Nurses and Midwives Association of Slovenia

Working group for non-violence in nursing and midwifery

Handbook for dealing with violence in health and social protection institutions

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VIOLENCE

NO!

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Handbook for dealing with violence in health and social protection institutions

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FAREWELL, HANDBOOK!

MONIKA AŽMAN,
President of the Nurses and Midwives Association of Slovenia

Working Group for non-violence in nursing and midwifery (the Working Group) has been active within the Nurses and Midwives Association of Slovenia since 2000. Like numerous other activities, it was initiated by the members of the Association who have been active in the Working Group as volunteers right from the start. In the beginning, it was of key importance to be aware of the presence and occurrence of violence, its tabooisation and consequences, not only in health care and social protection, but also wider in the society. This Handbook reflects two decades of numerous activities, project work and research. Furthermore, it is also proving the significance of the existence of such a group.

The diversity and structure of the content present the fundamental professional environment of employees in nursing and midwifery, various forms of violence that they encounter and also special approaches to dealing with violence in case of different vulnerable groups who often experience interpersonal and systemic violence.

Among others, the Handbook focuses on the expert in the health and social protection institutions as the perpetrator of violence. This aspect reflects an additional need for systemic approach and action for zero tolerance to violence at all levels and in all fields of health care and social protection.

The Handbook is very systematic and visually transparent and as such it is suitable also as learning material within formal educational (mainly study) process in all health care and other programmes, training for professional work in health care and social protection. At the same time, it can be used also in life-long learning, e.g., for keeping the licence for independent work in the field of health care. Therefore, it should be on the shelves of reference and other libraries.

As a member of the Working Group since its beginning and the president of Nurses and Midwives Association of Slovenia I would like to express my gratitude to all the authors and particularly the editors of the Handbook. The Handbook merges their knowledge, long-experience, skills, multiprofessionalism and also friendship that has been nurtured for more than two decades and contributed to the creation of this Handbook.

The Handbook is targeted at everybody who is committed to noble professions in health care and social protection and at the same time an appreciation of your work. The recommendations should be additional motivation for your work, aimed at comprehensive dealing and patient-oriented relationship – always with zero tolerance to violence. It should be the standard in the field of communication, conflict solving and prevention of violence in each clinic, department, office..., and always available for advice and professional and ethical action.

With deep respect for the authors, professionals in the field of nursing and midwifery, their colleagues in teams, and above all to patients and clients in health and social protection institutions I am hereby sending the Handbook to fare well.

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01 INTRODUCTION TO THE HANDBOOK

DOROTEJA LEŠNIK MUGNAIONI

"Violence is not an act, it's a phenomenon. An act has its beginning and the end. Violence does have a beginning, but it never ends for the victim. Violence is not defined by time, so the victim has to live with it for a long time after the act has stopped."

Vittorio Bufacchi

This finding by philosopher Vittorio Bufacchi (Sardoč, 2019) was taken as the premise by the Working Group for non-violence in nursing and midwifery when drafting a handbook on the topic of **dealing with violence and preventing it** in health and social protection institutions. It is primarily intended for **the nursing and midwifery professionals**, but we hope that it will find its way also to doctors and other healthcare professionals in health institutions.

The issue of defining violence is the first significant thing as we do not know a universal definition. Violence is always defined within **the cultural and social context** and therefore its perception is constantly changing. **Individual perception/definition of violence differs from the definition by various professions** (law, psychology, social work, sociology, medicine, anthropology...). What we feel as inadmissible intervention into personal space of physical, sexual, psychological, emotional, and spiritual inviolability and attack on our dignity and integrity, may only be a conflict or inappropriate communication or even a part of the job for a patient, colleague, resident or management of the institution. There is no consensus in the society what violence is, where the conflict finishes and violence starts, whether specific communication is still admissible or it is violent and therefore unacceptable.

During the last decades the definition of violence has been becoming wider as there are more and more behaviours and types of communication in interpersonal relationships and operation of institutions which are defined as violent. It is more and more accepted that **violation of rights is also violence**, particularly fundamental rights such as the right to life, safety, freedom. Consequently, according to some researchers that »the wider the definition of human rights the more present and unavoidable violence is becoming« (Kodelja, 2019).

There has been also an important **shift towards the »victim's perspective«**, focusing on the victim, his/her needs and consequences of the violence for him/her – contrary to the traditional culture of dealing with violence which did not believe the victim, making the victim (co) responsible and stigmatized, minimise violence and justify the perpetrator. Violence is more and more perceived as an act **which characterizes the victim permanently and damages the victim's integrity** (Sardoč, 2019) as an experience with violence (particularly in case of serious violence) and its consequences become an integral part of human personality.

The definition of violence does not refer only to interpersonal level as also **system/structural violence is known**. In health and social protection institutions the hierarchy of power, roles and relationships is extremely present, which affects the occurrence of system violence where the institutions apply their mechanisms to force, limit freedom, discipline, socialize, direct to conformism..., all in order to (re)produce the existing social relationships and power structure. **According to some authors, system violence is key as by invisible mechanisms of operation it often ensures reproduction of unjust social relationships and maintenance of inequality in the society** (Žižek, 2007). Although covert, these mechanisms are as violent as the visible, direct, interpersonal violence.

This **complexity of defining violence** is a big challenge for the development of preventive models in the field of preventing violence in health and social care. An additional factor, recognised by the Working Group for non-violence in nursing and midwifery **is the weakness of health and social protection institutions in recognizing and dealing with violence**.

In the handbook, we tried to deal with both challenges. The issue is presented as a very complex one – we deal with numerous, **different types of violence in health care and social protection**. At the same time we decided **to focus on taking action in case of violence** and present recommendations for dealing with different types of violence. **In our opinion, rapid, efficient and professional dealing with violence is the best prevention**.

The common premise of the authors are **fundamental principles of dealing with violence**, which have been established in last 30 years in operating doctrines of non-governmental and governmental organisations in the field of preventing violence in the family, at workplace, in health care, social protection, etc. (Lešnik Mugnaioni, 2012). The authors present the principles of dealing with violence within recommendations of dealing with different types of violence and thus point out that to deal with them in interpersonal relationships successfully **the attitude to violence and empathy to the victim are the most important, the skills, knowledge and protocols come only after them**.

PRINCIPLES OF DEALING WITH VIOLENCE IN INTERPERSONAL RELATIONSHIPS

- **Believe the victim and treat him/her in a respectful and ethical way.**
- **First talk to the victim about the violence;** the victim's deposition is the basis for further action. It is only after that that the perpetrators and observers present their perception.
- **Do not belittle or minimise the victim's experience with violence, do not judge based on your experience, emotions, opinions.** Everybody experiences violence individually and has the right to their own feelings and perception of an event, communication or relationship.
- **When dealing with violence, personal, social, positional and social power of the involved have to be taken into account.** Imbalance in the power of the victim and the perpetrator must be considered as it is a key element of understanding the committed violent act. Violence always destroys the power balance as it decreases the victim's internal psychological power and his/her integrity. Violence damages the victim.
- **Violent behaviour is a choice. It is always the perpetrator who is responsible for causing violence.** There are always different options of response to an unfavourable interaction or conflict – the choice of response is both, our power and responsibility. Therefore, dealing with violence is essentially different from conflict solving where all those involved in a conflict are responsible for the occurrence and also for solving it.
- **Do not confront the victim and the perpetrator.** Interviews with the involved have to be conducted separately as this protects the victim and allows him/her to talk about the experience. In the presence of the perpetrator the victim, who has been injured, harmed, humiliated, threatened, often does not dare or cannot express what happened. Confrontation can become only another opportunity for the perpetrator to control the victim psychologically and persuades the others about his/her »truth« about the event. Confrontation also sends the victim and the perpetrator a message that both are equally responsible for the committed violence and thus also for searching for a solution or rectification. Thus, confrontation indirectly relativizes violence and responsibility for it (Lešnik Mugnaioni, 2016).
- **Mediation and other conflict solving approaches are therefore not appropriate for dealing with violence**, as they may further victimise the victim and cause additional harm (Association for Non-violent Communication, 2017). Violence is the abuse of power, but that fact is often covert. Perpetrators may manage to interpret the events so that it seems that all the involved share the blame or that there is not enough information to see clearly what happened and we carelessly assess that it is a conflict. It is always necessary to obtain as much information as possible so that it is easier to investigate the ratio of power among the involved or power abuse, if any. In a violent relationship the victim is

losing his/her power because of fear, powerlessness, shame or feeling of guilt while the perpetrator's power is increasing, particularly if the perpetrator manages to intimidate the victim so that the victim does not tell anyone about the violence, hides, denies or even justifies experience with violence. This is the imbalance of power between the victim and the perpetrator, which prevents the victim to present and defend his/her truth, experience, and dignity in confrontation (Lešnik Mugnaioni, 2016).

- **The victim has to be supported in exiting the violent situation, finishing a violent relationship, searching for the way to stop violence.** The victim must not be directed to the strategies of surviving violence which allow for the violent relationship to continue, unless more time is needed to prepare a safe withdrawal from violence.

- **Do not impose responsibility for taking action to others.** In accordance with law/protocol/internal policy take action immediately, inform the competent persons, protect the victim and ensure your own safety. It does not make sense and it is not ethical to expect that the victim himself/herself will stop the violence, cope with violence efficiently and protect himself/herself and his/her safety. External intervention is essential in case of violence.

- **Team and multiprofessional** work are essential in dealing with violence and planning prevention. Dealing with violence includes numerous activities, actions, interviews, planning, documenting, evaluation of the efficiency of measures, etc. A multiprofessional team deals with all those aspects more rapidly and successfully.

Content of the handbook

The issue of violence in health and social protection institutions is divided into three groups:

1. **workplace violence,** where the employees are victims of violence, caused by patients, residents, relatives, colleagues...,
2. **domestic violence,** which the employees deal with it within caring and treating patients and residents,
3. **violence against patients and residents,** caused by other patients, residents, relatives or employees.

In the last part of the handbook there is a chapter about Working Group for non-violence in nursing and midwifery, which has been dealing with preventing violence within The Nurses and Midwives Association of Slovenia since 2000.

Versatile content, written by members and experts of the Working Group for non-violence in nursing and midwifery, includes also rich vocabulary and terminology. Although we were striving for the same structure and basis for all chapters, we also accepted our personal and author versatility as another aspect of our long striving for tolerant and non-violent culture.

We would like this handbook to help nursing and midwifery providers and other healthcare professionals when confronted with violence, and at the same time encouragement for more ethical and efficient prevention of violence.

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02 DEALING WITH WORKPLACE VIOLENCE

VIOLENT COMMUNICATION
prevention SEXUAL HARASSMENT
BULLYING discrimination
dealing with violence
WORKPLACE VIOLENCE
human rights ONLINE HARASSMENT
ECONOMIC VIOLENCE
de-escalation techniques
GENDER-BASED HARASSMENT
unequal treatment SEXUAL VIOLENCE
PHYSICAL VIOLENCE HARASSMENT
VERBAL VIOLENCE

Introduction

SONJA ROBNIK

Workplace violence is primarily a social phenomenon. The level of tolerance towards violence, the equipment of institutions for the prevention and dealing with violence, as well as (non) presence of the topic in the political agenda and in media as well as the way of presenting it – all those have a strong influence on the attitude of the society to the victims of violence on the one hand and to the people who cause violence on the other.

Workplace violence is also (and mainly) an organisational phenomenon. European Agency for Safety and Health at Work - EU-OSHA[1] places it among **psychosocial risks.** It is true that employers cannot act like Big Brother, controlling all the interpersonal relationships, but it is the employers who are primarily responsible to ensure **safe and healthy working environment.** In Slovenia, for instance, they are obliged by legislation to adopt measures aimed at preventing, eliminating, and managing cases of violence, bullying, harassment, and other forms of psychosocial risks at workplace which may endanger workers' health[2].

The causes for violence may also be individual or personal. Organisations have numerous levers for prevention and managing violence at their disposal – irrespective of who causes the violence. It all starts with preventive investing in respectful communication and conflict solving, making everybody who enters the organisation aware of (un)acceptable behaviour, and concludes with consistent sanctioning of violence. There are numerous measures in-between. Appropriate response by the organisation can send a clear message to all the involved and to the public that violence is not an acceptable way of solving disagreements, expressing dissatisfaction with the system or anything else.

Violence at workplaces in **nursing care and midwifery** is very diverse: it happens among the employees, and it can take numerous forms (from physical to psychological, verbal, sexual and economic) which, as a rule, can be classified to different types of violence. Some of them are usually defined in law (e.g., bullying, sexual harassment, harassment, online violence, violence by third parties, etc.) while others are not. Such diversity and multitude of people causing violence (from colleagues, superiors, inferiors to patients and their relatives) sometimes cloud our views how common that phenomenon really is. If as a society and employers in health care we want **quality working environment**, we should not deny that the environments are often toxic and hostile due to the relationships among employees and that employees are afraid of threats, bullying, verbal, and physical attacks by those entering those environments from the outside.

[1]https://osha.europa.eu/sl/themes/psychosocial-risks-and-stress
[2]Health and Safety at Work Act http://pisrs.si/Pis.web/pregledPredpisa?id=ZAKO5537; Employment Relationship Act http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO5944

Doroteja Lešnik Mugnaioni and Aljoša Lapanja

DEALING WITH VIOLENT COMMUNICATION

reporting an event SYSTEMIC TAKING ACTION
active listening documenting BY EMAIL
de-escalation BY SOCIAL NETWORKS tolerance
respect BY TELEPHONE informing superiors THREATS
setting boundaries zero tolerance ensuring safety
PHYSICAL ATTACK professional attitude DRAFTING A SECURITY PLAN
assertiveness THREATENING BEHAVIOUR
PERSONAL VERBAL ATTACK ORGANISATION OF PSYCHOLOGICAL HELP

Introduction

In comparison with other social subsystems communication in health care and social protection – among professionals, patients/residents, and relatives – is among the most demanding. **Two most important human values – health and consequently life – are in its focus.**

"Waiting room at the internal emergency department is full of patients. Daughter of a father who has been waiting for two hours, is becoming more and more irritated, she is complaining loudly, encouraging the others as well. She uses a harsh tone of voice when talking to the nurse who is calling the patients. The atmosphere in the waiting room is more and more tense, other patients join her in criticizing medical staff and health care system, they grumble that they have been waiting for too long and that such waiting is inadmissible. When the nurse comes to call next patient, several of them jump towards her, loudly demanding immediate examination.

Needs, interests and feelings of fear, powerlessness, sadness, anger, disappointment, and similar, often present with the patients or residents in health and social protection institutions and their relatives during treatment or care, create specific conditions which can be unfavourable for successful communication and constructive conflict solving. It is not possible to always avoid conflicts in health and social care because, **as a rule, the roles, responsibilities, power, knowledge, opinions, wishes and needs of the patients and their relatives and providers are different.**

In well-regulated and functioning systems where everybody feels safe and accepted and where the values and key interests of providers, users and their relatives are similar, **the sources of personal psychological and social power for constructive communication** are powerful. As a rule, in such circumstances we are able to communicate respectfully, tolerantly and assertively, listen to each other actively, respect the space of personal inviolability, look for common denominators in disagreements, use "I" statements, understand the position of the other in a conflict, etc.

On the contrary, **in crisis situations, when we feel threatened and unsure, lose control, in rapid and extreme changes (which may substantially increase stress and distress), also our internal psychological power decreases.** This makes us more vulnerable, our psychological flexibility, strength and resilience are tested, which may lead to (self)destruction, escalation of conflicts and aggressive behaviour.

How to react to the other person's aggressive behaviour; how to set boundaries in inappropriate communication; how to clearly point out disrespectful and insulting words; how to communicate assertively..., these are only a few of the key questions that we must pay attention to. It is all based on the premise that **it is primarily the organisation and its management who is responsible for systematic prevention and dealing with inappropriate and violent communication in health care and social protection.**

"A nurse in a specialist outpatient clinic receives a phone call. It is a patient with the referral for an examination. She explains the registration procedure and tells him that the waiting period is about 6 months. He will be officially informed about the examination by post. The man starts shouting that that is total crap, and he would be examined in a couple of days if he paid. The nurse tries to explain to him that they are a public institution and do not conduct paid examinations. The waiting period is unfortunately really long but it is the same for everybody. The man gets even more upset and shouts that they are »all mafia«. Before hanging up he threatens: »One day one of us will go mad because of corruption in healthcare. It might be me! Then you will see who you are dealing with! "

The management has to respond to such phenomena immediately and immediately adopt specific and precise instructions for the employees how to react in case of violent communication. The aim is to ensure that the employees react to violence in the same way and to increase safety, loyalty, and joint responsibility of all employees in the institution. In accordance with the (Slovenian) labour legislation the management has to appropriately protect the employees.

We suggest that a short notice is published in public places (at the entrance, waiting rooms, websites) of all health and social protection institutions:

- **commitment by everybody who participates in medical treatment – patients, relatives, and healthcare professionals to communicate in a respectful way,**
- **violent communication with healthcare professionals and other employees is not acceptable, there is zero tolerance to violence,**
- **management will react very decisively to any insulting verbal attack, threat, or physical violence.**

SUCH PUBLIC NOTICE HAS A PREVENTIVE EFFECT ON PATIENTS AND THEIR RELATIVES AND AT THE SAME TIME COMMUNICATES THAT VIOLENCE IS NOT TOLERATED AND THAT SUCH HARMFUL AND INADMISSIBLE BEHAVIOUR HAS NO PLACE IN OUR INSTITUTIONS.

Relatives are visiting a patient and they complain to the nurse that they have been calling the attending doctor to get some information, but they cannot reach him. In an angry and harsh tone, they demand to talk with the doctor on duty. When the nurse tries to explain to them that the doctor on duty is with another patient and she does not know when he will be available, one of the relatives starts to shout at her that he will report all of them to the patient ombudsman and call the media.

It is a common practice in residential home for older persons that in non-urgent cases the relatives can call the head of nursing or social worker in a certain period. One of the relatives does not respect that period and she calls at all hours, often several times a day. When she cannot reach them, she gets angry with the receptionist that there is a mess in the residential home and that such attitude to the relatives is inadmissible and that she has the right to get information about her mother's condition immediately. When the receptionist is tired of that and transfers the call to another nurse, the relative is unhappy again as »that person does not have any power to give her information«. She requests the head again, but he is not available, and the cycle of misunderstandings is repeated. The head has spoken to her for several times, told her about the instructions and asked her to respect them. The social worker has also spoken to her but all in vain. Everybody whom she calls regularly avoids communication with her as they feel harassed, they are more and more angry and stressed because of her unreasonable requests.

RECOMMENDATION FOR HEALTHCARE PROFESSIONALS ON HOW TO ACT AGAINST VIOLENT COMMUNICATION

WHEN IT HAPPENS	WHAT DO I DO?	HELP?
A SIGNED, INSULTING, AGGRESSIVE COMMUNICATION ON THE WEB, EMAIL, MAIL	• I do not answer, I do not try to explain the claims or content which is not directly connected with my work even if I do not agree with them or they are totally unprofessional. • I communicate only about the work-related matters (appointment, explanation about the treatment, information about the work of the institution...) • I stop further communication, which is not related to my work, provision of healthcare services or exercising patient's rights. • I report the event in the deviation system or register it as deviation. I inform the management.	• My direct superior. • Management of the institution if that is the internal policy. • Individual discussion or discussion in a team if I feel stressed, anxious, or upset. • Agreement about taking action if it happens again.
ANONYMOUS INSULTING, AGGRESSIVE COMMUNICATION ON THE WEB, EMAIL, MAIL	• I save the evidence (e.g., Print Screen). • I delete the message if the content is not threatening.	• Management of the institution if that is internal policy. • Agreement about taking action if it happens again.

WHEN IT HAPPENS	WHAT DO I DO?	HELP?
DIRECT TELEPHONE OR PERSONAL VERBAL ATTACK	• I stick to work-related content; I do not comment or persuade. • I formulate the information that I have to tell the patient as short and clear messages which I repeat if needed. • I set the boundary to violent communication. I repeat that there is zero tolerance to violence in the institution. • If the warning is not enough, I call my superior or finish communication. • I save the evidence. I report the event in the deviation system or register it as deviation. • I inform the management.	• My direct superior. • Management of the institution. • Individual discussion or discussion in a team if I feel stressed, anxious, or upset. • Agreement about taking action if it happens again.
PERSONAL OR TELEPHONE THREATS	• I finish the telephone conversation. • I save the evidence. I report the event in the deviation system or register it as deviation. • I inform the management. • In accordance with the seriousness of the threat the management assesses whether additional internal protection (security service) or reporting to the police is required.	• My direct superior. • Management of the institution. • Individual discussion or discussion in a team. Intervision. • Agreement about taking action if it happens again.
THREATENING BEHAVIOUR, DAMAGING THE EQUIPMENT OR PREMISES, THREATS OF PHYSICAL ATTACK	• In the team we try to de-escalate the agitated, aggressive patient. • We make sure that we are safe. • If possible, get help. • Report to the police. • I save the evidence. We report the event in the deviation system or register it as deviation. • We inform the management.	• Colleagues. • Security service. • Management of the institution. • Expert psychological help. • Individual discussion or discussion in a team. Intervision. • Security plan in case of another threatening of our safety.
PHYSICAL ATTACK	• Medical care. • Report to the police, security service. • Involving the management. • Immediate measures so that the violence is not repeated. • I save the evidence. We report the event in the deviation system or register it as deviation.	• Expert psychological help to the victim of violence. • Meeting in the institution (cooperation with external experts if needed): assessing the threat, evaluation of the safety plan. • Measures aimed at protecting employees.

WHAT DO I KNOW ABOUT VIOLENT COMMUNICATION?

1. Match the pairs of words which refer to violent communication.

MAINTAINING	1	A	VIOLENT COMMUNICATION
WITHOUT EXCEPTION	2	B	REPORTING AND DOCUMENTING
ZERO TOLERANCE	3	C	SETTING BOUNDARIES
OBLIGATION	4	D	PROFESSIONAL ATTITUDE
ASSERTIVE	5	E	COMMUNICATION

2. In case of a telephone attack I always first:

a) interrupt communication,

b) try to stay calm and control my emotions,

c) set the boundary to violent communication.

3. In case of verbal threats the management of the organisation has to:

a) document the situation and only monitor the development of events,

b) assess whether additional measures have to be taken to protect the employees, involve the security service or report the event to the police,

c) move the employee to a safer post.

Key: 1. (1-D, 2-C, 3-A, 4-B, 5-E), 2.b), 3.b*

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

**Applies for Slovenia. See your national legislation.*

Aljoša Lapanja and Urban Bole

USE OF DE-ESCALATION TECHNIQUES

PERSONAL SPACE
empathy RECOMMENDATIONS NON-PROVOCATIVENESS
communication sincerity non-verbal communication
COORDINATION OF VERBAL AND NON-VERBAL COMMUNICATION
preventing recognizing wishes and feelings
aggressive behaviour AGREEING tone of voice
SCALE FOR ASSESSING THE RISK OF AGGRESSIVE BEHAVIOUR ACTIVE LISTENING
short verbal communication self-control
FACIAL EXPRESSION eye contact BODY POSTURE
ensuring safety setting the boundary
OFFERING THE CHOICE OF BEHAVIOUR

Introduction

Ensuring safety for both, the patients and healthcare professionals is an important activity that the nursing and midwifery professionals as well as other members of the health team provide through a range of numerous interventions: therapeutic communication, application of de-escalation techniques, application of the prescribed therapy with medications and last selection activity – taking a special protective measures. Police intervention is required in emergencies.

"A patient at an intensive psychiatric clinic is distrustful and tense. He keeps saying that the staff is hiding something from him. He refuses the prescribed therapy with medications. He speaks loudly and threatens not to take the medication as we want to poison him and that we will see what will happen if we do not leave him alone. He knocks over the glass with the medication and throws it to the floor.

