Swearing: Impact on Nurses and Implications for Therapeutic Practice

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A thesis presented in fulfilment of the requirements for the degree of Doctor of Philosophy

University of Newcastle

January 2009
Declaration

I hereby certify that the work embodied in this thesis is the result of original research and has not been submitted for a higher degree to any other University or Institution.

Signed: ……………………………………………………
Date: ……………………………………………………

Teresa Elizabeth Stone
Dedication

This thesis is dedicated to my Mother and Pa who have given me a lifetime of love and support.
Acknowledgments

My list of dramatis personae for this study is long. My principal supervisor, Mike Hazelton, remained unfailingly encouraging and optimistic and his wealth of experience in research was invaluable. He told me he had been caught laughing to himself while reading through the questionnaire, a cameo of him that I treasure. Ed Clayton and Kim Colyas worked wonders with my statistics, and I painfully and slowly learned much and forgot more. Margaret McMillan came in slightly later in the piece, was completely inspirational, and really got me over the line. Jill Valdar is the editor and friend every girl needs, despite language that made her hair curl. Associate Professor Brian Taylor was a wonderful resource for all things linguistic and he gave freely of his own time. Heartfelt thanks to my wonderful husband Scott, who is forever supportive, and to Claudia, my dog, who has patiently accompanied me, snoring, as I wrote. Thanks, too, to the many nurses who participated in the study.
"As the matter stands, [this] poor devil of an author is proposing an expedition into regions that, despite many hundreds of years of literary enterprise, are still remote and untravelled. It were not surprising therefore at the onset that the readers should inquire if [s]he is sincere and reliable, or whether on the contrary [s]he is counterfeiting honesty with a sanctimonious face. It were perhaps right they should be assured that the trip is really intended for their welfare, and that the skipper is not given to risk the safety of [her] craft for a mere capful of wind."

(Sharman, 1884, p.11).
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Readers who are likely to be offended by swearwords are advised that the thesis contains many words which might be considered offensive.
Abstract

Swearing is a subject largely ignored in academic circles but impossible to ignore in the health workplace. Despite its prevalence there has been little academic research into swearing, and certainly none on its impact on nursing staff. Nurses are, of all health workers, most likely to be targets of verbal aggression with up to 100% of nurses in mental health settings reporting verbal abuse. Nurses encounter swearing from patients and their carers, staff, and managers, and use swearwords in communication with each other, but there is no reference in the literature to the effects on nurses of exposure to swearing.

This study set out to rectify that lack of research into swearing by answering three main questions:

1. What is the extent of swearing /verbal aggression in a health care setting?
2. What are the implications of swearing for a therapeutic encounter?
3. What is the impact of swearing on nurses?

A mixed methods approach was employed. Phase one of the study explored the context of care, utilising the Overt Aggression Scale to describe the nature and extent of swearing and verbal aggression across a range of acute and long-term inpatient mental health settings. Data were derived from 9,623 reports spanning a 10-year period. The sample comprised 384 (72.1%) males and 148 (27.9%) females aged between 9.5 years and 93.3, mean age 45.6, SD=21.00 years. Most frequently reported over the 10-year period was verbal aggression; incidents involving females occurred mainly in connection with the more severe levels of verbal aggression. “Psychosis” was recorded as the main perceived cause of verbal aggression, in itself an insufficient explanation. A rising tendency to cite psychosis emerged as the level of aggression rose and, on average, 1.9 interventions were recorded for each aggressive incident.

Phase two surveyed 107 nurses across three health care settings – paediatrics, adult mental health, and child and adolescent mental health – by means of a questionnaire designed to elicit a combination of both qualitative and quantitative data, the Nursing Swearing Impact Questionnaire, which included three standardised instruments. The quantitative data were subjected to descriptive and inferential statistical analysis.
High levels of swearing were reported, 29% of nurses being sworn at 1 to 5 times per week and 7% “continuously.” A similar incidence occurred within the nursing team, but being sworn at in anger by another staff member was rare and the major use was in jest or in conversation. The study failed to find significant differences between mental health and paediatric settings in the frequency of swearing but did find gender-based differences.

High levels of distress caused by being subjected to swearing were evident, particularly when the aggressor was a relative or carer of a patient. Moreover, the respondents appeared to have only a limited range of interventions for use in dealing with the experience of being sworn at. However, what emerges strongly from the data is the extent to which swearing is culture- and context-bound, and the fact that nurses share many of the views and attitudes about swearing held by society at large.

The culmination of the findings suggests that swearing is both widespread and under-reported in a range of health contexts. The implications of swearing are poorly understood by nurses. These, and the magnitude of their distress in being subjected to it, render them ill-equipped to deal with the experience. The concomitant negative effects on empathy result in the nurses’ distancing themselves from the patient when confronted and implementing only a restricted range of interventions and detrimental effects on the quality of the therapeutic relationship will have negative effects on patient outcomes. Given the levels of swearing reported and its consequences on the therapeutic relationship, further research is warranted.
### Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arvo</td>
<td>Australian slang term for “afternoon” as in see you Saturday arvo. “Arvo” is an example of a special feature of Australian English, the habit of adding “o” to an abbreviated word (Australian National University, 2007). Lacks the social stigma attached to “youse.”</td>
<td></td>
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<tr>
<td>ASQ</td>
<td>Attributional Styles Questionnaire</td>
<td>Seligman’s self-report instrument which measures explanatory style for good and bad events, using three causal dimensions: internal versus external, stable versus unstable and global versus specific cause.</td>
</tr>
<tr>
<td>Blasphemy</td>
<td>A deliberate vilification of religious symbols or names.</td>
<td></td>
</tr>
<tr>
<td>Clonazepam</td>
<td>Clonazepam (Rivotril) is in the benzodiazepine class of drugs. It is an anticonvulsant and anxiolytic and may be used as a sedative.</td>
<td></td>
</tr>
<tr>
<td>Connotative</td>
<td>Refers to the emotional nuances commonly associated with a word. The meaning of a word incorporates both denotation and connotation.</td>
<td></td>
</tr>
<tr>
<td>Coprolalia</td>
<td>Refers to the involuntary compulsive utterance of swearwords and is a type of verbal tic. (From the Greek, kopros = ‘dung’, lalia = ‘to chatter’).</td>
<td></td>
</tr>
<tr>
<td>Copropraxia</td>
<td>The uncontrollable performance of obscene gestures.</td>
<td></td>
</tr>
<tr>
<td>Denotative</td>
<td>Refers to the literal meaning of a word.</td>
<td></td>
</tr>
<tr>
<td>Dozens</td>
<td>Refers to verbal duelling in which deliberately provocative insults are exchanged. Recorded in use by Black American youths; participants taunt each other in a variety of savagely imaginative ways.</td>
<td></td>
</tr>
<tr>
<td>Dysphemism</td>
<td>The replacement of an inoffensive term by an offensive or disparaging term.</td>
<td></td>
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<tr>
<td>Empathy</td>
<td>Empathy is the capacity to understand another person’s subjective experience from within that person’s frame of reference (Bellet...</td>
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<tr>
<td>Abbreviation</td>
<td>Full term</td>
<td>Definition</td>
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<tr>
<td>&amp; Maloney, 1991)</td>
<td>&amp; Maloney, 1991)</td>
<td>and encompasses both affective and cognitive domains (Stueber, 2008).</td>
</tr>
<tr>
<td>Euphemism</td>
<td>The replacement of an offensive term by an inoffensive or acceptable term.</td>
<td></td>
</tr>
<tr>
<td>Pro re nata</td>
<td>Pro re nata (Latin)</td>
<td>Abbreviation for pro re nata meaning “as needed” or “when necessary.” In the present context this refers to prn psychotropic medications (medications given with the aim of changing the patient's mental state on an “as needed” basis).</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Questionnaire</td>
<td>A brief self-report screening test designed to detect psychiatric disorders in community and non-psychiatric clinical populations.</td>
</tr>
<tr>
<td>GTS</td>
<td>Gilles de Tourette Syndrome</td>
<td>Gilles de Tourette Syndrome is a neurological disorder characterised by motor and phonic tics; coprolalia, probably the most socially handicapping symptom of GTS, may accompany it.</td>
</tr>
<tr>
<td>LOC</td>
<td>Locus of Control</td>
<td>First posited by Rotter in 1966, LOC refers to the degree to which individuals perceive themselves as having control over outcomes.</td>
</tr>
<tr>
<td>NSIQ</td>
<td>Nursing Swearing Impact Questionnaire</td>
<td>The NSIQ [Appendix 5] totals 22 pages and comprises five parts, Items included both rating scales and open-ended short answer questions seeking information on frequency and nature of, and responses to, exposure to swearing. The NSIQ also included a number of standardised instruments assessing respondents’ general health using the GHQ, internal versus external control of reinforcement using the LOC instrument, and explanatory style using the Attributional Style Questionnaire.</td>
</tr>
<tr>
<td>OAS</td>
<td>Overt Aggression Scale</td>
<td>A standardised behavioural checklist developed for inpatient psychiatric units by Yudofsky, Silver, Jackson, Endicott and Williams (1986) measuring the frequency and severity of four categories of aggression.</td>
</tr>
<tr>
<td>Profanity</td>
<td>The replacement of an offensive term by an inoffensive or acceptable term.</td>
<td></td>
</tr>
<tr>
<td>Prn</td>
<td>Pro re nata (Latin)</td>
<td>Abbreviation for pro re nata meaning “as needed” or “when necessary.” In the present context this refers to prn psychotropic medications (medications given with the aim of changing the patient's mental state on an “as needed” basis).</td>
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<tr>
<td>Swearing</td>
<td>(a) refers to something that is taboo and/or stigmatised in the culture; (b) should not be interpreted literally; (c) can be used to express strong emotions and attitudes. (Adapted from Andersson and Trudgill, 1990, p.53).</td>
<td></td>
</tr>
<tr>
<td>Taboo</td>
<td>Taboo words are those that are forbidden or unmentionable, either because they are sacred or because they invoke disgust. Taboo in Tonga in its original form referred to prohibited behaviour, and tabooed expressions were avoided in the belief that they were evil or could cause harm, even death (Burridge, 1999b)</td>
<td></td>
</tr>
<tr>
<td>Therapeutic relationship</td>
<td>In this study the term “a therapeutic relationship” refers to the professional relationship between the nurse and the patient/client. The relationship has as its central focus goal-directed activities related to the healthcare needs of the patient; it is a vehicle for therapeutic change, and involves the establishment and maintenance of appropriate professional boundaries.</td>
<td></td>
</tr>
<tr>
<td>Verbal aggression</td>
<td>A communication intended to cause psychological harm to another person or perceived as having that intent (Vissing, Straus, Gelles, &amp; Harrop, 1991, p.225).</td>
<td></td>
</tr>
<tr>
<td>Youse</td>
<td>An Australian slang word. Plural of “you.” The English Dialect Dictionary attributes “yous” to Irish English. Possibly the lowly status in Australia of Irish versus British English ensured that youse would be common in colloquial speech but condemned in formal speech and writing; in Australia its use is associated with a lack of education.</td>
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Papers Arising From this Research

Peer-reviewed publications


Conference papers


Paper presented at the International Australian and New Zealand College of Mental Health Nurses Conference, Fremantle.


Paper presented at the Hunter Branch conference of the Australian and New Zealand College of Mental Health Nurses Conference, Newcastle.

Awarded the 2006 Hunter Mental Health Award.


Paper presented at the 33rd International Australian College of Mental Health Nurses Conference, Cairns.

Awarded the 2007 Australian College of Mental Health Nurses Research Award.


Invited speaker for NSW Branch of the Australian College of Mental Health Nurses Conference, Sydney.


Paper presented at the 34th International Australian College of Mental Health Nurses Conference, Melbourne.


1.1 Introduction

Indifference is possibly the only reaction I have not encountered when discussing the subject of my study. Both the divergence of opinion and the force of people's reactions have stunned me. Everyone had strong views: Lay people most often asked why there is so much swearing, themselves attributing it to ignorance and an inadequate grasp of language, bemoaning a perceived increase in the use of bad language and the moral decline thus implied. Several would not view films containing any level of swearing, and all cited particular words they would not use. Nurses were more pragmatic about it but opinions varied, some confiding having left jobs because of the high levels of swearing while others said they no longer noticed it. Often shock was expressed: Why was I doing the study at all – was it totally frivolous? Usually, however, by the end of what frequently were short conversations, nurses were fully convinced it was not only a worthwhile subject for study but in fact very important, and with Nash (1996, p.31) might have agreed that “this ostensibly simple, frivolous, unacademic theme turns out to be more complex and perhaps even more scholarly than one may suppose.”

This introductory chapter begins with the background to and stimulus for the research. There follows a brief overview of the present study, including the research questions, aims, design and scope. The significance of the study is discussed and the chapter concludes with an outline of the structure of the thesis.
1.2 Background to the study

The dearth of methodologically sound literature caused by the general lack of serious
research on the subject of swearing has tended to attract work that exploited its
salacious and sensationalist aspects (for example, Aman, 1977; Burgen, 1999;
Dooling, 1996; Johnson, 1995). An entire journal, *Maledicta*, exists which seems to be
more peer-reviled than peer-reviewed. Johnson and Fine (1985, in Beers Fägersten,
2000, p.2) speculated that the taboo nature of the language has led to researchers’
avoiding the subject. What literature there is has referred mainly to the historical and
linguistic aspects of swearing (e.g., Montagu, 1967 and Hughes, 1991); these texts
were based primarily on the written word and did not constitute a study of human
behaviour.

The field spans several disciplines; this literature review covers papers from linguistics,
anthropology, literary theory, psychology, sociolinguistics, sociology and philology,
illustrating Dooling’s (1996) contention that four letter words are “inextricably bound up
with almost everything.” What research there is does not provide a comprehensive or
integrated account (Jay, 1977) and is of varying quality, many studies being based on
small sample sizes with questionable methodology and an overuse of college students
as participants, and tainted by the view that swearing is invariably negative. There is a
dearth of recent research, as the dates on many of the articles cited in this thesis will
attest. Jay (1994) highlighted three problems that arise in connection with research on
swearing – defining swearwords, determining frequency of usage and determining
offensiveness – which the current study attempts to address.

Swearing not only expresses emotion, it can also give rise to it; it frequently involves
the transgression of social codes ranging from being “merely impolite” to the criminal
(Hughes, 2006, p.xv; Andersson & Trudgill, 1990);

Perhaps because of the strong negative response, little has been written about
swearing from an academic perspective; but it is the language of strong emotion and
plays a vital role in both normal and abnormal communication (Van Lancker &
Cummings, 1999, p.84) Despite the prevalence of their exposure to swearing there
has been little or no research on its impact on nursing staff; such research as there has
been has reflected almost exclusively a speaker-oriented approach, with little attention
However, numerous studies point to the fact that nurses are the main target of verbal and physical aggression, and swearing is not infrequently used as a means of intensifying verbal abuse; they are in a particularly vulnerable and challenging position because they have the major responsibility for ensuring safety on inpatient units (DelBel, 2003). The attributions or meanings nurses ascribe to the causes of the behaviour will affect their response to and management of swearing and verbal and physical aggression. How individuals cope with aggressive communication is an important factor in effective management of the behaviour. Knowledge about this type of communication may assist in countering any effects, and allow us to understand why swearing is used and its impact on others (Kinney, 1994).

1.3 Personal stimulus for the study

Some time ago I was called to the Emergency Department with a young male psychologist to assess a 16-year-old youth who had the previous day been arrested after crashing his mother’s car whilst drunk, with the intention of killing himself; in the process he managed to completely demolish two other vehicles. After asking the accompanying police to wait outside, the psychologist launched into the assessment, his first, with a polite and respectful question: “What brought you here today?” “The fucking police, what do you think? Are you fucking stupid?” was the reply. The psychologist looked at me silently, begging me to take over the interview; his reaction to the swearing was so intensely negative he could not continue.

Mental health nursing and swearing have in common that they are dealing with stigma and taboo and, as with mental health nursing, the study of swearing is a study of human behaviour and thought (Jay, 1999). My interest in the raw force and danger of taboo language arises also from another perspective. Arriving as a remote area nurse at Kintore, 800km west of Alice Springs, I learned that my own name was taboo. A young man called Terry had been killed in a car accident two years before and the name could not be spoken. Instead I was given a skin name by which I was always referred to in the community. But along with the traditional name came the responsibility of respecting both the obligations and avoidance relationships (taboos) associated with the naming.
1.4 Research questions

In order to begin to address the issues raised above, the research was directed towards answering the following superordinate questions:

1. What is the extent of swearing /verbal aggression in a health care setting?
2. What are the implications of swearing for a therapeutic encounter?
3. What is the impact of swearing on nurses?

The underlying questions were as follows:

- Which mental health disorders do nurses report as being associated with swearing in aggressive episodes in inpatient mental health settings?
- What is the association between nurses’ explanations of patient aggression, types of aggression, and forms of intervention?
- To what extent do nurses’ behaviours and beliefs about swearing impact on their capacity to provide therapeutic care?
- To what extent is the reported impact of swearing modified by factors such as inpatient setting, nursing position, nursing experience, mental health experience, and educational qualifications?
- To what extent is the reported impact of swearing modified by nurses’ personal characteristics such as gender, religiosity, age, locus of control, attributional style, or general health?
- How does it feel for a nurse to be sworn at by a patient or carer?

1.5 Scope of the study

This study aimed to address a gap in the literature: the absence of research on the effects of swearing on nurses. An understanding of the role played by swearing, in interpersonal encounters and in relation to mental health disorders, could lead to improvements in the therapeutic relationship between nurses and their patients and thus have positive effects on treatment outcomes.

1.6 Research design

The purpose of this study, drawing on both quantitative and qualitative methodologies, was to obtain more information about the impact of swearing on nurses and how swearing affected their interactions with patients. Because of the lack of previous research in this area, the objectives were principally exploratory: that is, by use of...
primarily inductive methods to explore the concept and phenomena of swearing and nursing (Onwuegbuzie & Leech, 2006).

The method adopted to address the research problem and answer the research questions involved two distinct phases:

1. Phase one (Chapter 5) of the study contextualised nursing practice, describing the nature and extent of swearing and verbal aggression in mental health settings.
2. Phase two (Chapter 6) focused on nurses’ experiences of swearing, and comprised a questionnaire completed by nursing staff and an exploration of the association between personal attributes of nurses and the effect on them of swearing.

1.7 Methodology

The debate about the relative merits of qualitative and quantitative methods is well known and well documented. This study employed both methods, partly to harvest the strengths of each and minimise the weaknesses, and also to enhance significance (i.e., using mixed methods in order to maximise the researcher’s interpretations of data) (Onwuegbuzie & Leech, 2006). Findings are reported together in an attempt to integrate the qualitative and quantitative elements thus overcoming a criticism of many mixed methodology papers, only 18% of which have integrated the findings (Bryman, 2007). Both approaches were used throughout the research process, including formulation of research questions, data collection, and analysis, although different research instruments were not used to collect the data.

Combined methods can enhance comprehensiveness and/or reliability and validity (Knafl & Breitmayer, 1989). This type of research provides a “broad and flexible approach to address complex research questions” (Borbasi, Jackson, & Langford, 2008, p.180), and the complexity of researching swearing in a health context with its multiple perspectives and its many aspects merited this approach. Both qualitative and quantitative approaches were needed to address the full range of the research questions, a requirement which appeared to the researcher to be more important than choosing a methodology based on a particular philosophical position. This pragmatic approach offered a “practical and outcome-oriented method of inquiry that is based on action” (Johnson & Onwuegbuzie, 2004, p.17). The authors opined that a pragmatist might take the view, when judging the ideas and philosophy behind a particular
research approach, that the empirical and practical consequences should be taken into account; they further observed that although Morse (1989) had pointed out the dangers involved in combining methods with different assumptions, it is likely that using methodologies from approaches with different ontological positions may, in some cases, make little practical difference to how research is conducted.

Polit and Hungler (1999) argued that the advantages of multimethod (or mixed method) research would become increasingly recognised. They viewed the blending of qualitative and quantitative methods as complementary, representing both words and numbers, the words adding meaning to the numbers.

Quantitative methods have been used in conjunction with qualitative approaches so as to allow the phenomenon of interest to be approached from several different perspectives – so called triangulation. Triangulation attempts to reconcile the differences which arise, as in this study, from two or more data sources, methodological approaches and data analyses, and moves towards more completeness or confirmation than any one research strategy could do alone (Ramprogus, 2005). Whilst it may be used as a rigorous means of validating the scope of the findings, it does not necessarily enhance accuracy (Ramprogus, 2005). In this study the focus was triangulation on a domain of interest – namely swearing.

The questionnaire study which comprised Part 2 of this research was an example of a within-stage mixed-model design (Johnson & Onwuegbuzie, 2004); it contained summated ratings scales (quantitative data collection) and more open-ended questions (qualitative data collection). With regard to the open-ended questions, the study adopted a qualitative descriptive approach, with the intention of exploring nurses’ reactions to swearing and their responses to it. As such the questionnaire was designed to capture the “who, what and where” (Sandelowski, 2000) of swearing; the author affirmed (p.336) that this approach offers a “comprehensive summary” of the event. As little is known about this area, a qualitative descriptive approach was considered to be most appropriate to explore and analyse it. Similarly I did not have a pre-existing philosophical or theoretical stance upon which to base my study. Instead this was a naturalistic enquiry intended to study swearing without any experimental manipulation of variables.
Sandelowski (2000) described this method as useful in fields, such as this, where little is known, and as a low inference method which is likely to result in easier consensus among researchers; further, that qualitative descriptive studies offer a comprehensive summary of an event in the everyday terms of the event.

The synthesis of qualitative and quantitative methods can pose epistemological problems because the beliefs underlying the methodologies may conflict. The difficulty in merging quantitative and qualitative data analyses has been overcome in the present study by, as Mitchell (1986) suggested, analysing each type of data separately according to the principles pertinent for the type of data, and either using multivariate statistical analysis or searching for “logical patterns of relationship and meanings between and within significant variables,” with the researcher “left to search for a logical pattern in mixed-method research . . . piecing together many pieces of a complex puzzle into a logical whole” (Jick, 1983 in Knafl & Breitmayer, 1989, p.216). These authors suggested that the downside of mixed methods research is its complexity and time consuming nature.

Throughout the study I kept an electronic diary of the progress of my research in which I recorded the main points of my discussions with colleagues and supervisors, and my thoughts and feelings as the research advanced and at times seemed to regress. This has provided a chronological audit trail of critical incidents and decisions made as well as a record of key points raised by supervisors and nurses when discussing my research. Critical turning points were reviewed in the diary. An observational study of interactions between nurses and patients was considered, but ruled out by ethical implications. I did not proceed as originally planned with in-depth telephone interviews because of the volume of data I had gleaned from the questionnaire study: sufficient, I believed to satisfy the study aims. Koch (1994) pointed to this kind of journaling as a means of increasing self-awareness and providing material for reflection, and thus enhancing the credibility of qualitative research.

1.8 Significance of the study

I believed results from this study would be clinically relevant and applicable to nurses working across a range of settings. As observed by Jay and Clermont (1996, p. 4) and in my own clinical experience, students entering the mental health workplace have not been well prepared to deal with clients who swear. Knowledge about this type of
communication may assist in countering its effects, and help us to understand why people swear and the impact of swearing on others (Kinney, 1994, p.213).

So-called mild types of aggressive behaviour, such as swearing, cursing and repeated non-compliance, warrant further investigation in order to: (a) better understand their possible role in causing distress for mental health care workers; and (b) ascertain whether there are patterns in the sequence of aggression, such as escalation from verbal aggression to severe physical aggressive behaviour (Arboleda-Florez, Crisanti, Rose, & Holley, 1994, p.199).

There is a definite correlation between a positive therapeutic relationship and improved outcomes (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003), and swearing can adversely impact the therapeutic relationship between patient and nurse if a nurse acts reactively and instinctively to a patient’s use of swearwords. Skills in dealing reflectively with a patient’s use of language and an ability to move from a focus on the symptom to an understanding of the emotion behind the swearing are vital in this regard.

1.9 A note about the language

Throughout this thesis the term “patient” has been used: it appeared to be most appropriate as those referred to were all inpatients at the time, and it was the term most commonly used by the respondents to the questionnaire survey.

Supervisory discussions took place about sensitivities regarding expression of swearwords in the thesis. Italicising or capitalising them in academic texts may give the words more prominence than is their due; therefore I have throughout the text used single quotation marks when mentioning particular swearwords. Readers who are likely to be offended by swearwords are advised that the thesis contains many words that might be considered offensive, but need to be seen in the context of optimising therapeutic outcomes. When presenting this data I give similar advice to the audience.
1.10 Structure of the thesis

The thesis is presented in seven chapters. This first chapter has laid the foundations, discussed the background to the study, and introduced the research questions. The research has been justified, definitions presented and the methodology briefly described, the thesis outlined and limitations explained. Following this introduction a critical review of the literature pertaining to swearing is provided in Chapter 2. Chapter 3 discusses the role of swearing and psychopathology, and Chapter 4 the impact of swearing on nurses. Chapter 5 details the first part of the study pertaining to aggression in mental health inpatient settings and nurses’ responses to it. Chapter 6 reports the findings of the questionnaire study; Chapters 5 and 6 both include aims, methods, results and discussion for the respective studies. Chapter 7 includes an overall discussion of the findings, and addresses the implications for practice and education and proposals for further research. A reference list and appendices are included at the end of the thesis.
Chapter 2
Sociocultural, Linguistic and Developmental Understandings of Swearing

“The first human who hurled an insult instead of a stone was the founder of civilization” (Sigmund Freud).

2.1 Introduction

In order to discuss its impact on nurses the general characteristics of swearing will be considered. This chapter will explore the definitional aspects of swearing and its frequency, and examine the taboo and offensive nature of swearing as well as its positive aspects.

Swearing is a complex social phenomenon, and any consideration of it necessarily draws on a “very wide range of evidence in order to begin to explain both the source of the undoubted power of bad language and the process whereby inferences are drawn about speakers using it” (McEnery, 2006, p.1). “Swearwords are particularly important in terms of personality and culture” and swearing is a universal phenomenon, (Hartogs & Fantel, 1967, p.18), but until recently swearing has not been considered a legitimate research subject and little has been published on the topic. An initial foray into established nursing databases with reference to swearing revealed nothing, so literature from less formal references that had potential relevance for this study were located using Google to research contemporary cultural aspects of this subject.

2.2 Definition of key terms

The term “swearword” was not used until 1883 with the recognition of a class of words that should not be employed in reputable publications or included in dictionaries (Davis, 1999). The type of words considered swearwords changes over time and between cultural groups (Morris, 1993). What constitutes a swearword is generally defined by social codes, therefore swearing resists a concrete definition (Limbrick, 1991). Beers Fägersten (2000) stated that this is necessarily so because swearing is defined not in terms of specific words but rather as a type of language, apparently
contradicting a previous statement that “modern swearing is identified and defined by the use of particular words” (Beers Fägersten, 2000, p.5).

The greater its potential to offend, the more likely the word is to be considered a swearword (Beers Fägersten, 2000), because “At the heart of the obscene lies the power of taboo expressions to evoke dirt, ambiguity, anomaly, disorder, outrage, and danger” (Morris, 1993, p.207). Context and intent have been introduced by other authors: for example, to swear is to “use a taboo word in order to outrage someone suddenly” (Dessaix, 2003).

Montagu (1967, p.100) defined swearwords as “all words possessing or capable of being given an emotional weight,” and swearing as “the act of verbally expressing the feeling of aggressiveness that follows on frustration in words possessing strong emotional associations.” Similarly Kidman (1993) recognised the emotive element, and believed that the definition of swearing should encompass the speaker’s attitude and intent and the fact that swearing is a deliberately “bad” act designed for emotional expression.

Although swearing can be used to convey strong emotions, these definitions exclude other motivations for its use. Andersson and Trudgill (1990) comprehensively defined swearing as language use in which the expression:

(a) refers to something that is taboo and/or stigmatised in the culture;
(b) should not be interpreted literally;
(c) can be used to express strong emotions and attitudes.

Therefore in this study I have used Andersson and Trudgill’s definition, but will re-examine it in the light of data obtained in the study.

Terms used as partly or wholly synonymous with swearing include: dirty words (Allan & Burridge, 1992; Arango, 1989; Davis, 1999; Jay, 1994); cursing (Hollander, 1960; Jay & Clermont, 1996); obscene language or obscenity (Baudhuin, 1973; Fine, 1981; Foote & Woodward, 1973); bad language (Davis, 1999; Andersson & Trudgill, 1990); expletives (Hughes, 1992; Staley, 1978); taboo words (De Klerk, 1992; Gallahorn, 1971); four letter words (Dooling, 1996); and profanity (Baseheart & Cox, 1993; Beers Fägersten, 2000). Some of the terms used to describe swearwords such as vulgar language, obscenities, bad words and dirty words are not value-neutral and denote a
negative attitude to the words (Mohr, 2003; Nurmi, 2004). Others, such as calling all swearwords “Anglo-Saxon words,” are misleading; only terms relating to excreta are exclusively Anglo-Saxon in origin (Hughes, 1991). This subjectivity is symptomatic of a phenomenon which is threatening and subversive: “The sheer absence of a secure name [is] a symptom of the taboo” (Veltman, 1998, p.302).

2.3 Classification

Many attempts have been made to define, classify, and characterise swearwords, for example into religious, sexual or excretory categories. What these classifications imply is that swearing is merely a linguistic category of words grouped by subject matter, and they fail to capture its quality as a “culturally-driven speech act” (Kidman, 1993; Wajnryb, 2004). A method more pertinent for this study is categorisation by function.

Eckler (1986, p.202) suggested the following functional categories:

1. To relieve frustration and pain, as when one has stubbed a toe.
2. To get attention; for example, an army sergeant speaking to an individual or small group “without animosity.”
3. To elicit a reaction; for example, children and obscene telephone callers using swearwords.
4. To shock or challenge society’s norms or laws; for example, graffiti writers, or writers of song lyrics, books or magazines who shock a “generalised absentee” target.
5. To reproach or reprimand.
6. To engage in witty verbal duels, such as “the dozens.”
7. To disparage perceived physical or mental differences.
8. To report conversations realistically in films or books.
9. To stimulate sexual excitement in an intimate relationship.

(Adapted from Eckler, 1986, p.202)

Eckler (1986) has omitted other categories worthy of mention, such as humour, casual use, the establishment of a group identity, and a form of “word magic.” It has been suggested that people who are inarticulate use swearwords largely as a result of impoverished vocabulary or as a sort of verbal “cement” (Burgen, 1999). Burgen also argued that if some English speakers were asked to omit the word ‘fuck’ their speech would be slow and halting, because their syntax is filled with various forms of the word and it is this that gives rhythm to their speech. Other authors have
termed this type of habitual swearing as “lazy swearing” (Ardo, 2001) or non-emphatic swearing (Hirsch & Andersson, 1985). Heilpern (1999, in White, 2002, p.30), an Australian magistrate, stated that he regularly had before him in court witnesses who used the word ‘fuck’ in every sentence, without intending to offend or realising that others would find it “other than completely normal.”

The use of swearwords and taboo words is also a linguistic device employed to affirm in-group status and establish boundaries and social norms for language (Dewaele, 2004). Swearing has further been described as a kind of “psychological magic” used to make an unpleasant situation disappear (Burke, 1993, p.5). For example, the cry of “Oh God” can be seen as an attempt to call upon divine intervention (Hirsch & Andersson, 1985), whereas other swearwords are uttered as a curse.

Swearwords are used primarily in a connotative way (Taylor, 1995). The connotation of a word refers to the emotional nuances commonly associated with it, whereas denotation refers to its literal meaning. Thus the usual meaning of a phrase such as “this food is crap” is a connotative one (i.e., the food is bad) rather than the denotative meaning (i.e., the food is actually faeces). Similarly, whilst various categorisations of swearwords have been proposed (e.g., excretory, sexual, religious) (Baudhuin, 1973; Cameron, 1969), these ignore the connotative sense (Jay, 1977). It is less useful to categorise the word ‘prick’ (applied to a person) denotatively, as a sexual word, than connotatively, as an insult meant to offend. ‘Copulate’ and ‘fuck’ bear the same denotative meaning but their connotations are quite different.

Given the words ‘fuck’, ‘shit’, and ‘bastard’ contextualised either connotatively or denotatively in sentences, participants in a questionnaire study were asked how frequently they used the words in the given context (Rieber, Wiedemann, & D'Amato, 1979). The word ‘fuck’ was reacted to more strongly than the other two words, but the connotative context predominated in use of all three. The authors concluded that obscenities used literally can be considered as harsher and more offensive than those used connotatively.

This view contrasts with that taken by Taylor (personal communication, 2004), who suggests that the connotative use of swearwords is usually associated with a deliberate intention to be offensive or to insult. Chandler (2002, p.1) also states that words may be regarded as less offensive in their denotative than in their connotative sense: for
example, “I need a shit” may be seen as less offensive than “this place shits me.” This harks back to the definitional debate on what constitutes swearing.

Words in the questionnaire forming a part of the current study were used in both connotative and denotative ways to assess whether nurses rate the degree of offensiveness differently according to contextual meanings. The hypothesis was that words used in a connotative sense would be rated as more offensive than those used in a denotative sense.

2.4 Taboo

A discussion of swearing invariably involves the concept of taboo. Taboo is used to refer to “norms whose violation can be expected to provoke inflexible, disgust-related responses” (Gutierrez & Giner-Sorolla, 2007). Swearwords are attached to taboo subjects, and all swearing is taboo language because its expression is restricted and dependent on context (Mercury, 1995). The use of offensive language is akin to the breaking of a social convention or violation of a taboo (Allan & Burridge, 1992; Hughes, 1991).

Linguistic taboos exist in most cultures (Risch, 1987). Taboo words are those that are forbidden or disapproved of and would be offensive if spoken in most contexts, with taboo language gaining its power through a process of stigmatisation (McEnery, 2006). But as Freud (1919) notes, the concept of taboo attaches not only to the dangerous, forbidden and unclean but also to the sacred and consecrated. In Western society taboos attach to bodily functions: bodily waste, sex, religion, ethnic groups, food, dirt, and death – frequently objects or acts too private to be shared (Abel & Buckley, 1977), and what are thought of as taboo terms are avoided because their use is regarded as distressful in particular social contexts. In mental health nursing there are taboos against referring to patients by such derogatory names as “loonies,” “schizos,” or “retards.”

Taboo words are by definition not spoken of or written in ordinary contexts of communication; when violated, the social constraints attached to taboo words can add great impact (Andersson & Trudgill, 1990; Peters & Taylor, 2002), and they are frequently used because they are powerful (Trudgill, 1983). Taboo terms are often described as being unpleasant or ugly-sounding because people react as if there were a real connection between the “actual physical shape of the words and their taboo
sense" (Allan & Burridge, 1992; Burridge, 2002, p.161), and believe “that words are able, in and of themselves, to corrupt” (Gray, 1993, p.316).

“The salient point about swearwords is that they must cause shock,” and with overexposure or changing societal norms the power to create this shock is gradually eroded (Ludowyk, 2001, p.3). The current frequency of use of words such as ‘fuck’ has for some people reduced their taboo status (Dessaix, 2003). It has been argued that the power of swearwords to shock and offend, and therefore their political potency, is being undermined by their assimilation into mainstream films and literature (Paletz & Harris, 1975). It is likely that some nurses, through constant exposure to swearing by patients and colleagues, no longer experience shock and outrage when they hear these words. Similarly, ‘bloody’ and ‘bugger’ are no longer taboo in Australia and therefore words of more “power and horror” are needed to replace them (Nash, 1996, p.26). Another way of increasing the power and horror is to use repetition or several swearwords in the same phrase.

Within the body of literature about swearing the emphasis has been on its historical aspects (Burridge, 1993; Hughes, 1991; Montagu, 1967); the grammar and semantics of swearwords (Goddard, 1991; Kidman, 1993); cultural aspects (Alford & Alford, 1981; Fine, 1976; Goddard, 1991; Lund, 2002; Wierzbicka, 2002); gender (Coates, 1993; De Klerk, 1992; Cohen & Saine, 1977; Kemper, 1984; McEnery & Xiao, 2004; Mills, 2003; Preston & Stanley, 1987; Selnow, 1985; Staley, 1978); word offensiveness (Jay, 1992; Jay, 1999; Foddy, 1981; La Barre, 1955); and the media (Atkin, Smith, Roberto, Fediuk, & Wagner, 2002; Ackland, 2004; Brown & Hendee, 1989; Corbridge, 2004; Minehart, 2004; Phillips, 2002; Strasburger & Donnerstein, 1999; Whittington & Patterson, 1996). Increasingly there has been work on the impact of swearing on others (American Academy of Pediatrics, 1996; Beers Fägersten, 2000; Dillard & Harkness, 1992; Ney, 1987); the use of swearing by health care professionals within the context of a therapeutic relationship (Ackerman & Hilsenroth, 2003; Kottke & MacLeod, 1989; Kurklen & Kassinove, 1991; Maier & Miller, 1993); and the developmental aspects of swearing (Haggerty, 1928; Hughes & Dunn, 2002; Slatalla, 2000; Suarez, 2002; Xie, Swift, Cairns, & Cairns, 2002).
2.5 Offensiveness

Offensiveness is defined as “material which causes outrage or extreme disgust” (Commonwealth of Australia, 2001a, appendix A). Jay (1977) described offensiveness data as referring to the emotional reaction generated by a swearword in a particular context.

Elias (1978) referred to a process beginning in about the 11th century which employed a more prescriptive approach to beliefs, norms and values about the body, bodily functions and body products. Attitudes towards natural functions became beliefs about what constituted civilised behaviour. In about 1530, previously publicly displayed bodily functions such as defecation and farting began to be conducted in private, associated with, from the 1600s, an increasing reticence in dealing with these subjects in the written word. Lawler (1991) noted the absence of explanation for the stricter standards of privacy for excretion and sexuality than for other functions such as eating.

Words used to describe offensive concepts, usually in the domains of taboo, disgust or religion, become offensive words (Jay, 1999). The greater its offensiveness, the more likely is a word to be considered a swearword. ‘Shit’, ‘fuck’, ‘cunt,’ and ‘motherfucker’ have been rated as the most offensive words, although the order in which they were rated varied (Baudhuin, 1973; Bostrom, Baseheart, & Rossiter, 1973; Jay, 1978; Mabry, 2003). In general words with a sexual connotation are rated as the most offensive, those with religious connotation least offensive, and those relating to excretory functions fall between in terms of offensiveness (Baudhuin, 1973, p.401; Jay, 1978).

Closely aligned with offensiveness is the emotion of disgust, defined as the prospect of “oral incorporation of an offensive object” (Rozin & Fallon, 1987). Disgusting items have the capacity to contaminate and are usually associated with animals or animal products (Rozin & Fallon, 1987). Participants in a study concerning body parts and body products rated as the most revolting substances vomit, shit, semen, snot, pus, urine, spit and farts (Allan & Burridge, 1991). These descriptive terms varied in their offensiveness, with medical terms less taboo than vulgar references for example, “urine” was less offensive than ‘piss’ (Allan & Burridge, 1991). Faeces, pus, vomit and some insects commonly evoke a reaction of disgust. Disgust is probably one of the
earliest emotions to develop (Rozin & Fallon, 1987) and words themselves can become disgusting through their association with disgusting items (Jay, 1999).

Offensiveness can also be gauged by complaints received when swearwords are used in films and television Jay (1999). The offensiveness ratings of The British Board of Film Classification are shown in Table 2.1 (McEnery, 2006):

Table 2.1 Scale of offence based on British Board of Film Classification

<table>
<thead>
<tr>
<th>Categorisation</th>
<th>Words in the category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Mild</td>
<td>bird, bloody, crap, damn, god, hell, hussy, idiot, pillock, sod, son-of-a-bitch, tart</td>
</tr>
<tr>
<td>Mild</td>
<td>arse, balls, bitch, bugger, christ, cow, dickhead, git, jesus, jew, moron, pissed off, screw, shit, slag, slut, tit, tits, toser</td>
</tr>
<tr>
<td>Moderate</td>
<td>arsehole, bastard, bollocks, gay, nigger, piss, paki, poofter, prick, shag, spastic, twat, wanker, whore</td>
</tr>
<tr>
<td>Strong</td>
<td>fuck</td>
</tr>
<tr>
<td>Very strong</td>
<td>cunt, motherfucker</td>
</tr>
</tbody>
</table>

In contrast the Australian Office of Film and Literature Classification Guidelines do not specify a full range of particular words, instead stipulating that a G-rated film may include the words ‘bloody’ or ‘bugger’, at ‘PG’ level it may include ‘shit’, and at ‘M’ level it includes ‘fuck’ (Commonwealth of Australia, 2001a, appendix B). “Coarse language” is described in more general terms as mild or strong, detailed, gratuitous, and aggressive (Commonwealth of Australia, 2001a, appendix A).

Earlier work found that hearing the word ‘motherfucker’ was rated as more offensive than witnessing extreme violence, defecation, or sodomy (Jay, 1978) and less offensive only than witnessing murder, rape, child abuse, or masturbation. This apparently extreme reaction to obscene language is seen in relation to other forms of obscenity and may include physical, cognitive, negative and positive responses (Foddy, 1981).

A survey by the Broadcasting Standards Authority of New Zealand found ‘cocksucking’, ‘motherfucker’, ‘cunt’, and ‘nigger’ to be totally unacceptable to 50% or

The present study aimed to address the limitations of one study in which Jay (1977) asked college students to judge how offensive “to a significant part of the population” certain words would be; the list included swearwords used only in a connotative way. This unsatisfactory requirement for participants to predict ratings of offensiveness to others would produce unreliable data; his terminology was vague and would result in variable interpretation (Beers Fägersten, 2000). In the present study nurses instead were asked to rate offensiveness from their own point of view, and contextualised swearwords were used in both connotative and denotative ways.

2.6 Context

Context, consisting of the speaker, the listener, physical setting and topic, is the ultimate decider of whether a word is offensive (Jay, 1977) and influences both use and perceptions of swearing. For example, “you son-of-a-bitch” can be used to express anger and disgust, or surprise and admiration. Cues to the correct interpretation would be gleaned from the speaker’s intent, facial expression, tone and gestures, and the relationship between the speaker and subject (Hirsch & Andersson, 1985). Context is critical in determining the meaning of an expression and what constitutes politeness (Allan & Burridge, 1991). In Bailey and Timm’s questionnaire study (1976), respondents frequently commented about the impact of context on the decision to swear or not: for example, refraining from swearing in front of religious people, parents or children. Despite the widespread belief that context is vital to understanding, there has been throughout the literature on swearing little systematic research on the association (Winters & Duck, 2001).

In an Australian judgment a magistrate ruled it not offensive to use the word ‘fuck’ when arguing with a neighbour, whereas it would be offensive in other circumstances such as “in a church or schoolroom.” He went on to say that the word was becoming “increasingly frequent in everyday use and must be losing its powers to shock” (Taylor, 1995, pp.230). But swearing in the wrong context can still cause public outrage: Adrienne Ryan, mayor of Ku-ring-gai, used the words ‘fuck’, ‘bloody’, and ‘dick’ in a
speech to hundreds of school children in a self-reported attempt to speak to the students as their equal, eliciting considerable disapproval from the public (Astle, 2004).

2.7 Frequency

Despite its frequent occurrence in everyday speech, linguists and psychologists have developed theories of language that exclude swearing (Jay, 1999). Many studies of word frequency have been criticised on the grounds that swearwords were omitted, that sampling was conducted in a biased manner such that swearing was under-represented (Beers Fägersten, 2000), and that the studies were outdated or based on written rather than oral samples (Jay, 1992).

It is a serious methodological error to assume that written and spoken English are equivalent, but the Thorndike-Lorge 1944 word frequency count was accepted for three decades as a baseline of word frequency although it contained no swearwords and was based on the written word (Cameron, 1969). Using the British National Corpus, a 100,000,000-word collection of samples of written and spoken present-day English, McEnery and Xiao (2004) found that ‘fuck’ occurred more than 12 times more frequently in the spoken than the written word and ‘fucking’ 20 times more frequently.

An oft-quoted study by Ross (1960) involved observation of swearing without the acquiescence of the participants. She noted that rates of swearing were socially determined, with non-swearers apparently inhibiting the swearing of the group. Ross observed two types of swearing: (a) “social swearing,” a sign of being one of the group and depending on the audience for effect; and (b) “annoyance swearing,” which was a reaction to stress regardless of the audience. Rates of swearing increased when the group were relaxed and happy and slightly increased under mild stress, but decreased when they were “really annoyed” or tired; these mood states were based on the researcher’s subjective judgments. Social swearing was easily inhibited by the lack of an appreciative audience or the presence of non-swearers: When three non-swearers left the camp, the swearing rate doubled and remained high.

Despite the numerous methodological weaknesses in her study, Ross’s conclusion that there were two types of swearing is still worthy of further examination. Ljung (1986, in
Also made a distinction between aggressive swearing and social swearing, with the latter apparently related to and strengthening group affinity.

Cameron (1969) found that swearing made up 8.06% of the average college vocabulary, 12.7% of leisure conversation, and 3.5% of work conversation, with 7 swearwords in the list of 50 most frequently used words. Nerbonne and Hipskind (1972) sampled a college population and found a similar percentage of swearwords (7.44%), but lower percentages in the general adult population; the authors suggested that the high percentage was related to the population sampled, and that undergraduate frequency rates were not representative of those of non-students.

Jay’s own attempt (1980) to establish word frequency in colleges and schools entailed the use of hidden mini-recorders to tape 15 minute segments of student conversations. The 15 most frequent words accounted for 25% of the data, and the words ‘fuck(in)’, ‘shit’, god(damn), and ‘hell’ accounted for most of the swearwords recorded; swearword usage was less than 1% in both samples, the low figure accounted for by the presence of adult recorders and the type of locations used on the campus (Jay, 1992). In another study Jay used a “field card” technique to record over 2,000 conversation samples containing swearwords, and found that males were more likely to swear than women: Males produced a range of 58 different words to females’ range of 19; and both males and females were more likely to swear in the presence of same sex companions (Jay, 1992). Again two words, ‘fuck’ and ‘shit’, accounted for a large part of the data set. Jay (1977) found that the association between word frequency and offensiveness was usually an inverse one – the greater the offensiveness, the less the word was used in public, the exceptions being ‘fuck’ and ‘shit’ which accounted for about 50% of swearing in public.

The results of frequency studies are contradictory. In more recent studies based on covert recordings of speech samples of college students, swearwords accounted for 1% of the words used (Jay 1992). It is clear that reported frequency of swearing differs depending upon source of data and research methodology. Frequency studies are influenced also by which words are defined as swearwords. Few Australians would consider words such as “crotch,” “dink,” “dog,” “douche,” “moron” and “puke” to be swearwords as does Jay (1992), and Nerbonne and Hipskind (1972) included words such as “suck,” “queer” and “boob.” No frequency data are available for the Australian context.
Although recently there has appeared to be a perception that the frequency of swearing was increasing (e.g., Wachal, 2002), people have misinterpreted less inhibited swearing as a sign of more swearing, and the actual frequencies are not easy to verify (Harris, 1990). Studying swearing on college campuses, Jay (1999) concluded that the swearing lexicon was “remarkably stable” \((r = 0.89)\) comparing data from 1986 with 1996, 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.

Speech is an obvious marker of socio-economic status and swearing is also a marker of status, with the language of power being characterised by a relative lack of bad language usage (McEnery, 2006). Hughes (1992, p.302), in a study of expletives of working class women, noted that swearwords were an integral part of their language and quoted one of the women as stating: “It’s not swearing to us, it’s a part of our everyday talking.” She concluded that rather than being employed as a weapon, swearing is more frequently used out of habit, because of frustration with authority or because of the lack of an alternative means of self-expression. More recently a frequency analysis revealed that greater use of taboo words was made 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, & Hodges, 1997).

### 2.8 Swearing and racism

Whilst words relating to sexual functions remain offensive, racial and ethnic words have perhaps become the most taboo in contemporary society (Burridge, 1999a; Wachal, 2002). In societies where people from diverse cultures live together with more proximity than assimilation, the ethnic slur has become a significant part of the language (Sagarin, 1962). Hughes reported in 1991 that in recent times there had been an increase in the number of terms; these racist epithets might refer to religious or ethnic origins. Racism was viewed by Hartogs and Fantel (1967) as obscenity in the socio-political sense, and they described the derogatory words applied to particular groups of people as designed to strip them of their humanity.
The current political climate has tabooed personal vilification based on looks, mental and physical capacity, and sexual preference (Butler, 2003) as well as racist, sexist, and ageist language, whilst profanity and blasphemy have lost much of their taboo (Allan & Burridge, 1992). The taboo against using racial terms such as ‘Abo’, ‘boong’, and ‘chink’, arising from changing social attitudes, has resulted in recently published dictionaries labelling such expressions as “offensive.” Ethnic slurs change their level of offensiveness in the same way as other swearwords: The term ‘nigger’ was not offensive to blacks until whites used it in a derogatory way (Hughes, 1991), and in Australia ‘wog’ has lost some of its taboo because of recent humorous usage.

Jay (1978) found that words based on racial or ethnic semantics appeared in the upper half of the offensiveness ratings, although not considered as offensive as words relating to deviant or derogatory features of sex. The British Broadcasting Standards Council observed in a selected group of respondents that women rated swearwords as more offensive than men did; as did older people compared with younger, although younger people were more offended by racially based words (Hargreave, 1991 in Hughes, 1991).

In a recent Australian example, the captain of South Sydney football club called an Aboriginal player a “black cunt.” In his apology the captain said, “I’ve done the wrong thing. It’s probably the worst thing you could ever do. Although it’s only words, they’re pretty harsh words that I’ve said ... it makes me feel ill what I said” (Pace, 2005).

2.9 Swearing and Religion

“[Swearing] is a kind of saying our prayers backward indeed... Tis the language of Hell, which can never fit us to be citizens of the new Jerusalem, but marks us out for inhabitants of that land of darkness” (Allestree, 1731 in McEnery, 2006, p.96).

In Britain until the end of the 17th century the penalty for blasphemy was burning at the stake (Peters & Taylor, 2002). Not surprisingly, religiosity is still linked to offendedness (Jay, 1999), and complaints about television content are linked to religiosity and sexual conservatism (Hughes, 1991; Jay, 2003). Researchers in a British study found that television viewers were more offended by bad language than by sex or violence, and observed a link between offendedness and those identifying as being religious (Wober, 1980 in Jay, 1992).
However, no significant correlation existed between religious background and swearword usage in an earlier questionnaire study based on 21 familiar situations, all but one of which were annoying or unpleasant and thought to be likely to result in the use of a swearword (Bailey & Timm, 1976). Contrary to expectations, some respondents reporting a strong religious background also described the highest frequencies of strong expletive use. Their belief, perhaps, gave them a more meaningful taboo to break (Wajnryb, 2004). Bailey and Timm found that use of strong expletives and extent of religious training were negatively correlated. The present study included assessment of the participants’ religious background and current active involvement in religious activities.

In another questionnaire study using methodology similar to that of Bailey and Timm (1976), Staley (1978) found, in a sample of 55 almost exclusively middle class linguistics students, a negative correlation between extent of religious training and swearword use. The survey also found, in confirmation of Taylor’s (1976) premise that Protestants would be likely to swear less than Catholics, that practising Protestants who reported extensive religious training averaged 3.8 swearwords per questionnaire and non-practising Protestants used 9.5. Staley reported that the difference between practising and non-practising Catholics was not statistically significant; however, the small sample size limits generalisation from the study. Aman (in Richler, 1999, p.150), from his lifelong study of swearing, believed that Protestant societies use swearwords based on body parts and functions, sex and excretion, whereas Catholic swearing employed more blasphemy.

2.10 Gender

In Tudor times women swore as much as men although they lacked their range, according to Montagu (1967); Queen Elizabeth used profanities such as ‘By God’ and ‘God’s death’, but “ladies” no longer swore in the 17th and 18th centuries. McEnery (2006, p.115) stated that by the end of the 18th century swearing was seen by some as more of a sin than “free association with carnal company” and only a few steps away from death and damnation. He noted that in the “passivisation and angelisation of women” that began in the Restoration bad language came to be seen as a negation of womanhood, a contemporary writer opining “there is no noise this side of Hell can be
more amazingly odious than a woman swearing” (Allestree, 1673 in McEnery, 2006, p.115).

Much has been written about the difference between the sexes in their use of obscenities: Smith (1951) boldly stated that women swear less than men due to their less aggressive nature; other authors have described women’s language as “euphemistic, correct, modest, and polite” compared with men’s (Preston & Stanley, 1987, p.209). Bailey and Timm (1976) asserted that men know a wider range of expletives than women, and that age is also a factor, with women over 43 refraining almost entirely from the use of strong expletives but younger women aged 19 – 34 frequently using them (Bailey & Timm, 1976). Other studies have shown that women report less use of obscenities, express a more negative impression of the use of profanity (Selnow, 1985), and react more strongly to obscene language than men do (Rieber et al., 1979). Fine and Johnson (1984) found that females begin using obscenities later in life than males, and adolescent boys are happy to use stronger expletives than girls (De Klerk, 1991).

Gender-based differences become apparent from the start of school and persist right through into old age, with swearing peaking during the adolescent years. School-aged boys swear more frequently than girls and use more offensive words (Jay, 1992). Stenstrom (1995) found no gender differences in frequency and choice of words in adolescents, but that adult women swore more although using less taboo swearwords than men. Similarly, two Sydney studies of adolescent speech showed how adolescents’ usage of language changes with age; girls become increasingly conformist, saying that they no longer like swearing, whereas boys embrace swearing as part of their language (Eisikovit, 1987; 1988 in Coates, 1993).

More recent studies have indicated that males and females are equally likely to use swearwords, but the words used differ: Males use more offensive swearwords than do females (McEnery, 2006). McEnery reported that males more often direct swearwords at a male than a female target, females are more likely to direct swearwords at another woman, and overall more swearwords are directed at males. Many respondents to a questionnaire indicated the use of milder expletives in consequence of an unexpected stumble in the presence of a member of the opposite sex than if alone or with a member of the same sex (Bailey & Timm, 1976). However Limbrick (1991) found that females increased their swearing in mixed sex conversations.
Studies exploring gender have tended to differ in their findings because of variation in the contexts in which they were conducted (Winters & Duck, 2001); in addition, small samples limit the generalisation of findings. It appeared to Cohen and Saine (1977) that norms associated with traditional sex roles have discouraged swearing amongst females, the converse being true for males. Stapleton (2003, p.23) concisely summarised recent research into gender in the following way: “Women’s swearing is shown to function in a range of subtle and context-specific ways which, against the backdrop of prevailing sociocultural norms and expectations, can provide a powerful identity resource for female speakers.”

2.11 Rules

Beliefs and attitudes about swearing will influence its use, and some research has focused on what “rules” people internalise: For example, role expectations such as those of parent or teacher may more than gender influence the use of swearwords (De Klerk, 1991). Andersson and Trudgill (1990) cited a Swedish questionnaire study in which it was found that 75% of adults disliked swearing and wanted their children to avoid it, although the same percentage swore themselves.

Basing her conclusions on a small questionnaire study of six working class women, Hughes (1992) found that the women had particular rules about swearing: All thought it was disrespectful to swear at or in front of parents but there was less concern about swearing in the presence of their doctor, and for only one of the six would her child’s presence deter use of particular words. In a questionnaire study of American college students, most people indicated they would restrict the use of obscenities near children (Foote & Woodward, 1973, p.271). In the questionnaire forming a part of this study, nurses were asked whether they observed any rules about their own swearing.

2.12 Positive aspects of swearing

The literature has tended towards the assumption that swearing is inevitably negative, and neglected the viewpoint that swearwords can be anything but “bad words” (Beers Fägersten, 2000), but the persistence of swearing and slang and other forms of bad language suggests that it does have a positive value; this is what in sociolinguistics might be termed “covert prestige” (Andersson & Trudgill, 1990, p.8).
Jay (1999) maintained that swearwords are fundamental linguistic expressions of deep emotional feelings, able to convey an intensity of feeling that a non-taboo word cannot, but society tends to deny their legitimacy as vehicles for personal or public communication (Maier & Miller, 1993). Verbal aggression is sometimes used to instil positive behavioural change: Military drill sergeants and sports coaches attack self-concept to motivate their charges (Infante, 1995).

Bad language is often associated with toughness, strength and rebelliousness, characteristics that may be valued amongst a particular subsection of the community. It can be used as a conscious strategy to elicit feelings of admiration and interpersonal identification with the speaker (Bostrom et al., 1973), although the authors suggested that the use of profanity was unlikely to be persuasive and for an audience was likely to reduce credibility.

Endorsing a frequently expressed view of the value of swearwords in "letting off steam," Berger (1973, p.283) referred to their contribution to his "psychological salvation." All but one of a sample of 40 college students cited emotional release as their reason for swearing (Foote & Woodward, 1973). This subject will be revisited in the following chapter.

Swearing can also be used as a "pat on the back" – the boss may swear or use a slang expression as a friendly gesture; it can be one of many ways of showing solidarity and strengthening a group (Andersson & Trudgill, 1990). The same words, for example, ‘shit’, ‘fuck’, ‘bullshit’, express negative feelings and also positive ones such as amazement and delight (Kidman, 1993). Similarly, in her 1992 study, Hughes recorded working class women calling their children "little bastard" or "little twat," and that these terms, unless in a disciplinary context, were frequently used as endearments. Winters and Duck (2001) stated that swearing might be an indication that the speaker was relaxed, and could be used for expressing sympathy or friendliness.

Well-educated people may use swearwords because they are "more honest and express their feelings more directly" (Nurmi, 2004, p.1): This was a point central to the defence in "The Lady Chatterley" trial, Regina v. Penguin Books Ltd: Counsel argued that D.H. Lawrence used four-letter words because there was "no proper language to talk about sexual matters," that he was attempting to redeem words usually viewed as
coarse and obscene (Hough in Rolph, 1961, p.44), and that the words in their original sense were not shameful (Gardner in Rolph, 1961).

Beers Fägersten (2000) found swearing to be a linguistic device to affirm in-group membership and establish boundaries and social norms for language use. Swearing can be a badge of membership (Dessaix, 2003), and is a powerful method of rebellion against the prevailing culture (Hartogs & Fantel, 1967). In-group swearing has as a component: “Other people would say this is a bad thing to say,” making the distinction between “them and us” (Kidman, 1993, 6.2). Thus swearing “can convey emotions which are antithetical to traditional notions of aggression/dominance [and] provides a group-defined way of expressing ‘strong feelings’.” (Stapleton, 2003, p.28).

