

RESEARCHING PROFESSIONAL DISCOURSES ON VIOLENCE

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This paper discusses the value of a multi-method approach for studying violence against professionals. It is based on a project currently conducted by the authors on the extent and impact of violence against three professions working in the community (General Practitioners, Probation Officers and Anglican Clergy). The paper starts by making some general points about the nature of our chosen occupations' professional discourses on violence and then discusses how quantitative and qualitative methods can be used to establish the extent to which the definitions of violence embedded in these discourses are meaningful for individual professionals. It is argued that both kinds of method are necessary to understand fully individual professionals' experiences of violence against them.

The study reported here is an ongoing investigation of violence by members of the British public against three types of professional workers based in community rather than large institutional settings: National Health Service (NHS) general practitioners, probation officers and Anglican clergy. The research aims to assess the extent and impact of violence (and fear of violence) on these professionals, and the response of professional agencies and organizations to violence and risk of violence in general and to specific incidents. Within both the professional press for each group and the mass media in general, there are many claims that violence against members of these groups is increasing. Mass media reports are, of course, likely to focus on the sensational, the rare and hence newsworthy incidents, such as the murder of the Reverend Christopher Gray in August 1996. It is possible that apparently mundane and unnewsworthy incidents of harassment and verbal abuse are much more frequent and have a much more insidious impact on members of our three occupations.

These three occupations might all be broadly characterized as professions. They all require a specialist training in a body of knowledge and craft skills. Members of these occupations have some autonomy in the organization of their work and all have some claim to be authority figures within the community or with respect to their clients. The decision to undertake a comparative study stemmed from our interest in the relationship between occupational cultures and organization and the experience of violence: behaviours that are regarded as 'normal risks' in one work setting may be perceived as exceptionally threatening in another occupational context. The focus on those who do 'front-line work' in the community, including clients' homes, reflected our interest in the experience of those who work outside the environment of a large institution. Those who work in the community typically do so alone, at least during much of their face-to-face contact with users of their services, and are faced with recurrent tensions between accessibility to clients and security.

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We also chose to study our three particular professions because we are interested in the ways in which their social characteristics, especially gender, affect the experience, interpretation and management of violence. Gender is particularly salient to these occupations because of changing patterns of recruitment and gendered occupational and organizational cultures (Hearn and Parkin 1987). Front-line probation officers are currently predominantly female but recent reforms presage possible remasculization as recruitment of ex-army and ex-prison service staff increases. In contrast, general medical practice is traditionally a predominantly male profession but the majority of young GPs are now women (Elston and Lee 1996). The relatively recent ordination of women in the Church of England may be raising new issues about violence towards parish clergy.

One vehicle for identifying and explaining the similarities and differences in the experience of violence between our three professional groups is a large-scale postal survey of GPs, probation officers, and Anglican clergy in South Eastern England. Besides allowing us to explore levels of incidence, the survey enables us to examine how violence towards professionals is patterned in terms of (a) social divisions, such as gender and ethnicity, (b) working patterns, (c) professional-client relationships, particularly as mediated by professional 'theories' about violence, and (d) differences in employment status and professional organization. Like all methodologies survey research suffers from constraints and limitations (Bryman 1988). Feminist writers have argued, for example, that definitions and explanations of violence in the existing literature have emphasized the visible and quantifiable aspects of violence to the exclusion of less visible manifestations. The implication here is that apparent physical injury takes precedence over psychological injury (Featherstone and Trinder 1997). Recognizing this point leads us beyond a purely quantitative study towards a multi-method approach, one aspect of which involves studying the meanings of violence through qualitative interviews.

In this paper we want to illustrate the value of our multi-method approach for studying violence against professionals in the community. We start by making some general points about the nature of our chosen occupations' professional discourses on violence and then discuss how quantitative and qualitative methods can be used to establish the extent to which the definitions of violence embedded in these discourses are meaningful to individual professionals. Our argument is that both quantitative and qualitative methods are necessary to understand fully individual professionals' experiences of violence against them.

