Editorial

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How can you treat someone who hit you yesterday with dignity and respect?

We know that relationships are central to recovery (e.g. Perkins and Dilks, 1992; Perkins and Repper, 1996; Russinova, 1999; Repper and Perkins, 2003). Gilburt et al. (2008) in research into people's experience of psychiatric hospital admission showed that:

> Contrary to previous research on patients' experiences, the themes that predominated related to the emotional not physical environment in which they stayed […] relationships form the core of service users' experience of psychiatric hospital admission (p. 8).

Wyder et al. (2013) explored the factors that facilitated or hindered recovery and emphasised the central importance of relationships and in particular shared humanity. Healing was hindered where staff were seen as distant, not caring, unreliable, having no time to listen, where communication was poor, and people felt they were treated as sub-human, a criminal or infantilised. On the other hand, people felt respected, supported and secure, and their confidence increased, where staff were perceived as reliable, attentive, trustworthy, showing concern, interested in their progress, and where people felt they were treated as a person, a fellow human being.

Relationships with mental health workers may not be the most important in a person's life – relationships with friends, family, peers are central to the well-being of all of us – but they can be particularly powerful for good or ill. If the professionals who are supposed to be helping you do not understand what you are going through, do not believe in your possibilities, then what hope can there be?

The relationships that foster the hope that is so central to recovery are ones in which people:

- really listen to us;

- accept and understand our lives and experiences;

- understand how things look from where we sit;

- appreciate the devastating impact of what has happened;

- are prepared to be with us in our distress;

- value us for who and what we are;

- believe in our worth and possibilities; and

- help us get through setbacks and disappointments: learn and get stronger because of them (see Perkins and Repper, 1996; Russinova, 1999; Repper and Perkins, 2003).

However, there will be times when it is very difficult for mental health workers – or anyone else – to do these things: how do you value someone who hit or abused you yesterday? While it is hard, at a personal level, to continue to respect and believe in someone who has hit you, it is sometimes harder to process personal insults and verbal abuse.

Much aggression and "inappropriate behaviour" may be a product of the way in which people are treated within mental health system (see Goffman, 1961; Perkins and Repper, 2017): indeed they may be a wholly understandable and "appropriate" way of responding to the dehumanisation, infantilisation, lack of attention and care, and coercion that characterise too

many people's experience of using services. Deegan (1990) has described this phenomenon as "spirit breaking":

> The experience of spirit breaking occurs when we are humiliated and made to feel less than human, in which our will to live is deeply shaken and broken, in which our hopes are shattered (p. 2).

If we, as staff members, did things differently, then undoubtedly people would react differently. It is certainly the case that the more we understand how things look from the perspective of the person using our services, the more we can prevent aggression, but some anger, abuse and violence may inevitably occur.

People come to mental health services when they are at their most disturbed and distressed state. Sometimes you have difficulty in expressing yourself and it is difficult for others to understand what you are going through. You may have used drugs or alcohol to numb your pain. You may have experienced trauma and abuse, broken relationships, debt, homelessness, loss of a job and the death of someone you love. To be diagnosed with mental health problems, and all that these mean in our society might be considered a form of bereavement (Repper and Perkins, 2003).

Spaniol *et al.* (1977) talk of a series of losses associated with a diagnosis of mental health problems: loss of a sense of self, loss of power, loss of meaning and loss of hope. To these we might add loss of all the "privileges of sanity" which include being believed by others rather than having one's utterances taken as a symptom of mental health problems. Anger is a normal reaction to loss. It is likely that such anger will be expressed to those around you in the form of aggression and, maybe, violence:

> Anger follows in the footsteps of despair. Anger at the illness which has so devastated us. Anger at the helping system that may have failed […] Anger at society and its attitudes. Anger at God for not taking better care of us. Anger at parents and friends for not being more helpful. Anger at our self for not being able to manage (Spaniol and Koehler, 1994, p. 8).

Anger is a normal part of the grieving process (Kubler-Ross, 1969) and of the process of recovery:

> Our anger is a necessary and important part of the process. Anger is a stimulus to recovery. It is normal and natural (Spaniol and Koehler, 1994, p. 8).