A prominent feature of Laskiowski 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 the males in late adolescence to mid thirties; conversational swearing was common but it was also used 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 was used 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.

Although swearing is used to express anger, racism, and other negative emotions, humorous and erotic verbal exchanges frequently employ swearwords (Crest, 1974 in Winters & Duck, 2001; Jay, 1994). Joking establishes group cohesion which derives from sharing experiences (Fine, 1976). The questionnaire study which formed part of the current study attempted to avoid the assumption that nurses would invariably find swearing offensive, and aimed to establish whether they used it in a therapeutic context.

2.13 Developmental aspects
Through learning and conditioning, children acquire knowledge of swearwords early in their language development and from the start of normal language use begin to apply them in varying degrees of offensiveness (Jay, 1992), progressing from swearwords based on scatological references and perceived differences about others in childhood to more abstract and socially-based swearing in adolescence (Jay, 1999). “Obscene words are learned along with the knowledge that they are powerful, dangerous forces that can get people punished or attacked” (Morris, 1993, p.200). Children have to learn to identify the appropriate swearwords as well as appropriate occasions, which requires the building of mental models of what is offensive and of contextual constraints, as in language development in general (Jay & Clermont, 1996). In order to swear “effectively,” children must learn what are the emotional effects on others of swearwords, as well as the semantic and syntactic rules for swearing and the linguistic rules associated with politeness (Jay, 1992; Jay, 1999).

Obscene or profane language is frequently an integral part of the subcultural language of prison inmates and other selected patient groups, such as adolescents (Maier & Miller, 1993), and verbal aggression is widespread in adolescents (Atkin et al., 2002). Adolescents use swearwords more heavily than adults, perhaps to establish group identity, but their primary usage relates to sex and drinking with the most frequently used swearword being ‘fuck’, whereas the taboo in adults’ expressions stems from religious origins, with the most frequently used word being ‘God’ (Stenstrom, 1995). Cheshire (1982, p.101) noted that swearing has particular value for adolescents as a “major symbol of vernacular identity;” this age group therefore exhibits a higher rate of swearing. McEnery (2004) found that the use of bad language increases up to the age of 25 and then generally steadily declines in both men and women. The degree of offensiveness of the bad language words shows a similar pattern.

No work has been done on swearing in an acute child and adolescent mental health facility, but Blanchard (cited in Jay, 1999, p.118) found that institutionalised children with developmental delay quickly acquired the use of profanity from others, and more intelligent children used profanities to express resistance to hospital routine and discipline. The most frequent targets of their swearing were their peers; swearing was frequently habitual but was also used in relation to teasing, discipline and disappointment.
2.14 Conclusion

This chapter has outlined the general characteristics of swearing, with particular emphasis on how it is related to nurses and nursing, and has laid the foundations on which the study was built. The next chapter will explore swearing related to psychiatric disorders and its relation to verbal and physical aggression.
Chapter 3

SWEARING AND PSYCHOPATHOLOGY

A famous swearer, Rabelais, in the 15th century said, “Swearing…doth your spleen a great deal of good…if I durst hazard upon a little fling at the swearing game, though privily and under the thumb, it would lighten the burden of my heart and ease my lights and reins exceedingly” (cited in Cohen, 1960, p.1657).

3.1 Introduction

Three kinds of factors affect swearing: (a) sociocultural (gender, cultural background, taboo, law and etiquette, context); (b) psychological (age, coping style, religiosity and moral reasoning); and (c) neurological (including the cerebral cortex, which governs speech comprehension and production, and subcortical systems, which regulate emotional reactions) (Jay, 1999). The preceding chapter dealt with the sociocultural and psychological aspects of swearing; this chapter will explore its relationship with psychiatric disorder, touching on some typically associated conditions such as Gilles de Tourette Syndrome (GTS). Psychoanalytic and neurophysiological theories of causation will be discussed, but the main emphasis of this chapter will be on the types of swearing encountered by nurses working in inpatient settings. The linkage between swearing and verbal aggression and between verbal aggression and physical aggression will be investigated, and also their measurement on inpatient units.

3.2 Normal and abnormal swearing

In order to examine abnormal swearing, it is necessary to define what “normal swearing” means. Swearing is often thought of as “uncivilised, primitive and animal-like, akin to non-verbal cries and gestures” (Veltman, 1998, p.306), but Jay saw swearing as purposeful and rule-governed with speakers acquiring the rules as they acquire their native language (Jay, 1999, p.22). Similarly, Taylor’s (1975) analysis of swearing in an Australian context noted that people swear according to well-defined rules. Social codes are observed and “successful swearers” stay within the conventions of the situation (Jay, 1992; Foote & Woodward, 1973), exercising discretion to avoid negative evaluation (Mercury, 1995, p.33). Use of swearwords is based on social utility, which may lead to benefits such as attention, praise, humour, and group cohesion; however, because of its sensitivity to context, inappropriate swearing may incur social costs such as social disapprobation, loss of job, or legal sanctions (Jay, 2003, p.148). Individuals who are disinhibited may violate these rules,
frequently using language at odds with the context, and may offend their audience and break social convention by, for example, swearing in front of children or around people of higher status.

3.3 Swearing associated with mental health disorder

Gilles de Tourette Syndrome (GTS) is a neurological disorder present in up to 3% of children and characterised by motor and phonic tics (Kwak & Jankovic, 2003, p.1). Coprolalia is probably the most socially handicapping symptom of GTS (Goldenberg, Brown, & Weiner, 1994, p.622) and can impair normal socialisation (Kwak & Jankovic, 2003, p.2). Coprolalia is a type of verbal tic and the term literally means “babbling about faeces” (Nuwer, 1982, p.364). It involves the irresistible urge to say obscene or taboo words and more specifically refers to the involuntary, egodystonic, explosive utterance of swearwords (Jankovic, Kwak, & Frankoff, 2006). It differs from “normal” swearing, which is a way of expressing emotion resulting frequently from frustration and is under voluntary control.

Obscenities and profanities are common, particularly when the speaker is surprised, frightened, or under other forms of stress (Nuwer, 1982, p.364). If swearing associated with GTS were also provoked by emotional distress then it might be assumed to involve use of words similar in type to those in other swearing, but Nuwer (1982, p.364) reported differences: In coprolalia physical obscenities are commonly used, religious profanities rarely, and there are differences in tone, pitch and volume, and in context. Kurlan (1992) noted sexual content as a characteristic and cross-cultural component of GTS, which accorded with previous studies, showing that the focus of coprolalia is often anatomy, sexual function and bodily function. Profanities and words with religious connotations are used infrequently, contrasting with approximately equal use by “normal” individuals (Goldenberg et al., 1992).

GTS also offers some evidence that coprolalic speech is generated in a different part of the brain from propositional speech, and the motor tics of Tourette's syndrome “are not preceded by the electrical brain impulses that precede voluntary acts” (Morris, 1993, p.199).

Coprolalia occurs in other neurological disorders such as cerebrovascular accidents and general paresis (Nuwer, 1982). Disorders also associated with excessive
swearing include latah (Bartholomew, 1994; Simons, 1994); encephalitis, klazomania, hemiballismus, Myryachit, dementia (Starling, 1987 in Van Lancker & Cummings, 1999); Sydenham’s chorea (Kushner & Kiessling, 1996 in Van Lancker & Cummings, 1999); post-ictal swearing in epilepsy (Chase, Cullen, Ernst, Niedermeyer, Stark, & Blumer, 1967); traumatic brain injury, paraplegia and spinal cord injuries (Van Lancker & Cummings, 1999); and in the elderly in the context of depression (Singer, 1997).

Swearing is likely to be a function of the right hemisphere in the majority of the population, whereas critical language abilities are represented in the left hemisphere, and expressive dysphasia is the result of damage in the Broca’s area located in the left frontal lobe (Jay, 1999). In adult speakers with aphasia and left hemispherectomy swearing is articulated almost normally, in contrast with other speech and language problems. It is not compulsive, as in GTS; it occurs when the patient tries to speak but instead substitutes a swearword (Van Lancker, 1988). Patients with aphasia may retain the ability to swear and react emotionally but are unable to produce the same words in a propositional context – for example, they may say “son of a bitch” but be unable to use the word “son” to refer to their male offspring (Van Lancker, 1990).

3.4 The psychoanalytic perspective

Freud (1905) in Wit and the Unconscious undertook an analytic study of obscenity, and in the same tradition Bergler (1936) viewed the relationship between obscene words and the Oedipus complex as unquestionable. Ferenczi (1911 in Bergler, 1936, p.229), in a study of obscene words completed on the basis of his own analytic experience, concluded that the “peculiar power” of obscene words derives from their inhibited development: “Obscene words have remained infantile and therefore retain their abnormally motor and regressive character” (Bergler, 1936, p.229). Bergler regarded “obscene words psychologically as oral flatus” (1936, p.230), a view based on earlier analysts’ theories and the observation that the majority of obscene words are anal in origin. Frequency studies would not support this statement, nor does it explain why words of a sexual nature carry more taboo.

Today biological explanations predominate, and little credence is given to the psychoanalytic explanations for coprolalia and the use of swearwords common in the
years between 1920 and 1970 (e.g., Stone (1954), tracing the cause to trauma or unresolved sexual conflicts (Morris, 1993).

### 3.5 The neurophysiological perspective

Swearwords differ measurably from neutral words in the process of storage and access, recall and recognition, with variations depending on gender and social situation (Allan & Burridge, 1992; Jay, 1999). Emotionally-laden words are more easily remembered than neutral words, an effect most significant in long term recall where swearwords are remembered four times more easily than neutral words (Dewaele, 2004). Taboo words are more arousing, as evidenced by physiological responses such as skin conduction, or neural activity such as amygdala activation, and are maintained in short term memory more accurately than non-taboo words (Jay & Janschewitz, 2007).

Clinical studies have shown that propositional (novel and creative) speech and non-propositional speech are mediated by disparate brain regions. Non-propositional speech is an automatic response (outside conscious awareness and difficult to control) to a strong emotion such as pain, surprise or frustration – arising in the right hemisphere of the brain, and comprising clichés, swearing, formulaic speech (such as greetings), and idioms (Jay, 1999; Van Lancker, 1988). Swearwords comprise a unitary “non-analytic” stimulus which is thought to be stored and processed wholesale, in contrast with propositional language words which can be arranged in various ways (Van Lancker & Cummings, 1999, p.96). Propositional swearing is the deliberate use of swearwords and is a more complex, controlled response (Jay, 1999).

### 3.6 Swearing, mood and psychosis

There is a paucity of literature on the link between swearing and the conditions commonly seen in inpatient mental health units in Australia. Jay (1999) noted that swearing may be associated with conduct disorder, anti-social personality disorder, and schizophrenia. Breiner (1983), in a rather superficial overview of children and their use of offensive language, stated that it is important to differentiate the basis of swearing as being functional or organic. He suggested that in schizophrenia obscene language will be expressed in a way that does not seem logical or organised and lacks the explosive quality of GTS, while in Bipolar Affective Disorder the expletives have a more organised quality. Frick et al. (1994) questioned the usefulness of swearing as a
diagnostic indicator of Oppositional Defiant Disorder because swearing was so widespread in the age group commonly diagnosed with this disorder, despite an earlier study showing its value as an inclusion criterion (Waldman & Lilienfeld, 1991).

In a study of 101 patients with severe mental illness, the majority suffering from schizophrenia or schizo-affective disorder, 40% had at some point during the illness threatened violence to their carers, 64% of whom reported regular shouting and swearing, and 42% of carers had experienced this quite regularly over the previous year (Vaddadi, Gilleard, & Fryer, 2002). There was no significant association between level of abuse and gender or educational status of patient (Vaddadi et al., 2002).

The only study of the frequency of swearing in a mental health setting entailed, during 160 hours of observation, the recording of all use of taboo, vulgar, obscene, and insulting speech on the shifts selected for investigation (Jay & Clermont, 1996). Participants were male and female patients with a DSM Axis I and/or II diagnosis, aged between 16 and 64 years. A total of 55 episodes was recorded, averaging three incidents per 8 hour shift (Jay & Clermont, 1996). The study showed that two words, ‘fuck’ and ‘shit’, accounted for 66% of the data, and these words together with ‘ass’ [sic], ‘hell’, ‘asshole’, and ‘piss’ accounted for 94% of the data. The main use of swearing was for expressing anger and frustration (Jay & Clermont, 1996).

3.7 Swearing and its relation to verbal aggression

English swearwords can be used in a figurative sense as terms of abuse (Taylor, 1994) and most definitions of verbal aggression include swearing or profanity (Adams & Whittington, 1995; Atkin et al., 2002; Cameron, 1988 in Uzon, 2003; Ney, 1987) with one author maintaining that “obscenity represents the most violent form of verbal aggression” (Buss, 1961 in Rothwell, 1971, p.235). Incorporating swearing in a verbally aggressive message intensifies the force of the communication (Kinney, 1994).

The combination of the threat of violence and offensive language has been perceived as high aggressiveness (Jay, 1999; Morrison, 1993). Swearing is unique because it can be used to provide an emotional intensity to speech that other words cannot achieve (Jay, 1999); for example, speakers may move up and down levels of taboo in order to accurately express their level of anger or vehemence (Taylor, 1994).
Verbal aggression is a communication “intended to cause psychological harm to another person or perceived as having that intent” (Vissing et al., 1991, p.225) and “denotes attacking the self-concept of another person” (Infante and Wigley, 1986, p.61). It may also be used to gain some reward through the use of aggressive speech (Infante & Wigley, 1986; Jay, 1999; Roberto, Meyer, Boster, & Roberto, 2003). Attacks can be directed professionally or personally and can include such behaviours as yelling, swearing, humiliation, verbal insults, and threats of harm.

3.8 The association between swearing, verbal aggression, and physical aggression

“Any inhibition of swearing merely serves to pile up an enormous amount of aggressiveness, and unless this aggressiveness can be expressed in some more acceptable manner…it is likely to prove disadvantageous to the general well-being of the person” (Montagu, 1942, p.200).

One motivation for studying swearing and verbal aggression is to ascertain whether there are patterns in the sequence of aggression, such as escalation from verbal aggression to severe physical aggression (Arboleda-Florez et al., 1994). This section will discuss the change from the concept of swearing as a substitute for physical aggression to the more contemporary view that it can act as an intensifier of aggression and as a portent of impending physical aggression, a matter of vital importance to nurses in their management of swearing and verbal aggression.

Montagu quoted Patrick (1901, in 1942, p.193) whose view was that swearing, as with all instinctive reactions, “does not generate emotion, but allays it” in a cathartic fashion. Swearing was seen as sharing the characteristics of other instinctive expressions of innate urges, those of crying and laughter: All are “a way of keeping the organism physiologically clean [and] getting rid of noxious humours,” and are characterised by definite physical changes (Montagu, 1942, p.200). Eckler (1986, p.203) debated whether swearwords were “a kind of safety valve, or an incitement to physical aggression.”

The view that verbal aggression serves a useful function as a substitute for physical aggression has had little evidence to support it; indeed, the escalation of aggression has been one of the two most researched effects of verbal aggression (Infante, 1995). Releasing one’s feelings may increase rather than decrease physical aggression. If the catharsis theory of aggression were valid then there would be a negative relationship between verbal and physical aggression: Instead Stets (1990) in her study on aggression within marriage found a positive and significant correlation – in more
than 50% of cases verbal aggression occurred alone, but when physical aggression occurred verbal aggression was also present in 95% of instances. The underlying model of aggression consistent with the findings suggested a two step process in which people moved from a state of no aggression to verbal aggression, and only then might they progress to a state in which physical aggression also was used; thus it was unlikely that physical aggression would not be preceded or accompanied by verbal aggression (Stets, 1990). Jay (1999) noted that the meaning to the speaker and addressee of verbal aggression was contextual and depended on the precipitants and consequences of swearing, implying that verbal aggression either could be a substitute for physical aggression or, in the form of insults, name calling and taunts, could escalate the addressee’s tendency to react with physical aggression.

In an inpatient setting violent language has been associated with similar behaviour; therefore staff needed to note its significance as a sign of imminent aggression (Kay, Wolkenfeld, & Murrill, 1988; Werner, Yesavage, Becker, Brunsting, & Isaacs, 1983). In a cohort study of 100 male inpatients diagnosed with schizophrenia, conducted by Werner et al. during the first seven days of their admission, 38 patients showed instances of verbal hostility and 15 patients were physically aggressive on one or more occasions; a moderate degree of association was found between the reported verbal and physical aggression. Twelve of the 38 verbally aggressive patients (32%) were also physically aggressive, and conversely 12 of the 15 physically aggressive patients were verbally aggressive. On the basis of those results, the authors calculated that predicting physical aggression from verbal aggression would result in a 68 % false positive rate.

Berkowitz (1962; 1973 in Infante, 1995) noted that verbal aggression frequently created the same reaction in the addressee, increasing in emotional intensity until physical aggression ensued, and Rothwell (1971, p.234) stated: “One of the principal functions of verbal obscenity is to provoke violent confrontations.” Verbal abuse has been found to have strong associations with physical assault (Linaker & Busch-Iversen, 1995), and can indeed signal potential physical aggression (Nield-Anderson, Minarik, Dilworth, Jones, Nash, O'Donnell, & Steinmiller, 1999). In a British study (Aiken, 1984) staff were interviewed immediately following an assault and asked to describe changes in three aspects of patient behaviour immediately prior to the incident. Of incidents of aggression reported, 81% were preceded by changes in verbal behaviour; in nearly 50% of cases this took the form of loud and/or threatening behaviour.
Another study, conducted in a psychiatric hospital by Whittington & Patterson (1996) and concerning behaviours displayed in the 5 minutes prior to an assault, showed verbal abuse (the best predictor) occurring 64% of the time, and swearing, present 52% of the time. None of the possible behaviours was exhibited by all of the patients during this time and the best predictor, verbal abuse, was present in only two-thirds of cases. Several of the behaviours commonly present prior to an assault were also seen commonly among the non-assaultive group: for example, 38% of the non-assaultive patients swore in the same time period and 54% were verbally aggressive. Swearing, unlike high overall activity level, loud voice, and fast speech, did not appear more commonly immediately prior to assault and was not a good predictor of aggression.

In a sample of 73 psychiatric inpatients whose aggressive behaviour resulted in staff applying restraints, 37 (51%) of the patients were loud and swore frequently prior to their aggressive outburst, but other behavioural cues such as anxiety and hostility were present more often (75% and 53% respectively) (Sheridan, Henrion, Robinson, & Baxter, 1990). In a study in a forensic setting, using the Overt Aggression Scale (OAS) [Appendix 1], Daffern et al. (2006) found that verbal aggression was the most common form of aggression (n = 196, 62% of incidents), followed by physical aggression (n = 92, 29.1%) and damage towards objects (n = 28, 8.9%).

The model of movement from no aggression to verbal aggression and then to physical aggression did not hold for verbal and minor physical aggression by women; low levels of verbal aggression and minor physical aggression appeared not to be separate and distinctive behaviours for women, as they were for men (Stets, 1990). A parallel explanation might be that because low-level female aggression was less likely to result in serious physical harm it was not regarded as seriously as male aggression, and therefore not reported to the same extent.

Generally young males are more likely to be aggressive, but in inpatient populations the research on gender differences in aggression by hospital patients is equivocal (Gillies & O'Brien, 2006). Swett and Mills (1997) concluded that gender was not a good indicator of aggressive behaviour; similarly Rabinowitz and Mark (1999) and Flannery (2002) found no differences between the genders in inpatient aggression. In contrast, several authors have found that male patients were up to three times as aggressive as females (Pearson, Wilmot, & Padi, 1986; Tardiff & Sweillam, 1979;
Saverimuttu & Lowe, 2000). However, others (for example, Hodgkinson, McIvor, & Phillips, 1985) found no differences in frequency between inpatient male and female involvement in aggression and Larkin, Murtagh, and Jones (1988) and Fottrell (1980) found that females were more often involved than males. Fottrell’s study found also that females, the majority of whom were diagnosed with personality disorder, were more likely to be aggressive but that this was mainly directed against themselves (Saverimuttu & Lowe, 2000). Beck, White and Cage (1991) found that females in psychiatric emergency settings and inpatient units were responsible for a higher incidence of assault and battery than males, although men made more verbal threats and were a source of more concern for the staff. The authors concluded that variables relating to violence in community samples – age, gender, and past history of violence – in their sample related minimally or not at all to aggression. Meta analysis of several studies revealed that the magnitude of gender difference increased with increasing seriousness of behaviour, and that physical aggression showed stronger gender differences than did verbal aggression (Campbell, 2006).

In a large scale Australian study conducted in acute psychiatric units males and females were found to be equally aggressive, and patients diagnosed with bipolar disorder and schizophrenia were significantly more likely to be aggressive than those with other diagnoses (odds ratios of 2.81 and 1.96 respectively) (Barlow, Grenyer, & Ilkiw-Lavalle, 2000). Saverimittu and Lowe (2000) note that important differences in method and design in studies on inpatient aggression make it difficult to compare findings.

Steinert (2002) also made the point that inpatient aggression was very different from community aggression and that such variables as gender, age and diagnosis had a very limited predictive power, whereas psychopathological variables such as severity of psychotic symptoms and hostility had a far greater role. He contended that the predictors for patients who showed only verbal aggression or threatening behaviour were not the same as those for physically aggressive patients. There was little agreement among nurses as to what constituted the most serious forms of verbal aggression (Morrison, 1993). Symptoms which were not necessarily related to diagnosis (such as personality traits), or specific symptoms, might also have a bearing on the tendency to be aggressive (Saverimuttu & Lowe, 2000).
3.9 Measurement of verbal and physical aggression

Many difficulties have been associated with measurement of aggressive incidents in psychiatric units: “Personal, interpersonal, cultural and subcultural factors tend to and will continue to influence the degree to which incidents are recorded” (Edwards & Reid, 1983 in Arboleda-Florez et al., 1994, p.186). Other problems include inconsistent data and under-reporting, only the most notable acts of violence being reported (Yudofsky, Silver, Jackson, Endicott, & Williams, 1986), whilst verbal aggression and aggression towards property are frequently ignored (Kay et al., 1988 in Arboleda-Florez et al., 1994). A large scale study of paediatric nurses also disclosed that verbal abuse was under-reported (Pejic, 2005). In contrast, another study (Owen, Tarantello, Jones, & Tennant, 1998a) found that incident forms were less likely to be completed for repeatedly violent patients, and reports were written as often for level 1 incidents (inflicted serious harm requiring medical care) as for level 4 incidents (touched another in a threatening way) (Owen et al., 1998a; Owen, Tarantello, Jones, & Tennant, 1998b).

In the light of these difficulties, the OAS was developed to define the nature and prevalence of aggression in an inpatient psychiatric population. Previously, many of the scales designed to measure anger and aggression were based on self-report questionnaires detailing angry feelings, violent thoughts, or reactions to anger-provoking situations. The validation of these instruments had often been in relation to non-violent, non-inpatient samples such as college students (Yudofsky et al., 1986), but the OAS was developed to capture patterns of aggressive behaviour in acute inpatient settings catering mainly for involuntary patients – a characteristic which, along with its being widely used, well validated, and practicable, made it ideally suited for the present study.

It has been suggested that the OAS ensures documentation of a significantly greater number of aggressive episodes and behaviours than might ordinarily be expected from review of hospital records, giving a more complete picture of aggression displayed on inpatient psychiatric units (Silver & Yudofsky, 1991). Although the OAS is widely used and has many advantages, it is not without its problems. Whilst it measures the type, frequency and severity of aggression, it does not examine antecedents or consequences of the incident and therefore fails to provide a full picture (Duxbury, 2002), and there has been further criticism that the less severe types of behaviour are
often missed (Arboleda-Florez et al., 1994). The verbal aggression subscale does not differentiate between aggressive acts directed at another person and incidents involving a patient shouting at no one in particular (Parrot & Giancola, 2007), a limitation likely to compromise the use of this instrument to predict escalating aggression.

Problems are likely to occur with whatever instrument is used to record aggressive incidents. Under-reporting of aggression may also occur because aggressive behaviour tends to happen in clusters, and nurses may not have the time to complete the OAS after every incident (Sorgi, Ratey, Knoedler, Markert, & Reichman, 1991).

### 3.10 Management of aggressive behaviour in inpatient settings

The attributions or explanatory models nurses use to describe the causes of the behaviour will affect their response to and management of swearing and verbal and physical aggression, but little is known about the meanings nurses ascribe to these causes (Luck, Jackson, & Usher, 2007). Nurses are in a particularly vulnerable and challenging position in the context of aggression because they bear the major responsibility for ensuring safety on inpatient units (DelBel, 2003). This section provides an overview of the research into the causes of aggression in inpatient populations.

In a review of the literature on causal models of aggression Duxbury (2002) identified three different explanatory frameworks: the internal model, which focuses on individual patient characteristics including age, gender, diagnosis, and substance misuse; the external model, which highlights environmental factors such as overcrowding, lack of privacy, under- and over-stimulation, unit design and routines, and staff characteristics; and the situational model, which emphasises the interactions between factors.

**Internal model**

Research into aggression has been characterised by an emphasis on the internal or individualistic model of explanation, with aggression in mental health patients viewed as being a manifestation of their psychopathology (Davis, 1991). Thus an explanation of a particular aggressive event might be that the patient’s psychopathology “peaked.”
For example, in a study by Barlow et al. (2000), the most likely causal factor for aggression was perceived to be mental state (65.7%); the patient’s admission status, such as being involuntary, accounted for 9.6%, and a confined environment 6.2%. Verbal aggression was present in patients with most types of diagnosis, particularly those with schizophrenia (72%), bipolar disorder (66%), and personality disorders (63%).

However, whilst links between psychosis and aggression are well established, identifying the patient’s psychopathology and demographic profile does not provide sufficient explanation (Whittington & Wykes, 1996); and whilst aggression may be influenced by a patient’s diagnosis, that does not mean that “behavioural and cognitive influences are absent” (Daffern, Howells, & Ogloff, 2007, p.102). Attempts to trace the cause of an aggressive episode by diagnosis may not be constructive because patients may not be symptomatic at the time of assault (Whittington, 1994); patients may have multiple diagnoses, making it impossible to tease out the particular contribution of each; there may be a difference in the base rate of particular diagnostic categories in study populations; and patients with particular diagnoses do not have a predictable course over time (Davis, 1991). In general, schizophrenia is most frequently associated with inpatient aggression: Mania, neurological disorders, personality disorder, organic brain disease and developmental delay have also been implicated (Davis, 1991, p.586; Nijman, a Campo, Revelli, & Merckelbach, 1999), and the highest incidence of assaults without precipitative aversive stimuli was amongst patients diagnosed with schizophrenia (Whittington & Wykes, 1996).

External model

Aggression as a reaction to external stimuli is taken into account in models of aggression in “normal” people (Whittington & Wykes, 1996), and the authors found it to be a factor in 86% of assaults on psychiatric staff. Aggression in close observation areas is frequently a reaction to forced compliance, a socially driven behaviour, rather than arising from factors internal to the patient (O’Brien & Cole, 2004). A diverse list of aggressive episodes was generated in a study (Sheridan et al., 1990) of 73 assaults in an American hospital inpatient psychiatric setting. The incidents preceding the episode were more often categorised as external to the patient than internal. Of the external factors (N=51), the most frequent were conflict with another patient (N=14), enforcement of rules by staff (N=10), denial of privileges (N=8), lack of money (N=6),
denial of other requests (N=4), and denial of discharge (N=3); the main contributing internal factors (N=31) included delusions (N=12), drug or alcohol intoxication (N=10), hallucinations (N=5), self destructive behaviour (N=2), and dementia or confusion (N=2).

**Situational model**

Nijman et al. (1999) employed a situational model and divided their explanatory model into patient, ward and staff variables, with aggression occurring as a result of the interaction between the three variables.

Cheung, Schweitzer, Tuckwell and Crowley (1997) observed that most assaults were precipitated by staff-patient interactions, and Morrison (1989) found that aggression frequently took place when staff had to place limits on patients. Four situations which might require limit setting were when the patient “wants something that is not possible,” “demands instant gratification,” “refuses to participate in what is desired,” and “demands immediate emotional attention (Morrison, 1989). Another study, using simulated scenarios, showed least patient anger in response to limit setting which both was empathic and offered solutions, and most for a belittling style of interaction (Lancee, Gallop, McCay, & Toner, 1995). A prospective study of inpatient violence found the most frequent precipitating factors to be demands on patients and/or staff refusing to accede to the patient’s wishes (52%), followed by attempts to have patients take medication (10%), and finally arguments with other patients (5%) (Benjaminsen, Gøtzsche-Larsen, Norrie, Harder, & Luxhøi, 1996); and a British study cited denial of the wish to leave the ward and issues regarding medication as the most frequent precipitants (Noble, 1997).

In a retrospective study of 130 incidents of aggression, 60% were classified as having been precipitated externally and 40% attributed to internal factors (Shepherd & Lavender, 1999). Content analysis of 45 aggressive incidents in inpatient settings revealed three main causes: patient illness, including insufficient medication and delusions; interpersonal conflicts; and limit setting, such as being prevented from leaving the hospital (Ilkiw-Lavalle & Grenyer, 2003). Patients saw illness as the cause of incidents much less frequently than did staff, instead citing interpersonal conflict as the source of aggression; staff and patients almost equally regarded limit setting as a causative factor. Indeed, nurses’ and patients’ perceptions of what motivated an
aggressive episode often seem to vary. For example, one study reported patients as describing teasing by other patients or provocation by staff as the cause of their assaultive behaviour, whilst staff perceived no reason for the attack (Quinsey 1979, in Davis, 1991, p.587). Despite the evidence that the situational model is likely to provide the best insight into the complexities of inpatient aggression, it is the least researched because of the difficulties in measuring the many variables involved.

It is not always possible to ascertain the precipitant for aggression. A 1998 review by the British Royal College of Psychiatrists found there was little conclusive evidence as to either the characteristics of the perpetrator or the environmental factors (Spokes, Bond, Lowe, Jones, Illingworth, Brimblecombe, & Wellman, 2002); external factors influencing aggressive incidents included privacy, access to open and private space, and ward restrictions (British Royal College of Psychiatrists, 1998 in Irwin, 2006).

*Intervention*

Causes of aggression in the inpatient milieu are internal, external and situational; therefore a combination of both medication and behavioural interventions is optimal (Nijman et al., 1999). In a large scale Australian study, Owen et al. (1998b) found that the response to most incidents was counselling. Other responses included medication, removal from immediate area, and physical seclusion; only a few involved removal to a different facility. Studies suggest (for example, Harris & Morrison, 1995; O'Brien & Cole, 2004) that interventions for aggression rely largely on traditional biomedical and controlling methods – control and restraint as necessary, *(prn)* medication, and seclusion – consistent with the view that the causes of the aggression are internal to the patient.

Nurses in a British study (Trenoweth, 2003) reported that the interventions they used were based on the patients’ diagnosis, and how this impacted on their behaviour and understanding of the situation; also considered were environmental factors such as other patients and noise levels. Knowledge of what had worked previously with a particular patient gave the nurses confidence to use a greater variety of interventions, and non-physical interventions tailored to the needs of individual clients. The use of seclusion, medication, and physical restraint were the methods for managing aggression most frequently cited in a study conducted in acute inpatient psychiatric facilities (Chen, Hwu, & Williams, 2005). The results of a cross-cultural study indicated
that the most important factor in determining staff preparedness to use a particular intervention was whether it was considered to be effective and safe for the patient; staff safety and patient dignity were not major considerations (Bowers, van der Werf, Vokkolainen, Muir-Cochrane, Allan, & Alexander, 2007).

3.11 Conclusion

The association of swearing with psychopathology and verbal and physical aggression is complex and little understood. This chapter has presented a summary of research in this area, to lay the foundations for a descriptive study which utilised the OAS in an inpatient setting, and also to provide a contextual framework for the following chapter on the impact of swearing on nurses.
Chapter 4

The Impact of Swearing on Nurses

“Swearing, no matter how familiar from the street and television, is still a form of violence” (Grant, 2005).

4.1 Introduction

The previous chapter examined the link between swearing and verbal and physical aggression, as well as outlining the role of swearing in psychopathology and providing a contextual framework for this chapter, which starts with an overview of the incidence of verbal aggression and its impact on nurses. There will then be an exploration of personal attributes and characteristics of nurses, such as their own use of swearing, which may affect this interaction. The chapter is intended to provide justification for the use of the standardised measures used in the Nursing Swearing Impact Questionnaire. The importance of nurses’ management of their response is then discussed in relation to the therapeutic alliance.

4.2 Verbal aggression and nurses: the incidence

Nurses are, of all health workers, most likely to be targets of verbal aggression (Adams, 2004; Chen et al., 2005; Gillies & O’Brien, 2006; National Audit Office, 2003), and they receive it from more sources (Braun, Christle, Walker, & Tiwanak, 1991). This is a longstanding problem: Cox (1987) remarked that aggression was so common in nursing that it was surprising that so many remain in the profession; one study reported that nursing staff injury rates from violence alone are higher than those in the mining, lumber, and heavy construction industries (Love & Hunter, 1996).

A recent British study using a modified form of the OAS disclosed that 89% of nurses had experienced verbal aggression and 82% had reported more threatening verbal aggression at least once in the preceding year (Nijman, Bowers, Oud, & Jansen, 2005). Uzon (2003), in a study of Turkish nurses, found that 100% of nurses working in psychiatric settings had experienced verbal aggression. Similar high rates were found in emergency (98%) and paediatric settings (96.9%) compared with an average of 86.7% overall. The most frequent sources of verbal abuse were patients and their
relatives and visitors (Farrell, Bobrowski, & Bobrowski, 2006; Ryan & Maguire, 2006; Uzon, 2003). High rates of verbal abuse, between 82% and 100%, have been reported elsewhere (DelBel, 2003; Jackson, Claire, & Mannix, 2002; Merecz, Rymaszewska, Moscicka, Kiejna, & Jarosz-Nowak, 2006; Ryan & Maguire, 2006; Sofield & Salmond, 2003). A Tasmanian study by Farrell et al. (2006) revealed that 63.5% of the sample of 2,407 nurses had experienced some form of aggression in the preceding four working weeks, verbal abuse being the most frequent type. The survey distinguished between several types of verbal aggression, and 62% of nurses reported experience of swearing. Mental health nurses were second only to corrective service staff in the reported amount of verbal abuse, 84.3% experiencing it in the period under review, and 57.6% of paediatric nurses reported verbal abuse.

In a British survey, 17% of health staff overall reported exposure to verbal aggression or threats during the previous 12 months, but rates were nearly doubled (30%) among mental health staff (Mackay, 1994 in Adams & Whittington, 1995) (UKCC, 2001 in National Audit Office, 2003). A study involving a large Australian metropolitan hospital, but excluding nurses in mental health and emergency settings, found repeated incidents of verbal aggression experienced by 95% of respondents during the previous 12 months, (O’Connell, Young, Brooks, Hutchings, & Lofthouse, 2000). In contrast with Uzon (2003), the researchers found that mixed medical/surgical wards experienced the highest rates of verbal aggression on a weekly basis and gerontological nurses on a monthly basis.

Studies addressing verbal aggression are few in number, but the data have suggested that the incidence is rising (Sofield & Salmond, 2003), even though up to four of every five incidents are unreported (Lion et al., 1981 in Whittington, 1994). Although a number of studies have shown an ongoing rise in the rates of aggression against psychiatric staff (Davis, 1991), Whittington cited several reasons for urging caution: Staff might have become sensitised to aggression and be reporting it more readily; once thought by mental health staff to be part of the job, aggression is now being seen as unacceptable, due perhaps to increased self-respect and status; definitions of aggression now include verbal aggression and threats; increasing recognition of the impact on victims and an acknowledgment of the costs of aggression, both monetary and legal.
An American study of nurses in a large teaching hospital reported that over 96% of the sample of 213 nurses had experienced verbal abuse: 79% reported having been abused by patients, 75% by other nurses, 74% by doctors, and 68% by patients’ families (Rowe & Sherlock, 2005); the most frequent sources were nurses (27%), followed by patients’ families (25%), doctors (22%), and patients (17%). Nurses’ reactions to abuse by other nurses most frequently were anger, sad/hurt, and frustrated; most also said they could handle it and chose positive coping strategies such as attempting to clarify misunderstanding, and dealing directly with the nurse, but there were also several passive reactions such as blaming oneself, withdrawing, ignoring the situation and wishing that it would go away.

The prevailing view is that verbal aggression is both under-researched and under-reported because of its frequency and the perception that reporting does not lead to positive changes (Arboleda-Florez et al., 1994), and may lead to further trauma for the nurse (Jones & Lyneham, 2000).

4.3 Effects of swearing and verbal aggression on nurses

The effect on nursing staff of exposure to verbal aggression by patients is poorly described in the literature, but many mental health nurses anecdotally describe intense immediate effects and report leaving positions because they have been “worn down” and demoralised by the levels of swearing. A Taiwanese study found significantly higher levels of anxiety among psychiatric nurses subjected to both verbal and physical aggression by patients than when physical aggression alone occurred (Chen et al., 2005).

Not surprisingly, research has shown that distress resulting from the perceived threat is a common reaction, ranging from feelings of anxiety to development of depression or physical illness. Lowered morale leading to increased errors and higher staff turnover has been reported, with 24% of staff in a questionnaire study linking verbal abuse directly to resignation from a previous position (Braun et al., 1991). Verbal attacks often cause hurt feelings, anger, irritation, embarrassment, discouragement, anxiety, and even physical aggression (Adams & Whittington, 1995; O’Connell et al., 2000; Roberto & Finucane, 1997). Verbal aggression can provoke feelings of distress, anger, powerlessness and job dissatisfaction, and adversely affect attitudes (Cox, 1991; Infante & Gorden, 1991 in Kinney & Segrin, 1998). The cumulative effects of verbal
aggression may lead to emotional exhaustion and depersonalisation (Winstanley & Whittington, 2002). Verbal aggression has been found to have more severe consequences, in terms of symptoms over time and leaving work, than physical violence (Gerberich, Church, McGovern, Hansen, Nachreiner, Geisser, Ryan, Mongin, & Watt, 2004).

Patients are responsible for the majority of physical and verbal aggression towards nurses, but patients' family and friends also account for a high rate (Jackson et al., 2002; O'Connell et al., 2000; Sofield & Salmond, 2003). In order of frequency, doctors, patient's relatives, patients, and nurse colleagues were perceived as most often being aggressive towards nurses; nurse-nurse aggression was the most distressing type to deal with followed by, in public sector nurses, aggression from patients' relatives (Farrell, 1999).

Cognitive factors may influence the type and magnitude of negative reactions, leading to variation in vulnerability or resilience against the effects of verbal aggression (Kinney & Segrin, 1998). Other personality variables relevant to the impact of swearwords are offendedness, attribution, locus of control, and the nurse's own use of swearing.

4.4 Offendedness

Personality is a factor both in motivation to use swearwords and in one's reaction to their use by others (Jay & Clermont, 1996). Jay (1999) defined offendedness as a speaker's sensitivity to offensive language and as an aspect of a person's personality. The notion of offendedness in the present study referred also to the sensitivity of the addressee to offensive words. The degree to which people are offended by emotional language about sex, religion, and bodily functions and products varies, but as previously discussed (2.9) Jay (1999) concluded that people with high religiosity and sex anxiety were highly offended by emotional language.

Kinney (1994), in a study of expletives used by working class women, asked participants to recall a message that had hurt them. The range of reactions suggests that personality variables or psychological conditions such as hostility, aggressiveness, guilt, and anxiety may function to alter one's perception of what constitutes a hurtful
message. An aggressive or hostile personality may be insensitive to apparently hurtful behaviour because of predisposition to interpret situations through an aggressive filter. In contrast, an anxious or guilty person may have heightened perceptions of aggression and hurt because of constant attempts to avoid potentially threatening situations and behaviour.

4.5 Explanatory style

Attributions or explanations about others’ needs or behaviours have important ramifications because they affect attitudes towards other people and reactions to their behaviour (Kelley & Michela, 1980), and can exert a significant effect on helping responses (Sharrock, Day, Qazi, & Brewin, 1990). “Attribution is a process which begins with social perception, progresses through causal judgment and social inference and ends with behavioural consequences” (Crittenden, 1983). Explanatory or attributional style is a cognitive variable that reflects how people habitually explain events and behaviour (Peterson, McClellan Buchanan, & Seligman, 1995). Attribution theory refers to a collection of theories addressing similar but distinct problems (Crittenden, 1983): for example, Heider’s (1958) attribution theory, and Weiner’s (1980; 1986) theories of motivation. Heider believed that behaviour was due to either of a two attributions (a) internal attribution, the inference that a person is behaving in a certain way because of something about the person, such as attitude, character or personality or (b) external attribution, the inference that a person is behaving a certain way because of something about the situation he or she is in.

Woolfolk, Doris, and Darley (2006) stated that the personal characteristic which has the most influence is the perceived causal role in an outcome: For example, if a nurse believes that a certain action is under the patient’s control and is intentionally brought about then the nurse is likely to hold the patient responsible; conversely if the patient’s behaviour is attributed to forces outside his or her control then the patient is not seen to be morally responsible for that behaviour. Sympathetic responses and an inclination to help patients are related to attributions of uncontrollability and instability of symptoms, and mental health staff frequently view patients with particular diagnoses such as personality disorder as being responsible for their actions and untreatable, and are less likely to help them than patients diagnosed with major depressive disorder (Forsyth,
It has also been suggested that observers’ default position is to assume that an action was intentional and therefore deserving of blame, and subsequently attribution might be adjusted in the light of mitigating factors (Woolfolk, Doris, & Darley, 2006).

Wanless and Jahoda (2002) maintained that the importance of nurses’ emotional response to challenging behaviour was central in both cognitive and behavioural models. Nurses’ cognitive appraisal, especially of the causes, would steer their emotional reaction. However, research has failed to produce the expected evidence of associations between staff cognitive and emotional variables and staff behaviour towards individuals with challenging behaviour (Grey, Hastings, & McClean, 2007), and a five day aggression management course achieved none of the expected positive changes in nurses’ perceptions of patients or levels of tolerance towards them (Needham, Abderhalden, Halfens, Dassen, Haug, & Fischer, 2005).

In an Australian study of emergency department nurses, Luck et al. (2007) found that judgments about the meaning of aggressive incidents were based on three factors: (a) the perceived personalisation of the aggression – that is, the degree to which it was believed to be directed at them personally rather than as a symbol of the health system; (b) the presence of mitigating factors, and (c) the reason for their presentation; the researchers suggested also (p.7) that nurses took into account “the perceived degree of self responsibility and capacity” of the patient.

The Attributional Style Questionnaire (ASQ) is one of the most common ways of measuring explanatory style; it has been used in this study to capture attributional style. It is a self-report instrument which contains six positive and six negative hypothetical situations; half of these relate to affiliation and focus on interpersonal relationships, and the other half to achievement in such areas as work and finances (Reivich, 1995).

4.6 Locus of control

Individuals with a high internal locus of control believe that events result primarily from their own behaviour and actions or relatively stable characteristics (Rotter, 1966), and expect to be in control of their life to a high degree (Chan, 1986). Those with a high
external locus of control believe that powerful others, fate, or chance primarily determine events, and expect to have little influence over what happens to them. Rotter, who posited the dichotomy and the scale with which it is measured, hypothesised that the internal-external variable was significant in understanding the nature of learning processes, and that consistent individual differences exist in the degree to which individuals are likely to attribute personal control to success in the same situation.

It has been reported that those with external locus of control are more vulnerable to psychological problems and other illnesses (Chan, 1986), and that this attitudinal characteristic is one of three which have the strongest association to staff assaults and injuries (Ray & Subich, 1998).

Locus of control is related to explanatory style, particularly in relation to the internal dimension; whereas Rotter’s theory was an expectancy about the future, internality refers to a cause in the past (Peterson et al., 1995). Where the theories differ is that Rotter conceptualised locus of control as applying to both good and bad events, but explanatory style assumes that different and independent explanations apply, a theory supported by research (Peterson et al., 1995).

4.7 The use of swearing by nurses

There are two aspects to the use of swearing by nurses: (a) swearing within the context of a therapeutic relationship; and (b) swearing within a work or leisure context.

4.8 Swearing within the context of a therapeutic relationship

No literature exists on the use of swearing by nurses in therapeutic interactions with patients. Although there has been acknowledgment that swearing could be used in a therapeutic context (Bostrom et al., 1973; Feldman, 1955; Hebusch & Horan, 1977; Kottke & MacLeod, 1989; Kurklen & Kassinove, 1991; Maier & Miller, 1993; Ross, 1962; Wiley & Locke, 1982), the literature has been contradictory. Therapists such as Ellis (1974), Ferenczi (1950) and Perls (1969) have used and advocated the use of swearwords in counselling (Kurklen & Kassinove, 1991), and researchers have noted that mental health nurses use conversational lay language to put patients at ease.
(Hamilton & Manias, 2006; O'Brien, 1999), but made no mention of the use of swearing in this context.

The casual use of swearwords (‘fuck’, ‘shit’, ‘hell’, and ‘damn’) by adult male counsellors resulted in their being rated by clients as less effective, and decreased client satisfaction with the interaction (Heubusch & Horan, 1977). This finding related to the casual use of profanity, not used to reflect the emotional content of what the client was saying, (Kottke & MacLeod, 1989) or the language used by the client; but a counsellor’s use of a swearword to reflect the client’s language did not yield a different result (Kottke & MacLeod, 1989), with observers indicating that they would be less likely to seek help from the female counsellor who used a swearword in response to a client’s. In contrast, in a study using videoed “counselling sessions,” undergraduate student raters found counsellors more effective and satisfying when they used profanity (Wiley & Locke, 1982). The authors cautioned against generalising their results to other populations, but suggested that the use of profanity might be an effective tool for establishing identification between a counsellor and college-age clients. The generalisability of these studies might be limited as the participants were in all cases college students. In an Australian context, Martin (1997) has advocated the judicious use of slang words “to get on side” with adolescents.

4.9 Swearing within a work or leisure context.

There is little literature on the prevalence of swearing amongst nursing staff. In one of the only studies of the use of taboo words by staff, Gallahorn (1971) observed daily staff meetings, the subject of which were patients, or staff-staff, or patient-staff problems. The author recorded 28 swearwords spoken by the 29 staff, and during the 128 days of the study 372 words were used averaging 2.9 words per meeting. The highest number of words in one day was 26, and on 29 days no swearwords were used. There was no correlation between an individual’s speaking time and the number of swearwords used, or between meeting time and swearword use. Gallahorn found that increases in swearing related to staff leaving the meeting to deal with difficult situations, such as sudden assaultive behaviour and a near suicide, and he viewed the use of taboo words as a barometer of ward tensions. In three periods of extreme crisis, there was no swearing. He also found that the highest number was used about patients with a personality disorder. Swearword use in the meetings was not related to status and a female aide was the highest user of taboo words; staff accurately
predicted their own frequency of swearing, and the words they used suggested that they were quite conscious of their use of swearwords in this specific setting. The questionnaire study elicited no relationship between the number of taboo words an individual used and his or her discomfort ratings for taboo words. In general, staff were more comfortable saying a taboo word than hearing it.

Baruch and Jenkins (2007) in a focus group study asked students to recall positive and negative applications of swearwords in the workplace. One member of the support staff of a nursing home in England recalled swearing among nurses of mixed gender during breaks, but not in the presence of the patients; swearing was used to emphasise dissatisfaction or create a good impression. In a similar focus group in Texas a female nursing assistant reported that female nurses would swear during their breaks; the authors speculated that the most frequently used word, ‘shit’, employed to report rising stress levels, corresponded to the nature of the usual cause of their stress. However, the word reported as most frequently used across all workplaces was ‘fuck’, with ‘shit’ coming a close second. Baruch and Jenkins did not explain how they quantified this; they used interchangeably the terms “hospital” and “nursing home,” and thus it was not clear whether the participants were describing nurses or care assistants. The authors came to the conclusion that “employees use swearing on a continuous basis, but not necessarily in a negative, abusive manner” (Baruch & Jenkins, 2007, p.502); it also was a social phenomenon reflecting solidarity, and functioned to enhance group cohesion as well as providing a means to release stress.

Nurses are expected to report accurately on patients’ speech and behaviour. Occasionally this requires that they violate the usual norm of using professional language when reporting a patient’s direct speech which contains obscenities. The contradictory role expectations and values are, as Coser (1960) noted, frequently treated with humour to resolve the conflict.

Ross (1962) surveyed psychiatrists and psychotherapists via questionnaire, and found an association between therapists who used swearwords in their private lives and the amount of swearing they heard from their patients. Some therapists believed that their own use of obscenity enabled patients to express their feelings about emotionally charged subjects and they rarely directed their patients away from these words. The author concluded that both therapist and patient should use the language with which
they are comfortable since that will enhance communication. Ross maintained that if slang and swearwords are excluded only 400 words are left with which to express emotions, although words describing actions are far more plentiful; he also asserted that intense anger is expressed by short words which have an explosive quality, and the intention is to arouse anxiety and guilt in the listener rather than empathy.

Maier et al. (1993) raised an issue which is familiar to many nurses, but particularly to those in acute mental health. They maintained that professional language fails to communicate the powerful emotion evoked in relation to patients who threaten and attack. Staff may become progressively insensitive as they attempt to meet the needs of those patients, and the authors postulated that since obscenities release tension there may be therapeutic value in allowing staff to express themselves in "language that is satisfying to them," including swearwords, if that would help relieve stress.

The Royal Commission into Aboriginal Deaths in Custody between 1987 and 1991 investigated factors contributing to the over-imprisonment of Aboriginal people. The Commissioner’s comments on the role played by the “police’s self-imposed reaction to swearing” by that group of people makes an interesting comparison with nurses:

Over and over again during this Commission there has been evidence about Aboriginals using the term ‘cunt’ in relation to police, usually with the result of a charge of offensive behaviour or at all events strong disapproval. I have been led to wonder how police could continue to remain offended by a term they heard so often and routinely…It is surely time that police learnt to ignore mere abuse, let alone simple “bad language.” In this day and age many words that were once considered obscene have become commonplace in many circumstances, and are in common use amongst police no less than amongst other people. Maintaining the pretence that they are sensitive persons offended by such language … does nothing for respect for the police. It is particularly ridiculous when offence is taken at the rantings of drunks, as is so often the case (Wootten, 1991 in Taylor, 1995, p.245).

The commissioner drew a comparison between a civilian who would ignore a “bit of lip” from a drunk and a policeman who would view the offensive language as an affront to his authority and lay charges (Taylor, 1995, p.245).
Unsurprisingly, when police are verbally abusive people have a less positive attitude towards them (Cox & White, 1988 in Baseheart & Cox, 1993). Use of offensive language of any kind negatively impacted on subjects’ perceptions of police officer credibility, friendliness, fairness and justness (Baseheart & Cox, 1993). This was remarkable because the taped scenario, involving a policeman making a routine stop of a motorist for a minor traffic violation, contained only one swearword, and the authors speculated that in a real life situation the reaction would be more profound because of the additive effect of paralinguistic cues.

Two studies (Bloom, 1977; Maier & Miller, 1993) despite their acknowledgment that strong feelings evoke obscene language, contended that it is never appropriate for patients to swear at staff, nor for staff to swear at patients or in the presence of patients. Nevertheless they went on to anecdotally report that staff repeatedly used the word ‘fuck’ in a group therapy session, thus undermining the potency of the word which had been used by patients to the detriment of staff morale and therapeutic efficacy. The same authors contended that, under the right circumstances, mental health professionals can use obscene language for therapeutic ends and that such words have a role in dealing with particular subgroups of patients. In particular they cited the above example illustrating demystification of particular words, but cautioned that there must be some guidelines about staff use of swearwords.

### 4.10 Therapeutic alliance

A wealth of literature (for example, Clarkin, Hurt, & Crilly, 1987; Fox, 2002; Ramjan, 2004; Thurston, 2003) supports the view that therapeutic alliance between nurses and patients is correlated with positive treatment outcomes in inpatient populations. Such alliances and treatment outcomes are likely to be adversely affected by swearing directed at nurses.

Maintaining connection with both self and other is a key challenge of therapeutic work in nursing. A nurse’s ability to monitor his or her own reactions to patients is imperative in establishing and maintaining a therapeutic relationship (Austin, Bergum, & Goldberg, 2003). Verbal aggression is threatening and the receiver is motivated to protect him or herself through physical, verbal or cognitive means (Kinney, 1994). Such defensive
action is a common response to being sworn at, but it is therapeutically necessary to overcome the emotional impact and address the patient’s needs, conflicts and stressors (Jay & Clermont, 1996).

Kelly and May (1982) included aggression and anger – emotions commonly associated with swearing and verbal abuse – in a list of patient behaviours perceived by nurses as “bad.” Gallop and Wynn (1987), in researching nurses’ reactions to difficult patients, found that their responses were more personalised and affect-laden than those of resident doctors who were more able to remain objective. Similarly Podrasky and Sexton (1998) were taken aback by the strength of reaction to posed vignettes of difficult patients: 19 out of the 73 nurse subjects said they would feel like striking the hypothetical patients, and used swearwords to describe them.

Bloom (1977) argued that adults who are intimidated by adolescents’ use of swearwords, in addition to being unable to help them, may exacerbate the problems. To be effective, Bloom stated, therapists need to attend to the underlying meaning of the communication, which frequently represents frustration, rather than reacting to the obscenities themselves, and if the therapist responds with anger or criticism the patient gains control over the situation.

Swearing may adversely influence nurses’ perception of a patient who is using swearwords. Its use may obscure the issue under discussion with the focus turning on the language, and swearing might also precipitate an aggressive response (Rothwell, 1971, p.241). Speakers employing profanity in a short speech were rated on the Speech Dialect Attitudinal Scale as lower in socio-intellectual status and aesthetic quality (e.g. pleasing-displeasing, beautiful-ugly) than speakers who did not use such language (Mulac, 1976).

4.11 Conclusion

This chapter completes the literature review and lays the foundations for the Context of Care Study and the Nursing Swearing Impact Questionnaire study.
Chapter 5

Context of Practice: Verbal and Physical Aggression in Inpatient Facilities

5.1 Introduction

This chapter (Part 1 of the research findings) constitutes an analysis of reported incidents of aggression using the Overt Aggression Scale (OAS) [Appendix 2], a well-documented incident form developed by Yudofsky et al. (1986). It comprises quantitative and qualitative data from the study and starts by referring to the relevant literature.

A major reason for studying the association between verbal aggression and swearing, as discussed in the previous chapters, is to ascertain whether patterns exist in the sequence of aggression, such as escalation from verbal to severe physically aggressive behaviour (Arboleda-Florez et al., 1994). If this were shown to be the case it would be an important advance in knowledge, enabling nurses to be better prepared to predict and perhaps prevent aggression.

In a study using the OAS in a forensic setting, Daffern et al. (2006) found verbal aggression to be the most common form of aggression (n=196, 62% of incidents), followed by physical aggression (n=92, 29.1%) and damage towards objects (n=28, 8.9%). Physical aggression is likely to be preceded or accompanied by verbal aggression (Stets, 1990), and an older study looking at criminal violence suggested that the first stage of an assault is a verbal attack on the identity of the other, the second threats and then physical attack (Felson & Steadman, 1983) Werner, Yesavage, Becker, Brunsting, and Isaacs (1983) suggested a moderate positive association between verbal and physical aggression in a study of hospitalised patients diagnosed with schizophrenia.

Previous studies have produced contradictory results regarding the role of gender in aggression: A large scale Australian study conducted in acute units showed males and females to be responsible for similar numbers of aggressive incidents (Barlow et al., 2000) and Hodkinson et al. (1985, in Whittington, 1994) found no difference between inpatient males and females in frequency of involvement in aggression, whereas Larkin et al. (1988, in Whittington, 1994) and Beck, White and Cage, (1991) found that
females were involved more often than males. The problem of under-reporting of both aggression and verbal aggression has been noted by many authors and is discussed in 3.9.

Literature is scarce on the link between swearing and the conditions commonly seen in inpatient mental health units, but Jay (1999) noted associations between swearing and conduct disorder, anti-social personality disorder, and schizophrenia. Association of verbal aggression in patients with schizophrenia, bipolar disorder, and personality disorders was noted by Barlow et al. (2000); they found also that patients diagnosed with schizophrenia and bipolar disorder were significantly more likely than those with other disorders to be aggressive, and that schizophrenia was likely to be associated with verbal rather than physical aggression. Davis (1991) found aggression on psychiatric inpatient units to be most frequently associated with schizophrenia; mania, neurological disorders, personality disorder and developmental delay were also implicated.

Attempts to identify by diagnosis alone the cause of an aggressive episode may not be constructive (Whittington, 1994). In one of several studies requiring staff to indicate what they believed to be the causal factors in aggression, mental state was perceived as the most likely cause (65.7%); the patient's admission status (e.g., being involuntary) accounted for 9.6% of the variance and a confined environment for 6.2% (Barlow et al., 2000). Content analysis of 45 aggressive incidents in inpatient settings disclosed three main causes: (a) patient illness, including insufficient medication and delusions; (b) interpersonal conflicts; and (c) limit setting, such as being prevented from leaving the hospital (Ilkiw-Lavalle & Grenyer, 2003), and patients viewed illness as the cause of incidents less frequently than did staff.

The view staff take of challenging behaviour (their cognitive appraisal of it) is thought to drive their emotional response; their causal explanations or attributions have a central role in predicting their emotional responses and behaviours. In a review of the literature on causal models of aggression, Duxbury (2002, p.326) identified three different explanatory frameworks: the internal model, which focuses on individual patient characteristics including age, gender, diagnosis, and substance misuse; the external model, which highlights environmental factors such as overcrowding, lack of privacy, under- and over-stimulation, unit design and routines, and staff characteristics; and the situational model, which emphasises the interactions between factors. In a retrospective study of 130 incidents of aggression, 60% were classified as having been
precipitated externally and 40% attributed to internal factors (Shepherd & Lavender, 1999, in Daffern & Howells, 2002).

An attribution is described as the inference drawn by an observer about the cause of his or her own behaviour or that of another person (Shearer & Davidhizar, 2000). Attribution theory analyses the means by which individuals form conclusions about behavioural causes and how those inferences affect their own subsequent behaviour. For example, if observers perceive the causes of a person’s problem to be internal they are less likely to respond with helping behaviour (Ogden & Knight, 1995; Wanless & Jahoda, 2002). Similarly, medical students studied by Brewin (1984) were less likely to assist if they considered patients to be responsible for life events.

