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On violence in health care: between violence against caregivers and violence of care

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Abstract. – After indicating some psychological characteristics of violence, the article focuses in particular on the phenomena of social, institutional, and political violence, and points out that after Freud's writings on war and the psychology of the masses, this topic has been somewhat neglected by psychoanalytic research. It then points out that in recent years, after 9/11, great interest has been aroused on the topic by psychoanalysts and group analysts. The socio-cultural roots of violence are explored, and the role exerted jointly by the norms and pressures of groups and institutional cultures as well as the passive-dependent and conformist tendencies of individuals. The article then deals specifically with violence in healthcare contexts, exploring violence targeted against caregivers, particularly after the COVID pandemic, both by users and by the media and public opinion, on a physical, verbal, and psychological level, as well as institutional violence – which fuels conflicts between the various actors in the health care system – and violence intrinsic to the processes of care, which often require the patient to undergo objectively distressing or coercive measures and conditions. In the concluding section, some approaches and methods that have proved useful in preventing these forms of violence are indicated.

Key words: violence; aggressiveness; institutional violence; conformism; care relationships; stress and burnout; illness and blame.

The issue of violence is now more central than ever in reflections on social reality, education, politics, the quality of working life, and citizenship, at a time in history marked by military, political, and economic clashes, religious persecution, street riots, group aggression and private violence. The issue is, moreover, much more complex than is sometimes stated or thought, in collective contexts as well as in private life, and is difficult to interpret when it occurs in 'places of care', such as hospitals, emergency rooms and family doctors' surgeries. There is often the tendency on the part of both public opinion and the individuals or institutions concerned to believe that it is sufficient to reiterate that violence should not be tolerated, to establish rules

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and sanctions against violent behavior, and to set up security devices such as alarm systems or police stations. Decisions such as these are undoubtedly necessary, but it is crucial to be aware that they are not enough.

A first consideration is that, given that violence in individuals, groups and societies have always existed, as history and common experience have shown (including current violence, since we are in wartime right now), one may wonder whether the problem today lies not so much in the increase in its force or frequency but rather in cultural changes, in the weakening of educational safeguards and in the waning of regulatory instances – what Kaës called 'meta-social guarantors' (Kaës, 2005), first of all in the family and at school, but also in collective contexts and, in particular today, in the world of digital and social media.

Secondly, we need to consider that the risks associated with a culture of violence – especially when directed at the world of health care – consist not only of physical aggression but also of much more frequent verbal and psychological aggression, which can appear in the form of a wide range of behavior, from rude phrases to facial expressions of contempt, from hate speech on Facebook to criminal complaints, all aggressions that are often no less damaging than material injuries.

Finally, I would like to point out a factor that is of great importance but is often ignored or underestimated: the violence of the institution, which sometimes reacts to that of individuals (as in the case of the armed forces, prison or public security), but at other times arises internally in a completely spontaneous and unpredictable manner, when it is not even intrinsic to its own basic culture, as in criminal organizations, terrorism and certain ideological extremisms, but to some extent even in financial markets, energy strategies, and migration policies.

Before addressing the specific topic of violence in health contexts, a clear distinction must be made between violence and aggression, even though they are often used as synonyms. One should first state that aggression and hatred, not unlike positive emotions such as love, tenderness, trust and solidarity, are completely natural, even physiological emotions in our species. To understand this statement, one only needs to observe the spontaneous behavior of small children in a nursery, for example, when one of them plays with another child's toy.

Without a congenital endowment of aggression, we would probably not survive for long even in a sufficiently safe social context.

Violence and aggression

Globalization has undoubtedly made violence a much more difficult phenomenon to define than in past times: currents of violence and oppres-

sion now move swiftly through all networks, connecting places, people, resources, and institutions in every part of the world. The most clamorous of its manifestations, war, which has ravaged the planet for centuries, to the point of verging on a nuclear holocaust and which is now once again threatening planetary balances, is today a more limited, local, mobile, and mostly short-lived phenomenon, either turning into a trickle of daily violence that lasts for decades, or becoming underground and insidious like terrorism, mafia trafficking or secret service operations. Added to this, however, are the new wars and violence of post-modernity, those fought with the weapons of financial markets, energy resources, migration, and labor policies, as well as the erratic and more or less ideological collective violence of certain extremist groups and in general of the impoverished and frightened urban masses. To some of this violence, the institutions of politics, justice, public order and even welfare respond, not infrequently, with symmetrical violence: just think of the brawls in Montecitorio where our Parliament convenes, the sheriff-mayors' crusades against tramps and immigrants, the beatings which a violent fringe of the police force indulges in, and, to stay in the mental health territory, the abuses of physical and pharmacological restraint.

