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Understanding Violence and Aggression in Care Settings

Mankind must evolve for all human conflict a method which rejects revenge, aggression, and retaliation. The foundation of such a method is love.

——Attributed to Dr Martin Luther King

Aggressive and violent behaviours present significant challenges to individuals and the society as a whole. Social scientists tend to view the capacity to commit interpersonal violence as a universal capability (McCall & Shields, 2008). The financial costs of interpersonal violence to employers can be extremely high, especially when the indirect costs are calculated along with the direct costs (Di Martino, 2005). Evidence has been found from archaeological examination of early Neanderthal skeletons about the occurrence of violence-related trauma, although the frequency of the deaths caused by it is still a moot point (Berger & Trinkhaus, 1995). Aggressive behaviours have remained a major topic of concern for many years in human services. Physical aggression can generate fear among care staff who are often expected to manage such behaviours in their day-to-day work (Singh, Lloyd & Kendall, 1990), and it can also generate strong emotional reactions in them (Bromley & Emerson, 1995).

The management of aggressive and violent behaviour in care settings is an important topic. This chapter will examine definitions of violence and aggression and will provide some basic knowledge of the theoretical approaches to the subject. Responses to violence and aggression will be discussed at both an individual and an organizational level. Finally, the training response to violence and aggression management will be examined.
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Definitions of Aggression and Violence

Definitions of constructs such as violence and aggression are important for researchers, as they often determine the responses of individuals. The terms violence and aggression are often used interchangeably. An understanding of these definitions can be important for both practitioners and researchers.

There are many definitional problems in defining violence and aggression. Anderson and Bushman (2002) regard the difference between aggression and violence to be a matter of degree. According to their definition aggression is the behaviour intended to produce deliberate harm to another, and violence is the behaviour that has extreme harm (such as murder) as its intent.

There are dangers to viewing aggressive behaviours as a homogeneous 'lump'. Specific definitions can help to provide clearer interpretations of data. To illustrate this point a distinction between verbal and physical aggression can be useful. Verbal aggression is reported as being far more common than physical aggression in hospital settings (Hahn et al., 2008). Understanding these differences can have positive implications for human service providers. At a macroscopic level staff responses to verbal and physical aggression may create different training needs.

Intentionality is a construct that has implications for both researchers and practitioners. Bandura (1973) distinguished between angry and instrumental aggression. Angry aggression is associated with highly charged emotional sequelae, and instrumental aggression is the term used to describe aggression that has a clear purpose. This is useful in distinguishing between explosive aggressive acts and those which have a planned component.

According to the UK law, in the case of aggressive behaviour there is a distinction made between the act (known in Latin as *actus reus*) and the intent (known in law as *mens rea* or a 'guilty mind'). Consider the example of a street thief who uses intimidation and openly aggressive behaviour to obtain money. This aggression is clearly instrumental in its presentation, as it is designed to obtain the primary goal of hard cash. This should be distinguished from an aggressive situation in which an individual may be overtly angry in order to achieve a goal but remains reasonably in control of their behaviour. In contrast an individual may experience an elevated arousal level and may actually lose control of their responses. In the latter circumstance the aggression and the violence may be less premeditated and more driven by emotional arousal. (In Chapter 2 this distinction will be used to formulate staff and service responses to aggression).

Aggressive behaviour can also vary in terms of its everyday presentation. Gomes (2007) distinguished between overt and covert aspects of aggression. Overt aggression includes, but is not limited to, hitting, shoving and pushing, whereas covert aggression includes actions such as rumour spreading, gossiping...
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and social isolation, which are not readily observable to others not enmeshed in the experience of the aggression. Bullying would fit into either the overt or the covert category, although most forms of bullying tend to be covert in nature.

Definitions also need to account for violence and aggression not just at an individual level but also at organizational and societal levels. Tiered definitions of violence can help to clarify key issues for researchers and practitioners. Bowie (2002) distinguished four categories of violence in the workplace: first, intrusive violence, which includes planned acts especially those involved in committing a crime; second, consumer-related violence, which includes violence committed by both service consumers and staff; third, relationship violence, which includes bullying and harassment in the workplace; and finally, organizational violence, which is caused by organizational structures and systems.

