the system for reporting and recording is adequate, it is what happens once the data has been collected that is the real issue. It would appear that a small group find the reporting system 'too bureaucratic' and their concerns are summed up in the comments of one teacher, who stated that:

> *'Staff have little confidence in the 'system' – in fact no one knows how the system works – not to the satisfaction of staff or indeed the decent pupils (who are in the vast majority).'* (E28b93)

This cohort - unlike the findings reported in the literature review - are relatively happy with the discipline, reporting and recording procedures (80%) within their schools. Eighty-nine percent of them know what the reporting and recording procedures are within their own schools. Only 19% of respondents feel that they are threatened by the investigation of a violent incident, however, despite this being a small group the comments they make clearly identify this as an area of concern. For example, they remark that 'you have to live the whole incident again and again' (E29b38) and frequently state that they are made to feel as if they 'have to justify that they had tried everything humanly possible' (E29b27) as it can 'leave you open to counter-accusations ... and made to feel inadequate' (E29b86). It is claimed that 'Pupils are very aware of their 'rights', the onus seems to be on teachers to prove they did not provoke the incident or act violently towards the pupil.' (E29b92)

5.8 Experiences of violence in hospitals

Doctors and nurses do not identify any particular group – by gender or age - as being especially associated with violence. One hundred and forty-eight of the doctors and nurses in this sample group have had personal experience of violence in the workplace and over 80% of all the respondents have knowledge of violence against another colleague.

Number of incidents	Experienced by Males	Experienced by Females
1 Violent incident	1	7
2 Violent incidents	2	20
3 Violent incidents	1	3
4 Violent incidents	1	3
5 Violent incidents	—	3
6 Violent incidents	1	4
10 Violent incidents	—	1
23 Violent incidents	1	—
Various incidents[20]	11	84

Table 11: Number of violent incidents experienced by gender

It is clear from the table above that females experience more violence in the workplace than males. However, it also has to be recognised that health care work in general is highly gendered (approximately 1 male for every 6 females) with more women working in this field than men. The table above shows that regardless of the 1 to 6 ratio women are

[20] Various refers to where respondents have indicated more than one incident but been non-specific about exactly how many.

experiencing higher levels of violence than men – the ratio in this sample group is 1 to 7.

It also has to be acknowledged that men tend to be over-represented in positions of authority and women are to be found more commonly in the nursing ranks. The table below shows the experiences of doctors and nurses of violence.

Number of incidents	Experienced by Doctors	Experienced by Nurses
1 Violent incident	1	8
2 Violent incidents	4	18
3 Violent incidents	1	4
4 Violent incidents	1	3
5 Violent incidents	2	1
6 Violent incidents	1	4
10 Violent incidents	—	1
23 Violent incidents	1	—
Various incidents[21]	9	90

Table 12: Number of violent incidents experienced by status

These gender differences are discussed in more detail in chapter 8. Typically the types of incident they report being exposed to include:

[21] 'Various' refers to where respondents have indicated more than one incident but been non-specific about exactly how many.

'Grandfather threatened to sort me out because I gave his daughter her dead baby to nurse. Father pushed me because I would not allow him to discharge his ill baby from hospital. Grandmother grabbed me by the hair and told me it was my 'fn' fault her daughter was exhausted with breast feeding. Held against a wall by a drug addict who was needing a fix in an attempt to get drugs from me. I have also been slapped, bitten and kicked when I worked as a general nurse in an acute surgical unit.' (H18b20).

'Black eyes, eye infection; pulled hair; kicked and punched; spat on; various bruising – arms and legs etc.' (H18b26)

'Bitten and scratched. Punched and slapped. Kicked. Spat on. Urinated on. Cut with broken glass. Head butted. Attempted strangulation with own tie. Hit with various objects. All perpetrated by patients, some by visitors and relatives.' (H18b86)

'Mainly due to a confused patient's post surgery or alcoholic's suffering withdrawal. Relatives unhappy with medical care often take it out on nursing staff.' (H18b109).

It is evident from the press coverage and the literature review that violence within hospitals is giving cause for concern. As Labour Research (1998) asks; Who's the real casualty? One of the key informants working in the field of health has commented that staff are now no longer prepared

to accept that violence is part of their working life. Consequently, if a client/patient is violent and/or aggressive and it is not perceived or understood to be part of the condition they are presenting at the hospital they are unlikely to be treated:

> *'They are forfeiting their right to the duty of care which we provide for them, by effectively rejecting it.'* (GRC)

Doctors and nurses report that they face a number of differing incidents of violence in the course of their daily work and as with teachers categorising it is not simple. Experiences of violence are often complex which can be evidenced in the comments below:

> *'Patients – kicking, spitting, punching, and throwing objects.'* (H10b3)

> *'A patient who appeared to be sweet and gentle until staff were at close quarters when she frequently scratched, bit and punched. This is only one of many similar cases. Incidents of nursing staff being punched and kicked during pregnancy.'* (H10b17)

> *'Demented patient being verbally/physically abusive towards me when trying to wash him, following him being faecally incontinent.'* (H10b90)

'Verbal threat to doctors associated with aggressive body manner and verbal tone in order to enforce doctor to enable him to see his wife's case sheet (even though actual violence not threatened but implied).' (H10b107)

*'A patient with alcohol abuse asked the nurse for a match as he wanted to have a cigarette. The nurse told him that she didn't smoke. He called her a f****** liar and punched her on the face. I went to her assistance and I was also punched, first in the stomach and then my face.' (H10b172)*

These comments highlight the range of behaviours and differing perpetrators that doctors and nurses experience and define as violent in the course of their work. They also identify the links to other conditions such as drink related violence. And to the unpredictability of violence in the case of the patients who 'appear to be sweet and gentle'. However, again as with education, we also see evidence of patients whose behaviours might be defined by others as non-violent and part of their medical condition.

The majority of medical professionals (58%) report that while there is difficulty in defining violent acts they can and do differentiate between disruptive/difficult patients and violent patients. They report that:

'Disruptive behaviour is generally patients who are uncooperative and constantly use bad language in everyday conversation to express themselves. Violent behaviour is

generally statements of physical harm towards staff with abusive language which in itself is threatening and abusive.' (H11b2)

'The issue is intent. A patient can be disruptive without intending to cause harm to the health professional.' (H11b53)

It is acknowledged that client groups may have nothing in common with the ethos of the institution – for example some patients will have little knowledge of hospital procedures and others only come into contact with some of them in extreme circumstances. In hospitals violence is identified as something that is brought into the hospital by the clients themselves and is often exacerbated by these clients being drunk. Hospitals have two procedures which come into operation here. If the violence is perceived by them as part of a medical condition the client or patient will be sedated so that medical care can be administered. If not,

'people who are abusive will be removed from the department.' (GRC)

Media reports in Chapter One have linked the 'problem' of violence in hospitals with young men under the influence of drugs or drink. However, the doctors and nurses have identified that it is not restricted to this group. They state that violence is perpetrated by either males or females who are patients, parents/guardians, ex-patients, or visitors. Not only that but there is a strong consensus (78%) that violence is very much on the increase in the workplace, even although it has always been a

feature of hospital life, in particular the Accident and Emergency department (88%) and as with teachers they also firmly reject (78%) the suggestion that it is only their perceptions of violence that have been raised by media coverage. They report that:

> *'Alcohol is being consumed on a daily basis in larger quantities and by younger age groups. I first started working in Accident and Emergency in 1964 and nurses were rarely if ever threatened in the work place – that was a rare occurrence. Nowadays it is a frequent occurrence. It is ingrained in our society.'* (H14b24).

> *'In general the public expect more and have a more aggressive attitude to hospital and staff. The general public seem to expect a perfect service at all times.'* (H14b43)

> *'Standards have fallen? Open visiting etc. Certain regulations have ceased. Visitors now think they have open forum on staff and the setting. Nursing has lost the respect it once had or perhaps the 'power base' of the nurse once seen as autonomous decision makers and now patients centred/partnership has had the opposite effect of who has what control. And in some cases does your manager or trust fully support and back you? If it does it should show it much more strongly.'* (H14b126)

The above comments highlight the social and attitudinal changes that are being faced by these professionals - the increased use of alcohol, but also increased frequency of violence and raised expectation amongst the general population about what type of service they expect have undermined professionals' control over, and their status in, the work environment. These experiences are further exacerbated by the lack of support from their employers.

The effects of such experiences of violence are not only distressing but can affect the working practices of the victims. Just over a quarter of respondents (26%) report that violence at work has had an effect on their health, with 35% claiming it has affected them either in the short or long term or both. Eight percent report being physically injured, 7% more nervous and 17% being affected both physically and emotionally. Only 4% of this group have been unable to work following a violent incident: 2 respondents for a period of 9 months and another 3 respondents for a period of 4 months. For the majority this does not impinge on their professional ability at work.

Over two-thirds of these respondents do not believe that their hospital is capable of protecting, or supporting staff who are exposed to or have experienced violence in the workplace. The majority of them are calling for more of a male presence; more male nurses and security staff and some for more staff training. For example,

> ***'Instruction on how to deal with violent patients. I have not had any training and have had to use my own experience and***

initiative. Also self-defence would be helpful. Security guards available at short notice – at moment porters are called to assist, which is not their job.' (H25b29)

'CCTV Cameras, Security Guards, Personal Alarms, Panic Buttons, frequent training on handling violent incidents.' (H25b158)

'Counselling – to be able to talk through incidents – usually talked through with colleagues. Management of aggression courses on a regular basis.' (H25b69)

These comments place a strong emphasis on the control aspects of the work environment and the needs of staff who are victims of the attacks. They would like to see more support generally from their institutions. Sixty-five percent of this cohort believe that their unions are supportive of them and just over half (51%) believe that the clinical directors or nurse managers take their concerns over violence seriously. However, less than half of them believe that neither the Trust Directors nor the local health authority take the concerns seriously but just over half (53%) think that central government do. Nonetheless 84% of respondents know of the reporting and recording system in their hospitals, but only 64% are content with how it operates. In particular staff are concerned that there is no feedback or follow up after an incident has been reported. As one of the respondents commented:

'I have experienced personal assault and no one has ever approached me to see if I was alright. I have received a letter from Occupational Health offering counselling. No senior member of my department offered any support.' (H28b215)

'The main concern of the senior nurses to whom these forms are returned is that they are "correctly" filled in, they have little concern for the individual concerned.' (N28b135)

'As stated the form is more to protect the aggressor – don't know if it would be worth while completing a form – I don't know, but feel staff would be asked to defend themselves – was it really the aggressors fault, did we ask for it, intimidate them etc.; (H28b128)

Despite this type of distress when it comes to investigating a violent incident only 15% report feeling threatened by that process. Those who do, report being made to feel guilty for complaining and fear possible follow up by their aggressor.

5.9 Conclusions

This chapter has examined the respondent groups and contextualised their perceptions and experiences within the working institutions of the schools and hospitals. It has examined the experiences of the respondents in relation to the views presented by their unions and professional bodies and to working definitions of violence in the workplace.

It has identified a number of areas where there are similarities in the experiences of the teachers, doctors and nurses. It has also shown similarity of experiences, in the internal working relationships within the institutional settings, in how their organisation - fields, habitus and capital - structures experiences of violence.

Three issues in particular have consistently been raised in the previous chapters and again in this chapter. They are concerns over the reporting and recording of violence and associated practices; the gendered nature of the work forces; and thirdly that of the relationship between illness, especially mental ill-health, and violence. Each of these issues is addressed in the following chapters starting with organisational procedures that impact on reporting and recording of violent incidents in Chapter Six.

Chapter 6

Exploring Violence in Institutions

6. Introduction

As discussed in the previous chapter the respondents in this study have reported that violence in the workplace is not new but from their experiences doctors, nurses and teachers feel it is increasing and needs to be addressed. Yet it remains an often 'hidden' form of violence. Davies et al (1999) for example, argue that the relationship between work, crime and employment is obscured 'because the blurred boundaries between crime and work produce the features of invisibility ..... no knowledge, no statistics, no politics, no panic and so on' (Davies et al, 1999:57). While concern from academic, professional and government bodies has increased in recent years it is still difficult to establish the extent of the problem. Recording mechanisms brought in have been used by the media sources quite arbitrarily to argue that the problem is growing, but there is no statistical evidence with which to clarify or dispute their assertions.

Victim surveys have been used to extend knowledge and understanding of forms of crime and violence; to expose the types and nature, and the reasons why some crimes go unreported and subsequently unrecorded in official crime statistics. Examples of this can be found in relation to domestic violence (Dobash and Dobash, 1992; Kelly, 1987 etc), racial violence (Bowling, 1993) and white collar crimes (Croall, 2001; Braverman, 2002), where the emphasis has been on exposing previously hidden crimes. Complex issues such as violence at work need a multivariant analysis to identify such factors and deliver 'a comprehensive policy response that takes

account of the full range of constitutive elements' (Lanier & Henry, 2004). This chapter will examine the official procedures for reporting and recording of violent incidents and examine the ways in which they support some forms of violence at the expense of others and aims to examine where changes in process are needed to allow for this to happen.

The previous chapter confirmed that doctors, nurses and teachers defined violence in a variety of different ways and contexts and that violence can be experienced along a continuum - verbal, physical, psychological and emotional. Furthermore context and content are particularly important in their ability to differentiate the disruptive from the violent incident and 'intentionality' – *meaning* to hurt - is the defining criterion. However, this does not fully capture their experiences, reports of which can also be misinterpreted by others.

6.1 Professionals' perspectives on violence

Personal experience and differing interpretations of violence are likely to affect the recording of incidents for as Bowie (2002:3) states 'One person may view a situation as violent and threatening, whereas a colleague may not. It is therefore essential that managers understand and recognise violence from the victim's perspective: that they allow the threatened person, or the person who has been victimised, the reality of their perceptions' (Bowie, 2002). The subjective nature of violence is of considerable significance here. There are numerous references, as discussed in the previous chapter, in the data to how violence is experienced but what one person perceives as violent may not be perceived in the same way by another person, and furthermore such inconsistency in defining violence is confusing for client groups. This is

particularly so for pupils where behaviour is allowed by one teacher and not by another.

However, '[o]rganisational responses to violence involve a complex pattern and network of agencies' (Hearn, 1996:53) which include statutory agencies such as the law, police and social services as well as the institutional, interpersonal and voluntary/support agencies. Consequently, there are differing interpretations of and interagency approaches to dealing with violence. This also means that there is the possibility of conflicting opinions emerging and violence being misrepresented and misunderstood. Therefore, 'power relations in organisations do embed themselves in a "larger", overarching system' where the 'exercises of power at the individual level *constitute* the organisational, yet there is always the possibility of change as individuals interpret their situation in different ways' (Halford & Leonard, 2001:232-23).

However, the habitus of the institution imbued with the ethos of the field ensures that difference in interpretation of the functions of the institution by members of the institution are very closely aligned, as opposed to the individual interpretations of violence, which is not part of the institutional functioning. Ultimately, Hearn & Parkin (2001:151) state that 'There is a need for strong procedures for dealing with sexual harassment, other harassment, bullying and physical violence in organisations'. They cite Randall (1997) as saying healthy organisations are those that 'will have in place anti-harassment policies and procedures which are fully integrated within the overall philosophy of the organisation and are regarded as highly as its working techniques and practices. Such commitment will help employees

feel the organisation they work in is as secure as their own home and that they are valued, respected and cared about as people, not just staff members with specific functions' (op cit :106).

In the true spirit of inclusion the need for a victim-centred definition of violence in the workplace that reflects the experiences of its victims is acknowledged (BCS, 1998; Gill et al, 2002; Stanko, 1998, 2003; Walklate, 2003). However, an inclusive definition that embraces the breadth of experiences as reported here has specific implications for the reporting and recording of violent incidents. Interpretation of reported incidents becomes highly subjective and it is felt by some individuals that their experiences are not taken seriously. Institutional capital in the habitus over-rides individual capital in the definition and interpretation of violent incidents. This highlights how understanding of violence is affected by different institutional and wider social experiences and may differ amongst institutional personnel and client groups. (Hearn and Parkin, 2001; Kimmel, 2000) Violence and its associated factors constitute an extremely complex paradigm. As Connell (1998) argues, 'it is equally important to acknowledge that each element of analysis - for example, contested definitions of violence, the attribution of responsibility, the explanation of action, the construction of knowledge about violence is inter-linked with the others.'

