Title: Understanding violence when the perpetrator has an intellectual disability: the perceptions of professionals

Abstract

Aim: The research sought to enhance professional understanding of the violence perpetrated by some people with an intellectual disability.
Background: The violent behaviour exhibited by some people with intellectual disabilities remains poorly understood, particularly with regard to a clear and informative definition.
Design: A qualitative study investigating the views and perceptions of professionals working directly with people with an intellectual disability in different settings.
Methods: 22 semi-structured interviews were undertaken with professionals from a variety of backgrounds and four themes were generated through data analysis.
Findings: Themes produced comprised the degree of intellectual disability, impulsivity, intentionality and unpredictability. Findings indicated tension between understanding violence as purposeful and explaining it in relation to the intellectual disability and/or additional conditions.
Conclusion: Intellectual disability is central to understanding the impact of the other three themes, though there is a professional reluctance to use such knowledge as evidence to inform practice.

Introduction

Violence perpetrated against staff working in the health and social care sectors constitutes an issue of longstanding significance (Jansen et al., 1997), with difficulties relating to recording, understanding, reporting and interpretation stretching back several decades (e.g., Lion et al., 1981), and the fields of intellectual disability and autism providing particular areas of concern (Cairncross & Kitson, 2013). Multiple studies confirm that direct care staff working with these groups experience considerable violence, though there is no real consensus over the exact amount, with verbal aggression ranging from 55% to 93%, physical assaults from 33% to 56%, and threatening behaviour from 40% to 71% (Emerson & Hatton, 2000; Harris & Leather, 2011; Mcgregor, 2010). These instances of violence, however, are extremely variable and range from single occasions of extreme violence, resulting in serious injury, to regular bouts of less intense aggression with no injuries sustained (NICE, 2015a; 2015b). The difficulty in establishing accurately whether violence against care staff and professionals is increasing is further complicated, not only by the uncertainty relating to definition, but also by the terminology employed. The term aggressive behaviour, for example, is preferred to violence in the context of dementia, perhaps because it is perceived as less emotive and pejorative (Pulsford & Duxbury, 2006), though also as a consequence of the difficult relationship between intentionality and dementia (Gates, Fitzwater & Mayer, 1999). This paper looks at violence in the context of intellectual disability, a population, who, as a discrete group, are not just more likely to be the victim than the perpetrator of violence (Hughes et al., 2012), but twice as likely as other groups to be the recipients of violence (Harrell & Rand, 2010). The great majority of people with an intellectual disability, furthermore, have no history of violence (Sigafoos, Arthur & O'Reilly, 2003).

Background

The initial difficulty, particularly when we seek to complicate the issue by focusing on

specific groups, such as the elderly, those with psychosis, or people with an intellectual disability, relates to one of definition. Violence tends to be most commonly conceptualized as a manifestation of disrupted or negative behaviour (Schuur, 1997), sometimes focusing on the purpose or intention (National Institute for Clinical Excellence, 2006; Wright et al., 2002), and varyingly including self-harm, damage to property, verbal abuse, threatening behaviour and physical attacks on persons or staff (Schnieden, 1993). The most comprehensive contemporary definition in relation to health care brings together many of these elements, settling on the "intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort (and includes) punches, slaps, kicks, head butts, scratches, nips, hair being pulled and strikes with weapons" (NHS SMS, 2009: 13). This definition is limited, though, by its clear focus on physical violence and neglect of verbal aggression, the impact of which should not be under-estimated (Dallender et al., 2001). This is particularly so when the language is profane, obscene, personal (McKenna, 2004), or likely to escalate into physical violence (Werner et al., 1983). A more complete definition, therefore, though less precise in some ways, is one that gives enhanced emphasis on other dimensions of violent behaviour, especially verbal abuse and threat (NHS Direct, 2012).