Formulating violence and aggression in such a ‘systemic’ manner would appear to enhance the explanatory power of such models. However, there is the real danger of such definitions leading to the mantra that it is the systems which need to be changed rather than the individuals. In reality violence and aggression can be conceptualized at a variety of explanatory levels.

Theoretical Approaches to Aggression and Violence

Drive and instinct theories

Psychodynamic approaches stress the importance of early life experiences in determining aggressive behaviour (Freud, 1930). Theories of aggression in the early decades of the twentieth century tended to focus on aggressive behaviour as being predominantly instinctive in nature. Models that combined both instinctual and environmental elements emerged after the Second World War. MacDougall (1947) proposed a hydraulic model of the behaviour in which emotions build up to a point at which they need to be released. Dollard, Doob, Miller, Mowrer and Seers (1939) maintained that the environment was more critical in the maintenance of aggression. They viewed behaviour as goal directed and held the view that the blocking of goals consequently leads to frustration and ultimately aggression.

These early models tended to focus on highly simplistic explanations of human aggression. A good example of this involves the concept of catharsis. Cathartic theories of aggression tended to stress the positive benefits of the release of anger or hostility. The concept of catharsis has been associated with purging and cleansing. The idea that violence and aggression can be released in some manner would appear to have high face validity. In reality such constructs are difficult to quantify. Consider the following two examples: In the first, a young man may be encouraged in therapy to strike or hit objects to reduce
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his aggressive tendencies. In the second, after returning from war soldiers were observed to display lower levels of violent and aggressive behaviours. In both these examples a release or purging of aggression is assumed. The construct of catharsis is used in a contextually different manner – one reflects an individual perspective, whereas the other stresses a societal effect.

Evolutionary models

Ethologist Konrad Lorenz (1966) described violence and aggression in terms of societies and larger groups. He proposed that humans were naturally aggressive and that they consequently release aggression through activities such as sports and military conflict. He furthermore argued that animals, especially the males, were biologically programmed to fight over resources. This behaviour should be considered part of the Darwinian process of natural selection, as aggression leading to death or serious injury may eventually lead to extinction of animals unless it has such a role. According to his approach aggressive behaviour could be adaptive in nature.

The evolutionary perspective on violence appears to have some attraction for researchers. These approaches tend to stress the adaptive nature of violence and aggression. There are, however, problems with this perspective. It could be argued that aggression and violence should be less prominent in developed Western societies, where presumably there are fewer individuals who need to compete for resources. The evidence for this assumption is limited. The murder rates among the Ju’hoansi of the Kalahari are similar to (or higher than) those of modern North American cities (Lee, 1979). In contrast, many stratified forager societies, such as those of the American Northwest, not only have historically had very high rates of violence but also have had culturally sanctioned, institutionalized violence as legitimate social activity.

Animal studies made famous by Calhoun (1962) show that crowding in the animal world results in what he calls the behavioural sink. In his now-classic study Calhoun provided a cage of rats with food and water that was replenished to support any increase in population, in a small quarter-acre plot in Maryland, USA. What Calhoun built was a quarter-acre pen, calling it a ‘rat city’, which he seeded with five pregnant females. Calhoun calculated that the habitat was sufficient to accommodate as many as 5000 rats. Instead, the population levelled off at 150 and throughout the two years that Calhoun kept watch never exceeded 200.

Calhoun claimed that the level of overpopulation produced clear behavioural effects. He reported that normal behaviour and reproductive habits in the rats began to fail. Aggressive behaviour increased when the animals competed for scarce resources. This work has been subjected to great scrutiny and has received considerable criticism (Ramsden & Adams, in press). These animal models may
appear quite attractive, but the explanation of this behaviour by crowding alone might not neatly apply to models of human aggression and violence.

This view of the role of evolutionary factors in violence and aggressive behaviours is not necessarily pessimistic. An acknowledgement of the human capacity for violence does not necessarily mean that the person cannot control their behaviour. This does not mean that societies cannot alter their patterns of violence and aggression, as there are clearly huge situational components to this behaviour.