Staff perceive the public as very demanding of their rights and become frustrated at not being granted what they perceive as *their* rights. For example, this comment reflects the views of health professionals that:

'The Patients' Charter in some individuals appears to dictate a certain right that the client/relative has over the system' (H14b51);

and this is supported by views from the educational professionals whose sentiments are summed up by the following statements;

'Parents feel they have the right to tell the school what to do (E14b14)....[they] are full of their rights but are not aware of their responsibilities and are aggressive in demanding their rights.' (E14b31)

The professionals report that their part in this process is not understood and that they become victims of the client's frustration. What staff are dealing with is typically confrontational, aggressive and deliberate behaviour that either distresses or hurts them. These incidents are distinct and different in that the intent is to hurt or frighten them. They feel intimidated and challenged in trying to do their job. Cultural, class and gender relations, for example, affect our understanding of what is and what is not violence - we do not all define violence in the same way. Furthermore O'Malley and Palmer (1996) found that where there is a breakdown in power relations it is important for all agents involved to be included in consultations to effect the best outcomes. This last point is one that is contested by some of the victims. Consequently, staff have called for their rights to be acknowledged in that process. For example:

'The rights and feelings of the victims – whether teachers or other children are dismissed, ignored or not taken seriously.' (E25b80)

'Patients and visitors demand their "rights". Most feel we are here to be shouted at and threatened if they don't get their own way. Staff have no rights – according to them. (H14b19)

6.2 Institutions and organisation

How those at different levels of the institutional hierarchy will view incidents in different ways is embedded in working procedures of the institution. Bourdieu exemplifies the working and reproduction of institutions by using the concepts of fields, habitus and capital. These he applies to the field of education as an example of how capital and habitus are deployed to ensure continuity of the institution. He argues that the 'act of scholastic classification is always, ... an act of ordination, ... It institutes a social difference of rank, a permanent relation of order: ... that is, a clearly delimited set (whether one belongs or one doesn't) of people who are separated from the common run of mortals by a difference of essence and, therefore, legitimately licensed to dominate (Bourdieu, 1998:21). This when applied to all institutions shows how in their operations they create homogenous groups who through their actions give the institutions their embodied form.

Bourdieu and Passeron (1990) argue that institutional power is perceived as natural because of its ability 'to impose meanings and to impose them as legitimate by concealing the power relations which are the basis of its force' (op cit, 1990:4). Traditionally the professions of health and education have

enjoyed relatively autonomous power both in the regulation and delivery of services to the extent that the individual agents do not see themselves as part of the process of the establishment of that power. Yet they are part of that process.

Acts of violence in these institutions challenge this power and authority. Challenges depending on their outcomes can lead to the affirmation of that power or to changes: shifts in the balance of power or changes in the way in which it is ultimately reinvested in the institution. Those challenges that are made on, but by agents external to, the institutions are likely to be more difficult to address for a number of reasons. Firstly, they are less likely to occur at the highest levels within the institution and therefore those with the most power and authority are unlikely to have first hand experience of these challenges – in this instance violent acts.

Secondly, it requires that those in positions of management recognise the experiences of employees as being legitimate concerns that need to be addressed. Thirdly, any policies - rules or regulations - brought in to protect staff and clients from violence have to be clear and unambiguous in their definition. Finally, these policies also have to be effective in dealing with situations when they occur, or they are likely to invoke further challenges.

Therefore it is necessary for institutions to be reflective in their operation and to create a dialectical process within their hierarchies. Failure to do so is to deny the experiences of their staff both in terms of their practice, and of the legitimacy of their complaints or concerns. Ultimately, denial of staff experiences can affect the entire service or even threaten the 'institution'.

An example, though not from the field of education or health but from the political field, of an institution that had become unresponsive to the demands being made of it is evident in the very public pronouncement of Dr J. Reid MP that the Home Office was 'not fit for purpose'.

This study finds in line with Poster (1996) and Prins (1999) that staff feel that dealing with violence as 'part of the job' is unacceptable (McGeorge et al, 2000). Furthermore when incidents are reported, they are often not taken seriously (Beale, 1999) and reporting procedures are too time consuming. Those at the head of the fields are endowed with the institutional capital necessary to effect institutional changes yet it is those working in the individual habitus of schools and hospitals that are more likely to experience violence.

To take education for example, Bourdieu & Passeron (1977:5) argue that 'all Pedagogic action (PA) is, objectively, symbolic violence insofar as it is the imposition of a cultural arbitrary by an arbitrary power' and that 'the school PA ... reproduces the dominant culture, contributing thereby to the reproduction of the structure of the power relations within a social formation in which the dominant system of education tends to secure a monopoly of legitimate symbolic violence.' (Bourdieu & Passeron, 1977:6). This clarifies how the process of the establishment of power is developed and produced through a series of practices within the education system and by extension within all institutions.

Action, they argue, carries the weight of authority, which has been established by an arbitrary process of inculcation. That is, the action has been repeatedly performed so that it is accepted unchallenged by those who

are subjected to it. Bourdieu and Passeron also emphasise institutional agency, not just mismatched codes. They argue that pedagogic action 'operates via a ruse of communication, a use of tacit assumptions and highly presupposing discursive forms to select for those who already know what they need to know, who already have what they need to have' (Calhoun et al, 1993:119); for example, the way in which institutions operate, and the language and general principles under which their services take place. These practices are symptomatic of the operation of most institutions and involve the distribution of power relative to their preferences, but always placing their personnel in positions of authority over their respective client groups. For example, the power and authority invested in teachers is reinforced by the authority of the School and the Education System itself – the educational field. Similar hierarchical structures are to be found in our health system and the functioning of our hospitals.

Violence is negotiated by capital values and the lack of a standard fixed definition undermines the capital of the staff in dealing with clients who resort to using violence. The use of violence inflates the capital value of those who use it, by enabling them to demand services/attention that they might otherwise not receive. However, as discussed in Chapter Four, that increase in capital may only be short lived and therefore 'illusionary' if it is deemed violent enough to warrant sanctions – formal or informal - being brought to bear on the perpetrator. This is the converse of how institutions are normally encountered by individuals as immutable organisations; institutional personnel as institutional representatives are imbued with relative power and autonomy, and the individual client is disempowered by their lack of it in the interface between them.

The findings of this study concur with those of Owen (1998) who found that there is a complex relationship within institutions between management structures and frontline workers in that staff report feeling they are blamed for incidents when they occur; that they lack the skills to deal with such incidents; that their reports of violent incidents are not believed; that they are not officially supported when they occur and subsequently that they do not report all incidents. It has been reported by teachers that:

> *'I am fairly sure SMT do not log all violent incidents. Some are not taken seriously.'* (E28b85);

while health professionals ask

> *'Incident forms – where do they go?'* (H28b213)

Quirk (2000) also found that staff felt unsupported both by the institution but also by supporting agencies such as the police when violent incidents occurred. Support, Paterson et al (1999) found, often came from informal channels: peer groups, family and colleagues.

This lack of support and understanding by institutional management leaves frontline workers in positions that are untenable: without acknowledging their reported experiences of violence as 'violence' it means that staff and institutions are unable to effectively respond to it. Freyne & Wrigley (1996) found that acknowledgement by managers of staff difficulties is an important element of support to staff in a violent work setting. Instead when reports are made they are met with a variety of responses and in some instances,

Beale (1999) suggests, if these reported incidents are 'deemed' not serious enough they go unrecorded.

What is evident is that the more we enquire into the relationship between reporting and recording the more issues percolate through that still need to be addressed. The central issue is that we need to know more about it, as endorsed by the Scottish Office's circular (1997) which states that 'we should now employ a reporting, recording and monitoring procedure in order to evaluate the problem thoroughly'. They stress however the importance of all having a voice and that it is not a one-sided problem. Recognition needs to be taken of all the issues surrounding violence. Merely having the mechanisms for reporting and recording may well create the impression of increasing violence, just because as figures are gathered they may be higher than expected. As one nurse commented:

> *There is a general lack of respect towards nursing staff whereas previously respect kept violence to a minimum. It was also tolerated more by nursing staff in the past. Nursing staff report violent incidents more these days.'* (H14b76)

This statement highlights an interesting point in relation to understanding and meanings of violence. On the one hand it quite clearly suggests that violence is increasing, but at the same time paradoxically it questions whether this is so. Stating that staff were more tolerant in the past raises the question as to whether violence has increased or staff tolerance to it has decreased. This combined with the subjective nature of violence is liable to inhibit rather than enhance our understanding of it if quite arbitrary

decisions are being made on what is included and what is excluded from the recording process.

6.3 Institutional processes

The British Crime Surveys show that reported incidents of violence at work have been increasing. Between 1992 and 1996 it rose by some 19% for violent assaults alone, and the British Retail Consortium Survey (1996) reported that over 9,000 staff had been exposed to physical violence and 167,000 staff intimidated and verbally abused. Similarly since official records of incidents have been kept regarding education the most recent figures released show a seemingly alarming increase (Scottish Executive, 2004) in the number of violent incidents reported within schools. However caution has to be taken with these figures as the first year's figures in particular, it has been acknowledged, were incomplete. Figures were first released in 1998, so there are now 3 sets of figures available and it is understood that all local authorities are now included in the figures. Furthermore with no previous detailed information on violence in these situations the temptation is to assume that it is something that is new when in fact the respondents report that:

> *'generations come and go through accident and emergency and everybody that is there thinks it is very violent when they are there.'* (GRC)

and that:

'I would probably say that there has always been a level of violence, abuse or whatever, ... I think that it has always been there and always will be there but the reporting mechanisms have changed to help us to understand it.' (HER)

Gordon (1994) on the other hand supports the views expressed by Hearn (1998) and Connell (1985) on the need to look beyond a simple analysis as whilst incidents may be targeted against individuals, they are rarely the locus of the incident, and by missing this responses and reactions to violence are not accordingly targeted. While the incident is enacted against the professional the causes of the violence are to be found not in a failure of interpersonal relations but in the institutional organisation – for example frustration on the part of the perpetrators at the length of time they have had to wait for treatment or resentment on the part of a pupil who sees no value in the education he/she is receiving in relation to his/her personal aspirations (Cathcart, 1999). Lindow (2000) supports this finding, that violent incidents are often a result of frustration and therefore endorses the need to look at institutional changes as part of a strategy to reduce violence. This is a feature in this study also, where waiting times and lack of understanding by the public of what they can and cannot have in relation to service delivery is raised. Violence, as remarked before, is more than just inter-personal relations, it is inscribed in institutional working and she (Lindow) highlights staffing levels as being a significant factor. She remarks that feelings of frustration and resentment felt by clients may well lead to more violence from them. Thus institutional/organisational relations affect the interface between professionals and client groups (Wells, 1994). Lindow (2000) argues that if institutions accept their responsibility to protect and support their staff

then the [professionals] they produce will be better equipped to deal with those they care for. Maturity and experience (Connell, 1985) rather than chronological age are more important in the successful intervention in violent incidents. He argues that the longer one is in a particular profession the better equipped one is at reading and dealing with situations when they arise; in other words you can often see that something is brewing and take early interventionist action to de-escalate the situation.

Halford and Leonard (2001) report that 'social relations between individuals in organisations as elsewhere, are part of a broader system of relations between unequal social groups, based on gender and/or class and/or race' (op cit, 2001:13) and that these divisions are a reflection of the dominant groups and structured in such a way as to maintain their control, and reinforce established practices. These may be accepted by some and unwelcome to others. For example, Gordon, Holland and Lahelma report that 'New students represent potential chaos in the context of the school's desired ordering...., and that particular effort is put into imbuing them with the necessary disciplines... (in McKie & Watson, 2000:94).

6.4 Institutions and physical space

Physical location (structure and layout of the building) also has to be included in any analysis as in both sites physical space and surveillance - or lack of it - are also important. Building design, structure and in particular the use of space in these institutions are significant factors. McGeorge (2000) found that in some cases design was unsafe in that staff were unable to see what was going on. The importance of 'surveillance' in regulation of behaviours has been well documented by writers such as Foucault (1977)

and Newman (1973), but in hospitals and schools there is the particular issue of closed confined spaces. In schools classrooms are closed environments and in hospitals the enclosed spaces can be even smaller. Their uses are part of the service provided. In schools segregation is by discrete class, in hospitals by ward. However within the hospital setting smaller zones can be created by the use of screens, ostensibly for the privacy of the patient, but they also obscure from view the actions and reactions of those working within them. Newman (1973) has discussed the importance of surveillance in regulating behaviour in social spaces, and suggests that where barriers real or symbolic exist regulation is maintained by a shared consensus on the utilization of space. Violence in its occurrence in these institutions is an example of the breakdown of consensus. However, being enclosed, obscured from observation, also means that there are no witnesses which leaves all events open to interpretation.

Furthermore, in hospitals illness can also be a contributing factor in acts of violence, particularly but not exclusively, for example, dementia (McCreadie, 2000) and depression, although Eastley and Main (1993) found that depression was least likely to be a factor in violent behaviour. 75% of psychiatric nurses report having been assaulted at least once in their careers (Poster, 1996). Clearly this is an issue for this study as well when you have some nurses and doctors calling for violence to include all acts regardless of the patient's condition, and other doctors and nurses contesting this. This is more understandable where external issues can be the cause of violence - drink and/or drugs, as opposed to a mental health issue.

Lindow and McGeorge (2000) suggest that working practices in the health

sector can be improved in a number of ways without dramatically increasing cost such as making better use of the space available, improving information systems and increasing direct contact. Similarly, in education changes have been suggested in working practices such as increasing the number of teaching assistants, cutting class sizes and a variety of policy suggestions on ways to deal with violent pupils in schools, from mentoring to exclusion.

However there are links with space and practices; addressing one without the other is unlikely to significantly reduce the incidence of violence. For example, the need for training on how to deal with violence has been highlighted by many (Lindow & McGeorge, 2000; Grenade & Macdonald, 1995; Lawrinson & Harris 1994; Monahan, 1993; and McCreadie, 2000). Prins (1999) has highlighted the need for a more efficient and effective record keeping system on violence and some procedure for sharing this information both internally at institutional level and with other relevant agencies, for example the police and social work.

6.5 Reporting and recording of violent incidents

One particular area that warrants a deeper examination is the reporting and recording procedures and how they are affected by the lack of a standard fixed definition of violence as this affects responses to, and in particular support for, victims of violence. There is a difference in perception of the level of the problem between those who are assessing it from official reports and those who work in the frontline, as official statistics on violence in the workplace under-estimate its extent, as discussed in Chapters One and Two. The official line is that all incidents should be reported and that violence has to be defined from the victim's perspective. This is very laudable but only if

it is supported within the institution. If, as some of the respondents have suggested, reports are not acted upon or ignored then it only further serves to violate the rights of the victim. The client groups report that they feel there is pressure from the employers not to encourage staff to report incidents. This is often identified as a middle management issue between the managers in the habitus and the managers in the field.

Regulation is embedded in institutions and has implications for the ways in which they deliver services and respond to all manner of things including reports of violence from staff. Responsibility for safety at work, as has been mentioned in Chapter Two and is discussed in more detail here, lies with the HSE and this includes the need to protect employees from violence. In 1995 legislation brought in the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) which made it mandatory for violent acts to be recorded. However, it is quite specific in its definition of what should be recorded and refers only to those cases where victims are physically injured, or are absent from work for 3 days or more following an incident. This regulation precludes violences that do not result in time lost from work from inclusion in the official statistics. Therefore the majority of violence reported in this study is extremely unlikely to ever be officially recorded. Hence official HSE figures can not be a true reflection of all incidences of violence faced by employees in the workplace as those who experience other forms of violence such as verbal abuse are unlikely to be absent from work for 3 days or more following an incident. The majority of respondents in this study do not report ever having had time off work as a direct result of a violent incident. While some report being upset and feeling stressed by the violence they face whether or not this is ever directly linked

to any absences they may have from work is doubtful. Added to this it has been identified that complaints procedures are also highly regulated and cumbersome, which makes them appear slow or unresponsive to the complainants. For example, 'change is [often] slow' (Hearn, 2001) and despite numerous interventions in relation to workplace practices - such as the Race Relations Act 1976, Sex Discrimination Act 1975, Public Order Act 1995, Health and Safety Executive regulations including RIDDOR (1995) and Emergency Workers (Scotland) Act (2005) - and the fact that criminal law also includes categories of violence, not all violence falls into these categories (Hearn, 2001). Legislation alone does not cover employees against all forms of violations (Hearn & Parkin, 2001:151); thus Tombs & Whyte (2007) point to 'the general conclusion that criminological definitions of violence still fail to recognise offences against workers and the public arising out of work.'

