CHAPTER 10

Coping with violent situations in the caring environment

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INTRODUCTION

In a recent survey of over 1000 people in the workplace, it was found that 19.6% could recall an incident involving threatening behaviour and 13.5% could recall an actual physical assault (Philips *et al.*, 1989). Yet carers are often surprised when they experience violence from those who are in their care (Owens and Ashcroft, 1985). Health service surveys do not present an optimistic picture; physical assaults can account for as much as 11.5% of all reported incidents; threat with weapons 4.6% and verbal abuse 17% (Health Services Advisory Committee, 1987). Despite these findings comparatively little research is available on how best to manage violent situations in care settings.

In this chapter some of the issues involved in managing violent situations both in community and institutional settings will be examined, with an emphasis on verbal and physical management strategies. Numerous definitions of violence and aggression exist. For the purposes of this chapter the definition made by Blackburn (1988) will be adopted, where violence refers to 'physical acts' and aggression subsumes all verbal behaviours, including threats and physical abuse.

DEFUSING INCIDENTS

Most violent incidents usually have several relatively predictable antecedents. They may be preceded by high levels of arousal and some form of verbal confrontation. Indeed, Luckenbill (1977) suggests that even crimes such as murder can have clear antecedents that build up

to the event. In a survey of battered wives, Dobash and Dobash (1984) found that the most common precursor of assault were arguments that led to physical violence. Threatening behaviours are a relatively commonplace occurrence. An example of this was reported by a health visitor in a recent study:

> I was greeted by a very large and irate husband who pushed me against the wall and accused me of not doing enough to help their family.
>
> (*Philips* et al., *1989*)

This typifies the problems faced by professionals when confronted by hostile clients.

Predicting violent incidents

Stereotypes of victims and offenders permeate society and the media. Lea maintains:

> Entirely random victimization is rare: the crazed gunman who walks down a street shooting at random is not a typical criminal offender. Most offenders have some social or economic relationship to their victims.
>
> (*Lea, 1992*)

These and other studies imply that there is a certain amount of predictability involved in a violent incident. However, it would be totally incorrect to automatically assume that the 'victim' is to blame for an event. It is similarly erroneous to assume that a 'perpetrator' wanders the streets looking for victims. Clearly, violence is interactional in nature and therefore, it would appear that the predictable aspects of these interactions need to be studied further if the frequency of violent encounters is to be reduced.

The 'assault cycle'

Kaplan and Wheeler (1983) describe a theoretical model that they refer to as the 'assault cycle'. This provides a useful analytical tool for the examination of potentially violent incidents. They describe five phases associated with incidents: (i) the triggering phase; (ii) the escalation phase; (iii) the crisis phase; (iv) the recovery phase; and finally (v) a depression phase that occurs after the crisis. Presumably, if a phase can be recognized then it can be potentially defused. The following section will examine some of the common defusion strategies recommended by researchers.

DEFUSION STRATEGIES

Mood-matching

In normal conversation, people tend to match each other's mood or state of arousal. This concept has been used by some authors when providing advice about the management of aggressive behaviours. For example, if a person is angry and upset and making personal or aggressive comments in a loud voice, an attempt would be made to match the loudness of the voice (arousal level) but not the emotional content or display. Davies (1989) recommends that the carer should attempt to match his or her degree of arousal with the client's. He suggests that: '... one would match the client's aggression with concern, involvement or interest' (Davies, 1989). Similarly, Breakwell (1989) advocates that 'the assailant who shouts, is shouted at: calm intensity is greeted with equal intensity'.

Thus, where 'mood-matching' has been advocated, it is implied that person A attempts to match the person B's arousal but not his or her emotion (Turnbull *et al.*, 1990).

The distinction between matching arousal and not emotional content is quite difficult to grasp and could be potentially very hazardous, particularly if an aggressor perceives an individual as matching both the emotional content and the arousal.

Stewart (1978) advises carers who approach a person who shows signs of becoming aggressive to: '... raise your voice to be heard if the patient is very noisy, but do not give any indications of being aggressive yourself'. This may be difficult. When a person speaks loudly they frequently display nonverbal signs of arousal (Argyle, 1988). Raising one's voice may well help to de-escalate a potentially violent situation, although Davies (1989) admits that it could be potentially dangerous to match aggression with aggression. The authors accept that mood-matching is an attractive option and makes theoretical sense. However, frequently it is not practical and it runs the risk of antagonizing a person who is presumably already highly aroused and possibly dangerous. Furthermore, relatively little is known about the cognitive triggers of violence. One person's aggressive trigger may dampen another person's aggressive intent. For example, social workers are frequently called upon to take both a therapeutic and statutory role when working with families. If a family member is angry or hostile they may 'calm down' when the social worker employs simple 'mood-matching' strategies. However, if the same social worker is required to become involved with the family on a legal or statutory basis, 'mood-matching' approaches may lead to injury or assault because the same social worker is perceived by the family member as a threat.