**Operant models**

Operant approaches have stressed the importance of the environment in causing and maintaining aggressive behaviours (Skinner, 1953, 1957). Reinforcement of behaviour, both positive and negative, has a causal effect on antecedent stimuli and behaviour. Early behavioural research tended to focus on the study of animals and aggressive behaviours. Skinner (1959) reported that he could induce aggressive behaviour among pigeons by rewarding a hungry pigeon if it attacked another bird. Azrin, Hutchinson and Hake (1966) reported aggression in pigeons when reinforcement was withdrawn leading to extinction.

Applying work conducted on animals to non-laboratory settings has been a major focus of applied behaviour analysts. Behaviourists often stress the role of directly observable behaviours and the reinforcement contingencies that maintain behaviours. Early studies attempted to apply behavioural methods to real-world settings. For example Fuller (1949) applied a shaping procedure to assist a person with intellectual disability to move their arm.

There is little doubt that the application of scientific approaches to behaviour analysis has led to significant positive developments in care settings. Early approaches tended to focus on the manipulation of consequences to behaviours. The use of token economy systems to control and manage behaviours can provide some insight into the change and adaptation of behavioural technologies. Token economies tended to be used in larger institutional systems in the past (Ayllon & Azrin, 1968). The advent of behavioural approaches which concentrate more on the antecedents of the behaviour (Goldiamond, 1974) has made these approaches less popular. However token systems are still in use in some institutional settings (Moore, Tingstrom, Doggett & Carlyon, 2001) and in some services for people with intellectual disabilities and autism (Kahng, Boscoe & Byrne, 2003).

The primary goal of a token economy is to increase desirable behaviour and decrease undesirable behaviour (Kazdin, 1982). Tokens are used to shape positive behaviours. In some cases individuals can lose tokens for bad behaviours. The decline in the applications of these systems may be more moral in nature than scientific. The use of response cost and fines can be perceived by
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practitioners in a negative manner and may be extremely controlling (Corrigan, 1995). Despite these reservations some researchers still believe in the positive aspect of these methods (Matson & Boisjoli, 2009).

The operant models began to focus more on the antecedents of behaviours rather than on the consequences; this was called the ‘constructional approach’ (Goldiamond, 1974). Further development of the behavioural model has included the introduction of distant antecedent events which may also influence behaviour. Wahlerr and Fox (1981) used the term ‘setting events’ for them, which was later superseded by the term ‘establishing operations’ (Michael, 1993). Deprivation and satiation are commonly used constructs in behaviour analysis (Murphy, McSweeney, Smith & McComas, 2003). That is to say the level of reinforcement can greatly influence behaviour. As a rule reinforcers are more powerful if the individual has been deprived of them.

Over the last decade there has been a substantial move away from interventions based on consequential punishment to those based on reinforcement contingencies (Donnellan et al., 1988; LaVigna & Donnellan, 1986; Lerman & Vorndran, 2002). Positive behaviour support is a development of applied behaviour analytic interventions in which ‘to remediate problem behaviour, it is necessary first to remediate problem contexts. There are two kinds of deficiencies: those that relating to environmental conditions and those relating to behaviour repertoires’ (Carr et al., 1999, p. 4).

Despite the optimism there have been criticisms levelled at these approaches. First, the implementation of these interventions can be time consuming (Donnellan et al., 1988). Second, staff turnover can affect the consistency of the programmes (Reid & Parsons, 2002). Third, many behavioural interventions are conducted on an informal basis, that is to say without professional guidance or in written form. A recent survey of behavioural programme implementation in Canada reported that 54% of behavioural interventions were conducted on an informal basis (Feldman, Atkinson, Foti-Gervais & Condillac, 2004).

Cognitive models

Behavioural models are sometimes referred to as ‘black box’ approaches, as internal events are not viewed as causal in them. Cognitive theories stress the role of internal events in the maintenance of behaviours (Salkovskis & Rachman, 1997). Cognitive constructs have extended and enriched the early behavioural approaches. Bandura (1973) described a social learning model of aggressive behaviour in which learning could take place both directly and indirectly. The later development of the self-efficacy theory (Bandura, 1977, 1985, 1995, 1997) introduced cognitive constructs which included the beliefs and expectations of the individuals.

