

Chapter 15

Warning – this Job Contains Strong Language and Adult Themes: Do Nurses Require Thick Skins and Broad Shoulders to Deal with Encounters Involving Swearing?

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Introduction

Swearing is used to express deep emotional feelings so it is not surprising that nurses encounter it because they connect with people at their most vulnerable. Perhaps more surprising is the frequency with which nurses are the target. This chapter will explore the complexities of the offensiveness of bad language in the workplace, whether nurses would benefit from becoming “thick skinned and broad shouldered” to counter the impact, or if some other method might more successfully deal with the emotional effect and assist them to cope with this sometimes “extreme behaviour with presence and attunement” (Delaney 2009a).

Swearing is a complex issue and an understanding of its causes and effects will assist nurses to deal with it. Three kinds of factors affect swearing: neurological (including the cerebral cortex, which governs speech comprehension and production, and subcortical systems, which regulate emotional reactions); sociocultural (including gender, cultural background, taboo, law and etiquette and degree of formality); and psychological (including age, coping style, religiosity and moral reasoning) (Jay 1999).

Swearing as a research topic has been largely ignored by academics and has not been discussed in the nursing context, despite the insight to be provided into “discourses of power and gender, social, group formation and maintenance, the acquisition of linguistic competence in young children, and . . . psychological and neurological disorders” (Burns 2008: 61). Even rarer is discussion of the positive aspects of swearing, or its impact on the victims.

Definition

Swearing will here be defined, following and building on Andersson and Trudgill’s (1990) definition of swearing, as those words which: (a) refer to something that is

taboo, offensive, impolite, or forbidden in the culture; (b) can be used to express strong emotions, most usually of anger; (c) may evoke strong emotions, most usually of anger or anxiety; (d) include the strongest and most offensive words in a culture – stronger than slang and colloquial language; and (e) may be used also in a humorous way and can be a marker of group identity.

Discussion of swearing invariably involves the concept of taboo: the greater its potential to offend, the more likely is a word to be considered a swearword (Beers Fägersten 2000). Some words are deemed offensive precisely because they breach taboos – “norms whose violation can be expected to provoke inflexible, disgust-related responses” (Gutierrez and Giner-Sorolla 2007). Freud (1919) understood taboo as a conscious external prohibition against the fulfilment of powerful unconscious desires, and probably the earliest form of conscience. According to the psychoanalytic perspective, offensive words refer to parts of the body, secretions or behavioural patterns that arouse sexual desire, trigger deep memories, revive incestuous conflict, and provoke trauma (Arango 1989). Thus a lust for violence and murder underlie the murder taboo, suggested Weibart (2010), who believed we have a strongly ambivalent attitude: we yearn to break taboos but at the same time are afraid of doing so, hence the fascination. Swearing is, like the abject, “both disgusting and irresistible, outraging and fascinating” (Holmes, Perron, and O’Byrne 2006: 308, Kristeva 1982). Taboos form the boundary between the allowed and the forbidden: in language, between the obscene and the acceptable or sacred (Werbart 2010).

In Western society taboos attach to functions such as bodily waste, sex, religion, ethnic groups, food, dirt, and death – frequently objects or acts too private to be shared (Abel and Buckley 1977), and what are thought of as taboo terms are avoided because their use in particular social contexts is regarded as distasteful. The decreasing role of religious institutions has been accompanied in Christian societies by the diminishing power of the taboo associated with religious terms (Wajnryb 2004: 97). From religion, body parts and sexuality, association has moved to personal vilification, tabooed in the current political climate when based on looks, mental and physical capacity, and sexual preference (Butler 2003), race, and age.

Swearwords are often described as being unpleasant or ugly-sounding, as though people imagine a real connection between the “actual physical shape of the words and their taboo sense” (Burridge 2002: 161). They believe “that words are able, in and of themselves, to corrupt” (Gray 1993: 316); because of the perceived relation between morality and physical cleanliness we behave as if a moral stain is actual physical dirt (Zhong and Liljenquist 2006).

While the assumption that swearing is invariably negative and is morally wrong pervades the literature on both swearing and verbal aggression, swearwords may have a role also in affirming friendships, establishing relationships, intensifying humour and signalling comfort with fellows. It can be a badge of membership (Dessaix 2003), and is a powerful method of rebellion against the prevailing culture. Swearwords communicate emotions more powerfully and succinctly than any

other words (Jay and Janschewitz 2007), and have the advantage of “guaranteeing maximum attention” (Morris 1998: 187). Mercury (1995: 29) used a striking example to show that omitting swearwords can weaken or change meaning: “this shirt is made of shitty material” is rich in connotative meaning when compared with the sanitised version, “this shirt is made of poor quality material.” The same is true of attempts to censor the expression of emotion; nurses and patients may need to employ taboo language to convey the ineffable depths of their experience. The force of the speaker’s emotional reaction is not conveyed when swearwords are replaced with euphemistic equivalents. Nurses might use swearwords to describe strong emotional reactions about patients, just as patients who have experienced abuse or psychiatric symptomatology beyond normal experience might resort to these words to describe their feelings.

Swearing can constitute a “pat on the back” – the boss may swear or employ a slang expression as a friendly gesture (Andersson and Trudgill 1990). Context is vital: the same words, “shit”, “fuck”, “bullshit”, can express negative feelings and also positive ones such as amazement and delight (Kidman 1993). Winters and Duck (2001) stated that swearing could be an indication that the speaker was relaxed, and might also express sympathy or friendliness. A more recent finding however was that chief executive officers when lying are more likely to swear (Zakolyukina and Larcker 2010).