Low-arousal approaches

Low-arousal approaches are based on the assumption that increases in arousal will most likely result in interpersonal assault. The most often cited principle is to **remain calm** (Department of Health and Social Security, 1976; Confederation of Health Service Employees, 1977; Breakwell, 1989; McDonnell *et al.*, 1991a). This can be achieved by speaking slowly and quietly to the client. An assumption here is that the person who is angry or upset may easily perceive more hostile approaches as threatening. In addition, staff are recommended to breathe normally and to avoid tensing their arms or gritting their teeth (McDonnell *et al.*, 1991a–c).

Nonverbal behaviours

The low-arousal approach has implications for nonverbal as well as verbal behaviours. Direct eye contact is a physiologically arousing phenomenon (Mehrabian, 1972), and prolonged staring at an individual can be interpreted as a signal of attack (Argyle, 1988). Therefore, in the low-arousal approach, eye contact is usually intermittent. To avoid direct eye contact several authors have suggested that a person should stand at a 45° angle from their potential attacker (Davies, 1989; Turnbull *et al.*, 1990).

Low-arousal approaches may have implications for touching people who are angry and/or aroused. Although touching an individual can be a sign of positive communication, aggression is also primarily expressed through bodily contact (Argyle, 1988). Thus touch can be a physiologically arousing phenomenon and it has been recommended that carers should avoid touching clients who are aroused or angry (McDonnell *et al.*, 1991b). Similarly, invading a person's space can be perceived as a threat, therefore potential aggressors should be given a considerable amount of personal space. Kinzel (1970) demonstrated that violent prisoners prefer larger interpersonal spaces than nonviolent prisoners. Turnbull *et al.* (1990) recommended up to '6 m if necessary' in institutional settings.

Posture is another powerful form of nonverbal communication. However, Mehrabian (1969) found that placing your arms on hips is often negatively construed by observers. Some authors recommend placing the hands either in pockets or behind your back. McDonnell *et al.* (1990b) strongly recommend that a carer should adopt a relaxed posture when confronted by an aggressive individual.

Surprise/shock methods

Nonphysical surprise and shock methods are recommended by several authors. To defuse a violent situation Lamplugh (1991) has suggested

using one's voice to 'voice off' an attack; '... if you want to give a potential attacker a surprise, expel the air with a bellow or as though you are about to be sick'.

Davies (1990) describes the case of a social worker who witnessed a fight between a father and son on a home visit. He recommended a strategy where the person might have said 'stop hitting him', 'loudly, repeatedly and authoritatively'. These approaches are in almost total contrast to the low-arousal or assertive approaches.

Alarms (either personal or room) are often recommended as an organizational and preventative strategy (Breakwell, 1989). Personal-attack alarms have been proposed presumably for their shock or surprise effect. Lamplugh (1991) proposed that such alarms should be sounded next to the attacker's ear. Presumably this is to surprise, shock or even disable the person. A weakness with this type of approach is when the assailant does not run away – one may then be faced with an aroused, very angry person. Moreover, there are no detailed experimental studies of human responses to the sound of these alarms, although there is a body of research, conducted in New York, that demonstrates the relative difficulty of obtaining bystanders' assistance, even for apparent medical emergencies (Darley and Latane, 1968).

Assertiveness training

Assertiveness has been recommended in a wide range of settings (Rees and Graham, 1991), as an approach to managing aggressive situations, and referred to by some authors as the first line of defence (Davies, 1990). Also it is a relatively popular training option for coping with violence in the workplace (Philips *et al.*, 1989).

The application of assertiveness training to self-protection assumes that people may be attacked or victimized, or are in danger of becoming aggressive themselves, partly because they do not express their wishes, or do so in a socially ineffective manner. As Davies puts it, 'By adopting an assertive attitude, you are telling the world that you are someone to be reckoned with'.