Cognitive models of aggressive behaviours have tended to focus primarily on the responses of individuals. Novaco (1975, 1978) introduced a cognitive
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behavioural formulation of aggressive behaviour in which an individual’s appraisal of events was critical in the maintenance of aggression. In essence a person may encounter aggressive behaviour, and their appraisal of the situation determines their emotional and behavioural responses. Novaco and Welsh (1989) argued that people who engage in aggressive behaviours often interpret everyday social interactions as threatening, which leads to the experience of anger and the open expression of an aggressive response.

Weiner’s attributional model of helping behaviour has also been proposed as an explanatory model for staff behaviour. In this model staff attributions and emotional responses determine their helping behaviour (Allen, 1999a; Dagnan, Trower & Smith, 1998; Wanless & Jahoda, 2002). In sum, if an individual’s behaviour is perceived as not necessarily within their control, then the behavioural responses to them should be more positive. Cognitive behavioural approaches would appear to provide a useful explanatory framework for aggressive behaviours. Cognitive behavioural approaches such as the attributional model of Weiner (1986) may offer a pragmatic explanatory framework to staff responses to aggressive behaviour in learning disabilities settings (Allen, 1999a; Dagnan et al., 1998). There is little doubt that the influence and application of behavioural and cognitive behavioural approaches in care environments are substantial (Turnbull, 1999).

Transactional models of aggression

Models of aggression and violence need to account for the wide differences in the manifestations of these behaviours. In psychology the importance of personality and situational characteristics has been heatedly debated. Mischel (1968) argued cogently that situational characteristics influence behaviour and that personality traits have little influence. Mischel (2004) later presented a model which reflected the complex interaction of these variables.

The power of situational factors and how they can interact with individual characteristics can be best illustrated by violence at football matches. Early sociological studies stressed the rule-governed nature of football fans who committed acts of premeditated violence (Marsh, Rosser & Harre, 1978). It would be easy to stereotype these individuals as generally being predisposed to aggressive behaviours, but in fact the data do not tend to support this view. Stott and Adang (2004) examined statistics from the English National Criminal Intelligence Service and found that the majority of the individuals who were arrested during the 2004 European Football Championships had no prior involvement with football-related violence. An understanding of group processes and categorization (see Tajfel & Turner, 1979) and crowd behaviour may account for some of this behaviour. Intuitively, there will be some individuals who have the capacity to be violent and aggressive in a variety of situations. In addition the vast majority of football fans never commit acts of aggression and violence.
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The example of aggression and violence at football matches illustrates the complex interaction of variables that relate to aggression and violence. It could be argued that the study of situations in which individuals manage to control their aggressive behaviours may be as useful for researchers as those in which they do not.

The general aggression model

In the field of aggression, Anderson and Bushman (2002) proposed a detailed model of aggression and violence which included elements of both the situation and the person. In their theory a person’s internal state is the sum of the interactions between cognitions, affect and arousal. These are described as the ‘routes’ to aggressive behaviours. Cognitions include hostile thoughts and aggressive scripts and may come to be highly salient or accessible to an individual. Affect includes negative or hostile feelings and anger. Arousal involves the person’s physiological state that may be the result of factors unrelated to anger, such as exercise or the use of drugs. These three routes are highly interconnected.

Anderson and Bushman (2002) distinguished between behavioural outcomes that can be relatively automatic (immediate appraisal) or controlled (reappraisal). The inferences a person makes about the situation are related to their internal state and social learning history. An important part of the appraisal process is the person’s resources to reflect upon the situation. Resources include the available time and the person’s cognitive capacities to analyse the circumstances. When an outcome or course of action is important to the person, and the immediate action is unsatisfying, reappraisal is more likely to take place.