Conceptualizing Violence

'Official' definitions of violence produced by or on behalf of professional groups are hardly consistent. Littlechild (1997), in his study of violence against probation staff utilized the definition used by the National Association of Probation Officers (NAPO), which includes:

A range of illegitimate or socially unacceptable behaviours either physical or verbal which are intended to be, or are perceived as threatening. (NAPO 1989)

For the Association of Directors of Social Services (ADSS), violence is defined simply as:

Behaviour which has a damaging effect either physically or emotionally on other people. (Kemshall and Pritchard 1996: 162)

By contrast, the recently revised Health and Safety Commission's Guidance on Assessment and Management of Violence defines work-related violence as:

Any incident in which a person working in the health care sector is verbally abused, threatened or assaulted by a patient or member of the public in circumstances relating to his or her employment. (Health and Safety Commission 1997: 2)

It can be argued that each of these definitions addresses a different aspect of violence. Littlechild's definition, with its emphasis on the illegitimacy of violence, is consistent with the idea that violent behaviours are transgressive acts that disrupt the taken-for-granted normative expectations surrounding professional-client interaction. In stressing the effect that violence can have on people, the ADSS definition is consequentialist in character. With an emphasis on 'incident' and a specific working domain, the Health and Safety Commission's definition is behavioural and situational in character.

To the extent that we have been able to produce a detailed, comprehensive and well-piloted survey instrument, we are in a position to explore, at least to some degree, each of these elements. As we shall see, however, while the survey is particularly suitable for exploring violence as a transgressive act and some of its consequences, qualitative methods are more suitable to explore other consequential aspects (e.g. the emotional consequences), and the situational dimension. In the next section we consider how we operationalized violence in our survey.

Operationalizing Violence

A main objective at the beginning of our research was the construction of three survey instruments containing a standard set of questions regarding the extent and nature of violence experienced by members of all three professions in the course of their work. Several considerations were taken into account during the questionnaire design phase. Amongst these were the translation of the different professional discourses and our emerging conceptualization of violence into measurable components; identifying the contexts in which work-related violence occurs for the three professional groups; and incorporating the terminology and language specific to the discourses of the three professions and presenting the questions in a user-friendly format. We shall consider each of these in turn.

Establishing measurable components

Drawing upon previous research (Hobbs 1994; Naish and Stevens 1998; British Crime Survey 1999), and policy documents (e.g. HSC 1997; NAPO 1989), which constitute professional discourse, a range of transgressive behaviours which might be categorized as violence was identified. Included in this range are impoliteness or rudeness to the professionals and their colleagues; vandalism to the workplace or property belonging to the professional; verbal abuse; threats to and assaults on the professional, both physical and sexual. These particular forms of socially unacceptable behaviour are not exhaustive of

all behaviours that might be termed 'violence', but they have been individually and collectively used as the key indicators of violence in previous research and professional discourses.

At the same time, we were mindful not to impose a judgment about which of these transgressive behaviours was more serious than another. Instead, the order of questions started with experiences involving the least physical contact with the victim, such as disruptive behaviour in the workplace, through to experiences which involved the most physical and intimate forms of contact, such as physical and sexual assault. This form of question order was considered to be appropriate practice for the disclosure of personal and sensitive information about the respondent.

Disruptive behaviour for the purposes of this study consisted of impoliteness, rudeness and vandalism and was measured in terms of the extent to which they were considered to be problematic for the professionals. The category of threats comprised both expressed and implied intention to harm the professional, a relative of the professional, or a colleague personally, or to vandalise property belonging to the professional or his/her workplace. With respect to physical assaults, we asked specific questions about behaviours such as being pushed, shoved, slapped, kicked, punched, struck or hit with a weapon, indecent assault and sexual assault.

As indicated earlier, we recognize the importance, in line with the discourse on violence as consequential, of acknowledging the emotional dimensions of violence, particularly, fear about violence. However, given the limitations of the survey method for capturing this aspect, in the questionnaire we only touched on the extent to which fear of violence is a feature of professional practice. In doing this, we concentrated upon identifying the frequency and contexts where professionals fear becoming victims of work-related violence, bearing in mind the distinction between fear of experiencing violence and perceptions of being at risk of violence (Ferraro and LaGrange 1987; Farrall et al. 1997; Smith and Torstensson 1997).