These definitional issues "contribute to a lack of common understanding among staff as to what constitutes either an act of aggression or violence" (Maguire and Ryan, 2007: 121), which might exacerbate the problem of under-reporting (Erickson and William-Evans, 2000). According to Zernike and Sharpe (1998), under-reporting may relate to the professional socialisation of healthcare workers into an ethos of compliance and acceptance of violence, effectively being considered as part of the job (Sandvide et al, 2004). A further concern revolves around the issue of seriousness, with some evidence that a reliance on formal reporting of incidents acts as a deterrent to reporting (Kho et al, 1998). Nurses perceive violence as offensive and destructive (Jonker et al, 2008), but there are issues with regard to reporting that are difficult to completely disentangle. There is little evidence of a lack of support or fear of repercussions, with the relevant policies, procedures and follow-up, such as counselling or supervision, being readily available. The difficulty appears to be more in relation to violence being considered either a part of the job or the incident being minor and not worth reporting (Skellern & Lovell, 2008). The violence might be sometimes significant and staff preparedness and awareness of how to respond, so much improved from years gone by, but tolerance appears an ongoing issue within intellectual disability services (Lovell & Skellern, 2012).

The difficulty with accuracy continues when we focus more specifically on a particular population, such as people with an intellectual disability, since the statistics for this group are absorbed into the broader statistics for people with mental health issues. The five-year trend, for example, which combines the Security Incident Reporting System (SIRS) with Reported Physical Assaults (RPA) doesn't offer a separate breakdown of statistical changes within intellectual disability services (Dixon, 2015). The reasons for violence in the context of working with people with an intellectual disability may be many, and include the absence of open and private space and staff-service user interaction factors, such as denial of requests, lack of appropriate activities, aversive social contacts and derogatory personal comments (Deb & Roberts, 2005: 34). The violence experienced is likely to be more severe in in-patient settings, though incidents in the community, where violence may present risks in the system around the service user, could, according to Daynes, Wills & Baker (2011), be significant. These incidents can be prolonged, lacking immediate support, extreme (Lovell & Skellern, 2013), with nurses absorbing much more direct violence than other professional groups

(Chaplin, McGeorge & Lelliott, 2006). The consequence has been an acceptance of some violence as being integral to the job (Hakeem & Fitzgerald, 2002), especially where service users have limited capacity to understand and take responsibility for their behaviour (Mathieson, 2005). A further implication is a "staff culture that accepts violent and offending behaviour", with a reluctance to involve the police and press charges (Chaplin, McGeorge & Lelliott, 2006: 109). In the context of health care, nurses most likely to be victims of violence tend, unsurprisingly perhaps, to be those with the poorest clinical and interpersonal skills (Spokes et al., 2002), least awareness of relevant policies and procedures (Martin & Daffern, 2006), and working within a punitive sub-culture (Meehan, McIntosh & Bergen, 2006). The evidence, furthermore, indicates that professionals' responses to violence reflect their beliefs about the reasons for aggression (Collins, 1994), which might be contradictory, confusing and influenced by different bodies of theory (National Institute for Social Work Research, 2000). Mental health and intrinsic factors, for example, are identified by staff as the main reasons for violent behaviour, whilst service users emphasise environmental factors and staff control (Duxbury & Whittington, 2005).

THE STUDY

Research Design

A qualitative research design was employed to facilitate exploration of professionals' understanding of the relationship between intellectual disability and violence, and the extent to which a certain amount of violence might be tolerated as part of the job. Three specific research objectives sought to:

1. Examine the relationship between professional acceptance of violence as part of the job and an individual's intellectual disability.
2. Increase understanding of how professionals' understand and conceptualize violence in the context of intellectual disability.
3. Describe the contributory factors to professionals' explanation of violence perpetrated by some people with an intellectual disability.

Data collection

A semi-structured interview schedule was constructed for use with professionals working directly with people with intellectual disabilities in healthcare settings. The schedule structure was designed as a thematic guide, in order to elicit specific responses around professional experience of aggression and violence in relation to working with people with an intellectual disability. Later questions sought to allow for greater exploration of issues raised by participants, enabling both expansion and depth in the responses provided. Interviews were undertaken over a three-month period in 2013, ranged from 40 to 60 minutes, were audio-recorded and transcribed verbatim.

Participants

The researchers successfully gained access to a diverse range of professionals currently employed within the intellectual disability directorate of one Foundation Trust based in the northwest of England. The sample invited to participate, all of whom accepted and subsequently participated, were representative of a range of intellectual disability services comprising assessment & treatment, low secure, respite and supporting people within community settings.