Not to mention the newest forms of violence organized and acted out on social media, from cyberbullying to destructive challenges, from sextortion (blackmail using erotic images stolen from private archives) to the innumerable forms of 'hate language' that populate the web.

Psychoanalysis, which since its beginnings has thoroughly explored the individual and family dimensions of violence, still seems somewhat ineffectual, both theoretically and operationally, in the face of complex phenomena such as social, institutional, and geopolitical violence.

For the purposes of this article, I shall neglect the whole *vexata quaestio* of the nature and origins of aggression, the opposition between 'dispositional' and 'situational' approaches, the dispute between the ethologists' innatism (including Klein's death drive) and the various frustrational (Dollard *et al.*, 1957), deprivative (Winnicott, 2005), post-traumatic (De Zulueta, 1999) or social learning-based (Bandura, 1973) theories. The influence of social structure, education and culture, which Freud had certainly not underestimated within the drive model, was, however, essentially traced back to the role of 'guardian' of civilization against the outburst of aggressive instincts, which were dealt with by repression or sanction by a SuperEgo embodied in current social norms (Freud, 1912-13; 1915; 1921; 1929; 1932; 1934-38).

Nor will I deal with violence as a mode of interpersonal relations or as a cause or, *vice versa*, as an expression of various forms of psychopathology.

I think it would be useful, as a preliminary, to consider the existence of different forms of aggression – from instrumental (to obtain a result) to

identity-based (to separate oneself from others), from impulsive (to release tension) to defensive (to protect oneself from danger) or post-traumatic (to evacuate the pain of trauma experience) – diversities that even neuroscience tends to trace back to different hormonal and neuronal systems.

As already mentioned, it would also be appropriate to distinguish between aggression and violence as different psychological setups, on an emotional, cognitive, and behavioral level.

In this sense, violence could be defined as 'a form of aggression that assumes in its development the purpose of causing harm to the victim'[1]. The violent component is incidental and therefore there can be a form of aggression without violence, while it is difficult to imagine a form of violence without aggression. These considerations allow us to realise that while violence must be prevented, countered and punished in order to guarantee a safe environment, on the other hand, we need to learn to know aggression in order to govern it and prevent it from turning into violence.

In his article 'Freud and Violence', David Benhaim writes:

> 'Freud's work is traversed by a dense, rich, rigorous and profound analysis of *Kultur*, which allows us to observe the phenomenon of violence in its essence. (...) from 'Totem and Taboo' to 'The Man Moses and Monotheistic Religion', passing through 'Current Considerations on War and Death', 'Psychology of the Masses and the Analysis of the Ego', 'The Malaise of Civilisation and Why War?', Freud never ceases to return to the question of man's violence, not only in its social dimension, but also cultural and anthropological.' (Benhaim, 2010)

However, the term violence, as Benhaim observes, is not part of the psychoanalytic lexicon, just as most analysts, from Freud onwards, are not interested in forms of social violence that go beyond the perimeter of family relations or the behaviour of psychiatric patients in care settings.

Violence has of course been the subject of extensive reflection and careful study by the historical, political and social sciences, and many authors, essayists and novelists, from Konrad Lorenz to Hannah Arendt, from Joseph Conrad to Primo Levi, have explored the 'heart of darkness' of mankind in depth, while psychoanalysts have dealt mainly with private vio-

[1] In fact, many psychological studies have explored the similarities and differences between aggression and violence, emphasising the former or the latter, as well as the presence or absence of intentionality in the aggression against the victim, the role of impulses and their controls, that of emotion regulation, that of unconscious fantasies and delusional beliefs, not to mention the crucial influence exerted by the culture to which one belongs and its social norms. For the purposes of this article, I will limit myself to considering a 'phenomenological' difference: aggression would essentially be an emotion, a state of mind, whereas violence is a behaviour, the consequence of which for the object at which it is directed, regardless of the underlying intentions, is always damage, injury, appropriation or even its destruction.

lence, hidden inwardly, very rarely leaning out of the window of the analysis room to look outside.

