more adequate system of support, could reduce these feelings of uncertainty.

I am keen to hear of other psychiatrists' experiences and comments.

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Violence and junior doctors working in psychiatry

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Aggression directed towards health care workers has been widely discussed (Health Services Advisory Committee, 1987), but information relating to British psychiatry has been anecdotal. The Collegiate Trainees' Committee (CTC) has recently expressed concern about the apparent dearth of training opportunities in the recognition and management of aggression, and the difficulty in obtaining post-incident counselling (1991).

There is evidence that verbal aggression forms part of a continuum with physical assault (McNiel & Binder, 1989), yet studies in this area often give little attention to the monitoring and management of such incidents. We have attempted to quantify the frequency of both verbal and physical aggression encountered by junior doctors working in psychiatry, focusing on the issues of education, reporting of incidents and post-incident counselling.

The study

Lists of junior psychiatric staff were obtained for 13 hospitals in six Health Board areas in West and Central Scotland. Questionnaires were sent to all those working as senior house officers and registrars in January 1991. Those who did not reply were sent a reminder three weeks later. Two other hospitals with junior psychiatrists were excluded from the study because we were unable to obtain staffing lists.

Findings

Of 83 questionnaires distributed, 61 were returned (73.5% response rate). The differential response rate was 92% for psychiatric trainees, and 40% for general practice trainees. Of respondents, 64% were female and 36% male; this reflected the sex distribution in the sample as a whole. Respondents had spent a median of 30 months in psychiatry, with a range of 4–79 months.

The doctors were asked from what sources they had obtained advice on the recognition and management of aggressive behaviour. Some respondents had received advice from more than one source. Of doctors, 32.8% had received advice from consultants; 60.7% from peers; 50.8% from nursing staff and 6.6% from formal postgraduate training; 3.3% had received advice from other sources. No doctor recalled any undergraduate training. Thirteen (21.3%) indicated that they had never received advice from any source.

Doctors were asked whether they had been physically assaulted while working in psychiatry. Thirty-nine respondents (65%) had never been assaulted; 15 (25%) had been assaulted once; 5 (8.3%) had been assaulted twice and one doctor (1.7%) had been assaulted three times. Five assaults (17.8%) were reported, while 23 (82.2%) were not. (Completion of an accident form or the reporting of an incident to a consultant were classified as a reported incident, while mentioning the incident to peers or nursing staff was not.) Doctors were asked to indicate whether support or counselling had been offered after each incident. In six incidents (22.2%) it was said to be unnecessary. Support had been offered after one incident (3.7%) and following 20 incidents (74.1%), no support was offered. No details were given for one incident.

Doctors were asked if, while working in psychiatry, they had felt in imminent danger without

the episode progressing to assault. Sixty (98.4%) responded, but two replies were excluded as they reported the number of episodes to be "too many to count". Of the remainder, 6 (10.3%) had not felt in danger of assault. Fifty-two (89.7%) reported a median of three episodes (range 0–10), with a total of 184 episodes.

Respondents were again asked how many episodes had been reported, and whether they had received post-incident support. Thirty episodes (16.3%) had been reported; 154 (83.7%) had not been reported. Six episodes (3.8%) did not require any post-incident support. In ten cases (5.4%) support was offered, and in 168 (91.3%) no support was offered.

Doctors were asked if they were aware of written hospital guidelines for the management of violent incidents. Six (9.8%) did not reply. Of the remainder, 15 (27.3%) were aware of such guidelines, while 40 (72.7%) were not.

Comment

This is the first British study to examine the frequency of aggression directed against junior doctors working in psychiatry. Our overall response rate was high. The lower response rate from general practice trainees may reflect the timing of the questionnaire, which coincided with the end of their psychiatric placement, making follow-up difficult.

None of our respondents recalled any undergraduate training in aggression management. Our findings support the impression of the CTC Working Party that there is little formal postgraduate training in aggression management. Only four doctors had undergone formal teaching – one in New Zealand. Such training may reduce both the frequency of assaults, and the likelihood of injuries resulting from them (Infantino & Musingo, 1985). In our study, much of the advice obtained had come from nursing staff and other junior medical staff. Such informal learning may be valuable, but is liable to be disorganised and inconsistent. Only one third of junior doctors recalled advice from consultant psychiatrists.

Infantino & Musingo (1985) found that, of those staff not trained in aggression management techniques, 37% had been assaulted in the course of their work: our findings are in line with these results. Of our assaults, 17.8% had been reported, similar to previous estimates (Lyon *et al*, 1981). Post-incident counselling had been offered in only one of our cases. It is interesting that one-fifth felt no support had been required, making comments such as "(it) was no more than a punch on each occasion".

A total of 184 episodes of imminent violence were recorded. Only 16.3% were formally reported despite the acknowledged continuum between verbal and physical aggression. These episodes seemed to be grossly under-reported and seldom discussed.

Lyon *et al* (1981) suggest that acceptance of violence as "part of the job" may contribute to under-reporting, and also propose that staff may be afraid that they will be blamed for the incident. Comments returned with our questionnaires suggested another reason, with some juniors feeling that their reports of aggressive incidents were not taken seriously. In addition, only 27.3% of respondents knew of hospital guidelines for reporting incidents, despite the Health Services Advisory Committee (1987) having stressed the importance of adequate reporting systems for all violent incidents, whether or not they result in injury.

Our results indicate a need for formal teaching in aggression management, preferably early in a doctor's career. In psychiatry, this could be part of the induction course for new doctors. Alternatively, it could be included in a day release course, but additional arrangements would be required to accommodate general practice trainees. The provision of written guidelines on the management and reporting of aggression should be a routine procedure. The Health Services Advisory Committee commented on the need for post-incident support and counselling but our results suggest that this is rarely offered in psychiatry.

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