The total number of interviews conducted (n=22) represented 7% of the total workforce and interviews were primarily conducted in the service setting, though 2 preferred to come to the researcher's base. There was no previous relationship with the researcher and sample selection criteria consisted of current, direct contact, in a working capacity, with people with an intellectual disability. A significant number of the sample were intellectual disability nurses working in assessment & treatment (A&T), low & medium secure (LSN; MSN) and as community and forensic community specialists (C/N; F/N) (12), with the others representative of clinical psychology (psych) (3), occupational therapy (O/T) (2), speech & language therapy (S&LT) (1), physiotherapy (physio) (2), social work (S/W) (1) and psychiatry (1). Further participant information is provided in Table 1 below.

Profession	**Gender**	**Age range**	**Years of experience**	**Additional information**
Nurses (RNLD)	Female 9 Male 3	24-56 years	3-32	Community 7 i.e. generic 4; children 1; forensic 1; health facilitation 1
Clinical Psychology	F 2 M 1	27-52	2-25	Generic 2 Adolescents 1
Occupational Therapy	F 1 M 1	31-55	4-30	
Physiotherapy	F 1 M 1	29-57	4-32	
Speech & Language Therapy	F	43	18	
Psychiatry	M	46	18	
Social Work	F	56	31	

Table 1: Participant information

Data analysis

A thematic approach to analysis was undertaken, which involved "bringing together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985: 60). The researchers sought to identify a number of fundamental concepts characterizing specific participant experiences by the more general insights apparent from the whole data set (Ryan & Bernard, 2003). The process of developing recurrent unifying concepts or statements (Boyatzis, 1998) was underpinned by Burnard (1991)'s 14-stage framework for analysing qualitative data, which ensured a structured, systematic approach and facilitated the working and re-working of the data. This was further supported by the computer software package, MAXqda, particularly effective in terms of data storage and organisation (Richards, 2009). The separate but simultaneous analysis of the data by both researchers supported the validity of the production of the themes, and this was enhanced further through the engagement of three interviewees (2 nurses and 1 occupational therapist) to read through their own transcripts and note salient points, which were then utilized to inform the themes.

Ethics

Ethical permission was obtained from the Faculty Research Ethics Sub-Committee and the Integrated Research Application System (IRAS), before access was successfully negotiated with the participating organisation. Participants were recruited voluntarily through the operational communication systems of the host organisation. Written consent was sought

following comprehensive explanation prior to the interview, information about researcher background and the study purpose. The interviewers sought to facilitate discussion around the issue of service user violence, its manifestation, individual consequences and interpretation.

Findings

Four themes were produced by the analysis: *degree of intellectual disability; impulsivity; intentionality; unpredictability*, and these are discussed below. Some participants used the term learning disability, which has been changed throughout to intellectual disability to ensure consistency. Table 2 elaborates on the meaning of the themes and provides examples of codes.

Theme	Intellectual disability	Impulsivity	Intentionality	Unpredictability
Meaning	Violence as being directly associated with the level of intellectual disability and influenced also by associated conditions	The extent to which one's violent behaviour was regarded as being connected with the desire to get one's own way, a source of tension for many staff	Interpreted in more personal terms, less random and more inclined towards causing hurt to a specific individual	Reflects the desire for the violence to be rational and conform to expectations, yet masks an underlying contradiction, that comprehending the motive sufficiently explains it
Codes	Severity; degree of culpability; social functioning; responsibility for actions	Tolerance; additional health issues; frustration; consequences	Deliberate; calculated; pre-planned; targeted	Ambivalence; contradictory; inexplicable; provocation

Table 2: Themes, over-arching meanings, and examples of codes and categories

Degree of intellectual disability – 'they know what they are doing'

The very existence of the intellectual disability coloured the issue of culpability, primarily through the belief that the greater the severity then the more calculated the assault with the consequent increased likelihood of injury. The impact of the intellectual disability restricted decision making, choices and maturity of response to frustration, and some participants emphasised the need for staff to understand this more fully. A further issue arose when participants spoke of how behaviour could be complicated by an associated condition, particularly autism spectrum disorder, which suggested to some that the violent behaviour was less deliberate and inherent in the individual's makeup:

."... those with a…profound intellectual disability…hitting out at others…shouting, swearing, biting…to the other extreme, people who are perhaps more able…violence is more premeditated, they know what they are doing" (O/T).

