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Editorial

Violence: a public health issue

Paula McGee PhD RN RNT MA BA Cert Ed
Editor, *Diversity in Health and Care*; Professor of Nursing, Faculty of Health, Birmingham City University, Perry Barr, Birmingham, UK

Mark RD Johnson MA PhD Dip HE (Warwick)
Editor, *Diversity in Health and Care*; Professor of Diversity in Health and Social Care, Mary Seacole Research Centre, De Montfort University, Leicester, UK

Regular readers of this journal will know that we take a very broad view of diversity, which incorporates a wide range of difference and includes subjects that are unaddressed in other arenas. In this issue we focus on one such topic, namely violence, which has been defined as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation' (World Health Organization, 2002, p. 5). One way or another, violence forms part of everyday life in both the public and private spheres. War, civil unrest and street crime complement the physical, sexual or emotional abuse and neglect that take place in homes. Most news bulletins contain accounts of violence. This morning the BBC news (www.bbc.co.uk/news) led with features on bombings in Iraq, a death at the G20 Summit and the discovery of the body of a murdered MI6 agent – just another 'normal' day. Even in our leisure time there are elements of violence. For some of us there seems to be nothing more relaxing at the end of a long day than sitting down to watch a good murder story on television, or curling up to read a good bedtime thriller. Judging by the popularity and sales of such entertainment, many of us enjoy this sort of thing. There is, it seems, a bit of a locked ward mentality in us that accepts violence as a normal part of life. There is nothing new in this. History abounds with massacres, murders and mayhem, and literature from as far back as the ancient world reflects this. Violence, we have learned, begets more violence: 'there appears to be a cruelty, a rage, a latent frenzy in humanity which is not explicable in terms of basic strivings for survival ... [that expresses] ... a hatred of life', fear and loathing (Mollon, 2000, p. 68). Born out of the violence experienced by the individual, rage and fear can only, it seems, be assuaged by terrifying others. Thus the weak and vulnerable become containers in which to deposit anger and fear.

Such behaviour incurs huge costs. Over a million people each year die as a result of acts of violence, and many more are damaged physically, mentally and socially, which increases the demand on health services. 'Violence is among the leading causes of death worldwide for people aged 15–44 years' (World Health Organization, 2002, p. 1). This means, as Jemima Dennis Antwi's guest editorial graphically explains, that a significant number of potentially economically active young adults do not, and indeed cannot, contribute to their society. If there are not enough people to keep society running, there is a real risk of economic collapse or descent into dependence when those who are fit enough to leave go away to work, while those who are left behind rely on what these individuals can send back. In monetary terms, violence is therefore a threat to the stability of a state. Consequently, societies have always tried to put in place systems for containing and preventing violence (e.g. through religious practices), which can be very effective, but which may be overpowered during periods of rapid change, creating 'conditions for a high level of violence. In addition, the removal of market constraints and increased incentives for profit as a result of globalization can lead, for example, to much freer access to alcohol, drugs and firearms' (World Health Organization, 2002, p. 14).

We cannot continue as we are doing at present. Violence is now regarded as a serious public health issue that can be prevented (World Health Organization, 2009). A series of briefings that were published last year set out clear strategies for preventing violence. These briefings reflect a perceived need for change across all societies: 'violence can no longer remain the preserve of national politics, but must be vigorously addressed also on the global level – through groupings of states, international agencies and international networks of governmental and nongovernmental organizations' (World Health Organization, 2002, p. 14). The series covers the establishment of relationships in which adults and children can flourish, and addresses

specific factors such as access to alcohol, guns and knives, promoting gender equality and victim support (World Health Organization, 2009). The accompanying website (www.preventviolence.info) provides a wealth of evidence and resources, such as victim profiling, developed in England to identify those most at risk. Victim profiling presents two major challenges, namely how to protect the weak and vulnerable, and how to persuade aggressors to change their behaviour. Our first paper, by John-Kall and Roberts, represents an attempt to address this second challenge with regard to violence against women in war situations. What is unusual about this paper is that it focuses not on rape and other violence by soldiers, but on violence perpetrated by male civilians. This paper represents a valuable addition to the literature, and we would welcome more articles that address such issues.

One of the points raised by John-Kall and Roberts is the need to understand the socio-cultural context in which interventions are to take place. Professional education forms an important part of this, as is demonstrated in our next and final papers. First, Tozer and her colleagues provide insight into the development and evaluation of a national programme for health trainers and advocates working with South Asian populations in the UK. In contrast, later in this issue, Ross and Carr focus on education about LGBT issues, which includes making audible the voices of one group of potential victims of violence. If victims are perceived as receptacles or containers for rage and fear, they become mere objects. By enabling their voices to be heard, perhaps at least some of their aggressors will start to recognise their shared humanity. Our other two papers contribute to the literature on two well-established topics. There have been a number of studies of stress in nursing in Western countries, but Oomen and colleagues have examined the subject in the context of working in rural India. One of the features that they describe is the element of fear in communicating with superiors. This is depressing news, as it reflects the way in which nurses were trained in the UK in the last century. That system generated high levels of stress, particularly among junior nurses and students, none of whom received support from more experienced staff. The high levels of stress resulted in the development of a strong tendency towards ritual task performance, constant checking, and the avoidance of change (Menzies, 1970). We hope that nurses in rural India will find ways to avoid such negative behaviours and develop more appropriate ways of relating to superiors.

Abrahamsson and her colleagues present their second paper about enabling members of minority groups in Sweden to access healthcare services. Their previous paper highlighted the role of bridge builders in brokering the interface between professionals and newcomers to Sweden (Abrahamsson *et al*, 2009). In their second paper they discuss the selective ways in which service providers engage with minority groups. As they point out, short-term projects address only surface issues, and do not provide a sound basis for long-term solutions to difficulties. Moreover, *projectification* can cause resentment and may ultimately alienate the very communities that it is intended to help.

Finally there are our regular features. In the Practitioner's Blog, Jo James provides a thoughtful reflection on the judgements that are made in healthcare settings about older people, in particular whether they are worth treating. Contributions to this column are always welcome; please contact Mary Dawood (at mary.dawood@imperial.nhs.uk). In our Did You See? feature, Svirydzenka draws our attention to a study in Ireland about children's behaviour in school. It seems that children who are members of minority groups are labelled negatively as having behaviour problems, in marked contrast to children who are members of the host population. Anyone who is interested in writing for this feature should contact Nisha Dogra (at nd13@leicester.ac.uk). As always, our Knowledgeshare feature presents a range of information and reviews that we hope our readers will find helpful. Anyone who wishes to contribute to this section should contact Lorraine Culley (at lac@dmu.ac.uk).

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