Owen, Tarantello, Jones, and Tennant (1998b) in a large-scale Australian study found counselling (not defined more narrowly) to be the main response to most incidents. Other responses included medication, removal from immediate area, and physical seclusion: only a few involved removal to a different facility. Ilkiw-Lavalle and Grenyer (2003) noted that staff accentuated “medication and medical management” in connection with both the causes of aggression and ways to decrease it, whereas patients placed more importance on effective conflict resolution and communication, the contribution of their illness, and limit setting. Gudjonsson (1999) observed that 67% of incidents occurring in a forensic inpatient setting over a period of 17 years resulted in the use of physical restraint, 36% led to the use of prn (as necessary) medication, and 11% were dealt with by transfer of the patient to an intensive care area, seclusion, bedroom, or elsewhere. It is generally agreed that restraint and seclusion should be measures of last resort when dealing with aggression and conflict resolution, problem solving and de-escalation should constitute the first choice of intervention (The International Society of Psychiatric Mental Health Nurses, in Cowin, Davies, Estall, Berlin, Fitzgerald, & Hoot, 2003).

5.2 Aims and hypotheses

This phase of the study (Part 1) had six aims which elaborate on the original thesis research questions set out in 1.4.

1. What is the extent of swearing/verbal aggression in a health care setting?
Hypothesis 1a: The total reported instances of verbal aggression will exceed those of physical aggression.

Hypothesis 1b: The reported instances of (more serious) levels 3 and 4 verbal aggression will exceed reported instances of (less serious) levels 1 and 2 verbal aggression.

Hypothesis 1c: The reported instances of (less serious) levels 1 and 2 physical aggression against others will exceed reported instances of (more serious) levels 3 and 4 physical aggression.

Hypothesis 2: The number of reported instances per 100 patient bed-days at each level of severity of verbal and physical aggression by male and by female patients will not be significantly different.

Hypothesis 3: There will be a positive correlation between the reported severity of verbal aggression and of physical aggression against others.

Hypothesis 4: Verbal and physical aggression against others will more often be associated with patient diagnoses of schizophrenia and bipolar disorder than with depression.

2. **What are the implications of swearing for a therapeutic encounter?**

Hypothesis 5a: Nurses will report that psychosis is the major cause of aggressive incidents.

Hypothesis 5b: Nurses will more frequently resort to the internal model versus the external model of causation to explain patient verbal and physical aggression.

Hypothesis 5c: Perceived internal causation of the aggression will be associated with more restrictive interventions.

Hypothesis 6a: The patient’s diagnosis will influence nurses’ perceptions of the cause of aggression.

Hypothesis 6b: The patient’s diagnosis will influence nurses’ interventions.
3. **What is the impact of swearing on nurses?**

The third superordinate research question is explored qualitatively in this chapter.

### 5.3 Method

#### 5.3.1 Setting

This study utilised data from the OAS database routinely maintained within the Regional Mental Health Service; the region consists of over 130,000 square kilometres, comprises industrial, urban, and rural areas, and has a population of 840,000. It provides health services to 12% of New South Wales's population; it is one of four rural health services in NSW, but is the only one with a metropolis within its borders.

Data were collected from several departments of a long-stay mental health facility, including: a forensic unit, which has several long-stay psychiatric rehabilitation beds and units catering since 1995 for the elderly mentally ill; an acute psychiatric facility, which includes an 8-bed intensive care unit; two 20-bed adult psychiatry units; a 16-bed dual diagnosis drug and alcohol/mental health unit and a psychiatric emergency centre for adults with serious mental illness; and (more recently) a 12-bed tertiary psychiatric unit catering since early 2004 for children and adolescents aged from 5 to 18 years with a wide variety of mental health disorders.

#### 5.3.2 Respondents

Phase one of the study explored the context of care, utilising the OAS to describe the nature and extent of swearing and verbal aggression across a range of acute and long-term inpatient mental health settings. Data were derived from reports of 9,623 instances during a 10-year period, averaging 96 instances per year. The sample comprised 384 (72.1%) males and 148 (27.9%) females aged between 9.5 years and 93.3, mean age 45.6, \( \text{SD}=21.00 \) years\(^1\) from 533 inpatients in the units described above for whom OAS reports had been generated (gender was not specified for one respondent who accounted for 6 OAS reports).

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\(^1\) There was a missing date of birth for one respondent which accounted for 1 OAS report.
5.3.3 Procedure

Ethical clearance to conduct this study was granted by the University of Newcastle Human Research Committee (HREC Approval No: H-030-0405) and the Area Research Ethics Committee (HAREC Approval No: 05/04/13/3.17) [Appendix 3]. Permission was received from the Director of the Area Mental Health Service to access information from the OAS database. The study was conducted in accordance with the ethical principles that have their origins in the Declaration of Helsinki (Association, 1964). Research was conducted with adherence to the National Statement on Ethical Conduct in Research Involving Humans (NHMRC, 2001) including Section 4, research involving children and young people; Section 5, research involving persons with an intellectual or mental impairment; Section 6, research involving persons highly dependent on medical care; and Section 9, research involving Aboriginal and Torres Strait Islander peoples.

The research team had access to re-identifiable data from the OAS database. OAS data for 1995 were incomplete, but all data collected between January 1996 and October 2005 were included in this study. The database contained details of completed and collated OAS reporting and included information on diagnosis, age, gender of patient, type and frequency of aggressive behaviour, including verbal aggression and swearing, perceived motivation for the aggression, the intervention used in response to these behaviours and the gender of the staff member reporting the incident.

5.3.4 Materials

The Overt Aggression Scale (OAS) (Yudofsky et al., 1986)

The OAS is a standardised behavioural checklist measuring the frequency and severity of four categories of aggression: (a) verbal aggression, (b) aggression against objects, (c) self-directed aggression and (d) physical aggression against others. Each category is made up of four items relating to increasing levels of aggression within each category. Table 5.1 details the levels for verbal and physical aggression against others. One item on the OAS relates specifically to swearing and is of particular relevance to Part 2 of the study – the verbal aggression question has as its third item “curses viciously, uses foul language in anger, makes moderate threats to self and others.”
Table 5.1 *Classification of OAS levels of verbal and physical aggression against others*

<table>
<thead>
<tr>
<th>Level</th>
<th>Verbal aggression.</th>
<th>Physical aggression against others.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Makes loud noises. Shouts angrily.</td>
<td>Makes threatening gestures, swings at people, grabs clothing.</td>
</tr>
<tr>
<td>2</td>
<td>Yells mild personal insults, e.g. “You’re stupid.”</td>
<td>Strikes, kicks, pushes, pulls hair without injury to person.</td>
</tr>
<tr>
<td>3</td>
<td>Curses viciously, uses foul language in anger, makes moderate threats to self and others.</td>
<td>Attacks others causing mild/moderate physical injury (bruises, sprains, welts).</td>
</tr>
<tr>
<td>4</td>
<td>Makes clear threats of violence towards others or self, e.g. “I’m going to kill you” or requests help to control self.</td>
<td>Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury).</td>
</tr>
</tbody>
</table>

The staff member completing the form (which takes about five minutes) following an aggressive episode is asked to check the most applicable item in each relevant category, and to record the nature of any staff intervention at the time of the incident (i.e. none, talking to patient, closer observation, physical restraint, immediate oral medication, immediate intramuscular (IMI) medication, isolation or segregation, seclusion, medical attention for perpetrator, medical attention for victim, and other). Staff can indicate the perceived motivation for the aggression (i.e. material gain, provocation, psychosis, self defence, unknown, and other). The OAS provides space for additional comments on interventions, which enables provision of further details of the interventions used with aggressive clients, and of strategies ranging from relaxation and distraction techniques to counselling and exclusion from activities.

The OAS has well established reliability and validity (Beauford, McNiel, & Binder, 1997; Malone, Delaney, Luebbert, Cater, & Campbell, 2000; Silver & Yudofsky, 1991). Interclass correlation coefficients range from 0.50 to 0.97 for verbal aggression and 0.72 to 1.00 for physical aggression (Beauford et al., 1997; Malone et al., 2000). The OAS can be used unmodified for children and adolescents (Kafantaris, Lee, Magee, Winny, Samuel, Pollack, & Campbell, 1996).
5.3.5 Data analysis

Data entry was checked for accuracy and completeness. Missing diagnoses and dates of birth were obtained from the manager of clinical information and a senior clinician at the major rehabilitation hospital who accessed patient files to ensure accuracy of information. Diagnoses on the database were recorded in both International Classifications of Disease (ICD10) (World Health Organization, 1992) and Diagnostic and Statistical Manual IV-TR (DSM) (American Psychiatric Association, 2004) schemata; these records were adjusted so that DSM diagnoses were used throughout. The DSM codes were then collapsed into major diagnostic categories: schizophrenia and other psychotic disorders; dementia; substance related disorders; adjustment disorders; bipolar disorders; depressive disorders; personality disorders; attention-deficit and disruptive behaviour disorders, and mental disorders due to a general medical condition.

The rate of aggressive incidents was calculated as the number of aggressive incidents per 100 occupied patient bed-days. The rate of incidents in different subgroups was estimated by dividing the total number of instances in each month by the number of patient bed-days in all inpatient units for that month. As the number of patients was not constant throughout the ten-year period, the research team obtained from records of admissions the total numbers of males and females in all inpatient units on the last day of each calendar month, and conducted analyses of all the 9,623 OAS reports completed on 533 patients from 1\textsuperscript{st} January 1996 to 31\textsuperscript{st} October 2005. Six reports, all relating to the same individual, omitted gender; these reports were included in all analyses which did not concern gender. Similarly, date of birth was omitted from another report, and these data were included in all further analyses which did not involve age.

Descriptive statistics were calculated and correlational analyses conducted using SPSS Graduate Pack 14.0 for Windows (SPSS Inc.2004). Average numbers of aggressive instances per month were calculated for the period of observations.

The number of aggressive instances per 100 patient bed-days was examined using exact methods as a Poisson distribution (Owen et al., 1998b). The relative risk (Zhang & Yu, 1998) of aggression for the main variables of interest (for example the relative risk of aggression by males compared with females) was calculated by means of the Genmod procedure in the SAS statistical program (SAS Institute Inc, 1997). Significant differences are reported as relative risk with 95% confidence intervals and $p$ - values.
from the chi-square analysis. In addition, changes in the number of aggressive instances per 100 patient bed-days over time were analysed by repeated measures analysis using the mixed model procedure in the SAS statistical program (SAS Institute Inc., 1997). Covariance parameters were modelled using a first-order autoregressive (AR(1)) covariance matrix with random effects (Clayton, 1999; Littell, Henry, & Amerman, 1998). Statistical significance for all analyses was set at alpha <0.05. Cross tabulation was used to examine relative frequency of perceived internal or external motivation for aggression and type of intervention.

In addition qualitative data from the OAS forms were analysed using qualitative descriptive methods. Answers to questions inviting comment were grouped according to the main thematic areas. The data were then dealt with in a priori coding, the categories being established prior to analysis based upon Duxbury and Whittington’s (2002; 2005) work on understanding inpatient aggression. They highlight three conceptual models for understanding inpatient aggression: (a) internal model, which includes psychopathology, age and gender; (b) external model which includes ward design, ward regime and lack of liberty; and (c) situational/interactional model which looks at the interplay between patient and staff; these are illustrated in Table 5.8.

Categories grouped concepts with similar meaning or connotation (Weber, 1990 in Stemler, 2001) and were mutually exclusive and exhaustive (Stemler, 2001). Authenticity was established by presenting the data to a group of experienced Prevention and Management of Violence and Aggression (PMVA) trainers who verified the process.

5.4 Results

5.4.1 Descriptive statistics

OAS forms totalling 9,623 were completed across rehabilitation, acute, and child and adolescent mental health settings in the participating health region, including 5,998 (62.33% of total reports) for males and 3,625 (37.65% of total reports) for females. Some 18,786 aggressive incidents were reported, as frequently more than one instance was included per form. Reports included 7,584 instances of verbal aggression, 3,619 instances of physical aggression against objects, 1,100 instances of
physical aggression against self and 6,465 instances of physical aggression against other people (Table 5.2).

Table 5.2 Number of OAS Reports of Aggression across rehabilitation, acute and child and adolescent mental health units from January 1996 to October 2005

<table>
<thead>
<tr>
<th></th>
<th>Total Reports</th>
<th>Verbal</th>
<th>Objects</th>
<th>Self</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Males</td>
<td>5998 (62.33)</td>
<td>4487 (59.16)</td>
<td>2089 (57.72)</td>
<td>645 (58.64)</td>
<td>4166 (64.44)</td>
</tr>
<tr>
<td>Females</td>
<td>3625 (37.67)</td>
<td>3097 (40.84)</td>
<td>1530 (42.28)</td>
<td>455 (41.36)</td>
<td>2299 (35.56)</td>
</tr>
<tr>
<td>Total</td>
<td>9623</td>
<td>7584 (78.81)</td>
<td>3619 (37.61)</td>
<td>1100 (11.43)</td>
<td>6465 (67.18)</td>
</tr>
</tbody>
</table>

*First percentage given is the percentage of reports made for males or females from total reports

*Values are percentages of OAS reports that contain an incidence of the specified aggression

The average number of inpatients per day on the last day of each month decreased over the period of the study by 42 beds (Figure 5.1), and a 12-bed tertiary psychiatric unit for children and adolescents commenced in April 2004 but is not represented in the bed-days figures. Males outnumbered females by approximately three to one.

Figure 5.1 Average number of male (●) and female (○) inpatients per day across all units included in the study from January 1996 to October 2005
The average number of instances of level 3 (Curses viciously, uses foul language in anger, makes moderate threats to self and others) and 4 (Makes clear threats of violence towards others or self, e.g. "I'm going to kill you") verbal aggression per 100 bed-days per month was significantly ($p < 0.01$) higher than the average number of instances of level 1 (Makes loud noises. Shouts angrily) and 2 (Yells mild personal insults) verbal aggression (Table 5.3). Conversely, the average number of instances of level 1 (Makes threatening gestures, swings at people, grabs clothing) and 2 (Strikes, kicks, pushes, pulls hair without injury to person) physical aggression against others per 100 bed-days per month was significantly ($p < 0.01$) higher than the average number of instances of level 3 (Attacks others causing mild/moderate physical injury (bruises, sprains, welts) and 4 (Attacks others causing severe physical injury – broken bones, deep lacerations, internal injury) physical aggression against others.

Table 5.3  *Average number of reported instances of verbal or physical aggression per 100 bed-days per month*

<table>
<thead>
<tr>
<th>Reported Level of Severity$^1$ of Aggression</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>$p$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal</td>
<td>0.41$^c$ ($\pm$ 0.029)</td>
<td>0.34$^c$ ($\pm$ 0.029)</td>
<td>0.80$^b$ ($\pm$ 0.029)</td>
<td>0.99$^a$ ($\pm$ 0.029)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Physical (Self)</td>
<td>0.08$^b$ ($\pm$ 0.011)</td>
<td>0.15$^a$ ($\pm$ 0.011)</td>
<td>0.06$^b$ ($\pm$ 0.011)</td>
<td>0.08$^b$ ($\pm$ 0.011)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Physical (Others)</td>
<td>0.82$^b$ ($\pm$ 0.026)</td>
<td>0.93$^a$ ($\pm$ 0.026)</td>
<td>0.30$^c$ ($\pm$ 0.026)</td>
<td>0.01$^d$ ($\pm$0.026)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

$^1$Values are least squares means $\pm$ standard error of the least squares means

Means in each row with different superscripts differ significantly ($p < 0.01$)

$^1$See Table 5.1 for description of level of severity of verbal or physical aggression
5.4.2 Change over time in verbal or physical aggression

Verbal aggression

Verbal aggression was the most frequent type of aggression noted, with 78.81% of the completed reports indicating some level of verbal aggression. Of the OAS reports containing an instance of verbal aggression, 4,487 (59.16%) and 3,097 (40.84%) were completed for males and females respectively (Table 5.2).

The number of reported instances of verbal aggression at each level of severity (1 to 4) per month (Figure 5.2A) and per 100 patient bed-days (Figure 5.2B) decreased ($p>0.001$) from 1997 to 2005. The number of reported instances of level 3 and 4 verbal aggression per 100 patient bed-days was significantly ($p < 0.001$) higher than the number of reported instances of level 1 and 2 verbal aggression over the entire period of the study.
Figure 5.2 Change in the average number of instances of level 1 (●), level 2 (◆), level 3 (■) or level 4 (□) verbal aggression (A) per month or (B) per 100 patient bed-days per month across units included in the study from January 1996 to October 2005.

See Table 5.1 for description of level of severity of verbal or physical aggression.
Physical aggression against others

The number of reported incidents of less severe physical aggression against others (levels 1 and 2) per 100 patient bed-days per month decreased significantly ($p = 0.001$) between 1997 and 2005 (Figure 5.3B). However, the number of reported incidents of more severe physical aggression against others (levels 3 and 4) per 100 patient bed-days per month did not change significantly over the same period ($p = 0.270$ and $p = 0.940$ respectively). The number of reported incidents of level 1 and 2 physical aggression against others per 100 patient bed-days was significantly ($p < 0.001$) higher than the number of reported incidents of level 3 and 4 physical aggression over the entire period of the study.
Figure 5.3. Change in the average number of instances of level 1 (♦), level 2 (♣), level 3 (■) or level 4 (□) physical aggression (A) per month or (B) per 100 patient bed-days per month across units included in the study from January 1996 to October 2005.

1See Table 5.1 for description of level of severity of physical aggression against others.
5.4.3 Differences between genders in verbal and physical aggression

Verbal aggression
Instances of level 1 verbal aggression per 100 patient bed-days were less likely to be reported for females than for males (RR = 0.78, 95% CI = 0.63 – 0.97, p=0.024). Instances of level 2, 3 and 4 verbal aggression per 100 patient bed-days were more likely to be reported for females than for males (Table 5.4).

Physical Aggression
Instances of levels 1, 2 and 3 physical aggression per 100 patient bed-days were more likely to be reported for females than for males (Table 5.4). Level 4 physical aggression against others was equally likely (RR = 1.06, 95% CI = 0.52 – 2.19, p=0.868) to be reported for females as for males.
Table 5.4 *Number of aggressive instances per 100 patient bed-days and the relative risk (RR) of aggression by females compared with males for each type and level of aggression measured by the OAS across the study units*

<table>
<thead>
<tr>
<th>Aggression</th>
<th>Number of instances&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Relative Risk&lt;sup&gt;2&lt;/sup&gt;</th>
<th>(95% CI)</th>
<th>p - value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>(F:M)</td>
<td></td>
</tr>
<tr>
<td><strong>Verbal Aggression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 1</td>
<td>0.2314</td>
<td>0.1809</td>
<td>0.78</td>
<td>0.63 - 0.97</td>
</tr>
<tr>
<td>Level 2</td>
<td>0.1430</td>
<td>0.1971</td>
<td>1.38</td>
<td>1.11 - 1.71</td>
</tr>
<tr>
<td>Level 3</td>
<td>0.3035</td>
<td>0.4994</td>
<td>1.65</td>
<td>1.39 - 1.94</td>
</tr>
<tr>
<td>Level 4</td>
<td>0.2961</td>
<td>0.7099</td>
<td>2.40</td>
<td>2.04 - 2.82</td>
</tr>
<tr>
<td>Total Instances</td>
<td>0.9741</td>
<td>1.5873</td>
<td>1.63</td>
<td>1.41 - 1.89</td>
</tr>
<tr>
<td><strong>Physical Aggression</strong> <em>(Others)</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 1</td>
<td>0.3701</td>
<td>0.4641</td>
<td>1.25</td>
<td>1.05 - 1.50</td>
</tr>
<tr>
<td>Level 2</td>
<td>0.4001</td>
<td>0.5351</td>
<td>1.34</td>
<td>1.14 - 1.57</td>
</tr>
<tr>
<td>Level 3</td>
<td>0.1331</td>
<td>0.1715</td>
<td>1.29</td>
<td>1.09 - 1.53</td>
</tr>
<tr>
<td>Level 4</td>
<td>0.0062</td>
<td>0.0066</td>
<td>1.06</td>
<td>0.52 - 2.19</td>
</tr>
<tr>
<td>Total Instances</td>
<td>0.9096</td>
<td>1.1773</td>
<td>1.29</td>
<td>1.13 - 1.49</td>
</tr>
</tbody>
</table>

<sup>1</sup>Number of aggressive instances per 100 patient bed-days. Data calculated from the average of the number of aggressive instances per patient bed day for each month from Jan 1996 to Oct 2005

<sup>2</sup>Relative Risk = Probability of females being aggressive / probability of males being aggressive

<sup>p</sup>-value = Chi Squared value for RR using robust error variances

<sup>1</sup>See Table 5.1 for description of level of severity of verbal or physical aggression
5.4.4 Association between the severity of verbal and of physical aggression

When verbal aggression and physical aggression against others were noted on the same OAS report, the reported severity of verbal aggression was not significantly correlated with the reported severity of physical aggression against others. 

\[ r(4826) = -0.003, \ p = 0.828 \]

When verbal aggression and physical aggression against others were reported for each gender, the reported severity of verbal aggression was significantly related to the reported severity of physical aggression against others for female \( r(2007) = -0.097, \ p < 0.001 \) but not male \( r(2817) = 0.034, \ p = 0.07 \) patients.

When the diagnosis of psychosis only was considered, the reported severity of physical aggression against others was significantly related to the reported severity of verbal aggression. The change in reported severity of verbal aggression is explaining only 0.5% of the variation of the reported severity of physical aggression against others due to the large sample size.

5.4.5 Association between verbal and physical aggression against others and mental health disorders

Verbal aggression

The total number of reported instances of verbal aggression (instances/year) was significantly \( p < 0.001 \) greater when patients were diagnosed with psychosis (M = 101.78, sem = 3.37) than any other disorder (Table 5.5). The total number of reports of levels 1, 2, 3 or 4 verbal aggression was significantly \( p < 0.001 \) higher when patients were perceived to be psychotic than those diagnosed either with Major Depressive Disorder (MDD) or Bipolar Affective Disorder (BAD) (Figure 5.4A). The total number of reports of levels 1, 2, 3 or 4 verbal aggression was not significantly different when patients were diagnosed with either MDD or BAD.
Table 5.5 *Number of instances of verbal or physical aggression per year for selected diagnoses as reported by the OAS from 1996 to 2005*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>p-values</th>
<th>Diagnosis Level</th>
<th>Diagnosis Level *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychosis</td>
<td>MDD</td>
<td>BAD</td>
</tr>
<tr>
<td>Verbal</td>
<td>101.78a (±3.37)</td>
<td>0.53b (±3.37)</td>
<td>7.53b (±3.37)</td>
</tr>
<tr>
<td>Physical</td>
<td>73.70a (±2.69)</td>
<td>0.80b (±2.69)</td>
<td>6.25b (±2.69)</td>
</tr>
</tbody>
</table>

Values are least squares means ± standard error of the least squares means

Means in each row with different superscripts differ significantly (p < 0.01)

1Physical = physical aggression against others

2Level = level of severity of aggression: See Table 5.1 for description of level of severity of verbal or physical aggression.
Figure 5.4 Average number of reported instances of verbal aggression (A) or physical aggression against others (B) for increasing severity of aggression (from 1 to 4) for major diagnoses of patients across in-patient units per year.

See Table 5.1 for description of level of severity of verbal or physical aggression.
Physical Aggression against others

The total number of reported instances of physical aggression (instances/year) was significantly ($p < 0.001$) greater when patients were diagnosed with psychosis (M = 73.7, sem = 2.69) than any other disorder (Table 5.5). The total number of reports of levels 1, 2 or 3 physical aggression against others was significantly ($p < 0.001$) higher when patients were diagnosed with psychosis than with either MDD or BAD (Figure 5.4B). However, the total number of reports of level 4 aggression against others was not significantly different between diagnoses. The total number of reports of levels 1, 2, 3 or 4 physical aggression against others was not significantly different when patients were diagnosed with either MDD or BAD.

5.4.6 Nurses' explanations for patient aggression

Verbal aggression

The total number of reported instances of verbal aggression (instances/year) was significantly ($p < 0.001$) greater when the motivation for aggression was perceived to be psychosis (M = 40.01, sem = 1.86) compared with any other motivation (Table 5.6). The total number of reports of levels 1, 2, 3 or 4 verbal aggression was significantly ($p < 0.001$) greater when the motivation for aggression was perceived to be psychosis compared with any other motivation (Figure 5.5A).

Table 5.6 Number of instances of verbal or physical aggression per year for perceived motivation for aggression as reported by the OAS from 1996 to 2005

<table>
<thead>
<tr>
<th>Motivation</th>
<th>Material gain</th>
<th>Provocation</th>
<th>Psychosis</th>
<th>Self defence</th>
<th>motivation</th>
<th>Level²</th>
<th>Motivation* Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal</td>
<td>10.92b (± 1.86)</td>
<td>5.79bc (± 2.08)</td>
<td>40.01a (± 1.86)</td>
<td>2.53c (± 2.51)</td>
<td>&lt;0.001</td>
<td>&lt;0.00</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Physical</td>
<td>7.25b (± 3.03)</td>
<td>6.44b (± 2.64)</td>
<td>31.93a (± 2.07)</td>
<td>2.76b (± 4.83)</td>
<td>&lt;0.001</td>
<td>&lt;0.00</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Values are least squares means ± standard error of the least squares means
Mean in each row with different superscripts differs significantly ($p < 0.01$)
²Physical = physical aggression against others
³See Table 5.1 for description of level of severity of verbal or physical aggression

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Figure 5.5 Average number of reported instances of verbal aggression (A) or physical aggression against others (B) for increasing severity of aggression (from 1 to 4) for perceived motivation for aggression across in-patient units per year.

See Table 5.1 for description of level of severity of verbal or physical aggression.
**Physical aggression against others**

The total number of reported instances of physical aggression against others (instances/year) was significantly ($p < 0.001$) greater when the motivation for aggression was perceived to be psychosis ($M = 31.93$, $sem = 2.07$) compared with any other motivation (Table 5.6). The total number of reports of levels 1, 2 and 3 but not level 4 physical aggression against others was significantly ($p < 0.001$) greater when the motivation for aggression was perceived to be psychosis compared with any other motivation (Figure 5.5B).

**Internal and external motivation for aggression**

The OAS form also made provision for staff to register their perceptions of motivation for client aggression. Some 1,829 such comments were recorded and the findings are given in Table 5.7. The main perceived causes for aggression were: organic brain damage ($n=500$); other patients and the ward environment ($n=187$); aggression in response to nursing or other staff intervention ($n=180$); and aggression resulting from the patient's personality or long-standing traits ($n=139$).
Table 5.7  Comments on perceived motivation for aggression

<table>
<thead>
<tr>
<th>Cause cited</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organic brain damage</td>
<td>500</td>
</tr>
<tr>
<td>Other patients/relatives/ward environment</td>
<td>187</td>
</tr>
<tr>
<td>Intervention from nursing/other staff</td>
<td>180</td>
</tr>
<tr>
<td>Personality/long standing traits</td>
<td>139</td>
</tr>
<tr>
<td>Unclassified</td>
<td>132</td>
</tr>
<tr>
<td>Temporary mood state</td>
<td>121</td>
</tr>
<tr>
<td>Confusion/misinterpretation</td>
<td>101</td>
</tr>
<tr>
<td>Unpredictable/impulsive</td>
<td>93</td>
</tr>
<tr>
<td>Unmet demands</td>
<td>90</td>
</tr>
<tr>
<td>Psychosis other psychiatric symptomatology</td>
<td>88</td>
</tr>
<tr>
<td>Attention seeking</td>
<td>61</td>
</tr>
<tr>
<td>Cigarettes (seeking)</td>
<td>37</td>
</tr>
<tr>
<td>Material gain/intimidation</td>
<td>25</td>
</tr>
<tr>
<td>Frustration</td>
<td>24</td>
</tr>
<tr>
<td>Medication</td>
<td>23</td>
</tr>
<tr>
<td>Retaliation</td>
<td>18</td>
</tr>
<tr>
<td>Defense of others</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1829</strong></td>
</tr>
</tbody>
</table>

These data were further analysed taking account of Duxbury’s (2002) model using the methodology described in the methods section 5.3 (see also Table 5.8). Patient aggression was most often viewed as being due to factors intrinsic to the patient (individual patient characteristics including age, gender, diagnosis, and substance misuse) with external causation (environmental factors) given as the least likely cause, and explanations which viewed as aggression arising from the interaction between factors (the situational model) were also not frequent. Data based on this model are presented in Table 5.9.
Table 5.8  *Motivating factors and classification into internal or external explanatory factors according to Duxbury’s (2002) framework*

<table>
<thead>
<tr>
<th>OAS “motivation” categories</th>
<th>Classified as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material gain</td>
<td>Internal</td>
</tr>
<tr>
<td>Provocation</td>
<td>External</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Internal</td>
</tr>
<tr>
<td>Self defence</td>
<td>External</td>
</tr>
<tr>
<td>Unknown</td>
<td>Not classified</td>
</tr>
<tr>
<td>Other</td>
<td>Not classified</td>
</tr>
</tbody>
</table>

Table 5.9  *Perceived motivation for aggression (after Duxbury 2002)*

<table>
<thead>
<tr>
<th>Cause cited</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>1197</td>
<td>65.4</td>
</tr>
<tr>
<td>Situational/interactional</td>
<td>318</td>
<td>17.4</td>
</tr>
<tr>
<td>External</td>
<td>213</td>
<td>11.6</td>
</tr>
<tr>
<td>Not classified</td>
<td>101</td>
<td>5.5</td>
</tr>
<tr>
<td>Total</td>
<td>1829</td>
<td></td>
</tr>
</tbody>
</table>

*Internal or external motivation for verbal aggression*

The total number of reported instances of verbal aggression (instances/year) was significantly ($p < 0.001$) greater when the motivation for aggression was perceived to be internal ($M = 55.23$, $sem = 3.00$) rather than external (Table 5.10). The total number of reports of levels 1, 2, 3 or 4 verbal aggression was significantly ($p < 0.001$) greater when the motivation for aggression was perceived to be internal rather than external (Figure 5.6A).
Table 5.10  Number of instances of verbal or physical aggression per year for perceived internal or external motivation for aggression as reported by the OAS from 1996 to 2005

<table>
<thead>
<tr>
<th>Motivation(^3)</th>
<th>(p)-values</th>
<th>(p)-values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internal</td>
<td>External</td>
</tr>
<tr>
<td>Verbal</td>
<td>55.23 (\pm 3.00)</td>
<td>6.88 (\pm 3.30)</td>
</tr>
<tr>
<td>Physical(^1)</td>
<td>42.32 (\pm 3.07)</td>
<td>8.14 (\pm 3.74)</td>
</tr>
</tbody>
</table>

Values are least squares means \(\pm\) standard error of the least squares means.

\(^1\)Physical = physical aggression against others

\(^2\)Level = level of severity of aggression: \(^3\)See Table 5.1 for description of level of severity of verbal or physical aggression

\(^3\)See Table 5.8 for description of internal and external motivation.

**Internal or external motivation for physical aggression against others**

The total number of reported instances of physical aggression against others (instances/year) was significantly \((p < 0.001)\) greater when the motivation for aggression was perceived to be internal \((M = 42.32,\ \text{sem} = 3.07)\) rather than external (Table 5.10). The total number of reports of levels 1, 2 and 3 but not level 4 physical aggression against others was significantly \((p < 0.001)\) greater when the motivation for aggression was perceived to be internal rather than external (Figure 5.6B).
Figure 5.6 Average number of reported instances of verbal aggression (A) or physical aggression against others (B) for increasing severity of aggression (from 1 to 4) for perceived internal or external causation of aggression across in-patient units per year.

See Table 5.8 for description of internal and external motivation.
5.4.7 The association between diagnosis and perceived motivation for aggression

Verbal aggression

The percentage of instances of any level of verbal aggression was significantly (p < 0.001) higher when psychosis was the perceived motivation for aggression compared with any other perceived motivation. The percentage of instances of verbal aggression where psychosis was the perceived motivation for verbal aggression was higher for females (M = 71.4, se = 1.50) than males (M= 65.1, se = 1.48). That is, the perceived motivation for 71.4% of any instance of verbal aggression for females was psychosis. The percentage of instances of verbal aggression where material gain, (p = 0.545), provocation, (p = 0.060) or self-defence (p = 0.381) was the perceived motivation for verbal aggression was not significantly different between males and females (Figure 5.7A).

The percentage of instances of any level of physical aggression against others was significantly (p < 0.001) higher when psychosis was the perceived motivation for aggression compared with any other perceived motivation. The percentage of instances of physical aggression against others where psychosis was the perceived motivation for physical aggression against others was higher for females (M = 74.6, se = 2.40) than males (M= 65.5, se = 2.28). That is, the perceived motivation for 74.6% of any instance of physical aggression against others for females was psychosis. The percentage of instances of physical aggression against others where material gain (p = 0.190), provocation (p = 0.065) or self-defence (p = 0.3771) was the perceived motivation for verbal aggression was not significantly different between males and females (Figure 5.7B).
Figure 5.7 Percentage of instances of verbal aggression (A) or physical aggression against others (B) for females (open bars) and males (shaded bars) for each reported motivation for aggression.
5.4.8 Interventions following an episode of verbal or physical aggression

The OAS lists interventions following an aggressive episode. Nurses were able to specify more than one intervention for each aggressive episode; in the following analyses these include interventions for all types of aggression, and on average 1.9 interventions per episode were recorded. *Talking to the patient* was the main intervention in just over 70% of cases, and *increasing the level of observation* the next most frequent at just over 40%. *Oral medication* was used in approximately 25% of instances of verbal aggression, and seclusion and segregation in approximately 20% of instances of verbal aggression (Figure 5.8).

![Figure 5.8 Recorded interventions following aggressive episode](image)

5.4.9 Interventions following an episode of verbal aggression

The most frequent intervention for all levels of verbal aggression was “Talking” (Table 5.11). The frequency of “talking” as the intervention for verbal aggression was highest when verbal aggression was level 3 or 4. Increasing the level of observation, oral medication and seclusion were also used as interventions across all levels of verbal aggression. Further analyses of significant differences in the frequency of interventions were conducted following the grouping of interventions into either “controlling” or “non-controlling” interventions.
### Table 5.11  Average number of recorded interventions (per year) for each level of verbal aggression

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Level 1 (±)</th>
<th>Level 2 (±)</th>
<th>Level 3 (±)</th>
<th>Level 4 (±)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1.6 (± 0.43)</td>
<td>2.1 (± 0.59)</td>
<td>4.0 (± 0.63)</td>
<td>5.2 (± 1.16)</td>
</tr>
<tr>
<td>Talking</td>
<td>53.5 (± 9.57)</td>
<td>38.9 (± 6.15)</td>
<td>86.9 (± 10.88)</td>
<td>97.3 (± 10.63)</td>
</tr>
<tr>
<td>Observation</td>
<td>29.3 (± 5.62)</td>
<td>22.6 (± 4.31)</td>
<td>53.0 (± 6.97)</td>
<td>66.9 (± 7.36)</td>
</tr>
<tr>
<td>Restraint</td>
<td>12.7 (± 2.67)</td>
<td>9.1 (± 1.69)</td>
<td>13.6 (± 1.51)</td>
<td>25.1 (± 2.44)</td>
</tr>
<tr>
<td>Oral</td>
<td>19.4 (± 3.53)</td>
<td>11.4 (± 2.11)</td>
<td>29.3 (± 3.98)</td>
<td>39.3 (± 5.63)</td>
</tr>
<tr>
<td>IMI</td>
<td>5.3 (± 1.64)</td>
<td>2.8 (± 0.93)</td>
<td>7.0 (± 1.27)</td>
<td>12.9 (± 2.14)</td>
</tr>
<tr>
<td>Isolation</td>
<td>15.9 (± 3.41)</td>
<td>10.3 (± 1.65)</td>
<td>21.8 (± 2.76)</td>
<td>33.0 (± 3.97)</td>
</tr>
<tr>
<td>Seclusion</td>
<td>1.5 (± 0.33)</td>
<td>1.1 (± 0.22)</td>
<td>2.2 (± 0.55)</td>
<td>4.1 (± 0.90)</td>
</tr>
<tr>
<td>Med Perp(^1)</td>
<td>0.7 (± 0.18)</td>
<td>0.4 (± 0.15)</td>
<td>1.2 (± 0.27)</td>
<td>2.6 (± 0.44)</td>
</tr>
<tr>
<td>Med Victim(^2)</td>
<td>1.0 (± 0.22)</td>
<td>0.4 (± 0.18)</td>
<td>1.0 (± 0.26)</td>
<td>1.8 (± 0.38)</td>
</tr>
<tr>
<td>Other</td>
<td>8.9 (± 2.02)</td>
<td>6.8 (± 1.17)</td>
<td>14.1 (± 2.11)</td>
<td>17.3 (± 2.39)</td>
</tr>
</tbody>
</table>

Values are means ± standard error of the means.

\(^1\) Medical attention for the perpetrator
\(^2\) Medical attention for the victim

**Controlling and non-controlling interventions**

The OAS lists eleven possible interventions for aggression. Interventions were classified as “controlling” interventions (including medication, medical management and physical restraint) and “non-controlling” interventions (including no response, talking to the patient and close observation which did not restrict the patient’s movements) (Table 5.12). Three additional categories – “unknown,” “other”, and “medical attention for the victim or perpetrator” – were not further classified or included in the analysis.
### Table 5.12  OAS intervention categories and their classification into interventions

<table>
<thead>
<tr>
<th>OAS ‘intervention’ categories</th>
<th>Classified</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Non-controlling</td>
</tr>
<tr>
<td>Talking with patient</td>
<td>Non-controlling</td>
</tr>
<tr>
<td>Closer observation</td>
<td>Non-controlling</td>
</tr>
<tr>
<td>Physical restraint</td>
<td>Biomedical/ controlling</td>
</tr>
<tr>
<td>Immediate oral medication</td>
<td>Biomedical/ controlling</td>
</tr>
<tr>
<td>Immediate IMI medication</td>
<td>Biomedical/ controlling</td>
</tr>
<tr>
<td>Isolation or segregation</td>
<td>Biomedical/ controlling</td>
</tr>
<tr>
<td>Medical attention for perpetrator</td>
<td>Not classified</td>
</tr>
<tr>
<td>Medical attention for victim</td>
<td>Not classified</td>
</tr>
<tr>
<td>Seclusion</td>
<td>Controlling</td>
</tr>
<tr>
<td>Other</td>
<td>Not classified</td>
</tr>
</tbody>
</table>

#### 5.4.10 The association between diagnosis and intervention

The interventions for any level of verbal aggression were not significantly different ($p > 0.05$) for patient diagnoses of BAD, MDD or psychosis (Figure 5.9A). For comparison of intervention between diagnosis and level of aggression non-controlling interventions were given a value of 1 and controlling interventions a value of 2. As the level of verbal aggression for patients diagnosed with psychosis increased from level 2 to level 4, the intervention was significantly ($p < 0.05$) more controlling (Figure 5.9A). The intervention for verbal aggression was not significantly different for each level of verbal aggression when patient diagnosis was either BAD or MDD.
Figure 5.9  Average intervention (non-controlling = 1, controlling = 2) for verbal aggression (A) or physical aggression against others (B) for increasing severity of aggression (from 1 to 4) for all causes of aggression
The interventions for any level of physical aggression against others also were not significantly different \((p > 0.005)\) for patient diagnoses of BAD, MDD, or psychosis. Using a value for non-controlling interventions of 1 and controlling interventions of 2, the intervention for more severe physical aggression against others (level 4) when patient diagnosis was MDD or psychosis was significantly more controlling than when physical aggression against others was less severe (level 2) (Figure 5.9B).

Comments on interventions
The OAS also provides space for additional comments on interventions; 1,275 such comments were analysed as described above (5.3), first into 59 separate groups which were further collapsed into 21 groups. These are presented in Table 5.13. The most frequently recorded intervention was separation from other patients \((n = 506)\) followed by medication \((n = 126)\) and walking \((n=110)\).
Table 5.13  *Intervention following aggressive episode*

<table>
<thead>
<tr>
<th>Intervention</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation from other patients</td>
<td>506</td>
</tr>
<tr>
<td>Medication</td>
<td>126</td>
</tr>
<tr>
<td>Walk</td>
<td>110</td>
</tr>
<tr>
<td>Increase level of nursing care</td>
<td>75</td>
</tr>
<tr>
<td>Description of event only</td>
<td>73</td>
</tr>
<tr>
<td>Placed in gerichair/slider (restraint)</td>
<td>62</td>
</tr>
<tr>
<td>Distraction/diversion</td>
<td>41</td>
</tr>
<tr>
<td>Withdrew</td>
<td>38</td>
</tr>
<tr>
<td>Verbal intervention</td>
<td>32</td>
</tr>
<tr>
<td>Allowed to settle</td>
<td>31</td>
</tr>
<tr>
<td>Remove weapon</td>
<td>28</td>
</tr>
<tr>
<td>Transferred</td>
<td>27</td>
</tr>
<tr>
<td>Medical care</td>
<td>25</td>
</tr>
<tr>
<td>Bed</td>
<td>25</td>
</tr>
<tr>
<td>Seclusion and restraint</td>
<td>22</td>
</tr>
<tr>
<td>Consequences for actions</td>
<td>17</td>
</tr>
<tr>
<td>Ignored/non-engagement</td>
<td>16</td>
</tr>
<tr>
<td>Smoke</td>
<td>7</td>
</tr>
<tr>
<td>Allowed behaviour</td>
<td>6</td>
</tr>
<tr>
<td>Observation</td>
<td>4</td>
</tr>
<tr>
<td>Shower</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1275</td>
</tr>
</tbody>
</table>
Data were then sorted inductively into traditional biomedical and controlling interventions and non-controlling approaches. It was not always possible to sort the data due to insufficient information: for example, sometimes it was clear that the patient chose to leave the area; in others it was evident that the staff moved the patient, but in the majority of cases this was not stated -- thus the category “separated/removed” contains the ambiguous entries. For example, locked out of dormitory and required two staff to escort him to day room, were classified as “separated/ removed”; pm medication as a biomedical intervention; and offered alternative energy outlets, reassuring words and warm drink and encouraged to use relaxation techniques as non-controlling approaches. Table 5.14 shows the results of this second sorting: only 27% of nursing interventions were classified as non-controlling.

Table 5.14  Intervention following aggressive episode (after Duxbury and Whittington, 2005)

<table>
<thead>
<tr>
<th>Intervention</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated/removed</td>
<td>419</td>
<td>32.9</td>
</tr>
<tr>
<td>Traditional biomedical and controlling interventions</td>
<td>415</td>
<td>32.5</td>
</tr>
<tr>
<td>Non-controlling approaches</td>
<td>343</td>
<td>26.9</td>
</tr>
<tr>
<td>Not classified</td>
<td>98</td>
<td>7.7</td>
</tr>
<tr>
<td>Total</td>
<td>1275</td>
<td>100</td>
</tr>
</tbody>
</table>

5.4.11 The relative frequency of perceived internal or external motivation for aggression and intervention

The intervention for any type of aggression was classified as “controlling” significantly more often ($\chi^2 = 81.1$, $p < 0.001$) when the perceived motivation for aggression was internal (non-controlling = 39.1%, controlling = 60.9% of interventions) compared with when the perceived motivation for aggression was external (non-controlling = 57.3%, controlling = 42.7% of interventions).

5.4.12 Perceptions about whether aggression is preventable

The OAS invites opinions on whether the aggression could have been prevented. A total of 9,630 completed OAS sheets produced 4,213 comments, which were analysed as described in the methods section 5.3 into like categories and then further grouped into broader categories. “Yes” and “no” comments qualified by further explanation were

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similarly categorised. The results were then verified by a senior group of expert nurses responsible for prevention and management of violence and aggression training across the region.

In reply to the question: “Could this incident have been prevented?”, 3,313 (78.64%) staff replied “no,” without explanation. Further information, when provided, featured factors internal to the patients such as their illness and personality as the most frequent cause (n=158). Typical comments included:

- No, hazard of working with dementia.
- Managing an unmanageable psychosis.
- No, due to cognitive impairment.
- Hindered by language barrier, patient speaks only Polish.

An important aspect of the “perceived not preventable category” was the need to perform nursing interventions to address patient’s immediate needs in the face of patient resistance:

- No. Patient mistakes nursing care for assault.
- Dilemma, as client resents reminder to shower.
- Incontinent of faeces, didn’t want to be showered.

Another perceived precipitating cause was the nurses’ refusal to agree to patient requests that were seen to compromise professional nursing responsibilities, such as allowing patients to smoke cigarettes, or to have liberty that was clearly contrary to medical order. One comment in this category summed up the nurses’ dilemma: “The incident could have been prevented if staff failed in their duty of care.”

Other perceived causative factors included the physical environment (n=118). With regard to physical facilities, staff frequently mentioned the need for more space and the capacity to segregate patients. Typical comments included:

- [Need] more areas for separation.
- [Needs] less crowded room and diversional activity.
- Behaviour not containable within open unit.

Aggression caused by interaction with other patients (n=64) was perceived as largely outside the nurses’ control:

- Assault on resident who drank all the milk.
- Not whilst noisy patients are on the unit.
- Personality conflict with other resident.
- Related to having ashtray thrown at him.
- “Stirring” from other patients can’t be prevented.
Explosive personalities in confined area.

When the data set was further collapsed into three categories: preventable; not preventable; and unsure or unclassifiable, only 7.26% of the instances were seen as potentially preventable (Table 5.15).

Table 5.15 Responses to the question: 'Was the aggression preventable?'

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventable and potentially preventable</td>
<td>306</td>
<td>(7.26)</td>
</tr>
<tr>
<td>No and not preventable</td>
<td>3813</td>
<td>(90.51)</td>
</tr>
<tr>
<td>Unsure/unclassifiable</td>
<td>94</td>
<td>(2.23)</td>
</tr>
<tr>
<td>Total:</td>
<td>4213</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Nurses' suggestions about means by which aggressive episodes might perhaps have been prevented frequently were limited to alternative methods of treatment: for example medication changes – Behaviour has regressed since ceasing Clonazepam – and failed to accommodate a range of other possible nursing interventions. Furthermore, frequently cited was the unsuitability of the physical environment and staffing issues.

Recommendations for improvement of nursing care were less frequent and generally non-specific, typically:

“A,” when feeling agitated to inform staff.
Better communication between staff.
Patient psychotic and needs more time to finish meals.

5.4.13 Nature of swearing

Although not directly asked to comment, in 51 cases nurses noted concerns about swearing, obscenities, and verbal abuse; for example: “Verbally abuses and demeans people regularly.” Several cases were reported of aggressive behaviour provoked by swearing by other patients.

[Aggression was a] response to other patient’s verbal abuse.
Irritated by fellow resident’s foul language and noise.
Offended by other patient’s blasphemy.
Received king hit from victim of his verbal abuse.
In one instance, the swearing was self-directed; in another the patient used a swearword to express distress: “No one gives a fuck about me.” In three examples, high-level offensive language was combined with threats:

Yelling, screaming obscenities and abuse – threatening to hit me, then picked up an ashtray and threw it.

Patient said he would get his uncle to bash me and then fuck me up the arse.

Threatened to get a gun and “fucking shoot youse.”

Other citations included “foul” or “offensive” language and sexual innuendo directed at staff.

5.4.14 Impact on nurses

Comments frequently revealed nurses’ affective response to the aggression; one nurse over the course of his shift completed four OAS forms on the same patient, and the comments disclose his increasing distress and frustration and the impact on the nature and extent of therapeutic care:

Bad day.
Continuing bad day.
A little more of a bad day.
Increasing bad day.

The nature and severity of the aggression for both nurses and patients is evident in several of the comments:

This boy has assaulted several staff in two days.
Waits until staff are busy to attack others.
Threatened to kill all staff.
Threatened staff with a knife.
Threatened to throw hot water over me.
Tried to burn resident with lighter.

A number of comments appear judgmental and will be commented on further in Chapter 7; for example:

Bad not mad.
“A” is vindictive and malicious with her insults.
Demented nasty old geezer.
“B” is giving in to one of his psychotic phases.
5.5 Discussion

This study reported rates of verbal aggression in mental health facilities, established which mental health disorders are reported by nurses as being associated with swearing and verbal aggression in aggressive episodes in inpatient mental health settings and explored whether the explanations nurses have for the motivation of aggression, especially verbal aggression, impact on their management of the patient.

The study findings, in common with other studies (for example, Duxbury, 2002; Foster, Bowers, & Nijman, 2007; Merecz et al., 2006) indicate that verbal aggression is the most frequently reported type of aggression. The finding that 79% of the completed reports cited some level of verbal aggression is rather higher than Duxbury's figure of 70% and Foster et al.'s figure of 60%. Whilst these figures are elevated, it is still probable that the actual figures are even higher; this theory is supported by anecdotal reports from nurses working on particular units featured in the present study, who maintain that levels of verbal aggression and swearing are so high that not only are they not reported, but also staff have ceased to register the behaviour as verbal aggression.

The OAS was designed to record levels of aggression in order of increasing severity and one might expect the results to reflect this, with the percentage of recorded aggression diminishing as its severity increased. However, this was not found to be the case: Despite verbal aggression being reported as the most prevalent category, “aggression against others” was the next most frequently recorded. “Aggression against self” was the category least likely to be reported, which perhaps reflects a perception that it does not constitute an aggressive episode because it is self-directed and does not pose a threat to others. Many authors have commented on difficulties involved in recording less serious incidents. The results suggest that verbal aggression is likely to be recorded for females only when the level of verbal aggression expressed is more severe.

There was a decrease over time (from 1996 to 2005) in the reporting of all physical aggression against others for both males and females. This might have been the result of inaccurate recording of incidents: Changes in requirements for reporting aggressive incidents have made it more administratively onerous. In addition, a major training
initiative for all staff across the area health service in the prevention and management of violence and aggression (PMVA) was commenced in February 2004, and anecdotal reports suggest that this has been effective in reducing the number of serious aggressive incidents.

In contrast to a decline in the number of reports of verbal aggression for females, the mean severity of physical aggression against others for females has increased significantly, with reported incident severity being significantly higher for females than for males in the period from 2002 to 2004. Beck et al. (1991) speculated that women who make threats inspire less fear than do men. If this is the case it might have led to nurses’ not dealing proactively with aggression and so account for this finding.

The relationship between reported verbal aggression and physical aggression is complex. When verbal aggression was reported to be level 1 (makes loud noises, shouts angrily), on average significantly fewer instances of aggression towards self were reported compared with aggression towards objects or others. Isolation from others almost always precedes the act of self-harm (Suyemoto, 1988) and thus it is unlikely to be accompanied by verbal aggression. It is unusual for physical aggression not to be preceded or accompanied by verbal aggression (Stets, 1990), and this is reflected in the results: As the reported level of verbal aggression increased from 2 to 4, the average number of reported instances of physical aggression towards objects, self or others increased significantly.

At a low level of verbal aggression and physical aggression, instances were significantly more likely to be reported for males than females; it may be that female aggression at low levels is not taken as seriously as male aggression because the consequences are less likely to result in serious physical harm, and it is therefore not reported to the same extent. The finding of a strong association between verbal and physical aggression has previously been made by Kay et al. (1988, p.544), but in this study was found to hold only for females. When the reported level of verbal aggression was more severe, instances of physical aggression were just as likely to be reported for females as males.

Discovering the causes of aggression is important because management and prevention differ depending on the underlying cause. Psychosis was perceived as the
main cause of verbal aggression, and a tendency to view it as the explanation increased with the increase in the level of recorded aggression. Psychosis is in itself insufficient explanation for verbal aggression, but this result resembles that of two previous studies with a similar population (Barlow et al., 2000; Davis, 1991). With regard to physical aggression, the total number of reported instances was significantly greater when patients were diagnosed with psychosis.

This finding contrasts with a study of 839 incidents in a long-term psychiatric hospital in the USA, where physical assaults motivated by psychosis were the least common despite the fact that many of the subjects had a primary diagnosis of a psychotic illness; the assaults that did occur were frequently motivated by paranoia (Quanbeck, Cameron, McDermott, Lam, Eisenstark, Sokolov, & Scott, 2007). The authors speculated that the small number of assaults might have been because patients were having treatment for their psychosis. Some of the wards in the current study were acute admission units with patients in a more acute stage of their illness.

In the written comments on motivation, a frequent perception was that the aggression was caused by the patients' being denied something, or their needs were not immediately met – frustration, a category corresponding with Ilkiw-Lavalle and Grenyer’s (2003) limit-setting, which similarly was found to be a major precipitant of aggressive incidents. Many comments related to aggression caused by patients reacting to nurses' direct verbal requests, again a precipitant which has previously been noted (Whittington & Wykes, 1996). Only one comment referred to the cause of aggression as relating to a threat or insult from a nurse; in this instance the aggression was in response to a patient being patronized. Although Whittington et al. found no tendency in staff to “whitewash” accounts of assaults, the fact that reporting in that study was not anonymous might have led nurses to under-report this category of aversive stimulation. The fourth type of aversive stimulation, perceived attack, was cited in 35 incidents. Many other comments did not fit easily into this framework: 587 specified the patient’s diagnosis as a causative factor, 420 of these citing dementia; interestingly, in some studies dementia has been found to present a reduced risk of aggression (Whittington, 1994).

Turning now to staff responses to aggression, it seems that typically more than one intervention followed an aggressive incident (the number of interventions per incident averaged 1.9).
This study follows a pattern similar to that documented by Pilowsky (1992, in Whittington, 1994) in which interventions were used in combination and tended to start with the least intrusive methods moving on to more coercive methods if necessary. In the present study, “talking to the patient” was recorded as the main intervention in just over 70% of cases; this refers to a category on the OAS but unfortunately does not convey sufficient information to be useful for analysis. “Talking” could include anything from reprimanding the patient to utilising psychotherapy, and the patients’ reactions to the different types of verbal intervention would vary accordingly as would the utility and suitability of the verbal intervention. It is unlikely that nurses could have performed any other intervention, intervention – for example medication or physical restraint – without explanation or verbal communication, and without detail on the content and intent of the “talking” little evaluative analysis is possible. Foster et al. (2007) also found verbal intervention to be the most frequent response to aggression, but their finding of 43.7% usage of this intervention differs markedly from that of the present study.

Administering oral medication was the next most frequently recorded intervention, and segregation the third. Seclusion and the requirement for medical treatment were the least used options. Terminology may give rise to discrepancy in recording interventions, the terms “segregation” and “seclusion” possibly being used interchangeably in some settings. Seclusion and segregation accounted for just over 20% of the interventions recorded, a figure somewhat lower than Foster et al.’s (2007) in which seclusion was used in more than 25% of cases. Results similar to those of the present study were found by Duxbury (2002) who reported that 47% of aggressive incidents were managed by medication, seclusion and restraint. In the present study, similar interventions accounted for 45% of the interventions.

Again, the 1,183 comments on the intervention used following an aggressive episode related most frequently to segregating the patient or removing other patients; however, also cited frequently was asking patients to take a walk, or accompanying patients for a walk outside the unit, and medication too was mentioned. The comments provided scope for nurses to supply more detail about the interventions used with aggressive clients -- strategies ranging from relaxation and distraction techniques to counselling and exclusion from activities.

With reference to Duxbury’s (2002) internal or external explanatory factors, motivation for aggression was viewed as arising predominantly from factors internal to the patient;
this had important associations with choice of interventions, controlling interventions being used more frequently than non-controlling for aggression with a perceived internal cause and the converse true for perceived external causation. This is perhaps consistent with the view of previous researchers that when problems are perceived to be internal helping behaviour is less likely (Ogden & Knight, 1995; Wanless & Jahoda, 2002).

As to whether an aggressive episode was preventable, interventions suggested by staff reporting in the affirmative primarily were consistent with the traditional biomedical model (Duxbury & Whittington, 2005), i.e., medication, seclusion or isolation, and changes to nursing and medical management of the patient. Changes to care most frequently advocated were to increase the level of observation and the numbers of nursing staff. Other proposals included incorporation of behavioural and dialectical behaviour therapy techniques with patients. There was some acknowledgement, consistent with interactional models, that nursing interventions could be a cause of aggressive incidents.

What is striking about the study findings is the considerable therapeutic pessimism regarding the preventability of aggressive incidents, with only 7% of the incidents being seen as preventable. This finding is perhaps consistent with the nurses’ opinion that the reasons for patient aggression were internal and therefore difficult to influence. It may also be related to the fact that this study has analysed reported events, and therefore represents the most serious incidents which are not as amenable to intervention. There is no mechanism for reporting incidents which nurses have prevented and the ways in which they did this.
5.6 Limitations

This study has overcome some of the methodological drawbacks of previous research in that it has a large sample size, includes several varied inpatient settings, employs a standardised instrument of proven reliability and validity, and uses data which were collected at the time of the incident. However, particular diagnoses may be over-represented in the sample, and base rates of each diagnosis for the inpatient population were not calculated. Despite the large sample size, there may also be systematic under- or over-reporting.

Although the database included all reported aggressive incidents it does not represent a record of all aggressive incidents on the units under study. Staff may not record a particular incident for any number of reasons; aggressive incidents may not be reported to staff and therefore remain unrecorded; aggressive incidents tend to occur in clusters, compromising nurses’ ability to record each individual incident (Sorgi et al., 1991); and staff may develop a high threshold for reporting verbal aggression because they have become inured to it. However, these reports do represent, as Werner et al. (1983) note of their own study, a record of those behaviours which staff members deem to be worthy of note.

Other possible methodological drawbacks concern the use of the OAS. Although it has been suggested that using the OAS ensures that higher numbers of aggressive episodes and behaviours are documented in patients files (Silver & Yudofsky, 1991), the issue of under-reporting relatively minor incidents remains. Ratey and Gutheil (1991) concluded that the OAS was practical only in smaller, more tightly run units, because staff turnover and fatigue would reduce the number of OAS reports submitted.

It should be noted that there is no formal training for nursing staff in the use of the OAS in the service settings which are the subject of this study. However, the instrument is straightforward to use and has been well accepted by nursing staff, particularly in the rehabilitation setting, and it is likely that reports from this setting reflect a reasonably complete record of incidents. The same cannot be said of the acute settings in the study where the instrument’s use was more sporadic.

Nurses completing the OAS are asked to record their name on the report: This lack of anonymity may lead to a tendency to report aggression in ways staff anticipate will be
acceptable to the supervisor, or that reflect what should have happened rather than what actually occurred. Also they may not feel free to identify shortfalls in management of aggression, including possible preventability, because of potential negative repercussions.

5.7 Conclusion

Verbal aggression might be viewed as a cathartic release. It has often been suggested that swearwords provide a means to “let off steam” (Berger, 1973). The OAS does not record the order in which verbal and physical aggression occurred and therefore provides insufficient information to conclude, as previous researchers have (Felson & Steadman, 1983; Nield-Anderson et al., 1999), that verbal aggression signals forthcoming physical aggression. However, the results of the current study, and of previous studies, suggest that there is no good reason to consider verbal aggression a form of emotional release.