"…frustration is often a trigger and by the very nature of intellectual disability they are very likely to have some difficulties in expressing that and dealing with that internally" (O/T2).

"I think for people who are very ill, or autistic, or who you don't believe do know the difference between committing a criminal act, and if it's just part of who they are, then it's

different…for some reason less threatening…than somebody perhaps who is very threatening and knows what they are doing, they feel more dangerous to me" (A&T nurse).

The issue of personal responsibility resisted a consensus, particularly around the level of intellectual disability influencing the capacity to take responsibility and whether it would be useful to involve the police:

"…there are some people for whom the rules shouldn't be any different than from you and I, but there are also people, who, their disability is such that, I'm not entirely sure that they could ever be held responsible" (C/N).

"I don't see the point in (involving the police) because they don't understand and it would be pointless really, they are not going to learn from it, they haven't got any insight into it and… to go to court they are not going to gain anything from it" (A&T nurse).

Participants discussed the influence of the intellectual disability on the capacity to function socially, describing how the interaction between emotional distress, communication difficulties and social context could be a recipe for violence, which was also frequently underpinned by complex personal history:

"Their ability to manage the situation…social functioning gets in the way of everything…if you're angry, emotional, and have an intellectual disability, and you can't communicate your needs, you are more likely to be aggressive" (FCN)

"…a lot of them are from such dysfunctional, and I mean seriously dysfunctional, families, that I believe a lot of their offences are related to that… to poor social skills…some of them, from a very early age, when its gone wrong for them" (S/W).

Impulsivity – 'a low tolerance of things not going his way'

Participants struggled a little with impulsivity, regarding it as having become more of a concern over recent years, but there was also a tension between understanding it as related to an individual's intellectual disability or associated mental health issue, and requiring that people take responsibility. Conditions, such as Attention Deficit Hyperactive Disorder (ADHD) and dementia are clearly understood in terms of the likely impact on propensity for violence, but the behavioural dimension, getting one's own way, is equally as influential:

"A man came to us from medium secure, adult ADHD, and if he didn't get what he wanted instantly, he would act physically and he had served prison sentences for assaulting staff…it wasn't anything new, he'd got a long history of it. And the tables would go flying, kick in some sockets or the light fittings, windows, doors, he just completely damaged the environment" (F/N).

"…there may be signs of dementia, which can be hinted through losing some of his inhibitions, and there is a long history really of impulsive behaviour…the reason for the referral was because he had assaulted a bus driver…a low tolerance of things not going his way" (O/T2).

The importance of an individual's care plan, regarded, in particular, as significant when there

is concern around someone over-reacting to circumstances not of their liking, could provide a framework for responding, and when ignored could almost facilitate violent behaviour. This might not just provide a means of avoiding the consequences, in this case the loss of a placement, but also improve the quality of a relationship. The emphasis here was less on the desire for an individual to take responsibility and more on those surrounding him to understand the intricacies of relating to a potentially difficult individual:

"You can't take their frustrations away, you can't give people what they want when they want it all the time, but there are ways of…working with that and that particular person…the care staff time and again haven't followed the guidelines, haven't understood what this person's issues are…and they have carried on with this 'we're in charge and you'll do as we say'. They are then being assaulted and have the police involved on occasions and ultimately he has had to move out of that placement" (C/N).

The implementation of a plan, whereby an individual was responded to consistently, was considered by some to be central, whilst others emphasised the strategic intentions of an individual in their use of violence. This constituted a shift in emphasis towards violence as a calculated means of environmental control, even a general way of leading one's life. It might still be impulsive and it still required a consistent response, but the disregard for the consequence of one's actions was a primary consideration:

"…he was assaulting people who weren't letting him have his own way…this chap was dangerous and he was inappropriately placed, he should be placed somewhere in higher security…he would just pick on someone and assault them and they would be moved and then he would pick on another one and they would be moved" (MSN).

Intentionality – 'because then it becomes personal'

The intention constituted a significant dimension of violence and comprised several elements – purposefulness, such as inexorable verbal abuse; the impact of the behaviour on someone, whether they feel threatened or intimidated; the relationship with the individual, such as understanding the impact of background or diagnosis. Some participants utilized such knowledge more, differentiating between verbal and physical violence, but conceptualizing it primarily in terms of intent:

"…the person who doesn't really have the purpose…to hurt you, so there's that kind of aggression…some people who just like to verbally abuse you all the time and swear at you… some members of staff seem to find that really distressing" (C/N3).