An exhaustive list of words that could be considered swearwords is impossible to devise, let alone a set of words that would be taboo in every culture: “the English language is rife with creative ways of depicting sexual or excretory organs or activities, [and] new offensive and indecent words are invented every day” (Cameron 2010).

Attitudes to Swearing

Many people, including nurses, disapprove of swearing, seeing it as representing a decline in moral standards or as a sign of limited education (Burns 2008) and public use provokes intense reactions. Others have equally strong but opposing opinions, typified by the witness for the defence in 1960 trial *Regina v. Penguin Books* over D.H. Lawrence’s book, *Lady Chatterley’s Lover*: “probably to the Crusaders, mere words were potent and evocative to a degree we can’t realise.” The evocate power of so-called obscene words must have been very dangerous to the dim-minded, obscure violent natures of the Middle Ages... In the past, man was too weak-minded, or crude-minded, to contemplate his own physical body and physical functions, without getting all messed up with physical reactions that overpowered him... It is no longer so. Culture and civilisation have taught us to separate the reactions (Rolph 1961: 78).

Swearing is frequently headline news and tension often arises between protests about bad language and freedom of speech. The furore over U2’s Bono who said on the 2003 Golden Globe awards night, “this is really, really, fucking brilliant”

resulted in a statement by the USA Federal Communications Commission that “the ‘F-Word’ is one of the most vulgar, graphic and explicit descriptions of sexual activity in the English language.. The tens of thousands of emails, calls and letters that poured in to the Commission opposing this broadcast are telling of the sexual connotation and offensiveness of that word” (FCC 2004). The appeal court, however, ruled that banning the fleeting use of expletives ran contrary to the First Amendment of the US Constitution which protects free speech (Allen 2010). In their judgement the Court commented: “sex and the magnetic power of sexual attraction are surely among the most predominant themes in the study of humanity since the Trojan War. The digestive system and excretion are also important areas of human attention. By prohibiting all ‘patently offensive’ references to sex, sexual organs, and excretion without giving adequate guidance as to what ‘patently offensive’ means, the FCC effectively chills speech” (United States Court of Appeals 2010).

National differences in offensiveness were highlighted in Tourism Australia’s disastrous campaign, “Where the bloody hell are you?”, when the UK’s Advertising Standards Authority clamped down on television advertising and requested that swearwords not be used in future tourism promotions. Scott Morrison, Managing Director of Tourism Australia, saw the phrase as “a uniquely Australian invitation that harks back to the days when Paul Hogan threw a shrimp on the Barbie”, but the word “bloody” ranks 27th on the British Broadcast Advertising Clearance Centre’s list of offensive words that may not appear in advertisements (Deutsche Presse-Agentur 2006). Other countries such as Canada had difficulty with “bloody” but also with “hell” used as an expletive; in Singapore the swearwords were deleted completely, but the advertisement was allowed to run in full in the USA and New Zealand despite protests from lobby groups.

The UK media regulator Ofcom recently updated guidelines on language, saying their research indicated more public acceptance of swearing (Laughlin 2010). Despite racial and ethnic words’ having become perhaps the most taboo in contemporary society (Wachal 2002), Ofcom ruled that “loony”, “nutter”, “mental”, “lezza”, “poof” and “queer” can be used at any time of day, while “fuck” remains unacceptable before a nine pm watershed (Laughlin 2010).

An Australian magistrate recently ruled that being called a prick was what a policeman should expect and therefore dismissed a charge of offensive language, inviting criticism that he was confusing what was to be expected with what was to be tolerated (Bolt 2010). The judgement provoked outrage from the NSW Police Association, concerned that their authority on the street would be undermined and pointing out the contextual differences: “It’s a very different situation for a police officer doing his job to have language directed at him in a very offensive way as opposed to hearing language in the street” (Remfrey in Kozaki 2010). Similarly a lawyer’s opinion was that telling a policewoman to “fuck off” was not obscene because it had become part of everyday language and was “not interpreted by anyone in the literal sense of the word” (O’Gorman in AAP 2010); ironically the newspaper report redacted the phrase to “f--- off.” The lawyer advised the proper

way to deal with the situation would be to say, “Please stop the language” and walk away, instead of “laying charges of public nuisance like confetti at a wedding.” This view is typified by Justice Kirby’s comment, quoted at the beginning of this chapter, that public officials are expected to be “thick skinned and broad shouldered in the performance of their duties.”

Swearing: our Research

Using a mixed methods approach Stone (2009) set out to explore the extent of swearing in three contrasting health care settings, the implications of swearing for a therapeutic encounter and the impact of swearing on nurses. The study findings suggested that swearing in a range of health contexts is both widespread and under-reported.

Frequency

Questionnaires completed by 107 nurses working in adult mental health, paediatrics and child and adolescent mental health focused on nurses’ experiences of swearing, an exploration of the association between personal attributes of nurses such as their own use of swearing, which may affect this interaction, and the effect on them of swearing. The methodology has been described in detail elsewhere (Stone, McMillan, and Hazelton 2010, Stone, McMillan, Hazelton, and Clayton 2010). Of the respondents 39 were male and 68 female, 15 worked in a paediatric setting, 40 in child and adolescent mental health, and 52 in adult mental health. Twenty-nine per cent of nurses reported being sworn at one to five times per week and 7 per cent “continuously”. Nurses in mental health settings reported experiencing higher rates of patient and carer swearing than did paediatric nurses; however, caution should be exercised in interpreting this result because of the small number of paediatric respondents. Comments from nurses on the question of frequency showed that this figure varied greatly over time, from one shift to the next and from one patient to the next. Other nurses found it difficult to recall the number of times they had been sworn at by patients or carers. A typical comment was: *I honestly can’t remember; it is often like water off a duck’s back*, whilst one comment suggested a conscious avoidance of being sworn at: *Usually do night duty for this reason*. The authors have heard from many nurses that they changed jobs because they could not cope in previous clinical positions with the high levels of swearing.