When faced with the aggressive patient behaviour, the healthcare professionals can apply **therapeutic communication techniques and de-escalation techniques**. The latter contribute significantly to the prevention and reduction of the risk of aggressive behaviour.

(In)appropriate communication and relationship to the patient with the risk of auto- or heteroaggressive behaviour play a decisive role. It is a wrong look or tone of voice or awkward sentence by the nurse or another member of the health care team which can destroy patient's trust. It is therefore essential that **all the members of the health care team are aware of the power of correct communication**. Application of the therapeutic communication elements and de-escalation communication techniques are of key importance in dealing with a patient with aggressive behaviour. The personality of the members of the health care team and their expertise are important factors in the application of those techniques.

Knowledge of de-escalation techniques allows us for the application of several possible interventions, important for more efficient **solving of situations which include various forms of aggressive behaviour.** At the same time, it contributes to our self-confidence when faced such situations and we are more relaxed, so it is easier and more successful to solve complications in communication.

Recommendations for the use of de-escalation techniques in health care

De-escalation is designed as a process which includes the ability of gradual resolving and management of aggressive behaviour. It consists of several communication steps, both verbal and non-verbal, aiming at preventing the escalation of aggression to violent behaviour.

The purpose of de-escalation techniques is to decrease the patient's level of agitation, hostility, anger and potential aggressiveness. It is recommended in specialised literature as the first choice in aggression management as it allows the patient and the person carrying them out a safer, less restrictive and fast alternative to traditional methods of aggressive behaviour management, such as taking special protective measures and chemical restraint (rapid tranquilization).

Therefore, **de-escalation techniques are one of the most powerful tools for decreasing the patient's or user's aggressive behaviour,** they facilitate establishment of therapeutic relationship and require emphatic and professional attitude, regardless of the patient's or user's behaviour.

It is important to recognise aggressive behaviour before the application of de-escalation techniques. Specialised literature mentions various tools which facilitate the recognition of aggressive behaviour by the employees in health care. STAMP Scale (Staring, Tone and volume of voice, Anxiety, Mumbling, and Pacing) is most often applied in the field of emergency medicine, OAS (Overt Aggression Scale) for children and adolescents, BVC (Broset Violence Checklist) is used mainly in psychiatric institutions, while BRACHA (Brief Rating of Aggression by Children and Adolescents) is applicable in the field of emergency medicine for assessing aggressive behaviour by children and adolescents.[3]

Although experts agree that de-escalation techniques should be the first choice in dealing with aggressive behaviour, the effect of de-escalation outcome has not been researched well. According to some research[4] the implementation of the programme of TeamSTEPPS de-escalation techniques resulted in the decreased level of the use of special protective measures. It has been found out that de-escalation was successful with the rate of 60%. It was interesting to note that de-escalation was less efficient with the patients who had been aggressive or violent before. The employees who attended the training on the application of de-escalation techniques, reported they had acquired more knowledge in the field of communication skills and self-confidence in managing aggressive behaviour.

A drunk patient is brought to the emergency psychiatric clinic for examination as he is threatening to commit suicide. He is rude, tense, he answers with questions, and he is raising his voice. He denies having threatened with a suicide and says his wife has made everything up in order to have him hospitalised. He is restless and walks up and down the clinic. He keeps saying that he does not want to stay in hospital. He tears the consent form and throws it to the floor.

DE-ESCALATION TECHNIQUES ARE COMMUNICATION TECHNIQUES THAT CAN BE LEARNED.

They are divided to knowledge and skills:

- **when to face the patient,**
- **how to ensure safe environment, and**
- **which de-escalation technique is to be applied.**

[3] Barzman DH, et al. "Brief rating of aggression by children and adolescents (BRACHA): Development of a tool for assessing risk of inpatients' aggressive behaviour." J Am Acad Psychiatry Law 39 (2011): 170-9.

Calow N, et al. "Literature Synthesis: Patient Aggression Risk Assessment Tools in the Emergency Department." J Emerg Nurs 42, no. 1 (Jan 2016): 19-24. 6.

[4] Some research in the field of de-escalation efficiency:

Du M, Wang X, Yin S, Shu W, Hao R, Zhao S, Rao H, Yeung WL, Jayaram MB, Xia J. De-escalation techniques for psychosis-induced aggression or agitation. Cochrane Database Syst Rev. 2017 Apr 3;4(4):CD009922. doi: 10.1002/14651858.CD009922.pub2. PMID: 28368091; PMCID: PMC6478306.

Haefner J, Dunn I, McFarland M. A Quality Improvement Project Using Verbal De-Escalation to Reduce Seclusion and Patient Aggression in an Inpatient Psychiatric Unit. Issues Ment Health Nurs. 2021 Feb;42(2):138-144. doi: 10.1080/01612840.2020.1789784. Epub 2020 Aug 4. PMID: 32749904.

Lavelle M, Stewart D, James K, Richardson M, Renwick L, Brennan G, Bowers L. Predictors of effective de-escalation in acute inpatient psychiatric settings. J Clin Nurs. 2016 Aug;25(15-16):2180-8. doi: 10.1111/jocn.13239. Epub 2016 May 3. PMID: 27139882.

Spencer S, Johnson P, Smith IC. De-escalation techniques for managing non-psychosis induced aggression in adults. Cochrane Database Syst Rev. 2018 Jul 18;7(7):CD012034. doi: 10.1002/14651858.CD012034.pub2. PMID: 30019748; PMCID: PMC6513023.

Communication:

- as early recognition as possible and establishment of rapport with a potentially aggressive patient,
- use of open questions,
- offer a choice or alternative to the patient,
- solving problems, making agreements,
- establishing reasons and looking for solutions together,
- understand the patient's emotions and feelings in the specific situation,
- expressing own emotions as a tool for establishing rapport,
- redirecting the conversation, use of clear and brief speech,
- paraphrasing/summarising, which shows understanding,
- use of humour where appropriate,
- being careful with the promises you will not be able to keep,
- avoid patronising and provocativeness,
- using the right tone of voice,
- being aware of your own body language, an open and non-threatening posture,
- maintaining eye contact, neutral facial expression,
- matching verbal and non-verbal communication,
- being aware of cultural differences,
- empathy,
- periods of silence which allow for the processing of information.

Self-control:

- do not judge the behaviour,
- assertiveness, self-confidence,
- do not take the aggression personally,
- evaluation (debriefing) after the incident: what was good, what could be improved.

> *A patient is examined in the emergency health centre because of poisoning with illicit drugs. He is brought in somnolent state (sleepy, semi-conscious). After the intervention by the healthcare professionals, he is stabilised and wakes up and starts to get upset. He demands immediate release as he has not asked for help, and he does not need it. He starts to tear infusion tubes, he strikes towards the nurse.*

[5] Hallett N, Dickens GL. De-escalation of aggressive behaviour in healthcare settings: Concept analysis. Int J Nurs Stud. 2017 Oct;75:10-20. doi: 10.1016/j.ijnurstu.2017.07.003. Epub 2017 Jul 4. PMID: 28709012.

NGUISHED OCESS OF ALATION[5]

Risk assessment:

- patient assessment,
- assessment of risks, associated with the de-escalation itself,
- observation and recognition of early signs of aggressive behaviour,
- know when to apply de-escalation techniques.

"A patient comes to the general practitioner clinic, and she is restless already when meeting with the nurse. She wants that doctor would prescribe her sedatives as she has run out of them. The doctor explains that he cannot prescribe them as she received them at the emergency health centre five days ago. However, he can prescribe another medication which is not addictive. The patient becomes loud, she is shouting, insulting, banging the table and knocks over a chair. She is threatening more and more.

Interventions:

- help the patient to overcome anger and frustration,
- setting boundaries which are based on respect, redirecting attention,
- ensure safe environment,
- decrease environmental factors which could result in the escalation of aggressiveness,
- application of an individual treatment plan.

Ensuring safety and safe environment:

- careful approach which does not surprise the patient,
- being aware of how to get out of the situation,
- ensuring support by colleagues and other supporting services,
- removing all dangerous objects from the room,
- ensure a bigger personal space for patients,
- evaluation (debriefing).

STRUCTURAL ILLUSTRATION

Respect personal space.

When approaching an agitated patient, there should be the length of at least two arms between you and the patient.

This additional space allows for avoiding being hit in case of an attack and both, the de-escalator and the patient are able to leave the room.

Establish verbal contact.

One of the main principles of de-escalation is that the de-escalator never challenges the patient's words.

De-escalation should always be started, conducted and finished by one person.

When one person is conducting de-escalation, another person has to ensure that additional staff are informed in case the de-escalation is not successful. When de-escalation techniques are being applied, attention should be paid also to the environment.

Other patients or staff who do not know what is going on should be prevented from entering the room as that could agitate the patient even more.

Repeat for several times that you will do no harm to the patient, that you are there to help the patient and that your institution provides a safe environment.

Do not be provocative.

Hands must be visible and not clenched into fists, the provider of de-escalation techniques has to show the patient with non-verbal communication that there is no threat.

Non-verbal communication has to match verbal communication as this gives the patient the feeling that the de-escalator is sincere.

> *"Passers-by notice an older man in the street, who is confused and shouts at them. When the paramedics come, he could not tell where he lived. He seemed scared and confused. He was becoming more and more restless and started to refuse help and push them away with his arms.*

Be short and brief.

Too much information could agitate the patient even more. Use short sentences and simple words.

Give the patient time to process information, repetition is of key importance so that the patient understands what you want to tell.

Never demand, always provide a choice.

OF DE-ESCALATION PROCEDURES WITH THE EMPHASIS ON VERBAL DE-ESCALATION[6]

Recognise wishes and emotions.

Ask the patient about his/her wishes, emphatic questions allow for rapid decreasing of agitation.

Pay attention also to trivial things that the patient is talking about. Pay attention to the patient's body language. This will help you recognise the patient's wishes and needs.

Listen actively.

Your verbal and non-verbal communication should be sending the patient a message that she/he has your full attention.

Agree with the truth. Agree with the principles. Agree with the options.

The golden rule is: when you really cannot agree with the patient, agree that you do not agree.

Set boundaries.

It is important that the patient is informed that his/her behaviour is not acceptable. Tell the patient that in your institution there is zero tolerance to violence.

Some behaviour, such as hitting the wall or inventory does not necessarily mean that special protective measures have to be taken. However, the patient has to be told that harming themselves or others is not acceptable behaviour. Also explain follow-up measures, such as assistance by the police if needed, but tell this as a fact not a threat.

Explain the consequences in a respectful way.

Give the patient a choice.

Give the patient a choice, which is a powerful tool for decreasing agitation.

Choice is one of rare sources for empowering the patient who thinks that violence is her/his only option.

To avoid aggressive behaviour, an alternative to violence should be suggested immediately and self-confidently.

In intensive psychiatric wards patients often demand smoking or a telephone call, which decreases agitation. However, you should always be aware that you cannot make a promise that you cannot keep.

[6] Within Project BETA in 2011 American Association for Emergency Psychiatry published a structural illustration of de-escalation approaches with the emphasis on verbal de-escalation (Richmond JS, Berlin JS, Fishkind AB, et al. Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2012;13(1):17-25. doi:10.5811/westjem.2011.9.6864

AM I FAMILIAR WITH DE-ESCALATION?

1. Match the pairs of de-escalation technique words.

OPEN	1	A	SUMMARIZING / PARAPHRASING
PERSONAL SPACE	2	B	CHOICE
THERAPEUTIC COMMUNICATION	3	C	TWO-ARMS LENGTH
TONE OF VOICE	4	D	CLEAR, DETERMINED AND KIND
ACTIVE PARTICIPATION	5	E	BODY AND ARM POSTURE

2. Is it essential for the verbal and non-verbal communication to match when implementing de-escalation techniques?

a) YES, because it is very important for de-escalation to be successful that what we say with words is expressed or confirmed also by body language.

b) NO, because the patient is focused mainly on what we are communicating verbally.

3. Is it true that at least two members of the health staff should communicate with the patient who is the subject of de-escalation?

a) YES, because in this way one is focused on verbal communication and the other one to non-verbal.

b) NO, because the basic rule of de-escalation is that it is always implemented by one person only whose communication is totally focused on the patient.

Key: 1. (1-E, 2-C, 3-A, 4-D, 5-B), 2.a), 3.b)

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

Sonja Robnik

DEALING WITH SEXUAL HARASSMENT AND GENDER-BASED HARASSMENT

SEXUAL HARASSMENT

OBSCENE COMMENTS
showing pornographic pictures FEELING OF POWERFULNESS
STRESS **victims** INVASION INTO PRIVATE SPACE
CONFUSION messages with sexual content
OFFENSIVE FLIRTING **abuse of power**
violence EMBARRASSMENT lustful looks
unwelcome courting STARING AT PARTS OF THE BODY
changing business topics into sexual ones
TOUCHING CRYING ENFORCED HUGGING SHAME
UNWANTED MASSAGE showing genitals
UNEASINESS OBSCENE LANGUAGE FEAR
SEXUAL ASSAULT

GENDER-BASED HARASSMENT

abuse of power REMARKS STRESS
jokes about bald men JOKES ABOUT BLONDES UNEASINESS
calling by names such as "cutie", "sweetheart", "honey"
violence HOSTILE WORKING ENVIRONMENT
AGGRESSIVENESS TO WOMEN mocking men SHAME victim
FEAR intimidating women AGGRESSIVENESS TO MEN
sexism HOSTILITY TOWARDS WOMEN CONFUSION
HOSTILITY TOWARDS MEN intimidating men
mocking women EMBARRASSMENT FEELING OF POWERFULNESS
SEXIST COMMENTS

Introduction

Sexual harassment or gender-based harassment are **much more common not only at workplaces but also in the society** than it seems at first sight. One of the reasons might be that they get attention only when escalated or a celebrity is the subject, or the perpetrator is a person with high organisational/social power. There are several reasons that it is not so visible in the working environment. Very often, there is lack of efficient organisational practices for managing them or we face the belief that the victims should be flattered when they get sexual attention. Victims also minimise the seriousness of their experience as they do not want to be labelled as someone without a sense of humour, as problematic or too sensitive.

This all proves that a lot of effort will be needed in order to efficiently manage the phenomena. Respectful interpersonal communication, respect for the diversity, empathy, psychological safety, and particularly zero tolerance to any violence are the first steps towards the work environment where everybody feels safe.

Sexual harassment as well as gender-based harassment belong to the group of psychosocial risks for occupational safety and health. Their consequences can soon grow from individual to organisational – by all means an additional argument that employers should invest in managing them. As a rule, jobs in health care and social protection are very stressful. Not only because of the responsibility that is a part of the job description, but also because of direct work with people. We all should critically consider whether our actions might contribute to creating a threatening, hostile, humiliating, demeaning, shameful or insulting environment.

> *Nurse Alice asks to be transferred to another clinic as she does not feel well at the present one. For a few months there has been a patient in her department (and he will stay for a few more months) who is constantly asking whether she will be wearing a shorter skirt in the summer, whether she has a boyfriend, and so on. The patient is immobile, so he has to be turned, washed, etc. When Alice and her colleague were turning him for the last time, he grabbed Alice's breasts. First, she thought it was by chance but later – when the colleague could not hear him – he asked her whether she liked it. At first, she did not respond to his questions and behaviour although she felt uneasy. When he started to touch her again, she asked him to behave decently. She told her superior about that but was told that she herself should make sure that it will not happen again, her colleagues do not have any problems with him, it is probably her who provokes his indecent behaviour.*

Recommendations regarding dealing with sexual harassment and gender-based harassment at workplace

What is sexual harassment?

Sexual harassment at workplace is a form of violence and sex-based discrimination. Women are more exposed to sexual harassment, not all harassers are men, however. Like in other forms of violence, sexual harassment is about control and abuse of power. Working environment is often tolerant to sexual harassment and the victim is receiving the message that she/he does not have any sense of humour, causes troubles and is problematic.

What is harassment?

Harassment is a form of discrimination, and it is based on personal circumstances. This means that certain unwanted behaviour is directed towards us because of one or more personal circumstances. Such circumstances are for example gender, nationality, race or ethnical origin, national or social origin, skin colour, health conditions, disability, religion or belief, age, sexual orientation, family situation, membership in a trade union, property situation... It is usually a personal circumstance due to which we are more visible in a certain environment (e.g., a woman in a predominantly men's organisation, a man in a predominantly women's organisation, older people among young ones, belonging to a race different from that of most colleagues, same-sex orientation, etc.).

Gender-based harassment

Gender-based harassment does not mean expressing unwanted sexual attention but the acts directed at a person because of being a woman or a man and which violate our dignity or create an intimidating, hostile, degrading, humiliating or offensive environment. For example, jokes which humiliate women – the most common are the ones about blondes. These are textbook examples of sexist jokes, based on the belief that men are better, smarter, and more capable than women. Various groundless beliefs, such as the belief that men are rational while women are emotional beings, that a father cannot provide emotional support to his children, that women belong to the kitchen and men to the pub..., are also considered sexism. Underestimating a person because of gender is also regarded gender-based harassment (e.g. "men are better leaders than women", "women are too emotional to be able to make rational decisions"), offensive comments ("a woman behind the wheel", "a man in the kitchen"), calling by degrading names, physical aggressiveness or intimidating a person due to gender...

How to distinguish sexual harassment from flirtation?

Sexual harassment involves abuse of power and control while **flirting** is expressing attention, desired by both. We have different relationships with people at the workplace: some of them are friendly and personal while others are only formal. Undoubtedly, people flirt and court and enter into love relationships also at the workplace and there is nothing wrong with it if it is wanted by both sides. However, when one person feels uncomfortable and does not want such attention, it is an unacceptable crossing the boundaries of another person's inviolability.

Mathew had an affair with his colleague Sarah. Nobody knew about the affair, which was Sarah's wish as she was married. After two years of empty promises that she would get divorced and start living with him, Mathew decided that he did not want the affair and finished it. Sarah was very offended but after some time she invited him for a coffee. He refused. After two days she invited him again – this time to a restaurant in a place far away. He refused the invitation. Then she invited him to a nearby cafe during the lunch break. He refused that invitation.

#MeToo Movement has revealed the extent of this issue. It is present all around the world in all occupations and activities – it is an issue, integrated into the social structure itself and consequently into the working environments. It is often heard that due to #MeToo Movement men do not dare to pay women compliments anymore and that working environments have become dull and boring. Actually, such thinking just diverts attention from the core of the problem. If somebody is of the opinion that sexual harassment is only an "innocent joke", "amusing diversification" or "commenting everything and everybody", it means that they do not understand the point: sexual harassment means all the behaviour which is unwanted and creates an intimidating, hostile, humiliating, degrading or offensive environment. Not all compliments themselves are considered sexual harassment. However, if a colleague does not feel well at the workplace due to our insensitivity, if the compliment is made in a patronising way, if a colleague is judged on the basis of her/his appearance and not work achievements, if jokes are offensive, if vulgar language is used in the working environment, we have to ask ourselves whether we truly respect the people with whom we spend a lot of time at the workplace. If being honest, the answer will be No. Prohibition of sexual harassment does not mean that all entertainment should be banned from the working environment – it means that what one person perceives as amusement, joke or compliment does not cause embarrassment or uneasiness to another person or even creates a hostile working environment.

When sexual harassment lasts for a long time, it can become **bullying**, i.e., systematic and repeated behaviour towards individual employees, which is reprehensible or obviously negative and offensive.

In the waiting room a patient likes to share his opinions about everything, also how the clinic and staff should work. Among others, he does not like men working as nurses – he belittles them.

Nurse Ann has successfully completed her masters study and she is celebrating it also at work. Her colleague Marc started his speech on behalf of the staff: »... who would think that our blond Ann is also smart ...«

IT IS HAPPENING TO ME – WHAT SHOULD I DO?

Anyone can become a victim of sexual harassment. However, women are much more frequent victims. The most common victims of **sexual harassment** are first job seekers, women in temporary and not regular employment, and women at workplaces where there are traditionally more men, same-sex oriented, members of ethnical minorities, divorced women ...

Not rarely, victims of **gender-based harassment** are highly educated, successful women with a lot of work experience – in other words: women who become a thorn in the others' side because they are successful.

However, there is a major difference among the victims. A victim with less knowledge will find it difficult to act and will often think that she is to blame for the situation. A person with more knowledge will recognise what is happening sooner, identify it and start looking for the solution.

WHAT DO I DO? HOW DO I DO IT?

NAME THE EVENTS WHAT THEY REALLY ARE.

- I do not pretend that nothing is going on. I do not deny the events or persuade myself that it is not important.
- I do not react to the events by humour – the perpetrator only receives a message that nothing is wrong with his/her behaviour.
- I know that I have the right to dignity.
- I know that sexual harassment is a form of violence and discrimination. The same applies to gender-based harassment.
- It does not have to be repeated – a one-off event is enough.
- Only when I have admitted to myself that I am a victim, I can start acting constructively.

HOW DO I RECOGNISE SEXUAL HARASSMENT OR GENDER-BASED HARASSMENT?

- I am exposed to behaviour of sexual nature which is humiliating for me, degrades and insults me or even creates intimidating, hostile working environment.
- Because of my gender I am experiencing behaviour which affects my dignity or creates intimidating, hostile working environment.
- Although I react to unwanted behaviour with apparent humour, I withdraw. I try to avoid the perpetrator and repeated behaviour, I feel uncomfortable, shame, I am stressed.
- I feel troubled by the event and I think about it for a long time after it happened.

WHAT DO I DO? HOW DO I DO IT?

WHAT QUESTIONS AND DILEMMAS MAY I FACE?

- *Am I too sensitive?* I am entitled to dignity and nobody has the right to behave in a way which insults my dignity.
- *I am wrong, he did not mean that.* If I feel that something is wrong, I take it seriously.
- *I am not the first one, others have experienced this as well.* Probably yes, but that does not mean that the perpetrator's' behaviour is less questionable. On the contrary, if it has happened to another person in your organisation and nobody stopped it, something is seriously wrong in the organisation.
- *I will be characterised as a person without a sense of humour and a troublemaker.* Maybe. But such acts characterise mainly those who stick such labels.
- *My family, friends, colleagues... everybody will think that I must have done something to cause such behaviour.* I must know: firstly, people do not know much about sexual harassment and it is often not even recognised; and secondly, I deserve support and I know that it is the perpetrator who is responsible for harassment and not me.
- *I think that the consequences for the perpetrator would be too serious if I complain.* The responsibility is borne exclusively and only by the harasser. In case of his/her respectful behaviour there would be no exposure to negative consequences.
- *I should be flattered if a man pays me a compliment.* Women are/were raised to believe that and men are/were raised to believe that it is their task to comment women's appearance and behaviour. However, we were not taught that such attention can also be humiliating and insulting.
- *I am a man – nobody will believe that I have been sexually harassed.* It does not mean that it has not happened – I was hurt by the event, it troubles me and I know that the employer has to ensure working environment without sexual or any other harassment to all employees, regardless of gender.

IF IT REPEATS, I WRITE A JOURNAL AND KEEP THE EVIDENCE.

- I write down chronologically: who the perpetrator is, when and where it happened, what happened, whether there were any witnesses, who was informed (by me) about the event, how it made me feel, whether there are any other consequences, whether I react and how. I also note if the event upset me so much that I had to take a medication.
- In case of consequences to health, I do not sweep them under the rug. The events at work should be recorded in the medical file (evidence).
- I keep the journal and medical documents at home, not on the office computer.

WHAT DO I DO?

HOW DO I DO IT?

I CHECK WHAT MEASURES MY EMPLOYER HAS TAKEN.