In this model there is a complex interaction between both internal and external stimuli and how individuals process information. The idea that information processing is a key component of aggressive and violent behaviours has been proposed by other researchers (i.e. Huesmann, 1988). More recently Metcalfe and Mischel (1999) proposed the existence of two interrelated memory systems, namely the hot and cool systems, involved in the execution of aggressive behaviour. The information stored in the cool system is narrative and episodic (e.g. autobiographical events) and is associated with a neutral mood. The cool system is responsible for novelty monitoring, semantic priming, problem solving, metacognition, control processes, planning and comprehension and is important for non-impulsive and self-controlled behaviours. The hot system stores the emotionally salient aspects of events and less elaborated memories. The hot system is important for rapid automatic responses that are more inflexible, stereotyped and affectively primary. Both systems do not always directly lead to actions or responses.

A recent analysis of information processing approaches to understanding aggressive behaviours has highlighted that aggressive behaviour should not be
viewed as fully automatic and as a consequence out of the individual’s control and that hot and cool processes may sometimes interact in a complex manner; it is possible for both components to operate during an aggressive or violent episode (Richetin & Richardson, 2008). The distinction between hot and cool processes as an explanatory construct for aggressive and violent behaviour would appear to have considerable face validity. Variables which may mediate these processes could include alcohol (MacDonald, Zanna & Holmes, 2000) and stress (Hennessy & Wiensenthal, 1999), both of which have been associated with aggressive behaviours. These factors may reduce an individual’s capacity to process information.

Anderson and Bushman (2002) described another aspect of their theory, which is called ‘scripts’. Scripts are collections of primarily well-rehearsed, exceptionally related concepts in memory, often involving contributory links, aims and action strategies. This theory proposes that when children watch violence in the mass media, they gain knowledge of aggressive scripts. Repeated practice of these scripts can generate associations to other notions in memory and amplify the strengths of these links. This idea of scripts illustrates how everyday behaviour may eventually produce aggressive behaviours in some individuals and not in others. This is because these scripts will vary dramatically among individuals.

The present author has used the general aggression model to demonstrate the complex interactions that can result in aggressive behaviours. The complexity of this model has great usefulness, as it would appear to have face validity and explanatory power (it appears to provide explanations to many complex observations). Theories also need to be high in predictive power. That is to say clear testable predictions should be generated (Hyland, 1981). Complexity in this case can rather be a ‘double-edged sword’.

Theoretical debates about the comparative efficacy of specific models of aggression will undoubtedly continue in the future. In conclusion aggression is regarded as a phenomenon determined by multiple factors (Patterson & Leadbetter, 1999). This complex transaction between the environment, affect and cognition has to be formulated within a cognitive-behavioural multidimensional model. In sum,

\[\text{violence is the result of interaction between a few important biological inputs and many strong situational inputs and environmental influences. (McCall & Shields, 2008)}\]

Applying this theoretical knowledge about the causes and maintenance of aggressive behaviours to non-laboratory settings is a major challenge for researchers. This book aims to have a pragmatic approach to the application of current scientific information to help to produce more effective management of these behaviours. The next section will describe some of the issues relating to violence in care environments.
Violence and Aggression in Care Settings

Workplace violence and aggression is acknowledged to be a serious problem. A recent European survey of workplace violence and aggression estimated that 1 in 20 workers experiences violence in the workplace with the highest rates being reported in the Netherlands, France, the United Kingdom and Ireland (Parent-Thirion, Macias, Hurley & Vermeylen, 2007). Aggressive behaviour in health care settings is a serious problem for service providers (Beech & Leather, 2006). This problem is not a new phenomenon. An advisory committee of the UK health services showed that violence was commonplace in health care, and specific areas such as accident and emergency, psychiatry and community care carried the highest risk (Health & Safety Advisory Committee, 1987). More recent official figures from the Security Management Service of the National Health Service (NHS) in the United Kingdom recorded 43,301 incidents of physical assault against NHS staff working in mental health and learning disability settings in 2004–2005 across England. This includes one assault for every five staff in mental health and learning disability settings.

In residential services violence and aggression can have a significant impact. Zuidema, Derksen, Verhey and Koopmans (2007) in a survey of Dutch nursing homes for older adults reported that more than 80% of these individuals presented with agitation/aggression, apathy and irritability. There are a number of studies which report associations between organic brain damage and aggressive behaviour in older adults (Pulsford & Duxbury, 2006).