While assertiveness training may help people who are not confident in managing difficult situations, the distinction between assertion and aggression must be appreciated and clearly understood. A drawback of this approach is that people may slip from being assertive to being aggressive. Unfortunately there are few studies of the impact of assertiveness training on people defined as 'high-risk' for violent or aggressive behaviours.

Summary and conclusion

In conclusion, there is a noticeable lack of research evidence for the effectiveness of the defusion strategies discussed in this section.

Some of the strategies mentioned, such as assertiveness training and low-arousal approaches, appear to make some intuitive sense. Strategies that are based on surprise or shock and to a certain extent 'mood-matching' appear to be a little more risky to the individual because they may have unpredictable consequences and encourage a fight and flight reaction. Some of the advice is not only contradictory (e.g. 'mood-matching' versus low-arousal approaches) but, in some cases, dangerous. Surprise and shock methods would appear to be useful only in cases of severe desperation. Much more research is needed to assess the relative merits of these strategies before firm conclusions can be drawn or clear advice given to carers. In the following section, the use of some of the more invasive methods recommended for dealing with aggression and violence will be examined.

RESTRAINT PROCEDURES

The lack of an adequate definition of physical restraint (Dabrowski *et al.*, 1986) makes consideration of the literature problematic. For the purposes of this chapter, the term physical restraint refers to, 'the restraint of an individual by the use of bodily force'. Mechanical restraint will refer to 'restraint that involves the use of devices that are physically attached to the person', such as protective splints, leather straps, etc. There is evidence that such procedures are used in a variety of care settings.

Physical restraint

A survey of Polish psychiatric facilities reported that physical restraint was used in over 30% of acute admissions (Dabrowski *et al.*, 1986). This rather high figure is accounted for by a broad definition of physical restraint, which included forced feeding, medication and the use of mechanical restraints. In a survey of a US hospital-based neurosurgical unit, physical restraint was employed in over 35% of cases of cerebral contusions (Edlund *et al.*, 1991). The authors found that 'restrained' individuals tended to be prescribed psychotropic drugs frequently during their stay in hospital and tended to have consumed alcohol prior to admission.

Physical restraint is commonly used in settings for the elderly, with figures varying between 25% and 84.6% (Evans and Strumpf, 1989). It has been employed with violent adolescents (Hunter, 1989) and in a recent study of carers of people with learning difficulties, physical restraint was used as a management strategy in 20% of incidents (McDonnell and McEvoy, in press).

Side-effects

The use of physical restraint can have serious side-effects on care staff. It is believed that most staff-related injuries in psychiatric settings are restraint- or seclusion-related (Haller and Deluty, 1988). In a study of staff injuries in a US Mental Handicap Service it was found that 29.5% of staff injuries could be attributed to the implementation of mechanical or physical restraint (Hill and Spreat, 1987). Physical restraint can also lead to the injury of clients (Dietz and Rada, 1983; Spreat and Baker-Potts, 1983).

Difficulties in using physical restraint

Although most surveys on the incidence and effects of restraint procedures suffer from a variety of methodological problems, the evidence suggests that physical restraint procedures are still widely used in a variety of caring environments. Yet there has been surprisingly little research into the effectiveness of various types of restraint procedures. Most methods appear to have developed without any experimental evidence for their effectiveness. Some procedures recommend two members of staff should carry out procedures (Harvey and Schepers, 1979; Lefensky *et al.* 1978; McDonnell *et al.*, 1991c), others suggest as many as four staff (Lion *et al.*, 1972; Reid, 1973). Often there is a lack of consensus over the restraint procedures themselves. Fidone (1988) referred to the problems of applying a 'baskethold' on clients in a supine position. In a reply Steinfield (1988) pointed out that the 'baskethold' was only applied in a prone position. If restraint is to be used, then the confusion surrounding terminology requires attention and the procedures need the utmost scrutiny, for the protection of both clients and care staff.

Mechanical restraint

Most of the published information reviewed here is from studies in the USA. There is little information about UK practices, although it is clear that mechanical restraints are sometimes used. They have been advocated for violent individuals in a variety of care settings (Evans and Strumpf, 1989; Van Rybroek *et al.*, 1987). A major problem with the literature is defining what types of devices are used. Mattresses (Penningroth, 1975) and blankets (Powers, 1987) have been recommended. Anders (1983) described a restraint method that involved a person being strapped to a bed in a supine position by use of leather straps. More recently the 'cold wet sheet pack' is reportedly still being employed in some institutions (Ross *et al.*, 1988). This is a procedure commonly used in the early part of the 20th century, which involved

wrapping people in cold, wet sheets. This allegedly had powerful sedative effects. Some physical restraint procedures involve the 'locking' of limbs, which, in effect, involves using pain to control a violent individual. An apparently new approach has been the adoption of preventative ambulatory devices (PADs) (Van Rybroek *et al.*, 1987) as an alternative to seclusion. This method involves the application of either wrist and/or ankle restraints, which have a remarkable similarity to 'handcuffs and shackles'.