Sometimes this anger and associated aggression will be expressed towards mental health workers because we are the ones who are with people when they are most distressed and find it impossible to express themselves clearly and calmly. Sometimes we will bear the brunt of people's anger and aggression at things that have happened to them outside our services or because drugs and alcohol deprive them of control. Sometimes we will inadvertently cause anger and aggression because we have not understood someone, or when a throw away remark hits a raw nerve. We cannot get it right all of the time.

Sometimes people may express their anger towards us because of what we represent. It is not unreasonable for someone to feel resentful because we represent what the person has lost or has never had. One of us (RP) remembers well a young man who stormed into her office, absolutely furious and screamed "You don't understand, you are all paradise people here. You come to your job, in your car, from your home. It's not fair – what did you do to deserve all of that when I have got nothing?"

Sometimes we are on the receiving end of people's anger precisely because we have provided a safe space in which people can heal: where people feel safe enough to express the range of emotions associated with the grieving process. To be able to accommodate these emotions is important in the recovery process. One young man described to us how he had felt he had a really good relationship with a member of staff: felt able to talk to him, confide in him and express how he was feeling. On one occasion, he was feeling very angry and frustrated and took this out on the staff member with whom he felt safe. He then described how "let down" and "unsafe" he felt when, after this, his relationship with the trusted staff member changed: the worker became distant, started treating him like a "naughty child": he had lost the safe space he so badly needed to accommodate what had happened and grow beyond it. How many of us can say that we have never taken out our anger and frustration on those who we trust – the people who are close to us – secure in the knowledge that they will still be there for us?

Mental health workers are human. Just like the people who use services, we will be wounded when we are abused, attacked, undermined and unappreciated. If we are to be there for people when they are at their most distressed, if we are to provide the safe space in which people can grow, then we need to think about how we can look after ourselves. The NHS "zero tolerance" campaign and the ubiquitous signs that adorn health facilities simply will not cut it … and have a hollow ring in mental health services where many staff have experienced abuse and aggression.

Perhaps we need to start in our training. We are not aware of any professional training that seriously addresses the likelihood that we will be abused, and even attacked, in the course of our work. That addresses how this may make us feel, how we can understand why it has happened and how we can accommodate it and move on: our own "journey of recovery" in the face of a distressing or traumatic event. If we do not address these issues as part of our core relationship skills we will never be able to fulfil the NHS values of treating everyone with compassion, respect and dignity required of us by the NHS Constitution (2015):

> We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need.

> We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits (Department of Health and Social Care, 2015, p. 5).

However, we cannot achieve these things unless we also think about how we can look after ourselves at work. This must go beyond the standard things about what we must do provided by "Prevention and Management of Violence and Aggression" and related training. It must include how we look after each other when we have experienced distressing abuse or violence at work. How we enable each other to continue to foster those compassionate, respectful, hope-inspiring relationships with those people using services who are at times abusive and aggressive.

Staff teams are usually pretty good at looking after each other in the immediate aftermath of violence or more serious aggression, although we may be less good at noticing "less serious" abuse that can be just as wounding. We are also encouraged to engage in staff "debriefing" sessions and formal staff counselling is available, although this does not usually happen immediately and the person is expected to go back to work in the meantime.

We are less good at "debriefing" that involves the person who was abusive or aggressive (or indeed other people using the service who witnessed what happened). Typically, speaking with the person afterwards involves telling them that their behaviour was unacceptable rather than seeking to explore their feelings and perceptions about what happened: trying to see things from the perspective of the person who was abusive/aggressive as well as the mental health worker. If we do not consider the person who has been aggressive, this is likely to make them feel unheard, misunderstood, infantilised and criminalised – precisely those things that hinder recovery (Wyder *et al.*, 2013). It will mitigate against the formation of a respectful, compassionate, hope-inspiring relationship; further alienate the person from services; and as a consequence increase the likelihood of further abuse and aggression.

We are also less good at thinking about how we can grow beyond what has happened and resume our relationships with people using the service. As one Deputy ward manager said to us: "Everyone was great at the time, but when I came in the next morning, it was as if nothing had happened. I was really wary of speaking to the patient again, but I was just expected to get on with it. Part of the job!"

How might we be able to support staff who have been abused or attacked to resume their work and relationship with the person who has been aggressive/abusive towards them?