Indeed, such an understanding may even be risky for staff, especially if it contributes to a tendency to downplay the seriousness of an episode of verbal aggression. Moreover, verbal aggression is important because it contributes to creating a stressful environment for nurses and patients. In the present study it was frequently nurses’ perception that swearing and noise from other patients was the trigger for aggressive incidents.

Data on the use of nursing interventions for aggressive incidents provide important information for those working to improve practice, review existing services or plan new mental health units. Some of the most time-honoured interventions for de-escalating potentially and actually aggressive patients, for instance walking in the grounds and other forms of constructive physical activity, are no longer as feasible given the mainstreaming of mental health facilities. While acute hospital co-located mental health units might satisfy some of the criteria for “least restrictive care,” in many other ways they could be said to work against this. In the mental health inpatient facilities of the 21st Century, nurses will need to be even more creative in assisting patients struggling with aggression.
Having established the reported prevalence of verbal aggression in mental health facilities and the explanations nurses adopt to understand aggression, the next chapter, Part 2 of the study, explores more specifically nurses’ experience of swearing and its impact upon them.
Chapter 6

The Questionnaire Study

Words have a magical power. They can bring either the greatest happiness or deepest despair; they can transfer knowledge from teacher to student; words enable the orator to sway his audience and dictate its decisions. Words are capable of arousing the strongest emotions and prompting all men's actions (Sigmund Freud).

6.1 Introduction

This chapter reports the quantitative and qualitative findings of the nursing self-report swearing impact questionnaire (NSIQ) which was completed by nurses working in a range of inpatient health settings involved in the study. Chapter 5 presented data on the incidence of reported verbal and physical aggression in mental health settings over a ten year period; the findings reported in this chapter address the impact on nurses of verbal aggression and swearing, the characteristics of nurses that may modify that impact, and consequences for the therapeutic relationship.

The chapter commences with a brief synopsis of the relevant literature pertaining to the study. This is followed by an overview of the methods employed in analysing the data. The results of the NSIQ are then reported, including the demographic characteristics of the respondents. The chapter concludes with a brief discussion of the findings which will be expanded upon in the following chapter.

There is little doubt that aggressive communication is an important nursing issue. Many studies attest that nurses are more frequently than other health professionals subject to verbal and physical aggression, and there is evidence of a number of adverse effects including hurt feelings, anger, anxiety, emotional exhaustion, depersonalisation, and distress that may impact on physical and psychological health (Kinney, 1994; Roberto & Finucane, 1997; Winstanley & Whittington, 2002). It has been suggested that mental health nurses are more likely than generalist nurses to experience verbal and physical aggression, but report lower rates of peer aggression (Merecz et al., 2006). Uzon (2003) found that nurses working in mental health (100%), emergency (98%), and paediatric (97%) settings experienced the highest rates of verbal aggression; this study will compare nurses working in mental health and in paediatric settings.
The meaning or attributions that nurses ascribe to aggression influence their emotional reaction to and actions in relation to the aggression ( Luck et al., 2007); therefore in the NSIQ survey, respondents were asked for their understanding of the causes of the swearing.

Characteristics of those experiencing the swearing may also moderate its impact. Individuals differ greatly in what they find hurtful (Kinney, 1994), and the sensitivity or degree to which people are offended by swearing varies: Jay (1999) defined offendedness as an aspect of personality. The research reported in this chapter used three standardised measures to ascertain whether in the sample of nurses there was a correlation of psychological ill health as measured by the GHQ, attributional style, and locus of control with distress.

Offensiveness and the related concept of offendedness were discussed in earlier chapters: In general, words with a sexual connotation were rated as the most offensive, those with religious connotation least offensive, and those relating to excretory functions fell between in terms of offensiveness (Baudhuin, 1973; Jay, 1978; Jay, 1978). The hypothesis of the present study was that nurses, whose training and ethical frameworks demand cultural sensitivity, would rate racist terms as more offensive than profanity and blasphemy, and equally as offensive as sexually based swearwords.

Individuals vary also in relation to their beliefs about swearing. It is likely that those who are still actively involved with their church will experience swearing as more offensive than those who do not have a religious background (Staley, 1978). It is hypothesised that less discomfort about swearing in therapeutic interactions with their patients will be felt by nurses more accustomed to social swearing, and the impact of being the target may also be modified.

Swearwords are usually used in a connotative (emotive) way. Opinions are divided as to whether words may be regarded as less offensive in their denotative (literal) than in their connotative sense (Chandler, 2002; Rieber et al., 1979; Taylor, 1995). This study aimed to explore that question and address a frequent deficiency of previous studies – the failure to distinguish between these two senses – by assessing nurses’ reactions to intentional swearing as opposed to swearwords used in a literal manner, such as “I need a shit” and “I need a crap.” It was hypothesised that nurses would find words
used in a literal sense more offensive than those used in an emotive sense because of the unexpectedness of hearing the words used in this way.

Swearing has been viewed in the literature almost invariably as negative, and although some literature has referred to the use of swearing within a counselling relationship no research has studied its therapeutic use by nurses. Accordingly, the research reported in this chapter examined whether nurses use swearing therapeutically in their interactions with patients, and if so how this is approached.

6.2 Aims and hypotheses

1. What is the extent of swearing /verbal aggression in a health care setting?
   Hypothesis 1a: Nurses in mental health settings will report experiencing higher rates of patient and carer swearing than will paediatric nurses.

   Hypothesis 1b: Nurses in mental health settings will report experiencing higher rates of staff swearing than will paediatric nurses.

2. What are the implications of swearing for a therapeutic encounter?
   Hypothesis 2a: Nurses will report using higher rates of swearing with colleagues than with patients.

   Hypothesis 2b: Male nurses will report using higher rates of swearing with patients than will females.

   Hypothesis 2c: Male nurses will report using higher rates of swearing with colleagues than will females.

   Hypothesis 2d: Nurses in a mental health setting will report using higher rates of swearing with colleagues than will nurses in a paediatric setting.

   Hypothesis 2e: Nurses in a mental health setting will report using higher rates of swearing with patients than will nurses in a paediatric setting.

3. What is the impact of swearing on nurses?
   Hypothesis 3a: Swearing will cause more distress when it is linked to threats and personalised insults.
Hypothesis 3b: Nurses in mental health settings will rate swearing as less distressing than will those in paediatric settings.

Hypothesis 3c: Male nurses will rate swearing as less distressing than will female nurses.

Hypothesis 3d: There will be a positive correlation between GHQ score indicating psychological distress and mean distress score.

Hypothesis 3e: Nurses with a negative attributional style will report greater distress related to swearing than will those with an optimistic attributional style.

Hypothesis 3f: Nurses with external LOC will report greater distress related to swearing than will those with internal LOC.

Hypothesis 3g: Nurses will rate sexually based swearwords as more offensive than profanity or blasphemy.

Hypothesis 3h: Paediatric nurses will rate swearwords as more offensive than will mental health nurses.

Hypothesis 3i: Females will rate swearwords as more offensive than will males.

Hypothesis 3j: Nurses identifying as currently having an affiliated religion will rate swearwords as more offensive than will those who do not have a current affiliated religion.

Hypothesis 3k: Nurses will rate swearwords as more offensive when used in their literal (denotative) sense than in their connotative sense.

The second and third superordinate research questions are also explored qualitatively in this chapter.

6.3 Methods
This phase of the study (Part 2) sought to address the research questions set out in 1.4 and the related hypotheses.

6.3.1 Setting

This study utilised data from nurses in a regional Area Health Service as described in Section 5.3: The region serviced covers an area of over 130,000 km, and comprises industrial, urban and rural areas with a population of 840,000.

6.3.2 Respondents

An opportunistic sample of respondents drawn from Registered and Enrolled Nurses involved in direct patient care in an acute psychiatric facility (comprising an 8-bed intensive care unit; two 20-bed adult psychiatry units; a 16-bed dual diagnosis drug and alcohol/mental health unit; a psychiatric emergency centre for adults with serious mental illness; and staff in the child and adolescent unit described in the previous study (Chapter 5). Additional similarly qualified respondents were recruited from a 12-bed generalist unit at a major regional teaching hospital catering for adolescents with medical, surgical and occasionally mental health conditions, and from paediatric units in two regional towns (one having 10-16 beds, the other 10 beds) caring for children and adolescents aged 0-18 with medical, surgical and occasionally mental health conditions.

In September 2006, following a successful application to the ethics committee, the setting for recruitment of respondents was extended to the long stay psychiatric unit described in the previous study (Chapter 5). The ethics committee also approved recruitment from two acute mental health facilities in large rural centres, of 24 and 25 beds respectively.

6.3.3 Procedure

Ethics clearance to conduct this study was granted by the University of Newcastle Human Research Committee (HREC Approval No: H-030-0405) and the Health Service Research Ethics Committee (HAREC Approval No: 05/04/13/3.17) [Appendix 3]. Written approval to conduct research was also sought and received from the
Director of the Area Mental Health Service. Ethical considerations are elaborated upon in 6.3.7.

6.3.4 Materials

The Nursing Swearing Impact Questionnaire (NSIQ)

The NSIQ [Appendix 5] totals 22 pages and comprises five parts, together with a cover sheet which gives basic information about the questionnaire, the research study and researchers, and confidentiality, and carries a prominent warning that the language may offend some readers. The first section contains questions related to demographics; the second the standardised instruments described below; the third has questions related to swearing and the use of swearwords; the fourth asks respondents to outline their most distressing experience of being sworn at by a patient or carer, and the last section focuses on a detailed account of one particular episode of swearing which occurred in a work context.

The draft version of the instrument was developed following discussion with professional peers and with the assistance of Dr Brian Taylor, Associate Professor in Linguistics at the University of Sydney, New South Wales, Australia, who has undertaken research into various aspects of swearing. The questionnaire utilised a researcher-imposed set of swearwords derived from observing the speech of others and adapted to the Australian context. Previous research on swearing has been concerned with the British or American swearing lexicon: both differ from the Australian lexicon. However, there is some crossover in studies such as that of Foote and Woodward (1973), where respondents were asked to generate a list of swearwords. The frequently occurring words included many employed in the NSIQ: for example, ‘shit’, ‘fuck’, ‘bastard’, ‘cunt’, ‘motherfucker’, ‘hell’, ‘damn’, ‘piss’, ‘bullshit’.

Demographic data sought included age, work location (i.e. ward/department), gender, years of experience in nursing, and qualifications. Questionnaire items included both rating scales and open-ended short answer questions seeking information on frequency and nature of, and responses to, exposure to swearing. The NSIQ also included a number of standardised instruments assessing respondents’ general health using the General Health Questionnaire, internal versus external control of reinforcement using the Locus of Control instrument, and explanatory style using the
Attributional Style Questionnaire. Respondents were asked to rate words in a list, usually by a numerical value according to a Likert-type scale, from non-offensive to very offensive. In addition, open-ended questions encouraged respondents to describe their most distressing experience as the target of swearing.

The circumplex model of affective space (Russell, 1980) (Figure 6.1) was used as the basis of the affective categories in part 5 of the questionnaire. This model, based on evidence about how laymen conceptualise emotions and from multivariate analyses of self-reported affective states, proposed that emotions are best represented as a circle in two dimensional bipolar space (Russell, 1980). The horizontal axis represents the pleasure–displeasure dimension and the vertical axis the arousal–sleep dimension; the remaining more affective states are not independent dimensions but define the quadrants, so that excitement is a combination of high arousal and pleasure.

![Figure 6.1 Eight affective concepts in circular order (Russell, 1980, p.1164)](image)

The General Health Questionnaire (GHQ-30)

The General Health Questionnaire (GHQ-30) [Appendix 5] is a reliable and valid measure of psychological distress. Goldberg & Williams (1991) described it as a brief self-report screening test designed to detect psychiatric disorders in community and non-psychiatric clinical populations. Widely used in research, the GHQ focuses on the psychological components of ill-health; the 30-item version of the questionnaire has been the most widely validated. It measures breaks in normal functioning rather than lifelong traits. The authors state that it focuses on the inability to carry out one’s normal
“healthy” functions, and the appearance of new phenomena of a distressing nature. It measures somatic symptoms, anxiety and insomnia, social dysfunction and severe depression, detects disorders of less than two weeks’ duration, and is sensitive to transient disorders. Andrews, Peters, and Teesson (1994) stated that it does not attempt to detect personality disorders, patterns of sexual adjustment, dementia, schizophrenia, or psychotic depression, and that it has excellent item reliability, adequate test-retest reliability, excellent construct and content validity, and adequate criterion validity. The scale was purchased for use in the study.

In the present study the GHQ was scored in two ways. The first of these, the “GHQ method” which takes into consideration only the number of symptoms, described by Goldberg and Williams (1991) as being likely to miss longstanding disorders, was used to distinguish between cases and non-cases; the second was the cGHQ (chronicity) method devised to pick up longstanding disorders, which also produces a more normally distributed pattern of scores and may increase the instrument’s sensitivity. The presence of a positive result, indicating that it described symptoms which would be classified as mild psychiatric morbidity, is defined as a score equal to or greater than 5 on the GHQ or a score equal to or greater than 13 on the cGHQ (Richard, Lussier, Gagnon, & Lamarche, 2004).

The Attributional Style Questionnaire (ASQ-30)

The ASQ (Shortened Form) [Appendix 5] is a self-report instrument which measures explanatory style for bad and good events using three causal dimensions: internal versus external, stable versus unstable, and global versus specific causes (University of Pennsylvania, 2006). It contains twelve hypothetical situations, six of which are positive and six negative. Respondents are asked to vividly imagine each situation happening to them and to allocate one major cause for each; then, along three 7-point rating scales, to indicate the degree to which the cause is perceived to be internal (factors relating to oneself) or external (factors associated with other people or circumstances), stable (factors which will always be present) or unstable (factors which will never again be present), and global (factors influencing all situations in life) or specific (factors related only to the particular situation). The ASQ takes about 20 minutes to complete but there is no time limit (Positive Psychology, 2004). Factor analysis of the ASQ has supported the presence of distinct attributional styles for negative and positive events (Fernandez-Ballesteros, 2002), and the scale is
satisfactory in terms of the internal consistency and stability of its composites (Peterson, Semmel, Abramson, Metalsky, & Seligman, 1982). The scale has established reliability and validity (Peterson et al., 1982; Peterson & Villanova, 1998). [Appendix 4: Permission to use ASQ].

Explanatory or attributional style is a cognitive variable that reflects how people habitually explain events and behaviour (Peterson et al., 1995), and the tendency to offer similar sorts of explanations for different events (Buchanan & Seligman, 1995). It is postulated as the personality trait that mediates between negative events and depression and involves a tendency to explain adverse events by factors that are stable, internal and global – constituting a negative or depressive explanatory style (Hewitt, Foxcroft, & MacDonald, 2004). A more optimistic explanatory style is associated with a tendency to explain adverse events by factors that are external, unstable and specific. There has been speculation that a negative explanatory style may be associated with low achievement and poor health, including depression (Burns & Seligman, 1989). In the present study it was hypothesised that nurses with a negative attributional style would be more likely than those with an optimistic explanatory style to experience being the target of swearing as distressing.

The Locus of Control (LOC) Scale

The LOC scale is a 13-item questionnaire developed by Rotter (1966) [Appendix 5]. It measures generalised expectancies for internal versus external control of reinforcement. The scale has well documented reliability and validity (Oberle, 1991). The LOC scale consists of 29 pairs of statements using a forced choice format and six filler questions. Each pair of statements comprises an internal (I) and external (E) statement and subjects make a choice between the two alternatives (Marsh, 1986). The scale measures where a person looks to or expects to find reinforcement, with the number of external choices summed to obtain a total score which may range from 0 – 23 (Ray & Subich, 1998). Permission to use the LOC scale is not required.

Locus of control refers to the degree to which individuals perceive themselves as having control over outcomes (Rotter, 1966). Highly external beliefs relate to the view that luck, fate, or powerful others (outside one’s own control) are responsible for outcomes. Those with an internal locus generally believe that they are primarily responsible for and in control of what happens to them (Glazer, Stetz, & Izso, 2004).
The literature suggests that people with an external locus of control are more vulnerable to psychological problems and other illnesses (Chan, 1986). It has been reported that “externalising” nurses experience greater job stress than “internalising” nurses (Glazer et al., 2004) and are more vulnerable to burnout (Schmitz, Neumann, & Oppermann, 2000). Based on the assumption that nurses who define stressors as controllable would be more likely to attempt to implement positive coping strategies, the hypothesis in the present study was that externalisers would find swearing more distressing than those with an internal locus of control.

6.3.5 The pilot study

Following ethics approval, a pilot study was conducted in July 2005 to assess the feasibility and acceptability of the Nursing Swearing Impact Questionnaire (NSIQ) [Appendix 5]. Ten nurses took part in the pilot study; seven of these were Registered Nurses drawn from the participating units and the remaining three were nursing clinical leaders (Clinical Nurse Consultants). Their feedback was sought about question acceptability, clarity, and the order of the standardised measures on the NSIQ, using a debrief schedule [Appendix 6]. Interested nurses, recruited by email, were sent an information sheet [Appendix 7] and a consent form for intending respondents to return to the research team [Appendix 8]. A questionnaire with a unique identifier was mailed back to them, to be completed and returned to the researcher in a sealed pre-addressed envelope clearly marked “private and confidential.”

Feedback indicated only minor or no modifications, and no need to further modify the NSIQ. Pilot study data were therefore included in the main study, as explained to the respondents in the Information Sheet for the pilot study.

6.3.6 The main study

With the instrument and research procedures tested using the pilot study, the main study commenced with potential respondents being advised of the study either by a poster displayed on staff notice boards [Appendix 9] or by email to participating units. The NSIQ was mailed directly to nurses electing to participate, who had read the information sheet [Appendix 10] and had signed a consent form which had been returned to the research team in pre-addressed envelopes clearly marked “confidential.” The questionnaire study was first disseminated in the child and adolescent mental health facility in September 2005 and extended two months later to
the participating paediatric units. In January 2006 the questionnaires were distributed in the acute adult mental health facility. Because of receipt of insufficient numbers (N=82) of completed questionnaires, and with the approval of the Director of the participating mental health service, an application was made to the ethics committees to extend the study to three further acute mental health units within the same health region and was approved in September 2006.

6.3.7 Ethical considerations

The study was conducted in accordance with ethics principles that were formalised in the Declaration of Helsinki (World Medical Association, 1964). Research was conducted with adherence to the National Statement on Ethical Conduct in Research Involving Humans (NHMRC, 2001).

Potential respondents were not approached individually; instead general invitations were issued (via posters and email advertisement) for those interested to contact the research team. Active consent was sought from all intending participants. The requirements of participation were explained by means of the Information Sheet (Appendix 10) which made it clear that involvement or non-involvement would not prejudice participants’ employment conditions in any way and that they could withdraw their consent and participation, including any data already provided, without suffering disadvantage. All respondents had an opportunity to ask questions, after which they were invited to sign the Consent Form [Appendix 8].

All data generated in the study were de-identified and kept in a locked filing cabinet located in the supervisor’s office in the School of Nursing and Midwifery, University of Newcastle. Only the research team members identified in the application had access to the data. Data collection sheets and questionnaires recorded only respondents’ coded identification numbers, and the code-breaking key to link respondents’ names to their identification numbers was kept separate from all other documentation.
Respondents derived no direct benefits from being involved in the study and associated risks were considered to be minimal. Completion of the NSIQ involved recall of recent incidents involving swearing and possibly verbal abuse, which might have evoked negative feelings and even distress in some respondents. Whilst the approved protocol for the study included contingencies for assisting respondents should they become distressed, it did not become necessary to use these.

There were no potential conflicts of interest for the researchers. The research higher degree candidate, whilst working with the nurses based at the child and adolescent unit, was not in a supervisory capacity: Nurse Managers of the participating units supervised the potential respondents. The researchers did not contribute to performance appraisals, or sit on promotion panels. The research did not involve payments, rewards or inducements to respondents. Confidentiality and anonymity of information received was ensured in several ways. Upon entry into the study all respondents were assigned a coded identification number which was used on all data collection forms and measuring instruments. Respondents were not identified by name on any data collection forms or measuring instruments and will not be identified in any publications or presentations arising from the study. Participating units and actual dates of the study were not identified. In transcribing raw data from measuring instruments to statistical analysis programmes there was no possibility of identification of respondents as coded identification numbers were used instead of names.

### 6.3.8 Data analysis

The survey data were entered onto an Access database, checked for accuracy and completeness, and subsequently analysed using the Statistical Package for the Social Sciences (SPSS) Graduate Pack 14.0 for Windows. Analysis allowed characteristics of the study population to be summarised through measures of central tendency (means, median and mode) and indicated how widely individuals differ through analysis of standard deviation and frequency distributions. Data were analysed for the effect of each predictor or outcome using t-test and analysis of variance (ANOVA).

Data analysis also included:

- Independent-samples *t*-tests to compare the distress ratings for nurses working in different work settings, and differences in perceived word offensiveness
between nurses working in different work locations, between genders, and between those with an affiliated religion and those without.

- Repeated measures ANOVA was used to examine differences in mean rated distress and contextual ratings of offensiveness.
- Two-way between subjects ANOVA was used to assess differences in means for ratings of distress in different work contexts and between genders.
- A non-parametric measure of correlation, the Spearman Rho coefficient, to examine correlation between distress and participant scores from the standardised instruments because the distress scale was ordinal.
- Cross tabulation to examine relative frequency of swearwords used in different settings and the effect of gender and work location on the use of swearwords.
- Factor Analysis was employed to detect structure and classify variables in (a) reported distress resulting from different categories of swearing and in (b) offensiveness ratings for various words.

The criterion for statistical significance was set at alpha <.05.

With regard to items requiring comment by the respondents the study adopted a qualitative descriptive approach with the intention of exploring nurses’ reactions to swearing and their responses to it. Respondents’ comments were read and re-read, to enable the researcher to carefully consider their meaning and the contexts within which these were made. Through this process the main issues were grouped and collapsed into like categories and meaning was attributed to the themes highlighted, which were coded and sorted into broad categories. Within each of the superordinate themes several sub-themes were identified which revealed and illuminated nurses’ use of and reaction to swearing.

Analysis followed Morse’s (1994, p.30) four stages in qualitative descriptive analysis: comprehending, synthesizing, theorising, and re-contextualising. Whilst I have read a great deal of literature on verbal aggression, swearing and therapeutic alliance and possess a working knowledge of the context of care in which respondents nursed, my endeavour was to separate this knowledge from the data set obtained from the study. When the data were aggregated into categories of similar concepts, there was a purposeful attempt to remain open to changes and to use respondents’ own words as labels (in vivo codes). When stories and patterns were identified and little new information was being generated, so were the data being “comprehended.”
In the synthesis stage I was able to identify norms and write composite descriptions of how people acted when sworn at, and provide specific stories to illustrate the generalisation. The next stage was theorising, in which data were analysed in order to create conceptual links, identify trends, values, and beliefs in the data and examine similar concepts in other settings (Morse, 1994).

Recontexualising, the final stage of qualitative descriptive analysis, comprises the development of emerging theoretical concepts or constructs based upon the propositions and ideas which emerged earlier. Themes were combined during the theorising stage into major themes and will be considered in the discussion.

The final section of the questionnaire invited respondents to describe in depth a particular incident involving swearing, using the format of the Critical Incident Technique (CIT) which includes the following important pieces of significant information: a description of the situation that led to the incident, the actions or behaviour of the focal person, and the results of the behaviour or actions (Anderson & Wilson, 1997). Kemppainen (2000) noted that whilst the face to face interview is the most satisfactory method for ensuring collection of all necessary details, CIT lends itself to telephone interview, self-administered questionnaire, group interviews, and direct observation; its goal is to assist respondents to recall from memory, and describe in a clear and detailed way, specific incidents. CIT has proven to be a flexible and versatile tool to enable nurses to reflect on and describe the meaning they attribute to being sworn at by a patient or carer, and to assess various aspects of nursing practice (Keatinge, 2002).

The data were analysed as described above. Concepts, categories, and themes were identified and coded for nurses' meanings, feelings, and actions. Processes and relationships between events were explored (Rice & Ezzy, 1999). This approach was selected because the concepts pertaining to swearing in a nursing context have not previously been identified. The CIT also has the potential for distillation of the “superordinate issues” and the generation of explanatory models and theories.

An important consideration at this point was the assumptions brought by the researcher to the study. Box 6.1 describes the approach taken to dealing with these.
Before commencing the qualitative data analysis I made an attempt to identify my assumptions about swearing and its impact on nurses. Some of these are reflected in the hypotheses of the study. Some have been companions as I read the available literature and others have arisen as a result of my reading.

These assumptions were that swearing would be more prevalent in mental health facilities and, as a result of both familiarity and training, would have less impact on mental health nurses; and that, because of this exposure to the lexicon and the nature of their work, mental health nurses would use swearwords more frequently with each other and with patients than would paediatric nurses.

I supposed that where an evident reason for swearing existed nurses would experience less of an affective response because they would be more easily able to explain or rationalise the use of the swearwords; and that swearing from carers or relatives of patients or from other staff members would provoke a negative affective response because nurses would be less able to ascribe the behaviour to the patient's illness or to necessary aversive or limiting procedures, and would perhaps internalise the negative import of the communication.

Other conjectures concerned gender and age: that younger and male patients would use more swearwords, female and older patients fewer; that expectation would colour the nurses' perception, and that where a discrepancy occurred nurses would have more of an affective response to older or female patients; that societal norms would be reflected in nurses' attitudes towards children's swearing, and that personal factors, including religious beliefs and "offendedness" of the nurse, would mediate all the external factors.

Additional assumptions concerned the therapeutic relationship: Ideally nurses would be able to reflect upon their own reactions, and either relate the swearing to the patient's mental state or use the occasion to reflect upon their own role in the interaction. I was prepared to find that some nurses would not achieve this level of sophistication. I reasoned also that nurses more open to their own feelings and reactions would be better able to empathise and form a therapeutic relationship with patients, and that it was not necessarily desirable for nurses to report total indifference to angry interactions. Further, I surmised that if nurses stayed open to their own feelings and those of their patients they were likely to be more vulnerable to hurtful messages.

6.4 Results

6.4.1 Demographic characteristics of respondents

As outlined above (see 6.3.2), respondents were drawn from Registered and Enrolled Nurses involved in direct patient care on adult mental health, child and adolescent mental health, and paediatric wards. Of the total number (N=160) of nurses expressing an interest in participating in the study and requesting an information sheet, 107 (67%)
returned the questionnaire. Six questionnaires (3.8%) were completed and returned by internal mail but were not received by the researcher. Non-returns numbered 47 (29.4%): of these paediatrics accounted for 9 (19.1%), child and adolescent mental health for 10 (21.3%), and adult mental health for 28 (59.6%). There is no information on the demographic characteristics of the nurses who chose not to participate in the study. As set out in Table 6.1, the sample comprised 39 (36.4%) males and 68 (63.6%) females. Respondents were aged between 23 and 67 years, mean age 41.9 SD=9.2 years; 70 (65.4%) were Registered Nurses, 13 (12.1%) Clinical Nurse Specialists, 6 (5.6%) Clinical Nurse Consultants, 2 (1.9%) Clinical Nurse Educators, 6 (5.6%) Nurse Managers, 6 (5.6%) Enrolled Nurses, and 4 (3.7%) Nurse Unit Managers. Of the sample 52 (49%) were nurses working in adult mental health, 40 (37%) nurses working in child and adolescent mental health, and 15 (14%) paediatric nurses. There was more difficulty in recruiting paediatric nurses; it is not known whether this was related to the research topic or other reasons.
Table 6.1 Demographic characteristics of the sample

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>(n=107)</th>
<th>n (%)</th>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
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<td>Usual work area</td>
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<td>Males</td>
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<td>Paediatrics</td>
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<td></td>
<td>Child &amp; Adolescent Mental Health</td>
<td>40 (37)</td>
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</tr>
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<td></td>
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<td>Australia</td>
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<td>宗教背景**</td>
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missing data
* n=107
**n=90
*** n=104

6.4.2 Research question 1:
What is the extent of swearing /verbal aggression in a health care setting?

Table 6.2 below displays responses to questionnaire items 34, 35 and 36 in which nurses were asked how many times in the last week they had experienced swearing. There were six (6%) non-numeric responses which were recoded into the numeric range 0-37 years, mean 16.12, SD = 10.38
frequencies following an examination of the distribution of the numeric responses [Appendix 11].

Sworn at by a patient or carer

More than half of the surveyed nurses reported relevant incidents in the last week concerning a patient or carer, with 32% being sworn at between 1 and 5 times and 7% being sworn at “continuously.”

Table 6.2 Reported times in the last week of nurses being sworn at by a patient or carer, by staff, and staff swearing within hearing

<table>
<thead>
<tr>
<th>Frequency of reported swearing</th>
<th>By patient/carer</th>
<th>By staff member</th>
<th>Staff swearing within hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n *</td>
<td>n **</td>
<td>n ***</td>
</tr>
<tr>
<td>No reported swearing</td>
<td>47 (48)</td>
<td>77 (76)</td>
<td>12 (12)</td>
</tr>
<tr>
<td>1-5 times in the week</td>
<td>31 (32)</td>
<td>14 (14)</td>
<td>31 (32)</td>
</tr>
<tr>
<td>6-10 times in the week</td>
<td>10 (10)</td>
<td>6 (6)</td>
<td>30 (30)</td>
</tr>
<tr>
<td>11-20 times in the week</td>
<td>2 (2)</td>
<td>1 (1)</td>
<td>11 (11)</td>
</tr>
<tr>
<td>21-30 times in the week</td>
<td>1 (1)</td>
<td>0</td>
<td>4 (4)</td>
</tr>
<tr>
<td>&gt; 40 Continuously</td>
<td>7 (7)</td>
<td>3 (3)</td>
<td>9 (9)</td>
</tr>
<tr>
<td>unknown</td>
<td>0</td>
<td>0</td>
<td>2 (2)</td>
</tr>
</tbody>
</table>

*n=98, **n=101, ***n=99

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:

This is less than usual – have been on night shift this last week.

It depends on the type of patients and how busy the unit is.

No such thing as a typical week when it comes to verbal abuse.

No “typical” weeks, I think on the whole I am sworn at much at all [sic]. However when it does happen it tends to be a particular patient who has taken a dislike to staff or sometimes me in particular but more often then not it is about the person’s frustrations and mental state and problems with appropriate communication.

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.*

**Sworn at by a staff member**

A large majority of nurses (76%) reported they had not been sworn at by staff in the last week (Table 6.2). However, three nurses reported being sworn at “continuously” by staff. The responses to this question [Appendix 12], examples of which are listed below, make it clear that being sworn at by another staff member in anger is rare and that the majority of the occasions referred to in Table 6.2 were in jest or in conversation:

*Swearing goes on all the time, but very rarely at each other.*
*In a joking way and no offence meant or taken.*
*Staff frustrated with service. Swore at system inadequacies.*

**Staff swearing within hearing**

Nurses reported a much higher frequency (88%) of staff swearing within their hearing than being sworn at by staff, and 8.4% reported that staff engage in swearing continuously. The responses to this question indicate that swearing by nursing staff was often too frequent to be enumerated and there were differences between workplaces:

*Staff frequently swear – too difficult to give a numerical value.*
*Could not count. How often do staff speak?*
*Generally staff in adult [sic] swear more than staff in child and adolescent mental health.*
*“Typical” depends on where I work – certain individuals swear a lot.*
*Some staff swear excessively in my work place.*

Nurses also commented on the reasons for swearing in the workplace:

*Nursing is a very stressful profession and you often witness a nurse losing patience with the workload and the system.*
Usual if ward over numbers or consumer being agitated and unsettled.

They were letting off steam about difficult patients.

Mostly to be humorous.

In the context of general conversation.

And several nurses commented on the low level of offensiveness:

Only mild words.

Words used as adjectives and descriptors. Not offensive or threatening.

It was not used in a threatening way.

Sworn at by a patient or carer by work location

Cross tab analysis was used to determine whether work location was related to the reported rate of patient and carer swearing at nurses. Kendall's tau-b statistics were used because of the ordinal nature of the scale and the results are presented in Table 6.3.

<table>
<thead>
<tr>
<th></th>
<th>Not sworn at</th>
<th>1-5 times in</th>
<th>6-10 times in</th>
<th>11-20 times in</th>
<th>21-30 times in</th>
<th>&gt; 40 continuously</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric</td>
<td>70</td>
<td>18</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Mental health</td>
<td>43</td>
<td>35</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td>81</td>
</tr>
</tbody>
</table>

The difference between locations in the use of swearwords was found to be significant (Kendall's tau-b =0.19, p=.03) but a chi-squared analysis did not show significance ($\chi^2 (5) = 5.6, p=.34$). As the data is ordinal in nature the more appropriate test is Kendall’s tau-b, and as it has greater power because it uses the ordinal nature of the data it showed a statistically significant difference, whereas the chi-squared test did not. This significant difference is due to the 10 respondents who reported being sworn at 11 or more times in mental health whereas for paediatric nurses there were no reports of swearing at these higher levels. In conclusion there is some evidence to suggest that
mental health nurses are sworn at more than paediatric nurses, thus supporting Hypothesis 1a that nurses in mental health settings would report experiencing higher rates of patient and carer swearing than would paediatric nurses. However, caution should be exercised in interpreting these results because of the small number of paediatric respondents.

Staff swearing within hearing by work location

Chi-squared analysis and ordinal measures of association were used to determine whether work location impacted on the reported rate of staff swearing overheard by nurses. Neither measure showed significant association between work location and amount of swearing ($\chi^2 (5) = 3.2, p=.67$. Kendall’s tau-b = -0.04, $p=.71$). Thus Hypothesis 1b that nurses in mental health settings would report experiencing higher rates of staff swearing than would paediatric nurses was not supported. The results are presented in Table 6.4.

### Table 6.4 Percentage of respondents reporting overhearing staff swearing (n=97)

<table>
<thead>
<tr>
<th></th>
<th>Not sworn at</th>
<th>1-5 times in the week</th>
<th>6-10 times in the week</th>
<th>11-20 times in the week</th>
<th>21-30 times in the week</th>
<th>&gt; 40 times in the week</th>
<th>Continuously</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric</td>
<td>14</td>
<td>29</td>
<td>21</td>
<td>21</td>
<td>0</td>
<td>14</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>12</td>
<td>33</td>
<td>33</td>
<td>11</td>
<td>4</td>
<td>9</td>
<td>83</td>
<td></td>
</tr>
</tbody>
</table>

### 6.4.3 Research question 2:
What are the implications of swearing for a therapeutic encounter?

Nurses’ reported use of swearwords

In order to investigate factors which impact on nurses’ use of swearwords, responses to questionnaire items 18, 19, 20, 21 and 22 were computed and compared. Table 6.5 below displays the results. Of interest is the observation that only four nurses (4%) reported that they never use swearwords with colleagues and 17 (16%) reported using swearwords often with colleagues. Nearly half the respondents ($n=47$ 44%) report never using swearwords with patients, with a further 45 (42%) using them only rarely,
and no respondent reported using them often. Further elaboration of the relationship between the reported frequencies of swearing in each context follows.

**Table 6.5** Nurses reported use of swearwords (n=107)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never n (%)</th>
<th>Rarely n (%)</th>
<th>Sometime n (%)</th>
<th>Often n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you use swearwords with colleagues?</td>
<td>4 (4)</td>
<td>33 (31)</td>
<td>53 (51)</td>
<td>17 (16)</td>
</tr>
<tr>
<td>Do you use swearwords with people you usually go out with socially?</td>
<td>5 (4)</td>
<td>36 (34)</td>
<td>45 (42)</td>
<td>21 (20)</td>
</tr>
<tr>
<td>Do you use swearwords when you are by yourself?</td>
<td>6 (6)</td>
<td>25 (23)</td>
<td>42 (39)</td>
<td>34 (32)</td>
</tr>
<tr>
<td>Do you use swearwords at home?</td>
<td>10 (9)</td>
<td>40 (38)</td>
<td>43 (40)</td>
<td>14 (13)</td>
</tr>
<tr>
<td>Do you use swearwords to hurt or offend people?</td>
<td>39 (36)</td>
<td>49 (47)</td>
<td>18 (17)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Do you use swearwords with patients?</td>
<td>47 (44)</td>
<td>45 (42)</td>
<td>15 (14)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

It was to be anticipated that there would be reasonable agreement between the use of swearwords as reported in Table 6.5 and the frequency of swearing as reported in Table 6.2 and, whilst not directly comparable, this relationship is evident; for example, 66% of nurses reported using swearwords “sometimes” or “often” with colleagues (Table 6.5) and 88% of nurses reported staff swearing in their presence at some time over the previous week (Table 6.2).

Repeated cross tabulation was used to examine each pair of questions in Table 6.5 to determine the relative frequency of use of swearwords in each setting. Table 6.8 is the focus of the discussion but, to illustrate how this was compiled, Tables 6.6 and 6.7 below are described in order to document how values in Table 6.6 were derived.

In Table 6.6 the reference question in the rows on the left, in this case “Do you use swearwords at home?”, is contrasted with the comparison question in the columns, “Do you use swearwords to hurt or offend people?” The main diagonal in Table 6.6 shows the percentage of times in which the swearing was reported at the same
frequency. The top triangle, where figures are in italics, reports scores which are higher in the comparison question (hurt or offend) than in the reference question (at home). The lower triangle reports percentages where the reference question had a higher frequency than the comparison question.

Table 6.6 Percentage of reported use of swearwords at home relative to reported use to hurt or offend people (n=107)

<table>
<thead>
<tr>
<th>Do you use swearwords at home?</th>
<th>Do you use swearwords to hurt or offend people?</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
<td>5.66</td>
<td>-3.77</td>
<td></td>
<td></td>
<td>9.43</td>
</tr>
<tr>
<td>Rarely</td>
<td>+16.04</td>
<td>15.09</td>
<td>-6.60</td>
<td></td>
<td></td>
<td>37.74</td>
</tr>
<tr>
<td>Sometimes</td>
<td>+13.21</td>
<td>+19.81</td>
<td>7.55</td>
<td></td>
<td></td>
<td>40.57</td>
</tr>
<tr>
<td>Often</td>
<td>+1.89</td>
<td>+7.55</td>
<td>+2.83</td>
<td></td>
<td></td>
<td>12.26</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>36.79</td>
<td>46.23</td>
<td>16.98</td>
<td></td>
<td>100.00</td>
</tr>
</tbody>
</table>

+Percentage of times in which nurses report swearing more in the reference condition than the comparison question- Percentage of times in which nurses report swearing more in the comparison condition than the reference question
Table 6.7 summarises the data from Table 6.6. The sum from the main diagonal, in which frequencies are the same in both conditions, is 28.3%; in the top triangle in which respondents reported using swearwords more to hurt or offend than at home it is 10.4%; and the sum of the lower triangle (61.3%) shows that a greater number of respondents reported using swearwords at home than with intent to hurt or offend people.

| Use swearwords at home the same number of times as to hurt or offend other people | 28.30 |
| Use swearwords at home less often than to hurt or offend other people | 10.38 |
| Use swearwords at home more often than to hurt or offend other people | 61.32 |
| 100.00 |

A similar process was used on all questions, and Table 6.8 shows the results of repeated cross tabulation comparing each pair of questions in Table 6.5. With regard to the relative use of swearwords it is noteworthy that 20% of respondents reported swearing equally with patients and colleagues, but most (80%) swore more with their colleagues than with patients, and no respondents reported swearing more with patients than with their colleagues. Hypothesis 2a, that nurses would report using higher rates of swearing with colleagues than with patients, was thus supported. About two-thirds of respondents (64%) reported swearing with colleagues with the same frequency as they would socially and 19% of respondents reported swearing less with colleagues than socially, which leaves 17% of respondents reporting that they swear more with colleagues than they do socially.
Table 6.8  Comparison of reported use of swearing between pairs of questions

<table>
<thead>
<tr>
<th></th>
<th>With colleagues?</th>
<th>With patients?</th>
<th>With people you usually go out with socially?</th>
<th>At home?</th>
<th>By yourself?</th>
<th>To hurt or offend?</th>
</tr>
</thead>
<tbody>
<tr>
<td>With colleagues?</td>
<td>--</td>
<td>+80 (**), =20</td>
<td>-19 ns, =64</td>
<td>+31 ns, =52</td>
<td>-35**, =50</td>
<td>+70(**), =26</td>
</tr>
<tr>
<td>With patients?</td>
<td>--</td>
<td>-77 (**), =23</td>
<td>-69 (**), =26</td>
<td>-81 (**), =15</td>
<td>-31 ns, =43</td>
<td></td>
</tr>
<tr>
<td>With people you usually go out with socially?</td>
<td>--</td>
<td>+28 ns, =58</td>
<td>-31*, =54</td>
<td>+71(**), =21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At home?</td>
<td>--</td>
<td>-37**, =57</td>
<td>+61 (**), =28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When you are by yourself?</td>
<td>--</td>
<td></td>
<td>+76 (**), =18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To hurt or offend?</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Positive values indicate that the reference question on the left has higher frequency of reported usage than the column question whereas negative values indicate that the reference question has a lower reported usage than the column question. The numbers after the = sign denote the percentage of nurses who report that they use the same amount of swearing in each circumstance.

The McNemar-Bowker test was used to test if the differences + or – were significant. Where the test failed due to the tables not being square because of one category not being used an approximate method was used by totaling the + cells and the – cells and treating the table as if it was a 2x2 table and using the McNemar test.

* = significant at .05, ** = significant at .01
ns = not significant
If these are in parentheses it means the approximate method was used.

Gender of nurse and use of swearwords

Hypothesis 2b posited that male nurses would report using higher rates of swearing than would females. Cross tab analysis was used to determine whether gender impacted on respondents’ reported use of swearwords with patients and colleagues explored in items 18 and 19 of the questionnaire. Kendall’s tau-b statistics were used because of the ordinal nature of the scale and the results are presented in Table 6.9.
Table 6.9  Reported use of swearing with patients by gender (n=107)

<table>
<thead>
<tr>
<th>Do you use swearwords with patients?</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>male</td>
<td></td>
</tr>
<tr>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td></td>
</tr>
<tr>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>

The difference between the genders in the use of swearwords with patients was found to be significant (Kendall’s tau-b = 0.30, p=.001). This was checked by use of a non-parametric test, the Mann-Whitney, which also found the difference to be significant (z =3.2, p= .001). The main differences were that more males (21%) than females (10%) reported swearing “sometimes” with patients, and similarly in the “rarely” category 56% of males as compared with 34% of females.

The difference between the genders in the use of swearwords with colleagues (Table 6.10) also was found to be significant (Kendall’s tau-b = 0.19, exact test p=.04). This was checked by use of a non-parametric test, the Mann-Whitney, and found to be significant (z =2.1, p= .04). Nearly twice as many males (23%) as females (12%) reported swearing often with colleagues, supporting hypothesis 2c.

Table 6.10  Reported use of swearing with work colleagues by gender (n=107)

<table>
<thead>
<tr>
<th>Do you use swearwords with work colleagues?</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>male</td>
<td></td>
</tr>
<tr>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>54%</td>
<td></td>
</tr>
<tr>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
</tr>
<tr>
<td>female</td>
<td></td>
</tr>
<tr>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>

Whilst there were differences, more marked in the higher frequencies, between the genders in their use of swearwords, these were not as marked as the gender differences reported between use with colleagues and use with patients.
Frequency of reported use in mental health compared with paediatric settings

Contrary to hypothesis 2d, no significant difference in reported use of swearing with colleagues was found between nurses working in mental health and paediatric contexts (Table 6.11) Kendall’s tau-b = -.014, p=.91 (exact test), Mann Whitney z= -.16, p=.88.

Table 6.11 Reported use of swearing with work colleagues by work location (n=107)

<table>
<thead>
<tr>
<th>Do you use swearwords with work colleagues?</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>Paediatric nurses</td>
<td>17</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>90</td>
</tr>
</tbody>
</table>

Similarly, no significant difference in reported use of swearing with patients was found between nurses working in mental health and paediatric contexts (Table 6.12) Kendall’s tau-b = .043, p=.66 (exact test), Mann Whitney z= .46, p=.64. Thus hypothesis 2e was not supported.

Table 6.12 Reported use of swearing with patients by work location (n=107)

<table>
<thead>
<tr>
<th>Do you use swearwords with patients?</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>Rarely</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>Often</td>
<td></td>
</tr>
<tr>
<td>Paediatric nurses</td>
<td>17</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>90</td>
</tr>
</tbody>
</table>

Use with colleagues

The importance of context was manifest in respondents’ comments when asked, “Do you use swearwords with work colleagues?”, one participant noting that s/he used swearwords to “fit in,” another remarking, “If they swear, I swear,” and others also commenting on the pervasiveness of swearing:

Swearing is part of the culture of my work area.

It is part of the language.

It is common in the workplace.
Since I started work it has been harder [to abstain from swearing] as it is an environment that seems contagious to swearing [sic].

Respondents’ replies implied a personal set of rules or values which governed when, where, and with whom they would engage in swearing:

*Usually only with male colleagues.*

*In privacy of the office – not in patient's hearing.*

Nurses also classified their reasons for swearing:

*Only in jest.*

*Rarely in anger. Often for fun or emphasis (social).*

*Yes, to de-stress or emphasise how annoying or demanding a patient or their family is or has been.*

*Maybe to let off steam in an unaggressive way.*

*When I feel very strongly about something.*

*When really angry about a situation or repeating something said to me by a client.*

The replies of some respondents indicated that their swearing did not sit comfortably with them:

*I do tend to swear too often.*

*Do not like to swear. Anger and frustration encourage me to swear.*

*Attempt to limit it (but I slip up occasionally). I am aware of when I do and I try not to but it happens.*

**Use of swearwords with patients**

Table 6.8 illustrates that nurses reported swearing less with patients than in any other situation. Nurses were asked also to “briefly outline an occasion when you used swearing with a patient in a therapeutic way.” A large percentage (44%) stated that they never used swearwords with patients. Various reasons were given ranging from rule/value-bound behaviour such as “Don’t swear with patients or family members” to more clinically specific reasons for not using swearwords:

*I don’t usually swear, I see listening as FAR more effective than swearing.*
It's not something that I do often in clinical practice. I would only use terms such as "It must have been bloody difficult for you." Generally I believe you can reflect without using a lot of bad language. It is useful sometimes to reflect intensity.

If patient is swearing as part of their vocabulary and within their own social context I have no issue with swearing and would do so if I felt the conversation need the expression that swearing offers, but I doubt I would use it just to get patient onside or as a "therapeutic" way.

Never – I don't believe this is a therapeutic approach. I don't like or encourage swearing. I actively find myself consciously not swearing as it's not who I am.

One participant reported having attempted the use of swearing in a counselling context and believed the patient did not like it, and thus has since consciously not used this technique.

Other respondents reported the use of swearwords in a therapeutic context for a variety of reasons – reflection of feelings, establishing rapport and expressing empathy, echoing language, validation of feelings and clarification of meaning:

When a patient was very upset about not being able to go on leave after an incident that had occurred the day before….The patient was crying and stated "this place is fucked." I reflected the feelings to show that I was listening to her.

Used the phrase "And then it all turned to shit" to reflect a situation in a level of language relevant to that particular client who was a forensic patient with low socio-economic status and limited vocabulary. He laughed and agreed, then began to disclose.

Occasionally agree with patients about something "pissing them off" or validate their anger and frustration over certain matters, e.g. "Yes I can see how that would give you and shits" etc. Or maybe jokingly to build rapport call them e.g. "a clever bastard" if they've done something they are proud of.

You said "fucking bastard?" - clarifying statement.

One participant described an instance of quite a different use of swearwords, in that they seemingly were not in response to an identified therapeutic intent. This was the only example in the data in which swearing was not explicitly linked to the language use of the patient or the relationship that existed between the patient and nurse, and thus it is difficult to judge whether it was therapeutic or not:

Was discussing coping with derogatory auditory hallucinations, suggested to consumer that she could always tell her voices to "get fucked!" as she was the one in control, not the voices she heard.
Respondents in the above examples appear to have been using “common language” consciously to manage the distance between themselves and the patient in order to lessen the patient’s discomfort and dependent status. They also explicitly reported their use of swearwords “to close the gap” between them and their patients:

*Persuading an elderly gentleman with alcohol brain damage to use the toilet...He responded to rough language including ‘piss’ and ‘shit’. Polite language would have had an effect of blocking communication.*

"This place must really be giving you the shits!” – establishing rapport by using empathy and common language.

*Have been known to use the term "on the piss" when speaking with individuals who are inclined to over-imbibe. It seems to relax same. One doesn't appear to be so "straight" – especially as I am old enough to be some of these people’s granny!*

*A client used the term "Step-Up, bitch" in an American Footballer/Rapper way, to mean "have a go if you dare." At the same time slapping her chest. Now when she is being unreasonable or threatening I can say to her "step-up bitch" and it works for us both to see the humour in the situation.*

Clearly how nurses classify a particular word will affect whether they consider their use of it to be swearing:

*Try not to, use the way I speak rather than certain swearwords, however, I don't consider some words from the lists as swearwords so with that in mind I probably do.*

*Don't remember a particular occasion but I've probably used very mild swearing e.g. damn, hell, when talking with patients.*

Other responses suggested that the employment of swearwords stemmed less from a conscious attempt to use them in a planned and therapeutic way than as a reflection of the nurse’s own use of language:

*I told a patient they were behaving like an arsehole and that if it continued I would call the police.*

*Settling a situation between two female patients, yelling at each other. Used "pissed off" etc.*
Social use of swearwords

There was no significant difference in reported frequency between swearing in a social context and swearing with colleagues (Table 6.8). Two comments imply that some respondents may swear more in the workplace than socially, contrary to studies suggesting that swearing is more frequent in a leisure context than at work (Cameron, 1969; Jay, 1994; Rieber et al., 1979):

Only if it’s a work function!

If I'm telling a joke with a swear word in it or I'm talking about my old boss I will swear but that's about it.

Other responses to the question, “Do you use swearwords with people you usually go out with socially?”, reveal that context and self-imposed rules continue to apply. Many nurses talked about their intention in swearing:

I usually feel awkward and uncomfortable swearing, unless really upset and want to get my point across.

For dramatic effect.

I do not use swearwords as "fillers" in a sentence, but deliberately, and not to swear AT them.

When I have had a few drinks, having a laugh.

I believe it can be funny, relieve tension and is a common part of life these days.

Gender issues were also apparent in the social use of swearwords:

Not "cool" to swear, especially being a female.

In the pub with the boys.

Nurses also reported swearing as a function of closeness and familiarity:

If you can't swear in front of them, then they aren't worth having as friends.

Especially mates.

.. the more comfortable I am with the person, the more likely I am to swear.

Mainly restricted to people with whom I am very familiar.
To a greater or lesser degree, all my friends swear. I think I would find it difficult to relate to someone who did not swear at all, due to some religious or social reasons.

Swearing at home

Quite disparate views were reported about swearing at home:

Yes my partner and I use swearwords very frequently as humorous banter – we find it amusing and frequently play word games, swear in foreign accents, play with “rude” words.

Never – have small children. I tone down swearing at home to set a good example for the child.

Only when very angry or upset/frightened.

Don't like other members of the family swearing – husband doesn't swear in front of me.

Swearing when by yourself

This category produced more agreement, comments such as these being typical:

Yes – help you feel better. Without thinking about it I would instinctively swear if I injured myself.

Automatic – if angry/in pain.

6.4.4 Research question 3:
What is the impact of swearing on nurses?

Nurses’ distress and swearing

Table 6.13 summarises responses to questionnaire items 30.16 - 30.21. Noteworthy is the finding that the majority of nurses find swearing associated with each work situation highly distressing: rated by 40-50% of respondents at the highest level of distress the instrument would allow, and 25 respondents indicated strong agreement to every question.
Table 6.13 *Nurses’ distress and swearing (n=106)*

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree n (%)</th>
<th>Disagree n (%)</th>
<th>Undecided n (%)</th>
<th>Agree n (%)</th>
<th>Strongly agree n (%)</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) In a work situation swearing associated with threats is distressing to me*</td>
<td>4 (4)</td>
<td>17 (16)</td>
<td>6 (6)</td>
<td>36 (34)</td>
<td>42 (40)</td>
<td>2.94</td>
</tr>
<tr>
<td>2) In a work situation swearing associated with physical aggression is distressing to me</td>
<td>6 (6)</td>
<td>16 (15)</td>
<td>1 (1)</td>
<td>30 (28)</td>
<td>53 (50)</td>
<td>3.07</td>
</tr>
<tr>
<td>3) In a work situation swearing associated with personally demeaning comments is distressing to me</td>
<td>3 (3)</td>
<td>12 (11)</td>
<td>5 (5)</td>
<td>33 (31)</td>
<td>53 (50)</td>
<td>3.18</td>
</tr>
<tr>
<td>4) In a work situation being sworn at repeatedly is distressing to me</td>
<td>2 (2)</td>
<td>12 (11)</td>
<td>9 (9)</td>
<td>37 (35)</td>
<td>46 (43)</td>
<td>3.10</td>
</tr>
<tr>
<td>5) In a work situation being sworn at by a patient’s relatives or carer is distressing to me</td>
<td>0 (0)</td>
<td>9 (8)</td>
<td>7 (7)</td>
<td>30 (28)</td>
<td>60 (57)</td>
<td>3.34</td>
</tr>
<tr>
<td>6) In a work situation being sworn at by another staff member is distressing to me</td>
<td>2 (2)</td>
<td>11 (10)</td>
<td>11 (10)</td>
<td>36 (34)</td>
<td>46 (44)</td>
<td>3.09</td>
</tr>
</tbody>
</table>

missing data

* n=105

A principal component analysis (PCA) was carried out on the 6 distress measures. Prior to performing PCA the suitability of data for factor analysis was assessed: only one component was needed to explain the variability. The first component accounted for 71.6% of the variance and the remaining components all had an Eigenvalue of <1. This indicates that all 6 items were of a similar nature as to the type of distress being experienced.

Mean scores of levels of distress were averaged across all six items for each respondent and the result is depicted in Figure 6.2 where 0 = strongly disagree that swearing is distressing and 4 = strongly agree that swearing is distressing. The Figure depicts a strong negative skew in the distribution of nurses’ reported levels of distress, with most responses concentrated on the right where agreement is indicated. For example, a score of 4 indicates that a nurse rated all six items at their maximum score.
of 4. In fact 25 respondents (23.6%) strongly agreed with all six statements, indicating the maximum amount of distress associated with swearing that the survey allowed. Thirty five percent indicated that they strongly agreed with five or more statements and 60% strongly agreed with three or more statements.

![Mean distress score](image)

**Figure 6.2** Bar chart depicting mean levels of distress scores averaged across all 6 items for each person (N=106)

The mean distress score was 3.09 ($SD = 0.94$) when 0 = strongly disagree “in a work situation swearing associated with (the situation) was distressing for me” and 4 = strongly agree. Repeated measures ANOVA was used to assess if there was a significant difference in mean rated distress between the 6 items (Greenhouse-Geisser adjustment $F(3.69, 384.3) = 4.66, p=.002$). A plot of the mean score for each item is shown in Figure 6.3. The repeated measures ANOVA was then used without Item 5 and there was no longer a significant difference between the remaining distress items,
indicating that the other items had similar distress levels and that Item 5, being sworn at by a patient's relatives or carer, was associated with higher levels of distress than the remainder; thus hypothesis 3a was not supported. The analysis above was confirmed by repeating it with a non-parametric test due to the ordinal nature of the variables, Friedman test, all 6 items, p<.001, with item 5 removed p=.054.

Figure 6.3 Means plot of distress scores for each question in the order in Table 6.8 (n=106)

1. In a work situation swearing associated with threats is distressing to me
2. In a work situation swearing associated with physical aggression is distressing to me
3. In a work situation swearing associated with personally demeaning comments is distressing to me
4. In a work situation being sworn at repeatedly is distressing to me
5. In a work situation being sworn at by a patient's relatives or carer is distressing to me
6. In a work situation being sworn at by another staff member is distressing to me
Distress and work location

An independent samples $t$-test was conducted to compare the distress ratings for nurses working in a paediatric setting against those relating to a mental health setting. There was a significant difference between the two groups, with paediatric nurses rating higher ($M=3.65, SD=0.37$) on total distress scores than mental health nurses ($M=2.98, SD=0.98$) ($t(104) = 2.77, p=0.007$) supporting hypothesis 3b.

Distress and gender

On gender there was a significant difference in total distress scores, with female nurses recording higher scores ($M=3.24, SD=0.92$) than male nurses ($M=2.82, SD=0.94$); $t(104) =2.21, p=0.03$), supporting hypothesis 3c.

ANOVA model of gender and work location

The relationship between gender and work location was tested using a 2 way between subjects ANOVA. There was no significant interaction between gender and work location ($F(1,102)=0.07, p=.93$), hence the effects of these can be considered to be independent of each other and the differences in means given above indicate the relative size of the two effects, work location being the larger.

The General Health Questionnaire, Attributional Style Questionnaire, and Locus of Control

Table 6.14 summarises scores from the standardised instruments used in part two of the NSIQ. Scores on the GHQ ranged between 0 and 17 ($N=104, M= 2.61, SD=3.5$); 18% of the nurses scored above 4, the level of mild psychiatric morbidity on the GHQ. The score for the cGHQ ranged between 0 and 23 ($N=103, M= 8.06, SD = 4.9$). Scores for the ASQ ranged between -3.83 and 8.33 ($N=102, M= 2.22, SD=2.35$) and scores for the LOC ranged between 0 and 17 ($N=104, M= 9.92, SD=3.81$).
Table 6. 14  Summary of scores on the standardised instruments

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHQ score</td>
<td>104</td>
<td>0</td>
<td>17</td>
<td>2.61</td>
<td>3.45</td>
</tr>
<tr>
<td>cGHQ score</td>
<td>103</td>
<td>0</td>
<td>23</td>
<td>8.06</td>
<td>4.92</td>
</tr>
<tr>
<td>ASQ</td>
<td>102</td>
<td>-3.83</td>
<td>8.33</td>
<td>2.22</td>
<td>2.35</td>
</tr>
<tr>
<td>LOC</td>
<td>104</td>
<td>0</td>
<td>17</td>
<td>9.92</td>
<td>3.8</td>
</tr>
</tbody>
</table>

The correlation between distress and measures of general health, locus of control and attributional style (as measured by the GHQ, CGHQ, LOC and ASQ) was investigated using Spearman Rho coefficient because the data for some of the variables were not normally distributed, especially total distress and GHQ which were very skewed. There was no relationship between distress ratings and LOC \((r = -0.01, p = 0.95)\), ASQ \((r = -0.15, p = 0.15)\) or GHQ \((r = 0.19, p = 0.06)\) and a weak positive correlation between distress and CGHQ \((r = 0.23, p = 0.02)\). Thus hypothesis 3d that there would be a positive correlation between GHQ score, indicating psychological distress, and distress related to swearing was only weakly supported. Hypothesis 3e that nurses with a pessimistic attributional style would report greater distress related to swearing than would those with an optimistic attributional style as measured by the ASQ was not supported, and neither was the hypothesis that nurses with external LOC would report greater distress related to swearing than would those with internal LOC (hypothesis 3f).