There has also been considerable research investigating rates of aggression and violence in services for people with intellectual disabilities. Allen (2000a) in a recent review of the literature on aggression has reported that weapons may be used by between 17% and 29% of individuals with intellectual disabilities who present with aggressive behaviours. Physically aggressive symptoms such as hitting, kicking and biting occurred less often (in less than 13% of the sample). In services for people with intellectual disabilities, studies have reported data on complete populations through state registers. Jacobson (1982a, 1982b) reported data from the New York state register, which contained records on over 30,000 individuals living with their own families, in community residences or in hospitals. The register included data on both children and adults. The overall prevalence of relevant behaviours included 10.9% for physical assault, 4.3% for property destruction, 1.4% for coercive sexual behaviour, 8.1% for actively resisted supervision and 5.9% for verbally abusing others (Jacobson, 1982a).

A recent meta-analytic review of 86 studies on challenging behaviours identified risk markers of challenging behaviours in people with intellectual disabilities and autism (McClintock, Hall & Oliver, 2003). Risk markers were identified for a number of presenting problems. In the case of aggression these included a
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higher prevalence of males with a diagnosis of autism and deficits in expressive communication.

Hahn and colleagues (2008) reviewed the published literature of aggression and violence in hospital settings. They identified 31 studies rated as being of good or moderate research quality. Several themes emerged from this review. First, staff experienced more verbal than physical aggression. Second, health care professionals working in general hospitals were at high risk for experiencing various forms of violence at some point during their career and also during the time frame of one year. Third, they found that threats and verbal violence were more common among patients than visitors. In addition, hospital patients tend to be more violent than visitors. The authors identified a number of important situational factors that were associated with aggression. Organizational factors, such as prolonged waiting times and difficult interactions between professionals and service consumer, were associated with aggressive behaviour. Frustrating experiences also contribute to aggression in general hospitals, especially in relation to medical procedures that induced pain and/or anxiety and procedures that encouraged the patients to feel as though they were not being taken or treated seriously (Winstanley, 2005). These findings do appear to increase the risk of aggression and violence against nurses.

Although surveys appear to present a negative picture the representation of the complex nature of these behaviours may be affected by recording difficulties. Surveys vary in their use of definitions and may not represent true levels of violence and aggression. Violence and aggression may in some cases be under-reported (Lion, Snyder & Merrill, 1981). In contrast surveys and increased public awareness may over-emphasize the level and impact of verbal aggression. Distinguishing between verbal and physical aggression in surveys is important. A good example of this is found in surveys which report high levels of verbal aggression. Nijman, Bowers, Oud and Jansen (2005) reported that 80–90% of mental health nurses had experienced verbal aggression in the previous year. Logically a great deal of verbal behaviour does not escalate into full-blown violent acts. Verbal aggression nearly always precedes physical aggression, but the inverse is not necessarily a correct assumption. It could be argued that verbal aggression in many cases may potentially predict lower levels of physical aggression.

The nature of aggressive behaviours

Emerson and colleagues (2001) in a study of the total population reported a number of forms of aggression, which included the following: hitting others with hands (75%), hitting others with objects (41%), scratching others (27%), pulling others’ hair (23%) and pinching (20%) and biting (16%) others. The use of objects requires more detailed investigation. Similarly, the categories do
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not specify the body location that was hit and whether people were hit with a clenched fist or open hand(s). The type of objects used was also unspecified. There is limited data about the physical manifestations of aggression and violence.

Institutional/organizational aggression and violence

Violence and aggression should not just be viewed from the individual perspective; the system can potentially cause and maintain such behaviours. Bowie (2002) described the relationship between organizational structures and management and their susceptibility to violence. Similarly, Braverman (2002) identified that organizational systems can be ‘crisis prone’ or that alternatively they can have a positive culture of crisis preparedness.

There are numerous documented cases of institutional structures condoning and in some cases colluding with aggression and violence. Institutional structures can lead to acts of abuse, especially where negative subcultures are allowed to develop. Martin (1984) reviewed inquiries in UK hospitals over a 15-year period. His analysis identified that isolated staff groups committed acts which to some extent became normalized. In a number of inquiries new staff tended to act as ‘whistle-blowers’ who often challenged cultures in which violent and other abusive acts became normalized.

