REVIEW ARTICLE

Folie du système? Preventing Violence Against Nurses in In-patient Psychiatry

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Abstract

Violence against psychiatric nurses is a difficult reality of work on in-patient psychiatry units. Health care providers and managers, nursing unions, and workplace protection agencies are looking for solutions to improve safety and quality of care. We are suggesting that simultaneous to this solution-seeking, there is also a need to critically reflect on the nature of violence itself within in-patient psychiatric settings. In this article we consider the gendered dynamics of power and violence within the in-patient psychiatric setting. The nursing profession is over 90% female. Given that violence in society often has a 'gendered' nature, and in light of a report from the Ontario Council of Hospital Unions which likened violence against nurses to domestic violence, we have put forth a view of the acute in-patient psychiatric milieu that considers gender and power in its analysis of violence against nurses. Intended to encourage enquiry into our pre-suppositions as health care providers, we use Foucauldian and feminist theories to up-end our notions of "anti-violence technologies", and to consider the unique and risky position that psychiatric nurses occupy as *carers*, care providers, and "anti-violence officers". We conclude by posing ethical questions which may be of interest for professional development, care planning, team building, and clinical ethics and education.

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In 2014, The Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario Canada was fined $80,000 under the Occupational Health and Safety Act, for "failing to provide sufficient information and supervision to protect a worker from workplace violence and failing to implement measures and procedures to protect workers from workplace violence" [1]. The incident that led to these charges involved the violent assault of two nurses by a psychiatric in-patient [1–3]. Those of us who work in the field of mental health know that these assaults occur all-too-often within in-patient psychiatric environments. Following the incident at CAMH, there has been a surge of local and national media attention around the issue of violence toward nurses, particularly in psychiatric care. This has brought the often under-reported and silenced issues of violence in psychiatric settings into the fore of public awareness [4–6].

Among health care professionals, Registered Nurses (RNs) are at the greatest risk of experiencing violence, both physical and verbal [4, 7–12]. In psychiatric settings, 44% of nurses report experiencing physical abuse and 70% report experiencing emotional abuse [13]. These violent encounters negatively impact nurses, and patients, as well as the therapeutic environment due to "the counter therapeutic effects of both violence and [the] measures to prevent violence" [14].

It is our contention that the milieu of in-patient psychiatric practice – and praxis – holds inherent contradictions: it is, on the one hand, an environment with the therapeutic aims of promoting psychological wellbeing and safety, and on the other, an environment that enacts force, control and surveillance – methods and structures which may (re)create and perpetuate experiences of trauma and violence against patients and health care providers. It is important to note that defining violence within this setting has been a challenge, as researchers and health care providers struggle to attend to a common definition; for example, "many [in-patient psychiatric nurses] initially remarked that verbal violence was such a common occurrence and thus not always considered to be a form of violence" [15].

Making the Case: Feminism, Foucault, and Faces of Violence

This normalization of violence with psychiatric care has been highlighted by research consultants Jim Brophy and Margaret Keith, in their work with the Ontario Council of Hospital Unions. They documented that violence against health care staff is systemically accepted. When interviewed by the Toronto Star, Brophy stated "It's become so normalized, so accepted, now it's really viewed as part of the job. You might as well put it as part of the job description" [3]. A recent research study by Hilton, Ham, and Dretzkat shows that approximately 30% of psychiatric nurses meet criteria for Post-Traumatic Stress Disorder, and that this finding was directly correlated with exposure to violence in their clinical work [16].

Broady, in his assessment of the scope and nature of violence in psychiatric care says "I was scandalized by how much it was replicating all the feature of domestic violence. Blaming the victims, keeping the dirty little secret quiet, [nurses] really internalizing all of this" [3]. Historically, domestic violence has existed on the periphery, was not discussed publicly, and was shrouded in silence and shame [17–19]. While Canadian society's attitudes about domestic violence have shifted in recent decades, we can draw a parallel between the silence, secrecy and shame that has shrouded domestic violence, and that same silence, secrecy and shame that nurses have experienced in relation to health care violence when it is enacted upon them – often feeling that they are to blame for not preventing the violence from occurring, despite efforts to follow best practices and protocols [10, 20–22].