There have nevertheless been some notable exceptions, such as: i) Hannah Segal and Franco Fornari on war and the nuclear threat (Segal, 1997; Fornari, 1966; Fornari *et al.*, 1978); ii) Rafael Moses, Shmuel Erlich, and other analysts working in the association PCCA (Partners in confronting collective atrocities) on issues such as the Holocaust, the Israeli-Palestinian conflicts, and other international violence (Erlich *et al*., 2009); iii) Vamik Volkan on interethnic conflicts and terrorism (Volkan 2006; Varvin and Volkan, 2003); iv) Silvia Amati Sas on torture and the treatment of refugees (Amati Sas, 2003); v) Peter Fonagy, Stuart Twemlow, and other American analysts on urban violence and bullying in schools (Fonagy, 2001; Twemlow, 2000).

An interesting volume edited by Janine Puget, René Kaës and others and entitled 'State Violence and Psychoanalysis' brings together the testimony and reflections of a number of Argentine analysts – including Armando Bauleo, Marie Langer, and Puget herself – who, in their lives and in their professions, suffered the violence inflicted by the military dictatorship. The Italian publisher's review raises some relevant questions in this regard:

> 'What are the consequences when state violence breaks into the history of men and women? How does the traumatism that is created differ from what ordinary psychoanalytic practice knows? (...) The authors question the genesis of authoritarianism, they analyze its effects in the emergence of severe pathologies, in the elaboration of particular mourning, in the transmission of horror and shame, in the work of memory in situations of extreme rupture (...) The importance of these contributions lies above all in showing us the psychoanalysts who are trying to think the unthinkable: in other words, to think of violence that tends precisely to destroy the capacity to think and act. The various essays interrogate psychoanalytic theory, clinical practice, and ethics in the regime of state terrorism.' (Puget *et al.*, 1994)

The attack on the Twin Towers on 11 September 2001 changed the face of the planet, confronting it with an unprecedented and unthinkable phenomenon, global terrorism, with its unlimited destructive power and ubiquity: violence without borders. Psychoanalysis, too, had to confront this new and bewildering abyss, if only to try to provide those who had to learn to live with it with their own distinctive contribution: thinkability.

Since then, the analysts' interest in the study of social violence has grown considerably, as some of the most recent publications on terrorism, war, and political violence testify. Another clear and strong signal within the community of Italian analysts is the pressing succession of events, seminars and conferences that have in recent years been dedicated to the theme of violence.

Violence, socio-cultural norms, and institutional dynamics

The experience of history – both past and present – tells us of violence that can hardly be referred to the private sphere, but points the finger directly at the role of the political-cultural context and institutions. Violence is not an impersonal product of society, it is the child of man and his shadow zones. But it is society and its institutions that evoke it, give it form and direction, and above all multiply it and turn it into culture.

Social psychology sees violence as the expression of a dialectic between the individual disposition to aggression and the influence of competitive, deprived or problematic social situations, which can generate traumatic experiences, attachment disorders and weakening of the social bond.

In one of his last interviews, Primo Levi said:

> 'The seed of Auschwitz should not sprout again, but violence is near, it is all around us, and there is a violence that is the child of violence. There are underground links between the violence of the two world wars and the violence we witnessed in Algeria, Russia, the Chinese cultural revolution, and Vietnam. Our society, together with the media (though so necessary) gives us the dissemination of violence. It has mechanisms that magnify it.' (Poli & Calvagno, 2013)

From this point of view, the data from research – the first of which dates back several decades – exploring the links between collective violence (of groups, masses, organizations, states, and societies) and the explicit and implicit socio-cultural norms that dominate the soft underbelly of our communities, what we might call the 'social unconscious' (Hopper, 2003), are impressive.

Leaving aside the obvious legal implications, we can say that violent actions are mostly considered illegitimate if they break current social norms: police violence when shooting back at criminals is experienced as legitimate, the opposite is true if they shoot unarmed people. Implicit and unwritten social norms can therefore legitimise certain forms of violence, sometimes even when the law considers them a crime. This is the case, for example, with the 'norm of reciprocity', which from the biblical 'an eye for an eye' right down to the US laws sanctioning the private right to possess (and use) a weapon, authorizes revenge as a response to violence suffered. Then there are the social norms which in every part of the world nurture 'gender violence', deeming violence almost acceptable if committed by males, particularly against women, or the norms which, in the name of family 'privacy', justify much of the violent behavior occurring within the domestic space.

