Marnie E. Rice
Grant T. Harris
George W. Varney
Vernon L. Quinsey

Violence in Institutions

Understanding, Prevention and Control

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Violence in Institutions:

Understanding, Prevention, and Control

About the Authors

Marnie E. Rice, B.A. (McMaster University), M.A. (University of Toronto), Ph.D. (York University) is the Director of Research, Mental Health Centre, Penetanguishene. She is a psychologist with extensive experience in applications of social learning theory to forensic populations. She has published in the areas of aggression and criminal behavior, social competence, institutional violence, sexual offenders, and arsonists.

Grant T. Harris, B.Sc. (University of Toronto), Ph.D. (McMaster University) is a Research Psychologist at the Mental Health Centre, Penetanguishene. Formerly he was responsible for the development of behavioral programs on a maximum security unit for dangerous and assaultive patients. His clinical and research interests also include criminal behavior, sexual preference, psychopharmacology, and cognitive processes.

George W. Varney, B.A. (University of Guelph) is a staff instructor in the Educational Services Department of the Mental Health Centre, Penetanguishene. He has clinical experience in behavior modification and social skills training. He also has considerable experience in the development and evaluation of a wide variety of staff training programs.

Vernon L. Quinsey, B.Sc. (University of North Dakota), M.Sc., Ph.D. (University of Massachusetts at Amherst) is a Professor of Psychology at Queen's University, Kingston, Ontario, and a consultant to the Kingston Psychiatric Hospital. The former Director of Research at the Mental Health Centre, Penetanguishene, he has published extensively in the areas of sex offenders, criminal behavior, and the prediction of violence.

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Mental Health Centre
Penetanguishene, Ontario, Canada

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This book is dedicated to Andrea, Anne, Austin, Eamon, Heidi, Ira, Sarah, and Thomas, for whom we would make the world a safer place.

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Introduction

This book is the culmination of over 15 years of effort on the part of the authors to understand the problem of violence in psychiatric institutions, and to develop a staff training course designed to control it.

The effort began while the fourth author was the clinical psychologist at the Oak Ridge Division of the Mental Health Centre at Penetanguishene, Ontario, Canada. Oak Ridge is a maximum security psychiatric hospital for males, the only one of its kind in the province. It was opened in 1933 as the "Criminal Insane Building," with its first 100 patients coming from a provincial reformatory. With the exception of a doubling in size in 1957 the building has undergone little change in physical structure in its 56-year history, physically resembling a prison much more than a modern psychiatric hospital. From the outset, it was intended to provide maximum security in that patients were to be prevented from escaping. Some of the precautions that were part of "maximum security" in the early days were learned from other institutions, and were incorporated into the architecture and the hospital routine from the beginning. In the early years there were some escapes and some suicides, which led to such increases in security as safety screens for windows, posting staff around the yard, guardhouses, tear gas guns, and reduction of the size of the outside work gang.

As in most maximum security psychiatric facilities, the patients in Oak Ridge today are a diverse group. Some of them have only been sent on a warrant of remand for 30 or 60 days for an assessment prior to returning to court. However, it is difficult to separate assessment from treatment, and these patients have traditionally shared wards with those undergoing treatment. Furthermore, some of these "remands" are ulti-

mately found unfit for trial and are certified so they can be treated until they are fit. Other patients have been sent from court after having been found unfit to stand trial or "not guilty by reason of insanity," usually for a serious crime of violence. Yet others come on involuntary certificates from other psychiatric hospitals or occasionally prisons because they have been found to be unmanageable in these institutions. Overall, patients span a wide age range, typically about 18 to 65, and all levels of mental ability from mildly retarded to above average. About 10% are illiterate and a further 10% are not fluent in English. To illustrate, in 1986 the average age on admission of the 187 patients admitted was 32 years, and the patients present on January 1, 1987 had been there for an average of 38 months. About a third had committed a homicide, and another quarter had committed some other violent criminal offense. The majority (61%) were diagnosed as psychotic, a sizeable minority (27%) were diagnosed as having a personality disorder, and a few carried a primary diagnosis of mental retardation.

The idea for the training program described in this book was born when the first author worked on the "token economy" unit that had appeared to be successful in its early years in modifying patient behavior (Quinsey & Sarbit, 1975). In the beginning of her tenure, much of her time was spent running workshops for staff in behavior modification techniques, identifying behavioral targets for patients' individual problems, and checking the reliabilities of staff ratings. However, it seemed that over time the token economy had come to serve more as a convenient way for staff simply to maintain order rather than as a way to actually change the "dangerous" behaviors that had brought the patients into Oak Ridge in the first place. For example, because of the bureaucratic way in which the institution was run, the staff were concerned with such things as keeping the wards neat and tidy, and thus the program included token reinforcement for room and self-care. Although these were not unreasonable targets, they were certainly not centrally related to the reasons for which patients were admitted to a maximum security hospital. The program also, of course, included points for other things such as mood, cooperation, work habits and social contact, as well as fines for various misbehaviors. However, while these behaviors should in theory have been rated somewhat independently by staff, they were all very highly intercorrelated (Rice, Quinsey, & Houghton, in press). In effect, it was as though there was a pervasive "halo effect", whereby staff rated patients according to whether they were "good" or "bad." "Good" ones were those who were clean, neat and caused no trouble for staff, and they were assigned high points in all categories. "Bad" ones were those who were dirty, messy, flagrantly psychotic, or argumentative, and they were given

low points in all categories. This phenomenon is a common one and has been noted by others working in institutional settings (Buehler, Patterson, & Furniss, 1966).

In the behavior modification workshops, most staff were enthusiastic and learned how to apply the techniques, but there was a temptation to use the program in a way that seemed to maximize payoff to themselves — that is, to have a ward that was clean, quiet, and easy to manage rather than in a way that would maximize achievement of patient goals. Ullmann (1967) described the objectives of the attendant as including the "safety and protection of his patients. . . and. . . cleanliness, cooperation, quiet and docility" (p. 23). Furthermore, although it was not intended to do so, the behavior modification program had the effect of taking away some of the positive human element of institutions. While it was successful in removing much bickering amongst staff about appropriate sanctions for patient behaviors, it was also used as a justification for the removal of discretion and judgment when they were indicated. Staff frequently quoted rules and gave patients fines "according to the book" without giving explanations or hearing alternate versions of incidents; a failing that many have noted with the use of token economies in institutional settings (Zeldow, 1976). Yet another problem was the continual tendency of attendant staff to lobby for increased fines for misbehaviors and give fewer and fewer points for positive behaviors. This too is a problem that others working within a correctional system have noted (Bassett & Blanchard, 1977). Finally, staff members sometimes assigned points for behaviors without actually having observed the behaviors in question. For example, they would sometimes give points for room care while remaining at the ward front and simply using a patient's "usual behavior" as a guideline. Milan (1976) noted this same phenomenon among correctional staff. Perhaps as a consequence of the way in which the token economy programs operated, many patients continued to exhibit dangerous behaviors, including assaultiveness.

The above remarks attest to the fact that this type of program does not always work in the way that was intended. In addition, data from another study at our institution (Rice et al., in press) showed that there was little or no relationship between a patient's program performance and his outcome upon discharge.*

* The authors initially wrote this book in nonsexist language. However, it sounded very cumbersome, and especially in the description of physical techniques, made the text almost unreadable. We therefore decided to make the word "patient" refer to only the male gender, since males are the aggressors in the very great majority of assaults. In referring to staff members we have used nonsexist language.

In summary, it did not appear to the first author that her efforts to improve the quality of the ward behavior modification programs were effecting meaningful changes in the behaviors that had brought patients into the hospital in the first place. She thus decided that direct patient contact might be more fruitful. However, because there were 144 patients on the unit, her efforts had to be focused on only a few at a time. One group of patients whose problems seemed to be especially ignored in the regular ward programs were those who were shy or unassertive and whose behavior rarely caused any problems for staff. There is some evidence that shy, unassertive behavior may be causally related to certain types of offenses (Harris & Rice, 1984; Quinsey, Maguire, & Varney, 1983).

The author thus designed a ten-week, thirty-hour program to teach such individuals to socialize with other patients and with staff, and to stand up for their rights. While participants demonstrated increased assertion on role-play measures as a result of this training, ratings of their social behaviors on the ward showed no changes as a result, at least not in the direction of improvement (Rice, 1983). In fact, it appeared as though ward staff rewarded quiet, compliant behavior more consistently than such behaviors as questioning one's treatment, making requests, and speaking up for one's rights, all of which might be seen as making the staff members' jobs more difficult. In a sense, then, it appeared as though the social skills training may have actually led to poorer in-hospital adjustment. Further evidence for this came from another study (Rice & Josefowitz, 1983; Rice & Quinsey, 1980) in which it was found that sociometric ratings of patients by other patients and ward staff ratings of social behavior were negatively correlated with some role-play measures of social skill. These results suggested that ward staff and co-patients tended to dislike assertive behavior by patients. Taken together, these studies suggested that teaching responsible, assertive behavior was not worthwhile unless one also changed the ward environment in such a way that this type of behavior would be rewarded.

One problem faced daily by staff who work with psychiatric populations, especially in security hospitals, is the possibility of being assaulted or of having to intervene in an assault between patients. The occurrence of violence within an institution has serious implications for everyone. At the Mental Health Centre in Penetanguishene, with approximately 500 treatment beds, between 1974 and 1979 there was an average of 532 work days lost annually through staff injuries as a result of patient-caused incidents. At least as serious a problem are the injuries incurred by patients during patient-staff altercations. Moreover, occurrences of violence incur fear in both patients and staff who witness an incident happening to one of their peers, and this creates an atmosphere that is

antithetic to that required for treatment. In fact, Paul and Lentz (1977) found that when assaults on treatment wards for chronic psychiatric patients increased due to a rule that restricted the confinement of violent individuals, the ward atmosphere deteriorated so drastically that treatment became virtually impossible.

A previous research study on assaultiveness (Quinsey & Varney, 1977a) led to the belief that violence was a particularly serious problem at Oak Ridge. That study had revealed that staff were the victims of the majority of assaults, and since there were many more patients in contact with other patients than they were with staff, the discrepant proportion of staff victims strongly suggested that their interactions with patients were major determinants of assaultive behavior. Most often staff claimed there was "no reason" for an assault, whereas in over 90% the patients would state that there was a reason, the most often-cited being provocation (teasing or abuse). Other often cited reasons were that they had been ordered to do something or refused a request. It is interesting to note that this is similar to Toch's (1969) finding that while citizens in police-citizen assaults claimed to be reacting to something the police officer had done, the officers most often viewed their actions as harmless and routine and attributed the assault to "irrational" behavior on the part of the attacker. See Box 1 for two examples of staff-patient altercations fairly typical of such incidents.

Our data, together with the results of the work on social skills training described above, suggested that violence was in large part a product of the ways staff customarily dealt with patients. It seemed to the first author that staff members were unwittingly provoking escalation and assaults; thus it also seemed clear that meaningful changes in the behavior of patients might best be accomplished by trying to modify staff behavior. As Moos (1974) noted, the treatment environment can be the most critical factor in determining treatment outcome. Staff training was the obvious intervention.

Despite the serious nature of the problem, little had been attempted in the way of formal training programs to aid staff in dealing with potentially dangerous situations. A limited program had been developed at St. Thomas Psychiatric Hospital (1976), and several courses had been designed for police officers to help them avoid violence in difficult officer-citizen encounters (Goldstein, Monti, Sardino, & Green, 1977; Levens & Dutton, 1980; Mulvey & Reppucci, 1981). We believed that many of the techniques used in the police courses were applicable in our setting. Furthermore, the fact that the courses had been designed for and accepted by police officers gave us confidence that such a course would be welcomed by our staff.

Box 1

Case I

John was a 23-year-old man diagnosed as schizophrenic. He had been admitted to the maximum security institution after having been found not guilty by reason of insanity for murdering his grandmother and aunt in a seemingly pointless attack. On admission he was noted to be depressed and unhappy, and although there were no florid psychotic symptoms he was placed on neuroleptic medication immediately and put in a ward that specialized in the management of psychotic patients. There, he experienced some side effects of the medication and complained he was "too tired" to participate in ward programs. Sometimes he was forced to attend the program and sometimes he was confined to his room for refusing to participate.

John's behavior got steadily worse over a period of several months. He was noted to be "demanding", several times he assaulted a co-patient, and he often refused to do things he once did (get dressed, go to the yard, etc.). He told staff he was tired and wanted to die. Throughout this period of deterioration he received a variety of medications — usually neuroleptics, but antidepressants were tried as well, and finally, six electroconvulsive therapy (ECT) treatments. Coincident with the ending of the ECT series he was noted to be more relaxed and cooperative, and after two more weeks was transferred to a maximum privilege ward and scheduled to begin work in the industrial therapy shop. After only four days, however, he lost that job and was sent back to his old ward where he was again reported to be hostile and uncooperative. Again he began attending off-ward recreation programs, did well, and was transferred to the maximum privilege ward, but again, four days later, was returned to his old ward because he had not "fit in."

Two days after the last ward transfer, while participating in the regular recreation program, John picked up a hammer from the tool cabinet, approached a male staff member from behind, raised the hammer and declared, "Okay Art, take me to the Front Office. I want out." The staff turned and slowly attempted to retreat out of range, while trying to talk John into putting down the hammer. He also made two unsuccessful attempts to grab John's arm or the weapon, yet despite this John did not attempt to strike him. Meanwhile, another patient slipped behind John and grabbed his arm. Other staff nearby immediately moved in, restrained and disarmed John, and returned him to his ward. There were no injuries to anyone but it was noted that (apparently unbeknownst to anyone in the recreation program) the murders that constituted John's offense had both been committed with a hammer.

After the incident, John was noted once again to be "hostile and uncooperative." Interviewed about two weeks later, he said he did it because he was just "too tired" to function in the program and wanted out.

Case 2

Ron was admitted to the maximum security division when only 14 years old after having attacked three patients in another psychiatric institution. He was diagnosed as having mild mental retardation, epilepsy, and a behavior disorder. Since the age of 7 he had been almost continuously institutionalized. He exhibited "intense hostility" and aggression from an early age, particularly towards his mother, who seldom visited him.

Ron often acted in a silly manner, and was most concerned about keeping his stuffed animals in his room at night. He was extraordinarily quick and coordinated; he would, for example, walk the length of the corridor on his hands. Although he often appeared friendly, he was frequently heard to be muttering threats and curses under his breath.

While walking the corridor one day, Ron struck another patient in the face for no apparent reason and the two squared off. The attendant in charge at the front of the ward unlocked the grill gate and came down to intervene. As he approached the pair Ron whirled around and punched him in the nose, causing a deep cut and temporarily blinding him with tears. Ron then ran down the corridor to the sunroom where he was overpowered by other attendants. Had he run up towards the grill gate, he would have been able to leave the ward entirely. Ron was later very boastful about this incident.

Some months later Ron was with a group of others near the ward front, waiting to be called downstairs for lunch. Patients were supposed to remain further down the corridor beyond a sign that instructed them to wait until called to the ward front by staff; this rule, however, was inconsistently enforced. On this occasion, an attendant ordered them away from the ward front and shooed them down the corridor. Ron was unhappy about this and muttered threats in a continuous whisper. In the dining room he was accidentally touched on the leg by another patient, whereupon he threw his tray, grabbed a fork, and struck at patients and staff. A wild melee ensued and Ron was restrained and brought back to the ward with great difficulty. After being placed in his room, he informed the staff that the next time he would stab somebody in the eye with a knife.

In the two years following his admission, Ron was physically assaultive on 25 occasions, many of them very serious. Eventually, he was confined to his room most of the time. It was many years before he stopped hitting people and became trusted by staff.

We therefore decided to design, implement and evaluate the course that forms the main topic of this book. The Controlling Assaultive Behavior Course was based on the view that, in large part, assaults are the product of staff-patient interactions, rather than of patient pathology per se.

We knew that if the project was to be successful and to actually change the system, attendant staff would have to be involved in all aspects of it. We therefore met with members of the union to discuss the project with them. They were very keen and readily agreed to such a plan, as did local management personnel.

Our next task was to select ward attendants to act as course trainers. On the one hand we wanted to choose individuals who were well respected by their peers, something that comes in large measure from being effective in physical encounters with patients. On the other hand, we wanted staff whom we perceived as being skilled in the other methods we were interested in teaching as well, namely how to *avoid* confrontation: how to talk patients down, how to interview them and mediate in their disputes, and how to prevent physical encounters. We also worried about finding sufficient staff who would be willing to stick their necks out and agree to cooperate with "professional" staff at a time when it happened to be particularly unpopular to do so. However, this turned out to be much easier than we expected.