A contributing factor to the problem of reporting and recording is the subjective nature of defining violence at work discussed at length in Chapter Two. In relation to institutions, Stanko (2003) comments that '[s]ocial institutions may confront or ignore violence within their midst'; one man's violence is another man's larking around – having a laugh, no harm meant. While much public information about violence is taken from official criminal statistics, there is now 'a growing body of evidence about violence collected outside the criminal justice system' (Stanko, 1998). Violence at work necessitates a broader definition as not all violent incidents reported here are necessarily criminal acts but are perceived as violent by the victims.

In these institutions, hospitals and schools, due to a lack of information about what is happening, they have tended to react to the developing situation on

limited knowledge. Consequently, they have tended to focus on the interpersonal aspects of violence and in particular on the more severe incidents: looking at what happened and how it can be avoided in future. Whereas at the institutional level, Braverman (2002) points out, 'some organisations develop the capacity for proactive crisis management by learning from experience'.

However, while this might appear as being supportive of a victim-centred definition of violence 'it is not quite as inclusive as it first appears, for the corollary of allowing people's experiences or perceptions of violence to *define* violence is that these definitions will be overwhelmingly influenced by dominant political, social and legal constructions of violence' (Tombs & Whyte, 2007). As a result the wider issues of violence at work and its relationship to these institutions have been denied or excluded in that process. Institutional understanding and responses to violence have become restricted to analysing the 'problematic individual behaviour', and the 'flawed organizational systems, or an interaction between these factors' (Braverman, 2002) have been excluded. Greenberg & Barling (1999), Mayhew and Quinlan (2002) all have something to say on the role of organisations in understanding violence in work and in particular how some responses to workplace violence by employers deflect attention from a potential key contributor to workplace violence – 'the ways organisations are structured and managed' (Bowie, 2002).

Many incidents of violence find themselves excluded from the official statistics as highlighted above: low level violence or violence as experienced on a continuum – persistent name calling - which can also have a very

profound effect on individuals' ability to work, is not necessarily picked up in these statistics; for example, stress due to verbal violence causing disruption in the class room:

> *'...verbal aggression is more painful and unsettling and depressing, more than physical violence.'* (HC77)

This kind of disruption is reported over and over again in the comments from teachers, but also from health care professionals. Shouting, swearing, muttering insults under their breaths, issuing threats, and constantly questioning actions are defined and understood by the respondents here as part of the process of violence they experience at work. These types of behaviours are however the very types of behaviours that are unlikely to be captured by official reporting and recording systems. Therefore official statistics don't accurately reflect, but obscure, the full extent and range of experiences of doctors, nurses and teachers.

As reported in the previous chapter violence is for these respondents more than just physical attack, and includes verbal abuse, psychological abuse, threatening behaviours, threat of future violence, abuse of property both personal and institutional. Central to their understanding of what makes an incident violent is the *intentionality* of the perpetrator and they are equally confident that there is a distinction between difficult/disruptive people and behaviours and the incidents they report as violent. It is the *intention* to hurt, physically or psychologically that makes an incident a violent incident. However, how that *intention to hurt* is conveyed in the reports they lodge would appear to be where the indifference to violent reports occurs.

Managers make arbitrary decisions but without the work experience of that particular habitus - classroom or A&E – they do not have the explicit knowledge with which to fully understand the meaning implicit in the report: the actions, tone of voice, facial expression and body language, which is explicit to the victim. To take some examples:

> *'I feel that the local authority does not take sufficiently seriously the threat of violence to staff. I suspect that there is an attitude among officials that teachers should be prepared to accept that a certain amount of violence goes with the job.'* (EC50)

> *Schools are under increasing pressure not to expel pupils and pupils know they can act violently and not receive a serious punishment. ... Local authorities and government need to address this, but as with so many other problems in education, are failing to do so.'* (EC92)

> *'Ward managers don't want to know. It would appear in their eyes that it is ourselves that have provoked the situation.'* (H28b129)

> *'You fill out a behavioural monitoring form on the incident and an incident report. They are generally never heard of or seen again'.* (H28b141)

'Once an incident is reported that is the end of the story.' (HC77)

'I get the impression that reports are just filed and forgotten.' (H28b193)

This reflects a degree of 'indifference' which Reiman (1998) argues 'is at least if not more culpable than intention, and ought to be treated as such by any criminal justice system (see Pemberton, 2004)' (cited in Tombs & Whyte, 2007). The evidence indicates that it is not the reporting of violent incidents that is in itself problematic but the processes that reporting violence invokes within the institutional setting. The majority of respondents know of and are happy with the processes that are in place for reporting incidents; what they are not happy with is the responses to them. Where they are unhappy with reporting and recording procedures they were particularly disgruntled. However, the process of reporting in both institutions is similar – by a process of line management – and as the example below shows, there are many links in the chain where checks may prevent the recording of all incidents in the official statistics. This process was summed up in one of the focus groups by a teacher who explained that:

'I would refer to the principal teacher who would interview the person – he would refer down the line if the incident was either not resolved or sufficiently bad enough for the guidance staff to have to be brought in to deal with it. From there it would be

referred to the SMT[22] *and/or the authorities (education/police or whatever).'* (PFG)

This description of the process was endorsed by the rest of the group but they also pointed out that they would disagree with the assertion that violent incidents are redefined; they did agree that:

'... a lot of schools will hesitate to call an incident a violent incident if they can sort it themselves' (PFG)

while another in the group reported that;

'... we are discouraged from using a violence report form.' (PFG)

From this it would appear that some incidents are not reported for two main reasons: in the first instance because of the lack of support for victims in recognising their experiences as violent, and secondly because reports once filed are in fact subjected to *redefinition* in the process. Tehrani (2002:192) argues that 'under-reporting, although unfortunate, is less surprising when one considers the attitudes held by many workers exposed to high levels of violence, victimisation and abuse who have come to regard personal attacks and violent abuse as "part of the job"' (Baines, 2005). This is something that many of the doctors, nurses and teachers report in their discussions of violence in schools and hospitals.

For example, almost two-thirds of doctors and nurses feel that they are not

[22] SMT – Senior Management Team.

adequately supported in dealing with violence at work and a fifth feel that the process invoked, the formal investigation that follows a reported incident, further victimised them.

> *'The whole discipline of the procedure makes you feel intimidated and adds more stress.'* (H29b157)
>
> *'Some managers automatically assume that the nurse is at fault rather than help them.'* (H29b196)
>
> *'The onus seems to be on the teachers to prove they did not provoke the incident.'* (E29b92)

These views are shared by many in the respondent groups, and they identify collaboration as a problem in the institutional setting. A few teachers have even suggested that collaboration is used against them by pupils, who will on some occasions support each other no matter what the situation. For example, one of the focus group discussions highlighted incidents where

> *'... 'fabrication' of events takes place.* [This they link to] *'gangs' who set about setting up teachers to gain one-upmanship over rival gangs.'* (CHSFG)

They recount two incidents, one where the 'fabricator' of the incident was supported by class mates and one where he wasn't.

'A first year boy challenged the teacher, "Why did you kick me?", when he had been nowhere near the boy. On this occasion the class did not back the boy up.' (CHSFG)

'A pupil was reprimanded for misbehaviour including the use of bad language; others in the class denied this incident.' (CHSFG)

The reaction of the class is something that was singled out as significant in another focus group:

'how the rest of the class respond to the incident will either help to escalate it or de-escalate it or increase/decrease the level of distress felt by the teacher.' (PFG)

As a result they argue that:

'Collaborated accounts from teachers are more favourably looked upon.' (EC29)

Collaborated reports of violence are more likely to be accepted in both institutional settings. Yet collaboration is difficult when many incidents take place away from public scrutiny, within enclosed spaces; examination rooms, classrooms or offices. Furthermore the issue of interpretation, or perhaps more accurately mis-interpretation, is increased the further removed the person dealing with the report is from delivering frontline services. Working experience of violence compared to management readings of violent reports

can polarise understanding. This is reflected by the respondent views of structural support for dealing with violence at work.

Between 50% and 85% of respondents feel that their concern about violence is listened to by immediate line managers but these percentages fall drastically the further removed from the working environment managers and law makers are – for example less than 10% of respondents believe they are listened to by central government; the exception to this being that 65% of all respondents feel that their union/professional representatives are supportive of them.

This has implications for both the recording of and responding to incidents of violence. It is reported here that some staff feel their reports of violent incidents are not acted upon and they are concerned that they are not being taken seriously. The majority of respondents never got any feedback or support.

> *'No action [is] taken unless the police are involved.'* (H28b206)

> *'There is no follow up once it has been recorded.'* (H28b15)

> *'It is a paper exercise. Nothing gets done.'* (H28b20)

> *'Another form to fill in and be filed – on paper it looks great. Data can be produced.'* (H28b34)

Non-physical violence such as psychological violence, verbal abuse and what some would term low levels of violence or bullying that cumulatively leave victims feeling victimised are prime examples of the types of incidents that it is reported are likely to be redefined. Yet, these forms of violence, on a continuum (the drip, drip effect of daily abuse), they report, can cause distress and stress to such an extent that respondents have identified it as particularly serious in that

> *'verbal aggression is more painful and unsettling and depressing - more than physical aggression.'* (HC77)

and another commented

> *'I think that actual violence is relatively rare. But the verbal violence in my experience is horrendous.'* (PFG)

This is felt particularly to be so when it is also racial and/or gendered or threatening. Furthermore, this lack of reaction from the institution in response to the lodging of violent incident reports leads to some not reporting incidents in the first instance as they feel there is no point. Perhaps more serious are the comments from those staff who feel that the response, when there is one, is intimidating. They report that investigations of incidents focus on whether or not the staff are culpable for what happened. They report feeling unsupported and vulnerable in this process.

The above examples show the capital of doctors, nurses and teachers is challenged on two fronts, one by the violence faced from client groups and

two by the flaws in the institutional processes which permits their experiences of violence to be redefined or denied and ultimately to remain hidden. Thus staff members are not protected and remain open to the possibility of continued violent incidents in the workplace.

This, report respondents, leads to low staff morale and self-esteem, to being exposed to future violence and to non- or under-reporting of incidents as they feel not all reports are acted upon. Acts of physical violence are more readily accepted as violence than other forms reported by staff. This is a reflection of how violence is defined in the wider political and legal fields – where the emphasis is on violence as a physical act. Such a focus denies or diminishes other forms, such as verbal violence, and has particular consequences for staff and policy developments.

Contested meanings in the field and habitus deplete the capital of front line employees as staff report feeling that sanctions against those who are violent are ineffective and inadequate in protecting them from future violence, which leaves them open to the possibility of repeat victimisation. Training is inadequate and staffing levels are too low to adequately cope with these situations when they arise. In order to address this, employees' reports of violence need to be taken seriously and they argue that the charters for patients and pupils need to include an element of responsibility as well as spelling out their rights.

6.6 Conclusions

This chapter has highlighted how the power and authority of the field impinges on understanding of the meanings of violence for professionals.

The field is identified as being unresponsive to the experiences of the professionals which it is argued is another form of violation for the victims of violent attack in these institutions. Policies developed to deal with this violence have implications for both victims and perpetrators in the field and habitus. Institutional working definitions of violence are premised on accepting the victims' experiences of it - an inclusive definition - but the respondents fear that their reported experiences are challenged and questioned as to whether or not what they report is, in fact, violence. This highlights the definitional problems of violence and identifies how some violence becomes hidden in the reporting and recording procedures within institutions; from a lack of trust in the system to adequately support professionals; and from fear of recriminations from their employers.

It has also alluded to but not discussed in detail two other important aspects of experiences of workplace violence which are those of gender and mental ill-health. Women have been and indeed still are subordinated in the patriarchal structure of institutions (Walby, 1990; Connell, 1995). Furthermore Davies & Jupp (1999:63) point out that 'women as offenders and victims in the work setting have been even more routinely marginalised and hidden from view than others'; this is linked with the focus on men and boys as the primary subjects of crimes (Heidensohn, 1996). And data also identifies that some question the status and culpability of those who suffer from mental ill-health and are violent. Some respondents report that irrespective of the patient's condition, violence is violence. This raises two points: 1) whether not defining these incidents as violence would limit our understanding of the nature and extent of violence experienced by staff; and 2) whether someone with a mental ill-health problem can be held culpable

for their behaviour irrespective of their condition. Being defined as violent, in the school or hospital setting, is likely to further marginalise those with mental ill-health: a group whose capital is already compromised. These issues are discussed in the following chapters.

Chapter 7

Workplace Violence and Mental Health

7. Introduction

This chapter examines in depth the issue of mental ill-health which was alluded to in earlier chapters. This issue is of particular interest because of the complex way in which status is inscribed within the fields of health and education. The interplay between fields, habitus and capital is used in examining how institutional practices affect understanding and meanings of violence for those suffering from mental ill-health. The mentally ill are it is argued often marginalised as a group, an 'unheard voice', and in the health sector they are exposed to the kinds of practices and violations so clearly illustrated in Goffman's (1961) work Asylums. It is also noted that the 'issue of violence in mental health services is a major concern for patients and staff' (Janner, 2005:16) and that mental ill-health is perceived as problematic in terms of community safety (Roberts, 2006/7:25). In education those with mental ill-health or behavioural problems have also been until relatively recently marginalised and educated in separate or special schools for those with 'special educational needs'. However, in the true spirit of an 'Inclusive Scotland' the emphasis in recent policy has been on re-engaging with these excluded or marginalised groups in mainstream schools or hospitals.

While such practice is laudable and in the spirit of anti-discrimination policy the practicality and reality of delivering it is somewhat removed from the theory. Consequently, and as discussed below, the implementation of these policies has had implications for both professionals and client groups in the experiences of *'violence'* in the workplace. And as Rogers & Pilgrim (2003:15)

argue '[m]ental health problems need to be explored as outcomes not just as mediators.'

7.1 Situating mental health

Bowie et al (2005:17:18) argue that 'Situations of workplace violence are frequently hidden by other critical issues that may divert attention, while heavy under-reporting seems to be the norm rather than the exception. ... However, despite the fact that concepts and definitions are loaded with cultural significance it would appear that a general, common understanding of workplace violence is emerging that includes physical, psychological and sexual violence at work.' Critical issues are varied and culturally specific but in the context of mental health and violence in the workplace they are most likely to be found embedded in the commonly held socially constructed perceptions about mental ill-health, which are inscribed in 'the broader prejudicial and discriminatory character of our current dominant political discourse, which emphasises the relationship between mental health problems and dangerousness' (Rogers & Pilgrim, 2003:134). This focus on 'dangerousness' in relation to those who are mentally ill has led to the rise in opposition to the Government's approach to mental health legislation (Roberts, 2006/7:24).

Despite this opposition, an integrative model for examining the role and influence of the *field* (institutions) in analysis of violence is undoubtedly necessary to understand how and what factors influence the scripts of the *habitus* (schools and hospitals) and contribute to the *scripts* (capital) with which individuals – professionals and clients - negotiate these two sites.

In understanding violence in relation to the experiences of professionals working in mainstream health and education services with those who have mental health problems this chapter draws together the complex working of these institutions and locates the inter-personal experiences of violence within the institutional organisation and its regulation using the concepts of fields, habitus and capital as defined by Bourdieu. These concepts Calhoun et al (2002:264) argue 'derive their greatest theoretical significance from their interrelationships' which creates the symbolic fabric of the field, reproduces and maintains its power base and in doing so establishes patterns of behaviour that indicate its function. Therefore these two institutions of health and education are defined socially and politically and evidenced in service delivery in schools and hospitals. It is the schools and hospitals or habitus that then become the site of contested meanings and negotiations and are 'definitively in the business of allocating resources or penalties to non-members' (Jenkins, 1996:157). Their habitus, 'the boundary of the field is a stake in the struggle, and the social scientist's task is not to draw a dividing-line between the agents involved in it, by imposing a so called operational definition, ... but to describe a state of these struggles and therefore of the frontier delimiting the territory held by the competing agents' (Bourdieu cited in Calhoun et al, 2002:295).

7.2 Contested meanings

Thus it is at the point of service delivery that the contested meanings of violence are most visible and institutions become the sites of violent acts against those who seek to educate and/or care. The media as discussed in Chapter One portrayed this as an 'insider'/'outsider' problem. The literature, the unions and the respondents in this study have all indicated that it is more

complex and has to do with knowledge of the service, social expectations and cultural beliefs.