There is no comparable research into the frequency of swearing in healthcare settings. The results of other frequency studies are contradictory. A study based on covert recordings of speech samples of college students found that swearwords accounted for 1 per cent of the words used (Jay 1992). Reported frequency of swearing differs depending upon source of data and research methodology. Recent perceptions of increase, for example by Wachal (2002), may have been based

on misinterpretation of less inhibited swearing as indicating greater frequency because actual frequencies are not easy to verify (Harris 1990). Comparing data on swearing on college campuses in 1986 and in 1996, Jay (1999) concluded that the swearing lexicon was “remarkably stable”, and that most swearing involved the use of a small set of words repeated frequently (e.g., “fuck”, “shit”, “hell”, “Jesus”, “goddamn”, “damn” and “God”). Rarely spoken were more offensive words such as “cocksucker”, “cunt”, or “nigger”. The main difference was that the rates of females’ swearing in public had increased. A frequency analysis conducted in the UK revealed that taboo words were used most frequently by males of all ages, and by both sexes aged less than 35, and that social class did not affect the use of swearwords (Rayson, Leech, and Hodges 1997).

Distress

It was noteworthy that the majority of nurses in our study, asked to rate how distressing it was to be sworn at in several different situations, found each scenario to be highly distressing; 40–50 per cent rated all situations at the highest level of distress the instrument would allow, and 25 respondents indicated high levels for all (Stone et al. 2010). Reported as most distressing was being sworn at by a patient’s relatives or carer, which rated higher than swearing associated with threats or physical violence. A significant gender difference showed in total distress scores, with female nurses recording higher scores than did male nurses.

The amount of distress felt is likely to be related to context: whether or not the nurse takes it personally; the level of personalisation and offensiveness; the religious views of the nurse; the nurse’s own vulnerabilities; and the degree to which the language is embedded in the context of the nurse’s life. Luck, Jackson and Usher (2007) found that in personalised verbal aggression, as when their appearance or manner was attacked, nurses felt emotional distress, whereas they were not so affected when perceiving themselves to be merely symbols for the “system” and the aggression to be not intended personally (2007: 5). Further, the impact of swearing was shown to be contextual – when it did not have the intent of personal harm it was not experienced as “verbal violence”. Several nurses reported feeling distressed or upset as a result of swearing which in most cases was caused by frustration arising, for example, from denial of liberty for patients being restrained, or admitted to a psychiatric hospital. Frequently the presence of others appeared to add to the feeling of distress: An example of the extremes of human behaviour with which nurses have to deal was recounted by one nurse:

An 11 year old boy with a burnt hand from putting a banger in a cat’s rectum was becoming very vocal when I did his dressing saying... ‘You’re not fucking touching me... Fuck off bitch and leave me alone.’ I was upset that his mother didn’t attempt to intervene or chastise. I wasn’t personally affronted but I was sad to hear this from an 11 year old to people who were trying to help him.

Impact

The impact on nurses covered a wide range of emotions: anger and annoyance, fearfulness, surprise, weariness, distress, indifference, disgust and repulsion, and being sad, wounded, embarrassed and uncomfortable. A few nurses reflected on their practice and what might have prompted the swearing.

Nurses described strong affective responses to swearing:

I HATE it – it really impacts on me now – makes me shake. I feel less clear thinking.

Distressed, disgusted, embarrassed, fearful for safety of staff, upset for other patients/parents/visitors who were subjected to this outburst.

A major affective response to swearing was fearfulness, the intensity ranging from “petrified” to “a little apprehensive” or “tense”. Nurses referred to being concerned about their safety, feeling vulnerable, and anxious about future interactions with the patient. The strongest affective response appeared to be produced by contextual dissonance: surprise caused by swearing “in a public place,” in a paediatric unit, by a fellow staff member; or misinterpretation of an intervention – for example, a nurse who “reached to touch someone who was distressed and anxious” and was told, “don’t fucking touch me.” Three respondents described feeling tired and weary when swearing was prolonged – on two occasions over several hours. Other reported reactions were being disgusted and repelled, in one case by a patient who told the nurse: “you stupid bitch – I’m going to follow you home and piss in your milk and kill your dog, you f...ing white c.t and on and on,” – evoking disgust related not only to the violation of sexual and possibly racial taboos but also to food and excretory-related taboos.

Most instances of feeling hurt and wounded involved a strong sense that it stemmed from the discrepancy between the care the nurse perceived s/he had invested in the patient and the patient’s or carer’s lack of appreciation of that care:

My patient has cancer and refused treatment. As she was found to be able to make that decision we were treating palliatively. Others present: patient and her husband. Daughter of patient [Female, mid-late 30s] said that I was an incompetent fuckwit who was unable to fucking do anything fucking right and would I go get some other stupid bitch nurse who might at least want to keep patients alive. Then she said she was going to take her mother out of this cunt of a place.

It is theorised that the greater the emotion and resources invested in a patient, the more hurtful it is to be sworn at in a situation where gratitude or appreciation is due, resulting in a gap between expectation and outcome. Remaining professional during incidents which produce such a strong affective response takes a great deal of insight and effort by the nurse to avoid a reactive response, and thus widen the therapeutic distance between patient and nurse. The discrepancy here is

emphasised by the high degree of taboo of the words directed at the nurse in the presence of the patient and her husband.