A workshop on teaching crisis intervention was held, for which we invited a consultant who had taught a crisis intervention course to police officers. He demonstrated material from that course (Levens & Dutton, 1980) and helped us to think about what we might include in ours. Because he had obviously had a lot of experience working with police, Dutton was able to relate his work in a meaningful way to our course.

Following this workshop, our course videotapes, class handouts, and evaluative measures were prepared. After approximately four months we had a course prepared in a pilot form which we tried out on eight staff members. The pilot course proved highly valuable in testing our evaluation measures, giving the trainers experience in teaching, and obtaining feedback about revisions that had to be made to our teaching materials.

In the years since the idea for this book was born there has been an increased acknowledgement of the need for training staff in methods of interacting with disturbed and potentially aggressive patients. Lion and Reid (1983) published an edited book entitled "Assaults within Psychiatric Facilities," in which several of the contributors pointed to the need for staff training in methods designed to prevent or minimize injuries. Several similar courses have been developed (Gertz, 1980;

Ramirez, Bruce, & Whaley, 1981; Romoff, 1985; Thackrey, 1987); however, as discussed in Chapter 1, none has been thoroughly evaluated, although there has been some evidence presented indicating that staff trained in aggression control techniques suffer fewer injuries than untrained staff (Infantino & Musingo, 1985). Lion (1987) has advocated mandatory training in aggression management techniques for psychiatrists and physicians who work with assaultive individuals, as well as for direct care staff.

This book consists of three parts. Part I represents a concerted effort aimed at understanding the etiology of institutional violence. Chapter 1 summarizes the empirical literature on violence and assaultiveness in several different settings, including psychiatric facilities and correctional institutions. Data on the characteristics of assaultive individuals, victims of assaults, and assault-prone environments are presented, followed by a review of the literature on a variety of classes of interventions (drugs, seclusion, mechanical restraint, behavioral treatment, staff training, etc.). Chapter 2 describes some long-term studies carried out at Oak Ridge on the characteristics of assaults and assaulters, and on the prevalence of and reasons behind patient-caused staff injuries. The findings from these studies provided valuable information for the design of our staff training course. In Chapter 3, we describe several specific examples of assaultive incidents, selected to illustrate some of the things that can go wrong in the management of violent individuals. Many of these incidents were ones that stood out in the minds of the authors and had led us to believe that a course such as the one described in this book was necessary.

Part II describes the content of the Controlling Assaultive Behavior Course that is offered at our institution: both the material that is presented to students, and additional information that provides empirical support for the techniques advocated. Chapter 4 deals with preventive measures, Chapter 5 with how to handle situations that have already reached the explosive point, and Chapter 6 with recommended follow-up action to violent incidents. Chapter 7 discusses some additional topics and strategies that are part of the course.

Part III is aimed at those readers who are considering or already involved in setting up similar courses. In Chapter 8 we provide teaching suggestions, ideas for class exercises, and summaries of relevant research for use in the presentation of the course, while Chapter 9 describes the measures we have used to evaluate our course, as a model for those considering evaluations of their own.

Part I

Understanding Institutional Violence:

Literature Review and Background Research

Chapter 1

Violence in Institutions: A Review

This chapter consists of two major sections. First, we will examine the literature on the characteristics of individuals who commit assaults within institutions, the characteristics of the victims of such assaults, and the characteristics of assault-prone environments. Next, we will review the literature on attempts to reduce this type of violence. This question is addressed under several subheadings: the use of drugs, seclusion and mechanical restraint, behavioral treatment, and staff training. Intervention strategies can be directed at different levels: they can be systemic (changing seclusion policy or implementing staff training, for example), or they can be directed at changing the assaultive individual himself (drugs, behavioral treatment, etc).

As an initial comment, it is clear that the scientific quality of the research varies systematically with the level of the intervention. Although there is a large body of literature on institutional policy changes and staff training, there are very few empirical studies of their efficacy; almost all papers offer advice unsubstantiated by any empirical evdence of their effects on the frequency or severity of assaultive behavior. There are very few data on the efficacy of seclusion and restraint, and only a small number of studies report adequate methodology (e.g., double-blind trials) for the evaluation of the effectiveness of drugs. The scientific quality of studies reporting the efficacy of behavioral treatments is the best, but these studies are fewest in number. As a consequence, the following review will reflect the *quality* of the data in each subarea rather than merely the volume of publications. While it is intended to be comprehensive, we will not include work that presents no empirical data on the characteristics of institutional assaultiveness or on the effects of organized attempts at its reduction.

CHARACTERISTICS OF ASSAULTS

Violence within institutions has become a major cause for concern among both administrators (e.g., Lion & Reid, 1983) and staff (Marshall, 1982). This concern has resulted in a considerable body of research on the phenomenon. Most studies have focused on psychiatric facilities, where assaults appear to be the most common and most serious (Melbin, 1969; Tardiff, 1982a; Tardiff & Sweilham, 1982; Yesavage, Werner, Becker, Holman & Mills, 1981), but there are also some data from correctional facilities, general hospitals, and institutions for the mentally retarded.

Before reviewing this work, an important initial consideration must be addressed: the *definition* of assault. Just as its meaning as a legal term varies across jurisdictions, investigators employ different criteria. Some require that physical contact be made (e.g., Tardiff, 1983) or that it be an attack causing injury (e.g., Depp, 1983; Ekblom, 1970; Jaywardene & Doherty, 1985); others include credible threats and unsuccessful attempts, which is a definition closer to the legal (e.g., Dietz & Rada, 1983). Yet others include self-injurious acts, property destruction and even "disruption" (Betancourt & Abbott, 1979; Damijonaitis, 1978; Haffke & Reid, 1983; Porporino, 1986; Rogers, Ciula, & Cavanaugh, 1980). Unfortunately, many researchers fail to make explicit the definition of violence employed (e.g., Adler, Kreeger, & Ziegler, 1983; Armstrong, 1983; Ionno, 1983; Myers & Levy, 1978). There is in fact some evidence that substantially the same conclusions can be drawn for a wide range of definitions (Dietz, 1981; Werner, Yesavage, Becker, Brunsting, & Isaacs, 1983). However, the most obvious difficulty in the scientific literature is a *lack of comparability across studies*. Because our primary interest lies in physically dangerous violence, this review will be limited to consideration of interpersonal assault (both completed and attempted), and only occasional mention will be made of less serious violent behavior.

Although not all assaults are reported (Lion, Snyder & Merrill, 1981), they appear to be on the rise. Almost every study that has collected data over any appreciable length of time (usually several years) has found an increase, both in psychiatric (Bidna, 1975) and correctional facilities (Jaywardene & Doherty, 1985; Solicitor General, 1984). Whether this increase is a reflection of a general societal increase in violence, is directly caused by the study of violence, is the result of an improvement in reporting or noting assaultiveness, or is the result of deinstitutionalization and a filtering process in which the most dangerous individuals tend to accumulate in institutions (e.g., Quinsey, 1981) cannot be determined from the literature.

Characteristics of Violent Individuals

By far the most research interest has focused on characteristics of the assaulter. In part this may be a result of the fact that many studies are retrospective in nature and rely upon information that can be obtained from institutional files rather than directly from participants or observation. Undoubtedly another reason comes from a psychological-medical-philosophical orientation, which assumes that pathological behavior is due to pathological conditions within the individual.

Virtually all investigators report that the vast majority of institutional assaults are committed by a small minority of individuals, whether psychiatric patients (Cooper, Brown, McClean, & King, 1983; Fottrell, 1978; Fottrell, Bewley & Squizzioni, 1980; Ionno, 1983; Jones, 1985; Kalogerikas, 1971; Lawson, Yesavage & Werner, 1984; Lion, Snyder & Merrill, 1981; Tardiff, 1981a; 1984a; Tardiff, 1982a; Tardiff & Sweillam, 1982), correctional inmates (Bennett, 1976; Flanagan, 1983; Henderson, 1986; Jaywardene & Doherty, 1985; Porporino, 1986; Sylvester, Reed & Nelson, 1977) or youths in detention homes (Millham, Bullock, & Hosie 1976). By far the best predictor of institutional aggression in a wide variety of settings is a previous history of institutional aggression (Bennett, 1976; Bernstein, 1981; Depp, 1976; Dietz, 1981; Edwards & Reid, 1983; Henderson, 1986; Jaywardene & Doherty, 1985; Millham et al., 1976; Myers, & Levy, 1978; Porporino, 1986).

There is some general agreement on the clinical characteristics of this assaultive minority. In psychiatric facilities, many investigators report that such patients are likely to be diagnosed as being nonparanoid schizophrenic (Cooper et al., 1983; Craig, 1982; Dietz, 1981; Ekblom, 1970; Evenson, Altman, Sletten, & Brown, 1974; Fottrell, 1980; Haffke & Reid, 1983; Jones, 1985; Lion et al., 1981; Madden, Lion & Penna, 1976; Pearson, Wilmot, & Padi, 1986; Reid, Bollinger, & Edwards, 1985; Rofman, Askinazi, & Fant, 1980; Tardiff, 1981a, 1982a, 1984a, b). While some authors fail to report enough details to ensure that their data are not subject to a bias caused by the fact that most mental patients are diagnosed as schizophrenic, the evidence that schizophrenia is associated with assaultiveness is nearly overwhelming. Of course, as noted above, only a small minority of schizophrenic patients actually commit assaults. Furthermore, there is evidence that assaults are not more common during antipsychotic drug "holidays" (Cooper et al., 1983). There is also evidence that other diagnoses are also associated with assaultiveness, including organic brain syndrome (Bennett, 1976; Craig, 1982; Depp, 1976; Ochitill & Krieger, 1982; Tardiff, 1981a; 1982a) and mental retardation (Depp, 1976; Tardiff & Sweillam, 1982; Tardiff, 1981c). Interestingly, there is

some evidence that psychotic symptoms associated with non-schizophrenic diagnoses are not associated with assaultiveness (Werner, Rose, Yesavage, & Seeman, 1984; Yesavage, 1983).

Violent individuals in other settings also appear to be those in the most acute distress, with the lowest level of functioning and/or the highest degree of disturbance. In general hospitals, assaults are associated with high degrees of pain (Lion, 1983; Reid et al., 1985; Ochitill, 1982), intensive care units (Reid et al., 1985), and emergency rooms (Wood, 1984). In prisons, some investigators have identified low coping skills as a factor (Bennett, 1976; Porporino, 1986; Toch, 1978, 1982). Investigators in a variety of settings also report that attempted suicide, self-injurious behavior, and withdrawal and depression are associated with assaultiveness (Bennett, 1976; Betancourt & Albott, 1979; Myers & Levy, 1978; Porporino, 1986; Tardiff, 1981c; Tardiff & Sweillam, 1982; 1980; Yesavage, 1983; Yesavage et al., 1981).

The finding that in the general population assaultive behavior is more likely shown by young individuals is also true within institutions (Bennett, 1976; Ekblom, 1970; Ellis, 1984; Evenson, Sletten, Altman & Brown, 1974; Flanagan, 1983; Haffke & Reid, 1983; Jaywardene & Doherty, 1985; Jones, 1985; Millham et al., 1976; Ochitill & Krieger, 1982; Pearson et al., 1986; Porporino, 1986; Quinsey & Varney, 1977; Tardiff, 1981a; 1984a; 1982a; 1981c; Tardiff & Sweillam, 1982). However, another general finding, that it is primarily a *male* behavior, is *not* necessarily true in institutions — particularly hospitals. Some studies do report that males are overrepresented (Armstrong, 1983; Craig, 1982; Depp, 1983; Evenson et al., 1974; Pearson et al., 1986), but others report no difference between the sexes (Tardiff, 1982a; Tardiff & Sweillam, 1982), and a few report a preponderance of assaults by females (Fottrell et al., 1980; Ochitill, 1983).

Some investigators report that assaultive individuals give cues to impending violence in the form of demonstrating negativity and noncompliance (Tardiff, 1983), making unreasonable demands (Ochitill & Krieger, 1982), demonstrating hostility (Werner et al., 1983), and making threats (Yesavage, 1983). Others, however, report that such behaviors do not reliably predict assaults (Cooper et al., 1983; Tanke & Yesavage, 1985; Werner et. al., 1984; Yesavage et al., 1981). In psychiatric settings, there is evidence that civilly committed patients are more assaultive than either forensic patients (Beran & Holtz, 1984; Deitz, 1981) or self-referrals (Rofman et al., 1980). Assaultive patients are typically not in their first few weeks of psychiatric hospitalization (Reid et al., 1985; Rofman et al., 1980; Yesavage et al., 1981). Finally, in correctional institutions, assaulters appear to be those who receive short prison sentences, independent of age (Flanagan, 1983; Porporino, 1986; Sylvester et al., 1977).

Characteristics of Assault Victims

Victims of assaults tend to be older and smaller than their assailants (Depp, 1976). Some studies report that institutional staff are less often victimized than are the assaulters' peers (Evenson et al., 1974; Jaywardene & Doherty, 1985; Kalogerikas, 1971; Millham et al., 1976; Porporino, 1986; Sylvester et al., 1977); however, others find that staff are overrepresented among victims (Jones, 1985; Quinsey & Varney, 1977). Interestingly, there is some suggestion that female staff are less likely to be victimized than males (Levy & Hartocollis, 1976).

Several investigators have reported characteristics of staff behavior that appear to be associated with being a victim. These include demanding activity from patients (Depp, 1976), refusing requests or imposing limits (Madden et al., 1976; Quinsey & Varney, 1977), imposing sanctions such as seclusion (Henderson, 1986; Lion et al., 1981; 1983; Ochitill & Krieger, 1982), and being perceived as weak (Millham et al., 1976). Inexperience is also associated with victimization (Bernstein, 1981; Sylvester, Reed & Nelson, 1977). In a related area, it has been reported that some police officers have a significantly higher than average likelihood of being assaulted in the line of duty (Renner & Geirach, 1975). This proclivity for victimization has been related to a discrepancy between the officers' perceptions of their own actions and the perceptions by the citizens (Renner, Groves, & Moore, 1976). Additional support for this view comes from the observation that staff who approach patients in an "authoritarian" manner are more likely to be attacked (Edwards & Reid, 1983; Henderson, 1986; Lion et al., 1981; Toch, 1982); from differences in reasons given for assault by assaulters and by victims (Cooper et al., 1983; Dietz, 1981; Quinsey & Varney, 1977); and from the fact that staff wearing uniforms are more likely to be assaulted than those in ordinary dress (Rinn, 1976).

Peer victims are also perceived by the assaulter as provocative because of teasing (Bennett, 1976; Henderson, 1986; Kalogerikas, 1971; Ruben, Wolkon, & Yamamoto, 1980) or crowding (Depp, 1976; see also Sylvester et al., 1977). Bizarre or symptomatic behaviors are associated with victimization as well (Dietz, 1981; Toch, 1982).

Characteristics of Assaultive Environments

As mentioned above, most research on institutional assaults has concentrated on the personal characteristics of the individuals involved. However, characteristics of the environment itself have also been associated with

violence. Crowding has been identified as a factor in prisons (Ellis, Grasmick, & Gilman, 1974; 1984; Porporino & Dudley, 1984) and psychiatric institutions (Kalogerikas, 1971), and there is some evidence that assaults are related not to crowding per se, but to the instability in the social environment caused by high turnover (Ellis, 1984; Porporino, 1986; see also Sylvester et al., 1977). Other characteristics of violence-prone environments appear to be gender-mixed wards and where patients are out of sight of staff; assaults are, however, not reduced by increases in staffing levels (Depp, 1983). They tend to occur when patients have relatively unrestricted access to each other and to staff, and at times when there is little structured activity (Damijonaitis, 1978; Dietz, 1981; Haffke & Reid, 1983; Kalogerikas, 1971; Quinsey & Varney, 1977; Rogers, Crola & Cavanaugh, 1980). They also tend to occur when there is a clear payoff for violence, or when it is excused (Paul & Lentz, 1977) and justified (Toch, 1982). Finally, there are self-fulfilling prophecy effects in that assaults tend to occur when institutional staff expect them to (Melbin, 1969).

Summary: Description of Assault-prone Institutions

Based upon the research reviewed above, institutions with a high level of violence have the following characteristics:

1) Rapid turnover of large numbers of young individuals with histories of institutional aggression, who have a diagnosis of schizophrenia, or organic disorders, or mental retardation, and histories of depression, suicide attempts, and/or self-injurious behavior.

2) Many individuals with backgrounds of poor community adjustment, particularly those with extensive histories of minor criminal behavior as opposed to single or a few major offenses.

3) Staff who are generally inexperienced and approach residents in an authoritarian manner while attempting to maintain control through the exclusive use of aversive or punitive consequences.

4) An environment in which residents have fairly unrestricted and unsupervised access to each other in a crowded area with little structured activity, and in which assaultive behavior is excused and staff impose no cost for its occurrence.

Unfortunately, many large correctional and psychiatric facilities or institutions for the mentally retarded have many or all of these characteristics.