Particularly widespread is the social norm, also implicit and unwritten, which justifies the violation of rules and laws limiting aggression, when people are part of a group or behave as a 'crowd'. Gustave le Bon, and sub-

sequently Freud and other authors, explored the behavioral and emotional dynamics of large groups: when a crowd is rendered blind by the idealization of the leader or dominant opinions, by the divestment of the ability to think and the disappearance of superegoic regulations, then mass violence is ready to spread like a tsunami, provided it is not enlisted by some political-economic interest pole that tries to turn it into an instrument of power.

I would certainly not call Facebook or Twitter violent institutions, yet in recent years the social media have often played the role of 'attractors' of collective violent behavior, mobilizing flash mobs, street rallies, and neighborhood brawls, or, on the other hand, on quite different levels, inciting various forms of cyberbullying, media persecution and moral lynching on the net. The press and television have also played their part, for instance by setting up so-called 'mud-slinging machines' against this or that public target. In both cases, as we know, people have paid with their lives.

The influence of the social group – especially the 'reference' group – on the individual's way of thinking and relational life has long been known, and as far as violence is concerned, we know that conformism can also lead to the enactment of behavior that single individuals would not adopt. The group, especially a large one, offers the protection of anonymity and the diffusion of responsibility. In this regard, dynamics of 'social contagion' have been described where 'groupthink' (Janis, 1982) can operate as an amplifier of aggressive tendencies through the implicit prescription of norms defining the behavior required of members in order to be accepted by the group, and to be able to continue to belong to it. The central conflict is the one between identity and belonging, and when in a subject or a group (or sometimes in a people) the former is precarious and the latter vital, then resorting to violence can also become an acceptable price.

The study of conformism and obedience as effects of pressure from the group or from an entire social system has produced experimental evidence of how easy it is to commit or not prevent violent acts, normally considered unacceptable, whenever some cultural, ideological, or scientific alibi offers some plausible justification. In Stanley Milgram's experiment (1974), several mature and well-balanced people ended up administering painful electric shocks to prisoners convinced that they were operating in the superior interest of science (in reality, there was no electricity in the machines and the 'guinea pigs' were actors trained in simulation). The experiment, which Milgram conducted in 1961, was initiated shortly after the start of the trial against Adolf Eichmann in Jerusalem, partly as an attempt to answer the question of whether it was possible that Eichmann and all his accomplices were simply following orders.

Ten years later at Stanford University in Palo Alto (California), Philip Zimbardo faithfully reproduced a prison environment, and for experimental purposes had it run by 24 university students, chosen from among the most

well-balanced and mature, randomly assigning them the role of prisoner or guard and establishing a set of very rigid and depersonalizing rules.

After just two days, the first episodes of violence occurred, with intimidation, cruelty and humiliation becoming progressively more and more uncontrolled and destabilizing until the experiment was interrupted to avoid the worst possible outcome. Zimbardo attributed these dramatic outcomes to a collective process of 'de-individuation', in other words, a loss of a sense of self and personal identity, engulfed by the institutional role and its demands. (Zimbardo, 2007)

We might say that instead of insisting on the usual ego/super-ego hinge, the ethical conflict shifted to the one between superego and institutional norms, where the culture of the institution, fixed in the basic assumptions of Dependence and Attack/Flight, can only offer its members two roles: that of victim or that of persecutor. Abu Ghraib and Guantanamo are already there, in all their clarity, as are the horrors of the Afghan and Iranian regimes and the tortures committed in the Santa Maria Capua Vetere prison.

When one speaks of institutional violence, one is describing a complex and multifaceted picture, which essentially consists of the following scenarios:

1. the institution 'infected by violence', where violent behavior in institutional life appears as 'polluting' forces capable of contaminating a sufficiently healthy original culture. We can imagine that 'healthy' organizations operate as solid, enlightened, and safe containers, capable of stemming the anxieties and toxic emotions that generate violence, such as envy, greed, fear, hatred and rivalry; but it may happen that something – stress, perverse cultures, reduced resources, growing insecurities from the environment – makes them 'sick' or 'intoxicated' thereby weakening their regulatory functions and opening the way to violent action as an evacuation of anxiety, anger and pain.
2. the institution subjected to 'rape', *i.e.*, affected by catastrophic or cumulative trauma, which determines its fate for a long time, either in terms of post-traumatic malfunctioning or in terms of 'transgenerational' reproduction of trauma and violence. Groups and institutions can become the object of violence and trauma, as several analysts have observed. Vamik Volkan in particular, with his dual experience in the institutional therapy of psychotics at the Austen Riggs Centre, and in the dynamics of large social groups in the context of international diplomacy, describes how in traumatized organizations and societies the trigger for violence is often a 'chosen trauma' (Volkan, 2001), an event taken up by a group or a nation as an open and unhealable wound, the cause and signifier of every difficulty, a traumatic memory and 'legacy' of violence to be passed on through the generations, as is sometimes the case with abused children.