7.3 Negotiating the field

How we make sense of these relationships, as explored in Chapter Four, is Bourdieu's concern; of making sense 'of the relationships between objective social structures (institutions, discourses, fields, ideologies) and everyday practices (what people do, and why they do it)' (Webb et al, 2002:1). Understanding workplace violence in a broader framework has allowed for links to be made that relate experiences of violence with policy, practice and procedures, and client groups within the institutional context of field and habitus. This shows that the experiences of violence, for doctors, nurses and teachers, constitute more than an inter-personal issue.

Bourdieu's concepts allow us to locate the institutional site and its agents within the field, and the field within the political and cultural field that is our society (see Chapter Three). Critical analysis allows us to see more clearly the hitherto hidden links between political and cultural discourse, institutional policy and working practices and in how these institutionalised processes arbitrarily assign labels and meanings that exclude or impose sanctions on particular groups of agents more so than others; in other words how our cultural and political world shapes the institutional site in quite arbitrary ways by a process of inculcation.

In Chapter Three capital was identified as the key to the operation of all social life and it was explained how it is acquired in different forms by skills and experience. Accepting violence as a purely inter-personal issue would

be to deny the significance of the institutional capital of the professionals and to deny the importance of institutional structures and policies in influencing and organising the capital values which establish the rights and responsibilities for negotiating or 'gate keeping' with client groups. Understanding the negotiating and networking role of capital creates a flow between habitus and field and between different habitus and fields but also identifies where capital is depleted and therefore exposes, subordinates or excludes in relation to the preferred capital of the institution. Capital value in the workplace is context specific but not fixed; it can be added to by experience and/or promotion and it can be eroded by sanctions. It can also be of enhanced value in one setting and of lesser significance in another, but overall it is an important signifier as it is a reflection of the values of the culture within which is it used. Thus those with depleted or subordinated capital value have less power and authority than others and are the most likely to be the subjects of control.

The issue of capital and mental ill-health is interesting because, on the one hand, institutional personnel should be in a position of power over the client groups, because they possess institutional capital. In the case of mental ill-health, or indeed mind altering degenerative illnesses – dementia or Alzheimer's - the ability to exercise any capital value by patients or pupils is severely curtailed, by their illness, institutional processes, mental health policies and public perceptions. The concepts of fields, habitus and capital have complex inter-relations.

As discussed in the previous chapters neither concept is totally independent of the other in the working of institutions but it is important to understand

that the institutional fields lie within the political and cultural field that is society. Grenfell (2004:28) succinctly explains this complex and dynamic relationship as 'this *fit* between *field* and *habitus,* what is doable and *thinkable* (and *unthinkable*) within the *fields* is limited and defined in terms of what is *legitimate* for that particular area of *social space.* This way of thinking and acting might be defined as the orthodoxy in this social territory – the *doxa.* Anything outside this is unorthodox – *heterodoxa* – and therefore a challenge to the status quo of the field. Clearly, what is *doxic* in one field might be *heterodoxic* in another, and vice versa. These complex interrelations - of the fields, habitus and capital and the implications they have had on the reporting, recording and outcomes for victims of this type of violence - are discussed below.

7.4 Regulation and organisation

The fields of health and education are built on strong regulated and organised routines. For example, schools as formal sites of education have set operating hours approximately 9am – 4pm Monday to Friday with clearly defined holiday periods. Within this time frame the day is split up into periods where activities change. In primary schools this occurs within the one classroom normally, in secondary schools it involves pupils and staff in moving around the building usually about once an hour. Intervals and lunch breaks are also regulated by the institution. Within this tight formal structure of organisation teaching takes place in discrete rooms – classrooms, which are normally not easily surveyed by those outside. In other words they are closed environments to both the outside world and to other members of staff. Activities within the room whether conforming to practice

or challenging are not observed as a matter of course until something – shouting for example – draws the attention of other staff.

Similarly in hospitals there is strict regulation of the physical environment. It differs from schools in that hospitals run 24 hours a day, 7 days a week, every day of the year. However, working practices are regulated, staff are deployed on a shift system of usually 8 hour duration, with formal change over of staff appearing to the observer seamless. Hospitals offer a number of services, including accident and emergency, out-patients or day clinics, in-patient medical and surgical health care. The physical layout of the hospital consists of wards for in-patients, waiting rooms and examination rooms for out-patient clinics and wards which are normally divided into cubicles in accident and emergency. Wards often are divided into smaller sections of 4 to 6 beds and of course there is always the possibility of creating smaller spaces with the use of partitions or by drawing curtains around individual beds. As with schools surveillance is often restricted.

This clearly locates the fields of health and education as *semi-autonomous* organisations, as discussed in Chapters Two and Four, as indeed it does all other fields (arts, sports, class etc), within the more powerful political field. The political field is the organising structure of social life which includes the power and authority to define smaller fields irrespective of size or structure within its boundaries, and importance is signified by capital value accorded them. Those fields with the more desirable skills and knowledge are accorded high capital value and are therefore in a more privileged position (Jenkins, 1992). They are both centrally funded institutions and their perceived autonomy is but illusionary in that they can only exist in their

current form so long as they are conforming to the *doxa* on which they were formed. The power vested in the political field (in effect the State), and by extension the legal system, confers on them the authority to shape and inform all aspects of their existence (Jenkins, 1992). Both fields reflect the political and legal ideology of the state in their formation and regulation and have some shared and some distinguishing practices which reflect the dominant discourse in their organisation and regulation.

One of the main features common to both these institutions is that they are free at the point of delivery: free compulsory education for all children between the ages of 5 and 16 and free health care for all from the 'cradle to the grave' are the underpinning principles on which the institutions are formed.

In the formation of the habitus - the working institution - roles are designated, which confers power and authority on institutional employees in what they do. However, the habitus being at the forefront or frontier of the field exposes those who work here to any challenges to the institution. This is the converse of what an institutional employee would expect: their implicit knowledge of the working, practices and procedures of these institutions, and their particular skills relevant to their institution, they would expect to place them in a position of power and authority and not in a position of vulnerability. The occurrence of violence undermines their ability to exercise their capital and, they report, leads to low staff morale and self-esteem.

The following section examines the issues of violence as experienced and

defined by doctors, nurses and teachers in relation to perpetrators who suffer from mental ill-health.

7.5 Violent or mentally ill

Mental ill-health is defined and treated by the medical profession once it has been diagnosed. In that sense mental health patients are, like other patients, 'disabled bodies', unwell and in need of medical care. Undiagnosed mental ill-health it is argued also labels sufferers as 'criminal bodies' or 'violent bodies'. However, labels such as 'disabled' or 'violent' also effectively define individuals as 'excluded bodies': one because they are 'different', the other because they are 'deviant'. They are flawed in some way. As Turner (1996:199) states, 'psychiatric labels provide an official stamp on behaviour which is regarded as socially unacceptable in the wider society and the effect of these official labels is social exclusion.'

Thus disabled bodies are labelled bodies (Gibbs and Erikson, 1975) but also excluded bodies, and much of this labelling and exclusion is often premised on visual difference - those with mental ill-health are often not so easily identified and consequently even less understood. Nevertheless they also face significant social exclusion and can be stigmatized by their mental ill-health (Goffman, 1961; 1963). Those who suffer mental ill-health are typically demonised and are defined as: 'persons whose behaviour falls completely outside the pale of normal human activity; such a person is a "monster"' (Turner, 1996:198). Lynch (2005:12) argues that 'distressed and unwell individuals, and, especially, those who behave in dangerous ways – the 'raving mad' – are useful resources for news media and film-makers, due to the perennial market for danger and excitement ...[and] ... may often be linked to sensationalised reports that effectively portray mentally ill people

as homicidal by virtue of their ill health and imply, incorrectly, that this is the case for all sufferers.'

Labelling in this way identifies, stigmatises and excludes those who are different. For example Morris (1999) argues that such stigmas and labels mean 'that some young disabled people are, in effect, being 'warehoused' in residential institutions' and the same can be said for the elderly': segregated societies, socially excluded from family, friends, freedom etc. 'Segregated school can mean isolation, loneliness and exclusion when it comes to life beyond the school gates' (Abbott et al, 2001; Morris, 1999; Watson et al, 1999). Experiences for those with mental ill-health are often of incarcerations in 'institutions in which custodial rather than therapeutic values have dominated' (Goffman, 1968; Braddock and Parish, 2001; Janner, 2005). They experience 'exclusion discrimination that is largely a product of attitudinal and temporal barriers' (cited in Hughes et al, 6). For example:

> 'Sitting at my kitchen table were two GPs, one psychiatrist, one approved social worker, one member of the local mental health crisis team and one very depressed person. Me. ... My gloom at the prospect of being sectioned was compounded when, in the middle of the proceedings and before the professionals discussed my fate with each other, an ambulance turned up to collect me! A psychiatrist friend to whom I subsequently moaned about this order of events was unsympathetic: "At least you didn't have the police as well." Indeed. The issue of violence in mental health services is a major concern...' (Janner, 2005:16).

The above example illustrates how the capital value of the 'patient' was completely over-ridden by the capital value of the 'professionals', and while it was not a violent act it does violate the rights of the individual by excluding them from the process of decision making about their own health and well-being.

Mental ill-health along with the labelling and stigma with which it is associated, effectively marginalises those who suffer. They have in the past been exiled to live in asylums and special educational institutions. However in the last couple of decades, policies have stressed community care and social inclusion. Consequently, we now have in mainstream education and health services those who previously would have been cared for or educated in specialist establishments. The issue that is emerging from this data is that in some instances respondents have identified those with a mental ill-health condition as violent. Conversely, others have made a distinction between violence and mental ill-health. The concern is that if violence is to be defined from a victim-only perspective, those who are already marginalised - even within an integrated society - will be doubly labelled or stigmatised as both mentally ill and violent which will only serve to exclude them even further. This is not to deny the violence experienced by doctors, nurses or teachers; indeed to do so would limit understanding of the types of violence faced at work and pose an even bigger challenge in dealing with and locating violence within the context of the institution.

Rogers & Pilgrim (2003:149) point out that 'Psychiatric patients are relatively powerless and their episodic loss of reason makes it easy for politicians to pick on a group which lacks social credibility in the eyes of others'. Yet

violence is an integral part of our interactions in society; but where it is an issue of mental health, it is framed in terms of individual pathology. Within criminology, biological, psychological and other 'deficit' theories identified the 'criminal' and indeed his or her environment as different, pathological and in this way medicalised crime (Croall, 1998). Pathologising mental ill-health, Rogers & Pilgrim (2003) argue, leaves those perceived as dangerous and violent vulnerable to 'detention that is open ended', 'without trial' and 'more draconian' than other forms of detention. When research has shown that

> **'[t]here is no quick legislative fix for what is fundamentally a service provision problem. ... there is no evidence that compulsory treatment improves outcomes ... what does actually work. ... is things like aftercare support for people leaving hospital, multi-disciplinary outreach teams in the community, and services to tackle stigma, exclusion and isolation.'** (Roberts 2006/7:25)

'Violence in relation to mental health is virtually always framed in terms of *individual* pathology (Rogers and Pilgrim, 2003:136) and there is a 'narrow and often prejudicially driven view to be found in media reporting and political populism' as is evidenced in the 'prejudicial and discriminatory character of our current dominant political discourse, which emphasises the relationship between mental health problems and dangerousness' (op cit:134). Yet Bean (1986) had observed that a person's mental state and their proclivity for violence may functionally be quite separate; hence suggesting that there may in fact be no difference in the relationships between violence

and disabled bodies, and violence and able bodies. Indeed Roberts (2006/7) reports that it is only a 'tiny fraction of all homicides' which are committed by those suffering from mental health problems and that since the introduction of community care this figure, contrary to public perceptions, has remained stable.

Typically disabled bodies are defined as unable to live up to – and to cope with – the demands of a 'normal social life'. They have been constructed as the 'other', as 'flawed' (Hevey, 1992). Consequently they lack 'cultural capital' – their mode of exchange is compromised in modern day society. They are flawed either because they are 'mad' or 'bad', depending on the level of violence and any offence they may be, or have been, charged with.

Furthermore, Rogers & Pilgrim (2003:161) point out that they are already further disempowered within the context of the school and hospital: for example patients who are disempowered by the process of schooling and health care (e.g. forced medication, which can either be to control a medical condition or to sedate a patient). Violence only compounds this situation further as violent patients, they found, can sometimes be sedated without the reasons for the violence being understood. These practices are all legitimised by the assertion of it being therapeutic – best for the patient.

Defining violence from the victim's perspective challenges the concept of inclusion for those who suffer from mental ill-health as it allows the victims to define them as violent as opposed to ill. This is in direct opposition to the Scottish Executive's commitment to social inclusion: removing barriers and providing open access to services for all; an integrated as opposed to a segregated society – special needs children in mainstream schools. The

Executive is committed to Zero Tolerance of violence at work; this includes schools: "Violence and threatening behaviour against teachers has no place in Scotland's schools." (Jack McConnell, 2001): and hospitals: "Violence and aggression against NHS staff is completely unacceptable in a modern Scotland." (Malcolm Chisholm, 2003). Thus it is clear that there are many anomalies in understanding the relationship between mental ill-health and violence that are still to be reconciled. While the Executive have been pro-active on the need for gathering information on the experiences of staff on this issue there is still a need for more information and for analysis to be context specific.

Gill et al (2002:27) have identified various jobs, including teachers and healthcare workers as being at a high risk of violence, and concluded that health care workers in A&E and psychiatric hospital workers were at greatest risk. And as discussed previously the media, NHS, various unions, the Education Authorities and the Scottish Executive have also raised awareness of violence in schools and hospitals and indeed are part of the Zero Tolerance on violence campaign in Scotland.

The inter-relationships between 'at risk' professions, government policy and mental ill-health are exacerbated by the difficulty that a definition of violence which accepts the victim's perspective, irrespective of who the perpetrator is and based solely on their behaviour, does not produce a definition which is undisputed. There is a split in how doctors, nurses and teachers believe violence as experienced from disabled, confused or frightened individuals should be classified when their violence is clearly linked with their underlying condition. This is of particular relevance because for the patient

or pupil who is ill it is problematic and only likely to further exclude a group who are already disadvantaged.

As pointed out elsewhere violence as defined by doctors, nurses and teachers includes verbal, physical and mental abuse, verbal threat or statement of intent to damage property, and witnessing violent acts within the workplace setting. Central to this is the knowledge that the violent act is "intentional"; knowing that the perpetrator means/wants to hurt or harm. The majority have commented that the unintentional act may hurt or harm but is not violent as it holds no malice and does not create fear. Furthermore, "intentionality" is also the definer staff use to differentiate between disruptive behaviour (for effect or attention) and potentially violent behaviour where the intent is to hurt, harm or abuse. Such a definition would suggest that those who are unaware, scared, frightened, confused – all attributable to mental ill-health – are not intentionally violent and therefore should not be defined as such. For example, pupils with behavioural conditions

> ***'can be disruptive in class but not necessarily violent'*** (E11b46)

and similarly patients -

> ***'...disruptive behaviour can be caused by patients with dementia or learning difficulties who are frightened as they are in strange surroundings - they do intend to be violent'.*** (H11b45)

However, a different perspective began to emerge from the data which raises the subjective nature of how violence is understood and it is evident in the victims' retelling of incidents that some believe that, irrespective of the context or conditions in which some incidents occur, they should be understood as 'violence'. Some 'disabled bodies', but mostly those with mental ill-health, emotional or behavioural conditions, were being defined by their violence. Violence was the primary definer and their condition was the secondary: the view was expressed that violence is intolerable, no matter what, and while other respondents were more differentiating between violence and illness, overall the qualitative data is peppered with comments that suggest that 'violence' is becoming the norm for the professionals in these institutions.

The comments are not without some justification in that striking or abusing someone is a violent act, but their intentionality is questioned by their mental ill-health. Nor were the staff who defined these types of acts as violent without an understanding of how they could be addressed to reduce the risk of violence. They are aware of measures that could be taken to help in these situations, which contests their definition of the incidents as 'violent' rather than 'conditional' on the mental ill-health of the perpetrators. For example, more staff, or more regular (as opposed to agency) staff might help reduce confusion and fear amongst elderly, confused patients; and increased staffing levels would allow staff more time in dealing with confused patients. My concern is that if it is not properly examined we are liable to see those who already experience exclusion, and have compromised 'social capital', further excluded and indeed 'criminalised' rather than being part of a more inclusive process that would foster the spirit of inclusion for all: appropriate nursing

and schooling resources to permit full integration in a safe working environment, an integrated society.