ATTEMPTS TO REDUCE INSTITUTIONAL AGGRESSION

When individuals in institutions act violently, or when violence appears imminent, there are several response strategies that staff characteristically consider: seclusion, mechanical restraint, and the use of sedating drugs. While it may appear that these strategies are sometimes employed to punish or deter further misconduct, their best and primary goal is the immediate and full control of the aggressor's behavior to prevent or stop injury, destruction and/or disruption. In this section, the effectiveness of these methods is discussed, along with that of behavioral interventions and the setting up of programs to train staff members to deal with violence.

Drug Treatment

Drugs for Immediate Behavioral Control

Many writers argue that the use of sedating drugs is currently the most effective and humane way to achieve control over violent behavior. A wide variety of medications has been used, but there seems to be considerable agreement about which ones are preferable (Tupin, 1985). Because the goal of such drugs usually is to produce rapid calming and even sleepiness (Applebaum, Jackson, & Shader, 1983), many can be rejected immediately. Amphetamines, alcohol, benzodiazepines, barbiturates, and opiates are all unlikely to be useful, either because they rarely produce sedation or produce it too slowly, because they produce disinhibition at dose levels close to those just short of sedation, because sedative effects occur close to doses that produce serious side effects or coma (Tupin, 1985), because they are addictive, or because they cannot be administered intramuscularly.

Among the few drugs that can be seriously considered for use in "snowing" seriously violent patient are neuroleptics (Appleton, 1965). Of these, the best candidates are fairly high potency, fast-acting drugs such as haloperidol (Conn & Lion, 1984). Indeed, rapid "neuroleptilization" or "digitalization" with haloperidol has been recommended as a safe and effective short-term tactic to deal with violent individuals regardless of psychiatric diagnosis, especially those in psychiatric facilities (Donlon, Hopkin, & Tupin, 1979). Sodium amytal, a barbiturate, and diazepam, a benzodiazepine, have been recommended as drugs of second choice,

especially in cases where the patient is subject to or cannot be closely monitored for the depressant effects of neuroleptics (Tupin, 1983). It should be noted that "effective" here merely means that the sedating effects occur safely and reliably. There is no empirical evidence about whether the use of this short-term management strategy reduces the future occurrence of aggression or discourages assaultiveness in general (Tardiff, 1982b; 1983). Means to achieve this longer-term goal are discussed below.

Drugs as Long-term Treatment

Various psychotropic drugs can profoundly improve the acute condition of many psychiatric patients (e.g., Davis, Janicak, Linden, Moloney & Pavkovic, 1983). Neuroleptics, for example, have a calming effect on agitated, excitable and hostile behaviors, as well as relieving other positive symptoms such as hallucinations and delusions (Davis et al., 1983; Stull, Bradham, Roark, Karb, & Seidenschnur, 1984). A person suffering from the manic phase of a manic-depressive psychosis can be given lithium to eliminate delusions that may lead to aggressive behavior (Tosteson, 1978). Severely depressed individuals may behave aggressively towards themselves or others as a result of their feelings of hopelessness, worthlessness, or delusions of being evil, and here antidepressant drugs may be effective in suppressing symptoms and eliminating the secondary aggression. Anticonvulsants may prevent the episodes of rage and aggression that are theorized to occur as secondary features of psychomotor or temporal lobe epilepsy (Devinsky & Bear, 1984). Thus, to the extent that psychiatric symptoms are associated with dangerous behavior and increased risk of physical aggression, drugs can contribute to increased safety or security (Liberman, Marshall, & Burke, 1981; Lion & Soloff, 1984).

Largely independent of the immediate and short-term sedative properties of some drugs, and indeed of the treatment of psychiatric symptoms in general, many institutionalized individuals who exhibit violent behavior are given regular doses of psychotropic drugs in the hopes that these will reduce the frequency and severity of their aggression in some direct way. Although careful behavioral management may be more effective under these conditions (e.g., Paul & Lentz, 1977, see below), there is suggestive evidence for the effectiveness of several drugs with specific diagnoses. Interestingly, the diagnostic groups for which the drugs appear to be effective in this way are often not the same ones for which they are generally prescribed.

An example is provided by the use of beta-blocking agents such as propranalol and pindol. Although normally prescribed for hypertension, cardiac arrhythmias, and migraine, these drugs appear to reduce the aggression shown by assaultive individuals, especially those with a diagnosis of organic brain syndrome or minimal brain dysfunction (Greendyke & Kanter, 1986; Greendyke, Kanter, Schuster, Verstreate, & Wootton, 1986; Mattes, 1986; Sorgi, Ratey, & Polakoff, 1986). There is no evidence that they reduce the aggression of individuals with a diagnosis of schizophrenia, and in any case they are contraindicated in conjunction with the prescription of neuroleptics.

As noted above, neuroleptics are most clearly indicated in the management of the aggression shown by violent schizophrenics (Conn & Lion, 1984; Lion, 1975; Tardiff, 1983; 1984c), but there are reports that their use with violent persons diagnosed as mentally retarded actually exacerbates assaultiveness and may interfere with the effectiveness of other treatments (Bruening, O'Neill, & Ferguson, 1980). There is also evidence that they may exacerbate violence in brain damaged persons (Liberman, Marshall, & Burke, 1981).

The use of benzodiazepines seems to disinhibit aggression in some individuals, particularly in correctional settings (Workman & Cunningham, 1975). Lithium has been reported to reduce the violent behavior of incarcerated primary personality or character disordered individuals (Mattes, 1986; Sheard, 1984). Rarely if ever would these persons receive a diagnosis of bipolar affective disorder, the diagnosis for which lithium is classically indicated. Similarly, carbamazepine, an anticonvulsant, has been shown to be effective in reducing the violent behavior of assaultive psychiatric patients, but the degree of improvement does not seem related to a diagnosis of epilepsy or an abnormal EEG (Mattes, 1986).

Finally, one might be tempted to conclude that because many assaultive residents of institutions also show signs of depression and suicidal behavior, antidepressants would effectively reduce aggression created by either of these disorders. Unfortunately, there is some evidence that tricyclic antidepressants can *induce* interpersonal aggression in some depressed individuals (Rampling, 1978).

Every drug discussed above presents difficulties in long-term use as an ultimate treatment for aggression. Virtually all have been reported to increase agitation and aggression in at least some individuals (Liberman et al., 1981; Lion & Soloff, 1984; Mattes, 1986; Stull et al., 1984; Workman & Cunningham, 1975), and untoward side effects ranging from the relatively trivial to death have been reported for most. Drugs can interact with other medications or foods to produce dangerous

effects. Some patients refuse to take psychiatric medications (Stull et al., 1984), and using manual restraint to force someone to do so could well represent more physical risk to the patient and others than the behavior the drug is intended to reduce (Harris & Rice, 1986). The occurrence of assaultive behavior even by the most violent individuals is so variable over time that very long periods of observation are necessary in order to observe any drug effects. Finally, the imposition of psychiatric medication treatment on an unwilling patient as a form of "chemical restraint" is fraught with legal and ethical difficulties for the physician, ward staff, and institutional administration (Wexler, 1984).

In sum, although there are reports of successful drug treatment of violent individuals, a review of this literature reveals many difficulties. There often appears to be no cogent theory on what causes the effectiveness of certain drugs. The cause for this lack of insight could be that the biological bases of violence are as yet far from understood, or that many unsuccessful attempts at drug treatment simply go unreported. Clearly, due to the risks of causing an increase in aggression, causing physical harm to the patient, becoming embroiled in legal and ethical controversy, and interfering with the patient's opportunity to benefit from other forms of treatment, the clinician who attempts to treat violent individuals in this manner must proceed cautiously in the absence of a theoretical rationale and can only hope for modest success.

Seclusion and Mechanical Restraint

Persons who are suicidal or aggressive sometimes require restraint in order to protect themselves and others. With respect to management of the mentally ill, there have been varying amounts of restraint employed throughout history. Contemporaneously, restraint and seclusion of disturbed individuals who present a danger to themselves or others exists even in primitive societies where there is no psychiatric establishment or modern concept of mental illness (Westermeyer & Kroll, 1978). Although the use of restraint and/or seclusion appears ubiquitous, the degree to which they have been relied on has varied widely. In 1793, Philippe Pinel was among the first to radically decrease the use of mechanical restraints for mental patients, although even he reserved punitive imprisonment for persons who were disobedient, incited others to be disobedient, did not work, or who, if they were female, stole things (Soloff, 1984).

Higher seclusion rates in psychiatric settings have been correlated with the use of drug-free assessment periods (Schwab & Lahmeyer, 1979); higher ratios of female to male staff (Convertino, Pinto, & Fiester, 1980); understaffing (Gutheil, 1984); the absence of structured activity (Oldham, Russakoff, & Prunsofsky, 1983); and various patient characteristics including history of previous violence (Soloff & Turner, 1981), youthfulness (Plutchik et al., 1978; Tardiff, 1981b), and being male (Oldham, Russakoff, & Prusnofsky, 1983). Psychiatric patients are most commonly secluded because of agitation or disruptive behavior, not because of physical assaultiveness (Gutheil, 1984).

Seclusion and restraint have been controversial for many years (Knoff, 1960) because although everyone agrees they are sometimes necessary, they appear inhumane, have been equated with neglect (Soloff, 1984), and have been related to a confrontational style of management (Joy, 1981). Variations in their frequency and duration over similar settings and with similar patients seem to imply that some institutions and health care settings are unnecessarily restrictive or even punitive. Historically, there has been greater support for their use among frontline workers than among hospital superintendents (Knoff, 1960).

This controversy has spurred a substantial number of empirical surveys in recent years. Most of these have been retrospective frequency counts of the number of seclusion episodes within a psychiatric ward or institution, and often have included a comparison of patients who were secluded at least once with those who have never been secluded (Convertino, Pinto, & Fiester, 1980; Dietz & Rada, 1983; Gerlock & Solomons, 1983; Mattson & Sacks, 1978; Okin, 1985; Oldham, Russakoff, & Prusnofsky, 1983; Phillips & Nasr, 1983; Plutchik, Karasu, Conte, Siegel, & Jerrett, 1978; Ramchandani, Akhtar, & Helfrich, 1981; Soloff, 1978; Tardiff, 1981b; Telintelo, Kuhlman, & Winget, 1983; Thompson, 1986). Prospective studies have been conducted by Schwab and Lahmeyer (1979) and Soloff and Turner (1981).

Unfortunately, the empirical literature is not as informative as one would like. A number of methodological problems have been identified in reviews by Gutheil (1984) and Soloff, Gutheil, and Wexler (1985). Seclusion frequency and duration vary enormously over studies, and although different recording practices account for some of the variation, it is clear that policies governing the practices differ in different settings. Even within settings as similar as state hospitals within the same state, Okin (1985) observed that there were large variations in seclusion frequency associated with whether it was employed for the threat of violence or only for actual violence. These policies are often not well articulated (e.g., Guirguis & Durost, 1978; Tardiff & Mattson, 1984).

An even more important drawback than methodological variation is that the problem researchers are attempting to address is often not clearly stated in the literature. Hospital staff need to know what the best policy of restraint and seclusion is in terms of ward safety, patient and staff morale, and treatment effectiveness, and this fundamental question is not addressed by the empirical literature, although there is a great deal of unevaluated, albeit sensible, advice pertaining to it (Guirguis, 1978; Gutheil & Tardiff, 1984b; Lion & Soloff, 1984; Roper, Coutts, Sather, & Taylor, 1985; Rosen & DiGiacomo, 1978). The basic premise of many of these studies is that seclusion is a necessary if unpalatable method for dealing with upset and potentially violent patients, but that it can easily be abused.

Seclusion and/or restraint is only one of a number of methods, such as medication or one-on-one observation, that can be used to control patient behavior. Very few studies, however, measure a variety of control procedures simultaneously (for an exception, see Tardiff, 1981b). In fact, seclusion can be used for a variety of different purposes: (a) to prevent violence (threat), (b) to maintain order (noise, agitation), (c) to contain ongoing violent behavior, (d) as a deterrent to the patient, (e) as a deterrent to other patients, (f) to retaliate for aggressive behavior, (g) for a variety of treatment or supervisory reasons (Gutheil, 1978), and (h) to suppress a particular behavior as part of an operant treatment program. The form and duration of seclusion and restraint also vary widely over settings and presumably influence their effectiveness.

Because of these difficulties, it cannot be decided whether a particular policy is desirable simply by measuring the frequency and duration of seclusions or restraints and correlating them with patient or setting characteristics. More or fewer restraint incidents may or may not be desirable depending upon what other sorts of control procedures are used and what the effects are on patient behavior, patient morale, and staff morale. For example, it may be possible to reduce the frequency of seclusion by radically increasing the use of medication; and such a course of action may be desirable if the patients' behaviors improve, if there is not a great increase in side effects, and if staff and patient morale improves or at least remains the same.

One of the reasons for which these observations are important is the legal concern that least restrictive alternative to control disruptive or aggressive patient behavior should be applied (Gast & Nelson 1977; Wexler, 1982; 1984). It is altogether unclear whether physical restraint and seclusion are the most restrictive alternatives available, as opposed (for example) to drug treatment (Gutheil, Applebaum, & Wexler, 1983). There have been several laudable attempts to scale the restrictiveness

of various types of control procedures by asking staff to rate them (Killebrew, Harris, & Kruckeberg, 1982; Ransohoff, Zachary, Gaynor, & Hargreaves, 1982). However, there is a peculiar myopia involved in these studies: the point, surely, is not how the procedures appear to staff or authorities but how they appear to the persons undergoing them! The issue here should not only be restrictiveness but simple aversiveness: legal doctrine aside, institutions have an ethical obligation to care for their charges in the most humane and pleasant manner compatible with effective improvement of behavior and safety to staff and other patients. With respect to management techniques, the only rational way to determine how to do this would be to construct a scale to measure restrictiveness based on patient perceptions. This measurement is not without difficulties (for example, with some retarded individuals physical restraint is positively reinforcing — see Favell, McGimsey, & Jones, 1978, 1981). However, it is certainly feasible, and has been done in one recent study (Harris, Rice, & Preston, in press).

There have been some attempts to measure recipients' opinions about seclusion. Patients tend not to like it, and tend not to know why it was done or that they were checked frequently while they were secluded (Binder & McCoy, 1983). Not surprisingly, they often report having been angry at the time they were put into seclusion (Plutchik et al., 1978). A study of patients' art revealed that they frequently depicted seclusion scenes that portrayed it as an extremely negative experience with long-lasting effects (Wadeson & Carpenter, 1976). Unfortunately, none of these studies have involved asking patients to rate seclusion in comparison to other control procedures they have experienced.

Remarkably little is known about the effects of seclusion on behavior. Time out as a treatment strategy has received considerable attention (Harris & Ersner-Hershfield, 1978), but the use of seclusion and restraint as a management procedure, particularly in comparison to other control techniques, has not yet been studied. Most of the literature is concerned with persons held in solitary confinement for lengthy periods (e.g., Gendreau & Bonta, 1984; Grassian, 1983). It appears that there is much room for improvement in our knowledge of the effects of various seclusion and restraint procedures.

Out of those studies that have been carried out, there are some recent data that indicate that restrictive procedures in institutions can intentionally be caused to vary. Davidson, Hemingway, and Wysocki (1984) recorded psychotropic drug use, seclusion time, restraint time, staff turnover, and days lost due to staff injury for a four-month baseline period and a 53-month intervention period in a large institution for the developmentally handicapped. Staff were instructed that one of the primary

goals of the institution was to reduce the use of restrictive treatment procedures, and monthly totals of seclusion, restraint, and psychotropic drug use were communicated to them throughout the intervention period. They were encouraged to pursue behavioral treatment options and to use medication, seclusion, or restraint as a last resort. Over the course of the study, restraint hours were reduced 99%, seclusion 88%, and psychotropic drugs 44%. There was no increase in staff turnover or in days lost to injury over this period.

This study is noteworthy not only because of its use of a quasi-experimental design and simultaneous monitoring of three control procedures together with indicators of staff morale, but because it indicates how malleable the use of these control procedures may be (cf. Hay & Cromwell, 1980). At least in this setting, the use of all restrictive procedures could be reduced substantially and simultaneously with no adverse effect on safety. Studies of this type in other, especially psychiatric, settings are to be encouraged.

Behavioral Treatments

There are two complementary behavioral strategies for reducing aggressive behavior. The first consequates aggressive behaviors immediately after their occurrence, and the second seeks to teach prosocial skills at other times.