Identifying the contexts in which work-related violence occurs

The second consideration in designing the questionnaire concerned identifying the contexts in which work-related violence occurs, in line with a situational definition of violence in professional discourse. Drawing upon existing literature (Naish and Stevens 1998; Hobbs 1994; Littlechild 1997), policy documents (Caris 1996; BMA 1996), and the advice and insights of longstanding professionals working in the three sectors, questions were constructed regarding the sites where professionals deliver or administer their services. Most workplace violence is assumed to occur within or close to the main site where the professional works (Budd 1999). Workplaces associated with the three sectors differ and the associated contextual distinctions contributed to the development of tailored questionnaires for each of the professional groups. For general practitioners, questions covered the location of the practice, the type of premises, the complement of staff and the additional sites visited by the professional in the course of his/her work. For probation staff, questions regarding the premises, the type of unit or team, complement of staff, type of probation supervision and 'client' contact, were drafted. Questions concerning the nature and type of ministry, the location of the ministry and the responsibilities assigned to the ministry, were included in the questionnaire for the Anglican clergy. These sets of questions are necessarily particular to the three sectors, but there are

work-related contexts shared by all three professions. These include visits to the homes of patients, clients and parishioners and engaging with the communities where the professionals work and may also live.

The three questionnaires also consisted of common contextual questions regarding the circumstances in which violent behaviour, such as that referred to above, arise. Using the most recent incident within the last two years as the index case, questions about where and when the experience occurred, who was involved, the way the incident was handled and the impact of the incident on the professional and his/her organization are included in the three questionnaires. This consistency is important for comparisons to be drawn within and between groups. Moreover, the data generated from these questions also enable us to draw some conclusions about the types of conditions associated with violence to professionals. Of course, such data provide only the professionals' perspectives on the incidents and do not cover the views of the other parties involved; therefore, conclusions arising from the data will be couched with this proviso.

Incorporating professional language and terminology

The third consideration when designing the questionnaires concerned the inclusion of professional language and terminology. In each of the three questionnaires terminology associated with the workplaces and work practices was included to make the survey more relevant and meaningful to the respondents in terms of their professional discourse. For example, following piloting, we changed the wording of some questions in recognition of the fact that one can have more than one church in a parish and some clergy ministers to several parishes. In designing a questionnaire, which was couched in appropriate professional terminology, the underlying intention was to construct a user-friendly and customized questionnaire for the three professions. These steps had an additional underlying function of increasing the chances of accessing professionals' time and attention.

Given that professionals are regularly approached to participate in survey research, competition to access their time is fierce. Consequently many postal surveys to such occupations yield a low response rate. This is particularly so for general practitioners where the average response rate has been calculated as no more than is 35–45 per cent (Cartwright 1978, 1983; Templeton *et al.* 1997). The choice of language used and the number and type of questions were therefore necessarily central considerations in the overall layout and presentation of the questionnaires (Cicourel 1964; Sanchez 1992; Dillman *et al.* 1993). Given that the professional's time is at a high premium, the questionnaire was designed mainly using questions with pre-coded answer options with the objective of aiding recall and capturing as much detail as efficiently as possible. To gauge the suitability of the questionnaires, all three were pilot tested with respective samples of general practitioners, probation staff and Anglican clergy, along with experts working with or in the three professions.

The final versions of the questionnaires were distributed during 1999 to 1,300 general practitioners, 825 probation staff and 1,400 Anglican clergy working in south-east England (including part of London). The respective response rates achieved to date are 62 per cent for general practitioners, 78 per cent for probation staff and 71 per cent for Anglican clergy (the latter based on two mailing waves). These response rates are clearly respectable, and suggest that recipients perceived the topic as relevant and the questionnaire as well designed.

Preliminary analysis of the general practitioner and probation surveys suggest that 10 per cent of the respondents have experienced assaults as defined in the questionnaire, at least once in the last two years. Approximately 37 per cent of both general practitioners and probation officers have had experience of having someone threaten to harm them personally, at least once in the last two years. Ninety one per cent of probation officers and 75 per cent of general practitioners reported that they had experienced verbal abuse at least once in the last two years.

These findings suggest that the types of transgressive behaviour we have included in our operational definition of violence are both recognized and sometimes experienced by members of the three professions. These findings illustrate how the questionnaire is a useful way of establishing the prevalence of the different kinds of violence reported in professional discourse. Preliminary analysis of the survey data also indicates that fear of violence is a sentiment which is widely recognized and reported. The survey also has a role to play in identifying the consequences of violence. However, the social meanings attached to different types of transgressive behaviour and its consequences may also vary between professionals in ways which the survey is ill equipped to capture. It is for this reason that we are also conducting qualitative interviews with the three professional groups and it is to this method that we now turn. The focus below is on interviews with general practitioners as the other two sets of interviews have yet to be completed.