"…a verbal component that received in such a manner that somebody might feel physically threatened…there's the abusive component, there's the physical component…I probably find the verbal abusive…easier to tolerate and may not feel threatened because of understanding perhaps the person, the behaviour, the condition, their diagnosis and wrongly or rightly not view it as a violent act even though it might be quite extreme" (F/N2).

The intention behind the violence also related to the extent to which it had been pre-planned, so that the target was conceived well in advance, a factor which influenced the decision to report it. This venture into the personal sphere altered the dynamic, so that the violence became deliberate, calculated, and thereby less an acceptable aspect of the job; the individual

is no longer an invisible victim of a random attack:

"…where I was hurt, I suppose, I felt it was more of a deliberate attack…if there is any element of planning…whereas…in a more random way and it's not very personally motivated then I wouldn't really feel it was worth making much of an issue out of it" (S&LT).

"…calculated, the intent, if there is not an intent it's almost like it is part of your job and, you know, you can manage it, you get to know the warning signs" (A&T nurse).

Participants, once this line had been crossed, and violence could be spoken about in such pre-meditated terms, then described an individual where the intellectual disability loses its modifying effect and the precise damage to be inflicted becomes an issue. The critical question revolves around insight, which facilitates a tougher response, clearly constituting proper violence:

"Physical aggression, where someone absolutely knows what they are doing, they know how to do it, and they know when to do it…the people who perhaps don't do it as often but when they do do it, they know what they are doing, in terms of the intention…they have the means to do the damage if they do" (C/N2)

"...a deliberateness...distinct from (someone being) distressed and challenging, who might lash out...an intent...because then it becomes personal...they had thoughts about hurting you which I don't think a person with challenging behaviour has...there's a motive" (psych3).

Unpredictability – 'I had always had a good relationship with him'

Occasionally, participants would illustrate a point through reference to an experience of quite extreme violence, shocking in any circumstances, but sometimes magnified by significant ambivalence in relation to comprehending the personal dimension of the assault. The violence in this incident is unpredictable in that there appears to be a case of mistaken identity, or, perhaps more accurately, the desired anonymity of the victim has been compromised:

"…he'd attacked me from behind in a corridor, it took 5-6 staff to get him off me…what was difficult to deal with was that I had always had a very good relationship with him…it really did seem to be so out of the blue…and I found that quite difficult for a few days afterwards… it was very apparent that during the incident and directly afterwards I don't think he had actually realised it was me and he was extremely distressed…they had to physically restrain him…when he realised it was me he had been hurting, you can see he got sort of distressed all over again and very hurt about it" (LSN).

An incident could appear unpredictable, however, but, as with the following quote, there may be signs to suggest otherwise, and there does also seem to be additional elements present, such as a degree of planning, calculated intimidation, and exploitation of the nurses' non-anticipation of what was going to happen. The seemingly unpredictable character of the incident, in effect, becomes something else:

"…we went to a new referral and we got locked in…an upstairs flat, and we got trapped…for about three hours and this man was very threatening and aggressive towards us and that was very challenging…social services put in the referral and never said there was any risk

visiting…fortunately his partner was in the flat as well and she was sort of able to talk to him, but he was very angry, very aggressive. All the time you were there you were looking for an escape route basically and we should have known really because he locked the door behind us when we went upstairs, you know, which isn't a good sign is it really" (C/N).

A further illustration of quite extreme violence occurs as the story of another home visit unfolds, and, again what is regarded as a good relationship seems to accommodate the opposite. The violence inflicted on the individual's mother comes to involve the professional, perhaps as an extension or, even more likely, the consequence of being exposed; whichever, the apparently unpredictable ceases to be so:

"(Her) mum went upstairs, Ellie followed her up…they'd locked themselves in the bathroom…she came out completely beyond calming at this point, she flew at me on the landing. She got hold of my hair, she kneed me in the face…I have quite a good rapport with this woman…she was hysterical…I don't feel why she did do that to me" (S/W).