Harris and Ersner-Hershfield (1978) have provided a comprehensive review of a variety of immediate-response techniques designed to suppress self-injurious behavior or physical assaults among developmentally handicapped and/or psychiatric residents of institutions. Among these techniques the following have received some evaluation: differential reinforcement of behaviors other than or incompatible with the unwanted one; extinction (no reinforcement following the target behavior); time out (contingent removal of reinforcement following the target response, often by brief isolation of the patient); overcorrection-restitution (immediately requiring the patient to restore the environment to an even better state than it was before the undesirable behavior was shown and to practice behaviors incompatible with it); and response-contingent shock. These techniques are often used in combination.

Overcorrection-restitution has been a very effective technique in the suppression of aggressive behaviors with adult developmentally handicapped institutional residents (Foxx & Azrin, 1972; Summer et al., 1974)

and aggressive children (Matson, Horne, Ollendick, & Ollendick, 1979). However, although the reduction in aggressive behaviors achieved with these interventions has been dramatic and swift, generalization to new situations requires additional training with these populations (Harris & Ersner-Hershfield, 1978). Webster and Azrin (1973) have also found a related technique, contingent required relaxation, to effectively reduce the aggressive behaviors of retarded residents. This technique involves requiring a resident to lie quietly in bed upon the commission of an aggressive act. Its rationale is that it focuses not on the acquisition of incompatible behaviors or a punishment effect but on the substitution of an emotional state incompatible with that which occasions the aggression, as well as the prevention of aggression-related reinforcement.

Paul and Lentz (1977) have presented very strong evidence that a combination of a 48-hour time out, fines in a token economy, and, if necessary, extended overcorrection-restitution completely terminates violent behavior among institutionalized chronic mental patients. Bostow and Bailey (1969) found that time out and differential reinforcement of other behavior greatly reduced the frequency of aggressive behaviors exhibited by a retarded resident. Similarly, Liberman et al. (1981) have found in a series of case studies that a combination of time out, token fines, and social skill training reduced severe aggressive behaviors of adult psychiatric patients.

In summary, behavioral approaches to reducing aggressive behavior within institutions that involve consequating the behaviors immediately upon their occurrence are extremely effective, particularly those employing overcorrection-restitution. These techniques have been applied primarily to chronic low functioning mental patients and retardates who exhibit high rates of physically aggressive behavior. It is questionable, however, whether they are feasible and effective with higher functioning residents, acutely psychotic individuals, or prison inmates.

Turning to approaches for decreasing aggression that do not involve contingency management, variants of anger control training have been the most popular. Novaco (1975) designed a cognitive-behavioral stress inoculation treatment approach involving (a) relaxation training, and (b) training to prepare for a provocation, to confront the provocation, to cope with physiological arousal, and to administer self-reward through the use of self-statements that maintain a task orientation by working through a hierarchy of increasingly provocative situations. Moon and Eisler (1983) have shown that Novaco's approach, social skills (assertion) training, and problem solving approaches to control were all more effective than a no-treatment control condition in a study of college students who reported

higher than average amounts of anger. Positive results have also been reported by Frederikson and Rainwater (1981), who employed social skills training, cognitive restructuring and relaxation training with psychiatric inpatients who had a history of violent behavior. In a study of forensic psychiatric inpatients, Stermac (1986) found that a brief cognitive behavioral stress inoculation intervention produced marked improvements in subjects' reported levels of anger and reported use of cognitive restructuring strategies relative to a control condition.

The above studies indicate that anger control and social skills training are promising interventions but, unfortunately, most of them involve self-report or analog data, and only a few have specifically targeted institutional violence. Of these, Goldstein and Glick (1987) used social skills training, anger control techniques, and moral education in two combined programs for adolescents convicted of a variety of criminal offenses. Compared to control subjects, the youths who participated in the program showed reductions in the frequency and severity of disruptive and violent behaviors exhibited within the institutions. They also subsequently showed reduced impulsiveness and improved community adjustment compared to controls. Benson, Rice, and Miranti (1986) compared relaxation training, self-instruction, and problem solving with a combined anger management condition among a group of mentally retarded adults. There were no differences among conditions, but vocational supervisors' ratings indicated that all subjects were less aggressive after the program than before.

Kaufman and Wagner (1972) designed a temper control program for a 14-year-old boy who hit his teachers, argued with his stepmother, participated in gang fights, etc. The program was embedded in a token system. First, aversive stimuli that occasioned aggression were identified and role playing techniques were used to teach more appropriate responses. Next, these stimuli were used on the ward in weak fashion and preceded by a cue "This is a barb." The client received tokens for an appropriate response, the barbs were gradually made more aversive, and the cues were faded out. The barb technique reduced the client's frequency of seclusions on the ward and increased his level of anger management skill. At postrelease follow-up no temper problems had reccurred.

Kolko, Dorsett and Milan (1981) treated three adolescent males with severe anger control problems in a psychiatric institution. Role play scenarios, consisting of a narrated description of a situation in which subjects responded inappropriately to aggression, were constructed after discussions with staff and direct observation. An extended multiple baseline design was used to assess acquisition of five postulated anger control skills: appropriate response latency, eye contact, facial expression, voice

loudness, and verbal response. Six role plays were used as training scenarios, and six as assessment probes. Unannounced on-ward provocations were used for assessment before and after training. Modeling, practice, and videotape feedback were used in training, which produced quick acquisition of the social skills that generalized to ward situations. The unannounced provocations were handled much better after than before therapy. Ward adjustment ratings also improved.

Similar results were obtained by Elder, Edelstein, and Narick (1979) who trained one female and three male aggressive adolescents in socially appropriate methods of interrupting, requesting behavior changes, and responding to negative communication (e.g., teasing). These patients readily acquired the skills in role playing situations, and received fewer fines and seclusions post-treatment.

In summary, the evidence that contingency management interventions, particularly overcorrection, are effective in eliminating institutional aggression among developmentally handicapped and chronic mental patients is very persuasive. The evidence for the efficacy of anger management training, although positive is much more limited. Taken together, the literature on behavioral treatment has important implications for staff training and the reduction of institutional violence. These data imply that staff can not only be trained to be able to intervene safely in a crisis situation and to defuse such situations when they arise, but also to act proactively so as to reduce the frequency of aggressive behaviors.

Crisis Intervention Training

Courses in crisis intervention for institutional staff have been influenced by work concerning the training of police officers to intervene in domestic disputes (Bard, 1971; Bard & Zacker, 1976; Driscoll, Meyer, & Schanie, 1973; Dutton, 1981; Goldstein et al., 1982; Levens & Dutton, 1980; Mulvey & Reppucci, 1981). Most current programs involve discussion of legal issues, verbal methods of preventing violence, self-defense training, and training in patient restraint.

The first description of a program for the prevention and management of disturbed behavior in a psychiatric hospital (St. Thomas Psychiatric Hospital, 1976) appeared in the journal *Hospital and Community Psychiatry*. It involved both a staff training program and administrative changes. The training program was given to all staff in five two-hour

sessions, and included a film and workbook to illustrate the major points covered. The workbook described preventive verbal and clinical techniques as well as physical self-defense and restraint methods. The administrative arrangements involved having the clinical teams conduct "psychological autopsies" on all incidents of disturbed behavior, and the creation of a hospital-wide committee that provided a review of incidents of such behaviors and policy recommendations to the hospital administrator.

Data were collected for the year before and after the introduction of the St. Thomas program. Decreases were observed in the number of incidents of violent behavior, the number of patient injuries, the number of Workers' Compensation claims, and the number of work hours lost (although not necessarily all due to patient action). Hospital management and staff were enthusiastic in their endorsement. However, because it was not designed as a research study, there were a variety of issues that it did not address. It is unknown whether staff actually acquired and remembered the skills taught, whether they used these skills on the wards, whether the course had an impact on their self-perceived effectiveness, which program elements (training, administrative, or both) were the effective ingredients, and whether the observed changes were due to the program, other concurrent changes, or random fluctuation.

The effect of implementing an "assault prevention task force" was prospectively evaluated in a 150-bed, all-male, maximum security psychiatric unit (Quinsey, 1977; 1979). This task force was comprised of attendant staff, attendant management staff, and a psychologist; in composition and function it combined elements of the St. Thomas Committee on the Management of Disturbed Behavior and the clinical team that conducted "psychological autopsies." Assault frequency in the 800 days before the task force began was .496 per day; post-task force, it was .477. Although overall assault frequency did not decline as a result of this intervention, attendants were less frequently victimized in the post-task force period than before ($p < .001$), while patients were more frequently victimized. These data suggest that the task force had its intended effect as far as staff were concerned, but are far from conclusive. In particular, it is unclear why assaults on patients increased.

It has been shown that mental health workers' confidence in dealing with aggressive patients is markedly increased following even a short training program. Thackrey (1987a) developed a 10-item Confidence in Coping with Patient Aggression scale (alpha =.92), and administered it to a group of mental health workers from settings varying in security level who were or were not exposed to an eight-hour "Therapeutics for

Aggression" program. Workers who had received training significantly increased their reported level of confidence in dealing with aggression at post-test and 18-month follow-up, while untrained workers showed no changes. Lehmann, Padilla, Clark, and Loucks (1983), in an uncontrolled study, have also found increases in clinician confidence associated with participation in a training program.

The effect of a three-day aggression control training program on patient assaults on psychiatric aides was examined in a state mental hospital (Infantino & Musingo, 1985). This study retrospectively compared assaults on 65 untrained aides with 31 trained ones over an average 9-month follow-up period. Significantly fewer of the latter were assaulted ($p < .001$). These data are encouraging, but are compromised by nonrandom assignment of aides to training conditions.

With the exception of the work described in this book (Rice, Helzel, Varney & Quinsey, 1985), the above literature is an almost exhaustive summary of the evaluative research on crisis prevention and intervention methods in institutions. There are a variety of other reports and descriptions of training programs (Barile, 1982; Basque & Merhige, 1980; DiBella, 1979; Fein, Gareri, & Hansen, 1981; Gertz, 1980; 1983; Moran, 1984; Ramirez, Bruce & Whaley, 1981) but these add nothing to the empirical evidence regarding the effectiveness of these programs. A review of these reports and an extended description of one such program can be found in Thackrey (1987b).

The data that are available suggest that staff welcome a well planned training program, that such a program strongly and persistently improves staff confidence in dealing with patient aggression, and that staff who receive such training are less likely to be assaulted. These inferences are all necessarily highly tentative because of the nonexperimental and sometimes casual nature of the studies.

Although this limited literature is encouraging, it raises more questions than it answers. Which of the various program components (verbal preventive skill teaching, self-defense training, training in patient restraint, discussion of policy and legal issues, administrative changes, etc.) are necessary and/or sufficient conditions for producing a decrease in the frequency of patient assaults? Indeed, can such a reduction be demonstrated in a controlled study? Do staff in fact learn, remember and use the skills that are taught in crisis prevention and intervention courses? In view of the variety of nonphysical prevention and intervention techniques described in the training course literature, which approaches are most effective? For which are there even compelling theoretical and/or empirical rationales? It is questions such as these that motivated the present research.

SUMMARY AND CONCLUSIONS

The most striking characteristic of the literature reviewed above is its atheoretical and pragmatic nature. Very few authors have viewed institutional assaultiveness as an opportunity to study a theoretically interesting phenomenon. Rather (and understandably) it is largely regarded as a problem to be eliminated. Thus, even the best work in this area has largely eschewed theorizing in favor of empirically motivated work aimed at assault reduction.

This atheoretical approach has some important consequences. Although some strategies to reduce violence have been identified (such as staff training, contingency management and some drugs), in the absence of coherent theories, institutional administrators have a very limited and concrete array of options to consider in their efforts to reduce assaultive behavior. A theory of institutional assaultiveness would have the practical benefit of increasing the generalizability of evaluative data to different settings.

The best synthesis of the existing literature would lead to the adoption of a number of strategies: careful management of contingencies (for example, the elimination of inadvertent reinforcement for assaultive acts); cautious application of some drug treatment; administrative policies and practices that reduce crowding and increase the stability of the social environment; increase of structured activities for residents; and administerial policies to review and monitor incidents (including interviewing assaultive individuals) as a way to discover policy changes that could prevent recurrences. Finally, the literature provides considerable support for the idea that significant reductions in institutional violence could be achieved by a staff training program aimed at teaching nonrestrictive, nonauthoritarian, and nonprovocative ways of interacting with residents; behavioral cues and situational characteristics associated with assaultiveness; and effective verbal strategies for use with highly upset individuals.

Chapter 2

A Long-Term Study of Institutional Violence

Only recently has the problem of physical assaultiveness in psychiatric institutions been subjected to much systematic study. There are obvious difficulties involved: first, because the behavior is highly variable across time and individuals, a large body of data must be collected before clear trends can emerge. Second, much assaultive behavior does not occur in view of the researcher. Third, researchers cannot usually control the object of their study because admission and discharge policies, personnel regulations and institutional routines often change unexpectedly. Fourth, there is good reason to believe that hospital staff underreport assaults (Lion, Snyder, & Merrill, 1981). Finally, few researchers are inclined to engage in long-term data-gathering efforts due to job changes, grant requirements, and boredom.

An unfortunate result of these factors is that investigators often do not accumulate sufficient data to permit generalization. The maximum number of assaults examined in any one study appears to be near 200 (Deitz & Rada 1983; Depp, 1983; Quinsey & Varney, 1977a), while numbers under 100 are more common (Haffke & Reid, 1983; Ekblom, 1977; Ochitill, 1983; Conn & Lion, 1983; Ionno, 1983). Another problem is that investigators do not use a consistent definition of assault. Some (e.g., Conn & Lion, 1983) include verbal attacks or threats, while others (e.g., Quinsey & Varney, 1977a) consider only physical altercations, either completed or attempted. It is also clear that institutional policy can have an impact. Some make assaultiveness a criterion for admission (Quinsey & Varney, 1977a); others make it a criterion for discharge (e.g., Armstrong, 1983). Researchers in the latter type of institution are likely to find environmental factors to be relatively important, while those in the former are likely to focus on the importance of individual differences.

This chapter describes a ten-year study on institutional violence carried out at Oak Ridge. Many of the findings from this study have served as a basis for designing the course described in Part II.

Before detailing the results of the long-term studies that form the backbone of the proposals presented in this book, we will briefly review an earlier study by two of the authors that looked at many of the same issues.

Quinsey and Varney (1977a) studied assaults by patients on staff or other patients over a one-year period on a maximum security psychiatric unit at Oak Ridge. This unit was seen as a particularly appropriate study setting because frequent assaultive behavior was a prime criterion for admission and its reduction a major discharge criterion; also, the compressed nature of the physical surroundings and the system of surveillance and recording permitted an almost exhaustive sample of all incidents. The authors obtained a nearly complete record by having a researcher visit the study wards almost every day to examine ward books and to interview patients and staff about any instance of physical assaultiveness that had occurred since the last visit. This researcher sought to present a neutral and nonevaluative stance, and so was able to maintain friendly personal relations with both staff and patients.

There were 198 assaults recorded over the study period, equivalent to .0039 per patient day. There was no variability attributable to month, phase of the moon, or day of the week; however, time of day strongly affected the distribution, with assaults being more frequent just after breakfast, in the early afternoon, and especially in the early evening — all of which were periods of unstructured activity. Seeking evidence of "behavioral contagion," "building tension," or "tightened security," the authors also examined sequential dependencies in order to see whether the probability of an assault was related to the prior occurrence of other assaults. This set of analyses yielded no statistically significant results.

Of the 198 assaults, 90% occurred on the two most secure wards of the four-ward study unit. Overall, 40% occurred in the corridor, 25% in patients' rooms, 15% in the sunroom lounge, 8% in the showers, and 12% in the yards and other off-ward locations. In order to gain access to less secure wards, the dining room shops, and the visiting area, patients had to demonstrate sustained stable behavior; hence, these areas were very seldom the locations of assaults.

Quinsey and Varney reported that a small number of the unit's residents were responsible for the majority of the assaults (18 patients committed four or more each). These individuals were younger than nonassaultive patients, and tended to be those who had been management problems in

psychiatric or retardation facilities as opposed to referrals from the court or correctional systems. They were therefore less likely to have had criminal charges leading to admission, and more likely to have poor pre-hospital social adjustment.

Of the victims, 66% were hospital staff. The authors concluded that "this discrepancy in the proportion of patient and staff victims strongly implies that interactions between staff and patients were a major determinant of assaultive behavior."

Finally, the authors examined the reasons given for assaults. In general, staff and patients viewed this very differently. Staff most often reported that they occurred for no reason, while assaulters regarded their behavior as having been deliberately provoked by staff or by teasing from a co-patient. Quinsey and Varney raised several important issues. First, they noted the importance of these differing perspectives, suggesting that actions regarded by staff as routine, plausible, and harmless may be seen by patients as arbitrary, punitive, capricious and personally motivated. They noted that although the resulting frustration for the patient is not necessarily inevitable and that frustration could be faded in gradually (Kaufman & Wagner, 1972), requisite control over staff behavior is very difficult.