- Under the Slovene legislation, employers are obliged to take measures aimed at protecting employees from sexual and other harassment.
- I check whether there are any rules adopted, which lay down the complaints procedure and dealing with them.
- I check whether there is an adviser appointed who can stand by me - I think whether I can trust that person and whether she/he is competent enough.
- If possible, I check how measures are implemented in practice.
- In case there are other (former) victims, I try to connect with them.
- I may tell the person who tells sexist jokes or jokes with sexual content, makes inappropriate comments about the appearance, changes business topics into sexual ones, that all the above is disturbing for me.
- I may ask the head or somebody that the colleagues respect, to define (in) acceptable rules of behaviour together.
- I am aware that my employer may be one of those who do not take sexual harassment seriously. However, this does not mean that I have to adapt to that: it is the employer's obligation to make sure that all the employees' dignity is protected.

I TAKE CARE ABOUT MYSELF.

- I am aware that I am not the problem.
- I am aware that I am not too sensitive and I do not exaggerate.
- I am aware that this is control and abuse of power and what is happening to me is not acceptable.
- All violence has **consequences**. They may be psychological (depression, anxiety, shock, anger, fear, disappointment, irritation, embarrassment, confusion, feeling of powerlessness, shame, self-blaming, isolation...), **physical** (headaches, digestive problems, insomnia, panic attacks, worsening of chronic illnesses...) as well as **career** (lower job satisfaction, lower productivity, motivation, loss of job, prevention of promotion, lower salary...) and **social** (worse relationships at workplace, inability to trust people...).
- I am vocal about what happened. It may have happened to somebody else. A lot of perpetrators do not stop with one victim – can we figure out together how we should act? Can I entrust a friend, somebody in the family? Some people may think that the event is not significant but that does not lower the level of seriousness it has for me. I am troubled by what has happened to me, and I am entitled to feel in this way.
- In case the events repeat, or I am in great distress due to one event, I seek help (psychosocial, legal, medical...). It will be easier if somebody helps me.
- I look for something that I enjoy and will help me »recharge my batteries«: hobbies, music, sport, relaxing...
- I maintain and strengthen my social network and do not withdraw.

WHAT DO I DO?	HOW DO I DO IT?
I WEIGH THE POSSIBILITIES AND MAKE INFORMED DECISIONS.	• I do not react in the heat of the moment. I obtain information, consider the advantages and disadvantages and then make a decision. • I consider the following for each reaction: long- and short-term consequences of taking action; is it really worse than keep suffering because of what is happening? • I think about talking to the perpetrator: Can I do that? Is there a chance of positive outcome? I use "I" Statements messages (e.g., *It hurts when you call me names as I want to be respected*) or direct demands (e.g., *Don't tell such jokes, please!*) • I think about talking to a member of the management: Will they listen to me? Is there a possibility that the harassment stops? • I contact my trade union where I can get legal aid free of charge. • If I decide to complain to the employer, I check the deadlines, way of filing the complaint, the procedure... I am aware that the result may not be favourable for me (the employer does not stand by me, colleagues cannot see how serious the problem is for me, the commission is not competent). • I am aware that the procedures will be difficult for me – I make a strategy how to survive with the least negative consequences possible (I take care about myself). • If I decide for a lawsuit, I check the experience of the selected law firm with such lawsuits. I am aware that the court may not recognise me as a victim. • If I decide to do nothing: I am aware that sexual harassment or gender-based harassment will not stop by itself.
I AM RECOVERING.	• Something so terrible has happened to me that I am suffering several consequences (from psychological and medical, to those which affect my private life and career development). • I am aware that it will be easier if someone stands by me in this process. I know that asking for help is not a sign of weakness but a sign of responsible caring about myself. • Recovery is a long process. Anger, despair, also aggression, disappointment, feeling of worthlessness, guilt, loneliness, distrust to other people... are very common. During this time there will be days when the world seems dark as well as the days when life will be a little better. • It is very important for me to find something that makes me happy, disburdens my dark thoughts and gives me energy. I maintain and strengthen contacts with my dearest.

It is happening to a colleague – what should I do?

Are you working in a team where it is acceptable to humiliate somebody just because they are a man or a woman? Where jokes insulting women are common? Or jokes insulting men? Where business topics are constantly being changed into sexual ones? Where personal space is constantly invaded, where hugs, kisses and touches are enforced? Have you noticed that a colleague has started to distance or withdraw from certain situations, that she/he feels uncomfortable during certain conversations, or even avoids a member of the staff? Undoubtedly, all the above does not mean that the colleague is suffering sexual harassment or gender-based harassment, but it is a sign that something is wrong. Do approach the person and offer human support!

Is a colleague of yours exposed to sexual harassment or gender-based harassment? How would you answer the following questions:

- Do I just silently observe when I see what is happening?
- Do I mock the victim or express doubt about her story? Do I minimise her story (»It is not what he thought«, »You are too sensitive«, »Just laugh and he will stop«…)?
- Do I clearly and decisively say that communication is inappropriate, that we are violating personal space and creating hostile working environment?
- Do I even fuel bad behaviour (also by belittling its seriousness)?
- Do I ask the victim what kind of support and help she/he needs?

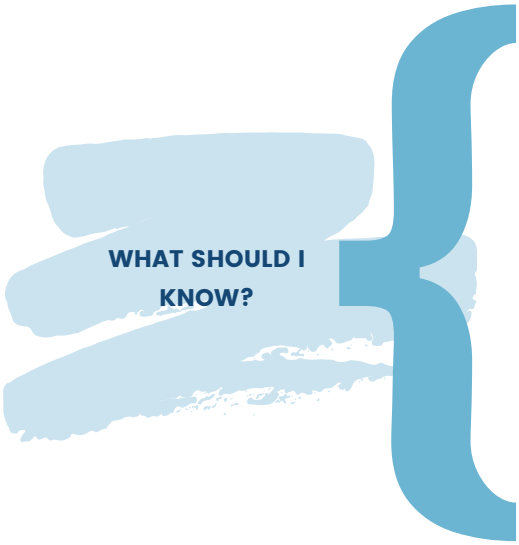
We must be aware that sexual harassment and harassment is not possible without the (silent) support of the colleagues. **TAKE ACTION AND SUPPORT THE VICTIM!**

You can find some advice in It is happening to me – what should I do?

Mary is a nurse in a health institution. That afternoon, there are almost no people, only one clinic is open. Mary receives a phone call – the Head of the institution wants to talk with the doctor. As the doctor is not available, Mary and the Head make small talk and then he says that he would like to talk to her after work about the possibility of her working in two outpatient clinics. He asks her to come to his office. When Mary later knocks on his door, he is on the phone. She wants to wait outside but he beckons her to enter and sit on one of the armchairs. Mary does not know who he is talking to but hears their conversation. She realizes that he is explaining to the other person about one of his sexual achievements. She feels uneasy, starts to squirm but she does not dare to leave and cannot help hearing him. When he finishes the phone call, she is extremely uncomfortable. The Head sits on the arm of her armchair and asks whether she would like to hear what he would be doing to her right now. Mary stiffens.

The following will be done in order to prevent sexual and other harassment in our organisation

- We will all strive for respectful communication.
- We are aware that people do not perceive only the words but also body language, tone of voice and facial expressions – they should all be respectful.
- We will think about the effects our words and acts could have on a colleague.
- We will pay only compliments about work and which make another person feel well. Comments and compliments which embarrass, humiliate or underestimate are not appropriate, and they are not allowed.
- We are not going to spread gossip – gossip hurts.
- Before doing something, which could hurt a female colleague, we will ask ourselves how we would feel if our mother, wife, sister, or daughter would be exposed to such behaviour.
- For men: If I am sure that my jokes, comments, and behaviour contribute to good atmosphere among the colleagues, I ask myself whether I would do that to my wife, partner, daughter, or mother.
- For women: If I believe that all men want sexual attention, I should think how I would feel if I were exposed to the same behaviour by my male college.
- We will not belittle others' emotions and feelings - we never know how bad it is for somebody else as we are not in her/his shoes.
- There should be zero tolerance to any kind of violence and we are not going to (silently) support any bad behaviour targeted at a colleague of ours.



- Sexual harassment and gender-based harassment at workplace are prohibited.
- Employers are obliged to ensure working environment in which employees' dignity is protected. Employers are obliged to take measures aimed at protecting employees from sexual and other harassment at workplace.
- Sweeping sexual harassment or gender-based harassment under the rug may quickly expand to hostile and poisonous working environment where everybody is suffering.
- The victim cannot be (partly) responsible for violence – the responsibility is borne only and exclusively by the perpetrator.
- All colleagues are responsible for wellbeing at the workplace. Also, by not allowing disrespectful communication or behaviour.

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WHAT DO I KNOW?

1. Sexual harassment cannot happen to me.

a) Yes, that is true, it cannot happen to me.

b) The perpetrator chooses whether we are exposed to sexual harassment or not.

c) There is no sexual harassment in my country.

2. Only young and attractive women experience sexual harassment.

a) That is true. Men in particular cannot be the victims of sexual harassment.

b) That is true and it is their fault because they dress provocatively.

c) It is not true – it is experienced by both, men and women. Sexual harassment involves abuse of power (social, organisational, psychological) and therefore age and appearance do not play a key role.

3. It is nothing wrong to use nicknames for nurses.

a) Such language is sexist – as a rule, belittling and devaluating for the group of occupations. This is gender-based harassment.

b) What other words should we use – who has time to use all those long occupational titles?!

c) If somebody is sensitive to this, they should look for a job elsewhere.

4. Sexual harassment is not the employer's business.

a) This is not true. The employer is obliged to ensure work environment without sexual harassment and has to adopt also measures for preventing, eliminating and managing sexual harassment.

b) Of course, interpersonal relationships are not the employer's business.

c) That is correct, the involved should solve the matter themselves.

5. If I report sexual harassment, everybody will say that I am too sensitive.

a) If I think again, the perpetrator was having an off day and I was really a bit too sensitive.

b) I will keep quiet, nothing can be done anyway.

c) Somebody might say or think so – but nobody has the right to violate my dignity. Sexual harassment is not acceptable, and I have the right to report if I decide so.

6. An act is called sexual harassment only if it is repeated.

a) Of course, only one forced hug does not mean anything.

b) It is not true – one-off unwanted verbal, non-verbal or physical behaviour or acts of sexual nature are also sexual harassment.

c) Everybody is too sensitive today, it could be called sexual harassment only if it lasts for half a year.

Key: 1.b), 2.c), 3.a), 4.a*, 5.c), 6.b)

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

**Applies for Slovenia. See national legislation.*

Sonja Robnik

DEALING WITH WORKPLACE BULLYING

DEPRESSION dignity
behaviour WORK-RELATED STRESS
procedures victim AGGRESSION rumours
employer SUICIDE abuse of power
HOSTILE WORKING ENVIRONMENT control
power violence unsolved conflicts ABUSE
ignorance MOBBING social isolation
BULLYING traumatic experience TEAM
aggressiveness

Introduction

Workplace bullying is an organisational phenomenon – it occurs in work environment and numerous causes include bad organisational management practices, organisation of work processes and inappropriate conflict solving.

Employers are liable to make mistakes when dealing with bullying – the most evident is sweeping disagreement under the rug, hoping that it will just disappear itself. The second one is confronting the victim and the perpetrator which often leads to even higher distress for the victim and sends the bystanders a wrong message that the responsibility for violence is divided among the involved. It is often thought that the perpetrator (particularly if it is a person who has hierarchical power) is indispensable for the organisation and therefore she/he should get away with it. A common mistake is also that the staff is of the opinion that everything will be fine when the victim has left – experience shows that the same perpetrator usually finds a new victim and the cycle of violence is repeated. It is also wrong to think that nothing happened if the bystanders perceive the events differently from the victim. Due to not knowing the dynamics of the violent relationship well enough (or due to ignoring it), it is often the victim who is called "problematic", and the staff more or less openly takes the side of the more powerful in that relationship.

Employers who **do care about the employees' wellbeing** will ensure work environment where the employee dignity is protected and there is no bullying. At first glance this requires a lot of investment in interpersonal communication, training for the managers, reviewing organisational practices or even changing organisational culture but it is a strategy that will bring a lot of benefits. Happier and more motivated and creative employees are also more loyal and efficient. This decreases the costs of fluctuation, sick leaves, also court proceedings and in times when there is a lack of employees can also mean a competitive advantage. By all means, there are a lot of reasons for investing in good interpersonal relationships. All co-workers are responsible for that – we all should make sure that our words or actions are not hurtful.

"Jane works in a small team and she is known as a conscientious, reliable, hard-working and respects everybody. She often helps others or takes over their tasks. There is an unwritten rule in the team that »our Jane is going to make everything right« when something goes wrong or there is not enough time. Then she falls seriously ill and she is on sick-leave for a longer period of time. This means that now other staff have to take over her tasks and consequently it is questionable whether they will be able to go on holiday. There is a lot of annoyance and tension in the air. Although nobody says it, they all blame Jane for the situation. When she returns after several months, she is still not completely healthy and works part-time. The staff expects the old situation – a colleague who works for two. As that does not happen, they look down on her, then they start whispering behind her back. There is a lot of gossip that she is pretending to be ill, that she does not want to work, that she is lazy and unreliable. They start to avoid her, »forget« to invite her for coffee, she gets a scornful nickname »the hard-working one«, they are intolerant, disrespectful and she becomes the black sheep in the team. Even if Jane wanted to describe the situation to someone, she would not be able to do so as everything is intangible and vague. Of course, she feels that the atmosphere is different, she does not feel well. If she asks someone what is happening, they tell her that she is too sensitive and has a vivid imagination.

Recommendations to deal with workplace bullying

What is workplace bullying?

Workplace bullying is psychological abuse in the form of attacking the victim's dignity, personality, work, position at workplace, and reputation, which may even escalate (although rarely) to physical attacks. As a rule, it is a series of targeted attacks, lasting for a longer period of time, preventing the victim to work and communicate with the colleagues well. The working environment is hostile to the victim, the victim is receiving messages that she/he is problematic and disturbing, colleagues socially isolate the victim, forcing him/her to eventually leave the working environment.

How to distinguish a conflict from workplace bullying?

Conflicts are a part of everyday life. They emerge because people have different values, beliefs, opinions, react differently to change, our personalities differ and we deal with power differently, and we also belong to different occupational and social groups. **As a rule, in a conflict dynamic the power among those involved is balanced and their acts are in cause-effect relationship:** when we are in conflict, we are protagonists and antagonists at the same time. Therefore, all the involved are responsible for the conflict and for resolving it. Each conflict can be solved and managed when all the involved strive for that. However, the greater responsibility for looking for solutions in a conflict lies with the participant with stronger personal or hierarchical power or social status. As a rule, conflicts can be resolved permanently only when those involved actively participate in resolving (try to understand the opponent's position in the conflict with dialogue, looking for a compromise, team resolving, intervention by a third person, mediation, etc.). In constructive resolving the involved people a.) change their relationship so that it becomes more respectful and tolerant, and b.) find an acceptable solution for key interests and needs of all those involved.

Workplace bullying is violence, and it means that there is power imbalance among those involved – abuse of power appears. It usually develops from an unresolved conflict, which develops its own destructive and very emotional dynamics, leading to violence. In the process of bullying which can last for several years, the initial cause for the accumulated negative and hostile emotions is usually forgotten. In the process of workplace bullying victims do not gain anything, as a rule, they lose a lot. The consequences of workplace bullying can last for life. A compromise is not a solution as the victim has given everything: dignity, health, reputation, even career. The only solution is that the perpetrator takes full responsibility for violence. Responsibility has to be assumed also by the team members and management of the organisation who have been silently observing or even supporting such inadmissible behaviour.

IT IS HAPPENING TO ME – WHAT SHOULD I DO?

Anyone can become a victim of workplace bullying. There is no such thing as a stereotype victim as the causes for the emergence of workplace bullying are various: it may happen to ethical, hard-working and fair people, whistle-blowers, kind, cooperative, highly qualified and intelligent people as well as to those who are more vulnerable due to previous traumatic experience or have been characterised as the black sheep in the team... It may happen to anyone who is at the wrong place at the wrong time.

However, victims have very different knowledge about the dynamics and consequences of workplace bullying and the abilities of perceiving violent communication, response to violence and looking for solutions. The sooner the victims recognise workplace bullying, the sooner they will be able to start looking for the resolution of the situation.

"John was replacing Tracy, head of community health service, during her maternity leave. When she came back, he still saw himself at her position. He cannot accept that he has lost the position and starts to look for mistakes in her work. When he does not find any, he starts with a different strategy: he is telling anyone who is willing to listen how incompetent Tracy is, that she got the position because of her connections, that she is a parvenu and that he has to do her work as she is incompetent also as the head. When Tracy asks him to do something, he does not do it or does it contrary to the instructions and when she confronts him, he says that she did not give him the right instructions. So, Tracy decides to delegate him all the tasks in writing. The staff tell her about the gossip that John is spreading, so she calls him and tells him that his behaviour is not acceptable, and she will initiate the relevant procedures if he does not stop. After the meeting, he files a complaint, accusing Tracy of ill-treating him, that she threatened him and that he is not treated equally as he is the only one who gets the tasks delegated in writing.

WHAT DO I DO?	HOW DO I DO IT?
NAME THE EVENTS WHAT THEY REALLY ARE.	• I do not pretend that nothing is going on or that it is not so serious. • It is only when I have admitted to myself that I am a victim, I can start acting constructively.
HOW DO I RECOGNISE WORKPLACE BULLYING?	• I keep asking myself what is wrong with me; although I am really making effort, I feel that something is not right; if I want to talk about it, the other person is angry or »does not know what I am talking about«; I am receiving messages that I am the problem and that it would be best for everybody if I leave. • My colleagues, even those I considered friends, are distancing from me. I feel isolated, lonely. • I feel that even my presence causes anger, hostility. • I have to force myself to go to work, I don't sleep well, my stomach is tied in knots, I find it difficult to concentrate, I keep thinking about what is happening, I feel ashamed and scared...

WHAT DO I DO?	HOW DO I DO IT?
I WRITE A JOURNAL AND KEEP THE EVIDENCE.	• I write down chronologically: who the perpetrator is, when and where each attack happened, what exactly happened, whether there were any witnesses, do I tell anyone, how it made me feel, whether there are any other consequences, whether I react and how. I also note if the event upset me so much that I had to take a sedative or any other medication. • In case of consequences to health (stress, depression, insomnia, anxiety, weakened immune system, headaches, palpitation, stomach problems...) I do not ignore the symptoms. I tell my doctor what work-related factors are causing health problems. • Medical documentation on health consequences is also regarded as evidence. I occasionally copy these medical records. • I keep the personal journal and copies of medical documents at home, not at work or on the office computer.
I CHECK WHAT MEASURES MY EMPLOYER HAS TAKEN.	• **Under the Slovenian legislation, employers are obliged to take measures aimed at protecting employees from workplace bullying.** • I check whether there are any **rules** adopted, which lay down the complaints procedure. • I check whether there are **specially trained staff or a bullying adviser** who can stand by me - I think whether I can trust that person and whether she/he is competent enough. • If yes, I check how **measures** are implemented in practice. • In case there are **other (former) victims,** I try to connect with them.
I TAKE CARE ABOUT MYSELF.	• I am aware that this is about control and abuse of power and not how much and how well I work. I set boundaries and stick to them: I do not stay at work longer than necessary. I rather direct my energy to empower myself. • I am aware that I am not the problem. • **I seek help** (psychological, legal, medical...) - I am aware that I need comprehensive help for the problem to be solved. • I might get help in non-governmental organisation, self-help groups..., which help people who have experienced workplace violence. • I look for something that I enjoy and will help me »recharge my batteries« and manage stress: a new hobby, a pet, work in a humanitarian organisation, music, sport, relaxing... • I maintain and strengthen my social network: although it will sometimes be difficult, I do not isolate.

WHAT DO I DO?

HOW DO I DO IT?

I WEIGH THE POSSIBILITIES AND MAKE INFORMED DECISIONS.

- **I do not react in the heat of the moment.** I obtain accessible information, consider the advantages and disadvantages, and then decide.
- **I consider** the following for each reaction: long- and short-term consequences of taking action, is it really worse than keep being abused?
- I think about **talking to the perpetrator: Can I do that? Is there a chance of positive outcome?**
- I think about **talking to a member of the management:** Will they listen to me? Is there a possibility that the violence stops?
- Can the **trade union** representative or trade union legal service help me?
- If I decide to **complain to the employer**, I check the deadlines, way of filing the complaint, the procedure… I am aware that the result may not be favourable for me (the employer does not stand by me, nobody wants to testify in my favour, I do not have solid evidence as everything was happening face to face etc.).
- I am aware that the **procedures will be difficult for me** – I make a strategy how to survive this stress situation.
- If I decide to **stay at the workplace**, I make a plan: I set boundaries and stick to them, I document everything, I seek support.
- If I decide to **leave the workplace**, I make sure that the consequences will be the least negative possible: I do not give notice in the heat of the moment, I think whether I can find a new job, can I resign in a way which makes me eligible to unemployment/other benefit, do I have enough means of subsistence in case I do not get another job…
- I am aware that my leaving might not stop the workplace bullying (e.g., the former employer sends the new employer a fabricated dossier about me).
- If I **decide for a lawsuit**, I check the experience of the selected law firm with such cases. I am aware that the court may not recognise me as a victim (lack of evidence, witnesses testify in favour of the other side, witnesses are afraid to testify in my favour…).
- If I decide **to do nothing**: I am aware that the violence will not stop by itself, but it will probably escalate and the consequences will be more and more severe.
- If **I leave without complaint**: can I just let it go although I know that the former team will perceive me as a problematic person who deserved such bad behaviour?

WHAT DO I DO?

HOW DO I DO IT?

I AM GOING THROUGH A TRAUMATIC EXPERIENCE.

- Something extremely serious has happened to me and I am suffering from numerous consequences (psychological, health, financial, social, affecting my private life).
- **I am aware that it will be easier if someone stands by me in this process.** I know that asking for help is not a sign of weakness but a sign of responsible caring about myself.
- **Recovery is a long process.** Anger, despair, also aggression, disappointment, feeling of worthlessness, guilt, loneliness, distrust to other people... are very common. During this time there will be days when the world seems dark as well as the days when life will be a little better.
- I am aware that sleeping and rest are essential for my recovery.
- It is very important for me to find something that makes me happy, disburdens my dark thoughts and gives me energy and sense.
- I keep and strengthen my contacts with friends, social network, people with similar experience.

"New head of nursing team in a hospital unit does not have direct experience with managing or work in a hospital as she used to work in a smaller health institution. She occasionally raises her voice, panics in stress situations and transfers that also to her staff. Her older colleague Maya once tells her in private in a very kind and softened way that the morale and motivation have dropped and that some of the colleagues are afraid when she raises her voice. The head accepts this with silence and Maya (today she knows that she was wrong) thinks that silence means self-reflection. Soon after that the head makes a professional mistake that Maya notices and eliminates it on her own (as there was a hurry and none of the superiors were present to approve the procedure). The head cannot forget that Maya pointed out the mistake. She starts watching Maya's work very carefully and keeps incorrect records about findings – mostly these are completely unimportant things that Maya could justify if she had the chance. One day Maya finds an older patient, rummaging in another's patient's locker in another room – she calls security service. The patient's son complains about her behaviour and adds some »details« to the story. The head openly takes the patient's side, she does not listen to Maya at all, and orders professional supervision against her. This has a horrible psychological effect on Maya, she is shaking, she becomes distracted, unsure about herself and her work. During a meeting with the hospital head of nursing, the head keeps talking about a »problematic colleague who is making life for the patients in the hospital hard". The hospital head does not remain indifferent and believes the head's story as she does not like receiving complaints against the employees. Maya is under a lot of pressure because of the supervision and she soon makes a mistake. Now the head publicly accuses her of incompetence and lets the other members of the staff know that Maya is the black sheep and she does not want anyone to talk to her or help her. Members of the team are already scared because of the raised voice and now they are afraid that they will be the next victims. During a longer sick leave Maya receives an unlawful termination of employment letter. She has no power to resist – after the end of the sick leave she manages to find another job in another health institution. The head finds that out and sends a comprehensive report about Maya to the new employer.