### 6.4.5 Offensiveness

In Item 23 respondents were asked to rate for offensiveness a list of 24 words. The mean offensiveness rating for this list of words 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.” Figure 6.5 depicts the distribution of mean offensiveness score. None of the respondents rated all items as highly offensive but several did indicate that they found none of the items offensive.
A simple calculation of the means of offensiveness pointed to three words, ‘cunt’, ‘fuck’, and ‘motherfucker’, being rated as significantly (p<0.5) more offensive than other words, thus supporting hypothesis 3g that nurses would rate sexually based swearwords as more offensive than profanity or blasphemy. A second group, ‘slut’, ‘fuckwit’, and ‘paedophile’, also rated as highly offensive (Figure 6.6), and nurses reported finding ‘arvo’, an Australian slang word, the least offensive word.
As a further way of understanding the association among the words in order to assess whether there were clusters of words that were related, a factor analysis was carried out using the principal component analysis as the extraction method and rotation method Varimax with Kaiser normalization. Three distinct factors emerged accounting for 61% of the total variance. Factor loadings on the rotated factors and inter-factor correlations are presented in Table 6.15. These results provide clear evidence that there are three empirically distinguishable components. Factor 1 was labelled “sexual/excretory words” these included sexual terms such as ‘cocksucker’ and ‘motherfucker’, anatomical terms such as ‘cunt’ and ‘prick’ and sexist terms such as ‘slut’ and ‘bitch’. Factor 2 was labelled “emphasis words” and comprised such words as ‘damn’, ‘crap’, and ‘hell’, largely used for emphasis and description. Factor 3 covered “everyday words” which included two Australian slang terms, ‘arvo’ and ‘youse’, perhaps reflecting the essence of the underlying similarity between the words within each factor. Thus nurses who rated the “sexual/excretory” words as offensive did not necessarily rate as offensive the words in the second and third factors. Two words, ‘paedophile’ and ‘cow’, did not correlate with any of the words in the three factors, indicating that these words were being treated differently and their connotations or usage differed from those of the other sets of words. The word ‘piss’ cross-loaded between “everyday” words and “sexual/excretory” words, which implies that some...
treated this word as an “sexual/excretory” word whilst others considered it part of every day language.

Table 6.15 *Specified three-factor solution of a factor analysis of offensive ratings (N=98)*

<table>
<thead>
<tr>
<th>Rotated Component Matrix(a)</th>
<th>Component 1</th>
<th>Component 2</th>
<th>Component 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>fuckwit</td>
<td>0.80</td>
<td>0.49</td>
<td></td>
</tr>
<tr>
<td>cocksucker</td>
<td>0.78</td>
<td>0.42</td>
<td></td>
</tr>
<tr>
<td>cunt</td>
<td>0.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fuck</td>
<td>0.77</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>arsehole</td>
<td>0.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>motherfucker</td>
<td>0.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>asshole</td>
<td>0.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bitch</td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bastard</td>
<td>0.73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>slut</td>
<td>0.71</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dickhead</td>
<td>0.64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prick</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>wanker</td>
<td>0.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bullsh*t</td>
<td>0.52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>damn</td>
<td>0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bugger</td>
<td>0.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bloody</td>
<td>0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>crap</td>
<td>0.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hell</td>
<td>0.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sucks</td>
<td></td>
<td></td>
<td>0.82</td>
</tr>
<tr>
<td>arvo</td>
<td></td>
<td></td>
<td>0.73</td>
</tr>
<tr>
<td>piss</td>
<td>0.40</td>
<td></td>
<td>0.69</td>
</tr>
<tr>
<td>youse</td>
<td></td>
<td></td>
<td>0.64</td>
</tr>
<tr>
<td>shit</td>
<td></td>
<td>0.52</td>
<td>0.56</td>
</tr>
</tbody>
</table>

Cut off 0.4 for display of factor loadings

Offensiveness and work location

An independent-samples *t*-test was conducted to compare the offensiveness ratings by nurses working in a paediatric setting and those working in a mental health setting. Contrary to expectation (hypothesis 3h), there was no significant difference in the way they viewed the offensiveness of these words: paediatric nurses (*M*=1.4, *SD*=0.62) and mental health nurses (*M*=1.21, *SD*=0.68); *t* (104)=1.12, *p*=0.27.)
Offensiveness and gender

However gender differences were evident with mean offensiveness ratings for females (M=1.37, SD=0.70), higher than those for males (M=1.03, SD=0.58): t(104)=2.55, p=0.01, supporting hypothesis 3i.

Offensiveness and religion

An independent-samples t-test was conducted to compare the offensiveness ratings for nurses who were currently affiliated with a religion and those who were not. There was no significant difference in scores of those currently affiliated (M=1.35, SD=0.71) and those not (M=1.21, SD=0.67; t(102)=0.93, p=.36. Neither was there a significant difference in offensiveness ratings by nurses brought up in a particular religion (M=1.30, SD=0.65) and those who were not (M=1.03, SD=0.70; t(102)=1.85, p=.07. Thus hypothesis 3j was not supported.

Contextual ratings of offensiveness

Using crosstab analysis in an examination of offensiveness taking context into account, offensiveness of words used in their literal or denotative form (“I need a shit”) was compared with usage in a connotative sense (“this place shits me”). Over half of the respondents (55, 52%) found the phrase “I need a shit” to be at the same level of offensiveness as “this place shits me,” whilst 42% found the literal phrase “I need a shit” more offensive than the same word used in a connotative sense. The literal phrase “I need a crap” was regarded as more offensive than the connotative “this place is crap” (54%) whilst 43% found the phrases to be of equal offensiveness. Similarly whilst 53% (n=56) of nurses found the word ‘piss’ in a literal sense equally offensive in a connotative sense, 39% rated the literal phrase “I need a piss” as more offensive than “this place pisses me off.” However, comparison between words used in a literal sense and in insults showed insults usage to be more offensive: For example, half the nurses rated the offensiveness of “piss off” as equal to that of “I need a piss,” and 30% rated “piss off” as more offensive. A similar result occurred when 34% of nurses reported finding the insult “you cunt” to be more offensive than the literal sense “my cunt is sore,” and 61% rated them as equally offensive. Thus Hypothesis 3k, that
nurses would rate swearwords as more offensive when used in their literal sense than in their connotative sense, was supported.

**Contextual ratings of offensiveness: connotative meanings, denotative meanings and insult**

To elaborate further on the effect of context, the offensiveness of words used as an insult was examined. A repeated measures analysis of variance revealed that respondents reported significant differences in the offensiveness of the uses of the word “piss” contextualised in a sentence, F(1.96, 200.1) = 18.0 P<0.001 using the Greenhouse-Geisser adjustment. Respondents rated “I need a piss” (M=1.11) as more offensive than “this place pisses me off” (M=0.73), F=(1, 102) = 17.5, p<0.001 and also rated “piss off” (M=1.22) as more offensive than “this place pisses me off” (F=(1, 102) = 38.0, p<0.001), but there was no significant difference in ratings of offensiveness between “I need a piss” and “piss off” F=(1, 102) = 1.8, p=.19. This tends to disconfirm hypothesis 3j, that nurses would rate swearwords as more offensive when used as insults than when used in a literal sense or connotative sense.

Several respondents noted the importance of context in the assessment of 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.

> "Nurse the bastard in the next bed wants a drink" could be said successfully in jest.

> Every situation would be different, i.e. what may sound offensive from a person may not seem as offensive coming from another.

> Depends on tone, anger, etc. Who says it.

Nurses’ responses also revealed that they have strong feelings about words they consider to be offensive; in all cases it was the word ‘cunt’ that was singled out for special mention:

> 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.
Several nurses made mention, throughout the questionnaire, that their intention was not to offend others:

*One does not know how a patient will feel about swearing.*

*Do not offend others.*

*If it is likely to be construed as offensive do not use.*

*Never be racially offensive and be respectful of whom I’m in company with – mainly with regard to age*

*Any descriptor of a person in the next bed is indicative of a value judgment and these offend me for that reason. I have a friend who uses these terms freely as well as “slopehead” and I CRINGE!*

Nurses’ responses also suggested that they have an internalised “hierarchy” of word offensiveness:

*Only mild words, e.g.: shit.*

*I will often joke with teenagers – I will use words like ‘bloody’ or ‘shit’.*

*Mild swearwords e.g. Bloody; bastard; shit; bitch.*

*Rarely in anger – usually only the softer words.*

Only one nurse mentioned the use of a euphemistic alternative to swearing: “Sugar” instead of ‘shit’.

*No blasphemy (Odd, as I am an atheist).*

**Literal and connotative use of swearwords and their offensiveness**

Item 17 asked nurses to rate the offensiveness of swearwords which were embedded in a context; repeated cross tabulation was used to examine each pair of questions to determine the relative offensiveness of the contextualised words. Half the nurses (n=50, N=103) rated ‘piss’ used in the literal context “I need a piss” as equally offensive as the same word used in an insult, “piss off”; 30 nurses found the insult to be more offensive than the literal use of the word. More nurses (54%) found ‘crap’ used in a literal sense in “I need a crap” to be more offensive than the word used metaphorically, “this place is crap,” whilst 43% found them to be of equal offensiveness; the results for
the word shit were similar, with 42% of nurses finding the literal phrase “I need a shit” to be more offensive than the phrase “this place shits me” and 52% reporting the phrases as equally offensive.

Nurses were asked to rate the offensiveness of 7 words (nigger, Abo, boong, Koori, wog, bastard, and motherfucker) used in a sentence; for example, “Nurse, the Koori in the next bed wants a drink.” To explore this repeated measures analysis of variance was used. Nurses rated ‘Koori’ as least offensive \( M=1.75 \) and four words, ‘nigger’ \( M=3.30 \), ‘Abo’ \( M=3.14 \), ‘boong’ \( M=3.18 \) and ‘motherfucker’ \( M=3.28 \), as highly offensive \( F(3.43, 35.70) = 53.8 \ p<0.001 \) with the first word found to be the most highly offensive. ‘Wog’ \( M=2.80 \) and ‘bastard’ \( M=2.52 \) were not rated as being as highly offensive as the other words.

**Nurses’ attitudes and beliefs about swearing and its function**

Three quarters \( (n=80) \) of respondents agreed or strongly agreed with the statement that there are certain words that people should not use (Table 6.16). About half (52%) disagreed or strongly disagreed with the statement that they do not approve of swearing, with 31% \( (n=32) \) agreeing or strongly agreeing with the statement. Similarly only 29% of nurses agreed or strongly agreed with the statement that “people who swear sound stupid,” but 69% agreed with the statement that swearing at nurses should not be tolerated.
Table 6.16 *Nurses’ attitudes towards swearing (n=106)*

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree n (%)</th>
<th>Agree n (%)</th>
<th>Undecided n (%)</th>
<th>Disagree n (%)</th>
<th>Strongly disagree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are certain swearwords that people should not use*</td>
<td>58 (54)</td>
<td>22 (21)</td>
<td>12 (12)</td>
<td>7 (7)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Swearing at nurses should not be tolerated</td>
<td>45 (43)</td>
<td>27 (26)</td>
<td>22 (21)</td>
<td>9 (8)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>I feel comfortable with my use of swearwords*</td>
<td>19 (18)</td>
<td>42 (40)</td>
<td>13 (12)</td>
<td>23 (22)</td>
<td>8 (8)</td>
</tr>
<tr>
<td>I don’t like to hear swearwords in song lyrics</td>
<td>16 (15)</td>
<td>34 (33)</td>
<td>16 (15)</td>
<td>27 (26)</td>
<td>12 (11)</td>
</tr>
<tr>
<td>Swearing is rude and disrespectful</td>
<td>13 (12)</td>
<td>41 (39)</td>
<td>28 (26)</td>
<td>22 (21)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>I don’t like to hear swearwords on television</td>
<td>12 (11)</td>
<td>21 (20)</td>
<td>25 (24)</td>
<td>36 (34)</td>
<td>12 (11)</td>
</tr>
<tr>
<td>Swearing can make communication more effective and meaningful</td>
<td>10 (9)</td>
<td>38 (36)</td>
<td>21 (20)</td>
<td>23 (22)</td>
<td>14 (13)</td>
</tr>
<tr>
<td>I don’t like to see swearwords in print*</td>
<td>10 (9)</td>
<td>22 (21)</td>
<td>20 (19)</td>
<td>37 (36)</td>
<td>16 (15)</td>
</tr>
<tr>
<td>I don’t like to hear swearwords in movies</td>
<td>8 (7)</td>
<td>21 (20)</td>
<td>24 (23)</td>
<td>33 (31)</td>
<td>20 (19)</td>
</tr>
<tr>
<td>Swearing is an important feature of my speaking style*</td>
<td>6 (6)</td>
<td>18 (17)</td>
<td>11 (10)</td>
<td>31 (30)</td>
<td>39 (37)</td>
</tr>
<tr>
<td>I don’t approve of swearing</td>
<td>5 (4)</td>
<td>27 (26)</td>
<td>19 (18)</td>
<td>38 (36)</td>
<td>17 (16)</td>
</tr>
<tr>
<td>People who swear sound stupid</td>
<td>3 (3)</td>
<td>27 (26)</td>
<td>30 (28)</td>
<td>31 (29)</td>
<td>15 (14)</td>
</tr>
</tbody>
</table>

*missing data
* n=105
Beliefs about swearing and its function

Most nurses agreed or strongly agreed with the statement that swearing can allow you to safely let off steam 57% (n=61), and about the same percentage (56%) thought that it served the same function for patients (Table 6.17). The statement that swearing can establish and maintain effective communication with certain patients was concurred with by 40 nurses (37%) whilst a similar number, 39 (37%), disagreed. Swearing by patients was believed to always be a precursor of physical violence by only 17 (17%) of nurses whilst a much larger number 53 (53%) disagreed.

Table 6.17 Nurses’ beliefs about swearing and its function (n=106)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree n (%)</th>
<th>Agree n (%)</th>
<th>Undecided n (%)</th>
<th>Disagree n (%)</th>
<th>Strongly disagree n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swearing can establish and maintain effective communication with certain patients</td>
<td>11 (10)</td>
<td>29 (27)</td>
<td>27 (26)</td>
<td>19 (18)</td>
<td>20 (19)</td>
</tr>
<tr>
<td>Swearing can allow you to safely let off steam</td>
<td>10 (9)</td>
<td>51 (48)</td>
<td>14 (13)</td>
<td>23 (22)</td>
<td>8 (8)</td>
</tr>
<tr>
<td>Swearing can allow patients to safely let off steam*</td>
<td>8 (8)</td>
<td>40 (40)</td>
<td>21 (21)</td>
<td>18 (18)</td>
<td>14 (13)</td>
</tr>
<tr>
<td>Swearing by patients is always a precursor of physical violence**</td>
<td>2 (2)</td>
<td>15 (15)</td>
<td>30 (30)</td>
<td>23 (23)</td>
<td>30 (30)</td>
</tr>
</tbody>
</table>

* n=101  
**n=100

Rules about swearing

Nurses were asked if they had any personal rules about swearing. The majority could articulate well formed views about their own “code of conduct” in relation to swearing; 84 respondents (80.8%) indicated having personal rules and a minority of 20 (19.2%) did not. Factors such as context, gender, and age were important in deciding appropriateness:

Cultural/social/work context, what is appropriate with some groups is not with others.

The context, with who and the circumstances affects whether it is OK or not.

Needs to be in context and appropriate for age.
Know the company you are in.

Others expanded on their reasons for this concern with context, such as a desire to avoid offending others or being offensive, and knowing that at work swearing was commonly viewed as unprofessional. A frequently voiced view was that it was wrong to swear in front of children, and teachers were highlighted as a profession that should not swear; similarly, some respondents stated that it was wrong to allow children to swear. A distinction was frequently made between “swearing with” and “swearing at.”

A recurring theme was control, with respondents frequently reporting that they attempted to control and restrain their own use of swearing:

Try not to swear, I personally don't like hearing it.

I try not to swear at all – socially/at work. I find I feel better by not lowering myself. If possible I try to speak politely.

Do not like it – try to self control. When really angry about a situation or repeating something said to me by a client.

Some respondents reported rules about swearing that were specifically word-based, with the most taboo and offensive words subject to particular rules:

Do not say 'fuck' or 'cunt' to clients.

Never use the c word ever.

Only say ‘cunt’ in front of my partner and one or two friends. Only say ‘fuck’ in front of friends.

Racist terms were also seen as “verboten” in order to avoid being offensive. Gender rules were mentioned by only a few nurses:

Don't like it. It's "unbecoming." I'm a lady.

Only swear around women if they have indicated, by their own language, that they’re cool with it.

Not in front of women; restrain myself as much as possible.
6.4.6 Swearing: Critical incidents

In part five of the NSIQ respondents were asked to “briefly outline the most distressing experience you have had when a patient or carer swore at you.” [Appendix 13]. In some cases the examples supplied referred to previous clinical settings. The format of this question was based on that of CIT: participating nurses were asked in a Situation, Action and Outcome (SAO) format to detail one or two examples of swearing from their clinical practice and 100 incidents were quoted; one respondent supplied two examples and seven did not participate. The perpetrator of the aggression was identified in 94 of the incidents: 72 (76%) involved a patient, 10 (11%) a relative or carer, and 12 (13%) a staff member. Thirty one incidents (28%) involved people under the age of 18 and 61 (58%) those aged 18 and over; in 9 cases age was not stated. Swearers’ ages were specified in 92 incidents; 31 (34%) involved people under the age of 18 and 61 (66%) those aged 18 and over; in 9 cases age was not stated. Gender of swearers was stated in only 93 incidents, as 52 male (56%) and 41 female (44%).

Table 6.18 details the perceived reasons for swearing. Respondents cited three main reasons: (a) patients or carers being denied something; (b) distress; (c) the patient being asked to do something.

Table 6.18 Perceived reason for swearing (=93*)

<table>
<thead>
<tr>
<th>Reason</th>
<th>n</th>
<th>%</th>
<th>Reason</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/carer denied something</td>
<td>29</td>
<td>31</td>
<td>Administering medication</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Distress</td>
<td>14</td>
<td>15</td>
<td>Other patients</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Patient asked to do something</td>
<td>12</td>
<td>13</td>
<td>Conversation</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>9</td>
<td>Good humour</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No understandable provocation</td>
<td>8</td>
<td>9</td>
<td>During physical restraint</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Missing data = 7

Nurses responded to swearing most frequently by ignoring the behaviour (31%, n=29) or attempting to placate the swearer (Table 6.19) and only 12 (13%) of the nurses confronted the behaviour or undertook other assertive action.
Table 6.19  How did you respond? (n=93)

<table>
<thead>
<tr>
<th>Response</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ignore</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>Placate</td>
<td>21</td>
<td>23</td>
</tr>
<tr>
<td>Withdraw</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Confront</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Echoes/reflects language/feelings</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Joking response</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Contacted security/police because of aggression</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Tone

Of the 95 nurses who answered this question, 51 (54%) classified the tone of the swearer as “angry,” 18 (19%) as a “threat,” 8 (8%) as “sarcastic,” 7 (7%) as “rebellious,” 6 (6%) as “distressed,” and only 3 (3%) as “anecdotal,” with 2 nurses defining the tone in another way (“mean-spirited” and “habit”). No nurses perceived the swearer’s tone to be either excited or humorous. Referring back to Russell’s circumplex model of affective space (Figure 6.1) it is clear that the majority of nurses were recounting incidents in which they recalled the tone of the swearer as being in the arousal/misery quadrant.
6.4.7 Emotional impact on nurses

Angry and annoyed

Within this category, the depth and intensity of the emotional response of the nurse ranged from extreme anger to irritation and indignation. The following scenario illustrates many of the factors which appear to have provoked a strong affective response:

SITUATION:
A relative ignored instructions not to enter the ICU to visit his wife. When asked to wait a short while, as she was having a medical procedure attended, he became aggro [sic].

Others present: Junior nursing staff (distressed++), patient (his wife), doctors, and eventually security staff.

SPEAKER: Male, mid-50s, "self-made man" (i.e. local businessman who's made some money). Observed to be mildly to moderately aggressive in nearly all interactions.

WHAT WAS SAID?
"You can't fucking stop me from seeing my wife whenever I want. No poofter male nurse can tell me what to do. Get fucked."

PERCEIVED REASON FOR SWEARING
Probable personality disorder. While not actually stating that he meant physical harm, his posturing, tone, choice of words indicated threatening intent.

NURSE'S RESPONSE
Confront. I asked the relative to discuss his demeanour, language and behaviour with me in a discrete office, with the Nursing Supervisor. We explained our rationale for restricting visits and discussed with him his inappropriate behaviour.

REFLECTION: HOW DID YOU FEEL WHEN THE PATIENT OR CARER SWORE?
I wanted to put his head through a wall.

The aggressor was a relative: nurses perhaps find it easier to rationalise swearing by a patient whose illness may explain the behaviour than aggression from someone whose wife is being cared for. The care context, an intensive care unit, is not one which normally engenders behaviour of this type. Despite the nurse's strong affective reaction to being subjected to personally demeaning comments ("poofter male nurse") and feeling physically threatened, he employed an appropriate and measured intervention to deal with the swearing.
Together with personally demeaning abuse, situations provoking anger included extreme threats against family and behaviour perceived as being entitled and demanding – that is, seen as unreasonable behaviour. In the vast majority of cases cited in this part of the questionnaire the swearwords used were those nurses found most offensive: ‘cunt’, ‘fucking’, and ‘slut’ – often combined with personalised insults such as “fat,” “stupid”, and “poofter.” Frequently the offender was described as being “personality disordered” and having other stigmatised characteristics such as being heavily tattooed, a drug or alcohol user, or unkempt. Notable exceptions were in the case of aggression by staff members who in the examples reported were all males. Nurses’ responses to interactions which evoked anger included confronting or ignoring, withdrawing, or attempting to placate the swearer.

**Fearfulness**

One of the major affective responses 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.

Several nurses reported threats against their families, for example:

> A psychotic client (mid 30s, male with dark skin, unkempt; bipolar disorder with antisocial personality traits) was making threats towards my family: "I'm gonna fuck your kid up the arse until they bleed and then I'm gonna rip her nipples off in a vice!"

The nurse observed that there was no understandable provocation, and in response “withdrew,” feeling “vulnerable; stressed; angry; violated.”

Understandably, threats evoked a strong emotional response. One nurse described confronting a visitor whose behaviour she knew to result from his anxiety about his acutely ill friend. She confronted the aggressor, but her actions did not reflect her feelings:

> I HATE it – it really impacts on me now – makes me shake. I feel less clear thinking. Pitch of voice as much as the words spoken – I deal well with yelling and/or confrontation.
In the sixteen reported cases evoking fearfulness or anxiety and the five incidents of surprise, this was the only occasion of reported confrontation of the swearer; in all other cases nurses described withdrawing from, ignoring or placating the person/s who had sworn at them.

**Surprise**

A few nurses were “taken aback,” “surprised,” “startled,” or “shocked” by swearing. The strongest affective response appeared to be produced by contextual dissonance: surprise arising from swearing “in a public place”; in a paediatric unit; from a fellow staff member; or misinterpretation of an intervention – for example, a nurse who “reached to touch someone who was distressed and anxious” was told, “Don’t fucking touch me.”

**Weariness**

Three respondents described feeling tired and weary when the swearing was prolonged – on two occasions over several hours – and in the third instance there was anticipation of a long and difficult admission to the unit for a patient whom the nurses considered to be feigning psychosis in order to escape a court appearance.

**Distressed**

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 being admitted to a psychiatric hospital. Frequently the presence of others appeared to add to the feeling of distress:

*Busy [paediatric] ward, all beds full. Fairly open. 14 year old male patient stood at front foyer yelling at top of his voice 14 year old male, thin, small, osteomyelitis requiring IV antibiotics via central line. Others present: His friends, all the other children with parents in the ward, visitors, another member RN (abuse was directed at her). “I can fuck you nurses any time I like, you are all cunts.” Patient asked to do something He had his undesirable newly acquired friends to show off in front of. [He was] also rebellious and threatening.*
The nurse described feeling: *Distressed, disgusted, embarrassed, fearful for safety of staff, upset for other patients/parents/visitors who were subjected to this outburst.*

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.”

In only one case in which nurses described being upset or distressed was there an attempt to confront the patient, in this instance a reminder about the “no tolerance” policy. In all other incidents attempts were made to placate or ignore the behaviour. The possible implications of this will be discussed in Chapter 7.

*Embarrassed and uncomfortable*

Scenarios generating reports of feeling embarrassed or uncomfortable appeared to show the common thread of having witnesses to the incident. The sense of discomfort was related also to a sense of danger. For example, “The individual had a history of assaults for no reason.” In every incident involving feelings of being embarrassed or uncomfortable the nurses attempted to placate, ignore, or withdraw from the situation.

*Sad*

In all four cases in this category, the emotion was an empathetic reaction related to feeling sad for a patient or carer. In one case a nurse described feeling depressed after enduring five nights of abuse from a patient described as “entitled and demanding.”
Disgusted and repelled

Other nurses described their reactions to swearing as disgusted and repelled. In one case the reaction was to 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.

In the case referred to above, where a 14 year-old boy was yelling that he could “fuck you nurses,” the disgust might have been in response to both sexual and age-related taboos. In a disturbing example, a nurse described feeling offended by colleagues swearing at a patient in order to incite a reaction.

Wounded

In most cases when nurses described feeling hurt and wounded by a patient’s swearing, there was a strong sense of the hurt stemming from the discrepancy between the care the nurse perceives s/he has 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.

One nurse attempted to intervene in a fight between two patients and as a result was threatened: “You stupid cunt. You should be fucked up the arse, you stupid bitch etc,” and described feeling “sick and bruised as if it were a physical assault.” In all cases nurses who felt wounded placated or withdrew from the aggressor.

Indifference

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.” This nurse was called a “stupid
fat bitch” when she went to sit near a patient. Whilst ‘bitch’ was rated by nurses as a low-level swearword, this was a personalised attack that one might expect to evoke a strong affective response. Another nurse stated philosophically, “Pretty much immune to it. If they're swearing they're not usually fighting.” It may be that this nurse viewed swearing as normal behaviour and the experience was not out of the ordinary. It is noteworthy that no paediatric nurses cited examples of swearing to which they felt “indifferent”; this reaction was found only in examples from mental health practice or when nurses described other nurses’ swearing.

**Reflection on practice**

Many nurses reported having an emotional reaction to the swearing but dealing with the situation and their role in it in a reflective way; for example:

*I felt at the time that due to the level of frustration that the patient was experiencing I thought it was warranted to a degree, mainly because I felt it wasn't so much directed at my colleague but more towards the system. Therefore I was able to deflect in my mind the onslaught of swearing.*

*I was uncomfortable at first, but I realised she didn't mean it, and she does swear to a lot of people.*

*I was more concerned about his level of distress than the language he used to convey it."

It was clear that some nurses used the interaction to reflect on their own practice:

*It made me consider that I may have been unempathic – that someone restrained and confused might be insulted by a cheery affect by his “captor.”

*The swearing didn’t bother me, however mindful of not losing control and inflaming situation.*

The use of reflection to assist some nurses to make sense of the experience of being sworn at points to the potential to use clinical supervision in a systematic way in working through and even learning from such experiences in practice.
**Appropriateness**

Numerous comments were made about the appropriateness or social acceptability of swearing.

*I do not like it, but it seems to be used as an aid with some people and has no impact on them because everyone is accepting of the words, e.g. ‘Fuck off’.*

*I felt a little shocked and that it was inappropriate to swear in the paediatric ward.*

*Felt it was inappropriate to swear so loudly in front of other patients.*

In this sense nurses were registering that the speaker had been impolite and violated a social norm.

**Interventions**

On 32 occasions nurses described ignoring the swearing behaviour, despite its having evoked a strong affective response:

*I felt really embarrassed, angry at the patient and distressed.*

*In this instance upset and embarrassed. I didn't feel good being called a “dog.”*

In these cases there is a strong sense that the nurses ignored the behaviour because they had no other way of dealing with it. In other cases nurses described ignoring the behaviour because they found it understandable in the context of the patient’s mental state: “I was uncomfortable at first, but I realised she didn't mean it, and she does swear to a lot of people,” and “Patient is unwell – not in control of actions.” In several cases nurses appeared to ignore the swearing because it did not affect them: “Just ignore it – ‘here he goes again’ – did not faze me.”

In 21 cases nurses described placating the swearer; in nearly every such case the nurses believed that the patients swore because they were denied something they wanted, such as smoking or to leave the hospital, or were asked to do something they did not want to do, such as take medication.
On 20 occasions nurses reported withdrawing from the swearing behaviour; on some this intervention was used in a considered way:

*I could understand the reason for the anger, frustrated that I was unable to make a difference at the time, realisation that withdrawal best option.*

*I realised that she was angry and if I left her for a period of time she would settle down. Which she did.*

But on other occasions the nurses felt threatened or uncomfortable and withdrew to protect themselves from physical or verbal aggression:

*Petrified. I thought he would physically harm me because he was large, irrational, very angry, and very close to me.*

*Felt wounded and upset to be spoken to like that.*

*Angry, upset, depressed. Had 5 nights. Went off sick after 4th night – had enough.*

However one nurse chose to withdraw even though s/he stated, “ Didn't bother me. If you are offended by being sworn at you are in the wrong job.”

On only a small number of occasions did nurses describe confronting the swearer. They were more likely to do so when others were being affected or they strongly believed that the swearing was wrong:

*Felt it was inappropriate to swear so loudly in front of other patients.*

*...I needed to control the swearing or behaviour of other patients so they didn't have to listen to it.*

*Angry that this person felt comfortable calling this woman who was in fact helping him such a derogatory name and also annoyed that this NUM ignored it – she deserves better. Saddened, angry.*

*Felt like taking this guy down a peg or two and educating him about professional conduct in the workplace.*

*I got him helping me with his friend and told him he was not helping anyone by swearing at me.*

One nurse stated, “I don't deal well with yelling and/or confrontation,” perhaps highlighting the apparent unease felt by the majority of nurses in dealing assertively with this behaviour as evidenced by large numbers who said that they withdrew or
ignored it. An alternative explanation is that nurses lack the skills to deal with swearing.

Nurses reported echoing or reflecting feelings in six of the reported incidents but little detail was recorded for many of these interactions, one exception being the following reflection: “I felt a little shocked and that it was inappropriate to swear in the paediatric ward. I also realised that he was honestly venting his feelings and that was calming him down.”

Nurses rarely reported using a joking response in relation to swearing, and in none of these incidents was personally demeaning or personally threatening language used. Two of these occasions related to non-threatening exchanges between staff members; in the third case the nurse tried several different tactics over a period of several hours during which the patient did not desist from swearing.

Moral judgment

A number of comments about the appropriateness of swearing or its management appeared to indicate that patients or their carers were held culpable for the behaviour:

- Annoyed. Swearing was more behavioural response than psychotic response.

- I was upset that his mother didn’t attempt to intervene or chastise.

Participant feedback on the process of completing the questionnaire

Respondents were asked for feedback on several aspects of the process of completing the questionnaire. The few negative comments concerned the standardised instruments, some expressing the view that the questions on these instruments did not make sense, and this was one of the main reasons cited to the researcher for non-return of the questionnaire. One participant found the questionnaire “very tedious” and another thought some questions “too complex and difficult to understand.” In retrospect, I believe the information sheet did not sufficiently explain the link between the standardised instruments and the study’s aims.
However, the majority of comments (73%) were positive and suggested that the questionnaire had provoked reflective responses:

*Passionately angry when thinking about part 5.*

*I felt I was questioning myself – on how I do feel about swearing. I’m sure I will be more aware of how swearing affects me and my environment – interesting! I learnt something about myself.*

*Brought to my attention that swearing often takes the place of meaningful conversation. Used as a mask to hide feelings of fear and/or vulnerability.*

### 6.5 Discussion

What is evident from the data reported in this chapter is the high incidence of swearing in the workplace by both patients and their carers, and that swearwords are commonly used among colleagues. The ubiquity of swearing among nurses was manifest in many responses, echoing previous research on a college student cohort (Beers Fägersten, 2005, p. 5) which described swearing as “everyday,” “normal,” and “regular” behaviour that “everyone” practises. It seems that nurses in general share many of the views and attitudes about swearing that are held by society at large. For example, definite opinions held by many nurses related to whether it was appropriate for women to swear, and there were decided views about who should and shouldn't swear. Similarly Beers Fägersten (2000) found that two-thirds of her university undergraduate respondents reported having personal rules for their swearing behaviour; in the main these dictated when to refrain from swearing.

It was difficult in many cases for nurses to quantify frequency of swearing, and they reported also that it varied a great deal depending on shift times and the characteristics of the patient population; doubtless numerous other variables were involved including characteristics of the staff, culture of the unit, and stress levels.

It is perhaps surprising that paediatric nurses’ experience of swearing and the frequency of their exposure to it do not differ markedly from those of their mental health colleagues, as was hypothesised. However, what emerges strongly from the data is the extent to which swearing is culture and context bound. The paediatric nurses’ accounts were all negative and experienced as harrowing. It is likely that context is a major factor: boundary-crossing and taboo-violating behaviour such as being sworn at in front of young children and their parents might conceivably be more confronting than
being sworn at in a mental health unit where there are fewer visitors and the main audience comprises other patients and staff.

Swearing clearly is a major source of distress for nurses; the strong affective responses reported by many respondents in this study has implications for the establishment and maintenance of a therapeutic relationship in that it colours the interactions nurses have with patients.

There was some correlation between GHQ scores and distress, and 18% of the nurses scored above 4, the level of mild psychiatric morbidity on the GHQ. This figure does not seem excessive compared with the two other studies which used the GHQ with nurses. In a study by Pryjmachuk and Richards (2006) the GHQ results indicated that 43.1% of midwifery students were stressed and had reached “caseness,” that is, described symptoms which would be classified as mild psychiatric morbidity. In an Irish study using the 28-item version of the GHQ, 27% of respondents were identified as “cases”; again this was a moderately high percentage. Nurses who had been assaulted or harassed were twice as likely to have psychological well being scores similar to those in a clinical population as compared with their colleagues who had not been assaulted or harassed (Royal College of Nursing, 2002).

Moreover, the respondents appeared to have only a limited range of interventions for use in dealing with it. The implications for the therapeutic alliance will be more fully discussed in the next chapter.

Offensiveness and offendedness are gender-related concepts about which there was some agreement and much individual variation among the nurses surveyed. Burgen (2002) distinguished between the intention of insults and swearwords to disparage or convey disrespect and the intention to wound, a distinction he used to explain why the literal use of words may be more distressing. Into this category come racist words, which nurses rated as highly offensive, and also personalised insults which focus on some aspect of the recipient’s physical appearance. The literal use of terms such as ‘crap’ was rated by nurses as more offensive than the metaphorical – perhaps because the novelty of the literal usage and its association with speakers from a lower economic class rendered it less acceptable. Despite a common belief – for example, Margolis (2002) – that the word ‘fuck’ was losing its power to shock, it was still among the handful of words which nurses found highly offensive. It was also the word which
featured most prominently in the critical incidents of nurses being sworn at in the workplace.

Nurses in this study reported the conscious use of swearwords as a therapeutic device; opinions as to its efficacy were contradictory among the respondents, as in the literature on the use of swearing by counsellors, psychologists and psychiatrists (Feldman, 1955; Heubusch & Horan, 1977; Kottke & MacLeod, 1989; Kurklen & Kassinove, 1991; Ross, 1962; Wiley & Locke, 1982). In their use of swearwords nurses demonstrated a consciousness of context, and usage was bound by factors such as how well they knew the patient, the level of taboo of the swearword, and the patient’s own use of language. It appeared that nurses were intuitively using swearwords more freely with young people because swearwords were more likely to be a part of this group’s lexicon; there has been some suggestion that counsellors are seen by young people as more effective and satisfying when they use this language (Rassin & Van Der Heijden, 2005; Wiley & Locke, 1982), and this approach has been advocated for use with adolescents (Martin, 1997).

6.5 Limitations

Data collected from open-ended questions in questionnaire studies are subject to limitations related to the writing skills of respondents, inability to use probing questions to draw out further knowledge, and the effort required to complete a questionnaire (Patton, 1990). This was undoubtedly a factor in the short responses to open ended questions in the NSIQ: Some responses to questionnaire items were brief and could be accused of being “skimpy” (Sandelowski, 2000). In contrast, nurses sought out the researcher to discuss their thoughts about swearing and enjoyed discussing the topic at length, and it is likely that a more interactive approach to this topic, such as conducting a focus group, would have yielded a rich seam of data. A third study, comprising telephone interviews with a random sample of questionnaire respondents, was planned but not undertaken because of the amount of data already obtained and the time limitations imposed by doctoral candidature.

6.6 Conclusion

This study aimed to address the gap in the literature on the effects of swearing on nurses. The questionnaire study, Part 2 of the research, aimed to address three limitations of previous research on swearing and in this progress has been made.
Firstly, it canvassed opinions about swearing from a group of people who are not college students; secondly, the questionnaire included contextual considerations – respondents have not been asked to rate offensiveness devoid of context; thirdly, the researcher has been enabled to distinguish differences in offensiveness between denotative and connotative meanings of words. The next chapter will more fully explore the implications of the findings.
Chapter 7

Discussion

“The misfortune that is often experienced in handling any subject lying wide of the beaten track does not necessarily arise from the inherent viciousness of the subject itself, but from the fact that a large number of people have previously arrived at painful impressions concerning it. It is therefore an obligation cast upon a writer to treat these preconceived notions with the utmost tenderness and respect” (Sharman, 1884, p.13).

7.1 Introduction

This chapter provides in Table 7.1 a summary of the study’s contributions to knowledge. These will be further explored in later sections, then evaluates and discusses the implications of the major findings in the context of previous research results, and offers a statement of the central tenets of the thesis. The definitional aspect of swearing will be revisited, also the study’s limitations, and recommendations for further research and nursing practice will be presented.

The research was directed towards answering the following superordinate questions which provide the structure for the discussion:

1. What is the extent of swearing /verbal aggression in a health care setting?
2. What are the implications of swearing for a therapeutic encounter?
3. What is the impact of swearing on nurses?
<table>
<thead>
<tr>
<th>Extant literature</th>
<th>Contribution of this study</th>
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| Frequency of verbal aggression. | Has not documented verbal aggression in in-patient units over an extended period.  
| Explored frequency of verbal aggression over a 10 year period. This is the first study globally to express aggression numerically per 100 bed-days. |
| Frequency of swearing in an Australian context. | None.  
| Explored frequency and type of swearing in a healthcare context. Disconfirmed expectations arising from the literature that swearing among nursing colleagues would be at a lower frequency than in a social setting. |
| Implications of swearing for a therapeutic encounter. | To a small extent, but not in a nursing context or an Australian context.  
| Explored the implications of swearing for nurses and patients in inpatient settings. |
| Link between verbal aggression and physical aggression. | This has previously been explored on smaller samples.  
| Used a large sample to explore the association between verbal and physical aggression. Also explored qualitatively nurses’ perceptions of this link. |
| Link between the attributions nurses make about the cause of aggression and interventions made. | This has previously been explored on smaller samples.  
| Confirmed previous research in this area. |
| Impact of swearing on nurses. | This has not been previously researched for any population group.  
| Qualitative exploration of impact on nurses and effects on the therapeutic relationship. |
| Offensiveness ratings | Explored to a small extent but not in an Australian context.  
| Explored nurses’ perceptions of offensiveness of swearwords commonly used in Australia. |
| Religious affiliation and offendedness | This has previously been explored but not in an Australian context.  
| Explored in relation to nurses in an Australian context. |
| Definition of swearing | Redefined in the light of findings from the study. |
7.2 The extent of swearing and verbal aggression in a health care setting

Despite the high prevalence of swearing and being sworn at in the workplace, this study is the first to survey nurses specifically about their experience of such incidents and also to express numerically the incidence of verbal and physical aggression per 100 bed-days. Results derived from this method of measuring aggression underline the view expressed by many researchers that aggression is under-reported – (for example Farrell et al., 2006; Holmes, 2006; Mayhew, 2000) – but also show that the rate of under-reporting may itself have been underestimated. An extensive survey of 4,481 nurses in the UK recorded that just over half of those who had been assaulted or harassed by patients did not report the incident. Only 36% of the nurses reported the incident if it did not involve physical assault; 60% reported it if physical assault was involved (Royal College of Nursing, 2002). Given the reported levels of swearing and the amount of distress generated by this aspect of the contemporary nursing environment, the results of the present study suggest that the previous lack of research in this area has been a major oversight.

7.2.1 Verbal aggression

In this study data about the extent of verbal aggression and swearing have been gathered in two distinct ways. The first, the context of practice study (Chapter 5) recorded 9,623 aggressive incidents over a 10-year period, averaging 96 incidents per year: fewer than the 130 incidents per year on a medium secure unit reported by Gudjonsson et al. (1999); the second was the use of a questionnaire (Chapter 6). The context of care study has shown verbal aggression to be the most frequently recorded form of aggression in the mental health inpatient units included in the study: 79% of the completed reports indicated some level of verbal aggression; males were involved in about 60% of the incidents and females in 40%, with female verbal aggression likely to be reported only at the higher levels. There has been speculation that the over-representation of female aggression at higher levels may be caused by stereotypic gender bias leading to staff tendency to underestimate and under-respond to female inpatients’ non-verbal cues and escalating behaviours (Robinson, Littrell, & Littrell, 1999); the data did support this conjecture – at the higher levels both physical and verbal aggression are reported equally for males and females, but verbal aggression appears to be overlooked at less severe levels for females. In incidents involving females the reported severity of verbal aggression and of physical aggression against others was significantly related, but not with male patients. This distinction is important
in educating nurses about how to recognise and prevent more serious aggression and alerting them to the fact that male and female patterns may differ.

### 7.2.2 Swearing

Turning now to the frequency of swearing, having looked more broadly at the prevalence of verbal aggression, more than half of the respondents to the questionnaire study reported being sworn at by a patient or carer in the last week, 7% “continuously.” Accurate records of frequency of swearing are notoriously hard to achieve (Jay, 1992) and the questionnaire study was no exception; asked to report the number of incidents experienced during the last week, nurses in many cases found it difficult to quantify because its frequency made keeping count impossible. Comments on questions of frequency highlighted its variability, dependent upon care context and patient mix. The expected differences in frequency of patient and carer and staff swearing reported by nurses working in paediatric settings compared with mental health settings were not evident. These settings were chosen because the literature suggests high frequencies in these areas, so perhaps this finding is not surprising. However, the subjective nature of a self-report instrument may lead to systematic bias: in settings where swearing is extremely prevalent nurses may not register it so acutely; similarly the accepted norm against swearing in front of children or by children may intensify its impact in a paediatric setting.

### 7.2.3 Reported use of swearwords with patients

Just over half the surveyed nurses reported occasionally using swearwords with patients: 42% only rarely and 14% “sometimes.” Given that none of the nurses reported frequent use of swearwords with patients, and that reported use with patients was less than in any other situation, within the context of a therapeutic relationship nurses do moderate their language. Reference was made to use of swearwords on occasion specifically to clarify meaning for patients in terms which they recognise; patients vary in their ability to understand and put into words their emotions, and it might be difficult for patients to expand further on the nature of their distress than “I feel like shit” (Jay & Janschewitz, 2007).

Swearwords were used also in a variety of ways to establish rapport. Native English speakers make judgments about appropriateness – when and where swearwords can be used – based on speaker status, physical location, and the speaker’s “turf” or...
control over location (Jay, 1999). In a hospital setting the nurses have the control, and swearwords may be used to "close the gap" in power and status between themselves and the patient. This conscious narrowing of the distance with the intention of lessening the patient's discomfort and dependent status is employed when swearwords are perceived to be part of the patient's language. Patients might use them in anger to intimidate and "bring the nurse down," whereas nurses might use them consciously to minimise the power disparity.

Nurses' use of swearwords with patients seems to accord with the belief that nursing language is profoundly rooted in everyday terminology rather than having as its basis jargon, concepts, and models which are poorly understood by patients (Crawford, Johnson, Brown, & Nolan, 1999). “Mental health nursing involves a care-focused use of everyday terms” (Crawford et al., 1999, p.340), and these may include the judicious use of swearwords. That only very few nurses acknowledged using swearwords intending to hurt or offend suggests that when they are used with patients it is with therapeutic intention. The disturbing account of a nurse allegedly using swearwords to provoke a patient is a rare exception. The small minority of nurses who indicated that swearing was their customary language may not conform to the “rules” of the majority of their colleagues or patients and thereby unconsciously give offence.

Nurses claiming never to use swearwords with patients offered as their reason the belief that it was not professional to use language in this way, and one mentioned not wanting this to be the image projected. Whilst many nurses gave examples of having used swearwords to good therapeutic effect, one recounted an occasion when such use with a patient proved to be untherapeutic.

Use of swearwords has also to accord with the nurse’s self image and ease in employing such language. For example, a mismatch is likely between the words an adolescent would freely use and those a nurse might find congenial. The use of swearwords and slang may not sit comfortably with some nurses; it thus may not be perceived as genuine by the patient and will not be effective in “closing the gap” between professional and patient.
7.2.4 Nurses’ reported use of swearing within the nursing group

Only 12% of the NSIQ respondents reported hearing no swearing within the nursing group during the previous week. Paediatric and mental health settings produced similar results, indicating almost universal experience of swearing among colleagues in nursing. Responses about swearing within the workgroup accorded with Ross’s (1960) identification of two types of swearing: (a) “social swearing,” a sign of being one of the group, and (b) “annoyance swearing,” which was a reaction to stress regardless of the audience. Most of the reported work group swearing was of the first category, with “annoyance swearing” reserved for irritations, managers and “the system.” In contrast the latter was the main type associated with patients’ swearing, which was perceived as a reaction to their distressed mental state. No published research exists on the use of swearwords between nursing colleagues, but one qualitative study examining conflict among nurses described “explosions” which included “screaming, yelling, swearing, and crying,” and described them as being “an expected part of working life as a nurse” (Duddle & Boughton, 2007, p.34). Nurses in that study described the outbursts as “distressing,” and referred to the importance of resilience in being able to adapt and persevere in the face of such conflict.

As in the patient population, the incidence of swearing within the nursing group surveyed in this study cannot be disentangled from the context. Respondents referred to refraining in the company of people who do not swear and to a number of other contextual factors which impact on decisions about appropriate language, congruent with Ross’s (1960) speculation that social swearing is easily inhibited by the presence of non-swearers. Other contextual factors cited as reasons for abstention from swearing were the presence of patients, children, or parents, and men referred to avoidance in front of women. Also mentioned was the link between “mateship” and swearing, reflecting Mercury’s (1995, p.32) opinion that “successful swearers swear among friends where social status is not a primary worry, and friends normally accept such behaviour.” Gender too was significant, male nurses reporting more frequent usage than females. Cultural aspects of swearing in an Australian context have been described elsewhere (Stone & Hazelton, 2008) (Appendix 14).

In an Irish study of swearing among a tightly-knit group of friends in a social situation (Stapleton, 2003), the reported reasons for swearing were most often relational/interactional and were, in order of frequency: humour/story telling; to create
emphasis; anger/tension-release; habit; it’s normal/expected; to show intimacy/trust; to cover fear/vulnerability; part of personality; and to shock. Not dissimilarly, in the present study nurses’ reported reasons for swearing were for humorous effect; for emphasis; when they feel strongly about something; to express frustration with patients or the system; and also to fit in. Swearing was seen by many as the manner in which nurses relate to each other. Personality factors, beliefs, and feelings of vulnerability within the system may also play a part in the characteristics of swearing within the team.

Whilst nurses are “playing by the rules” of the wider community with regard to swearing, it is still possible that some subgroups within nursing affiliate by swearing. It used to be the preserve of male-dominated working class workplaces and haunts – the locker room, the armed services, the shop floor – but this study has shown such language to be now part of the working lives of a predominantly female profession, and in some nursing groups and contexts in Australia it may have a role in the process of belonging; evidence for this view was provided by the frequent remarks about swearing being “the way that we talk around here.” The nature of the contemporary nursing environment or the customary language of the patients may create a tendency for particular nursing groups to swear more when together, and perhaps what is taking place in nurses’ use of taboo language with their colleagues is what Brown (1991) described as a universal human tendency to use verbal taboo to express intimacy. Parallels to this process appear in largely anecdotal accounts of high levels of swearing among other groups such as prison officers, the military and adolescent gangs. There was no suggestion of any coercion about the use of this language, but in some settings toughness and hardiness are viewed as desirable traits.

Nurses are unique in having to deal with the bodily effluvia most people find disgusting (Lawler, 1991), the names of which comprise a large percentage of taboo words, and their use of language may also reflect this. Entering a profession frequently entails acquisition of specialist language, and Lawler (1991) noted that finding appropriate language to explain aspects of nursing care and which words to use can be difficult; if anatomical names for body parts are used it is likely that patients will not understand, whilst the use of familiar terms may be taboo. Nurses in Lawler’s study commented that they had never been taught how to resolve this problem and, as reflected in the present study, they felt they had to come “down” to the patient’s level in order to communicate effectively. Lawler conjectures that nurses may find it hard to talk about their work because the subject matter is taboo so the only people they can talk to are other
nurses; this might also induce the adoption as in-group terminology of a type of language, such as swearwords.

The finding that nurses swear frequently among themselves may challenge community perceptions about the profession and those within it. Jay (1992, p.89) questioned American college students about the probability of hearing people of various professions using “dirty words.” The likelihood of hearing a nurse swear was rated at 19.37 on a scale 0 = not likely at all and 100 = highest possible likelihood. (Rated at 82.50 as most likely to swear was a male athletic coach; only the dean and librarians were rated as less likely than nurses to swear.) English researchers Johnson and Webb (1995, p.472) commented: “Conventional wisdom has it that in their ‘professional context’ nurses use relatively polite language,” and Johnson went on to say that only once in his career working in an intensive care unit:

“…had I been surprised by colleagues of both sexes using 'strong' or 'barrack room' language to describe their patients. This sort of language was not very common, and certainly was uttered with the aim of being out of earshot of patients in particular and also those nurses perceived to be of more delicate constitution.”

7.2.5 Reported use of swearwords in a leisure context

Whilst the present study did not calculate the frequency of swearwords as a percentage of the total word usage, previous studies such as Cameron's (1969) found swearing to be nearly four times as frequent in leisure as in work conversations. In the present study a fifth of nurses reported higher rates in a leisure context than with their colleagues but a much greater number (64%) reported equal usage in each situation, implying that the disparity found by Cameron did not exist within this nursing workplace. The discrepancy may be because of changing norms – Cameron’s (1969) study is now dated; it may also reflect cultural differences in rates of swearing in the USA and Australia, or it may be a function of different workplaces.

7.2.6 Reported use of swearwords at home

Lower incidence of swearing at home was reported than socially or with colleagues, the main reasons cited being not wanting to set a bad example for their children or the attempt to refrain from swearing in general. McEnery (2006) has found a general
decline in the use of swearwords after a peak in the age group 15-25; it is interesting to note that he reports a slight increase for the 45-60 year olds. He attributes the lower rates between the ages of 35 and 45 to parents refraining from swearing around their children.

### 7.3 Implications of swearing for a therapeutic encounter and its impact on nurses

This study has explored the incidence of swearing across a variety of health care contexts and will turn now to the implications for a therapeutic encounter, and the impact of swearing on nurses. The data set has led the researcher to conclude the following:

Swearing is widespread in a range of health contexts and is under-reported in health care. The implications of swearing are poorly understood by nurses who accordingly do not appreciate its potential detrimental effect on the quality of the therapeutic relationship of which empathy is a core component. The strength of nurses’ affective response can limit both their range and expression of empathy and the extent of therapeutic engagement with the patient.

The implications for therapeutic intervention begin with the attributions by nurses as to the causes of aggression, and how these attributions can shape empathy. Patient aggression was most often attributed to factors intrinsic to the patient (individual patient characteristics including age, gender, diagnosis, and substance misuse), termed by Duxbury (2002) an internal model. External causation (environmental factors) was cited as the least likely, and explanations based on the interaction between factors, the situational model, were also not frequent (Table 5.9). The underlying philosophy behind the preponderance of the internal model of causation in which nurses attribute aggression to the patient’s inherent characteristics is the biomedical model, which provides a justification for the use of medical treatment for aggression as well as freeing the nurse from individual responsibility (Hahn, Needham, Aberhalden, Duxbury, Halfens, & Feans, 2006). The link Duxbury (2002) found between the “internal” model and the use of isolation and mechanical restraint in the control of aggression is confirmed in the present study, which shows that only 27% of interventions involved the use of non-controlling approaches. Therefore the range of therapeutic interventions was limited, which tends to conflict with the recommendation that when dealing with aggression problem solving and de-escalation should be the first choice of intervention, with restraint and seclusion measures of last resort (Cowin
et al., 2003). Care must be taken in interpreting these data: It is likely that only the most serious incidents of aggression have been recorded and that interventions therefore mirror the severity of the incident, because incidents arising from external circumstances were prevented.

It has been hypothesised that the use of the “internal” model may be a defence mechanism to absolve nurses with poor communication skills from “personal involvement and accountability” (Hahn et al., 2006, p.202). A further explanation is that this may be an example of a universal tendency, when circumstances are ambiguous, to attribute the cause of another’s actions (but not one’s own) to the person’s own internal dispositions: this is termed the “fundamental attribution error” (Jones & Nisbett, 1971).

Another perceived precipitating cause for aggression was staff refusal to grant patients’ requests regarded as compromising professional nursing responsibilities, such as to smoke cigarettes or to have liberty clearly contrary to medical orders; one comment in this category summed up the nurses’ dilemma: “The incident could have been prevented if staff failed in their duty of care.” Similarly, in a study which uncovered high levels of verbal aggression in general medical wards and mental health settings, the authors suggested that close proximity, managing personal care, carrying out unpleasant duties, and not complying with patients’ demands create potential for conflict, but could not justify the extreme language used by patients in some cases (Ferns & Meerabeau, 2008).

On the perceived reasons for swearing, respondents believed that patients and carers being denied something, being distressed, or being asked to do something were the main precipitants (Table 6.18). These reasons contrast with those in comments on OAS forms on the causes of aggression which indicated over 50% of incidents as resulting from interactions and only about 25% from internal characteristics of the patients. Thus, when asked to consider an incident in more detail, nurses appear to have appreciated the role of dynamics between the environment and the patient. However the limited range of interventions used to deal with the behaviour was still evident, nurses most often ignoring it and only 9% making an attempt to deal with it assertively.
7.3.1 Conceptual framework

Whilst there are many ways in which the data from this study could have been analysed, the concept of therapeutic boundaries and therapeutic connection between patient and nurse informed the explication of the conceptual framework. Equally interesting explanations might derive from other perspectives, such as that of Michel Foucault (1991) or symbolic interactionism, which are not covered in this chapter but will be the subject of a future paper.

A nurse’s ability to monitor his or her own reactions to patients is imperative in establishing and maintaining a therapeutic relationship (Austin et al., 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 & Schenthal, 2008). Contemporary nursing environments are so complex, dynamic, and reactive that nurses may feel overwhelmed and boundary slippage may ensue. This may occur in many different ways; particular conditions or circumstances such as stress may increase the likelihood of further complication.

Implicit in the concept of boundaries (Figure 7.1) is the notion of over- and under-involvement, therapeutic and non-therapeutic practice. Maintaining appropriate boundaries ensures a safe connection between nurse and patient, based on the patient's needs (Holder & Schenthal, 2008). It is suggested here that swearing may precipitate a drift away from optimising the likelihood of maintaining or achieving therapeutic practice towards a situation more reflective of under-involvement. Behaviours reflective of optimal therapeutic engagement include the employment by nurses of empathic behaviours and judgments, considered responses leading to patient engagement, and comprehensive assessment of the emotional status of patients (Figure 7.1). Swearing by a patient might trigger negative countertransference reactions in nurses and influence them towards untherapeutic practice because they are sometimes unable to move beyond their affective responses, and this might lead to disengagement; avoidance of the patient; a narrow range of therapeutic interventions; and punitive behaviours and judgments.

There was no evidence from the study data that swearing by patients led to over-involvement by nurses. However, it could be speculated that services may become preoccupied with particular behavioural cues, such as swearing and verbal aggression,
and that risk discourse plays into and amplifies this “over-involvement” leading to risk management strategies focusing on coercive strategies.
Figure 7.1 A model of therapeutic intervention in response to verbal aggression and swearing (Stone, Hazelton, McMillan, 2008)
Figure 7.1 having been developed, it became clear that in relation to swearing by patients therapeutic engagement and empathy were essential to understanding the dynamic, and a second set of concepts is proposed which expands on the first (Figures 7.2 & 7.3) 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 & 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 also been found to reduce aggression (Hoffman, 2000). Swearing by patients has consequences in relation to feelings of empathy engendered in nurses: 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, and ability to reflect upon the clinical situation, and the inclination to invest therapeutic effort by putting into action appropriate and constructive responses.

Figure 7.2 depicts diagrammatically a model to illustrate how swearing may affect the relationship between nurse and patient. At the heart of this relationship are empathy and engagement. It is easier for nurses to establish and maintain an optimal therapeutic connection with patients when the nurse has characteristics and values that are not dissimilar to those of the patient. This promotes empathy and enhances the therapeutic relationship because most people empathise more with people whose needs and concerns are similar to their own (Hoffman, 2000). However, certain characteristics of the patient or nurse have the potential to create a therapeutic “gap” between nurse and patient leading to a sense of otherness and increasing vulnerability for the patient. In order to minimise this distance the nurses have to be mindful of the factors triggering their affective responses and are required to expend greater therapeutic effort in order to bridge this gap.
Figure 7.2 “Mind the Gap:” A model of potential therapeutic distance between nurse and patient
Figure 7.3 Mind the Gap Model: The factors leading to potential for creation of therapeutic distance between nurse and patient

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Figure 7.3 illustrates some of the triggers identified in this study which may affect nurses’ responses to patients and their ability to empathise, and therefore impair the quality of the therapeutic connection. These 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/judgment by the nurse**; 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** also plays a crucial role in the **level of word offensiveness** and both mediate the impact of swearing. These triggers will now be addressed in more depth. In addition, as discussed in 7.3, an internal model of causation for aggression may contribute to creating therapeutic distance between the nurse and patient.