They also concluded that punishing assaultiveness with long periods of solitary confinement is unlikely to be effective. The normal confinement procedure was seen as ineffective because it did not provide a true time out from positive reinforcement; because assaultive patients had become habituated to it; and because confinement did nothing to provide (and probably interfered with) opportunities to acquire more useful behaviors. The authors suggested that the popularity of confinement for violent patients was due to staff concerns for their own safety, a desire to punish on "moral grounds," and the appearance that confinement "works" with patients who are not already highly assaultive.

THE TEN-YEAR STUDY*

The purpose of the longer-term study was to examine physically assaultive behavior on a maximum security psychiatric unit over an extended period of time. Essentially, it extended the earlier work by Quinsey and Varney. The institutional location was the same (Oak Ridge), and the method essentially so: i.e., the researchers obtained a nearly exhaustive sample of all assaults, with data collected independently of the institutional

* This section is based on an article that appeared in the *Journal of Interpersonal Violence*, 1986, 1, 173-191. Reprinted by permission of Sage Publications, Inc.

incident report forms. This is an important methodological advantage, since as mentioned earlier there is good reason to assume that sole reliance on institutional records would yield results that grossly underestimate the true level of the problem (Lion et al; 1981). Unlike the Quinsey and Varney study, completed assaults were coded separately from attempted ones, and time-series analyses were employed in order to examine some of the temporal characteristics of the problem. Finally, as in the Quinsey and Varney study but unlike virtually all previous studies, assessment of inter-rater reliabilities were included.

Method

Setting

The physical setting and programs are well described elsewhere (Introduction, Quinsey, 1981; Quinsey & Sarbit, 1975; Quinsey & Varney, 1977a). In general, patients were sent to the four wards comprising the maximum security study unit at Oak Ridge because they were too inarticulate, psychotic, or physically assaultive to participate meaningfully in milieu therapy programs.

Throughout the study period, there was a steadily increasing trend away from referrals from the courts and correctional facilities and towards referrals from other psychiatric hospitals (cf. Rice, 1985a). This was reflected in several ways. By the end of the study period, fewer patients had forensic documentation while more were held on certificates of involuntary admission; more had no criminal offense leading to admission; fewer had never been to a psychiatric hospital before; and more were diagnosed as psychotic and fewer as personality disordered or mentally retarded. In addition, the length of stay decreased, especially for the involuntary patients.

Programs on the unit comprised token economies and recreational and vocational workshops. These basically remained unaltered over the course of the study, but some clinical and administrative changes did occur. Behaviorally oriented social skills training was introduced for residents who were assaultive (Quinsey, 1977; Quinsey & Varney, 1977b), unpopular (Rice, 1983; Rice & Josefowitz, 1983; Rice & Quinsey, 1980), and unassertive (Rice & Chaplin, 1979); for sex offenders (Quinsey, Chaplin, Maguire, & Upfold, 1987; Whitman & Quinsey, 1981) and firesetters (Harris & Rice, 1984; Rice & Chaplin, 1979). Its purpose was the improvement of these individuals' social functioning, and some cases, the explicit goal was the reduction of the antisocial behavior.

An Assault Prevention Task Force was instituted in 1977, composed of line staff, supervisory personnel, and a psychologist. Its mandate was the identification of problems in the care and treatment of violent patients; the design of training; the suggestion of program changes that would reduce assaults and avoid staff injuries; and the provision of support for staff. The Task Force met monthly, reviewed data on assaults, interviewed staff about any incidents, and provided an official record of incidents in preparation for possible investigation by the newly created provincial Ombudsman (who had considerable authority to investigate and redress patients' complaints) or the institution's administration. Due to changes in supervisory staff, it ceased operation in 1980.

The staff training program described in Part II was implemented and evaluated in 1980 (Rice, Helzel, Quinsey, & Varney, 1985). This training was shown to improve the skill of ward staff in predicting and intervening in assaultive and potentially assaultive incidents, and significantly reduced both assaultive behavior on the wards and the number of working days lost due to staff-patient altercations. By the end of the study period, over 80% of the unit's ward staff had gone through the program. After 8.5 years of the 10-year study period, the administrative structure of the institution was changed so that any assaultive patient in the entire institution could be referred to the study unit.

Time-series analyses were applied to the data to discover whether changes in the trend of assaultive behavior could be attributed to any of these clinical and administrative changes.

Procedure

The procedure was the same as that employed by Quinsey and Varney (1977a) who reported high inter-rater reliabilities as to whether an assault occurred and who was the aggressor. Subsequent annual checks confirmed that high agreement was maintained, ranging from 69% to 100%. The only significant alteration was to modify the definition of an assault. Incidents were classed as such if they involved patient-initiated intentional physical contact of a forceful nature between two or more persons. Unsuccessful attempts to do so were also recorded, but in a separate category.

All assaults and attempts that occurred in the period from January 1, 1975 to December 31, 1984 were recorded. Ward reports of significant incidents were examined daily, and in addition a researcher visited on a regular basis, read the ward books, and asked patients and staff about any assaultive incidents since the last visit. Any incident reported in any source that could be construed as indicating that an assault had occurred was investigated by interviewing the patient(s) involved and, where

possible, staff and witnesses. Respondents were asked about the time, causes, and actual physical events that had transpired, and when possible, the researcher also recorded what had happened just before and just after the incident. Staff responses were accepted over those of patients when accounts differed, although such differences were relatively rare. Opinions about reasons were solicited from both the assaulter and the ward staff, and recorded separately. In incidents involving only patients, the individual who first resorted to physical measures (regardless of provocation) was designated as the aggressor.

Results and Discussion

The Ten Year Trend

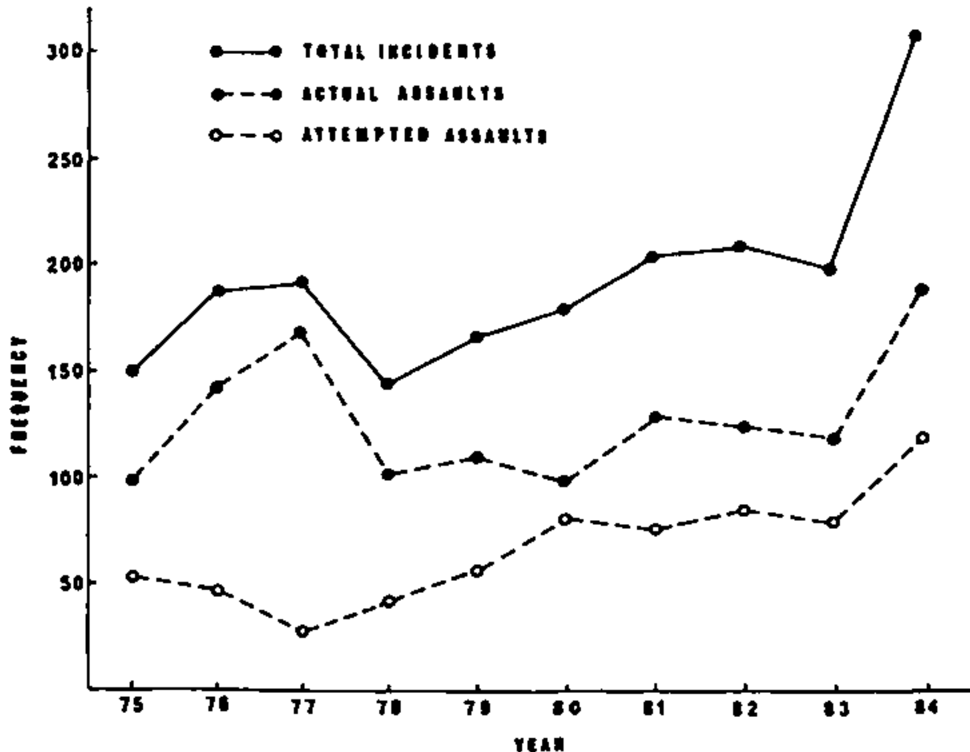
The overall trend for total incidents, actual and attempted assaults over the ten year period is shown in Figure 1.

There were year-to-year fluctuations in the numbers of assaults and attempts. Because of the prospective nature of the data-gathering procedure, the compressed nature of the physical environment, and the established reliabilities, we believe it unlikely that any of the fluctuations were due to incidents that were missed by the researchers.

The first questions addressed by these data concerned the effects of the Assault Prevention Task Force intervention. If the sharp drop in actual assaults in 1977 was indeed due to the activities surrounding the beginning of the Ombudsman program and the coincident introduction of the Task Force, the reduction should be most clearly reflected in those incidents involving staff. The ten year pattern for incident target by incident type is shown in Figure 2. As may be seen, there was a sharp reduction in the number of assaults involving staff in 1978. This was one of the only two years in which the number of incidents involving staff ever declined.

Data were subjected to time series analyses. First, the findings on the monthly incidence of assaultive incidents over the ten years were considered, and autocorrelations computed for all possible temporal lags (Glass, Willson, & Gottman, 1975). The results indicated that significant autocorrelations occurred only at short lags (1 through 6) indicating sequential dependencies at monthly intervals but no periodicity attributable to seasonal variation, for example. Next, the monthly scores for both all assaultive incidents and only those incidents in which actual physical contact was made were subjected to a time series analyses designed to reveal changes in linear trend (Tryon, 1982).

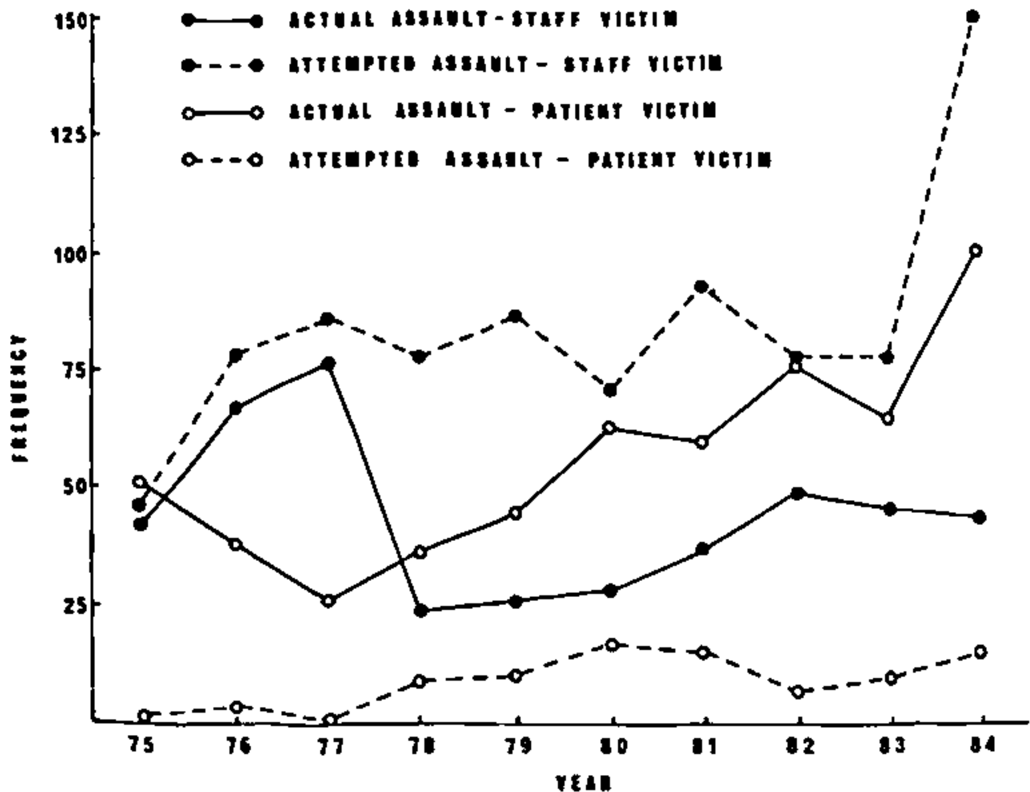
FIGURE 1
TOTAL INCIDENTS, ASSAULTS AND ATTEMPTED ASSAULTS
AS A FUNCTION OF CALENDAR YEAR



Overall, both attempted and actual assaults showed a significant positive trend throughout the study ($z = 5.73$, $p < .001$ and $z = 2.72$, $p < .01$, respectively). Using the same technique, pre/post analyses were conducted for the point at which the Assault Prevention Task Force intervention occurred in July, 1977. By using the original data from Quinsey and Varney, it was possible to obtain 40 data points before and an equal number after the intervention. The analyses indicated no significant trends or changes in trends attributable to the intervention in the data for all assaultive incidents. However, considering only *completed* physical assaults, the results indicated a significant overall positive trend before the intervention ($z = 2.07, p < .01$) and a nonsignificant negative trend afterwards ($z = -.352$). These results suggest that the Task Force intervention (possibly in combination with the Ombudsman) acted to significantly reduce the incidence of physically assaultive behavior on the study unit.

Changes in the *relative frequency of assaults on staff versus assaults on patients* (see Figure 2) may also have been due to this intervention. The staff training course described in this book began in 1980, and was likely responsible for maintaining this change in the pattern of assault

FIGURE 2
ACTUAL PHYSICAL ASSAULTS AND ATTEMPTED ASSAULTS AS A FUNCTION OF VICTIM/TARGET AND CALENDAR YEAR



targets. Finally, the sharp *increase* in assaultive behavior in the last year of the study indicated that the change in the patient recruitment policy of the study unit had a marked effect on the overall incidence of violence.

A closer look at the individual incidents that comprise the *attempted* assault category revealed that this category represents a very heterogeneous set of events. Some represented brutal attacks that fortuitously failed to make physical contact, but a sizeable number would be more accurately called "threatening gestures" or "vigorous struggling while in manual restraint." The fact that reports by staff of attempted assaults on one *patient* by another were very rare suggested that the "attempted assault" category was partly a matter of perception and attitude. That is, it likely was a reflection of a variety of staff patient conflicts rather than genuine violence alone. In contrast, incidents in the *actual* physical assault category were much more homogeneous, usually involving a single punch or kick delivered to another individual with whom the assaulter was already engaged in some verbal interaction.

Assault Characteristics

The most striking finding here was the nearly monotonic upward trend in assaultive behavior that occurred despite concentrated clinical and administrative efforts to reduce it. In order to examine the characteristics of incidents and perpetrators in more detail, we sought a relatively homogeneous data set. Thus, the more detailed analysis was confined to the last five years of the study and concentrated on only those incidents in which actual physical contact was made.

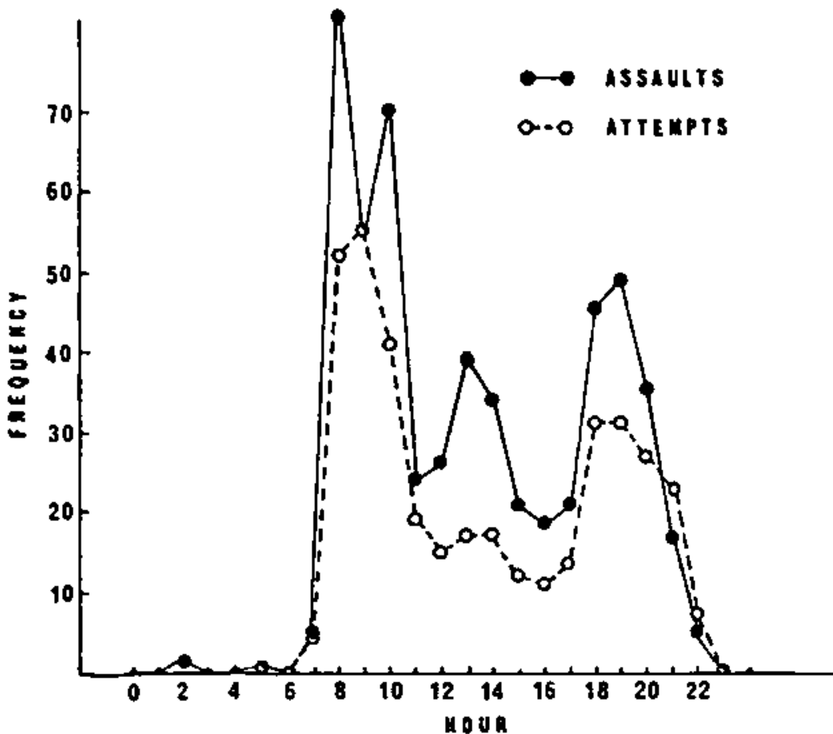
Location: Of the 642 assaults for which the location was determined, 74 (12%) occurred in off-ward areas. The most common of these was the exercise yard, while workshops and indoor recreation areas were infrequent locations. Of the four wards, the one that was the most secure and housed the most unmanageable patients accounted for over half the incidents (334, or 52%). Interestingly, the other secure ward on the unit, which was used for admissions, accounted for only a relatively small proportion of the assaults: (77, or 12%). This represented a change in the pattern reported by Quinsey and Varney, who found that 90% of the assaults occurred on the more secure wards. This result may indicate that the facility collected an ever increasing number of highly assaultive patients (cf. Quinsey, 1980) so that all wards including the lower, less secure ones, housed at least some. This result also indicates the absence of a necessary relationship between assaults and the level of ward security.