This apparent desire for the violence to be somehow comprehensible, explicable as a sort-of rational response to provocation, reflecting someone being at the end of their tether, or related to mental health, essentially meant that if these elements were missing, then the behaviour was seemingly inexplicable and thereby unpredictable:

"I was a little shocked, a bit taken aback really, and I think that was largely because I didn't see that we had done anything to provoke that, it had just gone from reasonably compliant to being extremely angry…either he had misinterpreted or he had had enough really" (O/T2).

Discussion

Many staff grappled with the notion of personal responsibility and the impact of the intellectual disability on an individual's relationship with violent behaviour, particularly the sometimes complicated distinction between mild intellectual disability and moderate/severe. These two latter categories are clearly not conjoined, but in the minds of many are rather more blurred than the differentiation between mild and moderate. A simple dichotomy was constructed by many professionals between lesser and more able, and a degree of responsibility attached accordingly. However, when probed, additional issues relating to social functioning and dysfunctional family background provided layers of complexity. Contradictory beliefs around attributing culpability and explaining through reference to extrinsic factors could be held simultaneously, especially in relation to those individuals who became aggressive because they were unable to immediately satisfy their demands. There was a desire, for example, to rationalize the violent behaviour as being a consequence of an additional condition, sometimes Autism Spectrum Disorder (ASD), and less often, Borderline Personality Disorder (BPD), Attention Deficit Hyperactive Disorder (ADHD) and Dementia. Difficulties relating to communication, problems understanding social rules, responding to sensory under or over-arousal, in the context of ASD, were described in ways that explained violent behaviour and facilitated professional empathy. This was less so with BPD, a condition where those diagnosed are frequently regarded as difficult, annoying and not ill (Bodner et al., 2015; Woollaston & Hixenbaugh, 2008). Mental health was referred to as potentially contributing to someone's violence, an acknowledgement that someone was unwell, but there was a reduced likelihood to articulate such thoughts in any detail, which

seemed to reflect both an absence of knowledge and, more specifically, a difficulty with perceiving how the symptoms of mental illness might manifest in the context of intellectual disability.

The role of ASD, however, in influencing participant understanding of violent behaviour, particularly the disputed territory of culpability, was not necessarily reflected in relation to other clinical conditions. Impulsivity, for example, discussed at length by many participants, is frequently associated with a number of conditions, including BPD, ADHD, impulse control disorder and substance misuse (Grant & Potenza, 2012). There was an acknowledgement of the multi-faceted character of impulsivity (Gomide Vasconcelos et al., 2014), as participants considered possible links with such conditions, but overall they struggled to give this credence, and issues of self-control and service user difficulties in understanding and abiding by social rules and norms ultimately made more sense to them. An individual's seemingly impulsive behaviour was more resolutely associated with an inability to accept a decision, particularly one involving having been refused something. The tension revolves around acknowledging the relationship between impulsivity and a clinical diagnosis, but according it similar credibility to behaviour associated with ASD. Difficulty in recognizing social cues and reading the motives of others, both associated with autism, were more acceptable to many participants than the seemingly selfish behaviour and problems of controlling one's temper, which are more associated with personality disorder or ADHD. There was a general tendency to accept impulsivity as "the tendency to act with less forethought than do most individuals of equal ability and knowledge" (Dickman, 1993: 151). This located it within a framework that accentuated the intellectual disability and placed less emphasis on the accompanying condition. A fuller, more clinical, definition focuses on a decreased sensitivity to negative consequences, rapid unplanned reactions to stimuli (without adequate processing of information) and lack of regard for long term consequences (Dell'Osso et al., 2006). Staff appeared less comfortable in explaining impulsivity as such a categorical construct, and viewed it more as a facet of personality (Moeller, 2012). The implication is that staff were more at ease with the impulsivity that might be associated with someone's intellectual disability than with the potentially more complicated problems posed by an association with other clinical conditions. They felt less well equipped to respond to violence that was impulsive, but also seemingly calculated, targeted and intentional. Staff, in effect, did consider conceptualizing as impulses that cannot be resisted, but generally preferred to interpret as impulses that are not resisted (Kaliski, 2015).