Power and violence are often gender-based and even inform our understandings of gender [23, 24]. In order to examine violence against nurses as a gendered profession, we draw on feminist discourse of domestic violence to illuminate the ways that power structures in health care may replicate this violence. A focus of this paper will be the gendered body of nurses:

> Just as we can use the phrase a body of knowledge, the bodies of medicine and nursing imply that the professions embrace collective values, views, ways of working, knowledge bases, etc. – which understandably affect how the two (collective and individual) bodies approach and understand each other [25].

Nurses, as individuals who are *embodied* and as a *body of nursing,* have direct relationships with one another; they inform and influence each other in their day-to-day activities. Therefore, keeping the lived body central in this analysis holds in view how oppressive power through violence is often enacted on the bodies of women [26] and on the body of nursing. Nursing is clearly a gendered profession; as of 2010, women represented 93.6% of RNs employed in nursing in Canada [27]. Despite advances in the establishment of nursing as a profession with specialized skills and areas of expertise, the nursing role is still perceived as a vocation of caring [28]. The values of the collective body of nursing – such as altruism, compassion and nurturing – shape individual nurses' bodies in terms of what one is willing – or ought, by virtue of being female, to be willing – to bear within the clinical encounter [25]. Being careful not to diminish these qualities that support compassionate, patient-centred care, these often-feminized qualities have placed nurses in a precarious position as they navigate violence in the workplace. As Michael Hurley from the Ontario Council of Hospital Unions stated in his letter to the Ontario Minister of Labour, "in no other occupation or walk of life would such abuse be tolerated" [3].

Building on the established relationship between gender and violence, we are able to see how power constructs bodies – both individually and collectively. By examining the power structure within which the body of nursing is situated and the activities that are carried out by nurses' bodies, we see the ways that these roles and activities "construct and recreate particular kinds of bod[ies] to perform particular types of tasks" [29]. Though not overtly stated, the acceptance of violence as inevitable may be seen, at least historically, as one of those particular tasks.

The body of nursing – subjected to violence, ever-evolving in skill and knowledge, and engaged to carry out medical orders – meets the definition of a "docile body" that "may be subjected, used, transformed and improved" [30]. While we recognize that individuals exercise agency and carry out acts of resistance within their roles, we situate the collective body of nursing as a *docile body* following Foucault's work [30], in order to appreciate the constraints placed on the body of nursing within the health care system. Drawing on Foucault's conceptualization of power, and incorporating a feminist conceptualization of violence, we argue for the importance of critical reflection on psychiatric praxis to promote system-wide improvements.

As evidenced in the ongoing media coverage of the incident that occurred at CAMH in 2014 and the growing concern and awareness of violence in in-patient psychiatric care settings (IPCS) [1–3] safety for staff and patients is paramount for health care planners and providers. The ruling under the Occupational Health and Safety Act against CAMH posits that more must be done to "implement measures and procedures to protect workers" [1], sending a clear message that IPCS are expected to provide safer work environments. The relationship between patients and providers with respect to violence, however, is multifaceted and complex; solutions for a creating a safe environment are therefore neither obvious nor straightforward. Foucault's conceptualization of *operations of power* [30] can help to elucidate the relational

aspects of violence within IPCS and the effect that the in-patient psychiatric milieu has on the perpetuation of violence. Incorporating a feminist perspective on violence is useful for tempering a Foucauldian framework, allowing for an understanding of power that sees it as at once diffused while also contextualized within gendered relations.

In-patient psychiatric care often occurs within a secure, locked environment where patients, especially those considered 'high risk,' can be easily observed at all times and where nurses often *do* the observing [30]. To use Foucault's language, the nursing station in psychiatry has become an "apparatus of uninterrupted examination" where nurses surveil their patients for possible signs of violence [30] or other potential risks; the apparatus is often further enhanced by the implementation of security cameras which intensify the environment of examination for both patients and staff.

Anti-violence technologies, including locked doors, plexi-glass walls and windows, areas of confinement and isolation, 15-minute bed-checks, and chemical and physical restraints all aim to regulate patients' bodies and behaviours in ways that do not *exclusively* seek to control and prohibit violence, but that also seek to identify, classify, and define violence. These forms of hyper-surveillance within psychiatric settings not only enable the classification of violent behaviours, but instill the suspicion that all patients require this monitoring by virtue of *being* patients. This spatial arrangement becomes more than just a locus of surveillance; it becomes a centralized structure from which nurses evaluate patients, discerning who might become violent [30].