For a significant minority of nurses indifference seemed to be the predominant emotional response, typically epitomised by one nurse: “didn’t bother me. If you are offended by being sworn at you are in the wrong job.”

Nurses’ caring responses were affected by these strong emotional reactions – their beliefs about swearing, negative social value-judgement about the swearer, perceived association between verbal and physical aggression, discrepancy between what was felt to be “deserved” and the way they were treated; for example, several comments about the appropriateness of swearing or its management appeared to indicate that patients or their carers were viewed as culpable for the behaviour.

Context and Offensiveness

Several respondents noted the importance of context in assessing offensiveness, and the vast difference between being *sworn at* and swearing used in conversation:

I don’t mind swearing in a general context – everyday conversation. But aggressive swearing really changes the meaning like “I have a sore cunt” is O.K, “You are a cunt” is very different.

Illustrating Ross’s (1962: 34) view that obscenity can be a variable concept, depending not only upon who is speaking the words but also to whom and when and where. Context, including context of care, the patient’s psychopathophysiology, and the broader societal context, clearly is a crucial moderator of both effects and perceptions of swearing.

Respondents were asked to rate 24 listed words for offensiveness: the mean offensiveness rating was 1.24 ($N=106$, $SD=0.67$) where 0: “not offensive at all,” 1: “a little offensive,” 2: “moderately offensive,” 3: “very offensive,” and 4: “extremely offensive.” Three words, “cunt”, “fuck”, and “motherfucker”, were rated as significantly ($p<0.5$) more offensive than other words, indicating that sexually based swearwords were regarded as more offensive than profanity or blasphemy. A second group also rated as highly offensive: “slut”, “fuckwit”, and “paedophile”. The swearword whose use was most frequently cited by nurses was “fuck”.

Nurses’ responses revealed strong feelings about words they considered to be offensive: in all cases the word singled out for special mention was “cunt”.

I don’t use the “C” word or blasphemy.

“Cunt” is a word which I have always found offensive in any context.

“Cunt” is the worst word ever, if a man ever called me that word I would never speak to him or have anything to do with him again.

Swearing's "in-group" role was evident in responses from nurses asked about their own usage of swearwords with colleagues: only four (4 per cent) replied never and 16 per cent replied often. Nearly half the respondents reported never using swearwords with patients, a further 42 per cent only rarely. About two-thirds reported the same frequency for swearing with colleagues as with social swearing, and 19 per cent less with colleagues than socially; 17 per cent reported more frequency with colleagues than socially, contrary to Jay's (1992) studies which showed that most people swear more in a social setting.

Interventions

The limited range of interventions described in response to patient swearing suggests that many nurses feel powerless and at a loss when confronted by it (Stone 2009). At worst they failed to explicate the encounter or consider ethico-moral-legal dimensions and duty of care. It is likely that such high levels of swearing-related distress threaten to overwhelm coping abilities, and possibly trigger non-therapeutic interventions. At one end of the spectrum nurses attempted either to placate or to ignore the patient: at the other they employed coercive interventions. One commented, "I don't deal well with yelling and/or confrontation," perhaps epitomising the apparent unease which for the majority inhibited assertive intervention, as evidenced by large numbers who withdrew or ignored the behaviour because of having no other way of responding. In contrast, some did not intervene because they found it understandable in the context of the patient's mental state. Nurses mostly described interventions which avoided active engagement; in only one case was there an attempt to confront the patient, in that instance a reminder about the "no tolerance" policy. In all other incidents attempts were made to placate or ignore the behaviour before resort to coercion.

Swearing and Healthcare

The contemporary view is that swearing can act as an intensifier of aggression, and also as a portent of impending physical aggression, perhaps a signal to others about one's state of mind (Burns 2008), and indeed Stone et al.'s (2010) study showed it was rare for physical violence to occur without verbal aggression in mental health care inpatient settings. In the past swearing was viewed as a substitute for physical aggression, enabling the expression of a strong emotional state in symbolic form instead of actual violence (Jay and Janschewitz 2007). The theory that swearing helps you let off steam or release tension featured in Stone's (2009) study in relation to nurses' attitudes towards swearing: "if they're swearing they're not usually fighting." The association between swearing and physical aggression is critical to nursing practice: if patient swearing is a substitute for physical aggression, nurses would be well advised to ignore it or even encourage

it, but if it is a precursor of physical aggression then nurses should take proactive steps to avert a more serious incident.

A prominent feature of Laskiwski and Morse's ethnographic study (1993) of quadriplegic and paraplegic patients in a Canadian spinal cord unit was the amount of swearing, the most frequent users being males in their late adolescence to mid-thirties; conversational swearing was common but it was used also to express anger and frustration. The researchers concluded that swearing had five main functions: (a) to maintain personal space; (b) to maintain the camaraderie of the group; (c) to release emotions; (d) to create personal space; and (e) to build facades. Swearing was a badge of membership and patients new to the group, even if they began as non-swearers, adopted the common language; it served to release overwhelming emotions, both positive and negative, and cover up feelings of insecurity. The authors noted also that crying was a socially unacceptable emotional release for adult males in Canadian society, as it would be in Australian society, and swearing was the acceptable means for the group to express strong emotions.

Also relevant to a healthcare context is the finding that swearing is a common response to pain (Stephens, Atkins, and Kingston 2009), and in comparison with not swearing it increased pain tolerance, increased heart rate, and decreased perceived pain. When using swear words men held their hands in iced water 30 per cent longer than when using words such as "brown", "square", or "wooden". Women were able to tolerate the iced water submersion 44 per cent longer when saying swear words. The researchers hypothesised that the observed pain-lesening effect might have occurred because swearing induces a fight-or-flight response and nullifies the link between fear of pain and pain perception.