On the wards, the vast majority of the assaults occurred in the corridor (59%), 19% in the sunroom, 13% in patients' rooms, 6% in the showers, and 3% in other locations. Compared to the results reported by Quinsey and Varney, fewer assaults occurred in patients' rooms, which may indicate some success for efforts to encourage staff not to enter the rooms of upset patients.

Incidence: Over the five-year study period, the probability of an actual physical assault per patient per day was approximately .0026. Although there were large month-to-month fluctuations ($\chi^2(1) = 26.82, p < .001$), no clear pattern emerges except that spring and summer months tended to represent extreme values. As noted above, time series analyses could identify no reliable seasonal variation. The daily distribution showed substantial variability. Just as reported by Quinsey and Varney, assaults occurred during periods of the day when patients mixed freely with each other in the absence of structured activity (see Figure 3).

Interestingly, a substantial number of assaults were committed by the patients of the lower wards (n = 138), but only a tiny fraction of these

FIGURE 3
TOTAL ASSAULTIVE INCIDENTS AS A FUNCTION OF INCIDENT TYPE AND HOUR



occurred in the off-ward recreational and vocational training areas even though virtually all patients from those wards attended such programs daily. Thus, a large share of the variability in assaultive behavior even by the most violent individuals is attributable to environmental factors.

Assaulters: During these five years, there were approximately 980 different individuals resident for at least some time on the study unit. As had also been observed by Quinsey and Varney, a small number of these were responsible for a majority of the assaults: 45 patients committed more than four assaults each, accounting for 73.9% of all incidents recorded. (While the overall incidence was .0026 assaults per patient per day, the incidence for this group was .011.) In order to make comparisons between assaultive and nonassaultive patients, a comparison group of 45 individuals who had never committed an assault was randomly selected from the unit's records. Comparisons between these two groups revealed several differences, depicted in Table 1. In general, compared to nonassaultive patients, the assaultive individuals were younger, were less often diagnosed as psychotic, had more often been referred from less secure psychiatric settings for unmanageable behavior rather than by the courts, correctional, or other settings; and were less often admitted on criminal

charges. Consistent with the earlier findings of Quinsey and Varney, they tended to show poorer pre-admission social adjustment. They less often had any previous occupation and had fewer years of education. Finally, they had fewer previous psychiatric hospitalizations, undoubtedly because they were almost never released from maximum security. By the end of the five-year study period most had not been discharged, while most of the nonassaultive patients had been.

Assaults committed by the 10 most violent patients were examined, in order to determine whether we could find evidence of patient-specific assault characteristics. The first variable looked at was the target of the attack. Of the ten, only three showed a pattern of target choice significantly different from that shown by all patients (evaluated by χ^2): two showed an exclusive preference for co-patient victims, and one an exclusive preference for staff. Statistically significant differences could not be established for any other study variables. Ward staff believe that many patients exhibit idiosyncratic assault characteristics, such as a preference for staff as assault victims, but for almost all patients, it was impossible to establish persuasive statistical evidence.

TABLE 1
COMPARISON OF ASSSAULTIVE AND NONASSAULTIVE PATIENTS

Variable	Assaultive	Nonassaultive
Age (1)	32.1 (S.D. = 9.38)	38.4 (S.D. = 13.09)
Diagnosed as psychotic (2)	53%	73%
Referred from less secure psychiatric setting (3)	91%	33%
Admitted on criminal charges (4)	22%	64%
Any previous occupation (5)	39%	67%
Years of education (6)	8.53 (S.D. = 2.94)	9.74 (S.D. = 2.76)
Previous psychiatric hospitalizations (7)	2.98 (S.D. = 3.73)	5.07 (S.D. = 5.81)
Discharged by end of five years (8)	20%	80%

(1) $t(88) = 2.66, p < .01$)
(2) $\chi^2(1) = 3.88, p < .05$)
(3) $\chi^2(1) = 31.98, p < .001$)
(4) $\chi^2(1) = 15.00, p < .001$)
(5) $\chi^2(1) = 7.27, p < .01$)
(6) $t(66) = 1.76, p < .05$)
(7) $t(84) = 1.99, p < .05$)
(8) $\chi^2(1) = 32.40\ p < .001$)

Whether consciously planned or not, the study unit had come to increasingly specialize in the treatment of acutely disturbed patients referred from less secure psychiatric facilities because they were too unmanageable to be kept there. Thus, assaultive psychotic individuals were being selected for, and the patient population approached a fairly homogeneous group (cf. Quinsey, 1980).

Reasons Given for Assaults: For all recorded assaults, the proportions for each reason are shown in Table 2. Clearly, staff and assaulters gave very different reasons for the occurrences of attacks. An evaluation of the level of agreement between them was performed, considering all possible reasons separately and all assaults. A kappa statistic calculated for this indicated that agreement was above the chance level ($K = .187$, $p < .001$), but its magnitude was low.

Next, we separated the incidents in which staff were victims. The kappa values indicated poorer agreement about the reason for the assault for incidents in which staff were directly involved than for those in which they were not ($K = .116$ *versus* $.204$). Both results departed from chance, but they were also significantly different in magnitude ($p < .001$).

Finally, we collapsed across reason groups to form three reason categories: No reason, Staff/Program reasons ("ordered to do something," "staff refused a request," "patient upset by ward rules," "staff provocation," and "other"); and Patient reasons ("teased by another patient," "crowded," "voices or delusional orders," "reaction to homosexual advances," "building tension"). This collapse of the reason categories resulted in modest improvement in agreement, but the finding of lower agreement for assaults in which staff were victims persisted ($K = .233$ *versus* $.264$). This difference was again statistically reliable ($p < .001$).

Summary and Conclusions

Changes in the administrative structure and in the way in which incidents are investigated (the Assault Prevention Task Force) had salutary effects on assaultiveness on the maximum security unit under study. Such policy interventions have been recommended by others (Snyder, 1983). In addition, institutional routine (see also Deitz & Rada, 1983) and staff practices (see also Depp, 1983, and Madden, 1983) may also have had positive effects. As suggested by others (e.g., Edwards & Reid, 1983), assaultiveness may be reduced by institutional policies and practices that give patients a vested interest in psychiatric improvement and behavioral stability.

TABLE 2
REASONS GIVEN FOR ASSAULTIVE BEHAVIOR (N=1172)

Reason	Ward Staff (%)	Assaulter (%)
None provided/no response	0.4	23.8
Ordered to do something	16.8	4.8
Request refused	4.7	3.5
Teased or "bugged"	6.4	20.5
Crowded	1.0	2.6
Voices, delusional orders	2.6	3.1
Reaction to sexual approach	0.3	0.5
Angry at ward rules	5.5	2.2
Provoked by staff	0.2	12.0
Building tension, upset	1.2	5.3
Other specified	2.3	6.2
No reason/unknown	58.6	15.4

However, despite these improvements, over the ten year period of our study both the frequency of assaults and the proportion of assaultive patients increased, and it is unlikely that this increase was due to changes in the way incidents were recorded. Lasting improvements in the institution's policies and programs were difficult to effect (cf. Rice & Quinsey, 1986; Rice, 1985b), and in the end, the increase in assaults was largely the result of a trend towards admitting only psychotic, non-forensic patients from other psychiatric facilities, and a parallel trend away from admitting prisoners transferred from correctional settings. As noted earlier, it was found in this study as well as previous ones that assaultive patients tended to be more psychiatrically disturbed and, in general, not "criminally insane" — that is, they had not been found "not guilty by reason of insanity" for some offense, but tended to be civilly committed transfers from less secure facilities (see also Toch, 1982). The result was the selection and retention (see also Quinsey, 1980) of many individuals who would be most assaultive, and thereby increased the likelihood that one patient on the unit would be assaulted by another. Ironically, this trend was largely the result of political pressure against having civilly committed patients housed with persons who had criminal charges, and due to a desire to avoid the security problems associated with "criminal" populations.

The internal pattern of assaultive behavior was similar to that reported by others. Thus, assaults tended to occur in times and places where patients were crowded together without structured activity (see also Deitz & Rada, 1983) and when staff "demanded activity" (see Depp, 1983). Consistent with other reports, a tiny fraction of the unit's patients contributed a substantial majority of assaults, and this cannot simply be because some residents stayed on the unit for extended periods of time. Despite strong staff beliefs to the contrary, it is difficult even with the very most assaultive patients to establish clear statistical evidence of idiosyncratic assault characteristics. The simple conclusion to the results summarized above is that assaultiveness, like other forms of behavior, is due to the interaction of environmental and internal factors.

Patients and staff viewed assaults as occurring for very different reasons. Most often staff reported that they did not know why assaults happened, and when they did express an opinion they most often reported that it was because the patient had been ordered to do something or because he had been teased or "bugged." Assaulters, on the other hand, saw their actions as most often the result of teasing or direct provocation. Generally, both groups agreed that assaults were not the direct result of psychiatric symptomatology but rather stemmed from the interpersonal conflicts that characterize the assaultive behavior of males anywhere. The effect of psychiatric disturbance, then, may be an interference with the assaulter's ability to select nonaggressive interpersonal strategies in situations perceived by him as provocative. Ten years earlier Quinsey and Varney (1977a) reported this same discrepancy in reasons given, and expressed pessimism that sufficient control could easily be gained over staff behaviors. While this conclusion may still be valid, the present study suggests significant changes in institutional assaultiveness were achieved by an assault monitoring committee and by efforts to train staff in relevant interpersonal behaviors.

Finally, it is to be expected that staff did not report a known reason for many assaults because they were the victims of only a minority of the altercations. However, when agreement on the reasons was examined, it was discovered that staff and assaulters agreed less often when the former were involved in an incident compared to when they had merely witnessed one. This result is consistent with experimental work that shows that aggressors and witnesses of aggression assign causal responsibility and blame very differently (Ferguson & Rule, 1983).

The results of this study provide validation for recent experimental work on aggression. Our findings (especially from the assaulter's point of view) support the idea that frustration and anger arousal (Bandura, 1983; Zillman, 1983) are important instigating components to the aggression

of psychiatric patients. Many assaults in the present study were said by patients to be due to direct provocation or thwarted goal-directed behavior. Because staff were the source of much of the frustration, these data support the view that aggression is related to power differences (Ferguson & Rule, 1983). They also support the view that deficits in social competence (Tedeschi, 1983) are responsible for aggression in that patients often seem to see no verbal alternatives to perceived provocation. Finally, environmental stressors such as noise, inactivity and crowding play a role in promoting aggressive behavior (Geen & O'Neal, 1976).

STAFF INJURIES SUSTAINED DURING ALTERCATIONS*

The study described above, like most research on violence in institutions, focused on deliberate assaults by patients. However, such incidents are by no means the only way in which staff may be injured. An informal survey at our institution suggested that struggles during *patient restraints* often resulted in injuries as severe or more severe than those sustained during assaults. By restraint, we refer to the staff-initiated application of manual physical control. Of course, many restraints are applied because of an assault, and many assaults occur during restraints. Lion et al. (1981) noted in their study of assaults in a state mental hospital that half of all the assaults on staff occurred during the process of restraining or secluding a disruptive patient.

In the study described here, we compiled an exhaustive list of all of the incidents over a seven-and-a-half year period at our institution in which staff lost time from work due to physical altercations involving patients. For comparison purposes we included an equivalent number of staff-patient altercations in no work time was lost. This gave us an index of whether an injury was serious (i.e., whether work days were lost) and degree of severity (the total number of days lost). To our knowledge, this is the first study to systematically examine staff injuries in this way. Although there have been many discussions of the severity of the problem of patient violence and a great deal of advice about how to minimize the risk of injury (e.g., Soloff, 1983), there are few data to inform such recommendations. One purpose of the present study was to find out what sorts of incidents resulted in staff injuries as an initial step towards finding ways to avoid such injuries in the future.

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Method

Setting

The study took place at the Mental Health Centre at Penetanguishene, Ontario, Canada. Over the period that it was carried out the institution had approximately 500 treatment beds, roughly 300 of which were in the maximum-security Oak Ridge Division. Almost all of the staff and all of the patients in this part of the facility were male. The remaining 200 beds were in a minimum security regional psychiatric hospital for both male and female patients. In addition, for some of the years of the study there were two medium security units housing about 70 patients, approximately 40 percent female. Staff in both the medium and minimum security divisions were of both sexes, with approximately 60 percent female. During the period of the study, the hospital employed an average of about 330 full-time direct-care nursing staff.

In the event of any incident or accident causing injury to a staff member, the standard procedure followed was for that member to complete a Workers' Compensation claim form outlining what had happened, whether or not the injury appeared serious at the time. In addition, if any patient was involved, an incident report was completed and a note put on the patient's file describing what had happened. Because staff members could only subsequently collect Workers' Compensation Benefits if they had filed a claim form at the time of the incident, they were highly motivated to complete this form whenever there was the slightest possibility that they might require time off work.

Procedure

The institutional records for the period January 1, 1977 to June 30, 1984 were examined in order to identify every instance of a staff member's claim from the Workers' Compensation Board (WCB) of Ontario for time lost from work due to injury. The claim was included in our study if the injury occurred during an altercation between the staff member and one or more patients. An altercation was defined as the occurrence of a non-accidental physically forceful behavior by any participant. Thus, to qualify, the injury did not have to be caused by patient action, but it did have to occur during a staff-patient interaction.

For comparison purposes, we identified an equivalent number of incidents in which a staff member completed a WCB claim form but did not lose time from work. As mentioned above, staff members frequently

took the precaution of completing these forms after the occurrence of an altercation just in case they discovered later that they had sustained a more serious injury than originally believed. For each study year, a number of no-time-lost incidents equal to the number of incidents in which time was lost were randomly selected.

Each qualifying incident was coded for several variables: whether the injury was caused by a restraint or an assault; the identities of the staff and patient(s); the date and time; the institutional location; the sexes of the staff and patient; the age and the years of experience of the staff; circumstances surrounding the assault or restraint (if known); the number of staff directly involved in the incident at the moment the injury occurred; the participant (staff or patient) who first laid hands (or feet, etc.) upon the other; the details of the injury-causing events; the body part(s) injured; and the total number of work days lost. Information came from WCB claim forms, hospital incident report forms, ward reports, and patients' clinical files.

Because there are subtle distinctions involved in some of the study variables, a detailed definition follows. First, it was determined whether the injury that formed the basis of the WCB claim was caused by the application of *restraint* (staff-initiated manual physical control), or *assault* (patient-initiated intentional forceful physical contact). Second, a judgment was made about who touched whom first, using a five-point rating scale where 1 corresponded to a certainty that the first physical contact was by the patient, and 5 to a certainty that it was by staff. The injury details variable referred to which of several events directly produced the injury — direct patient actions (punch, kick, bite, scratch, weapon) or other events (bumping into a door, sprains, muscle strains, one staff member falling upon another, etc.).

Finally, 16 incidents were randomly selected and coded independently by a second rater in order to establish interrater reliability. Similarly, all of the institutional records were examined by a third rater in order to establish agreement as to whether incidents qualified for the study.

Treatment of the Data

Univariate analyses were used to make two primary sets of comparisons. The first involved the incidents in which work days were lost (DL) versus those in which no days were lost (NDL). The second comparison was concerned only with the DL incidents, and related each study variable with total number of days lost. In addition, the correlations among all

study variables were calculated and the results used to select and simplify variables for subsequent multivariate analyses.

The multivariate analyses were conducted in order to assess whether linear combinations of study variables would permit stronger conclusions about which patient-staff altercations are associated with serious injuries to staff. This approach involved considering the study variables in three distinct categories: staff variables (age, sex, years of experience), altercation circumstances (who touched whom first, location, number of staff involved, restraint or not), and incident details (body part, injury details). The dependent measure was the total number of work days lost. For each variable category, the best predictor (largest zero-order correlation) was selected, and the three predictor variables were then entered into a simultaneous regression solution.

The multiple regression analyses were first conducted on the DL data only, and then repeated on the DL and NDL data combined. Finally, because the NDL data were not an exhaustive sample and the DL plus NDL data might thus be biased towards the inclusion of an unrepresentative number of incidents in which work days were lost, a multiple discriminant'analysis was conducted. This was identical to the multiple regression analysis conducted on the DL and NDL data except that the total days lost was coded as 1 for all the DL incidents.

Results

Over the seven-and-a-half-year period, there were 123 staff-patient altercations that resulted in lost working time. The mean number of days lost was 15.76 *(SD = 31.67)*. To put this figure into perspective, it represented approximately 20 percent of all days lost by staff due to on-the-job injuries, and less than 5 percent of the days lost due to sickness.