Effective and acceptable?

McDonnell and Sturmey (1993) have argued that the effectiveness of a restraint procedure is only one useful measure and the social validation of these methods must be addressed. A recent study asked a sample of young people to rate videotaped representations of three commonly used restraint procedures using the *Treatment Evaluation Inventory* (McDonnell *et al.*, 1993; McDonnell and McEvoy, in press). Two of the methods involved restraining a person on the floor, the third restraining a client in an armchair. It was found that all of the samples rated 'the chair method' as more socially acceptable. It is difficult to generalize to all care settings from the results of this study and clearly more research is needed before advocating the use of a single method. This highlights a methodology for investigating the acceptability of physical restraint procedures and verbal strategies for managing incidents. How procedures would be viewed by the public is just as important as their effectiveness. How would members of the public and care staff rate the acceptability of shouting at individuals even if it were an extremely effective strategy?

Staff training in restraint methods

A neglected area of research is the training and evaluation of care staff in physical-management procedures. A survey of 67 psychiatric nurses found that 75% had received no training in the prevention and management of disturbed behaviour (Basque and Merhige, 1980). A few studies have reported some evaluations of training. In a comparison of trained versus untrained staff in a state psychiatric hospital it was found that there were fewer reports of assault on staff who had received training (Infantino and Musingo, 1983; Whittington and Wykes, 1993) although others (e.g. Roscoe, 1987) have shown that trained staff are more likely to be included in violent incidents.

Gertz (1980) described the effects of a 2-day workshop taught to 317 staff members in a mental health centre. They found a reduction in patient-related accidents from 174 incidents to 117. Turnbull (personal communication) reported increases in self-confidence and performances of

care staff who attended a 2-week residential training course. More recently, McDonnell (in press) found increases in confidence scores of care staff who attended a 3-day workshop in the management of violent and aggressive behaviours. Staff skills in the use of a two-person restraint procedure were assessed by means of a videotaped role-play test. No studies to date have reported adequate follow-up data, and many of the studies have failed to include treatment control groups or measures of generalization of skills to the workplace. Future research studies might examine usefully the effect training in the restraint procedures might have on the reduction of staff injuries. Evaluation of staff training might also consider the extent to which staff are encouraged to feel more confident and able to cope with violent situations. In a study carried out by Whittington and Wykes (1993) a 1-day violence course using role play reduced levels of violence on wards but only when a significant number of staff from a ward had attended.

Seclusion

The seclusion of an individual involves his or her isolation in a designated locked area. Seclusion is frequently recommended for the protection of staff and clients from assault and for a decrease in sensory or emotional input (Hodgkinson, 1985). This emotional input may be in the form of negative interactions with staff or clients, or merely providing a quiet area for the person (Gutheil, 1978). However, it has been argued that there is no clear theoretical rationale for the use of seclusion (Drinkwater and Gudjonsson, 1989).

Difficulties in implementing seclusion

Several studies have reported difficulties with the implementation of seclusion. It may be used for a large number of behaviours and not only in cases of violence and may also be used more frequently in some institutions than others. Hodgkinson (1985) found that the most common reported use of seclusion was for general disturbed behaviour rather than violence *per se*. Carpenter *et al.* (1988), in a survey of 19 hospitals in New York State, found that city and large-town hospitals used seclusion more than suburban and small-town hospitals. In a study of a UK psychiatric unit, high usage of seclusion was associated with lower staffing levels and less experienced staff in charge of the ward (Morrison and LeRoux, 1987).

Seclusion practices raise several questions. Has training been provided to care staff as to how to move a violent individual into an area designated for seclusion and what form does this training take? The utility of seclusion can be questioned because it arouses negative

imagery associated with imprisonment. Furthermore, recent evidence suggests that psychiatric services can apparently manage without the use of these methods (Kingdon and Bakewell, 1988). The role of seclusion in UK special hospitals has been called into question and is now the subject of a proposed national governmental inquiry.