### 7.3.2 Moral evaluation of patients by nurses

A theme emerging from the data from the two parts of this study was that of moral evaluation of patients by nurses. Preparedness to put up with swearing or verbal aggression appeared to be dependent on the extent to which nurses thought the behaviour was excusable: Depending on the attributions nurses made about the cause of swearing, their empathy appeared to be reduced or neutralised when the patients were seen to be responsible for their own distress. Hoffman (2000) also found that when the cause of distress is beyond a person’s control the observer is sympathetic about that distress.

These findings accord with those of Luck et al. (2007, p.5), that nurses took three main factors into account: the degree of personalisation; the reason why the patient had presented for treatment; and mitigating aspects including “physiological, organic, psychological, psychiatric or medical” conditions, and circumstances which were believed to decrease the person’s capacity to act or respond in a “rational and informed manner.” The authors further observed (2007, p.6) that if patients were not seen to be responsible for their actions nurses reported increased empathy with the aggressor, towards whom they said they remained “calm, tolerant and sympathetic.” However, if the aggressors were perceived to be responsible, nurses’ attitudes towards them
showed less understanding and tolerance. The authors speculated that the meanings which nurses ascribe determine whether they see violence to be within normal limits and therefore do not report it, and that this may explain why aggression, including verbal aggression, is under-reported or differentially reported.

The process of social judgment has been described by Roth (1972) as a reciprocal relationship between the attributes of the patient and categories of staff. The evaluation may arise from concepts of social worth common in society at large and has a direct effect on assessment, attribution, and treatment. For example, in his observational study of health workers in an emergency department Roth (1972) found that those labelled as drunks were treated as being more undeserving than any other category of patient. In contrast Johnson and Webb (1995) emphasised the importance of context: “Social evaluations are not, in any clear way, tied to traits or variables which patients do or do not possess. Rather, evaluations of people in the ward were socially constructed in relation to a complex web of powerful social influences” (Johnson & Webb, 1995, p.474). Using the frame of the model in Figure 7.2, these processes can affect empathy and therapeutic distance between the nurse and patient, and the present study has brought to the fore the importance of both moral judgment and context in the process of evaluation.

The context of care component of the study (Chapter 5) highlighted a number of incidents which nurses labelled “demanding behaviour,” in accord with Roth’s (1972) finding that negative evaluation of patients was strongest when undesirable characteristics were combined with what were seen as illegitimate demands. There were many comments, of which the following are typical, about the nature of patients’ demands triggering a reaction in the nurse which increased the therapeutic distance between the two:

- Angry at not getting his own way.
- Continual demands which not met.
- Demands not immediately met by staff.
- “E” expects instant granting of her every whim.
- Wanted to go to the club and place a bet.

The use of the word “demand” by its very nature suggests that the patient did not have a legitimate reason to make a request. Clearly nurses cannot meet many of the patient’s “demands” such as to go home or have a cigarette, and this can become a catalyst for conflict.
Other comments imply strong negative evaluation:

*Bad not mad.*

“A” is vindictive and malicious with her insults.

*Demented nasty old geezer.*

“B” is giving in to one of his psychotic phases.

Leaving aside the professional consequences of writing entries like these, such assessments pose a clear danger of an adverse effect on the therapeutic handling of those patients. More measured, but equally distancing, were other frequent comments in the context of care study about precipitants, such as “behavioural,” “passive-aggressive,” “immature,” “personality.” Data from questionnaire respondents did not show this level of apparent frustration with patients. It is beyond the scope of this study to speculate about the extent to which this process of moral judgment is conscious, but Johnson and Webb (1995) believe that nurses at all levels experience intense guilt about the way in which patients are labelled, especially when it results in standards lower than they would wish to maintain.

### 7.3.3 The assumption that swearing is invariably negative and morally wrong

The assumption that swearing is invariably negative and is morally wrong pervades the literature on both swearing and verbal aggression, but swearwords may also have a role in affirming friendships, establishing relationships, intensifying humour and signalling comfort with fellows. Swearing’s role in in-group behaviour has been seen in patient groups (Laskiewski & Morse, 1993), and has been evident within nursing groups in this study. Swearwords communicate emotions more powerfully and succinctly than any other words (Jay & Janschewitz, 2007), and these words have the advantage of “guaranteeing maximum attention” (Morris, 1998, p.187). Mercury (1995, p.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. Replacing swearwords with euphemistic equivalents has the effect that the force of the speaker’s emotional reaction is not conveyed. Nurses might use swearwords to describe strong emotional reactions to patients, just as patients who have experienced abuse or psychiatric symptomatology beyond the ken of normal experience revert to using these words to describe their feelings.
It was clear from the questionnaire survey that nurses have constructed limits as to the acceptability of swearwords. The two items with regard to attitude to swearing with which there was most agreement were: “There are certain words that people should not use;” and “Swearing at nurses should not be tolerated.” These opinions seem to indicate that nurses have personal boundaries about swearing which may be contextual, but are most strongly apparent in relation to strength of taboo and to aggression. Nurses at work are usually in a position of power compared with the patient, and being sworn at by a patient may cause them to “lose face” and seek sanctions against the perpetrator. If a nurse believes that swearing is morally reprehensible and requires some form of punishment, this will clearly have negative repercussions for the therapeutic relationship, despite the fact that preventing a patient from swearing may be of no therapeutic value at all.

7.3.4 Rules

In general it seems that nurses share many of the conventions of courtesy, politeness, and accepted social mores that society applies to swearing, but they work in a complex and challenging environment, are sworn at frequently and may occasionally have to use coarse language in order to communicate effectively with patients, and as a result their “rules” may differ from those of the population at large. Although it is likely that respondents have not thought specifically about their attitudes and beliefs about swearing, they appeared to have no difficulty in articulating their position. Asked if they had rules to apply to their use of swearwords, most articulated several and recognised the central importance of context – the nature of the relationship with the patient, the level of word offensiveness, and level of patient’s distress. These may be viewed as manners or boundaries of acceptable behaviour, and undoubtedly reflect the cultural background, educational level and code of ethics of the nurse respondents. If a set of rules regarding appropriate and inappropriate swearing which the majority of nurses would adhere to were to be extrapolated, these might be as follows (Figure 7.4):
• Do not swear at others.
• It is not okay for patients to swear at nurses.
• Be aware of the context and company and do not cause offensiveness by your use of swearwords.
• Swearing with patients is an extension of the last rule: Use swearwords only with patients who use them as a part of their everyday language. If swearwords are used with patients there must be a reason to do so.
• Do not swear in front of children or allow children to swear.
• Do not swear in front of your parents.
• Managers and professionals should not swear.
• There are certain words, those which nurses deemed most offensive, which should not be used. These include racist terms.
• Swearwords are a part of friendship and “mateship.”
• It is okay to use swearwords when you are angry, they can assist you to let off steam.
• If staff swear at other staff there should be consequences for that behaviour.

Figure 7.4 Perceptions of appropriate and inappropriate swearing

Other studies have foregrounded similar rules. Over half of Beers Fägersten’s sample (2005) specifically stated that they did not swear in front of adults, parents, or the elderly. Her respondents also expressed the view that children should not swear because they are unable to understand its significance, and adults should not swear in front of children because it compromises their social status. Many other authors have observed that people refrain from using swearwords in front of children (Bailey & Timm, 1976; Jay, 1992; Foote & Woodward, 1973; Staley, 1978).

When patients or nurses “transgress” these rules it is likely that the swearing behaviour would be regarded as inappropriate, and this has the potential to “widen the gap” between what the nurse thinks is acceptable and the actual behaviour. Whilst they may represent the standards for appropriate language to the majority of nurses, these rules cannot be immutable because context is a crucial moderator and there will be unusual or extreme circumstances in which they may have to be broken.
Similarly it would be possible to distil a set of rules to indicate what most nurses would consider appropriate if they were to use swearwords with patients (Figure 7.5). These rules would in effect establish or maintain therapeutic connection with patients. Unexamined is the issue of whether some nurses apply rigid rules regardless of situation: “There is no reason – it is the rules.”

<table>
<thead>
<tr>
<th>When using swearwords with patients one may use swearwords:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- of only low-level or low offensiveness</td>
</tr>
<tr>
<td>- to reflect the intensity of patient experience</td>
</tr>
<tr>
<td>- when a good rapport has been established, or to establish rapport</td>
</tr>
<tr>
<td>- to reflect the patient’s own use of language, to communicate “on their level”</td>
</tr>
<tr>
<td>- when quoting others</td>
</tr>
<tr>
<td>- to clarify meaning when a patient does not know the euphemistic term</td>
</tr>
<tr>
<td>- rarely for humorous effect</td>
</tr>
<tr>
<td>- to “close the gap” between nurse and patient</td>
</tr>
<tr>
<td>- but never in anger, or to swear “at” patients, or if use will cause offence</td>
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</tbody>
</table>

Figure 7.5 Guidelines for using swearwords with patients

7.3.5 Therapeutic pessimism

Another theme emerging was therapeutic pessimism. In reply to the question on the OAS form: “Could this incident have been prevented?”, there were over three thousand (78.64%) “no” responses without explanation; only 7% of incidents were seen as potentially preventable (Table 5.15). Further information, when provided, featured factors internal to the patients such as illness and personality as the most frequent causes. Staff reporting that an aggressive episode could have been prevented primarily made suggestions consistent with the traditional biomedical model: that is, medication, seclusion, or isolation, and changes to nursing and medical management of the patient. The changes to nursing care most frequently suggested were increases in level of observation and nursing staff numbers. There was little evidence of staff attempts to work with patients to prevent future episodes of aggression by indicating other ways of dealing with frustration and anger. However, as mentioned above, an important aspect of the “perceived to be not preventable” category was the need for nursing interventions to provide immediate care for patients in the face of their resistance.
Sharrock et al. (1990) also found that mental health staff generally made internal attributions about patients and that these were global and stable and negatively affected staff optimism. This relates to a general tendency, when circumstances are ambiguous, to attribute the cause of another’s action to the person’s own internal disposition – the “fundamental attribution error” discussed in 7.3. The present study has replicated Sharrock et al.’s finding with regard to internal attributions for aggression. The narrow range of interventions appears to be related to the attribution of internal causation (Table 5.10) and the nurse’s being powerless or unwilling to intervene. There is an apparent lack of appreciation of the importance of context, the environment and interpersonal factors which may play a role in the patient’s behaviour, and may also represent a failure in empathy and potentially widen the therapeutic “gap” between nurses and patients.

7.3.6 Discrepancies between what is felt to be deserved and what is received by nurse

Nurses’ affective response also appeared to be strongest in incidents of discrepancy between the care the nurse perceived as having been invested in the patient and perceived lack of appreciation by patient or carer. People frequently feel angry and suspect injustice if believing they have put in more than they receive (Adams, 1965; Leary & Springer, 2001), and it is assumed they will attempt to impose equity because anger and resentment will drive them to restore the “balance.” This “Equity theory” was mooted in the context of organisations and the relationships between employees, and between employees and employers, and developed from the assumption that justice is a function of the proportionality of outcomes to inputs of the person and comparative others (Adams, 1965). It was tested on nurses and did indicate that the more injustice the nurses perceived the more likely they were to react to problematic events in a destructive way (VanYperen, Hagedoorn, Zweers, & Postma, 2000).

In the present study nurses referred to being hurt and wounded by being sworn at by patients with whom they had felt they had a good relationship and had invested a great deal of emotional effort into their care. For example:

“My patient [had] cancer and refused treatment. As she was found to be able to make that decision we were treating palliatively. [The daughter of patient] 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 least want to keep patients alive. Then she said she was going to take her mother.
It is theorised that the greater the emotion and resources invested in a patient, the more hurt the nurse if sworn at in a situation where gratitude or appreciation was expected, producing a gap between expectation and outcome. To remain therapeutic in incidents such as these which produce such a strong affective response takes a great deal of insight and therapeutic effort by the nurse to avoid a reactive and non-therapeutic response that might widen the therapeutic distance between patient and nurse. The discrepancy in this case is heightened by the high level of taboo of the words addressed to the nurse in front of her patient and the patient’s husband.

7.3.7 Strong affective responses

Verbal aggression has been linked with as many as 28 non-somatic effects on nurses including anger, fear, anxiety, and guilt (Needham, Abherhalden, Halfens, Fischer, & Dassen, 2005). Swearing associated with each work situation in the questionnaire study was rated as highly distressing by the majority of respondents, and by 40-50% at the highest level of distress the instrument would allow, with 25 respondents indicating strong agreement to every question (Table 6.13). Not only did respondents rate particular situations as highly distressing but some of the examples they recounted were at the outermost limits of human behaviour. For example, the nurse dressing the hand of a child who had incurred his injury torturing a cat was subjected to high level swearwords and the child’s mother did not intervene. Many of these cases represent the extremes of human experience but may be typical of such interactions in times of stress and aggression. It required a great deal of insight and therapeutic effort for the nurse to work through possible feelings of empathic anger on behalf of the injured animal and the natural impulse to believe that justice demanded that the child’s bad language be punished by the mother, and yet maintain empathy and a therapeutic relationship with mother and child.

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 et al. (2007) found that when verbal aggression was personalised, such as when appearance or manner was attacked, nurses felt emotional distress, whereas they were not so affected when perceiving that
they were merely symbols for the “system” and the aggression was not intended personally; further (2007, p.5) 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”.

The results do not contradict the finding of another Australian study that staff found verbal aggression as distressing as physical aggression (Ilkiw-Lavalle & Grenyer, 2003). Asked to describe in detail the incident which caused them most distress, first year nurses cited incidents of which 25% involved a verbal threat (McKenna, Poole, Smith, Coverdale, & Gale, 2003). “The common thread linking the various lines of research [into verbal aggression] is the experience of some form of distress stemming from one’s reaction to receiving a perceived verbal attack” (Kinney, 1994, p.186). Felson (1993) theorised that names do hurt and can lead to anger, retaliation, and shame. Leary and Springer (2001) observed that hurt feelings are predicted by the degree to which participants feel that other people do not value the relationship or adequately appreciate them, whereas anxiety may arise from a threat, and anger from an unjustified attack; the authors noted that in a study of respondents’ narratives about hurtful events, 80% indicated having expressed anger, and over half having said something critical or nasty, to the person who had hurt them. Similarly, the most frequent justification produced by police officers for using force is disrespect or verbal challenges to their authority (Tedeschi & Bond, 2001; Westley, 1970).

Defensiveness is a common response to being sworn at, but it is therapeutically necessary to overcome the emotional impact and address the patient’s needs, conflicts, and stressors (Jay & Clermont, 1996). Nurses’ conflict management style may also affect the way in which they react to swearing. Several researchers (for example, Cavanagh, 1991; Tabak, 2007; Valentine, 2001; Vivar, 2006) have cited avoidance and compromise as the main strategies used by nurses in the face of patient swearing, Tabak adding that these methods are linked to high levels of perceived stress. Avoidance and compromise were apt descriptors of strategies used in the present study: In only one of reported cases of being upset or distressed was there an attempt to confront the patient, in this instance a reminder about the “no tolerance” policy; in all others attempts were made to placate or ignore the behaviour. It is likely that such severe distress provoked by swearing would impair nurses’ coping abilities, possibly triggering non-therapeutic intervention.
In the present study avoidance was apparent in the use of seclusion and the non-assertive means of tackling patients who swore in an aggressive manner. The nature of means of containment of aggression is important to both staff and patients, and Bowers and Brennan (2006) assert that seclusion is not the favoured management method; they further point out (p.166) that the ability of staff “to regulate their own natural emotional reactions to patients,” or emotionally self-regulate, is one of three behaviours associated with a low-conflict, high therapy inpatient psychiatric unit.

7.3.8 Emotional blunting

Not all nurses’ reported incidents of swearing mentioned distress, a minority being “pretty much immune to it,” with the swearing being “neither here nor there.” Where verbal aggression occurs at a very high frequency, nurses may become inured or conditioned to it and it is likely there will be associated trauma (Nijman et al., 1999). Similarly, whereas a swearword can strengthen the emotional content, repetitive use can cause desensitisation or habituation. The concern about habituation to situations which most nurses would find uncomfortable and frightening is that it may be accompanied by some emotional blunting; this has been termed burnout and includes depersonalisation, defined as an “unfeeling and impersonal response to recipients of one’s service” (Maslach, 1986, p.4), and emotional exhaustion which refers to the inability to empathise with patients.

Hoffman (2000, p.198) frames this process in terms of empathy, describing it as empathic over-arousal, “an involuntary process that occurs when an observer’s empathic distress becomes so painful and intolerable that it is transformed into an intense feeling of personal distress, which may move the person out of the empathic mode entirely.” This process may lead to nurses’ avoidance of patients who arouse this level of emotion in them, and also to compassion fatigue or “blaming the victim” (Hoffman, 2000). In the context of this study nurses might distance themselves psychologically in order to protect themselves from affective distress and in so doing widen the therapeutic gap between themselves and the patient.

7.3.9 Context

It is clear that the context is a crucial moderator of both the effects and perceptions of swearing. This includes the context of care, the psychopathophysiology of the patient
and the broader societal context. Swearword usage is particularly sensitive to changes in context (Jay, 1977).

Not only the style of language used, but also the relative status of the speaker and the person to whom the swearing is addressed, as well as the social distance between them, affect the perception of swearing (Allan & Burridge, 2006). Social distance includes such factors as whether they know each other, comparative ages, genders, and socioeconomic background (Allan & Burridge, 2006); and differences in these factors between the nurse and patient potentially widen the gap between the two and require that the nurse expends further therapeutic effort in order to work effectively with the patient. Context will also be discussed below in relation to “swearing” and “swearing at” (7.3.12).

7.3.10 Word offensiveness

“The obscene achieves its apparently ineradicable place by weaving together powerful elements of our biology, psychology, and social life” (Morris, 1998, p.166).

“The salient point about swearwords is that they must cause shock.” (Ludowyk, 2001, p.3). The potency of words was labelled the “naturalist hypothesis” by Frazer (1911), who described the link between an object and the name used to denote it as a real and substantial bond, not merely an arbitrary association. This explanation, although not widely accepted today, explains why people react as if a word used to denote a thing is as “dirty” or obscene as what it represents, so that people may have a strong affective response to certain swearwords, believing them to be intrinsically nasty and disturbing (Allan & Burridge, 2006). Thus the most offensive swearwords are most likely to create an affective response which may render nurses unable to deal therapeutically with the person who uses them and, although nurses may be able to articulate their rules in relation to swearing, when confronted with swearing they may reach a stage of therapeutic paralysis which affects their ability to choose from a range of therapeutic options.

Three words were deemed by respondents in this study to be the most offensive: ‘cunt’, ‘cocksucker’, and ‘motherfucker’. All the words included in the highest category of offensiveness (Table 6.15) had sexual or excretory connotations, with the possible exceptions of ‘bitch’ and ‘bastard’. As found in other studies, the most taboo words derived their offensiveness from sexual connotations; rating in offensiveness between these and words deriving their taboo from religious connotations were words associated with excretion. Echoing results of previous surveys conducted in 1998 and
2000, Ludowyk (2001) in a British study found ‘cunt’, ‘motherfucker’, ‘fuck’, and ‘wanker’ to be rated as the most highly offensive words. In the present study ‘wanker’ was rated at levels of offensiveness similar to those of ‘bloody’ and ‘bullshit’. Other studies have rated ‘shit’, ‘fuck’, ‘cunt’, and ‘motherfucker’ as the most offensive words, though varying the order of level of offensiveness (Baudhuin, 1973; Bostrom et al., 1973; Mabry, 2003).

The word ‘fuck’ almost invariably appears in the examples nurses supplied when asked in part 5 of the questionnaire to focus on one episode of swearing. Also frequently occurring were high level taboo words, such as ‘cunt’, ‘slut’, and bitch,’ reflecting the gender of the target of the swearing. Jay (1977) found that the association between word frequency and offensiveness was usually an inverse one – the greater the offensiveness the less the word was used in public, the exceptions being ‘fuck’ and ‘shit’ which accounted for about 50% of public swearing. In this study the word ‘shit’ was not rated as highly offensive; it was described by more than one respondent as a “mild” word and cited frequently as one that nurses would use with colleagues and patients. It appeared rarely in descriptions of patient swearing, and only when accompanied by higher-level taboo words. One respondent reported use with a patient of the word in a literal sense to clarify meaning.

A second group of words was perceived to be not as offensive as the first. These were labelled “emphasis” words (Table 6.15) because they are frequently used to stress a point, and depending on context, may have a negative or a positive emphasis – for example, "you bloody idiot" in contrast to "bloody beauty." The third and least offensive group of words, referred to as “everyday language,” included two Australian slang words, ‘arvo’ and ‘youse’ implying that to the respondents these low-level swearwords had a taboo-loading similar to that of slang. Three words, ‘dickhead’, ‘wanker’ and ‘bullshit’, showed some cross-loading with everyday language. One word, ‘piss’, cross-loaded between “everyday” words and the most offensive category, which indicates either that the word has two distinct uses, perhaps connotative and denotative, or that its taboo loading is contextual.

As in other studies, in the present one words with a religious connotation, ‘hell’ and ‘damn’, clustered as “emphasis” words – less offensive than the sexual excretory category but more offensive than the words which grouped in the lowest offensiveness rating which included ‘sucks’, ‘shit’ and ‘piss’, and two Australian slang terms, ‘arvo’
and ‘youse’, with minimal taboo loading. Nurses reported using words of low offensiveness with patients and colleagues such as ‘bloody’, ‘bugger’, ‘piss’, and ‘crap’ as well as ‘shit’ – frequently in conscious reflection of the patients’ language use. Only one respondent noted using a euphemism – “sugar” in the place of ‘shit’.

Respondents found “paedophile” to be extremely offensive but did not classify it in the same category as other highly offensive words. Although this word describes an act which generates much disgust and represents possibly the most serious allegation a person can face in our society and the word is highly taboo, it is not conventionally classified as a swearword so this is not a surprising result. Despite its high level of offensiveness and taboo, there is no evidence that this word is becoming a swearword (McEnery in Spinney, 2007), although the abbreviation “paedo” is used as an insult in the UK television drama “The Bill.”

The second word which did not correlate with other words was “cow.” Interestingly this word has a low taboo rating in Australia but a higher one in the UK, and (with ‘bitch’) was one of two words deriving offensiveness from animal taboo by implicitly likening a person’s characteristics to the undesirable ones of an animal; frequently these characteristics are culture-bound (Jay, 1999). Both words are usually used of women (Allan & Burridge, 2006). “Cow” may exemplify some of the differences between cultures in taboo-loading. Undoubtedly the respondents’ country of origin had a bearing on offensiveness ratings but the sample was largely homogenous: Eighty percent were born in Australia, none of whom self-identified as Aboriginal or Torres Strait Islander, and most of the sample identified as being from an Australian (n = 59, 55%), Anglo-Saxon (n = 29, 27%) or Celtic (n = 11, 10%) background (Table 6.1).

Cultural issues come into play with other words. It is interesting to note that the uniquely Australian term ‘fuckwit’ was rated as so highly offensive. Words used in Australian advertising – ‘bugger’, ‘bloody’, and ‘hell’ – were all rated in the “emphasis” category. ‘Bugger’ was famously used in a series of Toyota Hilux advertisements televised in 1998 which apparently had wide appeal (Ligerakis, 2008), and the more controversial tourism advertising campaign “So where the bloody hell are you?” caused considerable offence overseas. The offensiveness ratings applied to the various words by nurses in this study accord with the Australian Office of Film and Literature Classification Guidelines, which stipulate that a G-rated film may include the
words ‘bloody’ or ‘bugger’; at ‘PG’ level it may include ‘shit’; and at ‘M’ level it includes ‘fuck’ (Commonwealth of Australia, 2001b).

7.3.11 Denotative and connotative meanings and offensiveness

Swearwords are unique because their connotative or figurative meaning dominates the denotative or literal meaning and these two aspects of meaning are difficult to disengage (Jay, 1981). Nurses rated words used in a denotative context at a higher level of offensiveness than the same words in a connotative context; for example, “This place pisses me off” was felt to be less offensive than “I need a piss,” which supports Rieber et al.’s (1979) conclusion that swearwords used literally can be considered as harsher and more offensive than those used connotatively despite the fact that the denotative use lacks the affective loading, which almost invariably is one of disgust or dislike. McEnery (2006, p.49) has speculated that swearwords can evolve and become, essentially, strong imagery rather than a literally-meant insult, and whether a swearword intended literally — as in "I fucked her" — is less offensive than used figuratively, as in "I can't stand that fucking Dean", and if the overuse of certain terms in their connotative sense may have inured us to their emotional charge.

However, connotative usage in direct verbal aggression/personal insult was found to be as offensive as the denotative use: For example, ‘piss’ was found less offensive when used connotatively, but “piss off” was rated at an offensiveness equal to its literal use; this supports Taylor’s (personal communication, 2004) contention that the connotative use of swearwords is usually associated with a deliberate intention to be offensive or to insult, and is likely to be seen as highly offensive. This phrase is most often used in an aggressive way to “swear at” someone: Nurses throughout the study made the contextual distinction between “swearing” and “swearing at,” the latter implying an intention to insult or threaten. Again the importance of context in this study of swearing is foregrounded. A nurse in Luck et al.’s study (2007) made a similar point, emphasising the difference between patients’ use of swearwords to describe their pain and swearing directed at staff.

7.4 Definition

This study opened with a discussion of the difficulties involved in defining swearing, and foreshadowed the intention to use Andersson and Trudgill’s (1990) definition of swearing which suggests it:
a) [is] something that is taboo and/or stigmatised in the culture;

b) should not be interpreted literally;

c) can be used to express strong emotions and attitudes.

The authors contended that the word 'shit', when used as a swearword, is meant not in the literal sense but instead in an emotive sense (1990, p.53). This definition does not accord with the intuitive sense of what constitutes swearing, which would classify some words, such as 'shit', as swearwords, in whichever way they were used. This is a difficulty in nursing – patients may lack euphemisms for bodily functions and use what are widely considered to be swearwords to discuss these functions with the nurse. Respondents’ reactions to words in the questionnaire have tended to strengthen the objection to Andersson and Trudgill’s definition. They reported finding to be more offensive words used in the literal than in the figurative sense, unless the words were being used aggressively. I would therefore propose an alternative definition. Swearwords are those 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 also be used in a humorous way and can be a marker of group identity.

7.5 Implications for methodology

Of the many questionnaire studies of word offensiveness in the literature, nothing substantial has been done in an Australian context. Also college students were the subject of most of them, and many omitted context – possibly the major factor in deciding offensiveness; again, most did not distinguish between the connotative and denotative uses of particular words. This study has attempted to address these deficiencies.

The research has concentrated on the “who, what, and where” (Sandelowski, 2000) of swearing. In an attempt to answer the study questions the mixed methods design used
for this study has used multiple approaches to the creation of a rich data set that has explored the extent of the problem of swearing in a nursing environment, the impact that it has on nurses, and their perceptions of the patient and therefore on their treatment of patients. Quantitative data on the type and severity of aggressive incidents from the NSIQ study were intended to elaborate, illustrate and clarify data from the OAS. This complementary use of data has enhanced the breadth, depth and rigour of the study and demonstrated the complex interplay of factors that influence nurses’ perceptions, values, and experiences.

In the endless debate about qualitative and quantitative methods the important thing is how to “combine findings from paradigmatically distinct studies of the same phenomena in ways that preserve the integrity of both method and findings” (Bottorff, 1997, p.228). I believe the mix of qualitative and quantitative methods in this study has extended the results in a complementary way. Mixed methods research is becoming increasingly accepted as a valid research design and the underlying philosophy is frequently pragmatism (Andrew & Halcomb, 2006); pragmatists would argue that qualitative and quantitative approaches are not incompatible, that the research question drives the study and is super-ordinate to either the method of data collection or philosophy.

Mixed methods studies are subject to evaluative criteria similar to those applying to purely qualitative and quantitative approaches, but other considerations arise (Borbasi et al., 2008), of which the most pertinent for this study include addressing the potential tension between conflicting paradigms in its design and implementation, the integration of the qualitative and quantitative data, and how conflicting results are explained. Use of mixed methodology presented a challenge and required the development of skills in qualitative and quantitative research and formulation of a way to present and discuss the findings in an integrated manner rather than in parallel. The process of data analysis differed according to the method and meant that different stages were reached at different times. In the process I have sidelined the ontological and epistemological issues and taken a pragmatic approach, as Bryman (2007) suggests other mixed methods researchers do. The personal challenge was to present the findings in a way which objectively gave the qualitative and quantitative findings the appropriate weighting; the former, in the shape of exemplars and anecdotes, provided the most insight into participant perceptions and dominated my reactions to the findings. Exploration of the exceptions is frequently omitted in qualitative analysis, and it is
frequently the exceptions to patterns that may be of the most theoretical interest (Dreher, 1994). It is worth noting the themes which did not emerge: In this study there was only one explicit mention of racist or sexist language despite the prompts in the questionnaire, and there was no discussion by participants of possible cultural aspects to swearing.

7.6 Limitations

Limitations have been dealt with in some detail above (Sections 5.6 and 6.5). The main limitations are summarised here. Swearing is a highly contentious subject; some nurses who are greatly offended by swearing would probably not opt to take part in the study, skewing the results towards those less distressed by swearing. The response rate as a percentage cannot be estimated because it was impossible to ascertain the total number of nurses eligible to participate. The proposed study was advertised to a wide group of nurses; collection of demographic data on the characteristics of those who did not volunteer for comparison with nurses who chose to participate was not feasible, and they may differ in a systematic way. It is therefore not possible to speculate about whether the sample is typical of Australian nurses in general.

Whilst the sample size for both sets of methods within the research underpinning the thesis was large, they both relied on self-report. Ethical considerations proscribed the use of an observational study on interactions between nurses and patients. Sampling was a problem with both studies in the thesis. In the OAS study many units, such as the Psychiatric Emergency Centre, record many aggressive incidents via other reporting mechanisms but are minimally compliant with completing the OAS, adding to the issue of under-reporting generally.

The spectre of generalisability with regard to qualitative research ever looms. Instead of provoking this debate the term transferable can be used: It implies that the findings in one context can be transferred to similar situations or participants (Holloway & Wheeler, 2002), and application or transfer of knowledge can occur across settings when both contexts are fully understood (Guba, 1981 in Johnson, 1997). It is likely that, as a group, nurses are more exposed to and perhaps more tolerant of aberrant behaviour and language and have explanations for that language and behaviour which make it more acceptable than it would be to the general population. However, nurses’ reactions to and exposure to bad language are not unique. While nurses were the subject of this study, there is no reason to suppose that the findings would not be
generalisable to other health professionals working with similar populations. Limitations are acknowledged but they do not detract from the significance of findings which instead provide a platform for future research.

7.7 Implications for health policy, nursing practice, and education

7.7.1 Policy context

The nature of the interpretation of any incident involving swearing needs to be viewed in context and the response governed by principles for safe and therapeutic practice. Current health guidelines on verbal aggression are punitive or inconsistent: policies such as the “Zero Tolerance” policy should take into account the importance of context and distinguish between types of swearing so that staff can continue to use their professional judgment rather than using mandated predetermined consequences for all incidents of aggression. Anecdotal accounts of people being excluded from healthcare, housing, and other services abound because of their use of swearing as a habitual part of their language. It is likely that Indigenous people, those from low socio-economic groups, and young people will be disproportionately disadvantaged by such policies.

An example from a context outside nursing exemplifies the need to ensure that service users’ rights are protected by institutional polices and practices:

A social worker told me that she struggles on an almost daily basis with clients who are refused service at Centrelink because of their bad language. Service staff personalise the abuse and having internalised the “no tolerance” message, then refuse to serve them. She is frequently asked to see these “difficult clients.” One young man was referred to her because he said to the staff “why should I fucking work,” she said to him “because we are fucking paying you” and he thanked her for at last explaining the process to him.
7.7.2 Supportive working environment

This study has shown that the impact of swearing on nurses is considerable. In an extensive survey the Royal College of Nursing found five variables which contributed to nurses’ well-being. Two of these are particularly pertinent to the present discussion: They concluded that providing a safe environment where risks of assault, harassment and bullying were minimised meant that nurses were more positive about their work; equally they needed to feel protected and supported and confident that their employers take these issues seriously and will act supportively if they do suffer injury (Royal College of Nursing, 2002).

To be able to value patients nurses must value themselves (Cook, 1999), and as Ferns and Meerabeau (2008) point out the development of confidence and self-esteem are problematic in the face of strongly negative language. Being the target of personalised or angry swearing challenges a good many aspects of this idealised self, and nurses need resilience, a supportive environment, and the ability to disengage from personalising abuse in order to remain emotionally buoyant and able to remain therapeutic with patients.

7.7.3 Clinical management of swearing

There is some ambiguity in the association between swearing and verbal aggression and physical aggression. As was discussed in Section 3.8, swearing has been seen as a substitute for physical aggression enabling the expression of a strong emotional state in symbolic form without using physical aggression (Jay & Janschewitz, 2007). The more contemporary view is that it can act as an intensifier of aggression and as a portent of impending physical aggression. This association 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 to physical aggression then nurses should take proactive steps to avert a more serious incident.

What Pinker (2008) terms the hydraulic metaphor for emotion, the theory that swearing helps you let off steam or release tension, is clearly present in nurses’ attitudes towards swearing: “If they're swearing they're not usually fighting.” But the widespread agreement that swearing “can help let off steam” does not appear to be borne out by the findings of this study — that it is rare for physical violence to occur without verbal
aggression. Indeed, such an understanding may even entail risk for staff, especially if it contributes to a tendency to downplay the seriousness of an episode of verbal aggression. Moreover, verbal aggression is important because it contributes to creating a stressful environment for nurses and patients, and nurses’ perception was that swearing and verbal aggression from some patients may be the catalyst for another patient’s physical aggression; thus it is unlikely that ignoring swearing associated with anger is a safe option.

Other studies also have found a link between physical and verbal aggression: In a British study (Aiken, 1984) staff were interviewed immediately following an assault and asked to describe changes in three aspects of patient behaviour immediately prior to the incident. Of incidents of aggression reported, 81% were preceded by changes in verbal behaviour; in nearly 50% of cases this took the form of loud and/or threatening behaviour. In contrast Whittington and Patterson (1996) found that swearing, unlike high overall activity level, loud voice, and fast speech, did not more commonly appear immediately prior to assault and was not a good predictor of aggression.

7.7.4 Conflict management and de-escalation

The limited range of interventions which nurses describe in response to patient swearing suggests that nurses feel powerless and at a loss when confronted by it. One nurse stated, “I don't deal well with yelling and/or confrontation,” perhaps highlighting the apparent unease felt by the majority of nurses in dealing assertively with this behaviour evidenced by large numbers who said that they withdrew or ignored the behaviour because they had no other way of dealing with it. This contrasts with nurses who described ignoring the behaviour because they found it understandable in the context of the patient’s mental state. In the majority of cases nurses describe interventions which avoid active engagement of the patient: At one end of the spectrum they attempt to either placate or ignore the patient, at the other the patient is dealt with by coercive interventions. Passive types of behaviour (withdrawing, wishing the situation would go away, being silent, and blaming oneself) were also observed in nurses dealing with verbal aggression from their colleagues (Rowe & Sherlock, 2005), and it is likely that teaching nurses assertive conflict management would benefit their relations with both patients and colleagues. There are many therapeutic strategies nurses could substitute including the use of de-escalation techniques, with the aim of calming distressed patients and redirecting them into constructive problem solving (Wand & Coulson, 2006).
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 may warrant this type of language. When very distressed it is likely that we suffer an impoverished emotional lexicon which may lead to swearing. Whilst there is a legitimate reason 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 the finding that nurses find the literal use of such words to be as offensive as those used in anger. Treating this behaviour in the same way may mean that the patient is disadvantaged by nurses distancing themselves or acting punitively towards those whose use of such words implied no harm to the nurse and did not pose a threat to the nurse’s safety or authority.

Jay’s (2006) views about parent’s reactions to a child’s swearing might also apply to adults: When patients swear and are punished for doing so, instead of addressing the situation which led to the swearing nurses are effectively reinforcing the behaviour. Jay believes 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 to guide therapeutic reactions and their responses should be empathic and not reactionary: What is optimal is that they deal with it as a sign of underlying distress rather than emotionally reacting to the linguistic content; in other words moving from symptom to understanding.

In summary, dealing with swearing in a helpful, salutary, constructive, and patient-focused way demands a clinical understanding of the phenomenon so that nurses can engage in clinical reasoning, and distinguish when swearing is a sign of underlying distress and when it is a precursor of more serious aggression. In their comments many nurses have carefully differentiated between swearing and “swearing at”, thus appreciating when swearing was the customary manner of self-expression. It is this distinction which 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.
A recent event made me realise how much my absorption in the meta-language of swearing has shifted my perceptions.

I was the subject of a torrent of abuse by a young man in a public place. My reaction was to speculate about what had caused the outburst; its apparent randomness led me to attributing it to drug abuse, or perhaps to displaced aggression.

The women to whom I recounted the event said that they would have felt very afraid, and men that they would have attempted to humiliate him or hit him. I realised that at the time of the verbal assault I was listening with some fascination to learn how many times he could say ‘fuck’ (too many to count) and the number of synonyms he had for ‘slut’. I found this encouraging because it leads me to believe that through an awareness of the role of swearing, and the provision of a platform to talk about it, it may be possible to “swear-proof” nurses against outbursts of verbal aggression.

7.7.5 Therapeutic use of swearwords

On occasions nurses have reported thoughtfully used 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 may 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 & Schenthal, 2008)

Figure 7.6 Reflection on the therapeutic use of swearwords
7.7.6 Reflective practice

Nurses need to develop culturally appropriate practice to deal with complex behaviours such as swearing, within a professional and ethical nursing framework which acknowledges their own sense of therapeutic agency and an appreciation of nursing as therapy. Care is optimised in situations where there is a clear appreciation of patient needs and an awareness of and ability to describe the therapeutic purposes of nursing actions.

Nurses need to be perpetually aware of their role in avoiding triggers which are unlikely to lead to truly therapeutic outcomes. The concept of being mindful of the gap illustrates the need for consciousness that they could themselves exacerbate situations leading to sub-optimal outcomes, or even transgression of boundaries and actions which lead to the slippery slope of unacceptable behaviour. Nurses must have awareness of and an ability to justify the therapeutic purpose of actions and also ensure that care is never withheld as a punishment. Any intent to cause pain or suffering as punishment based on punitive judgment is unacceptable.

Self-awareness is a critical ingredient of a therapeutic relationship. Cook (1999, p.1293) noted that the English National Board for Nurses, Midwives and Health Visitors (ENB) delineates self-awareness as an awareness of one’s own “values, attitudes, prejudices, beliefs, assumptions, feelings, counter-transferences, personal motives and needs, competencies, skills and limitations.” Developing this level of self-awareness requires reflective practice. Nurses need to reflect on their own needs, behaviours, values, and attitudes and beliefs in therapeutic and professional relationships, and the extent to which these might contribute to, in this instance, escalation of aggression and exacerbation of the situation. In order to develop reflective practice nurses need to seek and be open to constructive feedback. Clinical supervision is one way of providing a framework within which nurses could begin to work through the emotions unleashed by the experiences they described.

Nurses have the responsibility to be the therapeutic agent and to act openly and creatively; that is, in a way that is mindful of the potential for widening the gap between addressing the patient’s need for a therapeutic outcome and behaviours consistent with positive therapeutic intent. It is therefore necessary to avoid behaviours likely to lead to limited or coercive interventions with inappropriate consequences for the patient, the nurse, and the ongoing relationship between them. Uppermost in nurses’ minds must
be the need to ensure that the care episode is consistent with therapeutic intent. The more care is focused on the needs of the patient, the less likely is widening of the gap between the needs of the patient and the goals of nursing care. Nurses’ judgments are the result of critical reasoning, the ability to clearly and concisely frame the problems inherent in the situation in which they and the patient are immersed; systematic thinking and exploration of reasons will provide a range of alternative actions. Care needs to be action-orientated; an understanding of motives is not part of the therapeutic process unless it is married with action.

Nurses must be able to fully and accurately interpret the patient data to make accurate clinical judgments (Facione & Facione, 1996), open-mindedly and creatively explore possible solutions to particular care situations, and fair-mindedly evaluate the most promising alternatives consistent with the best outcomes for the patient. This demands a flexible and self-reflective approach to complex behaviours such as swearing. When considering the implications for nursing responses to aggressive behaviours one is reminded of the demands on nurses, but also that they themselves must be aware of their own biases and values related to swearing. The potential for prejudices (premature and inappropriate judgments) about particular types of patients or presentations and practices is even more reason for greater reliance on self-monitoring strategies for addressing complex and professionally and personally challenging care situations: Required is reflection demonstrative of fusion of experience, reasoning, and training into appropriate judgment, which entails conscious development of sound conceptualisation of the underpinning theoretical, ethical-legal and psycho-social aspects of the situation demanding nursing intervention.

**7.7.7 Recommendations**

The study has highlighted several areas of concern and from these flow the following recommendations that:

- In accordance with the views of Ferns & Meerabeau (2008), universities and healthcare environments should prepare students and nursing staff in the management of swearing and verbal abuse. Nursing curricula in tertiary education programs must include stimulus material and learning events that enable nurses to manage both aggressive behaviour and their own negative responses to it from patients, their carers, and professional colleagues.
- Clinical supervision should be widely available for all nurses and provide opportunities to discuss complexities in patient-nurse interactions.
- Support and debriefing should be readily available for nurses who have experienced distressing levels of verbal aggression in the same way that support is available for those exposed to physical aggression. A supportive work environment can ameliorate the negative effects of workplace aggression.
- Nurses should be equipped with assertive ways of dealing with conflict within the nursing group as well as with patients. This may enable them to broaden the range of interventions for aggressive behaviour beyond restrictive measures. Interventions might include training in mindfulness. Ideally this would embrace discussion of how to deal with the emotional content of the abusive message without reacting to it.
- Nurses should become aware of the sociocultural aspects of swearing to enable them to better understand their patients.
- Health policies such as the “Zero Tolerance” policy should become more multifaceted/comprehensive in order to recognise different types of communication and reflect clinical needs of patients as well as the safety of staff.
- Given the standardised instruments used in this research were not revealing in regard to the personal characteristics of nurses and the effects of verbal aggression, further study in this area is indicated and could focus on self-esteem, hurt-proneness, and resilience in the face of swearing.

7.8 Conclusion

“The human tendency to obscene speech is as fundamental as play or prayer, with which…it seems closely connected” (Morris, 1998, p.182).

Whilst exposure to swearing by patients is a common occurrence in nursing, this is the first study to survey nurses specifically to provide evidence about their experience of swearing and being sworn at. By exploring the effects of swearing on nursing staff, their beliefs about swearing, and the meaning they put on interactions with their patients which involve swearing, this study has provided nurses with concepts, frames of reference, and models that assist them in achieving greater awareness and a better understanding of why and how adults, children, and adolescents in inpatient mental health units swear. It has also reframed the function of swearing to indicate ways of dealing with it that minimise its potential negative impact and enable nurses to continue to engage with and relate to their patients in a therapeutic manner.
This research suggests that the issue of swearing is complex and deserving of further study. The focus of this study has been on the frequency of swearing, its impact on nurses, and the implications for therapeutic practice. Future research may focus in more detail on how to deal with swearing in a manner consistent with therapeutic outcomes.

The study highlighted disturbing evidence that nurses were frequently required to deal with extremely difficult behaviour, often felt personally attacked and physically threatened, and had a narrow range of strategies to deal with the behaviour. The association between the attributions which nurses make as to the cause of swearing and verbal aggression and their subsequent management of it has been foregrounded, as has the central role of context in the understanding of and incidence of swearing.

The subject of swearing at nurses cannot be seen in isolation, and is part of a broader story about the complexities and difficulties of nursing in today’s society. Further research is warranted into how nurses who are occupationally exposed to these kinds of extreme behaviours look after themselves and whether reflective practice assists them to cope with these behaviours. The use of swearing by nurses may be a means of closing the gap between the language used by the patient and by the nurse, whilst scholarly discussion and debate about swearing may assist in closing the gap between what is talked about in academic circles and what happens in clinical practice.

Swearing is a linguistic, a social and a relational emotional phenomenon determined by context and culture. Appreciation of this has the potential to move nurses from the treatment of swearing as an aberrant behaviour to an understanding of the underlying emotional components of the phenomenon and the experiences of all those in the interaction, thus enabling nurses to develop empathy.

The implications of this study go far beyond nursing within the contexts of health services. The focus on swearing has illustrated and contemporised the health care context and the sometimes apparently adversarial nature of contact between service providers and service users. Professionals such as teachers, ambulance officers, and police as well as people in frontline positions such as social security, criminal justice, housing, and welfare organisations are subject to similar language, and finding constructive ways of dealing with swearing could potentially minimise service-providers’
stress and more importantly reduce potentially serious consequences for service users which may include marginalisation, service exclusion, and even incarceration.


Ackland, R. (2004). Radio put on notice; the kiddies might be listening. *Sydney Morning Herald*.


Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses' experience of moral distress. *Nursing Inquiry, 10*, 177-183.


Pace, D. (2005, July 5). Fletcher cops it sweet after racial slur ban, fine. *Newcastle Herald*.


APPENDICES

Appendix 1: Glossary of Statistical Symbols and Terms
Appendix 2: Overt Aggression Scale
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## Appendix 1: Glossary of statistical symbols and terms

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANOVA</td>
<td>Analysis of Variance. A test of the statistical significance of the differences among the mean scores of two or more groups on one or more variables.</td>
<td></td>
</tr>
<tr>
<td>$\chi^2$</td>
<td>chi-square test</td>
<td>The most common test for significance of the relationship between categorical variables. Used to test if there are differences in a table by comparing the observed versus the expected values.</td>
</tr>
<tr>
<td>CI</td>
<td>confidence interval</td>
<td>Interval in which the true mean or proportion is expected to lie within a given confidence level.</td>
</tr>
<tr>
<td>$r$</td>
<td>correlation statistic</td>
<td>A statistic used to measure the level of association between two variables. Pearson’s Product Moment Correlation is one of these statistics.</td>
</tr>
<tr>
<td>Cronbach’s alpha</td>
<td>The most common internal consistency measure, usually interpreted as the mean of all possible split-half coefficients.</td>
<td></td>
</tr>
<tr>
<td>$df$</td>
<td>Degrees of freedom</td>
<td>Value associated with a statistical test that is used to determine the level of significance; this value is dependent on the number of cases and/or number of samples utilised in the statistical test.</td>
</tr>
<tr>
<td>$\lambda$</td>
<td>Eigenvalue</td>
<td>The variance in a set of variables explained by a factor or component. An eigenvalue is the sum of squared values in the column of a factor matrix. The eigenvalues equal the sum of the column of squared loadings for each factor in a factor analysis.</td>
</tr>
<tr>
<td>$\eta^2$</td>
<td>eta squared</td>
<td>Eta squared and partial eta squared are effect size measures for the association between a predictor and response variable.</td>
</tr>
<tr>
<td>$\eta_p^2$</td>
<td>partial eta squared</td>
<td></td>
</tr>
<tr>
<td>Kendall’s tau-b</td>
<td>A measure of correlation between two ordinal-level variables; used to measure the strength of association of the cross tabulations.</td>
<td></td>
</tr>
<tr>
<td>$F$</td>
<td>$F$-statistic</td>
<td>The test used in ANOVA to determine if a predictor variable has a significant effect.</td>
</tr>
<tr>
<td>Mann-Whitney test</td>
<td>The Mann-Whitney test, also called the rank sum test, is a nonparametric test that compares two unpaired groups to assess whether they come from</td>
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</tr>
<tr>
<td>Symbol</td>
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<tr>
<td></td>
<td>McNemar-Bowker test</td>
<td>McNemar's test is a non-parametric method used on nominal data to determine whether the row and column marginal frequencies are equal. For tables with more than two rows and columns, it is called the McNemar-Bowker test of symmetry.</td>
</tr>
<tr>
<td>$M$</td>
<td>mean</td>
<td>The average of all scores reported in the sample or category.</td>
</tr>
<tr>
<td>$r$</td>
<td>Pearson product moment correlation coefficient</td>
<td>A measure of the degree of linear relationship between two variables. It ranges from +1 to -1.</td>
</tr>
<tr>
<td></td>
<td>Principal components analysis (PCA)</td>
<td>Designed to capture the variance in a dataset in terms of principal components. In PCA the original variables are turned into a smaller set of linear combinations with all the variance in the variables being used.</td>
</tr>
<tr>
<td>$p$</td>
<td>probability value</td>
<td>The probability that a statistical result would occur by chance if a NULL hypothesis was true. A probability value less than .05 (i.e., $p &lt; .05$) would suggest that the probability of obtaining observed scores by chance would occur fewer than 5 out of 100 times.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therefore, when probability values are less than .05, observed scores can be described as “significantly different” since the likelihood of obtaining these observed scores by chance alone is minute.</td>
</tr>
<tr>
<td>$N$</td>
<td>sample size</td>
<td>Total number in sample</td>
</tr>
<tr>
<td>$SD$</td>
<td>standard deviation</td>
<td>A measure of the spread/dispersion of scores around the mean score.</td>
</tr>
<tr>
<td>sem</td>
<td>Standard error of least squares means</td>
<td></td>
</tr>
<tr>
<td>$\rho$</td>
<td>Spearman’s rho</td>
<td>Spearman’s rho is a measure of the linear relationship between two variables. It differs from Pearson’s correlation only in that the computations are done after the numbers are converted to ranks. It is used when the variables are not normally distributed.</td>
</tr>
<tr>
<td>Symbol</td>
<td>Term</td>
<td>Description</td>
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<td>--------</td>
<td>------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>$N$</td>
<td>sub-sample size</td>
<td>Total number in sub-sample</td>
</tr>
<tr>
<td>$t$</td>
<td>$t$-test statistic</td>
<td>A statistical test used to determine whether the difference between two sample means is significantly different. Two variations of this test have been utilised in this thesis: 1. <em>Independent Samples $t$-test</em>: compares the mean scores on a single variable from two different samples. 2. <em>Paired Samples $t$-test</em>: compares the mean difference of scores on a single sample.</td>
</tr>
</tbody>
</table>
Appendix 2: Overt Aggression Scale

XXXX Mental Health Service

Attach ID Label

Name:  Clinicians Name:

MRN #  Signature:

Overt Aggression Scale* (modified)

Date ……/……/.....      Time……………..AM/PM      Duration……………..

Location……………………...  

Please check the category that is most applicable.

1. **Verbal Aggression**
   - b. Yells mild personal insults eg. “You’re stupid.”
   - c. Curses viciously, uses foul language in anger, makes moderate threats to self and others.
   - d. Makes clear threats of violence towards others or self eg. “I’m going to kill you” or requests help to control self.

2. **Physical Aggression Against Objects**
   - a. Slams doors, scatters clothing, makes a mess.
   - b. Throws objects down, kicks furniture without breaking it.
   - c. Breaks objects, smashes windows
   - d. Sets fires, throws objects dangerously.

3. **Physical Aggression Against Self**
   - a. Picks or scratches skin, hits self, pulls hair with no or minor injury only.
   - b. Bangs head, fists onto objects, throws self onto floor or into objects (hurts self without serious injury).
   - c. Small cuts or bruises, minor burns.
   - d. Mutilates self, causes deep cuts, bites that bleed, internal injury, fracture, loss of consciousness, loss of teeth.

4. **Physical Aggression Against Other People**
   - a. Makes threatening gestures, swings at people, grabs clothing.
   - b. Strikes, kicks, pushes, pulls hair without injury to person.
   - c. Attacks others causing mild/moderate physical injury (bruises, sprains, welts).
   - d. Attacks others causing severe physical injury (broken bones, deep lacerations, internal injury)

5. **Interventions**
   - a. None.
   - b. Talking to patient.
   - c. Closer observation.
   - d. Physical restraint.
   - e. Immediate oral medication.
   - f. Immediate IMI medication.
   - g. Isolation or segregation.
   - h. Seclusion.
   - i. Medical attention for perpetrator.
   - j. Medical attention for victim.
   - k. Other

6. **Motivation**
   - a. Material gain.
   - b. Provocation.
   - c. Psychosis.
   - d. Self defence.
   - e. Unknown.
   - f. Other

Could this incident have been prevented?
IF YES Please comment

_________________________________________
_________________________________________
_________________________________________
_________________________________________

Additional comments:

_________________________________________
_________________________________________
_________________________________________
_________________________________________

7 July 2005

Professor M Hazeldon
School of Nursing and Midwifery
University of Newcastle

Dear Professor Hazeldon

Re: Swearing and Therapeutic Alliance in a Nursing Context: The Therapeutic Implications of Swearing (05/04/13/3.17)

The above protocol was reviewed by the Hunter Area Research Ethics Committee and the University of Newcastle's Human Research Meeting at their meetings held on 13 April 2005 and 20 April 2005 respectively. After the receipt of the requested clarifications and changes to the questionnaire, interview format for the telephone interview, flyers and information sheets the Hunter Area Research Ethics Committee has resolved that

the protocol Swearing and Therapeutic Alliance in a Nursing Context: The Therapeutic Implications of Swearing, the questionnaire (version 2 dated 16 June 2005), the interview format for telephone interviews (version 3 dated 30 April 2005), the information sheet for nurse participants (version 5 dated 30 June 2005), the consent form for nurse participants (version 2 dated 19 March 2005) and the information sheet for the pilot study (version 4 dated 30 June 2005). You may commence your research.

The University of Newcastle Human Research Ethics Committee will issue a separate certification of approval for the above protocol.

Approval from the Hunter Area Research Ethics Committee for the above protocol is given for a maximum of 3 years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

The National Statement on Ethical Conduct in Research Involving Humans, (1999), which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- a report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is July 2006. A proforma for the annual report will be sent two weeks prior to the due date.
- A final report be submitted at the completion of the above protocol, that is after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.
• All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

• The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
  - any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure.
  - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.
  - Copies of serious adverse event reports from other sites should be sent to the Hunter New England Human Research Ethics Committee for review as soon as possible after being received.
  - Serious adverse events are defined as:
    - Causing death, life threatening or serious disability.
    - Cause or prolong hospitalisation.
    - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.
    - unforeseen events that might affect continued ethical acceptability of the project.

• If for some reason the above protocol does not commence (for example it does not receive funding), is suspended or discontinued, please inform Dr Nicole Gerrand, the Professional Officer of the Hunter New England Human Research Ethics Committee as soon as possible.

The Hunter New England Human Research Ethics Committee also has delegated authority to approve the commencement of this research on behalf of the Hunter New England Area Health Service. This research may therefore commence.

Should you have any queries about your project please contact Dr Nicole Gerrand as per her contact details at the top of the previous page. The Hunter New England Human Research Ethics Committee Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Hunter New England Area Health Service website:


Internet address is: http://www.hnehealth.nsw.gov.au/ethics/researchethics.htm
PERMISSION TO USE THE ATTRIBUTIONAL STYLE QUESTIONNAIRE

The Attributional Style Questionnaire (ASQ) is copyrighted material and may only be used with the written permission of the author, Dr. Martin E.P. Seligman. This letter grants you permission to use the ASQ, so please keep it on file. The questionnaire may be used only for academic research or by a clinical psychologist for the diagnosis or treatment of patients. It may not be used for profit or for any corporate-related activities.

Sincerely,

[Signature]

Martin E.P. Seligman
Nursing Swearing Impact Questionnaire

Thank you for agreeing to complete this questionnaire. This study will examine the impact of swearing on nursing staff.

WARNING: THIS QUESTIONNAIRE CONTAINS STRONG LANGUAGE THAT MAY OFFEND SOME READERS.

About this questionnaire:

How long is this questionnaire?

The questionnaire contains three standardised instruments which will take you up to 35 minutes to complete and the Nursing Swearing Impact Questionnaire will take approximately thirty minutes. We would really appreciate it if you could complete all of it. It is quite okay to take a break and complete the questionnaire later.

Is this a test I can fail?

There are no right or wrong answers. We just want to know what you think.

Who is carrying out the research?

The research is being conducted by Teri Stone, Clinical Nurse Consultant for the Child and Adolescent Mental Health Statewide Network (CAMHSNET) (northern) under the supervision of Professor Michael Hazelton, Professor of Mental Health Nursing, Professor Kenneth Nunn, Director of CAMHSNET and Professor of Child Psychiatry at the University of Newcastle, and Dr Sandra Heriot, Statewide Director of Allied Health and Clinical Research, CAMHSNET.

What about confidentiality?

Any information or personal details gathered in the course of this research are confidential. We will code your questionnaire with an ID number – not your name.

Who will read what I write?

Only those in the research team have access to the data.

Why do research about swearing?

Nurses are a prime target of swearing and there has been no research on how nurses deal with this.

What if I find some words very offensive?

You do not have to answer every question if you don’t want to. Please contact Teri Stone on 02 49855817 if you have questions or need to talk about any aspect of the research. If the questionnaire evokes negative feelings you are encouraged to access the Employee Assistance Programme (02 49853289).

This research has been reviewed and approved by the Hunter Area Research Ethics Committee, Reference No. XXXX/XXX and the University of Newcastles Human Research Ethics Committee Approval No. XXXXXX.

Should you have any concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher or their supervisor, or if an independent person is preferred to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcast­le, University Drive Callaghan NSW 2308, telephone 02 49216333, email: Human-Ethics@newcastle.edu.au or to Dr Nicole Gerrand, Professional Officer, Hunter Area Research Ethics Committee, Hunter Health, Locked Bag 1, New Lambton NSW 2305, telephone 02 49214950, email: Nicole.Gerrand@hunter.health.nsw.gov.au.