From a methodological perspective, it was important that our raters were able to reliably classify every incident into one of two mutually exclusive categories — injury due to a patient's assault, or injury due to events that occurred while a patient was being restrained. The number of incidents for each 6-month period and the number of days lost due to incidents that occurred during that period are shown in Figures 4 and 5, respectively.

As may be seen in the figures, the data were highly variable. A simplified time-series analyses of these data (Tryon, 1982) revealed no consistent linear trend in either the number of incidents *(Z = 1.25)*, or days lost *(Z = .593)*.

FIGURE 4
TOTAL INCIDENTS IN WHICH WORK DAYS WERE LOST (CLAIMS)
BY SIX-MONTH TIME INTERVALS

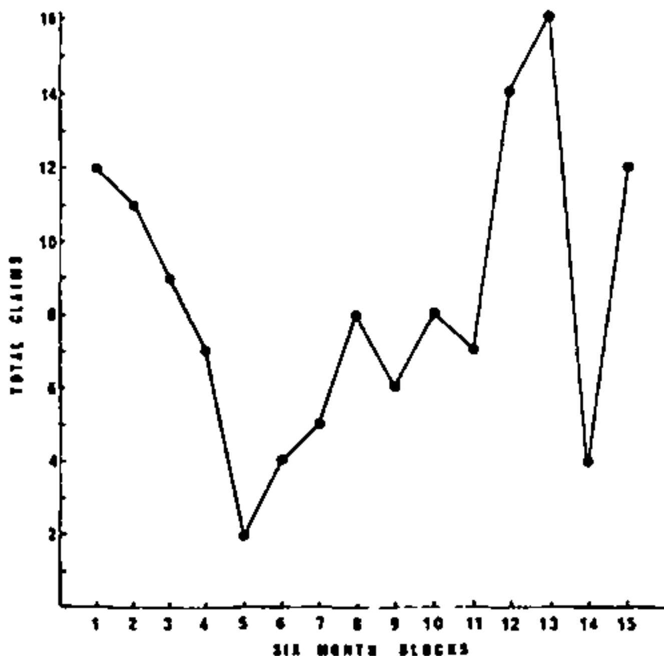
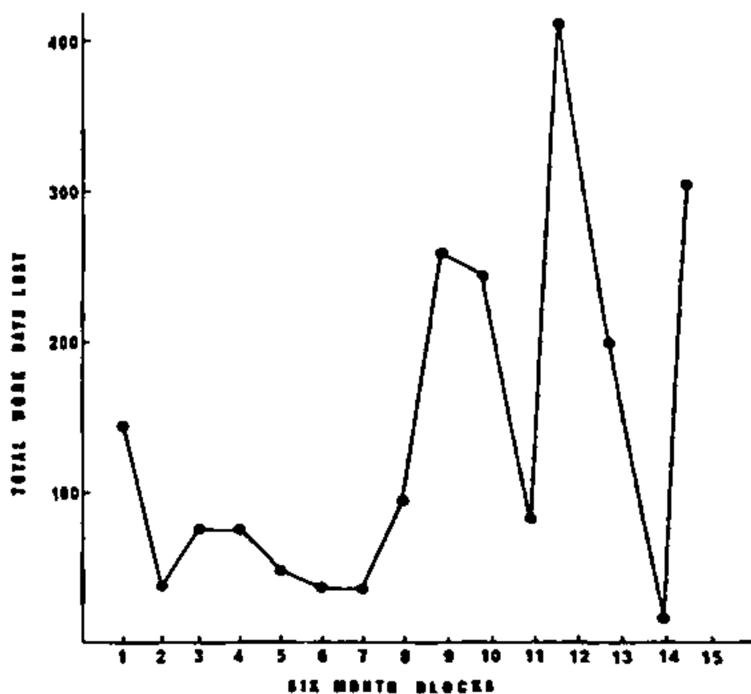


FIGURE 5
TOTAL NUMBER OF WORK DAYS LOST BY THE SIX-MONTH TIME INTERVAL
IN WHICH THE INCIDENT OCCURRED



Reliability of Measures

The results of the reliability checks indicated acceptable interrater reliabilities for all variables. Reliabilities were assessed by means of percent agreement for date, identity of participants, location, time of day, and sexes of staff and patient. Agreement was 94% for time of day and 100% for all others. Pearson product-moment correlations were calculated for staff age ($r = 1.00$), years of experience ($r = 1.00$), number of staff involved ($r = .71$), who touched whom first ($r = .82$), and the total number of work days lost ($r = .87$). The kappa statistic was computed to assess the reliability of the categorical variables: injured body part(s) ($K = 1.00$), incident details ($K = 1.00$) and restraint or not ($K = .74$). Out of the 253 incidents coded, there was only one disagreement as to inclusion criteria.

Univariate Analyses

The results of the univariate analyses are shown in Tables 3 and 4.

Based on preliminary analyses, two of the variables were dichotomized in order to simplify further analyses. For the part of the body injured, the data were categorized into those that involved one or more of the neck, back, knee or shoulder (major joint injuries) and those which involved any other body parts. For injury details, the data were categorized as described above (see Procedure).

As seen in Table 3, staff involved in incidents in which days were lost had more experience than those for whom no days were lost. Male staff were overrepresented in incidents that resulted in lost time, as were male patients ($p < .10$).

More incidents resulting in days lost occurred at the maximum security division than in the less secure regional division.

Restraints were much more likely to result in injuries requiring time off work than were assaultive incidents. Furthermore, incidents that resulted in injuries to major joints were more likely to result in time lost than injuries to other body parts. Finally, incidents in which the injury occurred as a direct result of patient action were less likely to result in lost time than incidents in which the injuries occurred for some other reason.

There were no significant correlations between number of days lost and the age of staff, years of experience of staff, or number of staff involved; although the correlation between years of experience and days lost approached significance ($r = .166, p < .07$).

As shown in Table 4, there were significantly more days lost in incidents in which the staff touched the patient first than in other incidents.

TABLE 3
UNIVARIATE COMPARISONS BETWEEN INCIDENTS IN WHICH WORK DAYS WERE LOST (DL) OR NOT LOST (NDL)

Variable	Type of Incident		Inferential Test	
	DL (n=123)	NDL (n=123)	Statistic*	Significance
Yrs. of Experience	8.32 (6.09)†	6.35 (5.32)†	$t = 2.04$	$p < .05$
Sex of Staff (% male)	95	85	$\chi^2 = 6.73$	$p < .01$
Sex of Patient (% male)	94	88	$\chi^2 = 2.72$	$p < .10$
Location (% maximum security)	76	60	$\chi^2 = 8.53$	$p < .005$
No. of staff involved	2.98 (1.69)†	2.82 (1.47)†	$t = .74$	ns
Who Touched Whom? (% staff touched first)	47	58	$\chi^2 = .89$	ns
Restraint vs Assault (% restraint)	66	32	$\chi^2 = 30.40$	$p < .001$
Body Part Injured (% back, neck, knee or shoulder)	38	25	$\chi^2 = 4.05$	$p < .05$
Incident Details (% direct pt. action)	44	68	$\chi^2 = 14.52$	$p < .001$

** for all t, df > 100* † *Standard deviation*

TABLE 4
MEAN NUMBER OF WORK DAYS LOST

Variable	M	SD	t*	p (2-tailed)
Location:				
Maximum Security	15.48	29.45	.09	ns
Lesser Security	16.10	36.99		
Who touched whom first:				
Staff	21.93	42.12	2.43	< .02
Patient	6.48	8.39		
Injury directly due to:				
Restraint	19.14	36.85	2.01	< .05
Assault	7.93	12.59		
Injury to:				
Neck, back, knee or shoulder	23.44	47.34	2.11	< .04
Any other body part(s)	11.18	14.86		
Injury caused by:				
Direct patient action	7.63	10.83	2.49	< .02
Other event	21.28	39.52		

** All df >100*

Finally, in order to examine how staff actions could be predicted by other variables, two subsidiary analyses were conducted. In each case, only the data in which work days were lost were considered. However, the number of days lost was considered a predictor variable in the incident details set. The first analysis considered the variable of whether the injury was due to a restraint or not as the criterion variable in a hierarchical analysis directly analogous to those already described. In the second, the who-touched-whom-first variable became the criterion. The results indicated that sex of staff, who touched whom first, and the injury details (direct patient action or not) significantly discriminated incidents in which injuries occurred as a result of restraint from those in which they resulted from assault (Multiple R = .719, Regression Anova $F(3,97) = 34.648, p < .0001$). Thus, injuries caused by patient assault were associated with female staff who were injured by direct patient action where the patient touched the staff member first. Similarly, using years of experience, whether the injury was due to a restraint or not, and injury details, incidents in which the staff touched the patient first could be significantly discriminated from those in which the patient touched the staff first (Multiple R = .740 and Regression Anova $F(3,97) = 39.112, p < .0001$).

In summary, the multiple regression analyses showed that linear combinations of study variables could account for significant amounts of variance in the number of days lost. However, the total amount of variance explained was relatively small.

Discussion

The most significant finding of the present study was that, compared to assaults, restraint situations more often led to days being lost by staff and resulted in more serious injury (as measured by greater numbers of days lost) when they did. This finding suggests that in many of the previous studies of violence in psychiatric hospitals, many of the most serious incidents have been overlooked. Of course, as Lion et al. (1981) have suggested, many assaults on staff occur during the process of restraining patients. However, our data suggest that the injuries that occur at these times are similar to those that occur during other assaults, and tend to be relatively minor. The most significant injuries incurred by staff come about as a direct result of the restraint procedure —falls, sprains, strains, etc., rather than of patients' actions. While assaults usually result in injuries to other parts of the body, restraints most often result in back injuries or injuries to major joints such as the neck, shoulder, or knee.

The finding that restraint situations are more dangerous than assault situations for staff has a number of important implications. The most

obvious have to do with staff training. Staff need to be made aware that any time they restrain a patient they are putting themselves (not to mention the patient) at risk of receiving a serious injury. If they were more aware of the risk of restraint, they might be able to find less drastic measures of intervention in some cases. For example, at the maximum security division of our institution, staff previously often felt obliged to go into a patient's room and restrain him in order to take him out for a shower or shave. Now, however, they very rarely do so; rather, they wait until the patient decides to come out willingly.

Soloff (1983) has argued that "seclusion and restraint may abort imminent physical assault" (p. 247), and states that their use is indicated for psychiatric patients when they exhibit poor impulse control, progressive psychomotor agitation, or other disruptive behavior whether violent or not. Our data would suggest that restraint should be used only in cases where staff have good reason to believe that a patient will act in a serious violent fashion unless they intervene. In fact, our results suggest that it may be less dangerous to use only verbal interventions until an assault occurs rather than to intervene physically, because the number of restraint episodes would necessarily be fewer. Much of the violence by patients in a psychiatric hospital setting may be iatrogenic in the sense that it is the restraint procedure itself that seems to provoke the violence — over a third of the assaults occurred while (and perhaps because) the patient was being restrained. Because restraints present such a high risk of injury to staff and patients, the staff training program described in this book emphasizes the use of defusing techniques designed to talk down highly upset patients and thus avoid the necessity of restraint.

Another obvious target for staff training is the restraint procedure itself. For example, we observed that in many areas of our hospital, staff used a restraint procedure that involved holding the patient down on the floor. However, after trying out different methods, we found that for many situations a technique used by Oak Ridge staff which involved restraining the patient against a wall was a much safer procedure because it did not involve getting the patient (and staff) down to the floor and later back up. Safer methods of restraint are now taught as a routine part of the course described in this book. Nigrosh (1983) has argued that training staff in physical contact skills (including a large component of learning when and when not to use them) should be compulsory, and that standardized training should be developed along the lines of Cardio-pulmonary Resuscitation training which is currently required of a wide variety of staff in health care settings.

Another interesting set of findings of the present study had to do with sex differences. Compared to incidents in which no days were lost,

incidents that resulted in lost time were more likely to involve males. In fact, only five and six percent respectively of incidents involving lost time involved female staff and female patients, despite the fact that women accounted for approximately 30 percent of the staff and 16 percent of the total patient population. Part of the explanation for this finding has to do with the fact that all patients and virtually all staff in the maximum security division, where the majority of the incidents occurred, were male. However, this cannot account for all of the effect. A likely interpretation is that male staff are more likely to initiate restraints, and are more likely to be sought to participate when restraints are being planned. Female patients are less likely to require restraint than males, and when they do their restraints were less likely to result in days lost for the staff.

Contrary to our expectations, more experienced staff were more likely to lose time in incidents than less experienced staff. Of course, more experienced staff tend to be older; however, the relationship was stronger than simply that between age and time lost. Perhaps experienced staff were more likely to intervene, or to be called to intervene when incidents were perceived as potentially more serious. Alternatively, they might be more willing to touch the patient first and less willing to talk an agitated patient down (thus risking assault) than less experienced staff.

Not surprisingly, incidents that occurred in the maximum security division were more likely to result in days lost than incidents in other divisions. However, of incidents that did result in lost days, no more days were lost in the former setting. This finding suggests that staff in the maximum security division are more often involved in incidents that result in days lost not only because the incidents are more serious, but also because they are more likely than are staff in other areas of the hospital.to touch patients first rather than wait for patients to initiate the incident

The results of the multivariate analyses showed that a significant amount of variance in the number of days lost could be accounted for by the staff member's years of experience, whether the injury occurred during restraint, and whether the injury was caused by direct patient action. However, although significant, this amount was relatively small, which indicates that factors *not* considered in the present study account for much of the remaining variance. One possibility that immediately comes to mind is staff morale. It is quite likely that when a staff member's morale is low, he or she is not motivated to hurry back to work after being injured on the job. If this is a contributing factor, we might also predict that the use of sick time (also known to be related to staff morale) would also be correlated with time lost due to on-the-job injuries. Future studies might profitably include such measures in order to improve the predictability of time lost from work due to staff-patient altercations.

Chapter 3

Examples of Violent Incidents

In this chapter we present several examples of assaultive incidents, all but the last three of which occurred at the Mental Health Centre in Penetanguishene. The details of these assaults were gathered by reviewing the patients' files, reading the incident reports and worker's compensation claims forms, and, whenever possible, interviewing the staff and/or patients involved. In the last two cases, the incidents involved staff deaths and had been extensively documented in subsequent investigations. The names of patients have been changed to protect anonymity, but no other details have been altered.

It must be emphasized that the cases presented here are *not* a random sample. Rather, they were selected because they stood out in the authors' minds as being among the most dramatic of those occurring over the past fifteen years or so. Many were chosen because they provide good examples of things that can go wrong. In the normal course of events, such disasters rarely occur even when a situation is poorly handled.

Each incident is accompanied by our comments about how it was handled. We present these comments with hesitation because, of course, it is always easier to detect errors after the outcome of an incident is known, and we cannot say with certainty that we would have followed our own advice had we been the ones faced with the actual situations. Consequently, we have tried to restrict our analyses to what we perceive to be the most important aspects of what transpired. As a general observation, it is remarkable how often staff grossly overestimate their own ability to safely resolve an incident through physical means.

Reviews of incidents such as those described here, combined with the results of the research studies and literature review presented in the earlier chapters, have brought us to the view that reductions in institutional

violenceand staff and patient injuries could be achieved by changing the ways in which staff interact with patients. This perspective is what led to the design of the staff training course described in the latter half of this book.

Example One

Peter was referred to the institution's medium security ward from a local general hospital, where he had been admitted after taking a serious overdose of anticonvulsant medication. His suicide attempt had been related to the breakup of his relationship with his common-law wife. Peter was a large, muscular young man with many tattoos, whose interpersonal style was marked by tough talking and anger about being in hospital. He was also noted to have a serious alcohol abuse problem. It was clear that he was indeed depressed about not being able to go home to his family.

Ward staff noted Peter to be occasionally irritable; nevertheless, he gradually acquired privileges such as shopping trips and day passes. On one trip he bought an explosive device which he placed in another patient's cigarette. On another, against the terms of his pass he went to a local bar and began drinking, and while there encountered his group therapist who scolded him for breaking the terms of his contract and letting everyone on the ward down. At eight-thirty that evening Peter returned to the ward bringing a bottle of beer with him, and sat in the lounge drinking it. Upon demands that he surrender the bottle, he smashed it against the side of a table and brandished the broken remainder, shouting and threatening to stab anyone who approached him. Staff members cleared other patients from the area and stood nearby out of reach, managing to prevent the incident from escalating by talking to him.

Meanwhile, a call for assistance was made to both the police and to the nearby maximum security division, where six attendants were called together and told to proceed to the medium security ward to deal with a "patient with a beer bottle." They were instructed to take along a plexiglass shield, but received no other information or instructions. Because it was the only transportation available, they travelled the short distance to the medium-security building in a flatbed truck, which they found amusing. There they were met by a local police officer who had not yet been to the ward and could not tell them any more about what was happening. Riding up together in the elevator, the staff were nervous and excited and did not discuss what they would do when they arrived.