3. the actual violent institution itself, *i.e.*, an institution dominated by an inherently violent organizational culture. Leaving aside the obvious reference to criminal organizations, I am essentially alluding to narcissistic and perverse institutions. Narcissistic organizations and their leaderships, dominated by self-centered cultures that pay little attention to the needs of others, are prepared to do anything to save their own balance of power and to dodge responsibility, mostly by offloading it downwards, *i.e.*, onto their employees. The paranoid (Jaques 1976; Kernberg, 1993), or totalitarian (Bar-Haim, 2013), or demagogic drifts to which they sooner or later give rise are ideal breeding grounds for the development of violent behavior, which takes the form of the emergence of the man of providence, financial, commercial or geopolitical conflicts, or conversely, the explosion of anger in the streets, and the masses against the violence of markets and global policies. These include, above all, corporate, political, and ethno-religious organizations.
   Perverse organizations, dominated by splitting and fragmentation, bureaucratic or masochistic-sacrificial cultures, obsession with control and procedures, and confusion of language, include mainly public sector and welfare institutions, where the rule is to say one thing and do another, *e.g.*, proclaim health values and practice cost-cutting goals. Significant potential violence also lurks in these organizations, and we realize this when our reasonable requests are not answered, or when the rules that are imposed on us have a clearly vexatious meaning, in the logic whereby the needs of the institution cannot take into account those of the people, whom they sometimes do not even know. Institutional violence is expressed here in more attenuated ways, such as a chronic conflictuality, which produces anger, distrust and egocentricity, and which cannot be contained due to the impossibility of giving voice to the malaise and the absence of conflict regulation devices; or it translates into real forms of 'ill-treatment', such as omissions, non-listening and non-answers, nagging procedures, changing the rules while the game is in progress, double-truths and all those hypocritical and emotionally neutral ways that Manfred Kets de Vries has defined as 'alexithymic' (Kets de Vries, 1989) and that aim at silencing the subject, or at producing his invisibility, in practice at his 'annihilation' through the weapons of bureaucracy.
4. the institution deputed to manage, repress or conceal violence generated elsewhere, in the widespread social fabric or in other institutions such as the family or the workplace. This is the case of the Armed Forces who must exercise this control vis-a-vis an enemy in order to defend the country; of the police who must curb or prevent it by acting against those who break the law or those who threaten public order; of the law itself and the judiciary who administer it by punishing the

guilty in the name of the people and in the interests of the community; of the prison system which contains and punishes it; of the trade unions which channel it into the labour claims; of the church which rejects it as a sin; and even of psychiatry which interprets it as a symptom of illness and seeks to cure or at least contain it[2].

The problem with these institutions is that violence soon becomes an 'institutional language' which unites managers and those managed, and risks making them as violent as their 'clients', in a mimetic process of cross-identifications which Kaës called 'isomorphism' (Kaës, 1976). Institutional isomorphism tends to turn institutions that have to manage violence into violent institutions themselves, sometimes going so far as to contaminate even the caring functions that they offer and perform.

Thus, for example, the army is involved in periodic 'gratuitous' massacres, from My Lai to Sabra and Chatila to Srebreniča (or even just extreme forms of 'bullying' of new recruits by the old hands), the anti-terrorist services implementing their own terrorist operations, the police with the G8 raids in Genoa, the church with pedophilia, psychiatry with its historical pincer dilemma between the violence of repression and the violence of abandonment.

Violence and institutions for care

Thus, when violence can be encountered as a frequent dynamic of social and organizational life, it is more than foreseeable that it may also start to contaminate healthcare contexts, which should instead be dominated by the values of caring for those in need, by the pursuit of well-being, and the working alliance between carers and those treated.