Swearing may bring to the fore underlying systemic cultural issues. Indigenous Australians are charged with 15 times as many language offences as would be expected given their proportion in the community (Muehlmann 2008, Heilpern 1999), but Aboriginal Australians use swearwords differently and may not recognise them as offensive. Health service policies which rigidly mandate Zero Tolerance for swearing whatever the context potentially discriminate against minority or traditionally disadvantaged groups.

It is clear that the majority of the nurses in our study were distressed and offended by being sworn at and necessarily could not follow the legal advice to "just walk away." The danger of repeatedly being subjected to this type of verbal onslaught is that nurses themselves can become emotionally exhausted, unfeeling, and attempt to protect themselves from stress by withdrawing from and becoming impersonal towards patients (Maslach, Schaufeli, and Leiter 2001); indeed general hospital staff who suffered frequent verbal aggression also displayed significantly higher levels of emotional exhaustion than those less exposed to it (Winstanley and Whittington 2002). How nurses are to be helped to remain open to their clients in the face of offensive language is a challenge which will be discussed later in the paper.

Mind the Gap: Models of Therapeutic Intent

A theme emerging from Stone's study (2010) was the moral evaluation of patients by nurses. A belief that swearing is morally reprehensible and requires some form of punishment will clearly produce negative repercussions for the therapeutic relationship, although prevention of a patient's swearing may be of no therapeutic value at all. Preparedness to put up with swearing or verbal aggression appeared to depend on the extent to which the behaviour was thought to be excusable. According to the attributions made about the cause of swearing, nurses' empathy appeared to be reduced or neutralised when patients were seen to be responsible for their own distress. Hoffman (2000) also found that the observer was sympathetic about distress when the cause was beyond the person's control. The result may be discrimination between excusable and inexcusable patients, and some being labelled as difficult (Johnson and Webb 1995). Holmes et al. (2006: 310) noted that "the marginalized and despised, those individuals portrayed as polluting and threatening, always provoke intense reactions, and when this polluting identity is associated with so-called transgressive practices, the intensity of these reactions is exacerbated"; a similar process seems to have occurred in this study.

The implications for therapeutic intervention begin with nurses' attributions as to the causes of aggression. Patient aggression was most often viewed as being due to factors intrinsic to the patient, some of which triggered moral evaluation (individual characteristics including age, gender, diagnosis, and substance misuse), termed by Duxbury (2002) an *internal model*. The underlying philosophy behind the internal model of causation is consistent with the biomedical model, which provides justification of medical treatment for aggression, and also frees the nurse from individual responsibility (Hahn et al. 2006).

A nurse's ability to monitor his or her own reactions to patients is imperative in establishing and maintaining a therapeutic relationship (Austin, Bergum, and Goldberg 2003). Parameters for achieving optimal therapeutic intention will be influenced by the potential for particular incidents to become catalysts for a drift towards limited therapeutic connection (Holder and Schenthal 2008). Contemporary nursing environments are so complex, dynamic, and reactive that nurses may feel overwhelmed and boundary slippage ensue, which can happen in many different ways; particular conditions or circumstances such as stress may increase the likelihood of further complications.

Implicit in the concept of boundaries (Figure 15.1) is the notion of non-therapeutic practice in terms of over- and under-involvement. Appropriate boundaries ensure safe connection between nurse and patient, based on the patient's needs (Holder and Schenthal 2008). It is suggested here that swearing may limit the likelihood of maintaining or achieving therapeutic practice and initiate a situation more reflective of under-involvement. Optimal therapeutic engagement results from nurses' empathic behaviours and judgements, considered responses and comprehensive assessment of the emotional status of patients (Figure 15.1). A patient's swearing might trigger negative counter-transference reactions leading to