SELF-DEFENCE TRAINING

Although no accurate surveys exist it appears that self-defence classes are quite a popular option in the UK. In their discussion of violence in the workplace, Philips *et al.* (1989) reported that self-defence classes were being introduced into worksettings and appeared to be popular with the 'youngest and oldest age groups'. Moreover, brief courses aimed at teaching essential combative skills are most certainly being taught to members of the caring services. The Department of Health and Social Security report entitled *'Violence to Staff'* gave an opinion about the use of self-defence techniques:

> Some authorities arrange self-defence classes for their staff of both sexes. We do not make such a recommendation ourselves. Although the boost to confidence is important, we are of the view that elementary self-defence techniques have little practical value in a real-life incident and might cause harm to the assailant or expose the victim to more serious injury.
>
> (*DHSS, 1988*)

Despite these warnings, it appears that self-defence training is an option for managing violent incidents in the caring services. GPs, social workers, midwives etc. often have to make home visits to areas that may have a high frequency of street crime. A distinction has to be made between an assault on a carer by a member of the public 'on the street' and the carer who is working in that capacity with a client in a caring context. While the law states that an individual may use 'reasonable force' to defend themselves if attacked, it is difficult to define operationally what is meant by the term **reasonable**. A person who defends themselves during a mugging may be able to argue that the vicious blows and techniques employed were in self-defence. However, a person working in a caring environment could be subject to dismissal for similar behaviour in the care setting. Several staff have gone to prison for assaults on clients despite using a self-defence argument (Martin, 1984).

Gaining confidence

Although a popular growth industry in the UK, there is little evidence for the efficacy of self-defence training. Pava *et al.* (1991) reported on

the effectiveness of self-defence training for a group of 11 visually impaired women. The course consisted of 12 2-hour sessions, involving physical resistance skills, rape prevention strategies and the discussion and rehearsal of 'rape scenarios'. The authors reported significant increases in the confidence women placed in the strategies they were taught and a statistically significant increase in the women's reported confidence in their ability to respond to a threatening situation. The authors reported post-test improvements in the physical skills taught on the course. However, the study did not include a control group and no follow-up measures were taken; despite these weaknesses the study is praiseworthy in its attempt to measure the effectiveness of such training.

An increase in self-confidence has been reported by researchers who have conducted staff-training courses containing physical self-defence components. Turnbull *et al.* (1990) found that most staff who completed a 2-week training course that included physical skills reported feeling more confident, although no data were presented. McDonnell (in press) reported increases in a pre- and post-test self-confidence scale following a 3-day training course for care staff in facilities for people with learning difficulties. Over 50% of this course involved the teaching of physical skills drawn from the martial art of Jiu-Jitsu and modified for the caring environment. Both Turnbull *et al.* (1990) and McDonnell (in press) used role play; a method recommended for use in self-defence classes (McGrath and Tegner, 1977).

Learning techniques and skills

The pop singer Lynsey DePaul (1992) has recently produced a short self-defence training video for women containing 19 different self-defence techniques, ranging from being grabbed by the wrist, to being pinned to the floor. It is difficult to comprehend how a person could master so many motor skills in such a short period of time, simply from video presentation. An analogy here would be to expect a person to learn to be a rock climber or drive a car as a direct result of watching and practising from a video. To some extent this video package is characteristic of the brief and extremely violent nature of self-defence procedures.

The problem of teaching and learning, at times quite complex, motor skills is not only unique to video recordings. The first author (a UK National Coach in the martial art of Jiu-Jitsu) reviewed a selection of books on self-defence. A review by the first author and Steven Alison (a member of the British Jiu-Jitsu Association) of books on self-defence published in Britain is shown in Table 10.1. A similar pattern to that found in video packages emerges, with a vast number of physical skills being described and visually displayed. These books comprise a

Table 10.1 An analysis of the numbers of physical techniques recommended in a selection of UK self-defence books