It is happening to a colleague – what should I do?

Are you working in a team where a colleague has started to isolate themselves, she/he is more and more quiet, scared, distrustful, bursts into tears, tries to hide emotions, finds it difficult to concentrate, is forgetful, slow, prone to injures, develops compulsive behaviour, does not take care about the appearance, in very usual situations reacts irrationally and inappropriately, even aggressively, does not have any will to live... Undoubtedly, all the above does not necessarily mean that the person is experiencing workplace bullying, but it is definitely a sign that something is wrong. Do approach the person and offer human support!

Are you working in a team where a colleague is treated badly? How would you answer the following questions:

- Do I just silently observe when I see a colleague is treated badly?
- Do I clearly and decisively tell that I will not participate in that?
- Do I even fuel bad behaviour?
- Do I offer the victim support and help?

We have to be aware that workplace bullying is not possible without the (silent) support of the team members/staff. Take action and support the victim! You can find some advice in It is happening to me – what should I do?

28 April was declared World Day for Safety and Health at Work by the International Labour Organisation.

The following will be done to prevent workplace bullying in our organisation

- We will all strive for respectful communication.
- Conflicts are a part of our life, also at work. We will be solving them with constructive discussions and willingness to make compromises.
- We will be attending conflict resolution trainings, workshops on assertive communication and violence prevention.
- We are not going to spread gossip about other people – gossip hurts.
- Do not belittle others' emotions and feelings - we never know how bad it is for somebody else as we are not in their shoes.
- There should be zero tolerance to any kind of violence, and we are not going to (silently) support any bad behaviour targeted at a colleague of ours.

Leo, who has just graduated as a nurse, gets a job in a hospital. Both, patients and colleagues like him as he is relaxed, positive, does not avoid work; he is described as somebody who »just absorbs knowledge«, he is full of energy and ideas. The head of nursing really likes him. In the beginning, she considers their relationship as excellent: she gives him advice – not only in relation to work but also personal – and he follows them unconditionally. Then he gradually does not meet her expectations anymore. At first, she is disappointed, then angry, perceives him as her personal failure and starts picking on him. She starts watching his work very carefully, does not let him attend trainings (she lets others without any problems), she allocates him to less favourable shifts, and sometimes comments about the »problematic colleague Leo« slip also in front of other healthcare professionals. Her attitude to him is openly hostile and gradually the staff is divided into two groups. Those who silently support Leo and those who are openly on the head's side. Leo is more and more reserved, he loses the joy of work, he is almost paranoid where the next »hit« will come from.

WHAT SHOULD I KNOW?

- In Slovenia, workplace bullying is prohibited by law.
- In Slovenia, employers are obliged to ensure working environment in which employees' dignity is protected. Employers are obliged to take measures aimed at protecting employees from bullying at workplace.
- Unimpeded bullying, targeted at one person, may quickly expand to hostile and poisonous working environment where everybody is suffering.
- The victim cannot be (partly) responsible for violence – the responsibility is borne only and exclusively by the perpetrator because violent behaviour is a choice.
- With the time passing, violent attacks are less likely to stop. It is important to recognise workplace bullying as soon as possible and take an active part in resolving it.
- When the team silently stands by and does nothing, the perpetrator sees it as a loud applause and encouragement that nothing is wrong with his/her behaviour.

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WORKPLACE BULLYING – DO I RECOGNIZE AND KNOW IT?

1.	Workplace bullying is prohibited by law*.	Yes	No
2.	It is possible that the staff bullies the head.	Yes	No
3.	In bullying the responsibility is divided between the victim and the perpetrator.	Yes	No
4.	When somebody "does not adapt" to the team there is nothing wrong if we show the person clearly, they do not belong.	Yes	No
5.	Sometimes someone hits our nerve and we raise our voice – it is simply not possible to do otherwise.	Yes	No
6.	A lot of bullying victims are not aware for a long time what is going on.	Yes	No
7.	If someone is insulting or rude at work, nothing can be done.	Yes	No
8.	Victims of bullying are often very loyal workers, people with high ethical standards, those who point out to the mistakes and are more competent than the perpetrator.	Yes	No
9.	Bullying does not affect only the victim, but the entire team and consequently the employer and the entire society.	Yes	No
10.	The person who feels as a victim should first ask what is wrong with him/her.	Yes	No
11.	Victims of bullying usually feel isolated, betrayed and ashamed.	Yes	No

Key: 1. Yes*, 2. Yes, 3. No, 4. No, 5. No, 6. Yes, 7. No, 8. Yes, 9. Yes, 10. No, 11. Yes

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

**Applies for Slovenia. See national legislation.*

Sonja Robnik

DEALING WITH ONLINE VIOLENCE

Introduction

Online Violence[7]

Although the internet has a lot of advantages – important information is just a click or two away, communication is faster, it allows remote working, no need to queue to deal with administrative and financial matters, etc., it has caused also new addictions, health issues associated with prolonged sitting, and also new forms of violence. Online violence **takes numerous forms and it is not something new** – you probably have already received an email from a Nigerian "prince", asking you for a small amount of money that he needs to get a more substantial amount which he will share with you; or a letter by an unknown person informing you that you have inherited a lot of money and what you have to do is only transfer a few thousand euros to pay for the procedures so that the inheritance will be transferred to you. Or a message that the sender has a proof that you have browsed pornographic or paedophile sites (and you know that you haven't) and if you do not transfer a certain amount of money, everybody will be informed about that. Online fraud is probably the oldest form of such violence and most of us just presses DELETE when such messages are received. **However, with the increasing accessibility of the internet also the new forms of violence are emerging –** sometimes so fast that even the names for them do not exist yet. However, in practice it is much easier to recognise a phenomenon as harmful and illegal when there is a word and definition for it. At this moment that does not exist (yet) which does not mean that online violence is allowed - **there are numerous countries where the Criminal Codes define various forms of such violence as criminal offence (e.g., stalking, unjustified imaging, personal data abuse, showing, producing, holding or submitting pornographic material, blackmailing, etc.)**

"Jane is a nurse in a general practitioner clinic in a small town. Patients perceive her as an accessible and kind person who is always encouraging. Her personal life, however, is a chaos at the moment - she has just found out that her husband has been cheating on her for several years. When she gives him an ultimatum – either her or his mistress, her husband is not happy. He had been reserved, now he has become hostile, and he threatens to »give her hell« if she leaves him. When Jane sees that he will not make a choice, she leaves him and files for divorce. However, she does not know that he has started a real campaign against her. Among others, he publishes her naked photographs on Facebook (they were made in the beginning of their relationship and Jane has forgotten about them), adding: »This is the bitch who threw me out of the house«. In the place where Jane lives and works, the photographs go viral. Jane is informed about them by a friend of hers. Jane is appalled, shocked, angry, sad, she feels ashamed and betrayed. She asks her husband to delete the post but he just scorns her. During the following days, weeks, and months she has a feeling that people at work whisper behind her back, point their fingers at her, scorn her or that they are even appalled. She thinks they do not want to look at her and that they are unusually reserved. She starts to isolate, becomes unsure of herself, absent-minded, she does not feel well, and she feels lonely.

[7] As there is no uniform definition of this type of violence, there are several terms used (e.g. online violence, cyberviolence, online harassment, cyberbullying...). For the needs of this Recommendations term online violence is used, as a term which is used most commonly and covers all different types of cyberviolence.

Recommendations to deal with online violence

What is online violence?

Sometimes we talk about online violence, sometimes about online harassment as a subtype of online violence, carried out with the help of information communication technology (ICT) – however, there is no uniform definition or term in the European Union. Considering some definitions, used in research and literature, such violence can be defined as violence, **carried out with the help of e-devices** (computer, tablet, smart phone) and **has or could have negative consequences**. It takes several forms, and the purpose or effect can be material gain, sexual abuse, ruin of reputation, control over the victim, etc.

Online violence is the use of computer systems in order to cause, allow or threaten individuals with violence, which has or could have physical, sexual, psychological or economic consequences or suffering and can involve exploitation of an individual's circumstances, characteristics, or vulnerability.

Types of online violence:

- **cyber harassment** – defamation and other damage to reputation, cyberbullying, threats of violence, including sexual violence, coercion, insults or threats, incitement to violence, online sexual abuse with the help of photographs/recordings, incitement to suicide or self-harm...
- **ICT-related hate crime** – against groups based on race, ethnicity, religion, gender, age, sexual orientation, disability, social status...
- **ICT-related direct threats of or physical violence** – murder, kidnapping, sexual violence, rape, torture, extortion, blackmail, swatting, incitement to violence, attacks on critical infrastructure, e.g., cars or medical devices...
- **online sexual exploitation and sexual abuse of children** – sexual abuse, child prostitution, child pornography, corruption of children, solicitation of children for sexual purposes, sexual abuse via live streaming ...
- **cybercrime** – illegal access, illegal interception, data interference, system interference, computer-related forgery, computer-related fraud, child pornography ...
- **ICT-related violations of privacy** – computer intrusions, taking, sharing or manipulation of data or images, including intimate data, sextortion, stalking, doxing, identity theft, impersonation...

Working Group on cyberbullying and other forms of online violence, especially against women and children (Svet Evrope): Mapping study on cyberviolence (2018)

Online violence has **numerous consequences** – a lot of them are similar to consequences of other types of violence.

- Undoubtedly, this type of violence **affects mental health and social inclusion of the victim.** Victims are often afraid, ashamed, they feel guilty, powerless, sad, hopeless. They may also be angry or upset. They may become suspicious, even paranoid. If they do not know who is behind the online violence, they often find it difficult to trust people in their surrounding and therefore they isolate, which has an adverse effect on their (mental) health. They may become depressive, suicidal, or even commit suicide.
- If this is happening in an organisation, online violence can escalate to bad atmosphere and general dissatisfaction. It is possible internal procedures will have to take place for the team to continuing working together. The violence can be transferred from online to direct communication and conflicts at the workplace, which may lead to **other forms of violence.**
- In case of blackmail, computer hacking, fraud or getting money out of somebody by establishing an emotionally dependent relationship, the victim may suffer also **economic damage.**

In 2016 Microsoft created an AI chatbot Tay which was chatting with the millennials on Twitter. The purpose was for the bot to be able to understand the chat and react logically. The bot was supposed to learn that from the texts that people were twitting. The bot was switched off in less than 24 hours as its twits were sexist, racist and anti-Semitic.

Source: www.reuters.com, article Microsoft's AI Twitter bot goes dark after racist, sexist tweets, 24. 3. 2016

Some characteristics of online violence

- Online violence **may take place without us being aware of it**. For example, somebody creates a group on social media where we are the subject of bad talking or scorning but we are not aware of it; somebody may have posted an untrue or insulting comment about us or our work and we do not know about it; somebody publishes photographs (processed in an insulting way) and we do not know about it.
- Another important characteristic is that such violence **can take place 24/7 with an overwhelming number of people participating**, e.g. sharing our intimate photographs, scorning and insulting us, even intimidating us in their comments.
- The third characteristics is that we cannot control sharing of the posts/photographs/recordings **and it may never be possible for us to achieve the deletion**.
- The fourth characteristics: unlike other forms of violence in interpersonal relationships, online violence **does not necessarily mean direct contact with the perpetrator, or we may not even know them**. Communication is often in one direction only; we may feel completely powerless and dependent on the perpetrator.
- And the fifth characteristics: that form of violence **follows us everywhere**, as in our society in the 21st century life without access to the internet is practically impossible.

Alice is a nurse in a hospital. Once, a patient takes a photo of her during work and publishes it on Instagram. His comment: »It's easier to recover when a sexy nurse is taking care of you«. #toosexy' Alice does not know that the patient took a photo of her or that anyone who types #toosexy in the browser can see her photograph.

Why is it so easy to write something on the internet that we would never say live?

Few people would say live everything what they write in comments on social media or as an anonymous user or with a false nickname on the internet forum. It is enough to look at the comments below articles about domestic violence against women, and we should be concerned about the society we live in. Or comments below the articles about rape – as if the person writing does not have the slightest human compassion. **The anonymity or invisibility** on the internet means that we are not responsible for our acts; there is no concern that somebody would think we are unethical, immoral, or even vulgar. Therefore, it is much easier to use obscene, insulting, aggressive or even hostile words. **As we do not see the response of the other person** we may not even worry about the effect of the comment - we are not careful what words we use or that the other person could be hurt. People often write something they think is funny or witty but they are not aware that the other person can perceive it as insulting, underestimating or even humiliating. One of the main reasons that some people find it so easy to release their anger, primitivism and hostility online is the use of nicknames and false names. If we use an **invented name** when commenting, we never face the fact that we are actually an indecent person that we would not like to interact with if met in person.

WHAT CAN EACH OF US DO FOR RAISING THE COMMUNICATION CULTURE ON THE INTERNET:

- do not hide behind anonymous or false identities and write only what you would say to the person face-to-face,
- do not participate in talking bad about other people - if possible, warn about respectful tone of communication,
- do not share insulting, underestimating, hostile, etc. comments,
- before liking a post or react with emojis, think what you are really communicating,
- consider whether a reaction could (silently) encourage improper, disrespectful, even hostile communication,
- report hate speech to the administrators/ operators of websites and social media or specialised organisations.

WHY SHOULD GENDER PERSPECTIVE BE CONSIDERED ALSO IN ONLINE VIOLENCE?

Women are more often exposed to domestic violence, sexual harassment, gender-based harassment, workplace bullying and also online violence. Intimate partner violence and workplace violence is often accompanied with online violence – the same perpetrator is engaged in various forms of violence against the same person.

There is another important reason why gender has to be taken into account when dealing with online violence. Not only that women experience violence more often, they are also exposed to it just because they are women. Online violence is not necessarily targeted at a certain woman, but it is hostility towards women in general. Such examples are sexist online comments belittling women. The most common targets are women active in public life – e.g., journalists, politicians, managers, also trade unionists and those, fighting for women's rights. Several women, who have experienced such online pogroms, start self-censorship and do not express their opinions anymore. Consequence: women's voices are rarely heard in public life which is contrary to the fundamental democratic principle of the right to express.

Women also experience more online violence in dating apps – particularly when they let somebody know that they are not interested in socializing with them. Consequently, they often receive hostile comments, threats with (sexual) violence, making fun of their appearance, etc. There is a pressure that the woman does not have the right to say no.

Insulting and scornful comments about the appearance of women are always present below articles about women – a star, a politician, a scientist, or a completely unknown woman. Photographs of men are rarely exposed to such comments, and the comments are more often positive. It can be said that the woman's body has never been exposed to such assessing as today.

> *A health institution regularly checks patient satisfaction. There is a website where anyone can leave a comment anonymously. Nina is a graduate nurse, she works in a gynaecological clinic. Patients respect her, she is often praised in the online comments. Once, the director of the institution praises her publicly in front of quite a big group of employees. About a week later, a series of negative comments about Nina's work appear on the website – what they have in common is that she is unkind, unprofessional, shouts at patients, leaves the door open so that everybody in the waiting room can hear the patient's personal information. Nina is shocked when a colleague tells her about those comments. She cannot believe this, so she checks it herself. It is true – she is mentioned with her name and surname and there are several lies about her. She is shocked, she goes to the director and asks her to delete the comments as they are not true. The director takes her complaint seriously and initiates an internal investigation – IT Department finds out that all the comments were sent from a computer in the health institution. Nina still does not know which colleague did that. She cannot trust anymore and every day she checks in fear whether anybody wrote anything untrue about her.*

What is the reason? We should go back to gender-based stereotypes again – those deeply rooted perceptions about the acceptable and suitable social roles of women and men – and the fact that at the moment no society in the world has outgrown and achieved the development level where the inequality of men and women would be only a historical memory.

If it happens to you:

- do not think that it will just disappear itself;
- remember that it is the perpetrator who is responsible for the violence;
- **act and seek for help;**
  - report the hostile and insulting posts to the operator/administrator of the social network and demand deletion,
  - seek support of your colleagues and friends,
  - inform the management if the perpetrator is a member of the staff or organisation,
  - seek counselling, psycho-social, legal assistance,
  - report violence to the police;
- **save evidence** (screen shots, e-messages, SMSs…);
- **block** calls, messages, person…

Mike is a nurse, working in the trauma department. A patient who needs a lot of help due to her mobility problems, has been hospitalised there for quite some time. Her relatives live far away and cannot visit her regularly, so Mike often checks whether she needs anything and encourages her to be optimistic about her recovery. Once, the patient takes a photo of Mike during work, publishes it on Instagram and tags Mike. One of her friends comments »how sexy her boyfriend is«, and this triggers a chain of comments. Mike sees the post only late in the evening. In the morning he asks the patient to delete the post. The patient is offended and says that it is no big deal, just a bit of joking. Mike insists and the patient reluctantly deletes the post. But she does not delete the photo from her telephone and uses a filter to add two devil horns and a big nose. She publishes the photo with a comment: »It was good while it lasted«. #ex. Mike's face cannot be identified but a lot of her followers recognise him as her "boyfriend" from yesterday – again there are a lot of different comments, but this time Mike knows nothing about them.

If it happens to a colleague, support them by:

- **believing** that the victim perceives the event(s) as violence;
- **helping the victim to look for information,** which will help them decide how to react (the procedure of reporting, where to find psycho-social assistance, whom to talk to), if it is happening among colleagues, if online violence is caused by patients, visitors, etc.;
- **not minimising the violence,** do not say it is not serious, that it will disappear or that the victim should forget about it;
- **not participating in the violence:** do not share the disputable posts/photographs/recordings, do not write or like insulting posts/comments, etc.

It is known that...

... all **violence**, including online violence, is **prohibited**;

... **it is the perpetrator who is responsible** for any violence

... violent behaviour **is a choice**;

... **the victim is not and cannot be responsible** for somebody else's behaviour;

... all **violence has consequences** - some of them can be for life;

... our **behaviour on the internet leaves traces** – even if a post/photograph/recording is deleted, it is not possible to control who has seen/saved/shared it;

... **behave responsibly on the internet**, communicate in a respectful way - just like you, everybody else has the right to the safe use of the internet;

... **do not act at the spur of the moment** – take time to think before you react;

... everybody has the right to privacy – post photographs/recording of others only when they agree with that;

... **safe passwords** consist of small and capital letters, numbers and special characters;

... do not stick your passwords at a visible place but **save them carefully**;

... **security settings** of e-devices are very important.

During lunch break a group of hospital employees stand outside in the fresh air by the emergency door. They are in small groups, some of them smoke, others eat, some of them only talk. A patient walks by and starts to shout at them and insult them and records all that - including his insulting comments - on his mobile phone. He publishes the recording with the comment »Look, they are not doing anything but telling me that they cannot admit me«. It is soon spread on the social media, it is even published by an online media portal. The publication triggers a sea of comments (mostly rude or with made-up nicknames) which are insulting, not respectful and even hostile.

Mary is the head of a nursing care team. She is known as extremely correct, professional, kind, and humane. She often works at night as she does not have a family and she is happy to work instead of a colleagues with young children. One night, she registers to an online dating app from pure curiosity. She is pleasantly surprised when she receives the first message only minutes after the registration. There is a charming middle-aged man on the photograph. She writes back and during the chat they find out that they have a lot of common interests. The man is kind, gentleman, he says that at the moment he is on his yacht, sailing among Greek islands. In the weeks to follow they write back and forth and... they like each other. Mary is soon trapped in emotional dependence – the man flatters her, says that he cannot live without her, how she means everything to him, how he can hardly wait to see her in person. But the meeting does not take place – when he is supposed to fly home, he writes to Mary that his yacht has broken down and he does not have the money to repair it as he had lost the USB stick to access his online bank. Through an international agent, Mary transfers a substantial sum of money for the repair. She has not heard from the man since.

A short time ago, John met Tracy in an online dating app. Her profile picture shows an attractive dark-haired woman of an indefinite age. They write to each other and the discussions are more and more naughty. One evening, Tracy persuades John to have sex in front of a web camera – saying, let's play together. When John looks back now, he is not sure why he agreed. He does not notice that Tracy pressed the record button. On that same evening John receives a message from an unknown email address that he should transfer EUR 200 to the account indicated (abroad) or the recording will be sent to the email of the director of the hospital where John works.

ONLINE APPLICATIONS AND SOCIAL NETWORKS ARE BEING CREATED AND CHANGED RAPIDLY AND THE ADVICE FOR SAFE USE MAY SOON BECOME OBSOLETE OR TOMORROW THE APPLICATION OR SOCIAL NETWORK MIGHT NOT BE POPULAR ANYMORE.

It is recommended to check the advice for safe use regularly on the dedicated websites.

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Council of Europe. https://www.coe.int/en/web/genderequality/gender-stereotypes-and-sexism

Council of Europe. https://www.coe.int/en/web/cyberviolence

HOW DO I KNOW THAT I AM A VICTIM OF ONLINE VIOLENCE?

1.	Somebody talks badly of me or spreads lies about me on social media, on forums or websites.	YES	NO
2.	Somebody blackmails me, threatening to publish my private photographs/recordings if I do not do a certain thing.	YES	NO
3.	Somebody is stalking me on the internet.	YES	NO
4.	Somebody has created a false profile with my details and/or photograph.	YES	NO
5.	Somebody found out my password for social media/email and now writes comments/ messages on my behalf.	YES	NO
6.	Somebody hacked my devices (computer, tablet, telephone).	YES	NO
7.	Somebody is intimidating me on the internet, undermining my self-respect, acts aggressively, insulting, damages my reputation, etc.	YES	NO
8.	Somebody has published my private photographs/recordings or shared our private conversations without my consent.	YES	NO
9.	Somebody is sexually harassing me on the internet: sending me sexually unambiguous messages/photographs/recordings, may even threaten with sexual violence.	YES	NO
10.	Somebody is acting aggressively towards me on the internet: uses hate speech, is sexist, insults me because of my personal circumstances (disability, sexual orientation...) etc.	YES	NO
11.	Somebody wants to lure me into prostitution on the internet.	YES	NO
12.	Somebody has posted a photograph/recording on attacking me (e.g., verbal, physical, sexual).	YES	NO
13.	Somebody has posted personal information about me.	YES	NO
14.	Somebody has sent my colleagues or superiors untrue information about me.	YES	NO
15.	Somebody has hacked my web camera.	YES	NO
16.	I am limiting myself because of a previous bad experience, targeted at me: I do not post comments, expressing my opinions anymore, I do not use a certain social media.	YES	NO
17.	When playing web videogames, I receive insulting, hostile, or aggressive comments.	YES	NO
18.	Somebody has processed my photograph in an insulting way and posted it on the internet.	YES	NO
19.	Somebody has created a group on social network where I am blamed, shamed, attacked...	YES	NO
20.	When I refuse an invitation for socializing/chatting in a dating app, the person becomes hostile, aggressive, writes lies about me, and similar.	YES	NO
21.	I am being excluded from online friend groups, groups for playing online video games, etc.	YES	NO
22.	Somebody pretends to have a relationship with me and then manipulates and flatters me, leads me to an emotional dependence relationship, may even borrow money from me.	YES	NO

*If you have answered any of the above questions with YES, you **could be (have been)** a victim of online violence (of course, there are several more forms of online violence and the above is not exhaustive). **Think about whether and how you would like to act.** Seek information about the possible ways of reacting – some of them are also on these pages.*

03 DEALING WITH DOMESTIC VIOLENCE

Istanbul Convention
INTIMATE PARTNER VIOLENCE
physical violence psychological violence
recognizing CONVENTION ON THE RIGHTS OF THE CHILD
economic violence
ABUSE OF OLDER PEOPLE "one on the ass"
stalking DOMESTIC VIOLENCE PROTECTION ACT sexual violence
dealing VIOLENCE AGAINST PEOPLE WITH SPECIAL NEEDS
DOMESTIC VIOLENCE humiliating punches
insulting VIOLENCE AGAINST WOMEN slaps
confidential consultation
taking action threats ridiculing
disciplining neglect
victim protection CHILD ABUSE
preventing contacts with others rape
taking money we believe touching
intimidating kicks
destroying personal belongings

25 NOVEMBER – INTERNATIONAL DAY FOR THE ELIMINATION OF VIOLENCE AGAINST WOMEN

Introduction

DOROTEJA LEŠNIK MUGNAIONI

The history of domestic violence is the history of a denied and tabooed social phenomenon, which had been considered a private family problem for centuries and, as a rule, the state did not intervene. Domestic violence was mainly violence against the weakest members (children, women, older people, people with special needs) who were completely dependent on the perpetrator in the social, legal, and economic sense. In the prevailing culture and state institutions they were not recognised as independent subjects with their inalienable human rights and therefore the state did not protect them against violence.