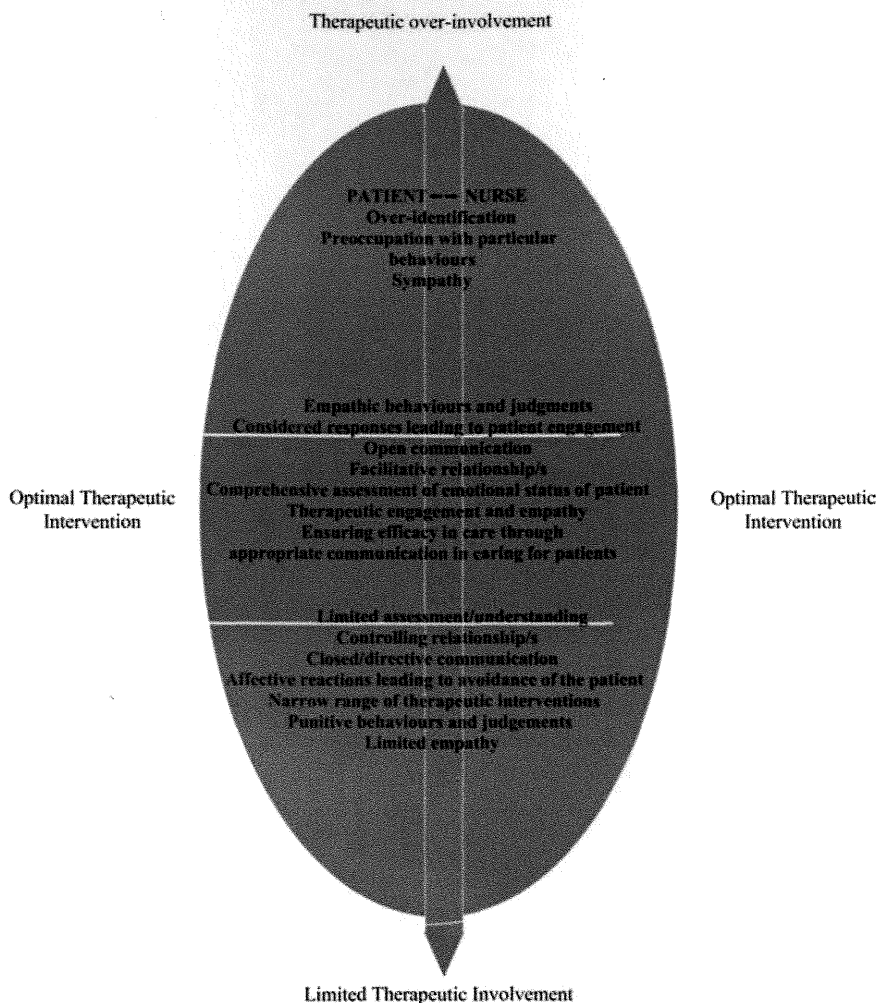


Figure 15.1 A Model of Therapeutic Intervention in Response to Verbal Aggression and Swearing

un-therapeutic practice: nurses sometimes cannot move beyond their affective responses to episodes of swearing which could produce disengagement, avoidance of the patient, a narrow range of therapeutic interventions and punitive behaviours and judgements. In addition swearing by nurses might represent a “boundary transgression” – that is, an intentional or unintended infringement of the established limit of a professional relationship – unless the nurse used carefully-chosen words with therapeutic intent. Nurses are expected to guide and coordinate therapeutic communication, observe professional boundaries and implement appropriate therapeutic action.

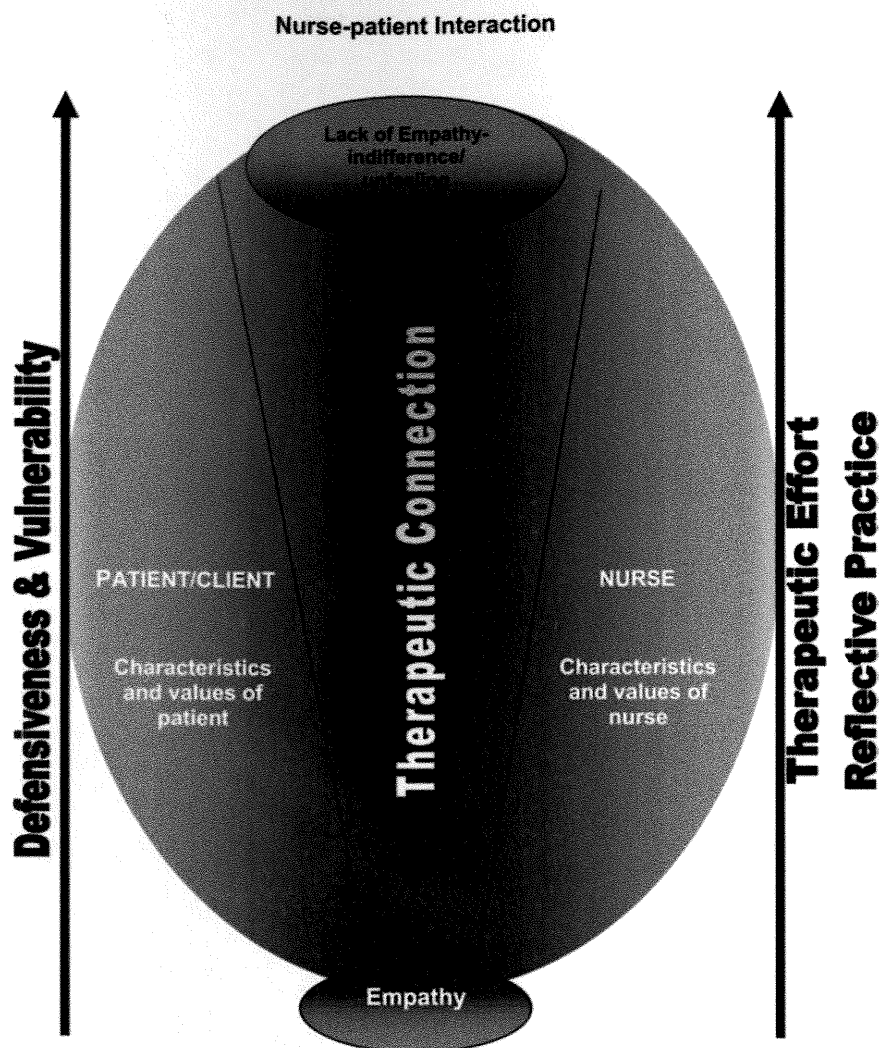


Figure 15.2 Mind the Gap: A Model of Potential Therapeutic Distance between Nurse and Patient

Figure 15.1 provided clarity in relation to swearing by patients, that therapeutic engagement and empathy were essential to understanding the dynamic, and a second set of concepts was proposed which expands on the first (Figures 15.2 and 15.3) and places these processes at the centre of the model. Empathy is the capacity to understand another person's subjective experience from within that person's frame of reference (Bellet and Maloney 1991), and encompasses both affective and cognitive domains (Stueber 2008). Crucial in this context is the notion that

empathic arousal precedes helping behaviour and has been found also to reduce aggression (Hoffman 2000). Swearing by patients has consequences for nurses' empathic feelings: the extent to which expression of empathy can be enhanced or diminished depends on both patient's and nurse's personal characteristics, the nurse's appraisal of both the situation and the patient, ability to reflect upon the clinical situation, and inclination to invest therapeutic effort by putting into effect appropriate and constructive responses.