Talking about Violence

In order to explore how professionals themselves talk about violence we are undertaking in-depth interviews with approximately 25 professionals from each of the three professions, making 75 in total. The questionnaire included an invitation to respondents wishing to participate in the interview stage to send us their names and contact addresses. From those who did, we selected for interview those who had also indicated on their questionnaire that they have experienced threats and/or assaults in the course of their work.

The topic guide for these interviews has been developed on the basis of a preliminary analysis of the survey data and feedback about the survey from respondents, as well as through pilot interviews. It has been loosely structured around the same broad topic areas as those covered in the questionnaire but other issues have also been included. As well as the specific incidents reported in the questionnaire, the topic areas include mapping the environment where the professionals work, the clientele who use the service, the kinds of interaction between professionals and clients and the extent to which they have changed over time, the nature of fear associated with the professionals' work, their own definition of violence and its causes, circumstances in which the professionals can discuss violence and the kinds of precautionary strategy employed to protect themselves in the course of their work. These topics are necessarily broad-ranging in order to allow the professionals to identify and explain, in their own way, the contexts in which they experience violence and the extent to which their experiences of violence are tolerated.

The in-depth interviews have enabled us to explore the extent to which our operational definition of violence accommodates the range of experiences labelled as

violent by professionals from the three sectors. This will allow the researchers to arrive at a more organic understanding of what violence means to professionals and of the discursive strategies professionals deploy in constructing and interpreting their social definitions of violence.

Below we consider some of the benefits of using a qualitative approach, focusing on the extent to which it enables one to capture the complexity of individuals' professional accounts of violence.

Professional presentation of self

Professionals such as general practitioners are socialized to present themselves as competent and knowledgeable experts whose authority is respected or at least accepted by their clients in face-to-face interaction. While it may be relatively easy to answer survey questions about incidents that have got 'out of control', and where they have been threatened or attacked, in such a way as to maintain this image of competence, talking about being on the receiving end of violence in a probing, in-depth interview presents our respondents with the possibility of revealing a professional self which is less competent than they might wish. Indeed they might be judged to be professional failures or as Hobbs (1994), puts it 'bad doctors'. Moreover, talking about such experiences might invite the expression of emotions which, as members of a profession, they have been trained to manage and even repress, in favour of professional affective neutrality (Hearn 1987; James 1989). The point being made here is not that the latter are intrinsically more valid (cf. Rhodes's (1994) criticism of this interpretation of Cornwell's (1984), distinction between public and private accounts). Rather, our interest lies in the extent to which, within a single interview, doctors would produce accounts that drew on both what is culturally normative for professionals to display in their practice *and* emotionally charged, personal, private experience.

Recognizing the potentially sensitive nature of the topic, we started the majority of the interviews by talking about the organizational arrangements that provided the context for the GPs' working lives. Such caution was not always necessary however, as a number of doctors, knowing the subject of the interview, started to discuss their experience of violence or their professional organization's policy on it even before the tape recorder had been switched on.

Once the topic of violence had been raised most doctors were able to discuss their experience of it quite easily, drawing on a range of professional discourses, as we shall see shortly. For a few, however, recounting their experiences was more difficult, mainly because they could not remember the incident they had reported on the questionnaire or, more often, the characteristics of the person who had assaulted them. Although this might raise some questions about the reliability of our survey data, it also indicated to us that not all experiences of physical assault or threat did carry an emotional charge for their 'victim' although many did.

Thus, when it came to talking about their feelings about the violent behaviour they had experienced the general practitioners varied in their response. Some seemed constrained and either tried to play down the experience or hesitated in answering the question. For example one general practitioner qualified his fear by saying that he was not really frightened. For example:

Interviewer: Could I ask you . . . in terms of moving the conversation on a bit again, to the issue of fear and situations where you may feel afraid when you're undertaking your work . . . Are there situations where you feel afraid or at risk of being subjected to aggression or violence ?