It was only after the Second World War that the attitude of the society to domestic violence started to change slowly. In Slovenia, there are two key turning points:

- **at the end of the 1980s feminist groups establish the first specialised non-governmental organisation Association SOS Helpline for Women and Children - Victims of Violence,** which starts to deal with helping women and children, victims of domestic violence in systematic way;
- **in 2008 the National Assembly adopts the Domestic Violence Protection Act.**

In the two decades in-between academic institutions were increasingly engaged in researching domestic violence; first safe houses and other civil society organisations were established to help victims of violence; police, social work centres, health and educational institutions started to thoroughly change their attitude to violence and action in the field of preventing domestic violence; Slovenia was signing international conventions and other documents in this field.

Domestic Violence Protection Act (2008) **defined domestic violence.** Domestic violence is "any use of physical, sexual, psychological or economic violence of one family member (perpetrator of violence) against another family member (victim) or neglect or stalking of the victim, irrespective of age, gender or any other personal circumstance of the victim or perpetrator of violence, and corporal punishment of children."
The Domestic Violence Protection Act specifically defines **that everybody is absolutely obliged to report violence, and this refers particularly to professionals in health**, education, childcare and social protection institutions. Rules for individual fields of expertise, also for health care, define dealing with domestic violence in detail.

In order to prevent domestic violence, it is of key importance that it is **recognized** as soon as possible, **protect the victims** and then **take action** in cooperation with other competent and expert institutions. **Health institutions are of key importance in recognizing domestic violence**, particularly against children, women, older persons, the sick and people with special needs who are the most vulnerable and have the least social power. Recognising signs of domestic violence at patients is the most efficient in health care because it has an extremely important role in the society.

In comparison with other institutions who provide help to victims of domestic violence (social work centres, police, counselling offices, non-governmental organisations...) **health institutions are the only public place which is not socially stigmatised, and it may therefore be an efficient entry point to taking action against violence.** It is easier for the victims to talk about their experience with violence in the context of their health problems.

Due to the specific nature and organisation of work, control of the victims by the perpetrators is the lowest in health institutions. By appropriate messages and measures healthcare professionals may limit the perpetrators and prevent them from talking instead of the victim or cover the real causes of injuries, distress, problems in mental health and other consequences of violence. As a rule, health institutions are the least risky entry point for the victims of domestic violence to stop violence.

Ethics and the content of work in health care require that employees are sensitive and emphatic, and they have various communication skills. They can efficiently use their skills of observation and understanding of the signs of violence, confident talking, informing about rights and options for protection, directing to suitable forms of help, psychological and social support. Thus, they can efficiently recognize and deal with violence.

A girl (14) cannot sleep this week. She is slow and she often just stares into the wall. She eats and drinks very little. It is difficult for her to go to school. She does not trust anyone. It is only her best friend who can make her feel a little better. At home she is distant, quiet, and obedient. She has an older sister who told her this week that their father was touching her under the table when they were sitting together. She also told her that their father was slapping and kicking her. Then the girl tells her mother that her father was physically violent to her as well and he was touching her. He was beating her with a belt and then he was stroking and caressing her. She didn't dare to tell her mother because father was threatening her. That was supposed to be their secret. »We are having a good time«, he said. If she tells her mother, she will destroy her family and will not see her sister and mother again. It was only when her sister entrusted her that she was able to tell her story to her mother. Mother took action immediately. She reported suspicion of a criminal act of sexual abuse of children to the police, moved out with her children and sought professional help for all of them.

Sonja Kovač in Doroteja Lešnik Mugnaioni

DEALING WITH DOMESTIC VIOLENCE AGAINST CHILDREN

DOMESTIC VIOLENCE PROTECTION ACT punches
kicks **child abuse** PHYSICAL VIOLENCE
slaps SEXUAL VIOLENCE **power abuse**
POLICE ECONOMIC VIOLENCE TELEPHONE AND ONLINE HELP insulting
humiliating PSYCHOLOGICAL VIOLENCE
threats **adult responsibility** intimidating
ridiculing **taking action by the state**
disciplining **child protection** exploitation
CRISIS CENTRE FOR CHILDREN AND YOUTH neglect CONVENTION ON THE RIGHTS OF THE CHILD
prevention SOCIAL WORK CENTRE **reporting abuse**
isolation **psychosocial support** terror
harassment **we believe**

Introduction

Child abuse is a complex social phenomenon with a medical, social, cultural, psychological, legal, anthropologic… aspect. Experts agree that cruel treatment of children is as old as the humankind (Tomori, 1994).

After centuries of the lack of protection from physical, sexual, psychological, economic, and institutional violence, a lot changed in the field of preventing child abuse in the 20th century. There is more awareness of the responsibility of the society regarding violence against its weakest members, also when that happens in the family, in educational, social, church institutions. The turning point was the **United Nations Convention on the Rights of the Child in 1989, when the contracting countries undertook for the first time in history to protect children from different forms of abuse, neglect and exploitation by appropriate legislation and other measures.**

The Convention was not only a legal basis for establishing national legal mechanism for the protection of children but also encouragement to change the attitude to the child abuse. Numerous governmental and non-governmental preventive programmes and specialised services for helping abused children and their families were developed (Brecelj Kobe et al., 2011).

Children are the weakest social group who need loving and caring adults for their psychological, emotional, social, and physical development, and the state for their status and citizen protection. Children are also socially, materially, financially, legally, residentially… dependent on adults until they come of age. This high vulnerability in the relationship to adults often exposes them to the abuse of power although adults should be taking care about them (Lešnik Mugnaioni, 2014).

Children enter the societal system through health, educational and social institutions. **Consequently, healthcare professionals and everybody else who works with children have to acquire appropriate knowledge and skills**, so that at all levels of health care we will be able **to recognise that the child is experiencing abuse**. Furthermore, health institutions should develop such ways of dealing with the perceived violence that will allow for immediate and efficient help for children. **Together with other institutions children have to be provided with comprehensive treatment and permanent protection against violence.**

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Recommendations for recognizing and dealing with domestic violence against children

In Slovenia, the legal basis for the recommendations is the **Domestic Violence Protection Act (2008)**, laying down that all the healthcare professionals, irrespective of their position, position power or belonging to an occupational group are obliged to report threatening domestic violence, particularly against children. Furthermore, it is laid down in the *Rules on procedures for dealing with domestic violence in the implementation of health activities*[8] that in urgent cases when the life of a victim of violence or her/his children is endangered, the healthcare professional shall immediately inform the police or the competent centre for social work.

Professional Guidelines for dealing with domestic violence for healthcare professionals[9], which is the umbrella document in this field, was the basis for defining the key steps of recognising and dealing with violence against children.

A lot of attention is paid to recognizing the signs of abuse as children are often not able to or cannot talk about the violence they are experiencing. Therefore, it is very important that healthcare professionals have the knowledge and skills in this field. It is only in this way that we will be able to act professionally and responsibly to protect children who are the most vulnerable part of our society, dependent on our ethical behaviour.

Our common premise should be that the child's safety always comes first!

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[11] Brecelj Kobe. Sum na trpinčenje otroka. Izbrana poglavja iz pediatrije. Faculty of Medicine, University in Ljubljana Chair of paediatrics. Ljubljana.; 2011: 292- 308.

VIOLENCE AGAINST CHILDREN IS CHILD ABUSE!

Child abuse includes all forms of bad behaviour, physical or emotional violence, sexual abuse, neglect, exposing children to situations which threaten or actually damage child's health, survival, development or respect within a relationship which involves responsibility, trust and power. Child abuse is anything that disturbs or limits child's personal development, building a positive self-image, intervenes destructively to building child's integrity and exploits his/her powerlessness and dependence[10].

It is difficult to recognise violence or child abuse. There are several signs, none of which proves abuse by itself as it may result from other conditions. All signs and symptoms have to be considered within everything associated with the child, family circumstances and relationships[11]. It is important to address it in a multidisciplinary way with the participation of different specialised staff.

Recognizing a child who is a victim of domestic violence

As a rule, healthcare professionals are in direct contact with juvenile patients and therefore they have a lot of opportunities to build trust. **They approach children with affection, understanding and empathy and thus create confidentiality,** which is of key importance for detecting violence against children.

Such trusting relationship opens the path to the child to talk about the distress they are experiencing, and at the same time allows the healthcare professional to recognise the signs pointing at child abuse. It is important to be aware that health care plays a key role in the field of discovering violence against children.

Violence against children or abuse can be divided into four basic forms: physical violence, sexual violence, psychological violence, and child neglect that can happen at home or in the family and also in institutional care, educational institutions, religious, sports, social, health and other institutions.

PHYSICAL VIOLENCE MAY RESULT FROM AN ADULT PERSON LOSING SELF-CONTROL OR CONSCIOUS AND INTENTIONAL CAUSING OF SUFFERING TO CHILDREN[12]. WHEN RECOGNIZING PHYSICAL VIOLENCE, WE HAVE TO PAY ATTENTION TO THE FOLLOWING:

Physical violence

- unexplained injuries,
- injuries which show a typical pattern,
- bruises at unusual places,
- injuries at different stages of healing,
- burns,
- refusing to talk about injuries,
- covered limbs in warm weather,
- baby injuries (head and face).

The most common forms of physical violence are: pulling hair, slapping, causing burns, hitting, fractures, injuries of internal organs, head injuries.

[12] Mikuž Kos. Psihosocialni vidiki trpinčenja otrok. Trpinčen otrok. Kako prepoznati in preprečevati fizično in duševno trpinčenje otrok. Meridiana. Ljubljana. 1996.

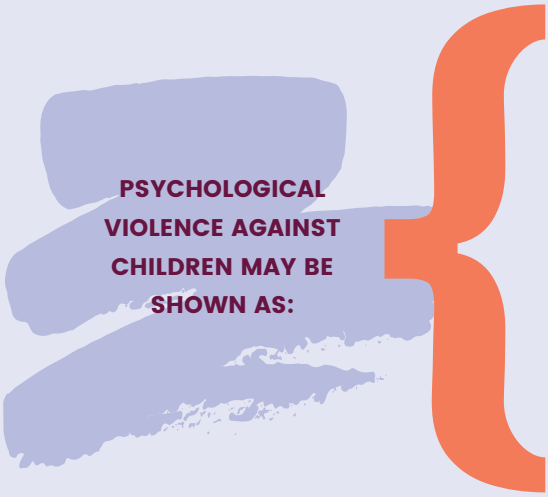
Sexual violence

Sexual violence or sexual abuse of children is each contact of an adult with sexually immature child aimed at sexual satisfaction of the adult or sexual contact with a child using force, threats or deception so that the perpetrator achieves child's cooperation. Sexual contact that the child could not refuse due to the difference in age, power or nature of the relationship with the adult is also considered sexual abuse. Sexual violence is behaviour with sexual content that the child was forced to and due to the development stage cannot understand the meaning. Perpetrators are often people that the child knows and whose relationship with the child means supremacy of power and responsibility.

- has an unexplained, persistent pain, injury, bleeding or unusual excretion from anus or genitals,
- has a sexually transmitted disease,
- pregnancy in minors.

Psychological violence

Psychological violence or psychological abuse is behaviour when the perpetrator causes fear, humiliation, feeling of inferiority, threat or other mental turmoil. Emotional abuse in the relationship between the parents and children means that the child's needs for affection, approval and safety are not met. Psychological violence is the most common form of domestic violence against children, but it is also the most difficult to recognise and prove as there are no obvious signs of injuries.



- attributing negative characteristics to the child,
- imposing responsibilities and work to the child too early,
- emotional unavailability of one of the parents,
- too much or too little child protection,
- withdrawing attention,
- insults,
- mocking,
- manipulation,
- intimidation,
- shaming.

MOST COMMON BEHAVIOURAL SIGNS OF A CHILD, EXPERIENCING VIOLENCE

Physical violence	Sexual violence	Psychological violence	Neglect
Escape from home	Hypersexualised behaviour	Loneliness	Hoarding of food and looking for food
Aggressive reactions	Forcing other children to sexual activities	Lagging behind in development	Missing school
Fits of anger	Sexually pushy behaviour to adults	Age-inappropriate behaviour	Tiredness
Impulsiveness	Knowledge about sex, inappropriate for the age	Fear of failure	Sadness
Fear of touch	Unusual receipt of gifts, money	Mood swings	Indisposition
Changed learning outcome	Secrets about new friends	Excessive obedience	Inability to concentrate during lessons
Withdrawal from family	Changed learning outcome	Excessive tidiness and cleanliness	Does not want to go home
Withdrawal from friends	Harmful use of alcohol and illegal drugs	Excessive seeking for attention	Bad personal hygiene
Negative self-image	Thefts	Bad peer relationships	Injuries
Suicidal thoughts	Fear of touch	Attempts to escape	Accidents
Autodestructive behaviour	Wetting the bed	Anxiety	
	Uncontrolled defecation	Concern	
	Eating disorders	Assuming parental role	

"A boy, 12, is aggressive to his school friends and teachers. He lives with his mother and a younger sister. He is very attached to his mother and loves her very much. His mother and father divorced when he was 6. It is difficult for him to work in a bigger group. He doesn't socialize much with his school friends and spends a lot of time alone. His behaviour is unpredictable, and he often finds himself in dangerous situations. He reacts to limitations and instructions with screaming, kicking, and pinching. In spite of adaptations at school he is often aggressive. He bangs on the table, breaks things, screams. After an examination by a child psychiatrist, he is referred to hospital treatment. He tells the psychologist that his father was never happy with him. Everything he did, was wrong. He could not sit correctly at the table. He could never hold the fork correctly. His room was never tidy enough. He had to go to the bathroom last as he never cleaned it well enough. He says: »Dad was always angry with me, my sister was always the best in everything. I was really trying very hard all the time. I don't know what I did wrong. I am not a good boy. I love dad so much."

A 15-year-old girl was admitted to hospital because she was suicidal and she had eating disorder problems. She has two brothers and three sisters. Her parent's relationship is tense and they argue a lot. She tells the psychologist that there is also physical violence. In school, she is described as an intelligent and communicative young girl. She used to be successful at school and accepted by her school friends. She was a happy, curious girl. Problems occurred during online schooling. She was missing lessons and did not submit her homework. During that time also her parents noticed that she became reserved, stubborn, she was counting calories and spending all the time online. They tell that she tried to commit suicide, she became distant to her friends, school friends and family. Mother knows that the girl is in trouble but she does not pay much attention to that. At the ward, at first she is quiet and reserved. Later, she accepts the regime at the ward and feels safe. During an evening talk she entrusts the nurse a traumatic event that happened a year ago. She finds it difficult to talk about that and she feels guilty. She tells the nurse that she was a victim of sexual violence, committed by a relative. Her parents did not understand or support her. She feels guilty. She thinks she betrayed her family and that it is all her fault. The hospital reports a suspicion of a child abuse to the police and social work centre.

Neglect

In its wider sense term neglect includes any acts by adults which endanger child's physical, emotional, and intellectual needs, thus preventing child's appropriate development[13].

IT IS SHOWN AS NOT MEETING CHILD'S BASIC NEEDS WHICH RESULTS IN NON-PROGRESS OF DEVELOPMENT AND MAY BE SHOWN AS:

- unsatisfactory diet,
- unsuitable clothing,
- bad personal hygiene,
- lack of sleep,
- lack of control,
- lack of routine, learning, rules,
- neglecting child's health condition,
- neglecting child's education.

[13] Uranker. Trpinčen otrok v zdravstveni negi. Obzor Zdr N 2000; 34: 33-38.

How to proceed when violence against children is detected

During medical treatment and in the procedures, following the detection of violence against children, healthcare professionals have to take into account special needs of children and the consequences they suffer because of experiencing violence. **Treatment of a child, a victim of violence, is professional only when it is based on the ethics of care and the principles that child's safety always comes first.**

Each health institution has to draw up instructions about protecting the victims of domestic violence, particularly children. Responsibilities and tasks of healthcare professionals, social service and management have to be defined clearly, when and how the security service takes action, when the police, social work centre or other competent institutions have to intervene.

If we witness any form of violent communication of a parent with the child, we have to react immediately with a clear message that such communication is not acceptable and demand the violence to be finished. We have to tell the parents that it is our legal obligation to react and report violence. At our own discretion - taking into account how endangered the child is - we may request that the parents talk to the social service of the health institution, duly document it, and inform social work centre.

An 8-year-old boy is admitted to hospital because of aggressive behaviour. During the attacks he was endangering himself and others. The outbursts of anger and destroying things were more and more common. It was happening at home, at school and in public places. The boy lives with his mother and grandmother. Father works abroad and rarely visits his son. He makes a lot of promises but never keeps them. Sometimes he also hits him and locks him to the room. All this makes the boy very upset. There is physical violence and alcohol dependence in the family. During the first days at the ward the boy is angry and negative. He retreats to his room and does not communicate. He is angry with the whole world. He slowly gets used to the ward regime and healthcare professionals. His problems slowly start disappearing and he starts to trust the employees. He shows his strong sides. He is very creative and his motor skills are very well developed. He starts making friends and completely calms down. He does miss his mother but trusts the staff. During an afternoon talk he tells the nurse that his father often beat him with a belt and then locked him in the room. His mum could not help him as she was beaten as well. He does not know why he was beaten. He says that he loves his dad and wants to be like him. »Dads have to be strong and children have to obey them«, he concludes.

1. Talking to children who show signs of violence

Children who are victims of violence are very vulnerable. We are careful when talking to them and take into account their age and level of maturity. Being able to recognise the signs of the consequences of violence is extremely important as the child cannot or is not able to tell what is happening to him/her. The child is dependent on the family and as a rule, defends it.

WHEN TALKING TO CHILDREN WHO SHOW SIGNS OF VIOLENCE, FOLLOW THE FOLLOWING GUIDELINES:

- **COMFORT THEM,**
- **ENSURE SAFE ENVIRONMENT,**
- **CAREFULLY CHOOSE THE WAY OF APPROACHING THE TOPIC,**
- **ASK CAREFULLY AND SLOWLY,**
- **BELIEVE,**
- **BE UNBIASED, DO NOT ANALYSE OR JUDGE WHAT THE CHILD TELLS US,**
- **LISTEN CAREFULLY AND PAY ATTENTION TO VERBAL AND NON-VERBAL COMMUNICATION,**
- **THE CHILD SHOULD TELL AS MUCH AS THEY WANT OR CAN, DO NOT URGE THEM OR PUT OUR WORDS, EXPLANATION, OR TERMS IN THEIR MOUTH,**
- **TELL THE CHILD THAT SHE/HE DID THE RIGHT THING TO ENTRUST US AND THAT WE ARE SORRY THAT THEY EXPERIENCED VIOLENCE,**
- **DO NOT JUDGE OR CRITICIZE FAMILY MEMBERS (ALLEGED PERPETRATORS) BUT FOCUS ON INAPPROPRIATE VIOLENT BEHAVIOUR THAT THE CHILD EXPERIENCES,**
- **KEEP TELLING THE CHILD THAT SHE/HE IS SAFE AND THAT WE WILL MAKE SURE SHE/HE GETS APPROPRIATE HELP.**

2. Documenting

When violence against children is suspected, the observations have to be recorded in detail, including all the information that could be important in further procedure. Documentation has to be as detailed and complete as possible.

All the facts, told by the child, have to be recorded. His/her words should be used, do not interpret or generalise.

Documentation has to be kept in the health institution in accordance with the relevant legislation.

"An eight-year-old boy, who is difficult to be managed, is admitted to hospital. He is very impulsive and aggressive. He is pushy and provocative to others. He often insults other children, swears, and occasionally hits them. It is difficult for him to wait for his turn and he seeks attention all the time. He gets offended very easily and it is difficult for him to work in a team. His hygiene is bad and neglected. During an afternoon talk with the nurse he says that he loves his mum and dad. He says: »Yesterday dad was angry with me. I don't know why. I was good and I did all my homework. I might not have cleared the table correctly. I don't know. He took the wooden spoon and hit me on my ass. Mum was angry, too. I had to stand in the corner. My friend at school told me that his mum and dad don't do that. Will you tell them that they shouldn't do that? Will you really?! I love my mum and dad."

3. Informing competent institutions

The fundamental principle in dealing with the detected suspicion of child abuse is to ensure safety and wellbeing of the child and report the detected violence to competent institutions without delay.

Suspected violence against children has to be reported by anyone who detects such suspicion. Healthcare professionals are particularly responsible for that. When violence against children is detected, the competent social work centre / the police have to be informed within 24 hours.

HOW WOULD YOU REACT?

1. When a child tells us about the experience of violence in the family, we have to be very careful:

a) because we cannot always believe children as they often don't tell the truth,

b) because intervening with such a problem can make problems for us, trigger parents' anger, proceedings, testifying at court...,

c) because inappropriate questions or claims (that we do not believe them; that the child probably did something wrong and that is why she/he was beaten; why she/he did not tell about the violence before) cause more harm and distress.

2. During the talk with an abused child it is the most important:

a) to get as much information as possible so we keep asking about the details of the abuse, irrespective of the child's feelings and circumstances,

b) to build a trusting relationship with the child as this is the only way to make it possible for the child to tell what happened and to cooperate with us,

c) to prevent all contacts with parents and other family members when domestic violence is suspected.

3. When dealing with domestic violence against children it happens very often that the child is scared and asks us not to tell anyone about that. What is the right thing to do?

a) Although we are in a difficult, ethical dilemma, we know that we do not have a choice. The only way for the child to exit violence is to report it to competent institutions (social work centre, police) and report the perceived violence to the superiors.

b) We must not betray the child's trust and therefore we do not tell anyone about it. We try to help in other ways – with support, talk, affection...

c) We decide not to report what we have found out; we inform only the psychological/social service who will provide appropriate psychosocial support to the child.

Key: 1.c), 2.b), 3.a)

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

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DEALING WITH DOMESTIC AND INTIMATE PARTNER VIOLENCE AGAINST WOMEN

kicks **social problem** punches
disciplining **RAPE** SAFE HOUSES **power abuse**
slaps **PHYSICAL VIOLENCE** SOCIAL WORK CENTRE insulting
intimidation POLICE taking income **ECONOMIC VIOLENCE**
ISOLATION ridiculing **taking action** humiliating
PSYCHOLOGICAL VIOLENCE **victim protection**
we believe destruction of personal belongings
COMMUNITY HEALTH SERVICE **psychosocial support**
NON-GOVERNMENTAL ORGANISATIONS **INTIMATE PARTNER VIOLENCE**
STALKING ISTANBUL CONVENTION preventing contacts
GYNAECOLOGIST threats DOMESTIC VIOLENCE PREVENTION ACT

Introduction

Domestic violence against women and intimate partner violence is a social phenomenon whose key risk factor is the unequal distribution of power between genders in the society. **Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (2015)** defines violence against women as a social and system phenomenon - a human rights violation and a form of discrimination against women. "Violence against women" refers to all acts of violence that result in, or are likely to result in physical, sexual, psychological or economic harm or suffering to women, including threats, coercion or arbitrary deprivation of liberty, whether occurring in public or private spaces, among present or former spouses or partners irrespective of whether the perpetrator still lives or used to live together with the victim". However, there are other risk factors affecting violence against women: personal, cultural, religious, legal, health, social, political, institutional..., but this type of violence in interpersonal relationships has to be dealt as s system problem.