Version 2, 23-03-05
Nursing Swearing Impact Questionnaire
Part 1

1. Age: _______  
2. Gender: Male ☐  Female ☐

3. Country of birth: 
4. Ethnicity: 

5. Years of residence in Australia (if born overseas): _______

6. Were you brought up in a particular religion or religious denomination? 
   Yes ☐  No ☐  If “yes” which? __________________________

7. Are you currently affiliated with an organised religion? 
   Yes ☐  No ☐  If “yes” which? __________________________

8. Employment details: 
   1. Enrolled Nurse ☐  5. Nurse Unit Manager ☐
   2. Registered Nurse ☐  6. Nurse Manager ☐
   3. Clinical Nurse Specialist ☐  7. Other (specify) ☐
   4. Clinical Nurse Consultant ☐

9. Which is the highest qualification you have gained? 
   1. Single nursing certificate ☐  4. Bachelor’s Degree ☐
   2. Multiple nursing certificates ☐  5. Master’s degree ☐
   3. Diploma ☐  6. Other (specify) ☐

10. Years of nursing experience: ____

11. Years of mental health nursing experience: ____

12. Usual area of work (tick one only): 
   1. Paediatrics ☐
   2. Child and adolescent mental health ☐
   3. Adult generalist ☐
   4. Adult mental health ☐
   5. Other (specify) ☐

13. Average hours worked per week: _______

14. Training in dealing with aggression: 
   1. No training in aggression management ☐
   2. Aggression minimisation training ☐
   3. PMVA (4-day course) ☐
   4. Other (specify) ☐

Version 4, 30-04-05
Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past. It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

<table>
<thead>
<tr>
<th>Question</th>
<th>Better than usual</th>
<th>Same as usual</th>
<th>Less than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 — been able to concentrate on whatever you’re doing?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 — lost much sleep over worry?</td>
<td>Not at all</td>
<td></td>
<td>Rather more than usual</td>
<td></td>
</tr>
<tr>
<td>3 — been having restless, disturbed nights?</td>
<td>Not at all</td>
<td></td>
<td>Rather more than usual</td>
<td></td>
</tr>
<tr>
<td>4 — been managing to keep yourself busy and occupied?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Rather less than usual</td>
<td>Much less than usual</td>
</tr>
<tr>
<td>5 — been getting out of the house as much as usual?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less than usual</td>
<td>Much less than usual</td>
</tr>
<tr>
<td>6 — been managing as well as most people would in your shoes?</td>
<td>Better than most</td>
<td>About the same</td>
<td>Rather less well</td>
<td>Much less well</td>
</tr>
<tr>
<td>7 — felt on the whole you were doing things well?</td>
<td>Better than usual</td>
<td>About the same</td>
<td>Less well than usual</td>
<td>Much less well</td>
</tr>
<tr>
<td>8 — been satisfied with the way you’ve carried out your task?</td>
<td>More satisfied</td>
<td>About same as usual</td>
<td>Less satisfied than usual</td>
<td>Much less satisfied</td>
</tr>
<tr>
<td>9 — been able to feel warmth and affection for those near to you?</td>
<td>Better than usual</td>
<td>About same as usual</td>
<td>Less well than usual</td>
<td>Much less well</td>
</tr>
<tr>
<td>10 — been finding it easy to get on with other people?</td>
<td>Better than usual</td>
<td>About same as usual</td>
<td>Less well than usual</td>
<td>Much less well</td>
</tr>
<tr>
<td>11 — spent much time chatting with people?</td>
<td>More time than usual</td>
<td>About same as usual</td>
<td>Less time than usual</td>
<td>Much less than usual</td>
</tr>
<tr>
<td>12 — felt that you are playing a useful part in things?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less useful than usual</td>
<td>Much less useful</td>
</tr>
<tr>
<td>13 — felt capable of making decisions about things?</td>
<td>More so than usual</td>
<td>Same as usual</td>
<td>Less so than usual</td>
<td>Much less capable</td>
</tr>
</tbody>
</table>

PLEASE TURN OVER
<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>No more than usual</th>
<th>Rather more than usual</th>
<th>Much more than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 — felt constantly under strain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 — felt you couldn’t overcome your difficulties?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 — been finding life a struggle all the time?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 — been able to enjoy your normal day-to-day activities?</td>
<td>More so</td>
<td>Same</td>
<td>Less so</td>
<td>Much less</td>
</tr>
<tr>
<td>18 — been taking things hard?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 — been getting scared or panicky for no good reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 — been able to face up to your problems?</td>
<td>More so</td>
<td>Same</td>
<td>Less able</td>
<td>Much less</td>
</tr>
<tr>
<td>21 — found everything getting on top of you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 — been feeling unhappy and depressed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 — been losing confidence in yourself?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 — been thinking of yourself as a worthless person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 — felt that life is entirely hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 — been feeling hopeful about your own future?</td>
<td>More so</td>
<td>About same</td>
<td>Less so</td>
<td>Much less</td>
</tr>
<tr>
<td>27 — been feeling reasonably happy, all things considered?</td>
<td>More so</td>
<td>About same</td>
<td>Less so</td>
<td>Much less</td>
</tr>
<tr>
<td>28 — been feeling nervous and strung-up all the time?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 — felt that life isn’t worth living?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 — found at times you couldn’t do anything because your nerves were too bad?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ATTRIBUTIONAL STYLE QUESTIONNAIRE

Directions:
1) Read each situation and vividly imagine it happening to you.
2) Decide what you believe to be the one major cause of the situation if it happened to you.
3) Write this cause in the blank provided.
4) Answer the questions about the cause by circling one number per question. Do not circle the words.
5) Go on to the next situation.

SITUATIONS

YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE.

1. Write down the one major cause: ____________________________

2. Is the cause of your friend's compliment due to something about you or something about other people or circumstances?
   Totally due to other people or circumstances
   1 2 3 4 5 6 7
   Totally due to me

3. In the future, when you are with your friend, will this cause again be present?
   Will never again be present
   1 2 3 4 5 6 7
   Will always be present

4. Is the cause something that just affects interacting with friends, or does it also influence other areas of your life?
   Influences just this particular situation
   1 2 3 4 5 6 7
   Influences all situations in my life

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME.

5. Write down the one major cause: ____________________________

6. Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?
   Totally due to other people or circumstances
   1 2 3 4 5 6 7
   Totally due to me

7. In the future, when looking for a job, will this cause again be present?
   Will never again be present
   1 2 3 4 5 6 7
   Will always be present

8. Is the cause something that just influences looking for a job, or does it also influence other areas of your life?
   Influences just this particular situation
   1 2 3 4 5 6 7
   Influences all situations in my life

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YOU BECOME VERY RICH.

9. Write down the one major cause:


10. Is the cause of your becoming rich due to something about you or something about other people or circumstances?

   Totally due to other people or circumstances 1 2 3 4 5 6 7
   Totally due to me

11. In the future, will this cause again be present?

   Will never again be present 1 2 3 4 5 6 7
   Will always be present

12. Is the cause something that just affects obtaining money, or does it also influence other areas of your life?

   Influences just this particular situation 1 2 3 4 5 6 7
   Influences all situations in my life

A FRIEND COMES TO YOU WITH A PROBLEM AND YOU DON'T TRY TO HELP HIM/HER.

13. Write down the one major cause:


14. Is the cause of your not helping your friend due to something about you or something about other people or circumstances?

   Totally due to other people or circumstances 1 2 3 4 5 6 7
   Totally due to me

15. In the future, when a friend comes to you with a problem, will this cause again be present?

   Will never again be present 1 2 3 4 5 6 7
   Will always be present

16. Is the cause something that just affects what happens when a friend comes to you with a problem, or does it also influence other areas of your life?

   Influences just this particular situation 1 2 3 4 5 6 7
   Influences all situations in my life
YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE REACTS NEGATIVELY.

17. Write down the **one** major cause:


18. Is the cause of audience's negative reaction due to something about you or something about other people or circumstances?

| Totally due to other people or circumstances | 1 2 3 4 5 6 7 | Totally due to me |

19. In the future when you give talks, will this cause again be present?

| Will never again be present | 1 2 3 4 5 6 7 | Will always be present |

20. Is the cause something that just influences giving talks, or does it also influence other areas of your life?

| Influences just this particular situation | 1 2 3 4 5 6 7 | Influences all situations in my life |

YOU DO A PROJECT WHICH IS HIGHLY PRaised.

21. Write down the **one** major cause:


22. Is the cause of your being praised due to something about you or something about other people or circumstances?

| Totally due to other people or circumstances | 1 2 3 4 5 6 7 | Totally due to me |

23. In the future when you do a project, will this cause again be present?

| Will never again be present | 1 2 3 4 5 6 7 | Will always be present |

24. Is the cause something that just affects doing projects, or does it also influence other areas of your life?

| Influences just this particular situation | 1 2 3 4 5 6 7 | Influences all situations in my life |
YOU MEET A FRIEND WHO ACTS HOSTILELY TOWARDS YOU.

25. Write down the one major cause:

________________________________________________________________________

26. Is the cause of your friend acting hostile due to something about you or something about other people or circumstances?

<table>
<thead>
<tr>
<th>Totally due to other people or circumstances</th>
<th>1 2 3 4 5 6 7</th>
<th>Totally due to me</th>
</tr>
</thead>
</table>

27. In the future when interacting with friends, will this cause again be present?

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1 2 3 4 5 6 7</th>
<th>Will always be present</th>
</tr>
</thead>
</table>

28. Is the cause something that just influences interacting with friends, or does it also influence other areas of your life?

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1 2 3 4 5 6 7</th>
<th>Influences all situations in my life</th>
</tr>
</thead>
</table>

YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU.

29. Write down the one major cause:

________________________________________________________________________

30. Is the cause of your not getting the work done due to something about you or something about other people or circumstances?

<table>
<thead>
<tr>
<th>Totally due to other people or circumstances</th>
<th>1 2 3 4 5 6 7</th>
<th>Totally due to me</th>
</tr>
</thead>
</table>

31. In the future when doing work that others expect, will this cause again be present?

<table>
<thead>
<tr>
<th>Will never again be present</th>
<th>1 2 3 4 5 6 7</th>
<th>Will always be present</th>
</tr>
</thead>
</table>

32. Is the cause something that just affects doing work that others expect of you, or does it also influence other areas of your life?

<table>
<thead>
<tr>
<th>Influences just this particular situation</th>
<th>1 2 3 4 5 6 7</th>
<th>Influences all situations in my life</th>
</tr>
</thead>
</table>
YOUR SPOUSE (BOYFRIEND/GIRLFRIEND) HAS BEEN TREATING YOU MORE LOVINGLY.

33. Write down the one major cause: ________________________________________

34. Is the cause of your spouse (boyfriend/girlfriend) treating you more lovingly due to something about you or something about other people or circumstances?
   Totally due to other people or circumstances 1 2 3 4 5 6 7
   Totally due to me

35. In future interactions with your spouse (boyfriend/girlfriend), will this cause again be present?
   Will never again be present 1 2 3 4 5 6 7
   Will always be present

36. Is the cause something that just affects how your spouse (boyfriend/girlfriend) treats you, or does it also influence other areas of your life?
   Influences just this particular situation 1 2 3 4 5 6 7
   Influences all situations in my life

YOU APPLY FOR A POSITION THAT YOU WANT VERY BADLY (E.G., IMPORTANT JOB, GRADUATE SCHOOL ADMISSION, ETC.) AND YOU GET IT.

37. Write down the one major cause: ________________________________________

38. Is the cause of your getting the position due to something about you or something about other people or circumstances?
   Totally due to other people or circumstances 1 2 3 4 5 6 7
   Totally due to me

39. In the future when you apply for a position, will this cause again be present?
   Will never again be present 1 2 3 4 5 6 7
   Will always be present

40. Is the cause something that just influences applying for a position, or does it also influence other areas of your life?
   Influences just this particular situation 1 2 3 4 5 6 7
   Influences all situations in my life
YOU GO OUT ON A DATE AND IT GOES BADLY.

41. Write down the one major cause:

42. Is the cause of the date going badly due to something about you or something about other people or circumstances?
   
   Totally due to other people or circumstances 1 2 3 4 5 6 7  
   Totally due to me

43. In the future when you are dating, will this cause again be present?
   
   Will never again be present 1 2 3 4 5 6 7  
   Will always be present

44. Is the cause something that just influences dating, or does it also influence other areas of your life?
   
   Influences just this particular situation 1 2 3 4 5 6 7  
   Influences all situations in my life

YOU GET A RAISE.

45. Write down the one major cause:

46. Is the cause of your getting a raise due to something about you or something about other people or circumstances?
   
   Totally due to other people or circumstances 1 2 3 4 5 6 7  
   Totally due to me

47. In the future on your job, will this cause again be present?
   
   Will never again be present 1 2 3 4 5 6 7  
   Will always be present

48. Is the cause something that just affects getting a raise, or does it also influence other areas of your life?
   
   Influences just this particular situation 1 2 3 4 5 6 7  
   Influences all situations in my life
1. Children get into trouble because their parents punish them too much. The trouble with most children nowadays is that their parents are too easy with them. 

2. Many of the unhappy things in people’s lives are partly due to bad luck. People’s misfortunes result from the mistakes they make.

3. One of the major reasons why we have wars is because people don’t take enough interest in politics. There will always be wars, no matter how hard people try to prevent them.

4. In the long run people get the respect they deserve in this world. Unfortunately, an individual’s worth often passes unrecognized no matter how hard he tries.

5. The idea that teachers are unfair to students is nonsense. Most students don’t realize the extent to which their grades are influenced by accidental happenings.

6. Without the right breaks one cannot be an effective leader. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. No matter how hard you try some people just don’t like you. People who can’t get others to like them don’t understand how to get along with others.

8. Heredity plays the major role in determining one’s personality. It is one’s experiences in life which determine what they’re like.

9. I have often found that what is going to happen will happen. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. In the case of the well prepared student there is rarely if ever such a thing as an unfair test. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. Becoming a success is a matter of hard work, luck has little or nothing to do with it. Getting a good job depends mainly on being in the right place at the right time.

12. The average citizen can have an influence in government decisions. This world is run by the few people in power, and there is not much the little guy can do about it.

13. When I make plans, I am almost certain that I can make them work. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. There are certain people who are just no good. There is some good in everybody.
15. In my case getting what I want has little or nothing to do with luck.  
   Many times we might just as well decide what to do by flipping a coin.  

16. Who gets to be the boss often depends on who was lucky enough to be in the right place first.  
   Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.  

17. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.  
   By taking an active part in political and social affairs the people can control world events.  

18. Most people don’t realize the extent to which their lives are controlled by accidental happenings.  
   There really is no such thing as “luck.”  

19. One should always be willing to admit mistakes.  
   It is usually best to cover up one’s mistakes.  

20. It is hard to know whether or not a person really likes you.  
   How many friends you have depends upon how nice a person you are.  

21. In the long run the bad things that happen to us are balanced by the good ones.  
   Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.  

22. With enough effort we can wipe out political corruption.  
   It is difficult for people to have much control over the things politicians do in office.  

23. Sometimes I can’t understand how teachers arrive at the grades they give.  
   There is a direct connection between how hard I study and the grades I get.  

24. A good leader expects people to decide for themselves what they should do.  
   A good leader makes it clear to everybody what their jobs are.  

25. Many times I feel that I have little influence over the things that happen to me.  
   It is impossible for me to believe that chance or luck plays an important role in my life.  

26. People are lonely because they don’t try to be friendly.  
   There’s not much use in trying too hard to please people, if they like you, they like you.  

27. There is too much emphasis on athletics in high school.  
   Team sports are an excellent way to build character.  

28. What happens to me is my own doing.  
   Sometimes I feel that I don’t have enough control over the direction my life is taking.  

29. Most of the time I can’t understand why politicians behave the way they do.  
   In the long run the people are responsible for bad government on a national as well as on a local level.
Nursing Swearing Impact Questionnaire
Part 3

18. Do you use swear words with work colleagues?
   Please comment on your answer:

0 1 2 3

19. Do you use swear words with patients?
   Please comment on your answer:

0 1 2 3

20. Do you use swear words with people you usually go out with socially?
   Please comment on your answer:

0 1 2 3

21. Do you use swear words at home?
   Please comment on your answer:

0 1 2 3

22. Do you use swear words when you are by yourself?
   (for example, if you stub your toe)
   Please comment on your answer:

0 1 2 3

Thank you for continuing to answer this questionnaire. You are now a third of the way through!

WARNING: THE FOLLOWING PAGES CONTAIN STRONG LANGUAGE
People may find that certain words offend them, so their use may be confined to certain contexts or company.

### 23. Please indicate how offensive you consider the following if the word was said to you (please circle)

<table>
<thead>
<tr>
<th>Word</th>
<th>Not offensive at all</th>
<th>A little offensive</th>
<th>Moderately offensive</th>
<th>Very offensive</th>
<th>Extremely offensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arsehole</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Arvo</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Asshole</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bastard</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bitch</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bloody</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bugger</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bullshit</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cunt</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cock sucker</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Cow</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Crap</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Damn</td>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Dickhead</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Fuck</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Fuckwit</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Hell</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Motherfucker</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Paedophile</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Piss</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Prick</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Shit</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Slut</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Sucks</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Youse</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Wanker</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### 24. On average would you use this word:

<table>
<thead>
<tr>
<th>Word</th>
<th>With Patients</th>
<th>With Other</th>
<th>In A Social Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arsehole</td>
<td>0 1 2 3 4 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arvo</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asshole</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bastard</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bitch</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloody</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bugger</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bullshit</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cunt</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cock sucker</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cow</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crap</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Damn</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dickhead</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuck</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuckwit</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hell</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motherfucker</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paedophile</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Piss</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prick</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shit</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slut</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sucks</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youse</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanker</td>
<td>0 1 2 3 0 1 2 3 0 1 2 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 25. In your opinion should any words be deleted from this group because you do not consider them swear words? If so which?

In your opinion should any words be added to this group? If so which?

*Please add further comments if you wish:*
27. Please indicate how offensive you consider the following statements (please circle)

0: Not offensive at all  
1: A little offensive  
2: Moderately offensive  
3: Very offensive  
4: Extremely offensive

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not offensive</th>
<th>Moderately offensive</th>
<th>Extremely offensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;God, it’s hot&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Christ, it’s hot&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Hell, it’s hot&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Jesus, it’s hot&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Jesus Christ, it’s hot&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;This place is crap&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;This place sucks&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;This place shits me&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;This place gets to me&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;This place pisses me off&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;I need a pee&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;I need a wee&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;I need a shit&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;I need a piss&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;I need a crap&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Piss off&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Bugger off&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Rack off&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Fuck off&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Shove off&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;My arsehole is sore&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;My prick is sore&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;My cunt is sore&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;You prick&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;You cunt&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;You arsehole&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;He’s a nitwit&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;He’s a halfwit&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;He’s a dumbwit&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;He’s a fuckwit&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the nigger in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the Abo in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the boong in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the Koori in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the wog in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the bastard in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Nurse, the motherfucker in the next bed wants a drink&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Please add further comments on the above if you wish.
28. Do you have any personal “rules” about swearing?

Yes ☐ No ☐

If ‘Yes’ please briefly outline what rules you have:

29. Is there a type of person you think should not use swear words?

Yes ☐ No ☐ Unsure ☐

If ‘Yes’ who do you think should not use swear words?

30. Please indicate whether or not you agree with the following statements by circling the appropriate number:

<table>
<thead>
<tr>
<th>Statement</th>
<th>0 strongly agree</th>
<th>1 agree</th>
<th>2 undecided</th>
<th>3 disagree</th>
<th>4 strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I don’t approve of swearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who swear sound stupid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing is an important feature of my speaking style</td>
<td></td>
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</tr>
<tr>
<td>I feel comfortable with my use of swear words</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing can make communication more effective and meaningful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are certain swear words that people should not use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing is rude and disrespectful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing at nurses should not be tolerated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing can allow patients to safely let off steam and reduce the likelihood of their resorting to physical violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing can establish and maintain effective communication with certain patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing can allow you to safely let off steam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t like to hear swear words in movies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t like to hear swear words in song lyrics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t like to hear swear words on television</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t like to see swear words in print</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a work situation swearing associated with threats is distressing to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a work situation swearing associated with physical aggression is distressing to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a work situation swearing associated with personally demeaning comments is distressing to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a work situation being sworn at repeatedly is distressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a work situation being sworn at by a patient’s relatives or carer is distressing to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a work situation being sworn at by another staff member is distressing to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swearing by patients is always a precursor of physical violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please add further comments on Q.30 if you wish:

31. Do you use swear words to hurt or offend people?

<table>
<thead>
<tr>
<th></th>
<th>never</th>
<th>rarely</th>
<th>sometimes</th>
<th>often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
32. Briefly outline the most distressing experience you have had when a patient or carer swore at you.

33. What was it about this episode that made it so distressing?

34. How many times in the last week were you sworn at by a patient or carer? Was this a typical week? Please comment:

35. How many times in the last week were you sworn at by a member of staff? Was this a typical week? Please comment:

36. How many times in the last week did staff swear in your hearing? Was this a typical week? Please comment:

37. Briefly outline an occasion when you used swearing with a patient in a therapeutic way (eg "getting on side", reflecting feelings).
Nursing Swearing Impact Questionnaire
Part 5

In this section we want to focus on the details of at least one specific episode of swearing that may have happened at work. If you are in a position to provide more than one example, please note that an additional sheet has been provided.

38. Please describe the context:

39. What exactly was said?

40. Was the swearing episode prolonged?  
   Yes [ ]  No [ ]

41. Please describe the speaker in general terms without identifying the individual (including age, gender and diagnosis).

42. Who else was there (for example, other staff, patients, family members)?

43. What do you think was their reason for swearing? (tick one only)
   1. No understandable provocation  
      swearing occurs for no obvious reason
   2. Other patients  
      results from provocation by other patients
   3. Psychosis  
      responding to voices etc
   4. Administering medication  
      response to staff encouraging medication
   5. Patient denied something  
      swearing as a result of frustration etc
   6. Asked to do something  
      swearing results from patient’s reluctance to comply with request
   7. Conversation  
      swearing occurs in a conversational context
   8. Good humour  
      swearing occurs in a joking way
   9. Distressed  
      swearing results from patient being depressed or very upset
   10. Other (please comment) [ ]

   Comments: _____________________________________________________________

44. What was the tone? (tick one only)
   1. Anecdotal  
      in good-humoured story-telling manner
   2. Angry  
      expressing annoyance or irritation
   3. Distressed  
      sad, miserable, very upset
   4. Excited  
      enthusiastic, animated
   5. Humorous  
      joking, amusing manner
   6. Rebellious  
      resistive, defiant, disobedient manner
   7. Sarcastic  
      derisive, mocking, scornful, cynical manner
   8. Threat  
      stated intention to inflict harm
   9. Other (please comment) [ ]

   Comments: _____________________________________________________________
At last …

you have finished! Thank you for completing this questionnaire. Your participation and cooperation are greatly appreciated. Please put your completed questionnaire in the attached envelope and place in the internal mail.
Nursing Swearing Impact Questionnaire
Part 5

Sheet 2.

38. Please describe the context:

39. What exactly was said?

40. Was the swearing episode prolonged? Yes [ ] No [ ]

41. Please describe the speaker in general terms without identifying the individual (including age, gender and diagnosis).

42. Who else was there (for example, other staff, patients, family members)?

43. What do you think was their reason for swearing? (tick one only)
   1. No understandable provocation swearing occurs for no obvious reason
   2. Other patients results from provocation by other patients
   3. Psychosis responding to voices etc
   4. Administering medication response to staff encouraging medication
   5. Patient denied something swearing as a result of frustration etc
   6. Asked to do something swearing results from patient’s reluctance to comply with request
   7. Conversation swearing occurs in a conversational context
   8. Good humour swearing occurs in a joking way
   9. Distressed swearing results from patient being depressed or very upset
   10. Other (please comment) ____________________________

Comments:

44. What was the tone? (tick one only)
   1. Anecdotal in good-humoured story-telling manner
   2. Angry expressing annoyance or irritation
   3. Distressed sad, miserable, very upset
   4. Excited enthusiastic, animated
   5. Humorous joking, amusing manner
   6. Rebellious resistive, defiant, disobedient manner
   7. Sarcastic derisive, mocking, scornful, cynical manner
   8. Threat stated intention to inflict harm
   9. Other (please comment) ____________________________

Comments:
45. How did you respond? (tick one only)

1. Withdraw
2. Ignore
3. Placate
4. Confront
5. Joking response
6. Echoes/reflects language/feelings
7. Other (please comment)

Comments:

46. Reflection: How did you feel when the patient or carer swore?
Debrief Schedule for Pilot Questionnaire

Thank you for agreeing to participate in this pilot study. I am trialling the Nursing Swearing Impact Questionnaire and seek your feedback.

1. Approximately how long did it take you to complete the questionnaire? __________

2. Are the questionnaire instructions clear and easy to follow? YES / NO

3. Are there any questions you did not understand? YES / NO
   If yes, please list the question numbers: ______________________

4. Are there any questions that you feel are ambiguous? YES / NO
   If yes please list the question numbers: ______________________

5. Filling out the questionnaire was (please circle your response)
   very easy           easy           difficult        very difficult
   If difficult or very difficult, please explain why:
   ______________________

6. The order of the questions flowed logically. YES / NO
   If no please comment:
   ______________________

7. The overall presentation of the questionnaire was (please circle your response)
   poor              fair           good            excellent

8. Have you any suggestions for improving the questionnaire? YES / NO

9. Any other comments or issues you would like to raise? YES / NO

Thank you for your time and feedback. Please return the completed questionnaire and feedback form to Teri Stone at the above address.

Version 1, 19-03-05
Information Statement for the Pilot Study

Study title: The Therapeutic Implications of Swearing and its Impact on Nurses

You are invited to take part in a pilot study for this research project to be undertaken by staff from the Hunter Mental Health Service and the University of Newcastle. The research is being conducted, as part of the requirements for the degree of Doctor of Philosophy, by Teri Stone, Clinical Nurse Consultant for the Child and Adolescent Mental Health Statewide Network (Northern) under the supervision of Professor Michael Hazelton from the School of Nursing and Midwifery, University of Newcastle, Professor Kenneth Nunn, Director of CAMHSNET, and Dr Sandra Heriot, Statewide Director of Allied Health and Clinical Research, CAMHSNET.

Why is the research being conducted?

The aim of this study is to obtain more information about the impact of swearing on nurses.

There is very little research into the frequency or type of swearing in inpatient mental health facilities. Despite its high incidence, the impact on nurses of swearing by patients is not well understood. Nurses are, of all health workers, one of the most likely targets of verbal aggression and those who work in psychiatric, emergency and paediatric settings experience high levels of verbal abuse.

Knowledge derived from this study will be clinically relevant and applicable across a range of settings, because of the high incidence of verbal aggression directed towards nurses.

Who will be asked to participate in the pilot study?

All registered and enrolled nurses who work in paediatric units within Kaleidoscope (excluding J2) at John Hunter Hospital and in Maitland Mental Health Unit are invited to participate. Casual and part-time nursing staff also are eligible.

What choice do you have?

Participation in the study is entirely by your choice. Only those who have given informed consent will be included in the research. Your decision whether or not to participate will not disadvantage you nor affect your employment conditions in any way. If you do decide to participate you may cease at any time without giving a reason, and will have the option of withdrawing access to any information provided during the study.

What will you be asked to do?

If you agree to participate, you

1. Will be asked to fill out a questionnaire which will include general personal information, questions about swearing, and three standardised measures asking about your general health and what meanings you place on your experiences. All information given will be confidential. This will take approximately sixty minutes to complete.

2. Will be asked to complete a feedback form about the questionnaire.

What are the risks and benefits of participation?

This project aims to examine swearing and its impact upon nurses. The questionnaire does contain strong language which some nurses may find offensive and/or distressing. Should you become upset, support is available through the Hunter New England Employee Assistance Programme (02 49853289) and senior nursing staff who will follow the approved protocol for such situations.
You are free to discuss any difficulties with the researchers or to withdraw from the project at any time without having to give reasons for doing so. Withdrawal will not result in any penalty or discriminatory treatment.

Swearing is an important field of study and little has been written about its connection with mental disorders and the therapeutic implications. It is anticipated that the findings will have important implications for the management of swearing and verbal aggression, and the therapeutic alliance between nurses and patients.

How will your privacy be protected?

All information or personal details gathered in the course of this research are confidential. No names or other identifying information will be used or published and data will be analysed and published as grouped information. Confidentiality of personal details gathered in the course of this research will be maintained through a numerical coding system that eliminates the use of names on data recording sheets. Names and numerical identifiers will be recorded by the researcher and held in a password-protected database on floppy disc, accessible only to the members of the research team, and will be destroyed after five years. During the collection process data will be accessible only to the researchers and held securely in a locked filing cabinet in the home office of Teri Stone and thereafter to be stored at the University of Newcastle. All raw data will be destroyed after five years.

The Human Research Ethics Committee of the University of Newcastle and the Hunter New England Research Ethics Committee have approved this study.

How will the collected information be used?

Information collected in the pilot study may be included in the main study and reported as grouped data in scientific journals and by presentations at professional conferences. It will not be possible to identify individual participants in any reports, publications or presentations arising from the study.

What do you need to do to participate?

Please read this information sheet carefully and be sure that you fully understand its contents before you consent to participate in the study. You can talk with the researchers if there is anything you do not understand, or if you have any questions. If you would like to participate, please complete and return the attached anonymous questionnaire in the envelope provided. This will be taken as your informed consent to participate.

You will be given a copy of this information statement to keep.

Professor Mike Hazelton
Professor of Mental Health Nursing
University of Newcastle

Dr Sandra Heriot
Director of Allied Health & Clinical Research
CAMHSNET

Professor Kenneth Nunn
Director
CAMHSNET

Teri Stone
Clinical Nurse Consultant
CAMHSNET

This research has been reviewed and approved by the Hunter Area Research Ethics Committee, Reference No. XX/XX/XX/XX and the University of Newcastles Human Research Ethics Committee Approval No. XXXXXXX.

Should you have any concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher or their supervisor, or if an independent person is preferred to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive Callaghan NSW 2308, telephone 02 49216333, email: Human-Ethics@newcastle.edu.au or to Dr Nicole Gerrand, Professional Officer, Hunter Area Research Ethics Committee, Hunter Health, Locked Bag 1, New Lambton NSW 2305, telephone 02 49214950, email: Nicole.Gerrand@hunter.health.nsw.gov.au.
Consent Form for Nurse Participants

The Therapeutic Implications of Swearing and its Impact on Nurses

I freely consent to participating in the above named research project by signing this Consent Form, of which I have a copy.

I consent to:

1. Completing a questionnaire which will include general personal information, questions about swearing and three standardised measures, asking about my general health, and what meanings I place on my experiences. All information given will be confidential.

2. Taking part in a telephone interview which will explore the topic of swearing in more detail. The interview will last approximately thirty minutes and will be recorded. Participants will be able to review the interview transcripts and edit or delete their contribution. I understand that participants for this part of the study will be selected at random.

I understand that:

➢ The research will be conducted as in the Information Statement, a copy of which I have retained.

➢ I can withdraw from the project at any time and do not have to give any reason for withdrawing.

➢ I have read the Information Statement and all my questions have been answered to my satisfaction.

➢ Any information about me or personal details gathered in the course of this research are confidential and that neither my name nor any other identifying information will be used or published without my written permission.

Signed: ___________________________________ Date: __________

Print name: _________________________________ Phone: (H) __________

e-mail address: _______________________________ (W) __________

Please ensure that you return this completed Consent Form in the accompanying reply-paid envelope.

Thank you.

Version 2, 19-03-05
Invitation to participate

Swearing and its impact on nursing staff

A Turkish study (Uzon, 2003*) found that 100% of nurses working in psychiatric settings had experienced verbal abuse. Similar high rates were found in emergency (98%) and paediatric settings (96.9%) compared to an average of 86.7% overall. Anecdotally nurses report that swearing is a major source of stress. Can it also be positive? What are your experiences with swearing in a work context? What are your views on this subject?

If you are interested in taking part in a study on swearing and its impact on nursing staff please contact Professor Michael Hazelton on 49 246 602 or Teri Stone on 49 855 817 for an information sheet.


This research has been reviewed and approved by the Hunter Area Research Ethics Committee, Reference No. 05/04/13/3.17 and the University of Newcastles Human Research Ethics Committee ref: H-030-0405.
Information Statement for Nurse Participants

Study title: The Therapeutic Implications of Swearing and its Impact on Nurses

You are invited to take part in this research project to be undertaken by staff from the Hunter Mental Health Service and the University of Newcastle. The research is being conducted, as part of the requirements for the degree of Doctor of Philosophy, by Teri Stone, Clinical Nurse Consultant, Hunter New England Mental Health Service, under the supervision of Professor Michael Hazelton from the School of Nursing and Midwifery, University of Newcastle, and Dr Sandra Heriot, Statewide Director of Allied Health and Clinical Research, CAMHSNET.

Why is the research being conducted?

The aim of this study is to obtain more information about the impact of swearing on nurses.

There is very little research into the frequency or type of swearing in inpatient mental health facilities. Despite its high incidence, the impact on nurses of swearing by patients is not well understood. Nurses are, of all health workers, one of the most likely targets of verbal aggression and those who work in psychiatric, emergency and paediatric settings experience high levels of verbal abuse.

Knowledge derived from this study will be clinically relevant and applicable across a range of settings, because of the high incidence of verbal aggression directed towards nurses.

Who can participate in the research?

All registered and enrolled nurses who work in Nexus, J2, The Maitland and Manning Base Paediatric Units, James Fletcher Hospital, Morisset Hospital, and Maitland and Tamworth Psychiatric Units are invited to participate. Casual and part-time nursing staff also are eligible.

What choice do you have?

Participation in the study is entirely by your choice. If you do decide to participate, you may withdraw from the study at any time, and you may also withdraw access to any information provided from the questionnaire or interview, at any time. Only those who have given informed consent will be included in the research. Your decision whether or not to participate will not disadvantage you nor affect your employment conditions in any way.

What will you be asked to do?

If you agree to participate, you

1. Will be asked to fill out a questionnaire which will include general personal information, questions about swearing, and three standardised measures asking about your general health and what meanings you place on your experiences. All information given will be confidential. This will take approximately sixty minutes to complete.

2. May be invited to take part in a telephone interview which will explore the topic of swearing in more detail. A representative sample of nurses from contrasting work situations who have given consent to the study will be approached to participate in the telephone interview. Those selected will be contacted via mail or email and will be given time to consider whether they wish to take part in the interview. Completing the questionnaires at this stage does not oblige you to take part in the interview later if you are approached. The interview will last approximately thirty minutes and will be recorded. Nurses will be asked about their experience of swearing in the workplace and their own use of swearing. Nurses will be able to review the interview transcripts and edit or delete their contribution.
What are the risks and benefits of participation?

This project aims to examine swearing and its impact upon nurses. The questionnaire does contain strong language which some nurses may find offensive and/or distressing: you do not have to answer any questions you do not wish to. Should you become upset, support is available through the Hunter New England Employee Assistance Programme (02 49853289) and senior nursing staff who will follow the approved protocol for such situations.

You are free to discuss any difficulties with the researchers or to withdraw from the project at any time without having to give reasons for doing so. Withdrawal will not result in any penalty or discriminatory treatment.

Swearing is an important field of study and little has been written about its connection with mental disorders and the therapeutic implications. It is anticipated that the findings will have important implications for the management of swearing and verbal aggression, and the therapeutic alliance between nurses and patients. The questionnaire and telephone interview may provide a useful focus for reflective practice.

How will your privacy be protected?

All information or personal details gathered in the course of this research are confidential. No names or other identifying information will be used or published and data will be analysed and published as grouped information. Confidentiality of personal details gathered in the course of this research will be maintained through a numerical coding system that eliminates the use of names on data recording sheets. Names and numerical identifiers will be recorded by the researcher and held in a password-protected database on floppy disc, accessible only to the members of the research team, and will be destroyed after five years. During the collection process data will be accessible only to the researchers and held securely in a locked filing cabinet in the home office of Teri Stone and thereafter to be stored at the University of Newcastle. All raw data will be destroyed after five years.

How will the collected information be used?

Information collected in the research study will be reported as grouped data in scientific journals and by presentations at professional conferences. It will not be possible to identify individual participants in any reports, publications or presentations arising from the study.

What do you need to do to participate?

Please read this information sheet carefully and be sure that you fully understand its contents before you consent to participate in the study. You can talk with the researchers if there is anything you do not understand, or if you have any questions. If you would like to participate, please complete the attached consent form and return it in the attached envelope. A questionnaire will then be forwarded to you for completion.

You will be given a copy of this information statement to keep.

Professor Mike Hazelton  Dr Sandra Heriot  Teri Stone
Professor of Mental Health Nursing  Director of Allied Health & Clinical Research  Research Student
University of Newcastle  CAMHSNET

Complaints

This research has been approved by the Hunter Area Research Ethics Committee, whose functions will now be performed by the Hunter New England Human Research Ethics from 1 January 2006) Reference No. 05/04/13/3.17.

Should you have any concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher or their supervisor, or if an independent person is preferred to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive Callaghan NSW 2308, telephone 02 49216333, email: Human-Ethics@newcastle.edu.au or to Dr Nicole Gerrand, Professional Officer (Research Ethics), Hunter New England Human Research Ethics Committee, telephone 02 492 14950, fax: 02 4921 48818, email: nicole.gerrand@hnehealth.nsw.gov.au.
Appendix 11: Non numeric frequency of swearing responses

Non numerical answers to questions related to frequency of swearing were coded as follows:

- **1** = swearing experienced 1-5 times in the week. This item also included nurses’ non-numerical replies “occasionally”, “daily”, “most days” (based on a five-day roster), “few”, and “rarely.”

- **2** = swearing experienced 6-10 times in the week. This item also included nurses’ non-numerical replies “many”, “lots”, “all the time”, “several”, and “often.”

- **6** = swearing experienced >40 times in the week. This item also included nurses’ non-numerical replies “countless” and numerous.”
## Question 18: Do you use swearwords with work colleagues?

### My rules

<table>
<thead>
<tr>
<th></th>
<th>Eg. Bloody, bastard, shit, bitch.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Out of hearing of patients.</td>
</tr>
<tr>
<td>40</td>
<td>Only in jest.</td>
</tr>
<tr>
<td>41</td>
<td>Rarely in anger. Often for fun or emphasis (social).</td>
</tr>
<tr>
<td>76</td>
<td>Usual only with male colleagues</td>
</tr>
<tr>
<td>123</td>
<td>In privacy of the office - not in patient's hearing.</td>
</tr>
<tr>
<td>125</td>
<td>Usually only in the right circumstances.</td>
</tr>
<tr>
<td>131</td>
<td>More with males. More in social situations. Certainly very choosy when I do.</td>
</tr>
<tr>
<td>139</td>
<td>On occasions.</td>
</tr>
</tbody>
</table>

### Intention/purpose

<table>
<thead>
<tr>
<th></th>
<th>When quoting others, occasionally to make a point.</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>Yes, to de-stress or emphasise how annoying or demanding a patient or their family is or has been.</td>
</tr>
<tr>
<td>13</td>
<td>When I feel upset/passionate/or for fun.</td>
</tr>
<tr>
<td>26</td>
<td>Maybe to let off steam in an unaggressive way.</td>
</tr>
<tr>
<td>72</td>
<td>When stressed or angry.</td>
</tr>
<tr>
<td>97</td>
<td>Usually in a joking way.</td>
</tr>
<tr>
<td>103</td>
<td>Usually with humour.</td>
</tr>
<tr>
<td>104</td>
<td>Not often, I prefer not to swear.</td>
</tr>
<tr>
<td>105</td>
<td>Usually in the context of jokes or anecdotes and out of earshot of patients. I never use swear words about patients (to describe them or their behaviour).</td>
</tr>
<tr>
<td>108</td>
<td>Yes, when frustrated or casually.</td>
</tr>
<tr>
<td>202</td>
<td>When I feel very strongly about something.</td>
</tr>
<tr>
<td>164</td>
<td>To illustrate/emphasise a point or giving examples/repeating what a patient has said.</td>
</tr>
<tr>
<td>176</td>
<td>If I was describing a situation which was difficult, I may let one slip</td>
</tr>
<tr>
<td>190</td>
<td>Not at my colleagues but in the course of a discussion if I am elevated over an issue/person.</td>
</tr>
<tr>
<td>186</td>
<td>I do not use swear words as &quot;fillers&quot; in a sentence, but deliberately, and not to swear AT them.</td>
</tr>
<tr>
<td>215</td>
<td>When really angry about a situation or repeating something said to me by a client.</td>
</tr>
<tr>
<td>6</td>
<td>Usually in context of strong emotion</td>
</tr>
</tbody>
</table>

### They swear I swear

<table>
<thead>
<tr>
<th></th>
<th>If they swear, I swear.</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>Depends who the colleague is - some people dislike swearing so you don't swear with them.</td>
</tr>
<tr>
<td>88</td>
<td>It depends which staff I'm working with and how familiar I am with them. Also what sort of day I'm having.</td>
</tr>
<tr>
<td>7</td>
<td>If I am aware that a work colleague is very sensitive to swearing, I will moderate my language. But most people I work with swear.</td>
</tr>
<tr>
<td>8</td>
<td>My rule is to find out who else swears and then know that they will be okay with the swearing.</td>
</tr>
<tr>
<td>32</td>
<td>Careful who I swear in front of. Usually swear in a humourless [sic] way to make people laugh - only use bad words if very very upset.</td>
</tr>
<tr>
<td>93</td>
<td>Depending on the level of intimacy of the professional relationship.</td>
</tr>
<tr>
<td>155</td>
<td>With some of my colleagues - ones who I know aren't offended by it.</td>
</tr>
<tr>
<td>200</td>
<td>Depends who you work with and how stressful your shift has been</td>
</tr>
</tbody>
</table>

### It is part of the language

<table>
<thead>
<tr>
<th></th>
<th>It is part of the language.</th>
</tr>
</thead>
<tbody>
<tr>
<td>101</td>
<td>It is part of the language.</td>
</tr>
<tr>
<td>79</td>
<td>It is common in the workplace.</td>
</tr>
<tr>
<td>110</td>
<td>To join in (fit in); to express emotion.</td>
</tr>
<tr>
<td>114</td>
<td>Used as common vernacular when appropriate. Intention is not to offend.</td>
</tr>
<tr>
<td>189</td>
<td>It seems to be culturally accepted in the workplace.</td>
</tr>
</tbody>
</table>
169 Swearing is part of the culture of my work area.
199 in general conversation.

**I don't mean to**

| 53 | When tired, joking with colleagues, don't mean to swear, when you feel passionate about things. |
| 45 | I am aware of when I do and I try not to but it happens. |
| 42 | Unprofessional. |
| 65 | I do tend to swear too often. |
| 151 | Do not like to swear. Anger and frustration encourage me to swear. |
| 196 | Attempt to limit it (but I slip up occasionally). |
| 185 | By accident and only in private. |
| 146 | Fuck yeah. |

**Question 19: Do you use swearwords with patients?**

<table>
<thead>
<tr>
<th><strong>Professionalism</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7 I try to put forward a professional demeanour when talking to patients.</td>
</tr>
<tr>
<td>13 As a professional I don't think swearing is appropriate in front of patients.</td>
</tr>
<tr>
<td>42 Very unprofessional.</td>
</tr>
<tr>
<td>146 Try to restrain myself as it may be seen as unprofessional.</td>
</tr>
<tr>
<td>101 I think it is unprofessional.</td>
</tr>
<tr>
<td>88 I don't believe that is professional.</td>
</tr>
<tr>
<td>125 I try very hard to be professional.</td>
</tr>
<tr>
<td>104 Maybe &quot;bloody&quot; otherwise no - it's not the image I want to convey.</td>
</tr>
<tr>
<td>127 Don't see it as professional.</td>
</tr>
<tr>
<td>189 It's unprofessional and potentially offensive.</td>
</tr>
<tr>
<td>131 I am a role model - only minor ones.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Restraint and Rules</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3 eg. If I’m quoting someone. Never swear with frustration.</td>
</tr>
<tr>
<td>103 Not in anger.</td>
</tr>
<tr>
<td>110 Only adult patients and depending on circumstance and patient receptivity (playfully).</td>
</tr>
<tr>
<td>60 Dependant upon situation, atmosphere and patient = no harsh language (Fs and Cs).</td>
</tr>
<tr>
<td>139 Depends on the established rapport.</td>
</tr>
<tr>
<td>44 Very careful usually what I say especially to children.</td>
</tr>
<tr>
<td>45 Much less now than I may have years ago.</td>
</tr>
<tr>
<td>32 Only if the young person swear in normal conversation. Only mild words, eg: shit.</td>
</tr>
<tr>
<td>65 I will often joke with teenagers - I will use words like &quot;bloody&quot; or &quot;shit.&quot;</td>
</tr>
<tr>
<td>40 Maybe to stress a point but never in anger.</td>
</tr>
<tr>
<td>196 Selectively.</td>
</tr>
<tr>
<td>186 Never swear AT patients. Might say something like -&quot;It's not the end of the world. Try just to say 'bugger' and move on.</td>
</tr>
<tr>
<td>200 Never in anger, mainly when speaking to them on their level.</td>
</tr>
<tr>
<td>202 Only when they will not comprehend simple commands.</td>
</tr>
<tr>
<td>169 Swearing is very much a part of the culture of PICU patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Empathy/engagement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Occasionally it is appropriate to agree by saying &quot;fucked with your mind&quot; - to show you understand - if that's what you really believe.</td>
</tr>
<tr>
<td>93 When trying to engage persons of a certain personality type or background.</td>
</tr>
<tr>
<td>41 An engagement tool.</td>
</tr>
<tr>
<td>155 If my client swears as part of their normal conversations I find that if I also swear ie &quot;speak their language&quot; it's easier to develop rapport and establish a therapeutic relationship.</td>
</tr>
<tr>
<td>114 In establishing a rapport.</td>
</tr>
<tr>
<td>114 Never swear at patients, occasionally swear with patients (as it seems to be the</td>
</tr>
</tbody>
</table>
only language they know) to build some "common ground" and a response.

**Echoing language**

<table>
<thead>
<tr>
<th>Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Only as a response - when it is their style of talking.</td>
</tr>
<tr>
<td>79</td>
<td>Usually if the client abuses them [swearwords].</td>
</tr>
<tr>
<td>105</td>
<td>I don't swear at patients but if they have sworn whilst talking about someone or describing a scenario I use the same language/terminology to reflect back.</td>
</tr>
<tr>
<td>32</td>
<td>Only if the young person swear in normal conversation. Only mild words, eg: shit.</td>
</tr>
<tr>
<td>6</td>
<td>Sometimes for effect</td>
</tr>
<tr>
<td>164</td>
<td>If it feels appropriate eg communicating with a patient on their level.</td>
</tr>
</tbody>
</table>

**So as not to be intimidated**

<table>
<thead>
<tr>
<th>Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>I don't swear at them but may repeat what they say to show it does not scare or intimidate me. For example &quot;Don't tell me to fuck off.&quot;</td>
</tr>
<tr>
<td>72</td>
<td>One does not know how a patient will feel about swearing.</td>
</tr>
<tr>
<td>190</td>
<td>It is hard sometimes but you shouldn't swear [at/with] clients.</td>
</tr>
<tr>
<td>176</td>
<td>I am very conscious of not swearing in their presence</td>
</tr>
<tr>
<td>64</td>
<td>Inappropriate.</td>
</tr>
<tr>
<td>76</td>
<td>Very rarely.</td>
</tr>
<tr>
<td>151</td>
<td>No as are children.</td>
</tr>
</tbody>
</table>

---

**Question 20: Do you use swearwords with people you usually go out with socially?**

**Intention and rules**

<table>
<thead>
<tr>
<th>Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>I usually feel awkward and uncomfortable swearing, unless really upset and want to get &quot;my point across.&quot;</td>
</tr>
<tr>
<td>41</td>
<td>For dramatic effect.</td>
</tr>
<tr>
<td>13</td>
<td>Sometimes, it can add humour or emphasis [sic] a point you are trying to explain.</td>
</tr>
<tr>
<td>155</td>
<td>If I'm telling a joke with a swear word in it or I'm talking about my old boss I will swear but that's about it.</td>
</tr>
<tr>
<td>125</td>
<td>I believe it can be funny, relieve tension and is a common part of life these days.</td>
</tr>
<tr>
<td>127</td>
<td>When quoting others, occasionally to make a point.</td>
</tr>
<tr>
<td>97</td>
<td>Again in a joking way.</td>
</tr>
<tr>
<td>186</td>
<td>I do not use swear words as &quot;fillers&quot; in a sentence, but deliberately, and not to swear AT them.</td>
</tr>
<tr>
<td>42</td>
<td>Brought up better than that.</td>
</tr>
<tr>
<td>6</td>
<td>My rule is to find out who else swears and then know that they will be okay with the swearing.</td>
</tr>
<tr>
<td>3</td>
<td>Mild swear words eg. Bloody; bastard; shit; bitch.</td>
</tr>
<tr>
<td>40</td>
<td>Rarely in anger - usually only the softer words.</td>
</tr>
<tr>
<td>202</td>
<td>Only if there are no children in earshot.</td>
</tr>
<tr>
<td>79</td>
<td>Some of them complain that I use it too much.</td>
</tr>
<tr>
<td>114</td>
<td>Not &quot;cool&quot; to swear, especially being a female.</td>
</tr>
<tr>
<td>45</td>
<td>When with the boys...........</td>
</tr>
<tr>
<td>76</td>
<td>In the pub with the boys.</td>
</tr>
<tr>
<td>93</td>
<td>Mainly ex-military colleagues.</td>
</tr>
<tr>
<td>131</td>
<td>Generally males.</td>
</tr>
<tr>
<td>103</td>
<td>Usually with male company.</td>
</tr>
</tbody>
</table>

**The boys...**

<table>
<thead>
<tr>
<th>Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>114</td>
<td>Not &quot;cool&quot; to swear, especially being a female.</td>
</tr>
<tr>
<td>45</td>
<td>When with the boys...........</td>
</tr>
<tr>
<td>76</td>
<td>In the pub with the boys.</td>
</tr>
<tr>
<td>93</td>
<td>Mainly ex-military colleagues.</td>
</tr>
<tr>
<td>131</td>
<td>Generally males.</td>
</tr>
<tr>
<td>103</td>
<td>Usually with male company.</td>
</tr>
</tbody>
</table>

**No**

<table>
<thead>
<tr>
<th>Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>104</td>
<td>I don't like swearing.</td>
</tr>
<tr>
<td>190</td>
<td>Not usually.</td>
</tr>
</tbody>
</table>

**Alcohol**

<table>
<thead>
<tr>
<th>Page</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>When I have had a few drinks, having a laugh.</td>
</tr>
</tbody>
</table>
1 More so with raised alcohol

176 Occasionally but very rarely especially if I’ve had a few alcoholic drinks

**Context**

72 Depends on circumstances.

88 Only if it’s a work function!

200 Depends on situation.

139 On occasions.

6 Depends on individual

146 Depends on who and where.

151 Depending on situation.

185 Depending on the situation and which friend I’m with.

62 Once again, depends on the person.

**That is what it means to be mates/friends**

114 If you can’t swear in front of them, then they aren’t worth having as friends.

189 Again, culturally OK and group norm.

164 Normal language to use with each other.

196 Especially mates.

60 People I associate with usually swear.

101 Part of the language, the more comfortable I am with the person, the more likely I am to swear.

169 Mainly restricted to people with whom I am very familiar.

105 With certain groups of friends.

65 I do it with friends but not with family.

32 Only when appropriate and with others who I know to swear.

7 To a greater or lesser degree, all my friends swear. I think I would find it difficult to relate to someone who did not swear at all, due to some religious or social reasons.

---

**Question 21: Do you use swearwords at home?**

<table>
<thead>
<tr>
<th>No</th>
<th>72 My cats don't provide much feedback or cause.</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>Try not to.</td>
</tr>
<tr>
<td>6</td>
<td>Try to avoid it</td>
</tr>
<tr>
<td>45</td>
<td>Costs too much…</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes when.</th>
<th>32 Far too much, especially after a bad day at work or a bad incident.</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Sometimes when I’m upset.</td>
</tr>
<tr>
<td>40</td>
<td>If a drop something or kick my toe!</td>
</tr>
<tr>
<td>41</td>
<td>For emphasis. Rarely in anger.</td>
</tr>
<tr>
<td>79</td>
<td>Mainly when angry or frustrated.</td>
</tr>
<tr>
<td>26</td>
<td>Again, to show family - “I’ve had enough.”</td>
</tr>
<tr>
<td>53</td>
<td>How I was brought up and values - not in front of a female.</td>
</tr>
<tr>
<td>62</td>
<td>Depends on the situation.</td>
</tr>
<tr>
<td>44</td>
<td>Sometimes, especially when cranky.</td>
</tr>
<tr>
<td>97</td>
<td>Yes, usually in a joking way.</td>
</tr>
<tr>
<td>103</td>
<td>Usually when home maintenance is involved.</td>
</tr>
<tr>
<td>127</td>
<td>When quoting others, occasionally to make a point.</td>
</tr>
<tr>
<td>139</td>
<td>Pending company and circumstances.</td>
</tr>
<tr>
<td>146</td>
<td>Fuck yeah.</td>
</tr>
<tr>
<td>151</td>
<td>Angry.</td>
</tr>
<tr>
<td>155</td>
<td>When I lose my temper.</td>
</tr>
<tr>
<td>200</td>
<td>A great way to let off steam after a stressful day.</td>
</tr>
<tr>
<td>202</td>
<td>I live alone so no-one else can hear or get offended!!!</td>
</tr>
<tr>
<td>176</td>
<td>in frustration, anger and confusion</td>
</tr>
<tr>
<td>164</td>
<td>if I lived with my parents No, but as I don't then Yes!</td>
</tr>
<tr>
<td>105</td>
<td>Yes my partner and I use swear words very frequently as humorous banter - we</td>
</tr>
</tbody>
</table>
find it amusing and frequently play word games, swear in foreign accents, play with "rude" words.

| 114 | Mainly when the missus needs straightening out. |
| 117 | If I'm frustrated with husband. |
| 186 | When things go wrong. I break something etc - 'shit!', Bloody hell' etc. |

**Not in front of the children**

| 8 | I try not to swear in front of my children. |
| 7 | I try to moderate my language around my children. Circumstances occasionally thwart this. |
| 60 | Endeavour to restrain in front of kids. |
| 42 | Never - have small children. |
| 3 | eg bugger; bloody. Other words can be just as effective. Don't like my kids swearing. |
| 88 | I have two small children so never. |
| 93 | Not in front of the children obviously. |
| 125 | Not in front of the children. |
| 51 | Not at all when children present. |
| 169 | I tone down swearing at home to set a good example for the child. |
| 189 | Generally not in front of the kids. |
| 214 | Not in front of my children though. |

**Only when/not unless...**

| 215 | Only when very angry or upset/frightened. Don't like other members of the family swearing - husband doesn't swear in front of me. |
| 190 | Not unless I'm very upset. |
| 196 | When I have an accident possibly. |
| 104 | Occasionally one slips out. |
| 110 | Only if REALLY annoyed. |

**Question 22: Do you use swearwords when you are by yourself?**

| yes |
| 76 | Yup - especially when to the computer. |
| 45 | x!@! Oath |
| 3 | Usually under my breath; most likely "fuck." |
| 93 | It takes a special kind of person not to! |
| 104 | I probably swear most alone - like your example - still doesn't happen often. |
| 169 | Always! |
| 196 | Yes. |
| 200 | Who doesn't? |
| 202 | Yes. I live alone so no-one else can hear or get offended!!! |
| 41 | Usually the same one. |
| 127 | When particularly stressed, but rarely. |
| 8 | Yes I do. |

**Catharsis**

| 13 | Swear words can act as a release. |
| 97 | Yes - help you feel better. |
| 189 | As a release. |

**Anger, upset**

| 26 | If I'm angry - I feel relief from swearing. |
| 131 | In anger, frustration, exasperation etc |
| 146 | Especially when frustrated, angry. |
| 110 | Very occasionally, if upset. |

**Pain**

| 32 | Only if not in too much pain to even speak. |
| 40 | If I stub my toe. |
| 105 | Yes, if I hurt myself I would. |
| 117 | Especially if it hurts. |
| 139 | If I hurt myself, yes. |
Without thinking about it I would instinctively swear if I injured myself.

Yes, I do if I hurt myself.

Especially if I hurt myself or if something doesn't work out the way I expect.

"Bloody", "shit", "bastard" due to frustration and pain.

**Automatic response**

It's an automatic response.

My first reaction to any negative circumstance, when I am alone, is to swear!

It is part of the reaction.

Automatic - if angry/in pain.

**When something goes wrong**

Only when something goes wrong, say in the car or accident around the house.

When things go wrong. I break something etc - "shit!", Bloody hell etc. Also 'damn and blast'

**Other**

"Sugar" instead of "shit."

Hopefully not in front of the children.

Why bother? Nobody about to note that you have done something which has annoyed/stressed you that much.

---

**Question 26: Comments**

"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.

This is a bit ambiguous: do you mean would I call a patient by this or just use it in front of them. I have answered this in saying would I use it in front of them. If you mean would I call them by it - then my answer is never.

Don't know what "arvo" means.

There is also no racial or homosexual related "swear" words eg Nigger, Fudge Packer, which are used often not as a racial or homosexual slur but as a derogatory phrase or "swear" word.

---

**Question 27: Comments**

I find these examples more comical than offensive. The thought of someone saying 23 or 37 seems slightly unrealistic.

All of the answers depends on the situation and the people saying the words. It is OK for an African American to use the word "nigger."

All depends in what context they are used, and the tone.

No. 36 could be said successfully in jest.

Some of those in the top 30 I would accept these from a friend but not from a patient or a patient's parent.

"Cunt" is a word which I have always found offensive in any context. 31-17: Any descriptor of a person in the next bed is indicative of a value judgement and these offend me for that reason. I have a friend who uses these terms freely as well as "slopehead" and I CRINGE!

I understand the name "Koori" can be used in denoting an Aboriginal person's place of birth so no. 34 would depend on the person who made the statement and their knowledge of the subject.

Clients should be named, not treated like an object.

36 & 37: This does not offend me but you would ask the person not to speak like that because it would probably offend the person in the next bed.

Much of this is contextual. This questionnaire is very artificial.

Every situation would be different, ie what may sound offensive from a person may not seem as offensive coming from another.

Try "the man/woman in the next bed...".

Q.34 would depend on if they were a Koori asking the question, as to how offensive it was.

of reference? 22 & 23. Had to laugh, don't know why really, guess those words reflective of a stereotypical undereducated rough Aussie.