As the body of nursing surveils for signs of violence, it then enacts anti-violence technologies on the *body of patients* by carrying out orders and completing the tasks of care [30] which may include such routine activities as bed-checks or the administration of PRN medications. This quandary – of *caring* in ways that patients experience as violence, or that may be perceived as violent by nurses themselves, or by their colleagues [31] – situates nurses within a moral and ethical dilemma. This dilemma, or unique "wedge" that nurses operate within, becomes critical for understanding violence against nurses, where nursing is a gendered body within the health care system.

The Thin Edge of the Wedge

Just as nurses have a gendered body that is subjugated, functioning within this 'wedge' between the roles of care provider and anti-violence officer, patients in the acute IPCS also have a subjugated body. The acute IPCS assumes that all patients are potentially violent, requiring control and monitoring to prevent and manage this violence. Patients who may or may not have histories of violence are monitored by many of the same technologies of power as those who exhibit violent behaviours. Because the in-patient milieu constructs the patient role as one where violence is embodied, this milieu, in turn, constructs the nursing role as the agent who carries out actions which may be experienced as violent by patients.

The enactment of these roles, which are built upon a system of hyper-surveillance and which seek to classify and define violence (and identify agents of violence) actually serve to attract reciprocal responses from the body of the other [31]. This reciprocal response may be demonstrated by attempts to evade surveillance [32] and this evasion by patients is often constructed within psychiatry as non-compliance. In this way, patients come to embody the role of resistance and come to be understood as being at higher risk for violence. This is an inscription of violence upon the patient's body and on the body of patients. The technologies of anti-violence position patients' acts of agency and autonomy as violent acts, which in turn make for violent people – a violent *patient body*.

The patient exercises what agency they perceive that they have by (re)acting to these technologies of surveillance, and to the role dichotomy within which they have been constructed. These acts, occurring within a system that is set up for violence, are inevitably *violent acts*. Both the observer and the observed exert agency within their interactions, which further reinforces these roles. These exertions of agency also provoke and reinforce the need for the technologies of surveillance already in place, to enable each body – that of nursing and that of patient – to fulfill its respective role completely.

The ongoing integration of anti-violence technologies, the construction of roles that become inscribed onto nurses' and patients' bodies within this system (and yes, physician, administrator and allied health bodies too), and the acts that are carried out by individuals within these individual and professional bodies, combine to create an environment that is infused with mechanisms to prevent, but also perpetuate, violence [32]. There is no escape for patients, nor is there for nurses. Every act in this setting is filtered and examined in relation to violence, and risk of violence. Risk of violence become the first lens through which clinical and therapeutic interventions are assessed.

Conclusion

Acting from professional positions of altruism at best and paternalism at worst, the vast majority of health care providers surely aim to do no harm. We, as health care providers and administrators however, must consider our roles as actors and even unintended perpetrators within this cycle.

Nurses occupy a unique position within this dynamic system. The body of nursing, and the nursing role, are experienced as the "front line" of this surveillance system; nurses spend more time than any other health care provider in direct contact with patients [33, 34]. Despite the gendered nursing-body's values of altruism, compassion and nurturing, the panoptic architecture of psychiatry and its embedded anti-violence technologies make nurses into unintended perpetrators of violence. This creates moral and ethical dilemmas in their daily practice. On the other side, individual nurses have violence enacted against them in the course of this work. This *wedge* within which the body of nursing and nurses' bodies function puts nurses at high risk to experience violence in IPCS.

This gendered occupational contextualization is essential if we are to understand the operations of power and the dynamics of violence in psychiatric care settings. This examination can open up new possibilities for understanding the meaning, intention, and application of policies and practices guiding IPCS, and may have significant implications for improved quality of care and staff safety. As health care planners and practitioners we can thus be empowered to critically reflect on our psychiatric praxis to promote system-wide improvements.