When treating patients who are victims of violence it is very important to **understand the dynamics of intimate partner violence** as the victims are often intimidated and powerless and due to repeated abuse they do not possess enough personal and social power to be able to leave the violent partner.

Knowing that specific violent dynamics makes it possible for us to believe the victim and **understand why she remains in the violent relationship,** why she does not get out of such relationship, why she defends the partner, minimizes or even denies violence. It is only when healthcare professionals understand characteristics of such violence, they are able to establish a trustworthy relationship with the victim, without judging or stigmatising, or giving simple advice. **The trustworthy and keen relationship of the healthcare professionals might encourage the abused women to recognize them as trustworthy experts.**

Domestic violence and intimate partner violence always has a negative effect on the victim's personality, health and life, as it is destructive for emotional, psychological, physical, social and economic life with short- and long-term consequences. In order to be able to reduce the consequences as much as possible, violence should be detected as soon as possible and dealt with actively. **It is very important for healthcare professionals to react already when domestic violence against a patient is suspected.**

A man brings a woman (41) to the emergency clinic and tells that she has fallen off a ladder. The woman is silent all the time, looking at the floor, she seems absent, while her partner is describing the circumstances of the event. He is very kind to the nurse and loving and attentive to his partner. When it is the woman's turn to be examined, he insists that he wants to be present, telling the doctor in advance in a pushy way about the circumstances of the fall and tries to enter the doctor's office. The doctor refuses his request. When examining the patient's health documents, the doctor finds out that she has often been treated because of different injuries, falls, burns. He suspects intimate partner violence. He asks about numerous injuries and asks whether she is experiencing violence caused by her partner, which she confirms, stressed and crying.

Recommendations on recognizing and dealing with domestic and intimate partner violence against women

In Slovenia, the legal basis for the recommendations is the **Domestic Violence Protection Act**[14], laying down that **all the health care employees, irrespective of their position, position power or belonging to an occupational group are obliged to report threatening domestic violence.** In accordance with that Act all healthcare professionals are obliged to carry out all the necessary procedures and measures to protect the victim, help the victim and ensure respect of the victim's integrity.

One of the basis in drafting the Recommendations were also **Rules on procedures for dealing with domestic violence in the implementation of health activities**[15] stating »that the healthcare professional who becomes aware of circumstances which may lead to assumption that there is domestic violence is obliged to inform the competent social work centre within 24 hours, save in cases the victim objects to such notification«. In case children are involved in domestic violence, such reporting is compulsory. **Professional Guidelines for dealing with domestic violence for healthcare professionals**[16], which is the umbrella document in this field, was the basis for the content of these Recommendations.

Being a woman is one of the major risk factors for experiencing violence as international and domestic research shows that every second woman experiences violence in the course of her life.

When they seek medical help because of the consequences of violence, as a rule, women do not tell the real cause of their injuries or diseases. They are often not able to talk about the violence because they feel guilty and ashamed; they believe healthcare professionals will not believe them; they are afraid it will be even worse when the truth is revealed; they do not believe it is even possible to escape the (long-term) violence. In order to be able to help them, **signs of domestic violence have to be recognized**[17], which is the only way to start dealing with this type of violence, often concealed in the society.

[14] Domestic Violence Prevention Act (Official Gazette of the RS, No. 16/08, 68/16 and 54/17 – ZSV-H)

[15] Rules on procedures for dealing with domestic violence in the implementation of health activities (Official Gazette of the RS, No. 38/11)

[16] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015.

[17] Plaz, M. Ponovno skupaj proti nasilju nad ženskami. Ustavimo nasilje nad ženskami. Utrip 11/2011.

RECOGNIZING DOMESTIC AND INTIMATE PARTNER VIOLENCE AGAINST WOMEN

Health consequences of domestic violence against women[18]:

* **Injuries which do not correspond to the stated cause, such as injuries in the kitchen, bumping into doors, falling down the stairs, and similar.**
* **Visible signs of repeated injuries at various stages of healing, such as burns, bruises, red blemishes on skin, corresponding to injuries resulting from slaps and hitting.**
* **Delayed examinations due to injuries or repeated similar injuries.**
* **Victims of violence often come to see a doctor due to unclear problems and symptoms.**

* **Symptoms of depression, anxiousness, post-traumatic stress disorder, sleep disorders.**

* **Suicidality, self-injury, alcohol and illicit drug abuse.**

* **Headache and other chronical pain syndromes.**

* **Unexplained chronical symptoms of gastrointestinal tract.**

* **Unexplained symptoms of urinary tract, including frequent bladder and kidney infections.**

* **Unexplained symptoms of reproductive organs, including pelvic pain and sexual dysfunction, repeated vaginal bleeding and sexually transmitted diseases.**

* **Repeated unplanned pregnancies or abortions.**

* **Late inclusion in pre-natal health care, bad outcome of pregnancy – spontaneous abortion, stillbirth, premature birth, low birth weight, and other.**

> *During a talk at her general practitioner a woman (60) says that the woman has to endure a lot and be patient in order to keep the family. When the doctor asks her to tell more, she says that she often had to take her children to go to her parents to sleep there as her husband was coming home drunk and breaking things in the flat. If they did not leave, he was insulting and hitting them. When he got sober, he would always promise that it would not happen again, but he never kept his promise. His drinking caused his early death and she remained alone with three children, which was difficult but at least they had peace, and nobody was beating them anymore.*

[18] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015, p. 36.

BEHAVIOUR OF A WOMAN, VICTIM OF VIOLENCE:

- hides the signs of injuries with clothes, minimizes injuries, states other causes of injuries,
- she is frightened, miserable, worried, desperate, indifferent, apathetic,
- she is frightened of the person who accompanies her (the perpetrator), does not speak in his presence, leaves the communication with healthcare professionals to him...

BEHAVIOUR OF THE PERPETRATOR OF VIOLENCE AGAINST THE WOMAN:

- accompanies the victim to the health institution and treatment, behaves violently, aggressively, does not trust the healthcare professionals, wants to be present during the entire treatment,
- is aggressive, offensive, threatens the victim,
- talks instead of the victim, constantly interrupts the victim, minimizes or objects her
- the perpetrator can also be calm, well-mannered, kind and we would not attribute violence to him,
- family members prevent visiting the victim at home, her care or hospitalization.

SOCIOPSYCHOLOGICAL DYNAMICS OF RELATIONSHIPS IN THE FAMILY OF THE WOMAN, VICTIM OF VIOLENCE:

- due to disorderly social conditions, conflict relationships, previous violence, divorce procedure, etc. the family or individual family members are being dealt with at the social work centre,
- the family or individual family members have been (are) the subject of police or court proceedings due to criminal or other offences,
- problems, associated with alcohol or illicit drug abuse have been detected.

Carrying out relevant procedures when domestic and intimate partner violence against women is detected

When healthcare professionals suspect domestic violence on the basis of signs of possible domestic violence and/or talk with the woman, victim of violence, **they have to carry out the following procedures after the completed treatment**[19]:

- measures to protect the victim in the health institution,
- talk with the victim and provide psychosocial assistance,
- advise and inform the victim about the possible forms of assistance inside and outside health care,
- document the victim's statement and the signs, showing to violence,
- assess the degree of risk for the victim,
- inform the competent institutions about the suspected criminal offence of domestic violence.

During the treatment safety of the patient – victim of violence has to be ensured, with the security service or the police, if needed. If the perpetrator of violence has been issued a restraining order and the victim of violence is in hospital, the healthcare professionals in the institution have to be informed so that they will be able to provide appropriate protection and immediately inform the police in case the order is breached. The head of the department or director of the institution is responsible for that.

"A woman (24) is brought to clinic by the police as she has reported sexual abuse. The girl tells that that she met the perpetrator on social media about two months ago and she had sex with him then. Then she wanted finish the relationship, but he did not agree. He was harassing her with telephone calls and threatened to publish the videos of their first meeting and sexual intercourse and so he lured her to come to his address. He wanted her to take off her clothes in the courtyard, which she did not do. He lured her into the room by threats and extortion and he forced her into a sexual intercourse. Then he forced her to put on her clothes and go home.

[19] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015, p. 40.

A patient comes to her general practitioner. She is restless in the waiting room, walking back and forth, constantly glancing at her watch. When she comes to the nurse, she says she does not have much time and that she has to be examined as soon as possible. The nurse tries to calm her and tells her it will be her turn soon. In spite of that after 5 minutes the patient knocks on the door again. She tells the nurse that she is really in a hurry as she has promised her husband to be back in an hour. Her husband is very worried if she is late, he is angry if she does not do what they have agreed. The nurse suggests that she should call him and tell him it will take some more time. Then she sees tears in the patient's eyes, so she closes the door to the waiting room and invites the patient to come in to talk. She asks her whether her husband is often angry when she leaves home or has some errands to run. Also, when she goes to see the doctor. What does her husband do when he is angry? Is he rough, insulting? Does he threaten her? Has he ever hit her? The patient tells that he is very hot-tempered and jealous and he shouts and threatens if she is late, and then punishes her with silent treatment. She has to come back home from work immediately, otherwise there is a storm. When the patient calms down, she thanks the nurse for her kindness and talk and asks her not to tell anyone about that, not even the doctor. Her husband must not get to know that she was talking about that as he would go mad.

Talk to the woman, victim of violence and provide psychosocial assistance

In case healthcare professionals detect signs, which lead to the suspicion of violence against the woman in the family, they have to discuss that with her. We have to be aware that questions about her experience with violence is an intervention into her emotional, social and intimate sphere. The aim of the discussion[20] is that she talks about her experience with violence and that we can then direct her to the appropriate forms of assistance.

Establishing trusting relationship

We provide a safe place and then kindly invite the woman to speak. We tell her that no violence is acceptable and that she is entitled to appropriate protection and assistance.

Active listening

We listen carefully, do not get ahead with the answers, and give the woman enough time to express her thoughts and emotions. By asking questions, we help her clarify the facts of the violence she is experiencing. We are willing to believe and listen to everything she entrusts us.

Discussion about violence

We are careful not to express prejudice about domestic violence. We do not minimise violence or judge according to our experience. We tell her that it is exclusively the perpetrator who is responsible for the violence. Never encourage her to stay in the violent relationship or to face the perpetrator of violence. In a violent relationship the victim is subordinate and does not possess equal psychological power. Therefore, no form of mediation, even if you are qualified for it, is appropriate in this case as it would only harm the victim. Do not look for proof or "objective truth" as this is the task of other institutions.

[20] Horvat, D. Zaupni pogovor z žensko, ki doživlja nasilje. Ustavimo nasilje nad ženskami. Workgroup for non-violence in nursing and midwifery. Utrip 11/2011.

EXAMPLES OF INDIRECT QUESTIONS IN CASE OF SUSPECTED VIOLENCE IN THE FAMILY OR PARTNERSHIP[21]:

How is it at home? Do you get on well with your partner?

How does your partner treat you? Do you feel safe at home?

How are the children? Are they healthy?

Ask direct questions in case of injuries or when you want to obtain evidence of physical or sexual assault. In case of an adult, say honestly why you are asking such questions.

Could you tell me how those injuries occurred?

Has your partner ever slapped, kicked or hit you or injured you in any other way?

Are you ever afraid of your partner or your family members?

Does your partner ever get angry with you? What happens then?

Has your partner ever destroyed or broken things that were dear to your heart?

Is your partner jealous when you meet your friends or talk to other people?

Do you feel that your partner wants to control your life?

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[21] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015, p. 37.

Providing moral and emotional support

Do not judge the patient, moralise or value her words, acts, way of life or her decisions. Treat her with respect. Pay attention to her emotions, try to disburden her emotional burdens. Encourage her. Remind her that she has to take care of herself and her sources of power.

Looking for the way out of violence

Each victim deals with violence in their own way and looks for the way out. Do not give advice or instructions how to act. Warn her of the dangers she and/or other family members are exposed to. Warn her also about her share of responsibility to the children and that she should protect them.

Awareness raising, informing, reporting violence

Inform the patient about her rights and that she can report violence. Inform her about measures, aimed at preventing further violence. Honestly tell her that you are obliged to report domestic violence, particularly when children are involved. When talking to the victim, ask about people who could help and support her (relatives, friends, colleagues). Inform her about other possible forms of assistance (social work centres, police, crisis centres, safe houses, non-governmental organisations).

Further psychological support for the woman, victim of violence

LATER, PSYCHOSOCIAL SUPPORT AND DISCUSSIONS WITH THE VICTIM OF VIOLENCE[22] WILL BE PROVIDED BY THE RELEVANT HEALTHCARE PROFESSIONALS (PERSONAL FAMILY DOCTOR, VISITING NURSE, PSYCHOLOGIST, PSYCHIATRIST, SOCIAL WORKER), AND, ABOVE ALL, OTHER COMPETENT SERVICES:

- social work centre,
- police,
- legal aid (legal information centre, non-governmental organisations),
- non-governmental organisations (SOS helpline, counselling, escorting, advocacy, self-help groups, accommodation in a safe house, crisis centre, and other).

When requested by the victim, healthcare professionals can contact the institutions which provide assistance and accompanying the victims of violence (non-governmental organisations) and provide information about those forms of assistance. Make sure that there are always enough leaflets, posters, brochures, and other information about those programmes at your workplace and in the waiting rooms.

[22] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015, p. 38.

Documenting detected signs and statements by the woman, victim of violence

Document in detail all your observations and facts, which have led to the suspicion of violence, as well as **all the statements by the victim and detected health consequences of violence** (physical and psychological). Record in the documentation if the person, victim of violence, denies it. Documentation has to be as detailed and complete as possible as some time in the future it may be used as evidence in court proceedings.

HOW TO ASSESS RISK EXPOSURE OF A WOMAN, VICTIM OF VIOLENCE?

Assessing the current risk, the victim is exposed to is important for taking further measures[23]. During the discussion with the woman **assess the risk she and children, if any, are exposed to**, according to the pattern of the abuse, how serious the injuries are, or even the risk of murder. Assess also how suicidal the victim is. The following questions may help:

- **HOW LONG HAS THE VIOLENCE BEEN GOING ON?**
- **ARE YOU IN DANGER AT THE MOMENT?**
- **HAS VIOLENCE ESCALATED OR BECOME MORE THREATENING LATELY?**
- **DO YOU THINK YOU ARE NOT SAFE IF YOU GO BACK HOME?**
- **IS THERE A SAFE LOCATION YOU COULD GO TO?**
- **IS THE PERPETRATOR OF VIOLENCE VIOLENT ALSO TO CHILDREN?**
- **HAVE THE POLICE INTERVENED AT YOUR HOME DUE TO VIOLENCE?**
- **HAVE YOU EVER BEEN TREATED/ HOSPITALISED BECAUSE OF THE CONSEQUENCES OF VIOLENCE?**
- **HAS THE PERPETRATOR OF VIOLENCE EVER THREATENED WITH WEAPONS OR EVEN USED IT?**
- **DOES THE PERPETRATOR CONTROL OR FOLLOW YOU?**
- **ARE YOU AFRAID FOR YOUR LIFE?**
- **DOES THE PERPETRATOR ABUSE ALCOHOL OR DRUGS?**
- **HAVE YOU EVER THOUGHT OF SUICIDE OR TRIED TO COMMIT IT?**

[23] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015, p. 41.

It is important to take into account that an adult victim of violence herself can best assess the risk and probability the violence continues.

Therefore, her assessment has to be taken into account when assessing the risk. Indicators of serious risk for the victim are mainly threats, also with murder or suicide, possessing or having access to weapons, extreme jealousy, physical attacks, following during divorce procedure, sexual assault, previous violent incidents with injuries, mental health problems, or psychotropic substance abuse.

Informing competent institutions about domestic violence

When domestic violence is suspected, in accordance with the Domestic Violence Prevention Act **health institution is obliged to inform the competent social work centre or police within 24 hours**. When the victim and her children are not directly at risk, the **competent social work centre** has to be informed.

Taking measures within health institution

Each health institution has to draw up instructions about protecting the victims of domestic violence, particularly vulnerable groups. Responsibilities and tasks of healthcare professionals, social service and management have to be defined clearly, when and how the security service takes action, when the police, social work centre or other competent institutions have to intervene.

HOW WOULD YOU REACT?

1. During the last year a patient has often come to the emergency department (fall off a ladder, in the garden, down the stairs...). She is accompanied by her caring husband who claims that she fell in the cellar when moving the shelves.

a) You believe the story as there are no indications of violence, the husband is kind to the staff and attentive to his wife, the patient tells the same story when she is being examined by the doctor.

b) You find the story doubtful as there have been too many falls recently, the patient is mostly silent, the husband is too kind, he is talking too much, explaining for his wife that she is often clumsy and keeps falling. You tell the doctor about your suspicion and the doctor orders another examination with plenty of opportunities and time for a detailed and confident talk with the woman.

c) You talk with the patient in confidence without the presence of her husband. When she says that her husband is sometimes violent and that she is afraid of him, you tell her that you cannot do anything and that she should go to the police and report the violence.

2. A patient comes for the examination in the emergency gynaecological clinic, accompanied by the police as she has reported rape. Her behaviour seems contradictory with her claim that she was raped: she is completely calm, she answers the questions calmly, nothing shows that she is under stress.

a) The patient is probably not a victim of rape as victims are usually in severe stress, scared, they cry, it is difficult for them to tell what is happening.

b) The behaviour of victims of sexual violence can be very different and the above situation does not prove at all that it has not happened. Very calm, rational, unhurt and absent behaviour may be the result of shock because of the violence. We need to be careful not to perceive the victims of (sexual) violence in a stereotype way.

c) The patient might not have been careful enough and her no was not decisive enough and therefore she is co-responsible for the rape. You think that this is why her behaviour is so unusual.

Key: 1.b), 2.b), 3.c)

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

3. A young woman tells the community health nurse, who is examining a newborn, that her husband is forcing her into sexual intercourse although she is not physically or psychologically ready yet and she does not want sex yet. What should the community health nurse do?

a) She listens to the woman and calms her down. She tells her to try to understand her husband and try to explain to him calmly why she does not want to have sex yet. He will probably understand her. After some time, when she feels well again, everything will be normal.

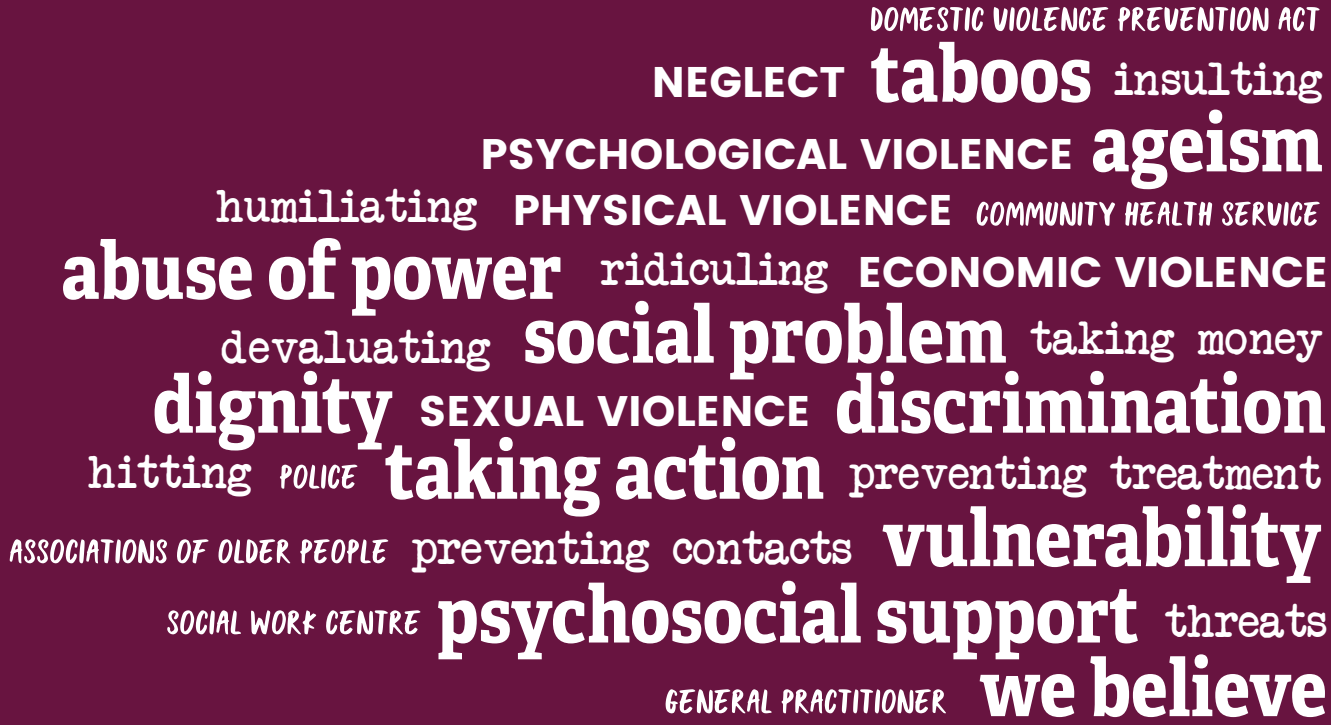
b) She suggests the woman and her husband should go to a specialist examination and tell that they have problems as far as sex in concerned. The expert will advise them how to solve the problems appropriately and professionally.

c) She feels the woman's stress and invites her to talk to her. She gently asks about her relationship with the husband: how he behaves; does she feel his pressure, dissatisfaction, anger; how he behaved during pregnancy; has he ever forced her to have sex or been violent... If the woman confirms her suspicion of intimate partner violence, she tells her that this is violence and that sexual violence in partnership is a criminal act and therefore action should be taken.

25 November - International Day for the Elimination of Violence against Women - since 1981 this day has been commemorated internationally to remember the brutal murder of sisters Mirabal, political activists from the Dominican Republic, in 1960.
This is the day of a global campaign on raising awareness about recognising and preventing violence against women.

Darinka Klemenc and Doroteja Lešnik Mugnaioni

DEALING WITH DOMESTIC VIOLENCE AGAINST OLDER PEOPLE



Introduction

Older people are one of **the most vulnerable social groups and thus particularly exposed to violence of all kinds.** Violence against the older persons includes different ways of inappropriate and harmful practice and attitude, threatening the abused person's health, dignity, safety, physical and sexual integrity, social inclusion and meeting mental and spiritual needs of an older person. According to the research, older women are more exposed to violence than men; the reason is longer life, higher exposure to poverty and social deprivation and lower social power.

The forms of violence against older people (in the family as well as in the institutional care) are the same as in other social groups, but the **risk factors for violence against older people are diverse** (social, medical, economic, safety, cultural...). They all refer to lower personal and social power which often renders older people very vulnerable, threatened, dependent, discriminated, overlooked, and forgotten.

The most recognized forms of violence against older people are as follows: psychological, verbal, economic, physical, sexual violence, blackmail and threats, social isolation, neglect. The older persons are often blackmailed by providers of different services, devices and other products which should improve the quality of life for older people.

The most common victims are women, aged between 70 and 75, who are socially isolated and need everyday care. Violence against older people is not researched enough, particularly there is a lack of research on the occurrence and characteristics of the issue in the family, in domestic environment. There is a lot of psychological and physical violence and neglect in residential homes for older persons and among the patients in health institutions and emergency clinics, while self-neglect, neglect, psychological and economic violence is more present in domestic environment (Primc, Lobnikar, Prislan, 2021).