Respondent: Mm . . . [pause] Well, there was one family, some sort of strange Polish man. I suppose he was all right but he had very, very aggressive children and normally if you went to do a house call there you had to sort of go past, run the gauntlet of these children who seemed to be doing very little for their ailing father. And on one occasion I had this argument with his son, because I told him I'd see his father in the middle of the day. He said 'What time is that?' And I said 'Oh, I don't know, twelve or twelve thirty'. He demanded me to see him at a specific time which I wasn't able to give him . . . I had a terrible argie-bargie here and felt I might have ended up getting punched. But, you know, I don't know, it just didn't worry me too much. I kind of was feeling angry myself so I wasn't really frightened. (male GP, code 2803)

Another seemed reluctant to talk about his emotions, and paused awkwardly before describing how a violent attack had changed his behaviour:

Interviewer: After that incident did that [experience] enable you to make particular decisions about your own safety when making home visits?

Respondent: I think it probably did . . . [long pause] I think it probably made me more scared. It probably made me more careful but there's a limit to how careful you can be when you go to blocks of flats in the dark . . . but some of the these blocks of flats you wander around trying to get into them, you can't. There's no numbers, it's, these estates are so badly marked, so you're wandering around, it's a nightmare at night. So it made me frightened. (male GP, code 2556)

Others seemed to express apparently contradictory sentiments at different points in their interview, at one moment expressing fear about undertaking their duties as a general practitioner and later denying any breach of professional competence altogether.

And yet other general practitioners were very willing to talk about how a violent patient had affected them emotionally. For example, a male GP recounted how he had been attacked when he found someone trying to break into his surgery during the lunch hour. He described this incident as particularly upsetting and said it had resulted in his subsequently suffering from 'post traumatic stress disorder'. Although the attack did not arise directly out of his professional duties, a sense of failure to conduct himself professionally seemed to be tied to his sense of masculinity and his inability to conduct himself 'like a man' and defend himself successfully.

Respondent: [On arriving back at the surgery I found a man trying to jammy the window], so I approached and said 'What are you doing here? Clear off' you know. And the next thing that happened was that he pulled out a knife and he . . . he tried to stab me in the chest . . . I managed to get out of the way . . . and then he lunged forward and slashed me across the stomach, so I had a sort of stomach wound. This more or less put paid to me, I sort of fell down . . . in fact the injuries were, turned out to be trivial but in my mind the guy was trying to kill me when he tried to stab me in the chest and it was very traumatic for me, and I was very unhappy that I'd not succeeded in disarming him or doing anything more, other than this sort of falling down bleeding thing, you know which was a bit pathetic . . . Uum [pause], so I mean I'm a fairly big sort of person, I feel I can look after myself, certainly in a one to one situation, which is why in this episode I sort of chickened out of it. I feel particularly guilty I was unable to cope . . . (male GP, code 2470)

A female GP described how she was knocked over by a male patient and how frightened and angry she had been at the time. But her account suggests that it was not her professional competence that she had been led to question by this event.

Interviewer: If you could tell me more . . . [about the incident you mentioned in the questionnaire] . . .

Respondent: Well it was a silly stupid event really. I was phoned one afternoon. I was on call—I was the only doctor in the practice—to say that a patient who I certainly knew about but I'd never actually met was in the mental health centre just up the road . . . He was very mad, he was probably hallucinating. They weren't sure how much was related to his drug abuse . . . So I was the only one around and I went in and it was ridiculous. I walked into the waiting room and I was vaguely aware of a young bloke sitting on my right . . . and I walked over to the reception desk and I didn't open my mouth and this person jumped on my back and pulled me to the ground. And it was this little receptionist who tried to stop him. And then I don't know how long it was before everybody arrived, not long but it was very frightening . . . I was very angry with the people on duty at the time. I felt he should have been in a more secure room . . . So I was taken completely by surprise and I didn't think it was my error of judgment there. I felt it was someone else's. (female GP, code 177)

The complexity of professional discourses on violence

Violence as consequential was not the only aspect of violence that the doctors in our study talked about during their interviews. They also elaborated on the transgressive aspects that we had concentrated on in our survey. Below, we describe briefly some of the distinctions they made in talking about violence in this way.