Those who agree state that:

> *'Elderly demented patients often lash out, but it is less threatening as – they are generally too weak to do much harm – the violence is not personal, they just strike anyone, and their mental condition is understood.'* (H18b74)

This group define the violence as a symptom of the condition – not an intentionally violent act.

The Local Authority Violence Reports (EORS) on violent incidents in schools almost exclusively referred to children with some kind of diagnosed behavioural problem, from ADHD[23] to psychological conditions which sometimes are as a result of the social conditions in which they live.

> *'Last year I had a boy in my P4-7 class who was very disturbed due to recent revelations of his sexual abuse. He paced around the class when asked to do anything he didn't want to do. All the normal strategies for defusing the situation failed and the result was he was throwing things at children violently and up-turning anything to hand. He started lashing out at me so I took his arm and pulled him away from the class. He was then pushing and kicking me violently and I had to restrain him with another teacher. He was*

[23] ADHD – Attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD) refer to a range of problem behaviours associated with poor attention span. These may include impulsiveness, restlessness and hyperactivity, as well as inattentiveness, and often prevent children from learning and socialising well. ADHD is sometimes referred to as hyperkinetic disorder. (http://www.netdoctor.co.uk)

screaming violently and using a lot of sexual language and only calmed down when I phoned the teacher from the behavioural support school – she spoke to him.' (E10b33)

'Some EBD (Educationally and Behaviourally Disturbed) pupils have swore, punched/kicked out at myself and other staff.' (E18b52)

'Confused patient who is disorientated in time and place often will not conform and become physically violent and verbally abusive.' (H18b167)

'Psychiatric Nursing Patient (hearing voices) struck me on the chin as I leaned over to tidy the bed.' (H18b162)

'Confused elderly patients who are disorientated and think you are intruding in their homes.' (H18b154)

'Male and female patients who are mentally unpredictable and are liable to be physically aggressive -70+.' (H18b153)

'Patient (male) 70 years old, about 5 years ago. Confused patient grabbed my arm and twisted behind my back, causing pain for weeks thereafter.' (H18b117)

'Confused patients. Confused Head Injuries.' (H18b90/91)

'Patient verbally abusive when attending to personal hygiene –age 82. Patient punched my chin when feeding him – 90.' (H18b23)

Another issue raised in a media report is the difficulty of determining whether someone is violent, mentally ill or suffering from head injuries. This was highlighted in the case of a 16-year-old boy[24] who had fallen from his bicycle and who it transpired had sustained head injuries. On arrival at the A&E unit he was behaving 'violently'; police were called and he was taken to the police station, handcuffed. Some 6 hours later, after becoming quite unwell in police custody, he was taken to another A&E department, admitted, put on life support and unfortunately died 2 days later. A fatal inquiry into this concluded that even if the diagnosis had been made when he was first taken to the hospital the outcome would have been no different, but there are those who were very sceptical about the Fatal Accident Inquiry (FAI) report. This incident highlights the difficulty for those with mentally disabled bodies as their behaviour can be misunderstood and consequently exclude them from the services they need.

Thus the concept of 'inclusion' for all is flawed and contradictory. 'Disabled bodies', who lack the social/cultural capital that is shared by the majority of society are doubly excluded if they have a mental ill-health condition that confuses/disturbs them and invokes a violent reaction. The victim perspective based on 'inclusion' of what they define as violent disempowers and further excludes them.

Doctors, nurses and teachers all identify staffing arrangements as problematic; patients may be sedated, but pupils are unlikely to be, and they report that higher

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[24] This case was highlighted in the local press – The Herald and Evening Times – from September, 1997 when the accident occurred until the conclusion of the fatal accident enquiry. It has also been referred to since then in relation to other incidents that have occurred at the initial receiving hospital.

staffing levels would assist them in the care of such 'bodies'. Continuity of staff in caring for and assisting these individuals is identified as central to reducing their confusion, distress and violence. Inconsistency, it is reported, heightens the confusion in these individuals. Thus there is a need to re-examine the way in which the 'medicalised body' is being re-defined as the 'violent body'.

This case study has highlighted how mentally ill patients are effectively silenced in a victim-led definition of workplace violence in the institutional setting. Low institutional capital together with low social capital further marginalises this group as their 'violence' is not understood in the context of their mental ill-health but as violence per se.

Institutional capital is key in determining how issues are understood, but within the institutional setting not all share it in equal measure. There are hierarchies that separate and divide professionals. For example in the medical professions doctors have more capital status than nurses but both work on the wards and both come into contact with patients and therefore have shared understandings of violence. In schools there is a similar hierarchy which is determined by increased responsibility for teaching and curricular duties. However there is also another administrative arm to both these institutions which is organised and negotiated differently. In schools the organisational administration is external to the school. This is where violent reports ultimately land and where any policy decisions are made – at some considerable distance from the location of the incident. The power of this sector of the education system supersedes the capital of the individual teacher or school. In hospitals the administration is slightly more integral to the working of the habitus but managers often don't have any clinical knowledge or experience and therefore are equally 'symbolically' distanced from

the site and the experiences of the professional doctors and nurses. This distance obscures aspects of violence.

7.6 Conclusion

This chapter has illustrated how capital in the operation of the field informs and shapes institutional roles; and informs their definitions and understanding of violence within the habitus. Political and legal discourse on violence has focused on the physical and it was argued that as a result other forms of violence become hidden. These cases have illustrated how depleted capital in institutional habitus affects the experience of violence and the issues of mental ill-health and violence as they are obscured by the dominant discourse.

The concepts of fields, habitus and capital were used to show how this exclusion has occurred. The political field is the most powerful and therefore has the ability to organise social life through its allocation of institutional resources. It is in the privileged position of having enhanced capital which allows it the ability to negotiate with all the other institutional fields in any given society. However it does not help us to understand why those who suffer from mental ill-health are being defined by some as violent rather than by their condition. This is an area that merits future research. These groups are being marginalised in different ways which has implications for both those who are ill and those who have to care for them. Policies developed on incomplete information are unlikely to be effective and possibly only further marginalise already marginalised groups.

Chapter 8

Workplace Violence and Gender Relations

8 Introduction

This chapter will examine the issues of gender and workplace violence to better understand the contexts in which women's experiences can occur. This is of particular interest because in the institutional setting there is a complex relationship between status and gender and between gender and inter-personal relations with client groups. Such an analysis merges the social with the working institutional structures of these women's working lives.

Gendered segregation in the workplace has been well documented (Walby, 1990; Connell, 1995) but the meanings of segregation have rarely been examined beyond the subordination of women to men and the lack of power and economic rewards. Feminist literature has extended on this by looking at the gendered nature of bullying and harassment – mostly sexual or racial - at work but there has been little work done specifically on the gendered experiences of violence in the workplace.

Relations in the working habitus are gendered as they are in the wider society which 'marginalises' and undermines 'capital value' of women. As Walby (1990) argues this is most relevant where it is concerned with industrial relations or employment law. Therefore the need to listen to and understand women's experience is central to ensuring that any interventionist policies or practices effectively address the issues they face (Wesely, 2006; Batchelor, 2001).

Gendered segregation in the institutional workplace it is argued here exposes women to particular 'risks'. These experiences are examined in the same analytical frame as was the previous chapter. An integrative model for examining the role and influence of the *field* (institutions) in analysis of violence is necessary to understand what - and in what ways - factors influence the scripts of the *habitus* (schools and hospitals) and contribute to the *scripts* (capital) with which individuals – professionals and clients - negotiate the sites.

8.1 Gendered employment

Institutions are sites of both control and inequality and are in many ways micro reproductions of the gendered relations of the wider society in which they are located. Fitzgerald & McKay (2006) report that '[w]omen make up nearly half (47%) of the Scottish workforce' and that academic achievements for girls are better than for boys in schools. However, this is not evidenced in the positions women are achieving in the workplace and while the pay gap is narrowing, for many women in Scotland their work experience is in the low-paid, low skill job market. The OECD (2006) has identified the top ten 'gender-biased' occupations for women in the table below:

Many more women than men work as:	Ratio of women to men
Pre-primary education teaching associate professionals	14:5
Nursing and midwifery professionals	10:1
Secretaries and keyboard-operating clerks	9:8
Nursing and midwifery associate professionals	9:5
Personal care and related workers	9:3
Primary education teaching associate professionals	6:2
Shop, stall and market salespersons and demonstrators	5:8
Special education teaching professionals	5:6
Domestic and related helpers, cleaners and launderers	21:7
Primary and pre-primary education teaching	15:9

Table 13: Concentration of employment in 20 OECD countries[25]

The above table clearly shows the gender-bias in the concentration of women in teaching and caring professions. Within Scotland a similar picture can be found: for example, the Scottish Executive's figures[26] show that within Scotland 75% (38,875 female teachers and 12,784 male teachers) of teachers are female; however as can be seen from the table below, there are differing gendered experiences between primary and secondary schools.

[25] Table 10 is adapted from the OECD (2006) report which cites the sources they used to draw up the original table as being: European Labour Force Survey and March Current Populations Survey for the United States.

[26] Figures taken from the report entitled: Gender Balance of the Teaching Workforce in Publicly Funded Schools.

Primary School Statistics **Secondary School Statistics**

Position	Female	Male	Total	% Female	Position	Female	Male	Total	% Female
Headteacher	1,651	348	1,999	83	Headteacher	83	274	356	23
Depute Headteacher	1,252	135	1,387	90	Depute Headteacher	543	747	1,290	42
Principal Teacher	1,465	121	1,584	92	Principal Teacher	3,729	3,362	7,091	53
Teacher	17,367	1,164	18,531	94	Teacher	11,099	6,246	17,345	64
Total	21,732	1,769	23,501	92	Total	15,455	10,628	26,083	59

Table 14: Teachers in Scotland by school type and position[27]

The table above shows that there is a highly gendered bias by school, the primary sector being almost exclusively filled by female teachers regardless of the position they hold within their schools. In secondary schools the total workforce is also predominantly female but there is a distinct difference in the status or positions held: men are disproportionately represented in the promoted posts, especially headteachers.

Similarly in hospitals there are distinct gendered differences in the employment ratios of males and females. Table 15 below shows the current statistics of doctors and nurses in Scotland. It is clear from the figures that there are distinctive gendered differences in employment types. Nursing is a clearly gendered profession with only 12% of nurses being male. However, the gendered split is less distinct for doctors, until the promoted posts are considered: 41% of all doctors are female but only 29% of them are consultants.

[27] Figures for this table were adapted from the Scottish Executive Statistics on Scotland's Education: Trends in Teachers' Numbers.

Employment Position	Female	Male	Full Time	% Female	Employment Position	Female	Male	Full Time	% Female
Registered	33,338	4,593	38,143	89	Consultants	1,016	2,608	3,625	29
Non-registered	2,788	11	2,799	99	Doctors in Training	2,658	2,678	5,336	50
Midwives	13,690	2,068	15,758	87	Other Medical and Doctoral Staff	531	672	1,202	44
Total	49,816	6,672	56,700	88	Total	4,205	5,958	10,163	41

Nursing Staff **Medical Staff**

Table 15: NHS Staff in Post[28]

The figures above show a slight improvement on the figures for the previous year, 2005, which reported that only 6% of nurses in Scotland and 7% for the whole of the UK are male[29], and 'women accounted for just over one third (38%) of medical staff in the NHS Scotland, ... [but] ... account for only one in five consultants[30]. However the ratio of approximately 6 nurses to 1 doctor in Scottish hospitals is consistent with traditional work patterns in hospitals.

Therefore the gendered workplace is clearly evident in schools and hospitals and while these professionals do not fall into the low-paid or low-skilled bracket in the job market, for the respondent population in this study they are undeniably highly gendered workplaces and are classic examples of the 'glass ceiling' effect.

What is significant for this study is that such gendered distinctions in the workforce increase the possibility that violence at work in these two

[28] Figures taken from the ISD Scotland statistics of Staff in Post in the NHS (updated 10/1/07).
[29] Figures taken from the report entitled: Nurses in Scotland 2005.
[30] Figures taken from the report entitled: Women and Men in the Professions in Scotland.

institutions is likely to be gender specific and place women at increased risk from violence. However it is felt that the focus on 'workplace' violence obscured the reality of it as a highly gendered form of violence. Tombs and Whyte (2007) argue, that definitions that focus on particular aspects are limiting understanding of the fullness of the experiences of violence.

8.2 Gender relations in the workplace

These complex interrelations - of the fields, habitus and capital and the implications they have had for the reporting, recording and outcomes for victims of this type of violence - are discussed below. As regards the issue of capital, in the case of institutional working practices women are concentrated towards the bottom end of the institutional hierarchy in nursing and classroom teaching positions. Therefore it places them in the frontline of service delivery.

Gendered experiences of violence Gelles (1998) and Rennison (2001) argue are linked with the degree of inequality between men and women in a relationship, community or society, and the greater the inequality the higher the rates of violence towards women. And West (1999:178) points out that 'Control of one's body and environment are in many aspects elusive goals for women in our cultural climate where violations of women are so routine'. Structural inequalities are reflected in the job market and Connell (1985; 2002) points out quite specifically the gendered nature of teaching. He argues that the

> '...pattern of gender relations [is] institutionalised in a school [which he calls] its "gender regime". The way it embodies

> patterns of authority is an important part of the political order of the school..... where most administrators, principals and subject heads are men. It can create difficulty when women are exercising authority even so well-institutionalised a form of authority as being headmistress...' (Connell, 1985:138/9).

Women *are* in positions of power. And this is one quite distinct and specific area where the gendered nature of institutions challenges the commonly held gendered assumptions. Both education and health as identified above have highly gendered workforces. Women are predominantly in the positions of authority in their institutional role – nurse to patient, teacher to pupil - but are also predominantly those who are the first point of contact with their respective client groups. This as Connell (1985) points out can be challenging for some males to accept. It disrupts and challenges their normal gendered experiences. It may also possibly be a contributing factor in the experiences of violence of women teachers and nurses.

Klein (2006:158) argues that '[n]ormalised masculinity encourages men to dominate women'. This is particularly pertinent in the institutional settings of the habitus which as argued above is traditionally patriarchal in form (Connell, 1995; Hearn & Parkin, 2001; Smart, 1990). Simpson and Cohen (2004) support the view of Collinson and Hearn (2000) that organisational power relations are themselves heavily gendered but also emphasise how this is more than just gendered segregation of jobs and status but also needs to be understood in 'terms of the discursive practices and assumptions that underpin the performance of management. For example, as Collinson and Hearn point out, the managerial prerogative can be seen as part of a highly

masculine discourse based on power and control' (Simpson & Cohen, 2004:182). Furthermore '[m]en who abuse women associate with other men who have the same beliefs, and who give them support for thinking in this way' (Schwartz and DeKeseredy, 1997:7)

Essentially the patriarchal structure of the institutions as a micro world - in which they 'share a common belief that social relations ... are part of a broader system of relations between unequal social groups, based on gender and/or class and /or race' (Halford & Leonard, 2001:13), and understand[s] and share[s] the focus of men and boys as the primary subjects of crimes (Heidensohn, 1996) - is unlikely to understand or problematise workplace violence as another form of violence against women.

8.3 Gendered experiences of workplace violence

This respondent population, as discussed at length in Chapter Five, is very gender biased in that 80% of all respondents in health and 68% of all respondents in education are women. This is reflected in their experiences of violence where there is a ratio of 2:1 in schools and of 10:1 in hospitals of women to men as victims of violent incidents.

What is significant in these statistics is not just the gender division of the workforce and victims, nor the gendered experiences of violence but the fact that these two institutions *are* gendered institutions and therefore what the statistical evidence highlights is that violence in schools and hospitals is also a problem of violence against women. However there is ambiguity in the data about experiences and perceptions of gender of perpetrators.

Over two-thirds of women teachers and over three-quarters of female doctors/nurses have been the victims of violent incidents and over two-thirds of these incidents in schools, and approximately three-quarters in hospitals, were perpetrated by men. 31% of male teachers, 15% of male doctors/nurses also have experience of violence: even here, 76% and 66% of incidents against male teachers, doctors and nurses were also perpetrated by men.