Questions for Consideration

In the spirit of this self-reflexive systemic analysis, we pose the following questions:

> **Q1** At what point is an act of (perceived) "violence" an acceptable response to the violence one faces in a space of restraint, control, and domination? Could we, as mental health care providers and administrators, change how we view "patient violence" in the context of systemic psychiatric violence? Is a patient's expression of agency, autonomy or

resistance necessarily an act of violence requiring suppression? What else might this mean, and how else might it be addressed? What are the systemic barriers to alternate approaches? How can these barriers be remediated?

Q2 With the increased proliferation of anti-violence technologies embedded within the acute in-patient psychiatric setting, the patient role may become increasingly one of a "docile body", while the nursing role may increasingly become one of surveillance, as care and suppression of violence become synonymous. In this scenario, does the nurses' moral and ethical dilemma dissipate, or intensify? What are the implications of this for attracting and retaining nurses in these settings? Does the patient remain a subject of care, or become solely a subject of control?

Q3 What does it say about our society that we continue to enact and accept violence against some of our most vulnerable members during their most vulnerable time? What lessons can we learn from the women's anti-violence movement and other contemporary social and political anti-violence movements?

Compliance with Ethical Standards

Conflict of Interest The Authors declare that there is no conflict of interest.

References

1. Clarke K. Ministry of labour lays charges against CAMH months after nurse allegedly beaten. The Toronto Star. 2014; Retrieved from https://www.thestar.com/news/gta/2014/12/23/ontario_ministry_of_labour_has_laid_charges_against_camh.html. Accessed 3 March 2017
2. Hong J. CAMH fined $80,000 after beating that left nurse "beyond recognition". The Toronto Star. 2016; Retrieved from https://www.thestar.com/news/gta/2016/07/18/camh-fined-80000-after-beating-that-left-nurse-beyond-recognition.html. Accessed 3 March 2017
3. Mojtehedzadeh S. Health-care workers face an epidemic of violence. The Toronto Star. 2017; Retrieved from https://www.thestar.com/news/gta/2017/03/13/health-care-workers-face-epidemic-of-violence.html. Accessed 3 March 2017
4. International Labour Office, International Council of Nurses, World Health Organization, & Public Services International. Joint programme on workplace violence in the health sector. Framework guidelines for addressing workplace violence in the health sector. Geneva, CH. 2002. Retrieved from http://apps.who.int/iris/bitstream/10665/42617/1/9221134466.pdf. Accessed 14 March 2017
5. Registered Nurses Association of Ontario. Position statement: - violence against nurses - 'zero' tolerance for violence against nurses and nursing students. 2008. Retrieved from www.rnao.ca/policy/position-statements/violence-against-nurses. Accessed 8 March 2017
6. 'Kicked, spat on, bit:' Hospital staff take stories of violence on the job to queen's park. CBCnews Toronto. 2017. Retrieved from http://www.cbc.ca/news/canada/toronto/health-care-violence-unions-protection-1.4388327. Accessed 3 March 2017
7. Arnetz J, Hamblin L, Essenmacher L, Upfal M, Ager J, Luborsky M. Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports. J Adv Nurs. 2015;71(2):338–48. https://doi.org/10.1111/jan.12494.
8. Chapman R, Styles I. An epidemic of abuse and violence: nurse on the front line. Accid Emerg Nurs. 2006;14(4):245–9. https://doi.org/10.1016/j.aaen.2006.08.004.

9. McPhaul K, Lipscomb J. Workplace violence in health care: recognized but not regulated. Online J Issues Nurs. 2004;9(3). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No3Sept04/ViolenceinHealthCare.html. Accessed 17 March 2017

10. Nolan P, Dallender J, Soares J, Thomsen S, Arnetz B. Violence in mental health care: the experiences of mental health nurses and psychiatrists. J Adv Nurs. 1999;30(4):934–41. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10520107. Accessed 17 March 2017

11. Ridenour M, Lanza M, Hendricks S, Hartley D, Reirdan J, Zeiss R, et al. Incidence and risk factors of workplace violence on psychiatric staff. Work. 2015;51(1):19–28.

12. Yassi A, Gilbert M, Cvitkovich Y. Trends in injuries, illnesses, and policies in Canadian healthcare workplaces. Can J Public Health. 2005;96(5):333–9.