	Number of pages	*Number of physical techniques*	*Percentage of book*
Streetwise: A Basic Guide to Self Defence (Lowe *et al.*, 1984)	112	25	22
Self Defence for Women (Warren-Holland *et al.*, 1987)	140	29	21
Hit Back: Self Defence for Women (Biffen and Search, 1983)	176	60	34
Protect Yourself: Every Woman's Survival Course (Whitelaw, 1985)	159	47	29
Hands Off: Hapkido Self Defence for Women (Adams and Webster, 1986)	95	29	30
The Official Self-Defence Handbook (Mitchell, 1985)	152	45	29
Protect Yourself: A Woman's Handbook (Davies, 1990)	160	23	14
Stand Your Ground: A Woman's Guide to Self Preservation (Quinn, 1983)	175	50	29

large number of pages on physical procedures even though it is unclear whether an individual is expected to learn these skills from the books on their own. Many of these techniques appear to be extremely violent in nature and the books include very little information on defusing violent situations. Lamplugh (1991) has cogently argued that '... techniques are almost impossible to learn from books, they need hands-on training and to be regularly practised'. However, Lamplugh later recommends in the same book: '... try twisting the ears off' and 'bend any finger right back (not just a little way). Stamp on them, bite them, pull them apart'. Of even more concern is the fact that accurate studies have not been undertaken into the maintenance and generalization of self-defence skills taught in evening classes throughout the UK.

Difficulties with self-defence training

It may be misguided to assume that relatively short self-defence courses will have major effects on human behaviour, although it would appear logical (but requiring much more empirical research) that self-defence training can increase an individual's confidence in managing a violent encounter and make that person more aware of preventative strategies. However, a major difficulty with self-defence based training is how it relates to the caring environment, especially the concerns about the content of such training. A preoccupation with violent and potentially lethal physical techniques seems to abound. Paul (1980) expressed concerns that self-defence class instructors appeared to be imparting potentially dangerous techniques. This finding is of particular concern when coupled with research indicating a negative relationship between skill level and aggressiveness (Nosanchuk, 1981). Theoretically, short courses could conceivably teach quite high levels of aggressive response to people with comparatively poor skill levels.

Are the procedures taught effective as well as socially acceptable? Does the person teaching the course have any experience of working with the client groups concerned? Are these instructors suitably qualified? Unfortunately the national guidelines on self-defence training are sufficiently vague to allow a frightening degree of variability in training and teaching competence. The growth industry associated with self-defence training requires a high degree of scrutiny and systematic research by members of the caring service. Its introduction to the care environment is fraught with dangers and, at present, leaves too many important questions unanswered.

GENERAL CONCLUSION

Simple answers to the provision of coping with violence in caring environments are not available, since many of the issues associated with the management of violent incidents in the care setting are multicomplex. Research into the strategies of managing these behaviours is woefully inadequate. The defusion strategies frequently recommended are sometimes contradictory, may in themselves prompt aggression and require careful consideration. Where physical procedures, such as restraint or seclusion are used, it is imperative that staff are trained in their usage and considerable investigation into the social acceptability of these methods is undertaken prior to implementation.

A further aspect worthy of systematic investigation is the viewpoint of the consumer. How socially acceptable to persons who are at risk of committing aggression are the procedures employed against them? To date, there appears to be little research into this interesting

avenue of enquiry. How would people respond to the question, 'what do you think of how you were secluded or restrained?'?

The need for staff training

Guidelines or a 'blueprint' for good staff training in the management of violence are lacking. Ideally, training courses might include aspects of environmental design, diffusion strategies and simple relatively non-violent methods of managing incidents. It appears to make intuitive sense that a person needs to feel confident if they are to defuse successfully a potentially violent incident. It is more likely that this confidence will be engendered if the person has had training in the prediction of violent incidents and the social skills training for defusing incidents, as well as dealing with the physical consequences of violent acts and the consequences of their own physical behaviour. This is true whether training involves restraint procedures, or exposure to simple physical skills in order to help the person escape from the situation. Concentrating on one aspect or another would appear to be only half the answer.

The need for research

In conclusion, the research on managing violent incidents especially in UK care settings is sparse, imprecise and confusing. Advice for carers on how to defuse and physically manage violent situations in caring environments is given with a confidence based on very shaky foundations. Most of this advice is based on anecdotal information and gives licence to the frequent employment of violent interventions in community and particularly institutional settings.

Physical solutions as responses to crises may appear to be sufficient in the short-term. However, such solutions frequently have negative side-effects in the long-term. Only when there is open and frank discussion of the complex issues involved, clarification of definitions and the systematic description of procedures undertaken will significant progress be made. Training care staff would appear to be a necessity; however, the content of the training is yet to be decided and is still a question of considerable debate. There needs to be more research data and fewer anecdotes in this field. Perhaps this could be achieved through anonymous data collection across UK care settings so that at least an overview of the types of physical techniques used could be catalogued.

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