Given that we concluded empathy and engagement are at the heart of the nurse-patient relationship, Figure 15.2 was developed to illustrate how that relationship may be affected by a patient's swearing. It is easier for nurses to establish and maintain an optimal therapeutic connection with patients when nurse and patient have not too dissimilar characteristics and values. The therapeutic relationship benefits because most people empathise more with people with similar needs and concerns (Hoffman 2000); however certain characteristics of the nurse or patient have potential to create a therapeutic gap between them, leading to a sense of otherness and increasing vulnerability for the patient. Nurses must be mindful of factors triggering their affective responses, and expend greater therapeutic effort in order to bridge this gap.

Figure 15.3 illustrates some of the triggers identified in Stone's (2009) study that may affect nurses' responses to patients and their ability to empathise, and therefore impair the quality of the therapeutic connection. They may include strong affective responses (high levels of distress or anger) and ultimately perhaps emotional blunting/burnout. In terms of the gap, nurses may have to acknowledge existing beliefs and mind sets such as that swearing is invariably negative and is morally wrong; that certain characteristics of a patient may lead to negative social evaluation/judgement by the nurse; and the perceived association between physical aggression, verbal aggression, and swearing and therapeutic pessimism. Additionally discrepancies between what is felt to be deserved and what is received by nurses can create therapeutic distance. Context plays a crucial role in the level of word offensiveness, and they both mediate the impact of swearing. An internal model of causation for aggression may contribute to creating therapeutic distance between the nurse and patient.

Towards a Resolution

Nurses deal with deformity, disfigurement, diarrhoea and other leakages of the human body, and their work exposes them to experiences which challenge the clean and proper body and can lead to fear and anxiety (McCabe 2010), but can we deal with "verbal filth"? There is no complete prescription for coping with swearing in all its expressions and complexities to optimise patient outcomes and ensure physical and psychological safety for the nurse, but what follows is a discussion of possible approaches.

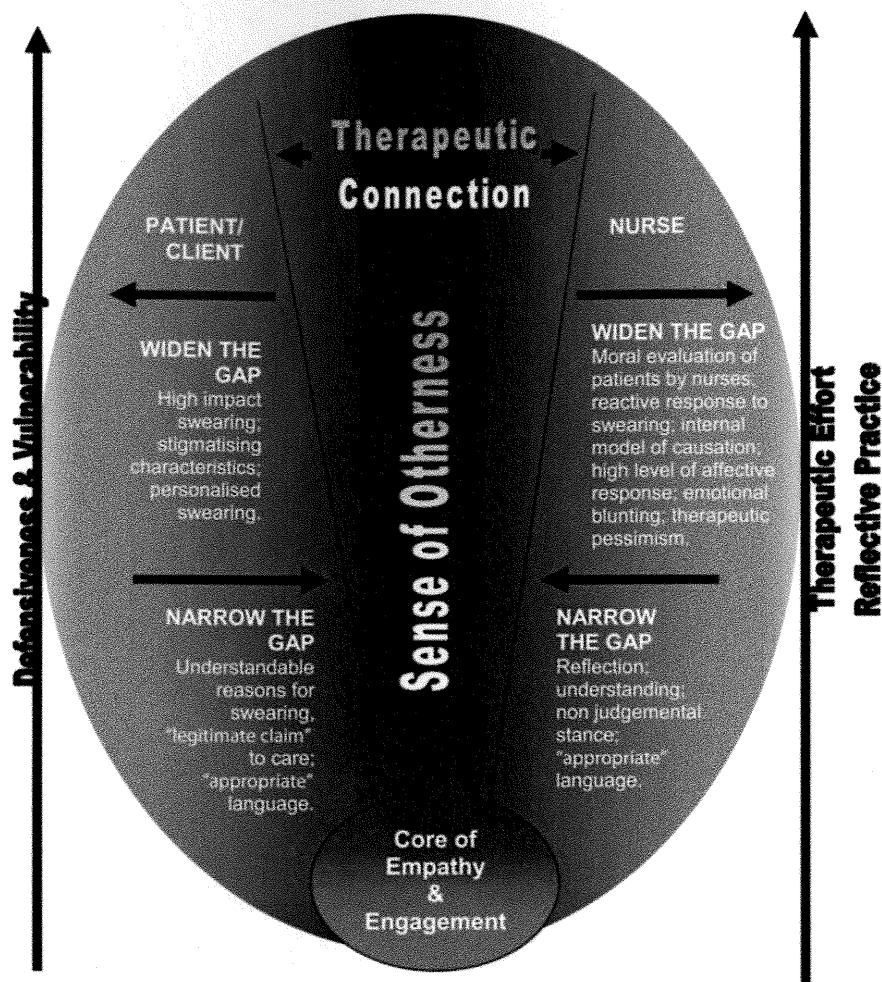


Figure 15.3 Mind the Gap Model: The Factors Leading to Potential for Creation of Therapeutic Distance between Nurse and Patient

Many of the interchanges reported in our study attack self-esteem by frightening, ridiculing, invading space, withholding politeness and keeping silent, or failing to act where politeness is expected (Culpeper, Bousfield, and Wichmann 2003: 1555). These attacks and the high levels of swearing negatively affect empathy and may result in nurses' distancing themselves from patients. Distancing in the form of passive types of behaviour (withdrawing, wishing the situation would go away, being silent, and blaming oneself) was observed in Rowe and Sherlock's (2005) study when nurses attempted to deal with verbal aggression from colleagues. It is likely that teaching nurses assertive conflict management would benefit

their relations with both patients and colleagues. Nurses could substitute many therapeutic strategies, including de-escalation techniques, with the aim of calming distressed patients and redirecting them into constructive problem solving (Wand and Coulson 2006).