13. Shields M, Wilkins K. Findings from the 2005 National Survey of the work and health of nurses. Ottawa: Health Canada and Canadian Institutes for Health Information; 2006. Retrieved from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/nursing/findings-2005-national-survey-work-health-nurses.html. Accessed 8 March 2017

14. Iozzino L, Ferrari C, Large M, Nielssen O, Girolamo G. Prevalence and risk factors of violence by psychiatric acute inpatients: a systematic review and meta-analysis. PLoS One. 2015;10(6):2. https://doi.org/10.1371/journal.pone.0128536.

15. Stevenson K, Jack S, Mara L, LeGris J. Registered nurses' experiences of patient violence on acute care psychiatric inpatient units: an interpretive descriptive study. BMC Nurs. 2015;14(1):35. p.39. https://doi.org/10.1186/s12912-015-0079-5.

16. Hilton NZ, Ham E, Dretzkat A. Psychiatric hospital workers' exposure to disturbing patient behavior and its relation to post-traumatic stress disorder symptoms. Can J Nurs Res. 2017;49(3):118–26.

17. Goldsack L. A haven in a heartless world? Women and domestic violence. In: Chapman T, Hockey J, editors. Ideal homes? Social change and domestic life. New York: Routledge; 1999. p. 121–32.

18. Shepard M. Twenty years of progress in addressing domestic violence: an agenda for the next 10. J Interpers Violence. 2005;20(4):436–41. https://doi.org/10.1177/0886260504267879.

19. Sokoloff NJ, Dupont I. Domestic violence at the intersections of race, class, and gender: challenges and contributions to understanding violence against marginalized women in diverse communities. Violence Against Women. 2010;11(1):38–64.

20. Child[s?], R. H., & Mentes, J. C. Violence against women: the phenomenon of workplace violence against nurses. Issues Ment Health Nurs. 2010;31(2):89–95. https://doi.org/10.3109/01612840903267638.

21. Needham I, Abderhalden C, Halfens RJ, Fischer JE, Dassen T. Non-somatic effects of patient aggression on nurses: a systematic review. J Adv Nurs. 2005;49(3):283–96. https://doi.org/10.1111/j.1365-2648.2004.03286.x.

22. Vrikki T. Habitual trust in encountering violence at work: attitudes towards client violence among Finnish social workers and nurses. J Soc Work. 2008;8(3):247–67.

23. Flaherty MP. Constructing a world beyond intimate partner abuse. Affilia. 2010;25(3):224–35.

24. Tripp AM, Ferree MM, Ewig C, editors. Gender, violence, and human security: critical feminist perspectives. New York: NYU Press; 2013.

25. Davis K. The body and doing gender: the relations between doctors and nurses in hospital work. Sociol Health Illn. 2003;25(7):720–42 p.722.

26. Burstow B. Radical feminist therapy: working in the context of violence. Newbury Park: Sage Publications; 1992.

27. Canadian Nurses Association. Workforce Profile of Registered Nurses in Canada. 2010. Retrieved from https://www.cna-aiic.ca/~/media/cna/page-content/pdf-en/2010_rn_snapshot_e.pdf. Accessed 27 March 2017

28. Lazenby M. Caring matters most: the ethical significance of nursing. New York: Oxford University Press; 2017.

29. Gatens M. Power, bodies and difference. In: Price J, Shildrick M, editors. Feminist theory and the body: a reader. New York: Routledge; 1999. p. 227–34. p.228.

30. Foucault M. Discipline and punish. (A. Sheridan, Trans.). New York: Vintage; 1977. p.136; 186.

31. Drach-Zahavy A, Goldblatt H, Granot M, Kostinski H. Control: patients' aggression in psychiatric settings. Qual Health Res. 2011;22(1):43–53. https://doi.org/10.1177/1049732311414730.

32. Foucault, M. The history of sexuality: volume I an introduction. (R. Hurley, Trans.). New York: Vintage; 1990.

33. Findorff MJ, McGovern PM, Wall M, Gerberich SG, Alexander B. Risk factors for work related violence in a health care organization. Inj Prev. 2004;10(5):296–302. Retrieved from http://injuryprevention.bmj.com/content/10/5/296. Accessed 17 March 2017

34. Paynton T. The informal power of nurses for promoting patient care. Online J Issues in Nurs;2009. 14(1):np. Available from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No1Jan09/ArticlePreviousTopic/InformalPowerofNurses.html. Accessed 8 March 2017

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