The majority (58%) of respondents in schools have indicated that they perceived male pupils as the more likely to be involved in violent incidents. However the majority (56%) indicate that there is no gender distinction in their experiences of violence when perpetrated by parents or guardians of pupils. The picture for hospitals however, was slightly different in that they perceived no gender differences in their experiences of violence whether perpetrated by patients, ex-patients, parents, guardians or visitors. This ambiguity is exemplified in their discussions and interviews where they repeatedly referred to male-perpetrated violence and in their comments on the types of violent incident of which they have had personal experience they consistently refer to males as the perpetrators. For example, medical professionals report the following as typical of the types of violence they face:

> *'Male parent – 30 year old approximately, using aggressive body language, issuing threats of future violence and being verbally abusive.'* (H18b62)

> *'Male patient punched me in the face.'* (H10b17)

'Male patient became violent and struck out with his arm, which had a splint on it, and hit me across the nose.' (H18b57)

Similarly the teachers report the significance of gender in their experiences of violent incidents:

'All caused by pupils – without exception boys.' (E18b:69)

'Pupil assault on two teachers – one was pregnant – boy aged 10... 1 year later assaulted headteacher' (E18b6)

'15 year old boy with fist raised threatening to "give me a doing" because I was stopping him from running out of school' (E18b77)

Respondents in focus groups also talked quite specifically of their experiences of violence as being gendered as evidenced in the following statements made by female teachers who described situations in which the perpetrators were male:

'standing up, the chair falls back and you are thinking, Oh, em, teacher go into submissive mode.' (PFG)

Another commented that what they are dealing with is

'the sort of thing that if that happened in the street, you would be calling the police.' (PFG)

In schools, female on female violence was also identified, and particularly so in relation to age. For example, a female teacher reported that young girls, particularly around 14 years of age, can be very troublesome, an attitude which she summed up in the following statement:

> *'I am young, you are not; I have got my life ahead of me, you haven't, kind of thing – you cannot tell me what to do.' (PFG)*

Furthermore gender and stature are also believed to be significant:

> *'I have another wee lady who is 4` 10``, em, who is very nice .... but she struggles.' (PFG)*

And while these latter two incidents are unsettling and difficult to deal with, irrespective of whether it is in hospitals or schools, what women find intolerable is the process of reporting, recording and investigation of them when, or indeed if, they are reported. The system they believe is problematic and they feel that when incidents are reported they are not supported.

8.4 Violent places

The respondents' views also identified that violence is not only 'gendered' but 'situational' as the majority of frontline staff are increasingly female, which, as pointed out by Connell above, places them in vulnerable positions in the workplace. However, despite some evidence to suggest there are changes in the gender balance of nursing - Ball and Pike (2005:11) claim that 'there has been a steady increase in the proportion of men [but] the numbers are too small to examine in the Scotland data' - the converse is to be found in

the teaching profession where Riddell et al (2005) report on the 'feminisation of the profession'; this change they identify with policy and social changes that have affected the role and status of teaching and teachers.

This places women at the forefront of the boundaries of the institutions – the vulnerable positions; for example, triage nurses and unpromoted classroom teachers are often those with whom first contact is made but they are often the staff with the least institutional capital: experience in dealing with difficult situations due to lack of training and length of time in the job. In general, line managers only become involved after the event; that is, in the investigative stage of processing reported incidents. For example:

> *'After spending 3 hours in the A&E Department of my hospital as a patient (one evening), I was totally shocked by the disruption and violent behaviour I witnessed.'* (H14b87)
>
> *'Patient wheeled in on a trolley by SAS (Scottish Ambulance Service), he leaned forward at me and shouted in an aggressive way. I automatically felt frightened.'* (H10b205)
>
> *'I would like to think that the management consider their staff just as important as their clients. Nurses seem to be thought of as "punch bags" and that violence towards them goes with the territory. The ethos of the NHS towards staff must change.'* (H25b:160)

The experiences in the education sector are also similar in content. For example:

> *'Nothing much is done about "low level" violence because it is not acknowledged or perceived by authority as meriting attention – only to be expected.'* (E28b14)

> *'Senior Management to back teacher up'* (E25b85)

Typically classroom and hospital wards are identified as the main locations where violent incidents occur, and they can range from low-level to major. The professionals in this study include the following examples of the violence they face in their normal work place: name calling or finger wagging to extremely severe incidents where objects up to and including televisions have been thrown at staff; staff have been grabbed by the hair, physically attacked by being hit, punched and/or kicked, spat upon, threatened; and in one incident a nurse was so severely attacked (grabbed by an elderly demented patient) that she had to have breast surgery following the event.

> *' ... it is increasing more ... I can deal with it ... more than 6 times a day - it does make an incredible strain. The regular indiscipline - be quiet. Please, I said, be quiet. Would you shut up, you know – that kind of small issues and they just go on and on and on ... Take your jacket off, take your jacket off, take your jacket off .... It's absolute murder. ... it is very stressful.'* (PFG)

This clearly shows the spectrum of incidents that are experienced as violence amongst these respondents. Violence here as elsewhere has many forms – physical, psychological, verbal etc. and for some, as the quotation above illustrates, can also be experienced as a continuum of low level indiscipline that creates the experience of being violated over the working day. The continual revisiting of the same problem in the same location increases feelings of violation to the point of abuse over time.

8.5 Lack of support

As is evidenced in respondents' comments above and on the reporting of violent incidents, as discussed in Chapter Six, the range of behaviours they experience are open to differing interpretations in the reporting and recording system. Line managers, they report, do not all support them or share the same understanding of what violence is. In addition, the gendered nature of the workforce and institutional hierarchy highlighted above indicates that there is the possibility of the women's reports of violence being questioned by men.

Those in positions furthest removed from the violence are identified by the respondents as those least likely to accept their experiences of violence as violence or at the very least to listen to their reports of it. This is not altogether surprising; as Messerschmidt (1997:4) points out '... individuals ... configure and orchestrate their actions in relation to how they might be interpreted by others in the particular social context in which they occur' and as discussed previously these institutions have remote hierarchical management structures where decisions are made by mostly male managers on whether or not the violent incidents reported by the mostly female

workforce are indeed to be understood and classified as 'violent'. Thus the power of policy makers within the institutional setting is entrenched in those who are furthest away from service delivery and the daily interface with the respective client groups. It is a typical example of the gendered relations of the workplace and the structural relations of power and inequality (Walby, 1990; Connell, 1995; Smart, 1990; Young, 1990; Dobash & Dobash, 1992; Hearn and Parkin, 2001; Halford and Leonard, 2001; etc).

While there is a general notion that we all know what violence is and that its intention is to hurt, the over-emphasis on its physical forms marginalises other forms such as 'verbally abusive behaviour' which Burman et al (2000) report can be 'potentially more hurtful and damaging than physical violence' and sends the signal to those who experience, for example, verbal abuse that their experiences are not regarded as valid. This is evidenced in the respondents' views of who listens to their reports of violence.

Over 64% of respondents in Health feel they are not offered adequate support in dealing with violence at work. However, in Education the picture is less bleak - only 24% feel that this is the case[31]. Furthermore 15-20% of respondents feel intimidated by the process of investigation following an official complaint. Numerous comments have been made to the effect that most of the investigations start by scrutinising the actions of the member of staff in the first instance to establish whether there is any evidence to suggest provocation or instigation by the employee. Some staff find this acceptable, but for a small but significant number this is felt to be intimidatory. In particular the need for more support is identified by both female and male

[31] This may in fact be as a result of an over-representation of headteachers. Questionnaires were distributed to the schools through the headteachers; however they are the line managers in schools and therefore are unlikely to comment against their own management styles.

doctors, nurses and teachers. The following statements reflect the breadth of views expressed on this issue:

> *'[...should be] handled in a supportive way [rather than having the victim need to produce] witnesses that you didn't do it.' (PFG)*

> *'I also think it is important that members of staff are believed.' (PFG)*

> *'Some managers automatically assume that the nurse is at fault rather than help them.' (H29b196)*

And others commented

> *'The risk is there that the teacher is blamed for provocation or unprofessional handling of incidents.' (E29b85)*

> *'......made me feel inadequate – criticised because the incident was 'allowed' to occur, not prevented' (E29b86)*

Headteachers also commented in discussion that:

> *'...they perhaps should have recorded incidents on Violent Incident Report forms, but did not because the issue/event/person/s had been dealt with – conclusions reached*

and the matter closed. To have reported it on a Violent Incident Report .... Might have made matters worse.' (PFG)

So it would appear that violence against women in the workplace becomes hidden behind the over-arching title of violence in the workplace and the structural processes and procedures in place only serve to doubly 'damn' women, which is redolent of the experiences of women and domestic violence that are already well documented (Dobash & Dobash, 1992: Aris et al, in Stanko, 2003; Kelly, 1987; MacKinnon, 1989; McKie, 2005).

It is also felt that the process of reporting, recording, and the nature of subsequent investigations leads to under-reporting of incidents. However, doctors, nurses and teachers also comment that they believe that with the lack of feedback from any report lodged they are left feeling quite isolated: their perception is that they are merely filed and no action taken in response to them. The inadequacy of the current sanctions available to protect them from further or future violence is also a matter of concern - another female teacher gives the following example:

'2 cases of 1st Year boys – one found concealing a knife .... and one concealing a baseball bat ......[creates] fear ... because you don't know once you have let a child into your class what is in his bag.' (PFG)

Apparently these boys were excluded for 3 days and then they were allowed *to return to the same school.*

Furthermore the gendered experience of violence is highlighted by the calls for more of a male presence, in the shape of staff, security, and/or police on site which it is thought by the female respondents would help to reduce the level of violence experienced.

Thus the rhetoric of support from Government in the Zero Tolerance campaigns is compromised by the subjective interpretation of definitions of violence. This leaves staff and in particular female staff open to victimisation and, indeed, they report that they are often re-victimised. Therefore there is a need for clearer understanding on what is and what is not to be classified as violent within the workplace and for a range of effective sanctions to deal with it, including criminalising some behaviours.

8.6 Conclusion

This chapter has examined gendered experiences and illustrated how capital and symbolic space in the habitus affect institutional understandings of workplace violence. Institutional role and hierarchical position are both identified as being a significant factor in how these professionals' experiences of violence are accepted and understood.

Institutional working processes and organisation have been shown to be highly gendered and the dominant view of violence and its association with masculinity is recognised as superseding other forms of violence in its significance. This has left the majority of the respondents in this study feeling unhappy with the current mechanisms for reporting and recording incidents when they do occur and for supporting them in dealing with them.

Current systems in fact have been identified by some as further exacerbating an already hurtful experience by turning the focus of the investigation on the 'victim' and how they 'failed to prevent' the situation developing, as opposed to the perpetrator and their motivations for committing the offence. Furthermore, the dominant social and cultural understandings of gendered roles are challenged by the positions of women in the role of teacher and nurse, who are in positions of power – however contested that may be – in the delivery of services. This places them in vulnerable positions.

Political and legal discourse on violence has focused on the physical and it was argued that as a result other forms of violence become hidden. These illustrate how depleted capital in the institutional habitus affects the gendered experience of violence and leaves women, especially nurses and teachers, in vulnerable positions.

Chapter 9

Conclusions

9. Introduction

The main aim of the thesis was, by using a Bourdieusian frame, to critically explore the experiences – the extent and the nature - of workplace violence for doctors, nurses and teachers. Workplace violence, especially in the public sector, was arousing concern in the Scottish Executive and increasingly becoming the focus of academic research interest. Media representations – which were considerable - while highlighting the issue, were problematising it within a narrow frame: hence the need to better understand the professionals' experiences of violence which were arousing concern. The thesis was concerned with both the inter-personal – client perpetrated violence – and environmental – the working practices of schools and hospitals. It was not concerned with the motivations of the perpetrators but with the experiences of violence from the perspective of those working in these institutions.

Their experiences were researched through interviews, focus groups and a questionnaire. Senior managers in the fields of education and health were also interviewed and contact was made with the unions and professional bodies representing staff. Secondary data from the media, unions, and literature on the social construction of violence, and in particular on violence at work, were analysed. Meanings of violence were grounded in their understanding and perspectives of violence: how they defined it in the context of their work environments. This meant that a number of questions could be addressed in relation to their experiences in the workplace.

Definitions were central, but so also was the context in which the violence occurred. What were the salient factors in their feelings of violation?

This thesis is therefore an empirical piece of work which is concerned to address contested definitions of workplace violence, to extend knowledge and understanding of the meanings of violence, and to adopt a new approach to this area of social enquiry. Hitherto the focus in discussion of the subject had emphasised its physical and interpersonal nature. My interest was in understanding interpersonal violence within the institutional context, and in exploring and examining the relationships between the institution, clients and employees. Such an approach marks a shift in orientation by locating experiences of interpersonal violence in interactive contexts (client/staff/institutions) within the working habitus, of school and hospitals.

The flexibility offered by Bourdieu's approach to doing research, and in particular his concepts of fields, habitus and capital, have helped to shed light on the complex interaction between interrelated institutional and personal phenomena that constitute workplace violence. His approach has produced qualitative data that has identified previously obscured aspects of it.

9.1 In fine

Understanding the problem from the perspective of the professionals was central to developing a deeply contextualised understanding of the nature and extent of the violence they face in the course of their work. Media reporting had problematised it as an inter-personal form of violence brought into institutions by 'bad' or 'pathological' clients who were irrationally

enacting violence on professionals; the message was that this was a new phenomenon, and that it was increasing. However, interviewees and union representations challenged this view, and the growing body of literature that was emerging was identifying how violence can be experienced in a variety of different ways. Clearly, therefore, defining what the professionals were experiencing as violence was crucial and data collection was grounded in their observations and descriptions of violent incidents.

In this study analysis has taken a different perspective, particularly from those which stress the interpersonal nature of violence and look primarily at the characteristics and assumed pathologies of offenders, and from those of victimology which centre analysis on the perspective of the victim (Walklate, 2003). This analysis has, while exploring the victims' perspective, located their experiences in the wider context of the working institution. Therefore it was interested in understanding the organisation and regulation of institutional working and its effects on the professional/client relations. To this end Bourdieu's model has opened up analysis and provided the opportunity for making connections: the inter-relation between violence, institutions and staff; between the expectations of institutions and clients; and between institutional staff and clients.

As discussed in Chapter One, initial understanding of workplace violence was media led, which was unhelpful in providing a full explanation. Their perspective was narrow in focus and provided a fractured analysis that was primarily concerned with problematising workplace violence as an interpersonal issue. While they did report issues such as inadequate resources, raised expectations of client groups linked to policy changes, and

in some cases the quality of service delivery, they failed to explore fully how these factors are connected, thus oversimplifying the issues. Locating violence in the broader frame, on the other hand, demanded an understanding of violence and its definitions beyond that of the violent interactions themselves and demanded inclusion of police, practice and cultural issues. Doing this exposed the variety of ways in which violence can be experienced in both symbolic and real terms. It was then located in the fields of education and health, and more generally as an issue for the HSE.

Whilst still focusing on the interpersonal nature of violence at work, the unions and professional bodies representing the interests of doctors, nurses and teachers did so from a slightly different perspective. Their concern was less with the violent behaviour and more with protecting the staff from future violence. Analysis was again within a narrow frame and restricted understanding as it did not address the issue of why this violence was occurring.

Analysing understanding within the wider frame identified the need for it to be located beyond that of the personal experiences of violence, whether they be physical, verbal, psychological or emotional. It also exposed how, in the nature of institutions, there are a multiplicity of perspectives. Hierarchical structures and differing social and cultural experiences all converge in the institutional site. However, distance from the experiences of violence, which is symbolic in that it is more to do with hierarchical structures than physical distance, is found to be highly relevant in understanding the contested nature of violence. Violence on paper, it would appear, is less violent than that of the A&E department or the classroom.

As is discussed in Chapters Two and Three, those within the field - executives and policy makers - are imbued with capital which confers power and authority on them by dint of their position – they are the autonomous 'men in suits' – they are in the position where they can and do define the habitus of schools and hospitals, which are semi-autonomous organisations in the delivery of public services – however hierarchical structures remove managers from frontline services. Frontline services are where the violence is experienced in the delivery of service and in the interactions with these institutions' respective client groups. However, violence is not what is expected as all institutional personnel benefit from the capital which being a member of the institution brings – awareness of the institutional procedures as opposed to their client groups who have relatively little capital that is of value in the institution. However, violence can and does have considerable capital value in that it can be used to control and induce fear and therefore compliance which is usually to the benefit of the perpetrator. But in some cases, especially cases where physical violence is used in public places, the value is likely to be illusionary as it will be very short lived. On the other hand the effects of it on the victim can be long lasting and effectively deplete their capital value in the job market as they either cannot perform tasks effectively or indeed are so traumatised they leave the profession altogether.