The question of intentionality pervaded participant responses, with interpretation as personal, specifically directed at them, proving a critical factor in understanding. This was the element that determined whether such violence should be legitimately considered as part of the job. Participants described the intent of the individual as relating to the use of physical violence, verbal aggression and threatening behaviour, with a potentially different intention underlying each one. The severity of the violence, for example, was associated with a capacity to use it in a particular way, perhaps inflicting a more precise amount of damage, and being associated with a particular, more physically able individual with a mild intellectual disability. This was perceived as targeted violence, less associated with the intellectual disability and more difficult to comprehend with any degree of acceptability. The use of verbal aggression, though generally given less emphasis than the physical, was described by some in terms of the impact. This was about the effect on the individual, their feelings with regard to having been threatened and intimidated in such a way. The personal dimension of violence appeared to encompass a number of closely related elements pertaining to the intentions of the perpetrator. Firstly, the level of calculation involved, essentially, the extent to which the

incident was planned and pre-meditated, so that the circumstances were figured out well in advance. Second, the deliberate nature of the violence, which might include the amount of hurt inflicted, the damage to property involved, and the engineering of the circumstances. The third element comprises the degree of insight the individual has at the time of the incident, which again moves beyond the intellectual disability, and revolves, to some extent, around mental health issues. Participants were able to consider the possibility of lack of insight, but were unable to elaborate and articulate the way in which this might interact with the intellectual disability or underpin violence. Intentionality, in sum, comprised these three core elements, calculation, deliberation, and insight, so that planning in advance conspired with the degree of precision in the implementation of violence, together with an understanding of the consequences of one's actions.

The final theme related to unpredictability, with many participants struggling to comprehend when there was no clear indication that a situation was going to escalate into violence. They sought to interpret violence in a straightforward manner involving a clearly defined motive, a recipient of the violence who was somehow comprehensible in terms of being a target. They desired to understand why people became violent, and they frequently had considerable experience of working with such individuals, but they struggled to understand in relation to theoretical knowledge or even utilizing their practice effectively. The notion of unpredictability illustrates this issue of the difficulties involved in the conceptualization of violence. There was a clear problem in being able to understand violence outside this limited frame of reference, as though the reason had to be either self-evident or connected to a seemingly inexplicable, yet paradoxically comprehensible, clinical condition. There is no consensus about the causes of violence, and seemingly different interpretations on the likely reasons (Duxbury & Whittington, 2005); yet staff seemed reliant on the need to explain in terms of a clearly identifiable reason, as being related to mental health, or categorize as no known cause. It was the personal character of violence that professionals struggled to comprehend, and sought to avoid, since it was this that made it somehow inexplicable, the knowledge that they had been somehow targeted.

Limitations

The participants worked within one UK NHS Trust so findings are difficult to generalise to other settings, and it is acknowledged that there are significant differences in the composition of intellectual disability services in different geographical areas. The sample was also quite small, particularly for the non-nursing professions, though the interviews were detailed and exhaustive and accurately represented the composition of the participating organisation. There has also been an attempt to enhance our understanding of different components of violence in the context of intellectual disability, such as predictability, so it must be acknowledged that this is quite ambitious given the limited sample.

Conclusion

The research undertaken suggests that it is imperative for services and educators to re-think the way in which violence is defined, perhaps scrutinizing it more closely to determine the various components. The role of the intellectual disability is critical in influencing the manifestation of violence, the central point that underpins the work of the professionals interviewed, and around which, issues of additional clinical conditions, impulsivity, intentionality and unpredictability revolved. There is a real need, though, for work to be undertaken exploring why staff might be reluctant to use the evidence to inform their work with potentially violent individuals and rely instead on a combination of basic knowledge, experience and, sometimes erroneous, but deeply held, beliefs. Evidence based practice is not

a new phenomenon, yet could, perhaps, be much more influential with regard to the ways in which the relationship between intellectual disability and violence is discussed.

Implications for Research and Practice

1. There is a need to re-think the definition of violence informing practice in relation to intellectual disability, particularly clearly differentiating from challenging behaviour.
2. The key components of a new definition of violence should consider the relationship between the elements of unpredictability, impulsivity and intentionality, and future research might focus on the ways in which these elements inform each other in helping to explain incidents.
3. Assumptions are sometimes made about the extent to which violent acts are unpredictable, impulsive and/or intentional, and there needs to be better understanding of the links with extraneous factors, such as additional clinical diagnoses.

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