Older people are the subject of all types of violence – in different forms, by different perpetrators, in different circumstances, also where people of different ages do not experience violence. It is essential to raise awareness of everybody who works in health care, social protection, civil-society organisations as a professional or otherwise takes care or meets older people.

Attention should be paid to the signs of violence, family, social and economic situation in which the older person lives, establish a trustworthy relationship as enough time should be taken for talking and **the victim has to be believed. Action has to be taken without delay** and in accordance with the Domestic Violence Prevention Act (see your national legislation) **the perceived abuse has to be reported to the social work centre and to the police.**

REFERENCES:

Primc T., Lobnikar B. in Prislan K. (2021). Nasilje nad starejšimi – analiza prihodnjih raziskovalnih potreb na podlagi sistematičnega pregleda dosedanjih raziskav. Retrieved from https://www.fvv.um.si/rV/arhiv/2021-3/04_Primc_Lobnikar_Prislan_2021_3.html

Recommendations for recognizing and dealing with domestic violence against older people

In Slovenia, the legal basis for the recommendations is the **Domestic Violence Protection Act,** laying down that all the employees in health care[24], irrespective of their position, position power or belonging to an occupational group are obliged to report threatening domestic violence. It is also laid down that older people, the disabled and people who are not able to take care of themselves due to personal circumstances shall be paid special attention when dealing with violence and providing assistance to the victims".

Rules on procedures for dealing with domestic violence in the implementation of health activities[25] and **Professional Guidelines for dealing with domestic violence for healthcare professionals**[26], which is the umbrella document in this field, were the basis for the content of these Recommendations.

Special attention is paid to recognizing the signs of violence as older people who, being dependent on the family or carers, often do not dare to talk about the violence, they are experiencing. Therefore, it is very important that healthcare professionals have the knowledge and skills in this field.

The recommendations, applicable to recognizing and dealing with domestic violence against older people, can be used also in dealing with the cases of violence in health institutions and social protection institutions.
The institutions are advised to prepare internal rules for dealing with the violence against older people on the basis of these Recommendations.

Recognizing domestic violence against older people

As a rule, **healthcare professionals** in health and social protection institutions are in direct contact with older patients and therefore they have a lot of opportunities to build trust with **affection, respect, understanding and empathy, which allows an older person to talk openly about his/her experience with violence.** It is important to be aware that nursing, particularly community health nursing care, plays a key role in the health care system in detecting abuse of older people.

[24] Terms in masculine grammatical form are used as neutral and apply to men and women and vice versa.

[25] Rules on procedures for dealing with domestic violence in the implementation of health activities (Official Gazette of the RS, No. 38/11)

[26] Professional Guidelines for dealing with domestic violence for healthcare professionals, Ministry of Health, 2015.

A bus driver calls the number of one of non-governmental organisations. He says that an older woman occasionally travels in his bus and she is complaining about neglect by her daughter who lives in the same house in her own flat. The daughter often enters her flat without asking, examining it, commenting and harassing her. The daughter does not even let her have hot water, heating is very low so she is often cold. She never asks whether she needs anything, she even has to take a bus to go to the doctor's although she is not physically very fit anymore. The bus driver tells that he has informed also the social work centre and community health service. As the competent services inform about the visit in advance, the daughter was always there, claiming that everything is OK, that mother is grumpy, demanding and suffers from mild dementia. She claims that she takes good care of her mother. However, the woman keeps complaining to the driver about her problems.

Signs and consequences of domestic violence against older people

HEALTH CONSEQUENCES OF DOMESTIC VIOLENCE AGAINST OLDER PEOPLE:

- **INJURIES WHICH DO NOT CORRESPOND TO THE STATED CAUSE (FALLS, BRUISES, BREAKS, ETC.),**
- **VISIBLE SIGNS OF REPEATED INJURIES AT VARIOUS STAGES OF HEALING, SUCH AS BURNS, BRUISES, FROSTBITE, ETC.,**
- **DELAYED HEALTH EXAMINATION DUE TO INJURIES,**
- **FREQUENT SEEKING FOR HEALTH ASSISTANCE DUE TO UNCLEAR PROBLEMS AND SYMPTOMS,**
- **REPEATED SAME OR SIMILAR INJURIES,**
- **UNDERNOURISHMENT AND DEHYDRATION,**
- **HYGIENIC NEGLECT AND ITS CONSEQUENCES (LESIONS DUE TO PRESSURE, INFLAMMATION, SKIN CHANGES, ETC.),**
- **WORSE MENTAL HEALTH,**
- **INCREASED RISK FOR DEPRESSION, AGGRESSIVENESS, PSYCHOSOMATIC DISEASES, CHRONIC PAIN SYNDROMES, GASTROINTESTINAL DISTURBANCES.**

DOMESTIC VIOLENCE AGAINST OLDER PEOPLE CAN HAVE THE FOLLOWING FORMS:

* **physical violence** (punching, slapping, pinching, pushing, rough gripping, choking, injuries with different objects, etc.),
* **emotional or psychological violence** (humiliating, underestimating, hostile behaviour, refusing communication, silence, degrading, gossiping, etc.),
* **verbal violence** (calling names, humiliating words, yelling, insulting, etc.),
* **blackmailing and threats** (threats of withdrawing care, isolation, wagging, threatening gestures, making care and love conditional on material goods, etc.),

* **sexual violence** (alluding to sex or sexual impotence, obscene talking and gestures, touching, requiring sexual intercourse, forced sexual intercourse, rape, etc.),

* **material or financial jeopardising** (taking money, pension or property, enforced conveyance to a relative or another person, excessive charging for services, etc.),

* **social isolation** (keeping from communication and contacts in the family, preventing social contacts outside the family, locking into the house, preventing an elderly person from maintaining social network, etc.),

* **neglect** (inappropriate clothes, food, drinks, bad hygiene, preventing treatment and care for an elderly person, etc.).

An 86-year-old woman lives on her own. Once a week her son, who lives 80 km away, visits her. She has pains in her spine and her knees which makes it difficult for her to move, she uses a walking frame in the flat and she practically never goes out. She is almost completely dependent on her son; she has some contacts with her neighbour and a community health nurse. They both see that her son is violent to her in several ways: psychological and verbal, sometimes also physical, which is seen from the bruises on hands, legs, and her face. The woman is silent and defends her son. Her hygiene is neglected, when the community health nurse visits her, she is often hungry or thirsty as it is difficult for her to prepare food provided she has it at all. Her son claims that he takes good care of her, but mother is grumpy, disobedient, demanding. The neighbour wants to stay away from that, even when she hears shouting or noise in the flat above. She is also afraid of the son. Thus, only the community health nurse is involved in solving the problem. The son continues to insist that his mother can be at home, that she is well taken care of and that he will not send her to the residential home for older persons (they do not have the money for that and he will not sell his mother's flat). When meeting the nurse or the neighbour, he communicates rudely.

BEHAVIOUR OF AN OLDER PERSON, VICTIM OF DOMESTIC VIOLENCE:

- denies having health problems as a consequence of violence,
- hides the signs of injuries with clothes or minimizes injuries,
- is frightened, sad, absent, worried, desperate, etc.,
- pretends not to hear or understand or is not able to communicate,
- justifies violent behaviour by the relatives,
- is frightened of the relative or person who accompanies him/her, does not speak in his/her presence, leaves the communication with healthcare professionals to him/her,
- recently his/her behaviour and communication have changed substantially.

BEHAVIOUR OF THE PERPETRATOR OF DOMESTIC VIOLENCE AGAINST THE VICTIM:

- behaves violently, aggressively, does not trust the healthcare professionals, wants to be present during the entire treatment,
- is aggressive, offensive, threatens the older person,
- talks instead of the older person, constantly interrupts the victim, minimizes or objects the deposition,
- ignores the ability of the older person to talk about the problems, needs, wishes and expectations with the healthcare professionals,
- is too kind, helpful, participating with the healthcare professionals, expresses excessive care for the relatives, which does not comply with the condition of the older person,
- cares about the older person in the family in an inappropriate way, which results in worsening the victim's health condition (does not follow the instructions by the healthcare professionals, does not take the diagnosis into account, applies harmful approaches of treatment, presses the older person to agree with his/her opinion about treatment and care, etc.).

SOCIOPSYCHOLOGICAL DYNAMICS OF FAMILY RELATIONSHIPS:

- due to disorderly social conditions and conflict relationships, the family or individual family members are being dealt with at the social work centre,
- the family or individual family members have been (are) the subject of police or court proceedings due to criminal or other offences,
- problems, associated with alcohol or illicit drug abuse have been detected,
- an older person and / or other family members live in socially threatening conditions.

Carrying out relevant procedures when domestic violence against older people is detected

During treatment in health institutions and in the procedures, following the detection of violence against older people, healthcare professionals have to take into account special needs of older people and the consequences they suffer because of experiencing violence. Medical treatment of an older person, victim of violence, becomes professional only when it is comprehensive and includes also that ethical aspect.

> *A patient, 70, is brought for an examination by her daughter. She tells that she found her mother at home in pain. The patient tells that she has had a tenant for two years who has attacked and raped her for several times. She didn't tell anyone as she was sure nobody would believe her. Today the sexual attack was particularly painful and she could not even get up. The healthcare professionals reported the event to the police.*

Taking measures within health institution

Each health institution has to draw up instructions about protecting the victims of domestic violence, particularly vulnerable groups, such as older people. Responsibilities and tasks of healthcare professionals, social service and management have to be defined clearly, when and how the security service takes action, when the police, social work centre or other competent institutions have to intervene.

If we witness any form of violent behaviour or communication with an older person, we have to react immediately with a clear message that such communication is not acceptable and demand the violence to be finished. We have to explain that it is our legal obligation to react and report violence.

Discussion with an older person who shows signs of violence

In case healthcare professionals detect signs, which lead to the suspicion of domestic violence against an older person, they have to discuss that with him/her. We have to be aware that questions about any experience with violence are an intervention into the emotional, social and intimate sphere.

> *80-year-old woman lives together with her daughter's family with three children. She does have her own room, but the door is always open. Grandchildren are coming to her room at all times, they play there, use her computer and she does not have any privacy. Recently, there has been more and more pressure to divide her pension among all the family members (they constantly need something). Particularly the grandchildren are tiring with their requests. It is difficult for her to say no although her pension is low and she often lacks basic goods, also food, not mentioning any treats. Recently she has noticed that her bank card has disappeared for several times. She always found it but there were withdrawals of smaller sums of money on the bank statement. It was her eldest grandson, a secondary school student, who withdrew smaller amounts of money from her bank account at an ATM. The woman is afraid to mention this problem in the family as she is afraid that the grandson will be punished, and this would worsen their relationship. She does not want to lose him. At the same time, she is afraid how much money he will take next time.*

THEREFORE, WHEN TALKING TO AN OLDER PERSON, THE FOLLOWING IS NECESSARY:

- provide a suitable room, where confidentiality, safety and intimacy of the discussion is guaranteed,
- check whether he/her can hear and understand well,
- focus on the person and listen actively,
- encourage the person kindly and carefully to talk,
- talk calmly, show affection and empathy,
- use words which are close to older people, understandable, clear and adapted to their ability of perception (as a rule, do not use foreign or professional terms),
- believe the deposition,
- by asking questions, help clarify the facts of the violent relationship they are experiencing,
- do not belittle or overhear the problems or consider them trivial,
- name and firmly condemn violence and disburden the person from feeling guilty as they are experiencing violence. State clearly that the perpetrator is responsible for the violence caused,
- never encourage the person to stay in the violent relationship but try to encourage the victim to exit the violent relationship,
- never encourage the victim to face or talk to the perpetrator - in a violent relationship the victim is subordinate and does not possess the same power as the perpetrator,
- try to reduce the emotional stress,
- encourage - remind the victim that they have to take care of themselves and their sources of power,
- look for other people from the victim's social network who can help – accompany the victim in procedures, provide psychosocial assistance, help in case of danger,
- do not judge / assess the perpetrator's personality, just his/her inappropriate and violent acts,
- do not give advice or make decisions instead of the victim, do not base anything on your own experience,
- when looking for an exit from violence and taking measures, take into account the victim's power, abilities and health condition,
- in case of threatening violence warn that it is necessary to report violence.

Due to their health, psychological, material, and social weakness, older people are often dependent on family members and subordinate to them and therefore they are afraid of conflicts and strained relationships with them. Consequently, they defend family members or deny violence.

Even if an older person asks you not to tell anybody what they have told you, you have to explain that it is your responsibility to report violence. Tell the person that this is the only way to stop violence.

Do not promise the victim that everything will be all right as you cannot guarantee that. Do your best for the victim to feel better in the health and emotional way.

> *A recently retired woman with quite a good pension lives in a house with her son and his family. As she wants to do a lot of things in retirement, also travel, socialize with friends and be socially useful, she buys a new coat. When she shows it her son, he says: "Why on earth do you need a new coat now, in pension? Would you not rather save and buy us something?" His family is not socially deprived, on the contrary, they are quite well-off.*

Documenting

When abuse of older people is suspected, the observations have to be recorded in detail, including all the information that could be important in further procedure. Documentation has to be as detailed and complete as possible.

All the facts, told by the victim, have to be recorded. His/her words should be used; do not interpret or generalise.

Informing competent institutions

The fundamental principle in dealing with the suspicion of violence against older people is to ensure safety of the victim.

When any kind of endangerment of an older person is detected, the competent social work centre or the police have to be informed immediately.

HOW WOULD YOU REACT?

1. Can we believe older patients / residents when they say they are experiencing violence?

a) No, when it is a patient/resident who suffers from dementia.

b) No, if we have noticed before that she/he is confused and sometimes wrongly interprets something.

c) No, if it has happened before that she/he claimed that some money was missing but it was not true.

d) We believe the patient/resident. It is her/his truth. Dealing with the issue should be based on their deposition and we try to find out in separate discussions with the involved and employees what exactly happened.

2. What should we do if a resident in a residential home for older persons tells that a relative was rude and insulting and often demands money?

a) Record the resident's deposition. Inform the superiors immediately. In accordance with the protocol take measures to protect the resident and stop the violence.

b) Do not say anything to the relative as that would only make the situation worse – the aggression could increase or the relative would not visit the resident anymore which would be very painful for the resident.

c) Advise the resident that she/he should be kind and understanding to the relative. In that way there will be no reason for aggressiveness. And most of all, they should not provoke the relative or talk about old resentment.

d) Advise the resident to record on the telephone next time when the relative demands money again. The residential home for older persons will be able to act only when they have evidence.

Key: 1.d), 2.a), 3.a)

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

3. A nurse in the health institution notices that an older patient's hygiene is very bad, her clothes are dirty, she has bruises on both arms. She knows that the patient lives in a house together with her son and his family.

a) She talks to the patient about the situation at home in a trustworthy and sensitive way. She tries to find out whether anybody helps her wash her clothes, hygiene, cooking. She asks her how she feels whether she is happy with the life at home. What about family relationships? Does she feel safe...? She tells the doctor about that and makes an appointment for the examination for next week. In the meantime she makes an action plan together with the community health nurse.

b) She talks to the patient about the situation at home in a trustworthy and sensitive way. When she finds out that the son's family does not help her and that she cannot take care for herself anymore, she calls the son, who is waiting in the waiting room, and tells him that such treatment of his mother is inadmissible.

c) She tells the patient that she does not take care about herself well enough and that such situation cannot continue. It is obvious that she needs home help or moving to a residential home for older persons.

As more and more attention is paid to the vulnerability of the older population and violence against older people, in 2011 General Assembly of the United Nations proclaimed

15 June as World Elder Abuse Awareness Day.

This supported the global campaign of raising awareness and preventing violence against older people.

04 VIOLENCE AGAINST PATIENTS IN HEALTH INSTITUTIONS AND RESIDENTS IN SOCIAL PROTECTION INSTITUTIONS

Darinka Klemenc and Doroteja Lešnik Mugnaioni


COMMUNITY HEALTH SERVICE
shouting
BLACKMAILING
taboos
not allowing treatment
PATIENTS' RIGHTS
PSYCHOLOGICAL VIOLENCE
dignity
RIGHTS OF OLDER PEOPLE
disrespect
PHYSICAL VIOLENCE
NEGLECT
threats
OLDER PEOPLE'S ASSOCIATIONS
breaks
SOCIAL WORK CENTRE
we believe
isolation
taking
money
insulting
taking measures
humiliation
VIOLENCE AGAINST PATIENTS AND RESIDENTS
ignoring
ECONOMIC VIOLENCE
bruises
PROTOCOLS FOR DEALING WITH VIOLENCE
SEXUAL VIOLENCE
social problem
rape
REPORTING
POLICE
ridiculing
vulnerability
patronizing
undervaluation

Introduction

During last 20 years there has been relatively a lot of discussion in health care and social protection about violence against healthcare professionals, particularly by the patients, which is increasing according to national and international research, but we **rarely talk** about the opposite direction. That refers to v**iolence against patients in health institutions or residents in social protection institutions** by experts who are treating and taking care of sick and older persons and other vulnerable people.

There is a lot of violence behind the four walls of "safe home environment", but we should also highlight the violence, occurring where it should definitely not – in health and social protection institutions. This is the most hidden area, the least researched and with the fewest instructions for employees how to act in cases of such violence.

Violence against patients/residents can be classified in three forms: by another patient/resident, by employees or by a relative or another close person.

Patients/residents rarely decide to report a violent event in the institution as they are often completely dependent on the help by the perpetrator; they can be hurt, threatened, ashamed or embarrassed because of violence. This is particularly true in case of physical and sexual violence, financial abuse, and various threats. They are afraid that the disclosure of violence might result in increased violence or that they will not get appropriate health or other care. Victims often do not talk about the violence because they think nobody will believe them. This is the most common in those vulnerable groups of patients/residents where the difference in the personal and social power in comparison with the institution is the biggest – children, older people and people with special needs. Those people/residents often do not trust that the institution will protect them, they do not know their rights or where to get help.

It is often difficult to recognize **violence against a patient in the health institution or a resident in a social protection institution by the employees** as it is often hidden, without witnesses or even accepted as a normal way of communication or behaviour. The perceived forms of violence are as follows: psychological (ignoring, bullying, mocking, humiliating…), verbal (harsh words, abusive speech, insulting, silence…), physical (bruises, unexplained breaks…), economic (thefts of money, bank cards, extortion of money…), and sexual violence (implying sexuality, inappropriate jokes, groping, rape…). Cases of violent and rough handling are perceived also in activities such as: maintenance of personal hygiene, moving, changing of position, feeding… There are also cases when

> *"When released, a patient informs the head of nursing that the nurse was not behaving professionally. During the first treatment, he sat on her bed and touched her knee. During the transport to the operating theatre, he said that he would prefer to take her somewhere else and not to the operation. He was coming to the room without any reason, his comments were too personal, entering her personal, intimate space. The head of nursing warned the nurse that his behaviour was inappropriate. In spite of that, he later sent the patient a friend request on FB, which means that he abused her personal details. When she was hospitalized again, the head warned the nurse not to go close to the patient. He did not obey the instruction, and he made inappropriate comments immediately when the patient came. That was interrupted by the supervising nurse.*

A patient, addicted to alcohol, comes to the outpatient clinic every 15 minutes, asking for additional medication for withdrawal crisis. The nurse keeps explaining that he cannot get them sooner than in two hours. When the patient comes for the fourth time, the nurse raises her voice and says angrily: "I have told you that you can't get anything now. Just suffer, it's your own fault! Go away, I don't want to see you again."

the patient's or the resident's pain is not relieved appropriately, which is inadmissible.

Violence among patients or residents is an issue which is not discussed enough. There is a lot of undiscovered violence (because of unawareness, healthcare professionals are overburdened…) and even less violence is reported. Only the most serious cases are disclosed, where the conflict or violence escalated to serious verbal or physical or sexual abuse. Violence among the residents in social protection institutions, especially in residential homes for older persons, is even more common than among patients in health institutions. People from different environments and different life stories are forced to live together in a room, living room, dining room although they have not chosen it. Consequently, there is verbal, psychological and physical violence. Economic violence is not rare either, particularly taking money or other personal belongings. Sexual violence should not be forgotten - from sexual harassment to rape. This is the topic, not mentioned in public or media very often, although sexual violence is present, particularly in residential homes for older persons and special social institutions but it is often not perceived or not dealt with appropriately.

The third aspect of violence – **violence caused by relatives** against the patients as well as residents – is increasing. In recent years, social, cultural and personal aspects and risk factors for that phenomenon have been increasing. There is more and more intolerance, social distance, destructive individualism, no will to solve conflicts constructively, irresponsibility to others and to the community; personal, family and social values have changed. Consequences are shown in the relationships to close relatives, mainly to the sick and older ones. Healthcare professionals perceive more and more intolerance, unkind communication, even aggressive behaviour by relatives towards patients and residents, extortion of money, and also scolding, forcing to unwanted activities (for example, forcing to eat, stand up, walk), threats, bullying, blackmailing (e.g. regarding inheritance issues).

Due to longer life and more developed health care the number of people who are in hospitals and in care is increasing, which means that the violence against/among patients and residents in social protection institutions or residential homes for older persons will have to be taken more "seriously", research it systematically, recognize and prevent it and deal with it.

AS THESE ARE THE MOST VULNERABLE SOCIAL GROUPS, THE SOCIETY WITH ITS INSTITUTIONS HOLDS TOTAL RESPONSIBILITY FOR THEM. IT SHOULD BE ADDED THAT ABUSE OCCURS IN INSTITUTIONS ALSO BECAUSE THERE IS NOT ENOUGH STAFF, THEY ARE OVERBURDENED, INAPPROPRIATELY QUALIFIED AND PAID, OR BECAUSE THE MANAGEMENT IS NOT SENSITIVE ENOUGH TO THE VIOLENCE AGAINST PATIENTS/RESIDENTS. CONSIDERING ALL THE ABOVE, **A SYSTEMATIC APPROACH TO SOLVING THIS ISSUE IS ESSENTIAL.**

Recommendations for acting in case of violence against patients in health institutions and residents in social protection institutions

IN CASES OF VIOLENCE AGAINST PATIENTS IN HEALTH INSTITUTIONS OR RESIDENTS IN SOCIAL PROTECTION INSTITUTIONS (HEREINAFTER REFERRED TO AS: THE PATIENTS), ACTION DEPENDS ON SEVERAL FACTORS:

- what injuries the victim suffered and the level of her/his endangerment or endangerment of other people, if any,
- how serious the violent acts are: whether there is serious violence or suspicion of a criminal act is involved, whether it is repeated violence, the number of people involved, total consequences of the violence committed, and others,
- who the perpetrator is (a patient or another resident, a relative, an employee).

A resident complains to the health professional in the residential home for older persons that he is more and more afraid of his son's visits. The son had apparently been blackmailing his father to give him his bank card and PIN so that he would be able to buy him personal items and treats and withdraw money. Father does not want to do that as he has had bad experience with his son who had taken his savings before. He does not know how to protect himself from his son's aggressiveness and blackmailing and at the same time he does not want the relationship with him and his family to deteriorate as they mean a lot to him.

Those factors define the violence and dictate the way of action; whether it could be dealt with internally, within the organisation or the competent institutions or other specialists will have to be included.

Cases of violence against patients, involving **psychological or verbally violent communication** which are **not criminal acts**, are dealt with within the organisation by applying formal and informal procedures and measures, laid down in legislation and internal rules. However, **threatening violence**, directed against physical integrity or inviolability of sexual integrity, financial abuse, neglect, use of illegal constraints, and others, have to be reported and dealt with in cooperation with competent institutions.

Dealing with violence - interventions

When talking about dealing with violence, we talk about the steps of action or interventions. In general, **immediate and process interventions** can be distinguished (Lešnik Mugnaioni, 2022). Their content depends on the seriousness of the act, victim's endangerment and injuries, circumstances, possibility of repetition, and others.