To avoid frequent misunderstandings, I would like to clarify that people's violent behavior, even if it is an expression of altered interpersonal relationships in a delinquent or psychopathological sense, is not necessarily an indicator of delinquency or psychic pathology. Criminals and paranoids are often aggressive – and this is certainly an additional burden for emergency and mental health workers – but much violence is committed by people who are neither habitual offenders nor carriers of some personality disorder.

A seemingly paradoxical – and in many ways cruel – aspect was the abrupt change of image and attitude that health professionals underwent during the pandemic, going from a celebratory phase in which they were applauded from balconies as modern-day heroes and martyrs in the war

[2] Until 50 years ago, there was also the asylum, where violence could be segregated.

against the virus, to a phase of angry devaluation, which saw them being accused of COVID deaths as 'plague-spreaders' or assaulted in emergency rooms at knifepoint or with foul language. I have spoken of an 'apparent' paradox because the fact responds to a fairly frequent emotional logic, the one whereby the disappointment of expectations that were unrealistic (in this case, healthcare as a magical and omnipotent bulwark against the epidemic) tends to turn the idealized object into a denigrated one as soon as the idealization is disproven by facts.

But violence against health and social workers is not a consequence of the pandemic, it is a phenomenon that precedes it and that has long since insinuated itself into care work, representing one of its most significant risks, not only because of the harmful consequences it has on the safety and health of caregivers, but also because of the negative impact on their motivation (which can lead to the abandonment of the profession or its dehumanization), and ultimately on the efficiency of the health system's performance. This is eloquently illustrated by the 'quiet quitting' (the silent abandonment of jobs by doctors, nurses and other workers) and the collapse of many emergency rooms as well as a large section of territorial healthcare services.

I will try to draw a provisional map of the aspects of care work that may expose caregivers (but not only them but also patients, family members, colleagues and managers) to experiences of violence, whether suffered, acted upon or witnessed, on the physical or psychological level.

A first aspect concerns the implicit and irrational perception of illness and death as guilt, a guilt on the part of the caregiver or of the patient or of both. Its origin dates back to religious conceptions, but in modernity, it has received various cultural and even institutional confirmations.

- In the Chinese tradition, the so-called 'barefoot doctors' were paid as long as the patient was well and stopped being paid when they became ill.
- In Bergman's film 'The Place of Strawberries', the elderly doctor utters the disturbing phrase: 'The doctor's first duty is to ask for forgiveness'; forgiveness for what? Perhaps for the guilt of not being able to avoid death?
- The National Health Service in the United Kingdom in the recent past 'punished' diabetic patients who did not follow their diets or prescribed therapies correctly by suspending free treatment.
- Until recently, in 'malpractice' lawsuits, the onus was on the practitioner to prove that he had not committed an error, rather than on the plaintiff to prove that he had.

As already mentioned with regard to the events of the COVID-19 pandemic, the idealization of medicine as omnipotent and salvific means that even the slightest denial (partial successes, errors, disappointed expectations) inevitably leads to a presumption of guilt, from which derive the

predictable reactions of accusation, mistrust, devaluation and aggression, which professionals usually have to endure but which they can occasionally spontaneously turn against themselves, causing violence to themselves, so to speak. Perhaps this is why the practice of caring tends to generate deep-seated feelings of guilt in those who engage in it.

The responsibility for this misguided idealization of medicine is manifold: sometimes it is the medical practitioners themselves who present an image of themselves and their science as something all-powerful and magical to their patients, but more often it is the latter – and with them, the public opinion – who imagine it, expect it or even demand it, not infrequently aligning themselves with certain triumphalist positions espoused by health institutions or even by the scientific literature. In order to understand this phenomenon, one need only recall how frequently patients' health conceptions are imbued with magical-irrational elements or childish attitudes, how often illnesses are linked with one's own fault or malicious action, with an aggressor operating from outside (a trauma a virus or perhaps the physician in charge of treatment) or from within, how easily an illness can be transformed into a deserved punishment, an exemption from responsibility, a way out of a conflict, an occasion for claims, demands, blackmail, and compensation.

In addition to patient expectations, the risks of exposure to violence are accentuated by two other aspects of the care relationship: proximity and continuity. When the situation becomes critical, due to a therapeutic failure or a worsening of the clinical picture, caregivers who spend more time in close contact with patients tend to be more exposed to the latter's aggressive reaction but also more prone to interact aggressively with them and sometimes even with colleagues. These conditions can occur to all health professionals, but to a greater extent to those who, as mentioned above, work in closer proximity and continuity of care, *i.e.*, nurses and care staff, family doctors, and mental health workers.