One major distinction which the general practitioners seemed to be making was between 'rational' and 'irrational' violence (see Table 1 for a summary). Rational violence from a patient is violence that the doctor could account for as a response to an illness (including 'minor' mental illness), failures in service provision, or a combination of social circumstances, including housing conditions and unemployment. A build up of circumstances, sometimes exacerbated by drugs or alcohol, creates a temporary lapse in what is normally a rational, thinking individual. The resulting behaviour is more likely to be verbal abuse or disruptive behaviour rather than physical assault.

TABLE 1 *Rational and irrational violence*

	Explanation	Nature of violence	Professional response
Rational	Minor mental illness Social circumstances	Usually verbal Unplanned Undirected Predictable Preventable	Conditional Recognisable warning signs Act to prevent
Irrational	Severe mental illness Malevolence Substance misuse	Physical Planned Directed Unpredictable Unpreventable	Unacceptable Take steps to minimise harm to self and other

One GP described such a situation as follows:

I can understand, you know, how a single mother whose got a child who she is worried has got meningitis is going crazy, you know, sort of getting frantic and, you know, sort of like getting frantic and may be abusing the receptionist. It's not right but I can understand it. (male GP, code 3953)

Here the violent behaviour is a consequence of her circumstances. The idea of rational violence is used to separate the perpetrator from the offence. This minimizes the amount of blame that can be attributed to the individual and makes it almost acceptable.

Respondents also saw this form of violence as not being premeditated. In these cases the onus was not only on the patient to desist, but also on the professional to take steps to avoid risk. Here the importance of situational aspects of violence was recognized. Understanding subtle verbal and non verbal signs of violence were seen by the GPs as being vital to the effective management of rational violence. Failure to recognize and act upon early warning signs was seen as reflecting a lack of professional judgment.

Irrational violence, which is arguably the potentially more dangerous form of attack, was defined as involving unacceptable and unpreventable behaviour. This form of behaviour was irrational in two senses. First, such behaviour is in itself irrational and perpetrated by individuals who are consistently 'mad' or malevolent or both. It was also irrational in the sense that the general practitioner could not apply a rational thought process to make sense of the behaviour. Irrational violence does not have a definable or known cause and gives the doctor little opportunity to take evasive action. It is also personally focused, premeditated and sometimes elaborately planned. Examples included direct physical attack, pushing, kicking and punching. Doctors reported situations where patients waited in car parks or outside surgeries with the deliberate intention of causing them harm. Such situations were seen as particularly threatening and difficult to handle. All they could do was to take steps to minimize harm to themselves. As one GP stated:

... there are some violent episodes that are totally unpredictable and unexpected and of course you can't plan in any way for that but you can see the signs of what's brewing and therefore hopefully avoid the situation actually getting worse than it is. (female GP, code 2447)

Discussion

In this paper we have attempted to demonstrate the advantages of using a multi-method approach to understand professional discourses on violence. We have shown that the survey method is adept at capturing the incidence of violence and its transgressive aspects. The consequential and situational aspects of violence can also be measured in a limited way, but qualitative methods are needed to capture the complex meanings violence in general and in specific instances have for individual professionals.

As we have seen, in-depth interviews can generate accounts that are simultaneously presentations of professional selves and of the emotional consequences of violence, which may be at odds with the culturally normative professional account. Establishing rapport (for example by not starting the interview with a discussion of violence unless the respondent wants to do so), and talking to those who have experienced a physical assault maximizes the chances of such an account being solicited in a one-off interview.

In-depth interviews also provide the opportunity to explore with respondents the nature of their understanding of violence as transgressive and the role of situational factors in interpreting how to respond to such acts. As we have seen, our preliminary analysis suggests that doctors translate professional discourse about violence as transgressive into rational and irrational dimensions. Identifying such distinctions is important if one is to understand how professionals try to manage different kinds of violent behaviour and identify the scope for prevention of violence against these professionals and the role for harm minimization strategies.

Our work remains in progress. We thus need to extend our qualitative analysis to encompass both probation officers and clergy. In particular, we are interested to see whether the discursive strategies characteristic of general practitioners are replicated in comparable forms in the other two groups. We also need to feed our understanding of how professionals experience and understand violence and its sequelae back into our quantitative analysis of violent incidents. In this way we hope to produce a more rounded and contextualized analysis of the inter-relations between the situational, transgressive and consequential aspects of violence against professionals.

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