There are ample numbers of social psychological studies which have tended to demonstrate that the so-called ordinary people can commit extreme acts of violence. In some cases people can be made to deliver electric shocks to individuals in contrived laboratory situations (Milgram, 1974). In the classic Stanford prison experiment students were asked to role-play as both guards and prisoners in a mock-up prison in the basement of the Stanford University psychology department. In a matter of days guards started to display controlling and abusive behaviours that led to the termination of the experiment (Haney, Banks & Zimbardo, 1971). One of the themes of these studies is to show the ability of individuals to normalize and justify their behaviour especially in group contexts.

Byrne and Stowell (2007) cogently described the negative ethos of some prisons: ‘The image of prisons as institutions of reform has been supplanted by the reality of the prison system whose stated purpose is undermined by a culture of fear, violence, and control’ (p. 554). These few examples serve to illustrate the role of organizational cultures in maintaining aggressive behaviours. A useful area of research is to reframe the power of institutions. If we accept that these settings and cultures can maintain aggression and violence, then it must be possible to create organizations and structures with a violence- and aggression-free positive ethos (Braverman, 2002).
Responses to the Prevention of Aggression and Violence

The views of cultures about the management of these behaviours can vary dramatically. A natural extension of organizational approaches to preventing violence and aggression is the societal approach. In the last decade there has been the trend to move away from single-factor solutions to violence to complex strategies which involve interventions at a variety of levels. This approach has been called the public health model of violence prevention.

The recent World Health Organization document (Butchart, Phinney, Check & Villaveces, 2004) described four steps in the public health model: ‘The first step is to define the problem using the systematic collection of information. The second step is to identify and research the risk and protective factors that increase or decrease the likelihood of violence, including those that can be modified through interventions. The third step is to determine what works in preventing violence by developing and evaluating interventions tailored to the demographic and socioeconomic characteristics of the groups in which they are to be implemented. The fourth step is to implement effective and promising interventions in a wide range of settings and, through ongoing monitoring of their effects on the risk factors and the target problem, to evaluate their impact and cost-effectiveness’.

Primary prevention seeks to prevent the onset of violence. The goal is to alter some factor in the environment, to bring about a change in the status of the host or to change the behaviour so that violence is prevented from developing. An example of this would be the application of positive parenting programmes. Secondary prevention aims to halt the progression of violence once it is established. This is achieved by early detection or early diagnosis followed by prompt, effective treatment. An example of secondary prevention is conflict resolution within schools. Tertiary prevention is concerned with rehabilitation of people with an established violent behaviour, which would encompass behavioural change programmes within a prison setting.

There is a conflict between public health and judicial approaches to violence and aggression management. Consequence-based methods to managing aggressive behaviours are reflected in many penal systems. The strategy of prevention of violence and aggression may prove to be cost-effective when compared with consequence-based methods. A Rand Corporation study compared the following four types of interventions to reduce crime among youth (including violent crime) in the United States: providing high-school students with incentives to graduate; parent training; delinquent supervision programmes; and home visits and day care. All interventions except home visits were found to be more cost-effective than the ‘three strikes and you’re out’ law of the state of California that incarcerates individuals for 25 years to life if convicted of three serious
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Crimes (King, 2004). The public health and criminal justice systems do have some fundamental differences in approaches; these include proactive versus reactive strategies and preventive versus punitive responses to violence (Sade, 2004).

There are difficulties with the public health approach to violence prevention. Most notable is that multi-layered interventions may not always produce short-term outcomes. The systematic evaluation of the model requires comparisons across service settings and cultures. Despite these reservations the systematic approach to violence prevention using such a model would appear to be a positive and constructional approach. In many ways it is also an optimistic strategy.

Violence leaves no continent, no country and few communities untouched.