The caring relationship and related emotions are strongly influenced by the quality of communication (verbal and non-verbal) and the level of mutual trust which can generate a working alliance between carers and patients. The importance of speech (and its consistency with mimic and body language) in care work has been amply documented by recent neuroscientific research, where it has been discovered that rude, angry, derogatory and insulting words - not to mention hate campaigns launched on social media - can 'hurt' not only one's self-esteem but also the brain and body through the release of cortisol and other 'stress hormones'.

Trust, that fundamental feeling in the therapeutic alliance, should also not be taken for granted; it is gradually built up over time through reciprocal experiences of respect, understanding and kindness, where an important role is played both by mirror neurons, engines of empathy, and

by eye-neurons, which, through the exchange of glances, promote the production of oxytocin in the amygdala of both interlocutors and, as a result, the creation of bonds of attachment and trustworthiness.

But trust can break down for a wide variety of reasons, giving way to mistrust and hostility, such as in the communication of 'bad news' or in cases of non-adherence to prescriptions, or when the patient also turns to other caregivers, perhaps even to Dr. Google. All of this teaches us that human relationships – and care relationships in particular – must equip themselves in order to deal with negative emotions as well, and learn how to manage the inevitable conflicts, in order to prevent contrast from becoming enmity and war, degenerating into violent conduct and stifling any possibility of collaboration between caregivers and patients, as well as discouraging each other from continuing to believe in the public health service.

Another factor that tends to prompt aggressive or violent attitudes is the actual healthcare context, which requires caregivers to provide care in particularly stressful situations. I am referring to critical and emergency areas, resuscitations, oncology, palliative and end-of-life care, places for birth and child care, work during epidemics, wars or catastrophic events, and mental health. An Emergency urgency acceptance department where assaults have occurred against caregivers is likely to be dominated for some time by feelings of fear and resentment, which are bound to affect the quality of care relationships and interventions, but also the cohesion and collaboration between caregivers; a typical example is the clashes between family doctors, continuity of care physicians, and doctors in the Emergency room.

In the healthcare 'places' most affected by stress, carers may experience forms of aggression enacted not only by the users but by the very institution to which they belong, a sort of 'institutional violence' that exposes them to the risk of losing their sense of self, their values and personal identity, swallowed up by the institutional role and its demands. This is what is now called 'moral injury' in the extensive chapter on burnout.

A specific example of institutional violence, which psychiatry has studied in depth in its effort to overcome its asylum-linked past, is stigma, a label used by certain cultures to indicate people's behaviour – and often also their opinions and emotions – according to pre-established criteria that aim to define negative, dysfunctional or presumed guilty roles and characters (actual scapegoats) in order to confirm beliefs and prejudices or to maintain some form of utilitarian and power balance.

Typical of hyper-competitive corporate cultures – but not infrequent in welfare cultures as well – is the sanctioning of anxiety as a sign of weakness and incapacity, or the interpretation of doubt as proof of incompe-

tence or disloyalty. In healthcare environments, stigma typically affects caregivers when they manifest malaise, fatigue, indecision in carrying out their work, or when they reveal their opposition to certain company policy choices. It is also for this reason that doctors, nurses and other health workers very rarely ask for help in stressful conditions, and even less so psychological help, nor do they accept it serenely on the occasions when the institution offers it to them; for a health professional, accessing a support desk or asking for the 'psychologist bonus' (a grant awarded to cover the cost of a psychologist's service) today still seems to imply some risk to one's reputation.

A final chapter – quite complex and delicate – concerns what I would call the 'implicit violence' in caring. If we think of care in terms of 'caring', of taking care of a person who is suffering and in need of assistance, we generally think of actions in terms of rescue, solicitude, closeness and sympathy; but we know all too well how 'caring', the treatment of illnesses and the carrying out of therapies, is also demanding for the patient, who not infrequently has to accept a certain degree of violence in order to be able to receive help, regardless of the fact that the caring relationship is based on adherence and on a working alliance between conscious adults.

Cures can be 'violent' in many different ways, due to the fact that they can: i) inflict physical and psychological pain; ii) generate anxiety and insecurity; iii) impose limits to one's freedom; iv) induce situations of dependency and feelings of powerlessness; v) denude the body, penetrating it (with instruments or drugs), injuring it and exposing its intimacy.