In the immediate aftermath, maybe we have something to learn from London Underground. Between 2000 and 2010, 643 people attempted suicide on the Underground[1]. This is extremely traumatic for the train driver who can do nothing to avert the tragedy other than apply the brakes and hope. As well as formal staff counselling, London Underground provides a helpline that drivers can call and, most importantly, a peer run "Trauma Support Group". Volunteers from among train drivers who had themselves and similar experiences receive three days of intensive

training and are able to provide immediate help to a colleague who has had someone jump in from of their train:

> We chatted, and the more I talked about what had happened the more I felt relaxed. T made all the difference that I was talking to someone who completely understood what I'd been through (Guardian Society, 2000, p. 1).

But what about going back to work with the person who has abused you? Perhaps the most important thing is that it should be routine to make an explicit plan to assist both the staff member and the person who has abused them. A facilitated "debriefing" where both staff member and the person who abused them could share what had happened from each other's perspective and how they felt. In the spirit of mutual understanding and the shared humanity that is so central for recovery facilitating relationships (Wyder *et al.*, 2013), it is important in this that the perspective and feelings of both staff member and the person who abused them are given equal weight and that each describe their own experiences. Rigid formulae for such interactions are probably not helpful, but perhaps the three key strategies that Boud *et al.* (1985) suggest for creating a supportive supervisory environment might be useful. They could provide a useful framework for reflection and learning both increasing mutual understanding and finding a way forward for both parties:

1. Exploration: the staff member and the person using services recounting their experiences in some detail, including their associated feelings and thoughts. It is important that the facilitator encourage both the member of staff and the person using services to speak only of their own experience rather than blaming the attributing motivations to the other. For example, "You were treating me like a child" might be reframed as "I felt you were treating me like a child". The facilitator might identify key common themes and divergences from the two accounts and beliefs that may have influenced them.

2. Conceptualising: this may naturally follow from the process of exploration, but here both staff member and person who has abused them are encouraged to step back from the experience, develop new ideas and consider alternative constructions of the situation. This would include the facilitator identifying and rectifying misunderstandings on the part of both the staff member and the person using services to achieve a greater mutual understanding.

3. Planning: supporting the staff member and person using services to work out a way forward and continue to work together.

Such a process does not replace individual support for the staff member, and the person who abused them. Clearly, it cannot be conducted in the heat of the moment and may not be a one off exercise: it may be necessary to go back and review with both parties how the plans are working. It must essentially be a supportive process for both parties and almost certainly needs facilitation to ensure that the perspectives of both the staff member and the person using services are both heard and heeded. Such facilitation has proved valuable in the development of effective Joint Crisis Plans (see Henderson *et al.*, 2004). The facilitator might be someone external to the team, or someone from another discipline within the multi-disciplinary team. It may be necessary for the facilitator to speak with each party separately before bringing them together. Not only would such a process support the re-establishment of relationships, it could also increase mutual understanding more generally and inform shared safety planning.

Maybe also we should return to the "zero tolerance" of violence signs and think about how they might be worded in a manner that is more understanding and supportive of the anger and frustrations of those using mental health services. When we visited a state hospital in Arizona, we saw a different sort of sign. It read "We understand that people may, at times feel angry and frustrated. If you feel like this, please talk to a member of staff. We want to make sure everyone is safe, so we cannot tolerate violence and will prosecute offenders".

Hope-inspiring relationships that are founded on compassion, dignity and respect and recognise our common humanity are central to recovery. But maybe we have paid too little attention to making these a reality for everyone who uses mental health services. Treating someone who is abusive and aggressive with dignity, respect and compassion is very difficult: it is probably the greatest challenge facing mental health workers – especially those working in inpatient settings.

If we are to achieve this enormous task we need to think more about how we prepare and support staff as a matter of routine. If we do not, then not only will our sickness rates and burn-out soar, but staff will inevitably distance themselves from those they consider to behave in an unacceptable and aggressive manner. This can only increase the destructive "them" and "us" barriers that result in relationships that are detrimental to the recovery of those who use services and increase abuse and aggression.

Note

1. See https://en.wikipedia.org/wiki/Suicide_on_the_London_Underground#Prevalence

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