Although it appears everywhere, violence is not an inevitable part of the human condition, nor is it an intractable problem of ‘modern life’ that cannot be overcome by human determination and ingenuity. (Butchart, Phinney, Check & Villaveces, 2004, p. 77)

Although the prevention of violence and aggression is a laudable aim, it is unlikely that all of these behaviours could be eradicated in care settings. These approaches also require significant financial investment and may take years or even decades to have an impact. For both practitioners and researchers it would appear logical to develop prevention and management approaches in tandem. The development of effective behaviour management approaches represents a logical step.

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As discussed earlier, Bowie (2002) distinguished four typologies of violence: intrusive violence, consumer-related violence, relationship violence and organizational violence. Both consumer-related violence and organizational violence would primarily encompass violence in care environments. Global interventions such as the public health model may have an effect on both organizational and consumer-related violence.

The development of crisis responses in care settings needs to take account of factors that may immediately reduce the risk of harm. Crisis interventions should be distinguished from longer-term interventions. McDonnell and Anker (2009) distinguished between behaviour change and behaviour management strategies. According to their definition behaviour change ‘involves changes in intensity, frequency or episodic severity that maintain across situations and time’, and behaviour management involves ‘strategies which contain a behaviour...’
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and reduce the risk of harm to service users and staff without attempting to alter the behaviour per se. In this model, reductions in intensity, frequency or episodic severity of aggressive behaviours may occur, but the primary goal is one of safety and containment. Managing these behaviours effectively and safely in care contexts would appear to have potential benefits to both staff and service users. At an organizational level these could include reduction of restrictive practices such as physical interventions, seclusion and mechanical restraint. In addition the reduction of injuries to both carers and service users could also be an achievable goal (Deveau & McDonnell, in press). Intuitively, training staff in crisis responses may also have an effect on the reduction of violence and aggression.

The training response to aggression and violence in care settings

This chapter has highlighted the complex interaction of variables which can lead to violence. In care settings the behaviour of staff can be a significant factor. Morrison (1990) proposed a model of aggression and violence in psychiatry, which emphasized that people are more aggressive and violent when they are being ‘controlled’ by care staff. The behaviour of staff and other carers may inadvertently trigger aggressive behaviours in services for people with intellectual disabilities (Hastings & Remington, 1994).

The nature of interactions between staff and service users can also influence aggressive behaviour. Whittington and Wykes (1994) interviewed psychiatric nurses within 72 hours of an assault: 86% of assaults appeared to have been preceded by aversive stimulation from nursing staff, 60% of incidents were preceded by staff approaching the person or initiating physical contact, 51% involved frustrating a person in their goals or refusing a request, and 38% included requests or activity demands to the person.

Staff and service users are also at risk of injury when managing aggressive behaviours. Staff training is one approach to managing this difficulty. The need for advice and training on how to manage these behaviours and for carers to defend themselves non-violently, while also ensuring client safety, has been acknowledged by researchers (Allen, MacDonald, Dunn & Doyle, 1997; Rusch et al., 1986).

This book will focus on the training response to the management of aggressive behaviour in care settings. Training staff to de-escalate violent and aggressive situations and to safely manage physical violence is an important goal. Although, staff training would appear to be an obvious approach, the effectiveness of training in aggression management, which includes physical interventions, is based on limited outcome data (Allen, 2000b; McDonnell...
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et al., 2009). A theme of this literature is the poor quality of the research (Stubbs et al., 2009; Beech & Leather, 2006).

The content of training is important, but another element of importance is the values base. Paterson and Leadbetter (2002) argued, ‘Training involves more than the acquisition of skills and knowledge; it involves either explicitly or implicitly the transmission of a culture and a value base’ (p. 141).

Many behaviour management training approaches are available (Beech & Leather, 2006). The current situation would indicate that in the area of behaviour management anecdotal evidence for these systems still predominates. The development of behaviour management within a person-centred and evidence-based model would potentially have significant benefits. The remainder of this book will describe the development and evaluation of a training course to support staff to manage violence and aggression in care settings. The training system has the title of the ‘Studio3 approach’. It was developed and evolved over a 20-year period. The next two chapters will describe the development of the training, and the subsequent five chapters will describe the application of the approach in a variety of care contexts. The final two chapters will review the current evidence for the training system and suggest future areas of research for both academics and clinical practitioners.