In psychiatry, the violence of treatment can also take the form of certain measures of coercion and behavioral control, or of therapeutic practices which can alter the consciousness, thoughts and even feelings of patients. And the fact that all this is mostly inevitable and serves to improve people's health does not eliminate the risk that at certain moments the treatment is perceived as violence, as something worse than the illness itself; and that consequently in the patients' minds the caregivers turn into rapists.

To conclude, we can ask ourselves what constitutes adequate protection from violence for health workers. The issue, as always a complex one, does not tolerate hasty simplifications such as saying that it is sufficient to set up police stations in emergency rooms, or increase the sentences for aggressors. These measures are undoubtedly necessary but probably not sufficient if they are not supplemented by a series of other instruments which I will try to list here.

1. A change in the organizational culture of the health care system, implementing greater responsibility for the well-being and safety of carers and a greater awareness of how they are intertwined with the aspects of care that relate to limitation, suffering, and the anguish associated

with the experience of physical vulnerability, illness, chronicity and death; all the above in the light of the current operational difficulties, which have escalated in part due to the pandemic, with increasingly tired and overburdened carers and an ever-increasing pressure to act.
2. A training and preventive model for health professionals that is not limited to procedures for the 'management' of aggressive events or to the collection of data and documents, but that fosters an understanding of the factors at play in reported incidents (What makes a patient or family member aggressive? What makes a caregiver aggressive?), improves professionals' skills in managing risk behavior and in reading the signs that anticipate a violent response, and also provides spaces for reflection on what everyday anger and tensions evoke in the inner world and in the behavior of those involved.
3. A series of measures that promote both real security (protective devices, escape routes, alarm systems, self-defense training) and perceived security, *i.e.*, environments and operating contexts that are felt to be safe - particularly in the reception and waiting areas for users - and physically and mentally present management who show genuine concern for safeguarding the well-being of carers and the working alliance with patients through a healthier and more sustainable organization.
4. Introducing in the common working hours of all health workers, stable, regular and protected meeting spaces, designed to promote sharing, reflection, cooperative learning and group support in a regulated and safe, non-judgmental and stigma-free context, managed preferably with psychodynamic-systemic group methodologies, such as Balint Groups and peer interview and support groups.

The expected results are the development of a working environment that is both self-protective and protected by the institution, where violent events – and the stress that fuels them – are reduced in number and severity, and where health professionals are not forced to defend themselves with inadequate mechanisms, such as risk denial, guilt projection, sacrificial masochism, symmetrical violence or flight from the profession.

Users (patients, family members, caregivers, *etc*.) should also be made aware of the issue to some extent so that they realize that scaring caregivers may make them unable to care for them.

Conclusions

Stanziano and Nunziante Cesaro (2013), in their work on violence against women, recall the distinction made by André Green between 'acting out' and 'acting in' (Green, 1991), essentially linking social violence with the lack of symbolization and with 'the absence of psychological and

cultural processing', and suggest that such processing would be precisely the most effective weapon to prevent it and perhaps even to cure it. There is no doubt that violence such as inter-ethnic violence, nourished by the fear of the different that transforms the stranger into an enemy, is sustained by these deficits, which are both psychological and cultural, and therefore I believe that this is the terrain where psychoanalysis could try to make a significant contribution, in the sign of the recognition of conflict, its thinkability and its non-violent management.

In his book on group and organization dynamics, Kets de Vries writes:

> 'There is a Sufi story about a man who noticed an annoying bump under a carpet. He tried everything he could to flatten the carpet, smoothing it, rubbing it and squeezing the bump, but it kept reappearing. Finally, frustrated and furious, the man lifted the carpet and, to his surprise, a very angry snake emerged.' (Kets de Vries, 2011)

For the author – a psychoanalyst with great experience in analyzing organizations – this story is a clear metaphor for the need to go and see and address real problems in depth, because remaining on the surface risks achieving only limited results. But, reading between the lines, it seems to me that it also says something else: that 'smoothing out' saliences and critical issues without immediately going to look at what is under the carpet, prolonging the denial of conflict and the disavowal of danger over time, only leads to their 'hardening'.

The Sufi tale does not state this, but I would bet that the snake must have bitten the man's hand. Angry snakes usually become violent.

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