1. **Immediate interventions** aim at stopping the violence, protecting the victim and preventing the repetition of violence. These are measures which are taken immediately when violence is perceived. Such interventions are taken immediately and without delay, following a protocol, defined or agreed in advance. As a rule, they are always the same, irrespective of the type of violence and who the perpetrator is. This particularly applies to violence when the victim's health or life is endangered.
2. That is followed by **process interventions**, where the aspects of dealing with violence, which allows for the adaptation of the system of work and organization to changed circumstances are taken care of and they are preventive. Process interventions monitor the efficiency of adopted measures and sanctions for the perpetrator, cooperate with the competent institutions and better preventive approaches in the organisation are developed on the basis of final evaluation.

> *A resident in the residential home for older persons shares a room with an immobile resident. She behaves in a patronizing way, belittling the roommate. She constantly controls her and makes comments about eating, sleeping, discharging and carrying out various services for her. She often tells her son and daughter about those activities. She also takes photos of her in different situations and sends photos to her relatives. The relatives bring her coffee and other treats as a replacement for such reporting and photographs. The immobile resident tells that to the healthcare professional, she is visibly hurt. She does not want her roommate to interfere with her privacy, life and family. She also complains that she is rude and patronizing. Although immobile, she can still decide about herself and her life and can do a lot of things for herself. She asks healthcare professional to talk to the roommate about the inappropriate behaviour but in a way which will not bring her more trouble.*

Rapid, efficient and systematic taking of measures or interventions is most important in case of threatening violent acts, although it is very common that it is those acts which are the most difficult to be dealt with. As a rule, they refer to crisis events/situations, where decisions have to be taken very quickly, adopt the measures to prevent the violence to be repeated, report the violence to competent bodies, sanction the perpetrator, take the essential precautions, which is very demanding for both, the management as well as for the staff and organisation.

Therefore, it is essential to act preventively and adopt an internal protocol before the violence occurs. The protocol should be detailed and specific, it should define what the employees have to do immediately; what they have to do to protect the victim; what individual measures are and who is responsible for them; how they can help the victim (in terms of health care and psychosocially); who reports the violence to the police /social work centre, etc.

The protocol **has to define interventions separately according to who the perpetrator is – other patients or residents, relatives or employees.** Regardless of the violence diversity, **general interventions always remain the same.** Dealing with violence will definitely be appropriate and efficient if those interventions are followed **and the measures focus on the victims and their protection.**

GUIDELINES FOR IMMEDIATE INTERVENTIONS IN CASE OF THREATENING VIOLENCE AGAINST PATIENTS OR RESIDENTS

- **In case threatening violence against patients or residents is perceived, measures, defined in the protocol of the organisation, legislation, competent institutions, have to be taken immediately.**
- **Security service has to be called and/or the violence has to be reported to the police.**
- **The victim has to be protected and provided with medical and psychosocial help.**
- **The management of the institution has to be informed.**
- **The victim must not be confronted with the perpetrator, as this could cause additional harm to the victim, distress and secondary victimisation.**
- **Separate interviews have to be conducted with all the involved (victim, perpetrator and observers/witnesses).**
- **The management has to take (temporary) precautions immediately in order to prevent the contact of the perpetrator with the victim. This prevents the violence to be repeated. If needed, also other patients/ residents have to be protected.**
- **Relatives of those involved in the violence, if they were not the perpetrators, have to be informed about the violence.**
- **The content of the interviews and other perceptions have to be documented, evidence, if any, has to be protected.**

"Healthcare professionals in a residential home for older persons perceive accusations by a daughter and abusive speech that her mother's care is too expensive, and she will have to make more effort for the benefit of everybody and not think only about herself. She reproached her angrily and loudly that she could put on her shoes herself, wash and comb her hair, clip her nails as she has time all day long and does not do anything. Mother tried to tell her that she is not able to do that herself and that the daughter should cover the costs from savings. The relative was relentless, repeating more and more angrily that those services were too expensive and completely unnecessary. "Make more effort, do not rely only on others for help, you are not as powerless as you are pretending to be! What will happen when you have spent all your savings? I am not going to pay for your care from my salary!"

GUIDELINES FOR PROCESS INTERVENTIONS IN CASE OF THREATENING VIOLENCE AGAINST PATIENTS OR RESIDENTS

- **The management takes also other organisational measures, which ensure greater control of interpersonal interactions and more rapid perception of eventual violence against other patients or residents.**
- **The management sets up a team from different areas of expertise who takes the necessary measures, evaluates the situation and plans the preventive activities. It is recommended for the management of the organisation to be involved in the activity of the team at least in the beginning. Also, later the management has to be promptly informed about all the team decisions/ activities.**
- **In order to clarify the circumstances, interviews have to be conducted also with other patients or residents who witnessed violent event or in contact with the perpetrator.**
- **This applies particularly to cases of violence in residential homes for older persons where residents can be exposed to long-term violence. It has to be discussed with all residents in confidence and with respect how they feel, their relationships with other residents, their fears, if any, unpleasant experience in communication with others, experience with violence, and other.**
- **Also, employees have to be asked whether they have perceived anything unusual or disputable, but they did not associate that with violence.**
- **All the information and perceptions have to be documented.**

> *"In an emergency psychiatric clinic, a patient with acute psychosis refuses to be hospitalized. He does not trust the healthcare professionals, he accuses them that they just want to harm him and lock him, that they do not believe him, etc. De-escalation techniques were not successful. The admission doctor decides to hospitalize the patient against his will, and there are five nurses helping him. When the patient is informed that he would be hospitalised and that he had to go to the ward, he becomes heteroaggressive. The doctor on duty decides for physical restraint with belts. The nurses use expert self-protective grip for physical restraining of the patient and the patient experiences that as physical violence against him, although in this case, use of physical force is technically justified.*

- **When considered appropriate, the competent social work centre has to be informed (especially in case of violence by relatives/ guardians).**
- **The patients or residents have to be empowered who they can tell if anything unpleasant or inadmissible happens and who can help them.**
- **The management has to inform also relatives of other patients or residents about preventive activities so that they pay attention to any signs of violence, expressed by their relatives.**
- **The events have to be discussed openly with the employees and, if needed, appropriate psychosocial help, supervision and support have to be provided.**

> *A patient informs the head of nursing that the nurse was behaving inappropriately as she removed the bell after a few calls, and later, during the night, when the patient felt very bad and had problems, she could not ring the bell and ask for help. Other patients in the room did have a bell. When the patient complained the next day, the nurse shouted at her and did not replace wet bed linen. The situation also repeated the following night.*

- **In subsequent activities the management should intentionally create the climate of trust and psychological safety for the employees so that they are encouraged to communicate openly about the perception of violence.**
- **A system of recording the occurrence of violence among patients/ residents – relatives – employees have to be set up.**
- **The recorded cases have to be analysed and included in the system of quality assurance and safety at work in the institution.**

> *It is stuffy and hot in the waiting room and a young patient opens the window. An older patient disagrees and closes the window, saying that there is a draft. After some time, the younger patient opens all the windows, which triggers a conflict – the older patient says the younger one is rude and selfish, does not think about the others who are ill and should not sit in the draft. When he goes to the windows to close them, the younger patient jumps and physically prevents it. He also scolds and swears loudly. There is some pushing, the older patient falls, injuring himself.*

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HOW WOULD YOU REACT ...?

1. A patient complains that one of the nurses was very rude and rough. He is afraid to ask her anything because he does not want her to get angry and scold him again. What do you do?

a) You promise him to solve the situation. Tell the colleague about the complaint and demand from her to communicate with the patients professionally and in no way aggressively. You tell her that you will inform the head of nursing if somebody else says that she behaved inappropriately.

b) You ask the patient whether it was a one-off event or she has been aggressive for several times. You also ask what words she used and whether she was physically rough as well. Inform the superior about the perception. Follow the institution protocol in further steps and take immediate intervention.

c) You don't tell anyone about the perception and try to find yourself first whether the patient's complaint is justified. During the following days carefully observe the colleague at work and communication with patients.

2. The objective of immediate interventions is:

a) by immediate taking action stop the violence, protect the victim (and other people present) and prevent repetition of the violence.

b) calm the victim and direct him/her to an expert for psychosocial help.

c) sanction the perpetrator as soon as possible and thus prevent him/her from being violent again.

3. A residential home for older persons does not have an agreement/protocol for dealing with cases of violence among residents. Do you consider this good practice?

a) Yes, because it is better not to accentuate such situations with protocols and bureaucracy. It is better to deal with such situations discreetly and not make a big deal about it.

b) Yes, there are so few cases that such protocols do not make sense. If something happens, the management should convene a meeting, the solution is discussed and then the management decides what to do.

c) No, it is not good. When violence is perceived, there is usually a lot of fear, dilemmas, there may be injuries, sometimes external institutions have to be included and without a protocol, agreed in advance, it is more difficult to take all the necessary steps professionally and efficiently in such crisis situations.

Key: 1.b), 2.a), 3.c)

Hint: if any of the correct answers does not make sense for you, find additional explanations in this chapter.

06 WORKING GROUP FOR NON-VIOLENCE IN NURSING AND MIDWIFERY: FOR LESS VIOLENCE FOR TWO DECADES

Darinka Klemenc and Irena Špela Cvetežar

When the **Working group for non-violence in nursing and midwifery** (hereinafter referred to as: the Working Group) was founded more than two decades ago (20 December 2000) the view of the violence in health care, particularly in nursing and midwifery, was very different from today. The issue of workplace violence was not discussed, it was not even perceived well. There were strong stereotypes of the figure of a nurse and midwife as the doctor's assistant, hard-working, devoted comforter for patients and it was not rare that the nurse was exposed also as a sex symbol in eyes of both, patients as well as colleagues. It was not desirable to expose the issue of violence in health care, practically a forbidden and taboo topic among nurses as well as among colleagues and superiors. The issue was not recognized as something that should be changed in the wider social environment either.

Therefore, **public disclosure of the presence of violence at the workplaces of nurses and midwives** was a very important step in the development of the profession, the topic was dealt with the help of an extensive national research, public presentation and a printed publication, which was the basis for further steps, action and development of the field. We were the first occupational group in the country and one of the rare ones which openly discussed that pressing issue, looking for the solutions to improve working conditions and more respect for nursing and midwifery professionals in health institutions. Other occupational groups followed only years after.

First steps, which had proved to be most essential, were in the **field of education**. First, it was targeted at our own professional group. There were a lot of trainings organised in regional professional associations and professional sections, active within The Nurses and Midwives Association of Slovenia. They included not only theoretical knowledge but also cases from practice and role play: *(Beyond all boundaries)* on recognizing and helping women, victims of domestic violence in the field of gynaecology; a short film, entitled *A pulse of concurrency*, raising awareness of violent communication in the light of our own mistakes in health institutions. Trainings and workshops for employees were organized in numerous health institutions and residential homes for older persons.

It is impossible to cover all the **Working Group activities** in this paper as it has been empowering, "upsetting", warning, educating, researching… for more than two decades. The work includes numerous campaigns, dealing with sensitive topics, pointing out ethical and moral aspects of violence in health care and wider, eliminating taboos and walls of silence, which proves self-reflection, professionalism, maturity and internal professional solidarity of nursing and midwifery professionals. Since its establishment the Working Group has been striving for systematic work in several areas: awareness raising, educating, preventing, researching, dealing with cases of violence, promoting non-violence, organizing notable campaigns as a way of helping the individual, profession and society. It has been adapting and developing its activities according to the needs of the members, profession, management, policy and social changes, dictated by the space and time. (Cvetežar, Klemenc, Lešnik Mugnaioni 2017)

A decision by The Nurses and Midwives Association of Slovenia that the contents regarding preventing violence are to be included in the **mandatory topics for keeping the nursing and midwifery licence**, namely within the field of health care legislation and professional ethics, was realized on the initiative by the Working Group. We regard this as important contribution

to raising awareness among our own colleagues in this field. Topics about violence were presented at numerous symposia and congresses within our professional association. The topic was interesting also for international promotion in the field of nursing and midwifery at national and international congresses in several countries, also members of ICN - International Council of Nurses or EFN - European Federation of Nurses Associations.

The Working Group intensified its activities during **16 days of international activism of combating violence against women (25 November - 10 December)**. In cooperation with non-governmental organisations, particularly Association SOS Helpline for Women and Children - victims of violence, different events and actions were organised almost every year. Among others, numerous protocols, recommendations, posters, brochures and other materials, aimed at empowering the members, were made. Regional professional associations, professional sections, educational and other institutions as well as numerous experts, also from other professions, participated in those activities. We often joined campaigns, organised by non-governmental organisations (e.g., 24-hour duty at emergency clinics – with stands in five Slovenian hospitals…). The Day of open door was mostly organised at The Nurses and Midwives Association of Slovenia registered office, where the members were provided with individual counselling. Also, various discussions and round tables were organized about workplace violence, domestic violence, sexual harassment, childabuse. We have worked together with experts (also international) from health care, law, social protection, non-governmental organisations, police and trade unions. An interesting topic was "Violence against pregnant women". We have also discussed conflict solving and de-escalation techniques. We organised a round table "Visits by Slovenian politicians in Slovenian maternity hospitals during Christmas", where we were successful to warn about inappropriate practice of visiting women who have just given birth by politicians. We also publicly warned about critical conditions during the epidemics. An international secret sign for help in case of domestic violence was also presented in our newsletter Utrip.

During COVID-19 pandemic we continued educating and supporting our members, as new challenges for both, the patients and healthcare professionals, occurred from the aspect of preventing and managing violence. Training modes changed, knowledge was transferred online (topics dealt with: conflict solving, de-escalation techniques, bullying, the importance of communication in crisis, round table "Say NO to violence", support for members of our professional association with an open telephone line). We paid particular attention to ethical aspects of media reporting in the light of patient rights protection and showing patients when they are most vulnerable – in intensive care in hospitals. Those images were discomforting for people, they triggered fear and distress. We often requested from all the involved (institutions, media) to show such situations in a humane way. Recommendations for the management of institutions, entitled "*The importance of communication in health and social protection institutions*" were drafted for that purpose. We requested the competent institutions in the field of social protection, police, health care, politics and others to ethically protect the rights and dignity of the weaker, particularly children, older people and women.

An important field of work is also **research. The first research** (1999–2000) was done within two diploma theses (Klemenc, Planinšek, mentor Pahor) and presented at the Nurses and Midwives Association Ljubljana. It interrupted 100 years of silence about the violence at workplaces of nurses and midwives. The research proved that the problem does exist, and we managed to start changing the attitude to the issue concerned. That was contributed also by intensive media reporting as the topic was new, interesting and current. Further research was conducted in different health institutions and/or professional fields (endoscopy, gynaecology, psychiatry, management, University Medical Centre Ljubljana). One of challenging research projects included also interviewing users of gynaecologic clinics. In 2011 the Working Group conducted the **second national research** concerning workplace violence in nursing and midwifery and the results were presented also to the wider public. Students of nursing and midwifery as well as other occupations were encouraged and supported in the research, particularly when writing graduate or post-graduate diploma theses or when looking for the materials for that purpose.

During the entire period we have been publishing **specialist content** in different publications, also in Obzornik zdravstvene nege (Nursing Journal) (mainly in the topical issue after the second national research in 2012), in newsletter Utrip, newspapers and magazines, in the bulletin, issued by the Nursing Trade Union of Slovenia, and elsewhere. On special occasions we were drafting press releases and participated in television and radio programmes, interviews... We have been actively involved in **creating guidelines, recommendations and protocols, aimed at preventing different types of violence** with the participation of other actors: Association SOS Helpline for Women and Children – victims of violence, Ministry of Health, Ministry of Labour, Family, Social Affairs and Equal Opportunities, Medical Chamber, Slovenian Academy of Sciences and Arts, Slovenian Federation of Pensioners' Organisation...). The Working Group translated and submitted to the members some documents concerning violence, submitted by international associations of nurses. We have also been publishing articles for the needs of preserving the history of nursing and midwifery (annual Almanac, a book, issued at the 90th anniversary of organised nursing in Slovenia), and others.

The Working Group has always been active also in the field of **publishing and communication with professional and general public**. The first leaflet on non-violence was followed by numerous other materials, covering different issues. There have been a lot of challenges concerning a special, big travelling poster which could not be folded or rolled. When it had been framed, it got the name: "Door". It was travelling to health institutions; among others it was placed in the main lobby of University Medical Centre Ljubljana. When (important) employees asked when it would be removed, the answer was when it would not disturb anyone anymore. That happened after six months.

We have been following current social affairs, and responded with our views, when it was considered necessary (for example support to #Metoo movement), support the efforts by female students to stop sexual harassment in Slovenian universities. We have informed and empowered with our documents, research and protocols nurses and midwives abroad (Serbia, Croatia, North Macedonia, Bosnia and Herzegovina, Kosovo).

In the period from 2009 to 2014 the Working Group was conducting **counselling in person or by telephone** in more than 50 reported individual or group cases of violence. Personal counselling was carried out by an external expert while members of the Working Group, several time also a lawyer, were participating if needed. In addition to individual counselling, other specialist services (trade union, police, social service, non-governmental organizations…) had to be involved in solving and helping in individual cases as multiprofessional approach was essential. The Working Group considers this as one of the most demanding areas of its activity. Due to the complexity, the Working Group ceased to be systematically involved in individual cases after some years, as counselling was beyond its capabilities.

We responded also in cases when **professional image of a nurse was shown inappropriately**, particularly in media. Among others, we reacted in case of Slovenian TV series »Our Little Clinic« where the character of nurse Franja was shown in an insulting way. We reacted also in case of inappropriate web posts, comments, blogs which were showing the work and image of a nurse in an insulting way.

Activities of the Working group prove that since the foundation we have been striving for monitoring and developing this demanding area and adapting to changes in the society and profession: scientific progress, visibility and reputation of the professional group in the society, ever increasing needs for education and training, changing values – professional, personal, social, requiring new approaches to work, particularly with younger generations. In addition, expectations of the members and management of The Nurses and Midwives Association of Slovenia, but also public are increasing and work is more and more demanding. Changed social and safety conditions require a lot of knowledge and skills, also motivation in order to be able to cope with complex challenges of the present and the future. New colleagues and other experts would be required for systematic and successful operation. However, the Working Group has not lost the enthusiasm; we believe that in the future we will contribute a lot of useful things. The profession, the colleagues and the public expect this.

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REVIEWS

Prof. Aleksandra Kanjuo Mrčela

Violence is a social problem with universal dimensions. Throughout the entire history of humankind it has always been a part of relationships among people and we are still dealing with it today. The occurrence of violence is associated with the social order and distribution of social power. (Non)acceptance of violence is the result of civilisation changes. When sensitivity to certain forms of violence increases and they are disapproved, eliminated and sanctioned (e.g., physical violence), other forms appear (e.g., cyber violence or new forms of economic violence). Throughout history, not enough has changed regarding some aspects of violence which have far-reaching consequences for major parts of the society (and trigger other forms of violence), such as systemic violence – violence by an inappropriate political, economic and social system, which does not ensure decent life for everybody.

It is very important that violence is dealt with and that the general public and people with minor or major responsibilities within social and state institutions are more and more aware that violence has to be eliminated. Therefore, publication of the Handbook for dealing with violence in health and social protection institutions is appreciated. It targets the professional community which is exposed when dealing with violence. Members of that community have very demanding and physically and psychologically tiring jobs with an extremely vulnerable population and as such they can be potential victims or perpetrators of violence. For the majority of professionals in health and social protection institutions the choice of career is based on altruism and helping others. However, instructions on how to function and keep the work environment violence free are more than welcome and needed. They help in professional socialisation, training the most suitable ways of communication, encouraging positive social changes in human relations and creating working and life environments based on human dignity standards.

The structure of the Handbook is excellent, encouraging the reader to actively use it. The Introduction is followed by four main topics. Three of them discuss the forms of violence (at the workplace, in the family, and against patients and residents in health and social protection institutions) while the fourth part describes the work done by the Working Group for non-violence in nursing and midwifery during the last two decades, which is an important proof of the significance of long-term and persistent dealing with the issue of eliminating violence.

The Handbook presents various forms and aspects of violence excellently. The theoretical insights and raising awareness about the causes, dimensions and consequences of violence are combined very well with practical advice, instructions and recommendations for every-day combating against violence. The text is informative and formative. It successfully reflects the most recent findings about the sources of social power and powerlessness which encourage or block violence in society. The Handbook includes the knowledge, required by the participants in demanding and challenging violence relations (victims, perpetrators, witnesses), informs and gives advice about their responsibility in preventing, recognizing, dealing with and solving violence. It correctly opposes individualisation and "privatisation" of violence and perceives violence as a social problem, abuse of power which requires public, institutionalised and comprehensive treatment with individual responsibility of those involved. The examples, sources and materials contribute to the comprehensive presentation of the topic.

Although it is mainly targeted at the professional community in health and social protection institutions, the Handbook is an excellent and necessary reading also for general public. The content is interesting and useful also for other institutions and environments. We would like to congratulate the editors and authors for their important contribution to the essential discussion about the best ways of eliminating violence in our environment.

Katja Zabukovec Kerin,
president of the Association for Nonviolent Communication

I am welcoming the Handbook by the valued authors who have been active in the field of preventing and eliminating violence for decades. This time, they are dealing with a topic which is an important issue for the employees in health and social protection institutions as well as for everybody who works with people. We are living in times when certain forms of violence are so widely socially permitted in society and it seems that people believe that by using violence they could achieve what they want. People try to take care for themselves, sometimes also for their close ones, by violence as they have learnt that it is a fast track to the goal, often without any unpleasant consequences. They are sure that violence works. However, there are also people who act inappropriately or violently because of an illness or injury. They cannot or they are not able to act differently, although they may endanger themselves and others. So, how to ensure that all patients and clients are treated correctly, how to establish zero tolerance to all forms of violence against them and at the same time ensure the safety of employees and all others who come to our institutions and programmes? This is a very challenging task and first we have to sincerely ask what is happening among people and how it affects us – particularly our beliefs of the world in which we live. People do not come to our institutions as blank sheets of paper, their behaviour is directed by their experience and their interpretation thereof. If they are sure that the environment is dangerous, they adapt their behaviour in order to protect themselves from any attacks. As they feel endangered and scared, they are becoming more and more intolerant and aggressive, even violent. And the vicious circle is complete.

That is why this Handbook has such an important role - it highlights the problems, challenges us with short questions to test our knowledge and beliefs and then offers solutions that work. It includes specific examples which show that it is not only us who encounter violence, but it is a widespread problem which has to be addressed widely. The authors describe de-escalation and other communication techniques, aimed at decreasing the dangers of violence, which anyone can learn to use, and place them appropriately into the wider social context. This does not give the sense that violence would not be happening if we could communicate better. They do not only describe different forms of violence but offer information on how to address, prevent and stop violence. Power and role of an individual to change a community for the better are emphasised, and it is pointed out that systemic solutions and proactive approach are required. You will get a lot of information on how to communicate and specific instruction will empower and motivate you to set boundaries to inappropriate, aggressive behaviour and violence.

The Handbook reminds us that employees in health care and social protection have a lot of power when intervening into the life of our clients and patients. That power has to be used consistently with the highest ethical and human standards. This can contribute to creating a community where people will have different experiences and start to believe that violence does not work and they will start solving problems in a different way. And it starts - as always – with each of us individually.

notes ...

It is impossible to cover all the activities of the Working Group for non-violence in nursing and midwifery at The Nurses and Midwives Association of Slovenia as it has been empowering, "upsetting", warning, educating, researching... since 2000. Its work includes numerous campaigns, dealing with sensitive topics, pointing out ethical and moral aspects of violence in health care and wider, eliminating taboos and walls of silence.

The Handbook focuses on dealing with different types of violence in health and social protection institutions. It is based on the premise that the attitude to violence and empathy to the victim are the most important, and the skills, knowledge and protocols come only after that.

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