This group of respondents identify that space, culture, experience and gender all affect understanding of what violence is. Verbal abuse may be denied its significance because in the reporting and recording process the intentionality, tone of voice, body language can be lost, which leaves victims open to future violence and feeling doubly violated, once by the perpetrator and secondly by the system or the institution.

Official statistics it was argued in Chapter Six under-estimate the full extent of violence in the workplace, for a number of reasons. Official HSE procedures are likely to exclude much of the violence reported in this study because of the qualifying categories of RIDDOR, which is really only concerned with events where victims are unable to work for 3 consecutive days following an incident. The majority of the violence reported by this respondent group was relatively low-level, verbal and threatening or intimidatory behaviour which would not be captured by this procedure. Furthermore, some in this study do not report incidents as they feel the internal reporting and recording system adopted by their institution is intimidating and more concerned with identifying the professional as incompetent for allowing a situation to arise than with bringing the perpetrator to justice.

However while such a focus may be justified in a number of cases, in others it is the institutional practices that are identified as a major problem - for example, informal reporting and recording systems were found to be more effective in getting clients to report incidents - and a lack of belief in the system to support is another. Furthermore the role of the institution itself is lost in this type of analysis: for example pupils being curtailed by a curriculum and forced into subjects etc they don't like or see any value in and patients being kept waiting for hours on end or sedated when it has been identified that since the introduction of the Parents' and Patients' Charters client groups' expectations have been raised beyond what the institution can deliver and that clients have become more demanding of their rights but evade or avoid any responsibility in their actions.

The respondents in this study overwhelmingly agreed that violence was physical, verbal and that the effects of it can be long lasting, but they also identified that these effects could be heightened or extended by institutional responses and/or reporting and recording procedures.

Ultimately what both the media and unions were concerned with was the effects of violence on staff, and they therefore supported calls for the exclusion of those who were violent from mainstream education and health services. Such action is perhaps likely to reduce the violence experienced in that particular site but it is also possible that it will only move the violent perpetrators to another site.

The application of Bourdieu's concepts of fields, habitus and capital to workplace violence has allowed for the inclusion in the analysis of the power constructs in institutional practices and procedures, interpersonal interactions and social, cultural and gendered differences. In particular his concept of fields indicates how the most desirable or dominant capital creates hierarchies of power. For example, the most powerful is the political field which legitimises all other fields and imbues them with cultural values and beliefs. What became clear was that an understanding of the nature and interplay of fields or 'force fields' was of fundamental importance in the organising structures of the habitus; the institutions in question.

Institutional sites or habitus reflect wider social values and the importance of capital in organising and negotiating social interactions. Institutional employees within a given habitus have, as indicated above, explicit knowledge and skills which place them in positions of authority over their

clients through their acquisition of institutional capital. However, it is this authoritarian role that also places these individuals in positions where they are vulnerable to victimisation and violence.

The staff / client interface is particularly problematic because it is more than just the interaction of the individuals involved. It is, rather, a complex situation which involves imbalances of power, differing social values and norms, and contested definitions of violence. The habitus or institutions lie at the boundaries of the fields and therefore are sites of contested values as they interact with all other fields as argued in Chapter Six.

Therefore staff and clients are entering into an interaction from different perspectives; institutional staff have expectations of how clients should behave; and clients have expectations of the services they should receive. When these expectations are not met some clients challenge this and some do so violently. These challenges on the staff member are also challenges against the institution as they both affect the victim and disrupt the normal working practices of the institutions. However, exercising violence only represents limited capital value for the perpetrator but can have long lasting effects on the institutional capital. For example, at the individual level it can incapacitate staff members through injury and also through fear of future violent attacks. At the institutional level highly skilled staff may be lost through injury or fear of violence. These connections were not captured by the more simplified analysis presented by the media or the unions. This further justified the need for the victims' voices to be heard.

Respondents' definitions of violence as reported in Chapters Four, Five, Six,

Seven, and Eight have clearly indicated that violence in institutions is more than just the experience of physical acts. They have identified that 'intentionality' is key to their experiences of violence; knowing that the perpetrator is meaning to inflict harm or fear. Other forms of violent behaviour such as verbal abuse and aggressive body language, can, they report, be just as distressing as physical violence. Policy changes are also believed to have raised client groups' expectations beyond what institutions can deliver which is a factor in the confrontations they face: for example, policy changes to include those who suffer from behavioural or mental ill-health problems into mainstream services.

A further issue that has emerged from the data is the gendered nature of experiences of violence at work: it had not hitherto been made apparent that the violence being reported in these institutions was mostly violence against women. These institutions, as discussed in Chapter Eight, are highly gendered. The majority of nurses and teachers are women whose over-representation at the lower end of the institutional hierarchy places them in vulnerable positions. They are often in the front line of contact with their respective client groups and due to institutional working practices, both sets of staff work in locations which are confined and difficult to subject to surveillance within their respective institutions.

Also emerging from the discussions is that clients who suffer from behavioural or mental ill-health problems are being defined as violent by some respondents and ill by others. This indicates an area that is prime for further research.

The problem of violence at work has consistently been conveyed in the media as 'new', and 'increasing'. This study has shown that this is an unsubstantiated claim as there is a lack of data to confirm this assertion. The respondents' perception is that it is increasing, but that it is not new. There are a number of issues raised here that make it impossible to accurately assess if there is indeed an increase in the level of violence. There is a lack of existing data with which to compare new data. The new data itself may not be accurate as the respondents have indicated that they believe there is an under-reporting of violent incidents because on the one hand they fail to report all incidents, as 'it had been dealt with'; and the reporting and recording procedures in institutions were not user-friendly. Furthermore, some respondents claim that the contested nature of defining incidents as violence may mean that reports filed are not recorded as their interpretation is challenged by line managers. Therefore the need for continuing research in this area which takes account of the institutional context is paramount. Finally the respondents identified the 'usual suspects' as being the perpetrators of violence – mainly young men. However, they all believe that violence is perpetrated by either gender.

It is evident from these conclusions that more work is needed to identify the backgrounds of perpetrators, to examine their actions in the context of the institutional setting and to give consideration to their interpretation of their roles as patients or pupils.

Violence against public service workers is not decreasing. Recently there have been serious attacks on ambulance workers and the fire brigade in the execution of their duties, up to and including being shot at with air guns. On

the 3rd May 2007 the Edinburgh Evening News had a headline reading 'Staff at ERI (Edinburgh Royal Infirmary) are facing a barrage of violence' and the article reports that police were called to 84 incidents over the past two years. Similarly on 7th September 2006 the BBC reported a rise of 25% in attacks on teachers in the last year and on 1st February that in England a teacher suffers a violent attack almost every school day. Clearly this is an area in need of further research.

Unstructured Interviews

Only one open-ended question was used (see below) but there were a number of particular issues I was interested in hearing about. These are also noted below.

Question:

I am interested in hearing your opinions on violence in your school/s or hospital/s.

Issues of particular interest:

Definition

Did they have one?

What did it mean – how was it being interpreted?

Increasing

Is it really an issue and if so why? What was different?

Victims

Who were they? Any particular characteristics?

Perpetrators

Who were they? Any particular characteristics?

What to do about it

Did they have a policy for dealing with violence?

What was it?

Was it used?

Problems/ issues arising from it?

Why it was happening

What in their opinion was causing violence?

Appendix 2

Semi-structured Focus Groups

My interest is in understanding violence in hospitals and schools from the perspective of the doctors, nurses and teachers. What are your experiences of violence at work?

Issues to listen for and raise if possible:

Violence is reported as increasing – did they think it was?

Did they experience violence?

Did they know what the definition of violence at work in either health or education was?

Did it include the types of violence they experienced?

What sorts of behaviours did they define as violent?

Did they differentiate between disruptive, violent and ill health or behaviour problems in their definition?

Who were the main perpetrators of the violence they knew about?

Did they feel policy protected them from violence?

Did they feel supported?

Did they know how to report a violent incident?

What would they like to see done/implemented etc.?

Violence At Work Questionnaire Appendix 3

Education

Section 1 - Statistics

This set of questions is to get a statistical background of respondent, by age, gender and the educational environment they are working in.

1. Gender (please circle) Male Female

2. Age Group (please tick the appropriate box):
   - Under 30 ☐
   - 30 - 40 ☐
   - 40 - 50 ☐
   - 50 - 60 ☐
   - Over 60 ☐

3. Please circle the type of Educational Establishment you work in.

   Primary Secondary

4. a) Would secondary teachers please indicate subject/s taught:

   ____

   b) Would primary teachers please indicate which year of Primary

   Education they are teaching. ______________________________

5. What position do you hold at present? (please tick the appropriate box)
   - Head Teacher ☐
   - Depute Head ☐
   - Assistant Head ☐
   - Principal Teacher ☐
   - Assistant Principal Teacher ☐
   - Senior Teacher ☐
   - Teacher ☐

6. How long have you been in your present post? ____________________

7. How long have you been a teacher? ____________________

8. Please indicate which of the following best describes the social location of your school:

   1. Area of deprivation ☐ 2. Typical working class ☐
   3. Typical middle class ☐ 4. Mixed catchment area ☐
   5. Other ☐

9. Which Local Authority do you work for? ____________________

End of section 1. Please proceed to section 2.

Section 2 - Defining Institutional Violence

It is important to define 'violence' in a manner which is meaningful to those who are experiencing it, and to those who are interested in how it affects teachers and how it could be best addressed. This section is to identify those events which are clearly perceived by teachers as being different from the routinely disruptive behaviour - as being, in fact, violent incidents.

10. a) Which of the following would you define as a 'violent' incident? Please indicate from the list below the behaviour/s you feel would constitute calling an incident violent.

verbal abuse:
- ☐ aggressive manner and tone to the voice;
- ☐ with the use of bad language;
- ☐ and/or with aggressive body language.

physical abuse:
- ☐ being deliberately jostled in the corridor or the classroom;
- ☐ being deliberately pushed aside, or struck by another person;
- ☐ being physically struck with an object by another person.

threat to yourself:
- ☐ where a specific verbal statement of intent to harm you is made.

threat to your property:
- ☐ where a specific verbal statement of intent to damage your property is made.

mental abuse:
- ☐ combination of incidents which cumulatively leads to one feeling extremely stressed.

group threat:
- ☐ where underlying tensions or fights within the class - even though not directed at yourself - cause you to feel fearful.

Other(please specify): ☐

____

____

____

____

b) It would be useful if you could give (an) example(s) of (an) incident(s) which you perceive as defining what constitutes 'a violent incident'.

____

____

____

____

c) Which of the following statements would you agree describe a 'violent' incident? Please indicate your level of agreement or disagreement with each of the statements.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Only a physical act of aggression can be classified as violent.					
Verbal abuse only constitutes violence if a specific threat of physical harm is issued.					
Name-calling is violent.					
Deliberately jostling someone is violent.					
Addressing someone in an aggressive manner is violent.					
Use of weapons is extremely violent.					
Damage to property is violent.					
Aggressive body language is violent.					
Throwing objects at someone is a violent act.					
Threat of future violence is in itself a violent act.					
Challenging trespassers can meet with a violent response.					
Intervening in brawls between youths can expose one to the possibility of a violent attack.					
Threat of blackmail by making false statements against you is an act of violence.					
Use of bad language alone is non-violent.					

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Constant talking in class can be stressful but not threatening.					
Aggression or 'attitude' when accompanied with bad language is violent.					
Verbal abuse is only upsetting.					
Disruptive behaviour is non-violent.					
Feeling fearful is what makes an incident violent.					
Verbal abuse can be as violent as physical abuse.					
Disruptive behaviour is only a distraction.					
Threat of violence to you can be just as distressing as actual physical assault.					
Disruptive behaviour is never threatening.					
Being physically attacked is a violent act.					
Being pushed or slapped is violent.					
Witnessing a violent act between pupil's etc. is similar to the experience of violence.					
Facing overtly aggressive behaviour from a pupil or group of pupils is an act of violence.					
Classroom indiscipline never leaves you feeling threatened or fearful for your own safety.					
Violence can be experienced as a cumulative effect: constant disruption/indiscipline leaves one feeling violated.					

11. (a) The two issues of disruptive pupils and violent pupils in schools can be separated. **Agree/Disagree**

(b) Could you please explain why you either agree of disagree with the above statement.

____

____

____

____

____

____

____

____

____

12. Is 'violence in the school' on a continuum - i.e. from low level continuous disruptions to major incidents? **Yes/No**

End of Section 2. Please proceed to Section 3.

Section 3 - Situation

This section is to identify where violence occurs in schools and what may be contributory factors to it.

13. Who in your experience are the perpetrators of violence in schools? (please tick; you may have more than one response)

Is it:

a) Pupils ☐

If yes, who are most likely to be so:

1) Boys ☐
2) Girls ☐
3) Just as likely to be either ☐

b) Parents/guardians of pupils ☐

If yes, who are most likely to be so:

1) Males ☐
2) Females ☐
3) Just as likely to be either ☐

c) Ex-pupils or pupils who have been excluded ☐

If yes, who are most likely to be so:

1) Boys ☐
2) Girls ☐
3) Just as likely to be either ☐

14. a) Is there a general feeling amongst your colleagues that violence in schools is increasing? **Yes/No**

If yes, please answer part b of this question. If no, please proceed to Q15.

b) If yes, please indicate why teachers feel this way.

____

____

____

____

____

15. Please indicate by ticking the appropriate box whether you agree or disagree with the following statements:

	Agree	Disagree
Violence has always been a feature of school life.		
Even although violence has always been a feature of school life, it has increased in recent years.		
Violence in schools is a new problem.		
Violence in schools is not a problem.		
Violence in schools is a new and increasing problem.		
Although violence has always been a feature, it is not increasing, it has only been raised in teachers' perceptions by media coverage.		

16. a) Is there a particular age group that causes you more concern than others? **Yes/No**

b) If yes, please indicate which age group/s:

- 5 - 7 year olds; ☐
- 7 - 9 year olds; ☐
- 9 -11 year olds; ☐
- 11-13 year olds; ☐
- 13-15 year olds; ☐
- 15-17 year olds; ☐
- 18 year olds; ☐
- Over 18 year olds. ☐

End of Section 3. Please proceed to the final section, Section 4.

Section 4 - Quantifying

This section is to record violent incidents and to quantify the level of the violence in schools.

17. Have you ever personally experienced a 'violent incident' in schools?

Yes/No

If no please proceed to Q. 21.

18. **a)** If yes, please indicate how many there have been. ____________________

b) Could you please briefly describe these incidents including the following details where possible: who was the perpetrator - pupil, parent or ex-pupil; age and gender of the perpetrator; and when the incident occurred. Could you also indicate if you are subjected to this 'violence' out with normal school hours.

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19. Does the experience of violence at work have an effect on your health?

Yes/No/No Experience of Violence

If yes, please answer part a and b otherwise proceed to Q. 22.

a) The effect of violence on my health is:

- only in the short term ☐
- only in the long term ☐
- both of the above ☐

b) How have you been affected:

physically injured (please specify)________________________
more nervous________________________
a combination of both ________________________
other? ________________________

20. Have you ever been unable to work due to a violent incident? **Yes/No**

If no, please proceed to Q. 22.

21. If so, for how long were you unable to return to work? ______________

22. Do you consider that 'violence' or fear of 'violence', curtails or restricts your ability to perform as a teacher? **Yes/No**

23. Do you personally know any other teachers who have been the victims of 'violence'? **Yes/No**

24. Are the discipline procedures within your school in your opinion capable of coping with such violent pupils? **Yes/No**

25. a) Does your school offer you the kind of support and protection you would like against 'violence'? **Yes/No**

If yes, please proceed to Q. 26.

b) If no, what kind of support and protection would you like to be available?

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26. Do you feel that the worries and concerns of teachers in school are listened to by:

	Yes	No	Don't know
Departmental Principle Teacher			
School Management Team			
Local Authority			
Teaching Unions			
Central Government			

27. Is there a recording system in operation for violent incidents in your school? **Yes/No/Don't Know**

28. **a)** Are you happy with the reporting and recording mechanisms for violent incidents in operation in your school? **Yes/No**

b) If no, please state why.

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29. **a)** If the incident is investigated do you feel further threatened by the focus of the investigation when a violent incident occurs? **Yes/No**

b) If yes, please explain why.

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End of Questionnaire. Thank you for participating.

Comments:

Focus Groups

If you would be interested in taking part in a focus group discussion on violence in schools please fill in this form and return to me at the address below.