3 Depends on tone, anger, etc. Who says it.

### Question 28: Do you have any personal “rules” about swearing?

<table>
<thead>
<tr>
<th>“Swear in the right context”</th>
</tr>
</thead>
<tbody>
<tr>
<td>103  Swear in the right context.</td>
</tr>
<tr>
<td>27   Do not offend others.</td>
</tr>
<tr>
<td>146  Watch out where you are and who you’re with. Depends on mood, context.</td>
</tr>
<tr>
<td>155  I don't swear when there are people around who I think will be offended.</td>
</tr>
<tr>
<td>169  I try to keep my swearing appropriate to the social setting.</td>
</tr>
<tr>
<td>176  Usually only with my peers under stressful situations</td>
</tr>
<tr>
<td>177  If it is likely to be construed as offensive do not use.</td>
</tr>
<tr>
<td>195  Cultural/social/work context, what is appropriate with some groups is not with others.</td>
</tr>
<tr>
<td>209  The context, with who and the circumstances affects whether it is OK or not.</td>
</tr>
<tr>
<td>60   Only in the presence of those I know I won’t offend.</td>
</tr>
<tr>
<td>62   Only used in certain situations/contexts.</td>
</tr>
<tr>
<td>64   Depends on the company.</td>
</tr>
<tr>
<td>29   Not in front of strangers unless enraged.</td>
</tr>
<tr>
<td>48   Needs to be in context and appropriate for age.</td>
</tr>
<tr>
<td>41   Know the company you are in.</td>
</tr>
<tr>
<td>59   Not directed at or about a person. Only with people I know well.</td>
</tr>
<tr>
<td>23   Subconsciously aware of what words are used in what settings.</td>
</tr>
<tr>
<td>Not in front of the parents</td>
</tr>
<tr>
<td>99   Not in front of parents</td>
</tr>
<tr>
<td>65   I don't swear in front of my parents or siblings.</td>
</tr>
<tr>
<td>40   Not in front of my parents.</td>
</tr>
<tr>
<td>22   I don't swear in situations I believe it is inappropriate ie in front of parents.</td>
</tr>
<tr>
<td>101  Don't swear in front of my parents</td>
</tr>
<tr>
<td>189  Not in front of parents</td>
</tr>
<tr>
<td>54   Not to swear in front of parents.</td>
</tr>
<tr>
<td>Not in front of the children</td>
</tr>
<tr>
<td>79   Avoid swearing in front of young children.</td>
</tr>
<tr>
<td>13   No swearing in front of children</td>
</tr>
<tr>
<td>1    less swearing with women/children/family</td>
</tr>
<tr>
<td>7    Try not to swear around children.</td>
</tr>
<tr>
<td>5    Try not to swear around small children.</td>
</tr>
<tr>
<td>2    Not in front of children.</td>
</tr>
<tr>
<td>101  Don't swear in front of my child.</td>
</tr>
<tr>
<td>99   Not in front of children</td>
</tr>
<tr>
<td>219  Not swearing at home. Not tolerating others swearing there.</td>
</tr>
<tr>
<td>54   Not to swear in front of children</td>
</tr>
<tr>
<td>213  Never use with children, only use with teenagers as a mechanism to reflect issue</td>
</tr>
<tr>
<td>expressed by the teen &amp; who used that language in their descriptions.</td>
</tr>
<tr>
<td>51   Never swear in presence of children. Never swear at people.</td>
</tr>
<tr>
<td>29   Not in front of very young persons.</td>
</tr>
<tr>
<td>40   Not in front of the kids</td>
</tr>
<tr>
<td>88   Never in front of my children.</td>
</tr>
<tr>
<td>94   Not in front of children</td>
</tr>
<tr>
<td>93   Don't swear near children.</td>
</tr>
<tr>
<td>191  Don't swear in front of children</td>
</tr>
<tr>
<td>213  Never in front of kids</td>
</tr>
<tr>
<td>202  Not in front of children</td>
</tr>
<tr>
<td>189  Not in front of kids, strangers, some gender and/or stereotypes</td>
</tr>
</tbody>
</table>
1. not in front of the children, 2. not with clients or strangers, 3. never AT people, 4. not in a formal situation

**Children should not swear**

- Children and adolescents should curb their swearing.
- I don’t let my own children swear at me.
- Swearing at home is not to be repeated by kids, outside.
- My kids and I don’t use foul language.
- I try to restrict my teenagers’ swearing.
- My kids are not to swear at their elders.
- Don’t swear in front of parents or in-laws or kids if I can help it.
- My children are not allowed to use harsh swear words.

**Rules for work**

- Try not to swear at work.
- Not swearing in front of patients, and other people who may find it offensive.
- Less swearing at work with professionals.
- Don’t swear near patient visitors or new patients.
- Don’t swear at patients.
- On the occasions when I swear, not in front of patients, older people.
- Moderation of use with patients and avoid use with those who find swearing offensive.
- not (?) offensive at work.
- Never use swear words with my patients.
- Try not to swear in front of patients and staff.
- Unprofessional and unnecessary.
- Not appropriate in professional context. Very contextual and culturally based.
- Never in a de-escalation situation.
- Not in front of patients, visitors.
- Do not say 'fuck' or 'cunt' to clients.
- Only among trusted/close friends or colleagues.
- I consider the person/s I am speaking to. Never swear in front of patients.
- No swearing in front of or directed to patients.
- Never swear at a patient.

**Not in front of women**

- Only swear around women if they have indicated, by their own language, that they’re cool with it.
- Not in front of women; restrain myself as much as possible.

**Older people**

- No swearing in front of elderly people.
- Not in front of elderly persons.
- Never swear at an old person.
- Not in front of the elderly.
- You should be able to express yourself without using offensive language.
- Possibly not in front of parents or elders.
- Never in front of parents etc.
- Never be racially offensive and be respectful of whom I’m in company with - mainly with regard to age.

**Try not to**

- Try to NOT swear.
- Don’t like it. It's "unbecoming." I’m a lady.
- Unnecessary language so I don’t use it.
- Try not to use words that I consider swearing.
- Try not to.
- Don’t approve generally.
- Try not to swear, I personally don’t like hearing it.
If you don't want it used to or about you don't use it about someone - something else.

Careful about swearing in work/social situations. Don't call people names directly, that is, someone annoys me in travel by cutting in I'll say "fuckwit" but would not say this to someone's face - call someone a "fuckwit."

I try not to swear at all - socially/at work. I find I feel better by not lowering myself. If possible I try to speak politely.

Do not like it - try to self control.

I try not to swear and I really watch my swearing when I meet people until I know their views.

Alone and in private.

**Word specific rules**

"Cunt" and racist terms are verboten.

Don't use the word "cunt" around females;

Never use the c word ever. Try not to swear at people just about something. Be choosy who I swear to.

Fuck and cunt are not necessary - be creative.

Only say "cunt" in front of my partner and one or two friends. Only say "fuck" in front of friends. Most other words would say in front of family/parents etc. Don't swear at patients but with them if they use the word first.

I don't use the "C" word or blasphemy.

No blasphemy (Odd, as I am an atheist)

*answers that related to more than one theme were split and entered under the appropriate theme.

Question 29: Is there a type of person you think should not use swear words?

**Women**

177 Ladies in the "real" sense of the word.

1 Women

17 Women in a social setting.

**Children**

5 Young children

7 Children

37 Young children.

29 Children

40 Children.

213 Children.

48 Young children - need to understand the words being used.

49 Children

125 Children

53 Children.

54 Children.

16 Children and young adolescents.

62 Children.

146 Young kids.

151 Children,

65 I don't like to hear children swearing.

176 Children

1 Children

186 Young children.

79 Children.

99 Children.

94 Children.

85 Kids in social context with adults.

93 Children.

190 Children.
<table>
<thead>
<tr>
<th>Count</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>131</td>
<td>Children and young people,</td>
</tr>
<tr>
<td>195</td>
<td>Children and adolescents who do not understand the above mentioned social</td>
</tr>
<tr>
<td></td>
<td>context.</td>
</tr>
<tr>
<td></td>
<td><strong>Not in front of children</strong></td>
</tr>
<tr>
<td>56</td>
<td>Mothers to their children.</td>
</tr>
<tr>
<td>110</td>
<td>People with young children (in front of them).</td>
</tr>
<tr>
<td>203</td>
<td>Parents, people looking after children.</td>
</tr>
<tr>
<td>214</td>
<td>Parents</td>
</tr>
<tr>
<td></td>
<td><strong>Everyone</strong></td>
</tr>
<tr>
<td>73</td>
<td>Everyone</td>
</tr>
<tr>
<td>126</td>
<td>No need for anyone to swear.</td>
</tr>
<tr>
<td>104</td>
<td>Everyone should try to limit them - I think.</td>
</tr>
<tr>
<td>79</td>
<td>Society as a whole should reduce the level of swearing.</td>
</tr>
<tr>
<td>186</td>
<td>Mostly it's best to avoid swearing</td>
</tr>
<tr>
<td>87</td>
<td>Everyone</td>
</tr>
<tr>
<td></td>
<td><strong>Religious figures</strong></td>
</tr>
<tr>
<td>164</td>
<td>Priest</td>
</tr>
<tr>
<td>155</td>
<td>Clergy</td>
</tr>
<tr>
<td>125</td>
<td>Clergy</td>
</tr>
<tr>
<td>93</td>
<td>Nuns</td>
</tr>
<tr>
<td>139</td>
<td>Clergy, Nuns</td>
</tr>
<tr>
<td>131</td>
<td>Priests</td>
</tr>
<tr>
<td>200</td>
<td>Nuns, priests, the Pope.</td>
</tr>
<tr>
<td>203</td>
<td>Priest, nun</td>
</tr>
<tr>
<td>4</td>
<td>Nun, priest</td>
</tr>
<tr>
<td>53</td>
<td>Nuns, priests</td>
</tr>
<tr>
<td></td>
<td><strong>Professions</strong></td>
</tr>
<tr>
<td>21</td>
<td>In professional contexts, teachers, health professionals, childcare</td>
</tr>
<tr>
<td></td>
<td>workers.</td>
</tr>
<tr>
<td>151</td>
<td>Teachers, nurses, doctors.</td>
</tr>
<tr>
<td>27</td>
<td>Those employed within professional setting.</td>
</tr>
<tr>
<td>97</td>
<td>A professional person at work.</td>
</tr>
<tr>
<td>127</td>
<td>A professional, in a professional context.</td>
</tr>
<tr>
<td>131</td>
<td>Responsible people,</td>
</tr>
<tr>
<td>139</td>
<td>Perhaps doctors.</td>
</tr>
<tr>
<td>56</td>
<td>Professionals to their work colleagues.</td>
</tr>
<tr>
<td>100</td>
<td>Professional workers with their clientele.</td>
</tr>
<tr>
<td>49</td>
<td>Professionals</td>
</tr>
<tr>
<td>88</td>
<td>They shouldn't be used in a professional setting.</td>
</tr>
<tr>
<td>164</td>
<td>Managers in a professional situation.</td>
</tr>
<tr>
<td>93</td>
<td>Teachers whilst at work.</td>
</tr>
<tr>
<td>214</td>
<td>Professionals</td>
</tr>
<tr>
<td>4</td>
<td>Professional person in work situation, teacher,</td>
</tr>
<tr>
<td>203</td>
<td>Teacher</td>
</tr>
<tr>
<td>53</td>
<td>Nurses,</td>
</tr>
<tr>
<td>53</td>
<td>Managers,</td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>202</td>
<td>It always surprises me when someone swears and I don't expect them to.</td>
</tr>
<tr>
<td>4</td>
<td>Anyone who demands respect.</td>
</tr>
<tr>
<td>41</td>
<td>Those who cannot &quot;read people&quot; well and be able to gauge their reaction.</td>
</tr>
<tr>
<td>215</td>
<td>People in positions of power and authority to show a good example.</td>
</tr>
<tr>
<td>94</td>
<td>Elderly</td>
</tr>
<tr>
<td>103</td>
<td>Drunks.</td>
</tr>
<tr>
<td>2</td>
<td>Those who wish to maintain a high moral position.</td>
</tr>
<tr>
<td>3</td>
<td>Managers. Anyone who is modelling behaviour for someone else.</td>
</tr>
<tr>
<td>37</td>
<td>Older people</td>
</tr>
<tr>
<td>37</td>
<td>Patients.</td>
</tr>
<tr>
<td>82</td>
<td>Anybody with care of other people.</td>
</tr>
<tr>
<td>131</td>
<td>Public figures, leaders.</td>
</tr>
</tbody>
</table>
**Question 30: Comments**

<table>
<thead>
<tr>
<th>Answer</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Swearing can emphasise communication in a socially appropriate way. Use of appropriate language in reflecting meaning that a client understands and in building rapport - this must be done in a mindful manner. Being sworn AT is different to being sworn TO, in this context the intent of the swearing is to offend or intimidate. Being sworn TO may reflect a communication style.</td>
<td></td>
</tr>
<tr>
<td>3 All of these answers depend on context. E.g. sometimes swearing can make a joke funnier.</td>
<td></td>
</tr>
<tr>
<td>22 Some answers depend on the context of the situation.</td>
<td></td>
</tr>
<tr>
<td>146 Depends on mood with context.</td>
<td></td>
</tr>
<tr>
<td>125 As situations change the way in which swearing is used, perceived and tolerated also changes.</td>
<td></td>
</tr>
<tr>
<td>40 I don't mind swearing in a general context - everyday conversation. But aggressive swearing really changes the meaning like &quot;I have a sore cunt&quot; is OK , &quot;You are a cunt&quot; is very different.</td>
<td></td>
</tr>
<tr>
<td>37 It all depends on the situation and if the person is seriously angry when swearing at you. A lot of people use swear words in everyday language.</td>
<td></td>
</tr>
<tr>
<td>155 I feel that swearing can be a useful tool in opening up the lines of communication with clients however I think that swearing with someone is very different to being sworn at.</td>
<td></td>
</tr>
<tr>
<td>160 Being sworn at is more annoying than distressing.</td>
<td></td>
</tr>
<tr>
<td>72 Swearing AT is a quite different situation than swearing as parts of speech.</td>
<td></td>
</tr>
</tbody>
</table>

**Question 37: Briefly outline an occasion when you used swearing with a patient in a therapeutic way**

<table>
<thead>
<tr>
<th>Reflecting feelings</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Reflecting with a patient, who was saying that people give them the shits - “what happens when you get the shits?”</td>
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<tr>
<td>10 Reflected - talking with depressed patient.</td>
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<tr>
<td>16 When a patient was very upset about not being able to go on leave after an incident that had occurred the day before. The patient was crying and stated “this place is fucked.” I reflected the feelings to show that I was listening to her.</td>
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<tr>
<td>60 Usually during reflection of feelings.</td>
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<tr>
<td>67 Reflecting feelings - “mood is crap.”</td>
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<tr>
<td>99 Reflecting back what they have said getting them to clarify or telling joke or story where appropriate.</td>
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<tr>
<td>100 Adolescent having difficulty with parents. Couldn’t get on with them due to social restrictions. Reflective feelings of own childhood.</td>
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<tr>
<td>51 When indicating that I have heard and understood a patient's feelings and concerns, or when seeking clarification of same.</td>
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<tr>
<td>213 Client said &quot;Dad's being a total fuckwit and I can't take it.&quot; I said &quot;So you say he's a total fuckwit, but please explain exactly what he's actually doing to annoy you.&quot;</td>
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<tr>
<td>202 Patient complaining of withdrawals so reflected &quot;You feel like shit eh?&quot;</td>
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</table>

**Empathy**

<table>
<thead>
<tr>
<th>Answer</th>
<th>Details</th>
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<tbody>
<tr>
<td>1 When talking to an adolescent who used swear words repeatedly and my use of swear words made him understand his situation better.</td>
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</tr>
<tr>
<td>13 I think I have used the expression &quot;I know you feel like shit.&quot; It was to let the patient know I had some empathy for the way they were feeling and in a</td>
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</table>
language they used and understood.

17 Empathy for situation or past events ie child abuse, neglect, grief.

20 "That must have pissed you off" (establishing empathy).

169 I frequently use swearing as a tool to relate to patients. Eg I frequently agree that this ward is "a fucking hole" to demonstrate my empathy with patients.

108 To understand how a patient is feeling eg crappy, shitty.

Echoing language

3 Talking to a patient and saying "She’s not really a bitch….. Your mother really loves you."

26 A 16-y-o girl who had just come out of a manipulative relationship said "he was fucking with my heard. And I had to agree yes, "he was fucking with your head."

32 Adolescent with eating disorder, uses the words shit, bloody and cow all the time. I used those words occasionally to assess how she was feeling about certain things, eg. "So have you been feeling a bit shitty today?" or "Have you been thinking ‘those bloody nurses are really being cows today’?"

27 "Bullshit", "Get on the piss" VERY occasionally used with older teenagers.

22 Trying to talk to a mentally ill patient explaining that "yes it sucks" to be here but they are getting the help they need.

40 Explaining the use of vaginal treatments 1) I used the word "cunt" so she understood where I wanted her to put the cream ….. The penny finally dropped! 2) "Where do you want me to put the fucking bottle?" (client) "In the fucking bathroom" (me) - and we both laughed and there was no more swearing in the consultation.

41 After an episode of anger a patient said to me "I'm a dickhead!" I replied, "Yes, you can be a dickhead sometimes."

70 When an adolescent is upset or worried, sometimes you have to use their language to communicate and gain trust and rapport.

93 Used the phrase "And then it all turned to shit" to reflect a situation in a level of language relevant to that particular client who was a forensic patient with low socio-economic status and limited vocabulary. He laughed and agreed, then began to disclose.

94 If the patient is swearing, during interview (but not aggressively) then I would say something like "so you feel like crap" or if something is a bit unrealistic "your bullshitting?"

105 If a patient is recounting an incident and describes partner/landlord/neighbour etc as "dickhead" "bastard" etc I will often use the same terminology, eg "So what did the bastard do next?" It usually invokes a smile/eye contact - some connection or empathy/understanding.

176 I used the term "pissed off" to a young patient to describe a feeling of frustration.

191 Had client, older man from farming background continued to wet himself despite being taken to toilet etc. Success with toileting if asked him if he wanted a "piss" instead of asking if he wanted to go to the toilet.

131 When dealing with particularly rough clients. When I thought that I'd be a bit "soft" if I said "have you opened your bowels today?" When client/patient is swearing and it seems appropriate to be at that level to some extent.

155 I swear in general conversation with some clients as I feel it can make it easier for them to then relate to me. I also use swear words to echo back to the patient what they're saying, to make sure I can understand what they're saying and where they're coming from.

44 Told a patient you understood them feeling pissed off at parents/friends sometimes. It was normal. Good to let off steam sometimes through swearing.

101 I have said "You're in the shit" in context of alcohol abuse meaning if you continue "You'll be in the shit." To a middle-aged blokey male who I had rapport with.

48 Have on rare occasion used swearing to relate to a patient or their carer as this removed the feeling of superiority and gave a sense of empowerment to them by making them feel more comfortable about what to them is stressful ie hospital admission.

Try not to
<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>4</td>
<td>None.</td>
</tr>
<tr>
<td>21</td>
<td>Try not to, use the way I speak rather than certain swear words, however, I don't consider some words from the lists as swear words so with that in mind I probably do.</td>
</tr>
<tr>
<td>37</td>
<td>I don't swear at patients.</td>
</tr>
<tr>
<td>45</td>
<td>I have tried this when counselling a patient. Perhaps saying something like &quot;I guess you were pretty pissed off about that.&quot; I have noticed that patients don't like this and I have since avoided this technique.</td>
</tr>
<tr>
<td>54</td>
<td>Haven't used swearing in this context.</td>
</tr>
<tr>
<td>62</td>
<td>Never have.</td>
</tr>
<tr>
<td>64</td>
<td>Never.</td>
</tr>
<tr>
<td>59</td>
<td>Can't recall one.</td>
</tr>
<tr>
<td>82</td>
<td>I have never used swearing in a therapeutic way.</td>
</tr>
<tr>
<td>85</td>
<td>Can't remember.</td>
</tr>
<tr>
<td>87</td>
<td>Never.</td>
</tr>
<tr>
<td>90</td>
<td>Never.</td>
</tr>
<tr>
<td>91</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>97</td>
<td>I don't usually use swear words with patients. If they use them offensively I reprimand them. If they just use it in conversation I am not offended.</td>
</tr>
<tr>
<td>98</td>
<td>Never.</td>
</tr>
<tr>
<td>107</td>
<td>I have never.</td>
</tr>
<tr>
<td>122</td>
<td>Nil.</td>
</tr>
<tr>
<td>123</td>
<td>I have never found this necessary.</td>
</tr>
<tr>
<td>111</td>
<td>Don't swear with patients or family members.</td>
</tr>
<tr>
<td>126</td>
<td>Never - I don't believe this is a therapeutic approach. I don't like or encourage swearing. I actively find myself consciously not swearing as it's not who I am. Since I started work it has been harder as it is an environment that seems contagious to swearing [sic].</td>
</tr>
<tr>
<td>127</td>
<td>I don't usually swear, I see listening as FAR more effective than swearing.</td>
</tr>
<tr>
<td>190</td>
<td>I can't recall using this approach.</td>
</tr>
<tr>
<td>180</td>
<td>Haven't.</td>
</tr>
<tr>
<td>185</td>
<td>I don't recall using swearing with patients.</td>
</tr>
<tr>
<td>214</td>
<td>I would use slang words but not swear.</td>
</tr>
<tr>
<td>79</td>
<td>It's not something that I do often in clinical practice. I would only use terms such as &quot;It must have been bloody difficult for you.&quot; Generally I believe you can reflect without using a lot of bad language. It is useful sometimes to reflect intensity.</td>
</tr>
<tr>
<td>194</td>
<td>If patient is swearing as part of their vocabulary and within their own social context I have no issue with swearing and would do so if I felt the conversation need the expression that swearing offers, but I doubt I would use it just to get patient onside or as a &quot;therapeutic&quot; way.</td>
</tr>
<tr>
<td>196</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>

**Humour**

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<table>
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<tbody>
<tr>
<td>7</td>
<td>A patient recently apologised for the smell, in an enclosed space, of the bedpan he had used (GI bleed → malena!). I replied &quot;Don't worry about it, I'm the only person around here whose shit doesn't stink.&quot; My patient, a former timber-getter/farmer, appreciated the joke.</td>
</tr>
<tr>
<td>57</td>
<td>A client used the term &quot;Step-Up, bitch&quot; in an American Footballer/Rapper way, to mean &quot;have a go if you dare.&quot; At the same time slapping her chest. Now when she is being unreasonable or threatening I can say to her &quot;step-up bitch&quot; and it works for us both to see the humour in the situation.</td>
</tr>
<tr>
<td>28</td>
<td>When young person is spinning a story about self or listener. Sniffing in air - &quot;I smell bullshit somewhere?&quot;</td>
</tr>
<tr>
<td>103</td>
<td>Often use swear words in right context (usually in humour) to assist with making a therapeutic alliance.</td>
</tr>
<tr>
<td>110</td>
<td>When a patient with dementia was constantly pulling cannulas out I said &quot;Oh you're a bugger. What are we going to do with you?&quot; Most staff had been verbally aggressive with the patient prior to this. Patient slowed down pulling out IVs and would comment when seeing me, &quot;I don't touch that do I nurse?&quot;</td>
</tr>
</tbody>
</table>

**Therapeutic rapport**
23 With adolescent youth I have used terms such as "pissed off" in asking "How pissed off were you?" Used to help gain therapeutic rapport.

30 Persuading an elderly gentleman with alcohol brain damage to use the toilet. He responded to rough language including "piss" and "shit." Polite language would have had an effect of blocking communication.

31 To help may a patient feel comfortable with myself [sic].

77 When a patient clearly used swearing as normal part of expressive language. It was an attempt to form a therapeutic alliance.

114 "This place must really be giving you the shits!" - establishing rapport by using empathy and common language.

125 Used swearing as a way to communicate more effectively eg "Do you need a piss?" Have also used mild swearing to develop a rapport with a patient.

167 Usually with a patient I know fairly well and know that they use swearing as part of their regular language. To establish rapport - using language they understand.

215 Occasionally agree with patients about something "pissing them off" or validate their anger and frustration over certain matters, eg "Yes I can see how that would give you and shits" etc. Or maybe jokingly to build rapport call them eg "a clever bastard" if they've done something they are proud of.

Other

8 Sometimes when told to fuck off I will repeat the phrase ie "Don't tell me to fuck off." Whether right or wrong I think it shows that it does not scare or intimidate me.

42 2-3.

151 Young girl 16 speaking of Father. Her relationship with father.

53 Talking them down, opening up dialogue. "Bloody boring here, isn't it?" "Pretty crap you know."

72 Have been known to use the term "on the piss" when speaking with individuals who are inclined to over-imbibe. It seems to relax same. One doesn't appear to be so "straight" - especially as I am old enough to be some of these people's granny!.

73 Sometimes in PICU it may be appropriate. It's easier to cope with swearing etc when client is psychotic, rather than from a behavioural/personality disorder way.

78 Don't remember a particular occasion but I've probably used very mild swearing eg damn, hell, when talking with patients.

200 None recently.

A reflection of nurse's own use of language?

38 Settling a situation between two female patients, yelling at each other. Used "pissed off" etc.

49 "Te made a 'bloody' mess," when blood spilt.

6 I told a patient they were behaving like an arsehole and that if it continued I would call the police

88 I occasionally use "bloody" when trying to explain why people are waiting so long to see the doctor.

104 "Bloody hell, it's hot" - don't you think it's humid?

65 I asked a 10 yr old with leukaemia and having chemo if "he felt like shit" - he told me that he did. I replied that I knew what that felt like as I had had chemotherapy myself.

56 Go and brush your "bloody" teeth!

Emphasis

160 Was discussing coping with derogatory auditory hallucinations, suggested to consumer that she could always tell her voices to "get fucked!" as she was the one in control, not the voices she heard.

186 With clients who catastrophise, I often say: but what is the worst that can happen? What if you just said - so I dropped my shirt on the floor - bugger - pick it up and move on!

146 "Mate what a fucken ripper idea." Used to emphasise point.
### Question 47: How did you feel when completing this questionnaire?

<table>
<thead>
<tr>
<th>Comments on questionnaire</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 Difficulty with some questions (ASQ).</td>
</tr>
<tr>
<td>17 ?relevance of Part 2 to the study</td>
</tr>
<tr>
<td>56 Poor photocopy on first few pages. Hindering reading.</td>
</tr>
<tr>
<td>45 Took about 1 hour and I was working hard.</td>
</tr>
<tr>
<td>49 Very tedious.</td>
</tr>
<tr>
<td>16 I did it at work over three days.</td>
</tr>
<tr>
<td>66 Some questions were too complex and difficult to understand.</td>
</tr>
<tr>
<td>97 Had a good laugh doing the first section hope you did too.</td>
</tr>
<tr>
<td>191 I probably should not have done the questionnaire when tired.</td>
</tr>
<tr>
<td>195 I felt it was a worthwhile endeavour.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Feelings evoked</th>
</tr>
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<tbody>
<tr>
<td>40 Good luck.</td>
</tr>
<tr>
<td>122 Bemused.</td>
</tr>
<tr>
<td>104 Passionately angry when thinking about Part 5.</td>
</tr>
<tr>
<td>98 Uncomfortable completing questions 16 etc.</td>
</tr>
<tr>
<td>53 I felt comfortable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reflections on learning and swearing</th>
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<tbody>
<tr>
<td>26 I felt I was questioning myself - on how I do feel about swearing. I'm sure I will be more aware of how swearing affects me and my environment - interesting!</td>
</tr>
<tr>
<td>202 Brought to my attention that swearing often takes the place of meaningful conversation. Used as a mask to hide feelings of fear and/or vulnerability.</td>
</tr>
<tr>
<td>180 Our society appears to accept much more &quot;inappropriate&quot; language these days.</td>
</tr>
<tr>
<td>155 I learnt something about myself.</td>
</tr>
<tr>
<td>65 I think swearing in context is OK among friends but I don't think it should be tolerated in the patient/staff context or parent/staff context.</td>
</tr>
<tr>
<td>209 Wonder if there are benefits from questionnaire as the whole issue is complex. Accuracy would vary plus many way to looking at things. But possible benefit an expected behaviour may be installed even in psychotic patients, i.e. It is not acceptable to be to be abusive or unreasonably aggressive (verbally or physically) i.e. They should try other approaches. Also staff should reduce situations that cause frustration and provoke same.</td>
</tr>
<tr>
<td>160 Interesting to see study results!</td>
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<tr>
<td>ID</td>
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<td>93</td>
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<td></td>
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<tr>
<td>Others present: domestic staff</td>
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<td>94</td>
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<td>105</td>
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<td>123</td>
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<td>127</td>
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<td>155</td>
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<td>164</td>
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<td>167</td>
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</tbody>
</table>

Weary, angry because medical officers insist upon admitting this patient who has no mental illness and leaving him in Unit for long periods of time.
<table>
<thead>
<tr>
<th>Page</th>
<th>Event</th>
<th>Patient Description</th>
<th>Staff Description</th>
<th>Reaction</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>176</td>
<td>Refusing to allow patient to smoke</td>
<td>25 years, 6 foot 5 inches, large build male paranoid schizophrenia</td>
<td>It doesn't matter what you give me. I'm gonna fucking go off. Patient denied something</td>
<td>Placate</td>
<td>I understand his frustration but we needed to deal with the situation to stop it from escalating and patient potentially becoming physically violent.</td>
</tr>
<tr>
<td>177</td>
<td>Patient initially requested to go outside with his mother for a cigarette. Then when told no he began</td>
<td>Young fellow who gets upset easily when told No. Has past history of ADHD.</td>
<td>Thank you very fucking much. You're a cunt nark, all I want is to go outside for five fucking minutes. Patient denied something</td>
<td>Ignore</td>
<td>I felt at the time that due to the level of frustration that the patient was experiencing I thought it was warranted to a degree, mainly because I felt it wasn't so much directed at my colleague but more towards the system. Therefore I was able to deflect in my mind the onslaught of swearing</td>
</tr>
<tr>
<td>126</td>
<td>Fucken, arsehole, cunt, bitch.</td>
<td>Female, schizophrenic, 35 years of age, with frontal lobe brain damage.</td>
<td>&quot;You bitch, I want a fucken cigarette, I can't fucken cope, you are fucken cunts, fucken arseholes.&quot; Patient denied something. New admission, not used to the No Smoking policy.</td>
<td>Ignore</td>
<td>I felt very afraid, because she was known to be previously aggressive, she was intimidating in body language and I did not want to address the situation as she was a new admission and unknown to me. I let the RN handle her as they knew her. I felt great distress and stressed about going out on observation rounds. I felt she may harm me if given the chance, actually harm any of the staff as she had no reasoning at this time.</td>
</tr>
<tr>
<td>186</td>
<td>Client was burred up by another, I tried (unwisely) to intervene, copped a very nasty mouthful.</td>
<td>Male, 40s, BPD, drug induced psychosis, &quot;wild man of the woods&quot; build and appearance.</td>
<td>You stupid cunt. You should be fucked up the arse, you stupid bitch etc</td>
<td>Other patients</td>
<td>I felt sick and bruised as if it were a physical assault. There was significant property damage too</td>
</tr>
<tr>
<td>Page</td>
<td>Observation Area</td>
<td>Others Present</td>
<td>Client Description</td>
<td>Client Action</td>
<td>Staff Action</td>
</tr>
<tr>
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</tr>
<tr>
<td>186</td>
<td>In observation area</td>
<td>Male, 20s, antisocial personality disorder</td>
<td>Drug damaged.</td>
<td>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</td>
<td>Client had demanded something quite unreasonable (I forget details) so request was denied.</td>
</tr>
<tr>
<td>191</td>
<td>Client unhappy about inability to smoke.</td>
<td>Staff, patient, could hear throughout ward.</td>
<td>Mid 40s, male, bipolar - hypomania.</td>
<td>I have fucking rights, give me a fucking smoke.</td>
<td>Patient denied something</td>
</tr>
<tr>
<td>200</td>
<td>Patient admitted to locked ward, was entitled, demanding.</td>
<td>Male colleague (a different one each night as they kept calling in sick for the next night).</td>
<td>Female, 30s, frequent admission drug psychosis.</td>
<td>Called various names repeatedly: cunt, fat cunt, fuck off, I’ll have you sacked.</td>
<td>No understandable provocation</td>
</tr>
<tr>
<td>202</td>
<td>Psychotic patient, polysubstance withdrawals, angry re no smoking policy.</td>
<td>Other staff, patients.</td>
<td>24 year old, male schizophrenia, polysubstance withdrawal.</td>
<td>You can go and get fucked, stick it up your arse.</td>
<td>Patient denied something</td>
</tr>
<tr>
<td>190</td>
<td>Client personally demeaning to me.</td>
<td>Other staff.</td>
<td>Anti-social personality disorder</td>
<td>You are a motherfucker, cocksucker, pooper, etc and others continued for several minutes.</td>
<td>Patient denied something</td>
</tr>
<tr>
<td>No.</td>
<td>Patient</td>
<td>Others Present</td>
<td>Patient's Situation</td>
<td>Patient's Words</td>
<td>Patient's Action</td>
</tr>
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<td>8</td>
<td>Patient needed to be searched; there was a lighter on his person. He was not consenting to this.</td>
<td>Staff, patients</td>
<td>14 year old male, conduct disorder.</td>
<td>Fuck off, gronk, I'll fucking smash you. You're a rock spider. There were variations on these three statements.</td>
<td>Patient asked to do something</td>
</tr>
<tr>
<td>15</td>
<td>Young woman returned to unit after absconding and smoking THC. Placed in HDU.</td>
<td>Mother</td>
<td>16 year old female with mood disorder.</td>
<td>&quot;You fucking slut cunt whore.&quot;</td>
<td>Patient asked to do something, and was rebellious</td>
</tr>
<tr>
<td>32</td>
<td>Busy [paediatric] ward, all beds full. Fairly open. 14 year old male patient stood at front foyer yelling at top of his voice.</td>
<td>His friends, all the other children with parents in the ward, visitors, another member RN (abuse was directed at her).</td>
<td>14 year old male, thin, small, osteomyelitis requiring IV antibiotics via central line.</td>
<td>&quot;I can fuck you nurses any time I like, you are all cunts.&quot;</td>
<td>Patient asked to do something He had his undesirable newly acquired friends to show off in front of. Also rebellious and threatening</td>
</tr>
<tr>
<td>44</td>
<td>Patient was distressed and wanted me to leave her alone.</td>
<td>Staff</td>
<td>Female, 16 year old - bipolar.</td>
<td>Fuck off, leave me alone.</td>
<td>Distressed</td>
</tr>
<tr>
<td>57</td>
<td>Being asked to do something - like get out of bed.</td>
<td>Other nurses</td>
<td>14 year old male with ADHD - antisocial traits.</td>
<td>&quot;Fuck off or I'll kick your head in.&quot;</td>
<td>Attempting to intimidate staff.</td>
</tr>
<tr>
<td>60</td>
<td>A male patient with behaviour disorder repeatedly swearing at staff.</td>
<td>Staff, patients</td>
<td>15 year old male, conduct disorder.</td>
<td>&quot;fucking cunts.&quot;</td>
<td>Patient asked to do something</td>
</tr>
<tr>
<td>65</td>
<td>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.</td>
<td>Mother, another</td>
<td>An 11 year old boy</td>
<td>&quot;You're not fucking touching me… Fuck off bitch and leave me alone…&quot;</td>
<td>Patient denied something</td>
</tr>
<tr>
<td></td>
<td>RN.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>72</td>
<td>Client was being encouraged (by another staff) to go indoors so ward could be locked for the night. Others present: Myself (the swearing was at the male staff member with me).</td>
<td>Male, drug addicted, age 19.</td>
<td>&quot;Piss off and leave me alone, you fucker cunt.&quot;</td>
<td>Patient asked to do something</td>
<td>Placate</td>
</tr>
<tr>
<td>91</td>
<td>Offering prescribed medication to patient. Others present: Other staff and patients.</td>
<td>female, 20-30 year old, psychosis</td>
<td>&quot;Stick the fucking stuff up your arse you fucking slut.&quot;</td>
<td>Patient asked to do something</td>
<td>Placate</td>
</tr>
<tr>
<td>107</td>
<td>Patient became upset and angry when told she needed to drink to keep up fluids. Others present: Just me and her.</td>
<td>Young female, depression.</td>
<td>&quot;Fuck off, leave me alone.&quot;</td>
<td>Patient asked to do something</td>
<td>Ignore</td>
</tr>
<tr>
<td>160</td>
<td>Brought in by police after smashing up his department of housing house. Loud, pressured, verbally abusive on admission. Requested to come into bedroom so depot IMI could be given. Others present: Other RN in Observation unit.</td>
<td>Young adult male, psychotic and had used illicit substances.</td>
<td>&quot;Alright, I'll have the fucking needle you fucking cunt.&quot;</td>
<td>Administering medication</td>
<td>Confront</td>
</tr>
<tr>
<td>185</td>
<td>I asked a very drunk father to leave the ward until he sobered up. Others present: Other staff, patients, other family member (mother) and other visitors.</td>
<td>Male, 24-25 year old, father of patient, Aboriginal, drunk.</td>
<td>I was called a fucking bitch and a fucking c*** (I don't like this word).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>209</td>
<td>Patient asked to &quot;Return to your ward.&quot; Others present: No others.</td>
<td>Female patient, 30s, manic/drug abuser.</td>
<td>&quot;Fuck off!&quot;</td>
<td>Patient asked to do something</td>
<td>Ignore</td>
</tr>
</tbody>
</table>

Patient restraint and seclusion
<table>
<thead>
<tr>
<th>ID</th>
<th>Event Description</th>
<th>Age</th>
<th>Gender</th>
<th>Diagnosis</th>
<th>Description</th>
<th>Response</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Restraint for intra muscular medication due to medication non-compliance.</td>
<td>37 yr old, male</td>
<td>Schizophrenia</td>
<td></td>
<td></td>
<td>Administering medication</td>
<td>Withdraw</td>
</tr>
<tr>
<td>37</td>
<td>I can’t remember one particular incident, it happens daily. I do a patient called me a fuckin cunt and told me she hated me while restraining her.</td>
<td>15, female</td>
<td>Bipolar</td>
<td></td>
<td></td>
<td>Distressed</td>
<td>Ignore</td>
</tr>
<tr>
<td>67</td>
<td>While patient being restrained.</td>
<td>Male, ADHD, depression, 15 years</td>
<td>Bipolar disorder</td>
<td></td>
<td></td>
<td>&quot;Fuck off you cunt, bitch, fucking whore.&quot;</td>
<td>Ignore</td>
</tr>
<tr>
<td>111</td>
<td>Patient needing &quot;restraint&quot; due to violence against staff.</td>
<td>Boy, 13 year old, behavioural problems, oppositional, conduct disorder.</td>
<td></td>
<td></td>
<td></td>
<td>&quot;You're fucken dead you slut.&quot;</td>
<td>Patient asked to do something Called Security - violence too great.</td>
</tr>
<tr>
<td>196</td>
<td>Placing someone into the seclusion room.</td>
<td>Male, mid 20's, personality disorder.</td>
<td></td>
<td></td>
<td>&quot;Fuckin you wait, ya bastard! I’ll fuckin punch ja light out when I get outta here.,”</td>
<td>Patient asked to do something</td>
<td>Withdraw</td>
</tr>
<tr>
<td>197</td>
<td>Code black situation.</td>
<td>25 yr old woman with substance abuse problems.</td>
<td></td>
<td></td>
<td>Get rid of that fucking cunt. Restraint. Angry about being detained as an involuntary patient</td>
<td>Withdraw</td>
<td>Not good!</td>
</tr>
</tbody>
</table>

**Patient emotional/mental state**
<p>| 27 | On-call unit locked - let a burns victim into unit with friend. Others present: Patient with burns, security person. | 40 year old, male. | Fucking nurse, bloody, bitch. | Scared for friend, drunk, wanted immediate care, Confront. I got him helping me with his friend and told him he was not helping anyone by swearing at me. | I HATE it - it really impacts on me now - makes me shake. I feel less clear thinking. Pitch of voice as much as the words spoken - I don't deal well with yelling and/or confrontation. |
| 28 | Young girl, admitted to surgical ward - very unhappy and patients absent and unable to meet needs. Others present: Registrar | 17 year old female. Depression - borderline traits | &quot;Fucking cunts. My dad's a fat wanker. My mother's a fuckwit.&quot; | Distressed | Echoes/reflects language/feelings |
| 151 | Angry girl. Others present: Father | 16, female, depression, suicide. | &quot;Fuckin bitch.&quot; | Distressed | Ignore |
| 40 | Frustrated youth - SMSing me. Others present: I was in a meeting - following a phone call. | 18 years, female, suicide - angry, agitated, borderline personality | &quot;Fuck them fuck everyone I'm sick of all of them, sick of you, you don't have to believe me, I don't care. Just fuck of them, its all bullshit, I don't care, if I cared I wouldn't be doing this right now, leave me alone, I told all of them back at school | Distressed | Ignored swearing but responded to issues. |
| 22 | Whilst working as an Ambulance Officer I had to assess someone in the police cells that had just been arrested. Others present: A fellow Ambo, police. | Approx. 27-30 yr old male, history of asthma. Lower socioeconomic status. | I was told to &quot;fuck off&quot; about 14 times. Didn't want my &quot;fucking help&quot;, wanted to &quot;fucking die.&quot; | Distressed | Placate |
| <strong>Psychosis/disorientation</strong> | | | | | |
| 29 | I was asked to assess this man in custody. He had just been arrested. He had had prior contact with Mental Health | Male, 30 year old Drug induced psychosis. | Called me a fucking cunt, dog, etc. | Psychosis | Initially taken aback, briefly angry then more philosophical. |</p>
<table>
<thead>
<tr>
<th>Service.</th>
<th>Others present: No</th>
<th>17 year old male Aboriginal with schizophrenia.</th>
<th>Cocksucker, piss off, fuck off, cunt.</th>
<th>Psychosis. Habit, the way he talks</th>
<th>Ignore</th>
<th>Just ignore it - &quot;here he goes again&quot; - did not faze me.</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>Young Aboriginal man with chronic schizophrenia constantly mutters swear words under his breath.</td>
<td>Elderly psychotic lady.</td>
<td>20 swear words +, fuck, cunt, witch, etc. etc.</td>
<td>Psychosis</td>
<td>Ignore</td>
<td>Made me uncomfortable, although she was unwell.</td>
</tr>
<tr>
<td>73</td>
<td>Sometimes in PICU it may be appropriate.</td>
<td>Young male with history of psychosis exacerbate [sic]</td>
<td>Called me &quot;fat bitch who does fuck all - so just fuck off&quot;</td>
<td>Psychosis</td>
<td>Ignore</td>
<td>I felt really embarrassed, angry at the patient and distressed.</td>
</tr>
<tr>
<td>88</td>
<td>Patient brought into hospital by police - agitated and had been using amphetamines.</td>
<td>Long-term inpatient client.</td>
<td>&quot;F'n slut.&quot;</td>
<td>Treatment resistant psychosis.</td>
<td>Ignore</td>
<td>Fine. Patient is unwell - not in control of actions.</td>
</tr>
<tr>
<td>98</td>
<td>Female client swearing at staff.</td>
<td>45, male schizophrenia, long history, very aggressive and intimidating when unwell.</td>
<td>&quot;Don't fuckin' look at me, you dopey cunt.&quot;</td>
<td>Psychosis</td>
<td>Ignore</td>
<td>A little tense, but not threatened or feeling unsafe.</td>
</tr>
<tr>
<td>101</td>
<td>Psychotic paranoid male constantly accusing staff.</td>
<td>Age - 39 approx, male paranoid schizophrenic with a history of extreme aggression.</td>
<td>He described us as being &quot;poofter arse fuckers&quot; just waiting to strike.</td>
<td>Psychosis</td>
<td>Ignore</td>
<td>It was a very tense situation which may have resulted in violence. It made everyone present quite anxious - however was resolved satisfactorily.</td>
</tr>
<tr>
<td>169</td>
<td>A paranoid patient accused myself and other staff of being homosexual rapists who were planning to molest him.</td>
<td>Male in early 30s, heavily tattooed, muscular, approx 6ft tall, poor hygiene, shaven head, presents with psychotic symptoms usually in context of</td>
<td>&quot;I know where that fucker lives, I know he's got kids too.&quot;</td>
<td>Patient denied something</td>
<td>Contacted police and completed incident report.</td>
<td>Annoyed</td>
</tr>
</tbody>
</table>

**Patient/carer discontent with care**

<p>| 21      | Adult male wanting access to his case manager so that he could complain about protective office controlling his money. | Male in early 30s, heavily tattooed, muscular, approx 6ft tall, poor hygiene, shaven head, presents with psychotic symptoms usually in context of | &quot;I know where that fucker lives, I know he's got kids too.&quot; | Patient denied something | Contacted police and completed incident report. | Annoyed |
| 26 | Client was describing an incident to me. Others present: There was a patient (10 year old) and mother in room - behind the screen. | 15-y-o male who was admitted due to lacerations to hand after aggressive outburst | &quot;The bitch wouldn't let me go down for a cigarette.&quot; | Distressed | Echoes/reflects language/feelings | I felt a little shocked and that it was inappropriate to swear in the paediatric ward. I also realised that he was honestly venting his feelings and that was calming him down. |
| 38 | Telling patient, theatre's been cancelled. Others present: Other patients within hearing distance. | Adolescent male with fractured leg. | Lots of fucks etc towards staff, hospital, etc. | Patient denied something | Ignore | Anxious because patient upset, anxious and angry and hospital system let him down. |
| 48 | Parent abusive to me and other staff due to being not in control and wanting to do something against the health of their child but not understanding. Others present: Staff and visitors and other parents and patients. | Poorly educated, low income level. | Vitiolic abuse. Called a bunch of fuckwits and the word fuck used multiple times. | Patient denied something | Called security due to level of impact to ward and other people who had a right to not be subjected to this level of abuse. | The swearing didn't bother me, however mindful of not losing control and inflaming situation. |
| 49 | Parent complained about care given to her child. Others present: Patient. | 30-40 years old Indigenous, mother of patient with necrolising fascitis[?]. Patient 10 months old. | &quot;That's not going to fucking help.&quot; | Denied something | Ignore | |
| 56 | Patient to myself: Patient unhappy with a team decision of which I was involved with. Others present: Co-workers and patients. | Adolescent female - 16 yrs old. Bipolar disorder. | Patient said that she didn't trust me anymore and called me a &quot;fucking fat bitch.&quot; She then proceeded down the hallway calling me names. | Patient denied something | Ignore | Hurt for a short time (momentarily). Ignored the situation and carried on as usually. Patient apologised about one hour later. |
| 70 | A mother of one of my patients, accidentally read her child's notes and saw that I intended to make a Doc's report about her aggression etc to her child. Others present: Other nurses on the ward, her 3 year old child. | Early 30s, female, substance abuser, long association with DOCS. | &quot;I'll kill you, you fucking bitch.&quot; | Saw that I was going to report her yet again to DOCS for aggression/abuse to her child. | Placate | Annoyed, but saw her in a pathetic light. |
| 78 | Prospective patient in assessment waiting room. Usually involuntary patient or one wanting/needling admission. Others present: Police, nursing | Male, 25 yrs, drug induced psychosis. | &quot;Fucking arseholes...&quot; similar phrases - usually directed at nursing staff. | Patient denied something | Placate | Made me feel threatened as it was said in threatening manner (along with same body language). |</p>
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97</td>
<td>After assessing a patient he became abusive when informed he was going to be scheduled by the medical officer. Others present: Patient's partner, two police officers, MO and other staff members. 42 yr old male in a hypermanic episode who was paranoid, pressured in speech, using cannabis and suicidal. &quot;You fucking bitch I trusted you, you didn't fucking listen to me. I'm going to get you.&quot; Distressed Ignore Upset, worried about my safety, worried about future interaction with this patient.</td>
</tr>
<tr>
<td>99</td>
<td>Carer angry at my treatment of mother. Others present: Nursing supervisor, girlfriend, mother and child of offender. Housing commission, low socio-economic, early 20s, male. You stupid fucking cunt nurse. angry at situation. Withdraw Belittled - unable to get myself heard to explain situation.</td>
</tr>
<tr>
<td>100</td>
<td>Single mother one child fit for discharge demanding to be released with medication. No money - social worker assisting. Couldn't wait to get out of hospital. Things to do despite the fact staff were assisting her. Young white single mother, unemployed. &quot;How fucking long is the medication going to take? Haven't got all fucking day. You bitches aren't helping me.....&quot; etc Patient asked to do something Placate Embarrassed for other children and families to witness such behaviour.</td>
</tr>
<tr>
<td>110</td>
<td>Patient's relative unhappy with mother's treatment and new changes to same. Others present: Myself, other patients, other family members. Female approx. 40 years of age. Medical diagnosis - ileostomy (?) with secondary pulmonary oedema (resolved). &quot;Will someone f...ing tell me what's happening? Where is the bastard of a doctor?&quot; Distressed Echoes/reflects language/feelings I felt empathy for the patient's relative. But angry that the &quot;worst&quot; of it was over before she went off.</td>
</tr>
<tr>
<td>131</td>
<td>A client was upset at my application for renewing a community treatment order. Others present: Male 36, schizoaffective disorder. &quot;I am really fucking angry about the CTO...I am not mentally ill...you are mentally ill...get fucked you silly fucking lunatic...go and die&quot;. Anger Wary of client, reported to other staff and manager. safe as I was in my office</td>
</tr>
</tbody>
</table>
| 155  | My patient has cancer and refused treatment. As she was found to be able to make that decision we were treating. Daughter of patient. Female, mid-late 30s. [Daughter of patient] said that I was an incompetent fuckwit who was unable to fucking do anything fucking Grief, loss of power. Placate. Calmly explain that her mother has the right to choose her treatment. I was very hurt. I was doing everything I could to ensure her mother had everything.
| 31 | Having conversation with patient/assessment.  
Others present: Patient and myself. | Female, age 16 years. | Can’t remember exactly what was said, but swear words were used through conversation such as “shit”, “bitch”, “bullshit” - describing situations/people. | Conversation | Echoes/reflects language/feelings | No problems, as they were not swearing at me, but only swearing in conversation about situations in their life. |
| 42 | Kids swearing at each other used in general conversation.  
Others present: Other patients, staff. | Mental health, male - depression. | F… I’m sick of this, sh… Patient denied something Also distressed and rebellious | Confront | Nil | That I needed to control the swearing or behaviour of other patients so they didn’t have to listen to it. |
| 45 | On many days I hear offensive language coming from adolescent girls and boys on my unit.  
Others present: All of the above. [Other staff, patients, family members.] | A recent memory is a 16 year old female with depression and suicidal ideation. | Things like ”I hate this fucking place” or ”Fuck-off.” Although appears to occur in general conversation, there are periods when it is louder and more pronounced and I believe it is associated with agitation. | Ignore | Nil | Wondering how far this was going to escalate? |
| 195 | Aggressive patient conversation.  
Others present: Other staff. | male, 25s, white. | You’re all fuckwits. | Distressed | Placate | Nil |

**Conversational**
<table>
<thead>
<tr>
<th>16</th>
<th>Staff member angry with others as patient was not in seclusion room after verbally assaulting him.</th>
<th>35-40 yrs, male, psychiatric nurse.</th>
<th>“Don’t you know that that bitch has just threatened me”  “I refuse to step out of this fucking nurses’ station until she is in seclusion.”</th>
<th>Scared, distressed, upset, threatened.</th>
<th>Other</th>
<th>Sad for the staff member.</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>A “Senior Manager” new to the town made a request to the local hospital storeman. The storeman, a known alcoholic with a violent temper swore profusely in a highly intimidating fashion.</td>
<td>Late 50s, living in a violent community. Known as verbally violent, abusive, intimidating man but because he was a “good storeman” this was tolerated and even accepted in the violent outback culture of the town.</td>
<td>“You fucking managers are a bunch of cunts who think you can flick your fucking fingers and make everyone jump. Well you’ve got a fucking big surprise coming your way.”</td>
<td>No understandable provocation. An individual with personal illness and issues of Also distressed; threat.</td>
<td>Disbelief that this level of language was occurring in the workplace. Lodged a written complaint detailing the exact circumstances and language used and was informed by the G.M. that was just the way this storeman was and that this was the first time a written complaint had been lodged.</td>
<td>Having a full caution issued by the General Manager. Felt like taking this guy down a peg or 2 and educating him about professional conduct in the workplace.</td>
</tr>
<tr>
<td>20</td>
<td>Discussing some sort of betrayal by a supposedly really good friend.</td>
<td>Professional white male.</td>
<td>Cunt [………?]</td>
<td>Good humour, empathy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>56</td>
<td>Staff member to staff member: Phoned another ward to speak about a patient.</td>
<td>Male manager of **.</td>
<td>“Who the fuck are you?”</td>
<td>Felt that he was above talking to me.</td>
<td>Hang up.</td>
<td>Indignant.</td>
</tr>
<tr>
<td>Others present: Two other staff.</td>
<td>Colleague having interpersonal problems with another colleague having problems getting service manager to understand a point she was making.</td>
<td>Middle age, female.</td>
<td>&quot;Fuck [name of manager], is that the best you can come up with?&quot;</td>
<td>Distressed</td>
<td>Ignore</td>
<td></td>
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<tr>
<td>Staff describing presentation of patient.</td>
<td>Others present: Other staff.</td>
<td>Mid 40s, male, staff.</td>
<td>&quot;He was fucken nuts&quot;</td>
<td>Good humour</td>
<td>Joking response</td>
<td>Nothing - it's normal.</td>
</tr>
<tr>
<td>Staff swearing at a patient to incite them.</td>
<td>Others present: Other staff.</td>
<td>Male - middle-aged, staff.</td>
<td>Can't remember but physical assault happened.</td>
<td>No understandable provocation</td>
<td>Withdraw</td>
<td>Offended, confused, angry.</td>
</tr>
<tr>
<td>Staff conversation.</td>
<td>Others present: Other staff.</td>
<td>Male 46, female 38.</td>
<td>&quot;Get fucked - oh fuck! Bullshit!&quot;</td>
<td>Conversation</td>
<td>Ignore</td>
<td>I feel there are other ways of using words to describe feelings.</td>
</tr>
<tr>
<td>One co-worker complaining to me in private about another co-worker.</td>
<td>Others present: No-one.</td>
<td>30s-40s, female, RN</td>
<td>&quot;She's a pain in the fucking arse.&quot;</td>
<td>Good humour</td>
<td>Joking response</td>
<td>Surprised.</td>
</tr>
<tr>
<td>Discussing new unit policy.</td>
<td>Others present: Just me.</td>
<td>40-yr old nurse, female.</td>
<td>&quot;This is fucking stupid.&quot;</td>
<td>Conversation</td>
<td>Echoes/reflects language/feelings</td>
<td></td>
</tr>
<tr>
<td>A staff member asked for assistance with faxing. I apologised and said that I couldn't due to the work I had to do. They swore and I had failed to recognise their work stress. Could have easily been other staff present but I don't think anyone else heard.</td>
<td>A reasonable mate and male and mature allied health professional</td>
<td>&quot;Ahhh...fuck it then...fuck...forget about it&quot;</td>
<td>work colleague's frustration and anger and disappointment in me</td>
<td>I apologised for not recognising their desperation for help and said I genuinely couldn't help at that moment</td>
<td>Bad</td>
<td></td>
</tr>
<tr>
<td>Nurse was frustrated over faulty equipment.</td>
<td>CNS, 49, male (frustrated).</td>
<td>&quot;This fucking printer ...... It's fucked.&quot;</td>
<td>Faulty equipment; needed replacing for a long time</td>
<td>Ignored. Short duration only.</td>
<td>Better.</td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td>Event Description</td>
<td>Age and Gender</td>
<td>Diagnosis</td>
<td>Provocation</td>
<td>Response</td>
<td>Emotional State</td>
</tr>
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<tr>
<td>79</td>
<td>I was providing a cigarette (roll your own) to a client who had an injured arm and asked if he needed assistance to roll it. He took offence and commenced a barrage of abuse. Others present: Other staff.</td>
<td>Around 40 yrs, male, chronic schizophrenic, high aggression.</td>
<td>Things like &quot;you think I'm fucking stupid.&quot;</td>
<td>No understandable provocation</td>
<td>Withdraw</td>
<td>Stressed, fearful.</td>
</tr>
<tr>
<td>87</td>
<td>I went to sit next to a patient on the lounge. Others present: Patient, staff and family members.</td>
<td>13, female, depression, post traumatic stress disorder</td>
<td>&quot;Fuck off you stupid fat bitch I don't want you to sit there. I don't want anyone fuckin near me.&quot;</td>
<td>Distressed</td>
<td>Withdraw</td>
<td>Didn't bother me. If you are offended by being sworn at you are in the wrong job.</td>
</tr>
<tr>
<td>203</td>
<td>Reached to touch someone who was distressed and anxious. Others present: Other staff.</td>
<td>16 - female - mental health issues</td>
<td>&quot;Don't fucking touch me&quot; .</td>
<td>Distressed</td>
<td>Placate</td>
<td>Startled - for a second. Reassess situation.</td>
</tr>
<tr>
<td>104</td>
<td>A NUM was walking from nurses' station to a patient's bedroom, unprompted a patient called her a stupid slut. Others present: Other patients, other staff, myself.</td>
<td>Male, 20s, drug related psychosis (resolving).</td>
<td>&quot;Stupid slut, stupid slut.&quot;</td>
<td>No understandable provocation</td>
<td>Confront</td>
<td>Angry that this person felt comfortable calling this woman who was in fact helping him such a derogatory name and also annoyed that this NUM ignored it - she deserves better. Saddened, angry.</td>
</tr>
<tr>
<td>125</td>
<td>A psychotic client was making threats towards my family. Others present: No one else.</td>
<td>Mid 30s, male with dark skin, unkempt. Bipolar disorder with antisocial personality traits.</td>
<td>&quot;I'm gonna fuck your kid up the arse until they bleed and then I'm gonna rip her nipples off in a vice!&quot;</td>
<td>No understandable provocation</td>
<td>Withdraw</td>
<td>Vulnerable; stressed; angry; violated.</td>
</tr>
<tr>
<td>215</td>
<td>A patient (very unwell) called me a &quot;dumb slut&quot; and told another staff person (about me) &quot;I hate the dog.&quot; I had been extremely helpful and nice to this patient. Others present: Myself/security staff/members of nursing staff from cardio respiratory and ultrasound members of the public walking past a clinic.</td>
<td>Psychotic, female, mid 30s, schizoaffective disorder with an 11-wk old foetus</td>
<td>I'd hoped I'd been building a rapport with her and was giving her good care and also she abused me in front of others. I felt hurt and felt it was unfair.</td>
<td>Patient denied something</td>
<td>Ignore</td>
<td>In this instance upset and embarrassed. I didn't feel good being called a &quot;dog.&quot;</td>
</tr>
</tbody>
</table>
FEATURE ARTICLE
An overview of swearing and its impact on mental health nursing practice

Teresa E. Stone and Mike Hazelton
University of Newcastle, University Drive Callaghan NSW 2308 Australia and Hunter New England Mental Health, Newcastle Australia.

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