In managing patient swearing nurses need to appraise their rehabilitative, long-term therapeutic goals. They must “re-cognise” and manage their immediate negative emotional responses, and prevent their emotions from overtaking the thinking parts of their brain (Beauregard, Levesque, and Paquette 2004): If nurses block all feeling – becoming “thick skinned” – they may not be able to maintain a therapeutic connection with the patient.

Dealing with swearing in a helpful, salutary, constructive, and patient-focused way demands a clinical understanding of the behaviour so that nurses distinguish between swearing as a sign of underlying distress or as a precursor of more serious aggression. Many nurses carefully differentiated between swearing and “swearing *at*”, thus recognising when swearing was the customary manner of self-expression. It is this distinction that is important in guiding practice: to treat these two behaviours similarly is to risk overreaction to the first and to underestimate the impact of the second. Patients and carers swear for many reasons and in many cases nurses are dealing with people at the extremes of experience, which it could be argued might warrant this type of language. When very distressed it is likely that we suffer an impoverished emotional lexicon which could lead to swearing. Although there is a legitimate cause to feel anxious about swearwords intended to intimidate or hurt, there is no clinical reason to treat swearwords used in other ways as a threat, despite our finding that nurses regard the literal use of such words as being as offensive as their use in anger. Treating this behaviour in the same way may cause disadvantage through nurses’ distancing themselves or acting punitively towards patients whose use of such words implied no intent of harm and posed no threat to the nurse’s safety or authority.

Jay’s (2006) views about parents’ reactions to a child’s swearing might apply also to adults. When patients swear and are punished for doing so, instead of dealing with the situation that led to the swearing nurses are effectively reinforcing the behaviour. Jay believed this happens for two reasons: first that an extreme response to a word alerts the patient to its power; and secondly that the cause of the swearing is not addressed. Nurses have the responsibility of guiding therapeutic reactions, and their responses should be empathic and not reactionary: what is optimal is that they deal with the swearing as a sign of underlying distress rather than emotionally reacting to the linguistic content; in other words moving from symptom to understanding.

As Delaney (2009b) described the skills needed to cope with affective dysregulation in children, so nurses need to read patients’ affect, step in, and help them to understand and dampen down emotions, maintaining a positive tone with appropriate and matching body language to reduce the sense of threat. Though it may be hard, the first step is to learn not to personalise what is said: see the swearing not as a personal affront but instead as the patient’s way of communicating

emotions (Castillo 1978). It is important to remain calm and use “I” statements rather than pointing out the patient’s inappropriate behaviour. Anecdotal evidence suggests that, if patients are using swearwords to recount a story, asking them to tell the same story without swearwords can reduce the negative emotional affect of what is said and assist the patient to use constructive problem solving skills.

Use of Swearwords in a Therapeutic Way

On many occasions nurses themselves reported thoughtfully using swearing to fulfil several complex relational functions. The ability to adapt verbal communication style to ensure effective therapeutic communication is an attribute of a skilled clinical practitioner. Questions that may be useful to promote reflection on the appropriateness of swearing with patients include:

Were swearwords used in a consciously therapeutic way in order to benefit the patient?
 Does language fall within policy and ethical guidelines?
 How does this use of language appear to the patient and others?
 Was the goal or expected outcome for the interaction met?
 Has the language the potential to destroy the professional relationship?
 May the language cause harm to the patient?
 Does the language represent a sexual boundary violation?
 Did the language occur because of stress, loss, or trauma suffered by the nurse?
 inspired by Holder and Schenthal (2008)

Preparation for Practice

How are we to train clinical staff to deal with these issues? Usually training involves safely mimicking actions, yet when we talk formally about verbal aggression we generally sanitise the content by euphemism (the f-word), clinical terminology (defecatory adjectives), and obfuscation (objectionable utterances). Yet raw language carries a much more powerful emotional content. Authenticity also is essential: training in prevention and management of aggression is an important part of preparing clinicians for difficult aspects of their role in order to preserve the therapeutic relationship and maintain staff and patient safety. Nursing scenarios frequently leave out important aspects such as florid, destabilising, erratic and distasteful expressions. A good example of why authenticity is difficult to achieve involved a local health service trainer in New South Wales Australia in 2001, realistically enacting a situation to illustrate methods of prevention and management of aggression; staff participants were learning how to respond in a measured way to verbal abuse: a human resources manager, unaccustomed to encountering such events, interrupted the proceedings and complained about the language used.

The need to maintain verbal hygiene and avoid offending anyone while confronting the realities of clinical experience leaves clinicians ill equipped to

deal with everyday practice. We would contend that education and training must include the full spectrum of actuality, such as extreme language, in order to better understand, monitor and moderate our responses. We must prepare our workforce to cope with incidents that are beyond the range of normal human experience.

Conclusion

Just as the physically unclean side of nursing is overlooked in academic literature (Holmes et al. 2006), so is the dirty, dangerous and “disgusting” language of swearing. Hospitals and health facilities reflect contemporary society, dealing now with chronic debilitating illness and multiple psycho-pathologies, and are expected to absorb and treat the victims of society’s system failures. They are no longer safe havens and realistically cannot ever achieve a “zero” verbal aggression state. Our response therefore must equip clinicians and nurses to manage swearing, to stay protected without retreating or becoming therapeutically blocked. Nurses need to develop an other-directed model to include awareness of greater complexity underlying the behaviour, and look beyond it to attempt helpful, thoughtful, emotion-centred interactions which build and do not damage the therapeutic relationships.

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