Name ______________________________

Address ______________________________

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Phone Number ______________________________

Please return to:

Mrs. E R Frondigoun
University of Strathclyde
Department of Government
McCance Building
16 Richmond Street
Glasgow, G1 1X

Violence At Work Questionnaire

NHS Doctors and Nurses working in hospital environments.

Section 1 - Statistics

This set of questions is to get a statistical background of respondent, by age, gender and the environment they are working in.

1. Gender (please circle) Male Female

2. Age Group (please tick the appropriate box):
   - Under 30 ☐
   - 30 - 40 ☐
   - 40 - 50 ☐
   - 50 - 60 ☐
   - Over 60 ☐

3. Please state which Department within the Trust you are working in.

   ____

   a) Do you only see patients on the wards? **YES/NO**

   b) Do you see patients in the wards and at out-patients clinics? **YES/NO**

   c) Do you only see patients in the Accident and Emergency Department? **YES/NO**

4. What position do you hold at present? (Please tick the appropriate box)

   Doctor ☐ Nurse ☐

   Please state your position or grade? ____________________

6. How long have you been in your present post? ____________________

7. How long have you been a Doctor/Nurse? ____________________

8. Please indicate which type of Hospital best describes the one you work in:

   1. Large Teaching Hospital. ☐
   2. Hospice/Respite Care. ☐
   3. General Non-teaching Hospital. ☐
   4. Children's Hospital. ☐
   5. Maternity Hospital. ☐
   6. Other ☐

9. Which Local Authority Area do you work in? ____________________

End of section 1. Please proceed to section 2.

Section 2 - Defining Institutional Violence

It is important to define 'violence' in a manner which is meaningful to those who are experiencing it, and to those who are interested in how it affects Doctors and Nurses and how it could be best addressed. This section is to identify those events which are clearly perceived by them as being different from the routinely distraught or frightened behaviour of patients or carers - as being, in fact, violent incidents.

10. a) Which of the following would you define as a 'violent' incident? Please indicate from the list below the behaviour/s you feel would constitute calling an incident violent.

verbal abuse:
- ☐ aggressive manner and tone to the voice;
- ☐ with the use of bad language;
- ☐ and/or with aggressive body language.

physical abuse:
- ☐ being deliberately touched or handled;
- ☐ being deliberately pushed or struck by another person;
- ☐ being physically struck with an object by another person.

threat to yourself:
- ☐ where a specific verbal statement of intent to harm you is made.

threat to your property:
- ☐ where a specific verbal statement of intent to damage your property is made.

mental abuse:
- ☐ combination of incidents which cumulatively leads to one feeling extremely stressed.

group threat:
- ☐ where underlying tensions or fights between patients - even though not directed at yourself - cause you to feel fearful.

Other(please specify): ☐

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b) It would be useful if you could give (an) example(s) of (an) incident(s) which you perceive as defining what constitutes 'a violent incident'.

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c) Which of the following statements would you agree describe a 'violent' incident? Please indicate your level of agreement or disagreement with each of the statements.

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Only a physical act of aggression can be classified as violent.					
Verbal abuse only constitutes violence if a specific threat of physical harm is issued.					
Name-calling is violent.					
Deliberately jostling someone is violent.					
Addressing someone in an aggressive manner is violent.					
Use of weapons is extremely violent.					
Damage to property is violent.					
Aggressive body language is violent.					
Throwing objects at someone is a violent act.					
Threat of future violence is in itself a violent act.					
Challenging trespassers can meet with a violent response.					
Intervening in brawls between patients can expose one to the possibility of a violent attack.					
Threat of blackmail by making false statements against you is an act of violence.					
Use of bad language alone is non-violent.					

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Constant talking/questioning by a patient can be stressful but not threatening.					
Aggression or 'attitude' when accompanied with bad language is violent.					
Verbal abuse is only upsetting.					
Frightened patients behaviour is non-violent, merely disruptive.					
Feeling fearful for ones own safety is what makes an incident violent.					
Verbal abuse can be as violent as physical abuse.					
Disruptive behaviour is only a distraction.					
Threat of violence to you can be just as distressing as actual physical assault.					
Disruptive behaviour is never threatening.					
Being physically attacked is a violent act.					
Being pushed or slapped is violent.					
Witnessing a violent act between patient/staff or patient/patient etc. is similar to the experience of violence.					
Facing overtly aggressive behaviour from a patient or group of patients/relatives is an act of violence.					
Patient lack of self-discipline never leaves you feeling fearful for your own safety.					
Violence can be experienced as a cumulative effect: constantly constantly assessing patients levels of indiscipline leaves one feeling violated.					

11. (a) The two issues of disruptive and violent behaviours can be separated. **Agree/Disagree**

(b) Could you please explain why you either agree of disagree with the above statement.

12. Is 'violence in the course of your work' on a continuum - i.e. from low level continuous disruptions to major incidents? **Yes/No**

End of Section 2. Please proceed to Section 3.

Section 3 - Situation

This section is to identify where most of the violence occurs and what may be contributory factors to it.

13. Who in your experience are the perpetrators of violence? (please tick; you may have more than one response)

Is it:

a) Patients ☐

If yes, who are most likely to be so:

1) Males ☐
2) Females ☐
3) Just as likely to be either ☐

b) Parents/guardians or Carers ☐

If yes, who are most likely to be so:

1) Males ☐
2) Females ☐
3) Just as likely to be either ☐

c) Ex-patients or patients who have been refused treatment ☐

If yes, who are most likely to be so:

1) Males ☐
2) Females ☐
3) Just as likely to be either ☐

d) Visitors of patients ☐

If yes, who are most likely to be so:

1) Males ☐
2) Females ☐
3) Just as likely to be either ☐

14. a) Is there a general feeling amongst your colleagues that violence in the course of your work is increasing?

Yes/No

If yes, please answer part b of this question. If no, please proceed to Q14.

b) If yes, please indicate why you feel this way.

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15. Please indicate by ticking the appropriate box whether you agree or disagree with the following statements:

	Agree	Disagree
Violence has always been a feature of Accident and Emergency Medicine.		
Even although violence has always been a feature in the A&E Department, it has increased in recent years.		
Violence in Hospitals generally is a new problem.		
Violence in Hospitals generally is not a problem.		
Violence in Hospitals generally is a new and increasing problem.		
Although violence has always been a feature, it is not increasing, it has only been raised in Doctors and Nurses perceptions by media coverage.		

16. a) Is there a particular age group that is more likely to be violent than others? **Yes/No**

b) If yes, please indicate which age group/s:

- 5 - 10 year olds; ☐
- 10 - 15 year olds; ☐
- 15 - 18 year olds; ☐
- 18 - 21 year olds; ☐
- 21 - 25 year olds; ☐
- 25 - 30 year olds; ☐
- 30 - 40 year olds; ☐
- 40 - 50 year olds; ☐
- 50 - 60 year olds; ☐
- Over 60 years old. ☐

End of Section 3. Please proceed to the final section, Section 4.

Section 4 - Quantifying

This section is to record violent incidents and to quantify the level of the violence experienced by staff in Hospitals.

17. Have you ever personally experienced a 'violent incident' in the course of your work in a Hospital?

Yes/No

If no please proceed to Q. 22.

18. **a)** If yes, please indicate how many there have been. ____________________

b) Could you please briefly describe these incidents in a general way indicating where possible: who was the perpetrator - patient, parent/relative/carer; age and gender of the perpetrator; and when the incident occurred; including a brief description of what happened. Could you also indicate if you are subjected to this 'violence' outwith normal working hours.

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19. Does the experience of violence at work have an effect on your health?

Yes/No/No Experience of Violence

If yes, please answer part a and b otherwise proceed to Q. 22.

a) The effect of violence on my health is:

only in the short term ☐

only in the long term ☐

both of the above ☐

b) How have you been affected:

physically injured (please specify)________________
more nervous________________
a combination of both ________________
other? ________________

20. Have you ever been unable to work due to a violent incident?
Yes/No

If no, please proceed to Q. 22.

21. If so, for how long were you unable to return to work? ________________

22. Do you consider that 'violence' or fear of 'violence' in work, curtails or restricts your ability to perform effectively in your profession?

Yes/No

23. Do you personally know any other Doctors or Nurses who have been the victims of 'violence'? **Yes/No**

24. Are the safety procedures within your Hospital in your opinion capable of coping with such violent incidents? **Yes/No**

25. **a)** Does your Hospital offer you the kind of support and protection you would like against 'violence'? **Yes/No**

If yes, please proceed to Q. 26.

b) If no, what kind of support and protection would you like to be available?

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26. Do you feel that the worries and concerns of Doctors and Nurses are listened to by:

	Yes	No	Don't know
Clinical Director/Senior Nurse Managers			
Trust Directors			
Local Health Board			
Professional Bodies - Unions, BMA etc.			
Central Government			

27. Is there a reporting system in operation for violent incidents in your Hospital? **Yes/No/Don't Know**

28. **a)** Are you happy with the reporting and recording mechanisms for violent incidents in operation in your Hospital? **Yes/No**

b) If no, please state why.

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29. **a)** If the incident is investigated do you feel further threatened by the focus of the investigation when a violent incident occurs? **Yes/No**

b) If yes, please explain why.

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Please return the completed questionnaire by

End of Questionnaire. Thank you for participating.

Comments:

Focus Groups

If you would be interested in taking part in a focus group discussion on violence in hospitals please fill in this form and return to me at the address below.

Name ____

Address ____

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Phone Number____

Please return to:

Mrs. E R Frondigoun
University of Strathclyde
Department of Government
McCance Building
16 Richmond Street
Glasgow, G1 1X

Post-questionnaire Focus Groups

These focus groups were semi-structured in that I had specific issues that I wanted to discuss and explore in relation to the findings from the questionnaires. In particular I was interested to tease out how respondents talked of their experiences. Topics included:

Intentionality
Disruption as opposed to violence
Support systems
Fear
Stress/distress
Reporting procedures

The Research Process

There were three stages to data collection followed by a write up period:

Stage 1:

Interviews, formal and informal
Negotiating access
Explorative focus groups.

Interviews were carried out with key individuals in the education and health sector: Consultants, Headteachers, Local Authority Officials and NHS Executive Employees, Union Representatives as well as a number of individuals who have or have had an interest in understanding or dealing with violence in schools or hospitals. Informal discussions were also engaged in with friends, colleagues and acquaintances.

Access was negotiated by post and phone calls with officials at the local authority level and headteachers or clinical directors.

Explorative focus groups were held with willing teachers and health professionals.

In tandem with this stage I was also developing a questionnaire.

Stage 2:

This stage was mainly concerned with piloting, finalising, distributing and analysing the questionnaire. However, I also collected data from one Local Education Authority and continued to engage with as many professionals as possible.

NUDIST was explored for analysis of the qualitative data, but at that time (similar programmes are much better now) it was found to be quite a lengthy process and the results were not found to be as helpful as I had hoped.

Stage 3:

Comprised mainly of focus groups which were structured around the issues that were raised in the data already collected. A number of issues were worthy of exploration as highlighted in Appendix 4.

Throughout the entire process the media and local press in particular were scoured for information on violence in schools and hospitals.

A number of conferences were attended to hear the views of others working with and researching violence.

Literature was and still is accessed continuously as interest in the topic has strengthened.

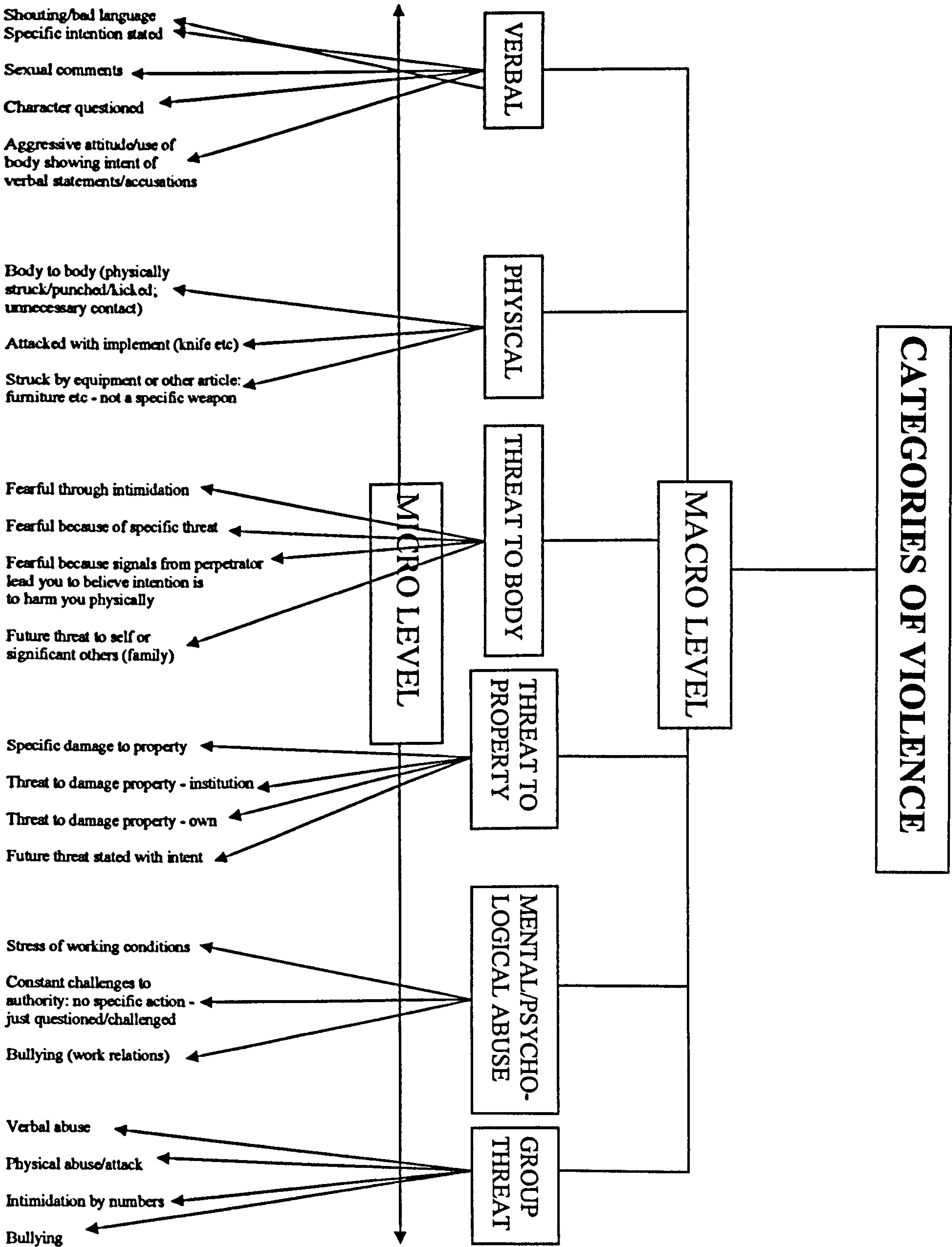
Data Coding/Analysis

Quantitative Data

The quantitative data collected by questionnaire was coded to anonymise it and code books drawn up. The information was then loaded on to SPSS to facilitate statistical data analysis.

Qualitative Data

Transcripts were written up almost immediately following interviews or focus groups taking place. Each transcript was also given a code name to anonymise it. Field notes were attached and used to assist in analysis of the data. Consideration was given to loading this data on to NUDIST but on the advice of my supervisor at that time, it was rejected. Analysis was undertaken by reading and categorising manually using the violence categories chart overleaf.


CATEGORIES OF VIOLENCE
MACRO LEVEL
MICRO LEVEL
VERBAL
Shouting/bad language
Specific intention stated
Sexual comments
Character questioned
Aggressive attitude/use of body showing intent of verbal statements/accusations
PHYSICAL
Body to body (physically struck/punched/kicked; unnecessary contact)
Attacked with implement (knife etc)
Struck by equipment or other article: furniture etc - not a specific weapon
THREAT TO BODY
Fearful through intimidation
Fearful because of specific threat
Fearful because signals from perpetrator lead you to believe intention is to harm you physically
Future threat to self or significant others (family)
THREAT TO PROPERTY
Specific damage to property
Threat to damage property - institution
Threat to damage property - own
Future threat stated with intent
MENTAL/PSYCHO-LOGICAL ABUSE
Stress of working conditions
Constant challenges to authority: no specific action - just questioned/challenged
Bullying (work relations)
GROUP THREAT
Verbal abuse
Physical abuse/attack
Intimidation by numbers
Bullying

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