Ward staff at the lounge scene were meanwhile engaged in defusing the situation, but they could not control access to the area because of the many doors, stairways, etc. that opened onto it. By all accounts, the

incident was prolonged because Peter witnessed the activity associated with the arrival of the reinforcement staff and police. The elevator doors opened, and when the maximum security staff member with the shield saw Peter in a corner holding the bottle, he immediately charged him, followed by the others. The patient was pushed backwards by the shield, all six attendants attempted to grab him, and in the melee everyone fell to the floor. One staff member was struck by the bottle and another injured his elbow on the floor: each lost three days' work as a result.

Peter was disarmed, bound with material restraints, administered a sedative injection, and taken, restrained lying down on the flatbed truck, to the maximum security division where his legal documentation was changed from informal to involuntary. After two days during which he was noted to be quiet and cooperative, he was returned to his original ward. On arrival, his physician informed him that his status was being changed back to informal and that he would be discharged immediately. He was told he would receive $20 and a bus ticket to the city.

While preparing to leave, Peter told the ward staff that he wanted to stay and work on his problems. This was arranged, and he stayed for approximately two more weeks. Then, as a result of the incident, he was charged by the local police with assault and possession of a dangerous weapon, and was discharged to their custody.

Comments: There are many points to consider in this example. The first is whether it was wise for the patient's group therapist to have scolded him at the time for drinking in a bar. Perhaps a more prudent course of action would have been to have waited and discussed the incident at the next group therapy session when the patient was sober. Similarly, the staff who found him drinking a beer back on the ward might have considered allowing him to finish it and imposing sanctions later. Demanding of an upset person that he surrender a half-consumed drink is a high-risk situation, and it is likely that all Peter intended to do was finish his one bottle before he retired for the evening.

After Peter had broken the bottle and threatened to use it, staff had a very difficult situation to deal with. However, they skillfully removed other patients from the vicinity and contained the incident by talking to him. This seemed to be working, and had the attendants who were called in from the maximum security division taken time to notice this before they intervened, there may have been no injuries. Later, they said they didn't feel they should have been called in the first place because there was already sufficient staff on hand to handle it. They also ought to have been given more information about the incident in progress, both at the time of the call and when they arrived at the building. Because they knew

so little, they were unable to make a plan about how to handle it. Of course, when they arrived on the ward they ought to have observed the scene for a few moments before rushing on the patient.

Because the patient involved was in the hospital voluntarily, the staff had no special legal authority to restrain him. They did, however, have the same legal rights that any citizens have to use force if necessary to stop or prevent an act of violence. It therefore was probably a prudent decision to call the police as witnesses, in the event that the patient later charged the staff with assault.

Finally, it is ironic that after the incident staff members were prepared to discharge him to the street, while at the same time encouraging the police to charge him for the offense.

Example Two

Tom was admitted to the maximum security division after being found not guilty by reason of insanity on a charge of murder and diagnosed as schizophrenic. His first two years there were marked by considerable difficulty, including problems in participating in group therapy programs because of such serious psychotic symptoms as hallucinations. From the start, he requested that he go to jail rather than participate in programs. He received a variety of neuroleptic drugs, and was often confined for noncompliant or disruptive behavior. It was clear to everyone that Tom was deeply unhappy. He was eventually transferred to a different unit with token economy programs where group therapy was not emphasized, but his early adjustment to the new ward showed no improvement. Several times, he escaped in vain attempts to return to his old ward.

After several months Tom succeeded in earning a transfer to a less secure, higher privilege ward and obtained a paying job in a contract workshop. However, he was still very unhappy. He asked that he be permitted to have a guitar, for example, but was told that it was impossible — although even prisoners in penitentiary are permitted to have musical instruments. Around this time he began to express reluctance to attend work, and for several days was confined instead. After each period of confinement, he would agree to work again.

On the last occasion, while in the workshop he used a knife to slash a co-patient across the face in a completely unprovoked attack — his first act of violence in his two year stay. He was immediately restrained and disarmed by staff without a struggle and placed in confinement. Interviewed afterward, Tom said that he had committed the assault in

the hope that if he committed a serious criminal offense he would be sent to prison. He was told that this was an impossibility.

After the attack, his privileges were gradually increased again and he received increasing freedom on the high security ward where he now lived. However, he wrote many letters to the Queen, the Prime Minister, and the Chairman of the Review Board, begging to go to prison. One evening, about four months after the last assault, without any warning he bludgeoned a co-patient on the head from behind with a heavy scrub brush. As before he was restrained and disarmed without resistance, and again stated that his goal was to get to prison by committing a serious crime. Again, he was assured that this would not happen. By now, all staff were very wary of Tom. Most felt that although he may not have been voicing it, he would attempt other serious unprovoked assaults.

Two years passed before there was much relaxation of the heavy security precautions imposed on him, and throughout this period he continued to express the desire to go to prison and to write many letters toward that end. He remained very unhappy and obviously felt trapped: the security precautions meant that his life was severely restricted, with very few opportunities for interesting activities or interpersonal interaction. Eventually the restrictions were gradually relaxed, but one day he brutally attacked another patient with a baseball bat during a game. Just as on the other occasions, he was restrained and disarmed without resistance and stated that he had committed the assault in order to get to prison.

Three years later, Tom has once again earned considerable relaxation of the security precautions that were imposed after the third attack. Changes to the programs have permitted him to earn access to a guitar, for example. However, he remains one of the patients about whom institutional staff are most concerned.

Comments: The patient in this example was an excellent guitar player, and being able to play his instrument was very important to him. It is difficult to see how allowing him supervised access to his guitar would have represented a serious security risk, and it is quite possible that had the staff done so, none of the assaultive incidents would have occurred. Once he was told that it would be impossible for him to have the guitar in his current institution, a vicious circle began in which he assaulted someone in order to be sent to prison, and the fact that he would do such a thing only strengthened the opinions of staff members that he was dangerous and mentally ill and should be further restricted in his privileges.

Example Three

Jack was admitted to the maximum security division after being found not guilty by reason of insanity for murder. He was diagnosed as suffering from paranoid schizophrenia. During the first few years of his stay he was regarded as a "good" patient: he was usually a reliable worker, was compliant with the instructions of ward staff, and was never in a fight. However, he acted very "crazy," frequently asserting that he was a "king of kings," that he had animals in his stomach, and that hospital staff had secret papers about him. Nevertheless, he eventually earned a transfer to the highest privilege, lowest security ward.

Over a period of months, staff became increasingly dissatisfied with Jack's performance, reporting him as showing poor personal hygiene and poor motivation in the contract workshop. They had him transferred to a more secure, token economy unit, but he quickly earned a transfer back to the maximum privilege ward. Immediately thereafter the staff noted that he had returned to being "dirty and lazy." They began a practice of calling him back to clean his room, with little positive result. Throughout this period, Jack frequently told people that he was the "King of Canada" and complained of a variety of impossible somatic ailments. A cyclic pattern continued for almost a year of his being sent to a more secure ward and quickly obtaining a transfer back. It was clear that the staff on Jack's home ward were completely frustrated in their attempts to get him to be a "good" patient, and felt that the token economy programs on the other units were making no lasting impact on his behavior.

One day Jack was called back to the ward from the shop and asked to provide a routine blood sample, which he refused. The staff member in charge told him to go to his room. As he went, a nearby attendant made a remark, intended to be humorous, the gist of which was that Jack could now spend some time cleaning his messy room.

Jack picked up the cleaner's broom and started jumping up and down. He turned around and started yelling "You monkeys have no right to keep me here," and attempted to punch the attendant, who backed up and pressed the alarm button. Jack then attempted to strike the staff member in charge and, after missing him with the push broom, turned around and hit the first attendant, causing the end of the broom to come off. He continued to hit him with the handle until it broke into smaller pieces, then tried to stab him in the face with the broken end, causing a cut and scratches. The attendant managed to grab Jack's hands and flipped him over his shoulder to the floor, at which point Jack attempted to bite him. More staff responded and helped restrain the patient.

Jack was immediately transferred to a high security, low privilege ward. Despite many provocations there (such as being assaulted by co-patients), he has never committed another assault. Nevertheless, several years later, he still has special security precautions placed upon him.

Comments: In this example, the staff on the maximum privilege ward were frustrated with the patient because, although he kept earning his way to their ward when in a strict behavioral program, he did not conform to their idea of a "good" patient once he got there. Mostly they were upset that he was unkempt and his room was constantly messy. Rather than institute a well-thought-out program to help him with this, they instead inconsistently called him back from work to clean his room. This only irritated the patient, and was so erratically applied that it had no positive effect.

When he was asked to provide the blood sample the patient at first believed that he had been called back yet again to tidy up his room, and when he refused the sample, which was within his rights, he was sent to his room anyway. The staff member who was attacked unwittingly provoked the attack by joking with the patient, who by this time was quite upset. This incident provides a good example of the risk involved in using humor with a patient in this condition.

Another point of interest regarding this example concerns the ease with which everyday objects can be turned into very effective weapons. A broom happened to be nearby, and the handle made a dangerous weapon that became even more dangerous once the brush came off and the end became splintered.

A final aspect that deserves comment is that the staff member in charge at the time saw the entire incident, but apparently never intervened. Instead, he "froze" and stood by helplessly. It seems that even experienced maximum security workers who have been trained to expect occasional acts of violence cannot always be counted on to be able to help in an emergency. Thus, it is extremely important that staff do everything in their power to avoid physical incidents even when they think there are sufficient co-workers on hand to assist.

Example Four

Bruce was admitted to the maximum security division from a federal penitentiary where he had been serving a seven-year sentence for robbery with a firearm. For someone only 24 years old, he had a long criminal history of property offenses. The prison physician had thought he was suffering from a "serious mental disturbance" because in prison he had

become withdrawn, staying in his cell pacing back and forth, fasting and exercising, and refusing to take antipsychotic medication.

Psychological testing revealed average intellect and no abnormality, but upon psychiatric examination he was diagnosed as suffering from both an antisocial personality disorder and a schizoaffective disorder. On the admission ward, he at first refused to answer routine questions and to attend groups "on grounds that it may incriminate me." He remained quiet and cooperative, however, and eventually began to attend groups, though his participation was minimal. In the only conversation with his physician, he insisted he was not mentally ill and declined psychiatric medication. Because he was quiet and volunteered for cleaning jobs, ward staff soon regarded him as not representing any management problem.

Eleven days after his admission, while attending a group Bruce suddenly grabbed the patient sitting next to him in a head lock and held a piece of sharpened arborite to his neck, saying he wanted to return to prison. The attendant present immediately shouted, "Staff up!" for help, and the ward supervisor and another attendant who were observing a group in the next room came hurrying over. When they arrived in the open doorway, they saw that Bruce had a co-patient in a head lock but did not notice his weapon, nor had they heard him say anything. The supervisor immediately instructed the other attendant to "grab his left arm," and both men moved forward in an attempt to restrain Bruce. At that point another patient warned them about the arborite, and the staff realized they would have to disarm him. However, it was too late: as they had moved toward him Bruce thrust the weapon towards his hostage's throat. The arborite snapped in two, and the hostage received only a minor cut on the cheek. Bruce was then restrained, and his victim wriggled free and ran out of the room and all the way to the end of the ward where another attendant stopped him. The hostage was extremely upset and said he felt very frightened and unsafe.

Meanwhile, Bruce was placed in confinement. Over the next 24 hours he screamed, kicked his door, and attempted to chip a hole in the wall of the seclusion room. On one occasion, ward staff successfully talked him into peacefully leaving his room to receive a sedative injection. During the second day, Bruce was quiet and slept most of the time.

Two days after the hostage incident, Bruce was taken back to prison under sedation and in mechanical restraints.

Comments: This incident again exemplifies the dangers involved in acting before carefully observing what is happening. The staff who were called to the scene failed to observe that the aggressor had a weapon held to his victim's throat, and when they rushed him he attempted to use it. It

was only through luck that the weapon broke and did no serious damage.This incident, like the previous one, again illustrates the ease with which a determined patient can find an object to use as a weapon, even in a maximum security environment.

Another sad aspect concerns the fact that the hostage-taker ended up getting exactly what he demanded (i.e., going back to prison) as a direct result of the incident, in spite of the fact that it verified the prison physician's opinion that he suffered from a serious mental disturbance.

Finally, as in the previous example, one of the staff members present (the first one to witness the incident) apparently "froze" and was unable to help out.

Example Five

Ivan had been transferred to Oak Ridge as an involuntary patient because less secure institutions had been unable to control his violent outbursts. He had been variously diagnosed as suffering from an immature personality, a sexual deviation, and an organic brain syndrome, but was not guilty of any serious criminal charges, nor was he facing any court appearance.

Ivan came from what appeared to be an enviable family setting, being the only child of a father who was a successful physician and a mother who had stayed at home to raise him. But his childhood included a series of problems, escalating from early tantrums to destructive rages that culminated in his institutionalization at the age of eight. During interviews with health care staff in later years, Ivan would recall vague memories of sexually provocative encounters with his mother in the bedroom and fearful, violent episodes with his father.

As an involuntary patient Ivan had the right to have his case annually reviewed by an external board, which has the power to grant immediate discharge if board members believe that an individual does not require hospitalization. Since Ivan did not want to be in Oak Ridge and hospital authorities refused to release him, he asked to see the review board. On the afternoon of his hearing, Ivan was sitting in the hallway outside the room where it was to take place, waiting to be called in. He was escorted by an elderly male attendant who had just returned to work after an extended illness, and who did not know Ivan because he worked on a different ward. This part of the hospital was unfamiliar to both men, and two locked doors separated them from other attendant staff.

This hallway was often used by professional staff whose offices branched off it, and as Ivan sat there a young and attractive female social worker walked by. Ivan told the attendant that he was going to get a drink

from the fountain down the hall, and followed her. Just as she turned into her office, he grabbed her from behind and began to fondle her. Two elderly women who shared the office area called out for him to stop, but their route to the alarm button was blocked. The escorting attendant managed to find an alarm button and then ran over and began to wrestle with Ivan, assisted by a male professional staff member who had heard the commotion and also came running in response.

Ivan settled down quickly and went passively with the two staff back to the ward. They were met there by a large group of attendants who had responded to the alarm but had not been able to get through the locked doors.

Comments: There were several problems with the way this incident was handled. First, because patients' appearances at review board hearings are usually quite important to them, staff expect that patients will be on their best behavior. Because of this, only one staff member had been assigned as an escort. Even worse in this case, that one staff member neither knew the patient nor was he in good physical condition to intervene in case of a physical altercation.

Second, the physical set-up was poorly designed. A busy hallway is a poor location to have patients wait their turn: the ward would have been a much safer place.

Third, when the incident was in progress, the attendant had to spend some time searching for an alarm button. When he finally found it, other staff responded but couldn't get through the two locked doors to come and help because the ward supervisor, who happened to be absent at the time, had the key.

Finally, this patient had a history of assaulting women in institutions. If the attendant who had accompanied him had known that, extra precautions might have been taken when he was in an area with many females.

As a direct result of this incident, two staff are now assigned to accompany all patients to review board hearings.

Example Six

Karl arrived seeking admission in the emergency room of a general hospital. Six feet two inches tall, weighing over 200 pounds, and with a muscular frame, he intimidated the nurses on duty with his agitated, and aggressive behavior. The doctor on call felt that he was a more appropriate admission to the Mental Health Centre, and arrangements were quickly made to take him there. Karl was admitted to a low-security unit of the hospital around 2:15 in the morning. Very little information

arrived with him other than reports that he was an alcoholic, possibly diabetic, and had been on heart medication but had stopped taking it two months ago.

Because of the patient's agitated state, a bed was arranged for him in a corridor area behind the nursing station where he could be kept under close observation. The unit was staffed at that time with three female and one male nursing staff.

After admission, the patient remained highly agitated and threatening. In the next hour he stripped naked, threw his mattress at staff, and trapped one of the female nurses in his room. Phone calls were made to adjacent units for back-ups, and a search made for the duty doctor to prescribe sedative medication.

The first staff member to respond to the call was a male nurse who was also an instructor with the Controlling Assaultive Behavior Course. He quickly reviewed Karl's history with the nurse in charge, and then went to the observation room and introduced himself. His goal was to calm the patient down, get him dressed, and walk him over to a more secure room. Karl would not be calmed however: he spoke loudly about "sailing around the world in seven days," often appeared to be praying, and shouted that he was ready "to take everyone on." At one point the nurse placed his hand lightly on Karl's shoulder to encourage him to leave the room, but Karl responded by striking out with his fist.

Approximately five minutes later two more male staff arrived on the scene, and all three talked to Karl about going quietly to another room. Just then an order was received from the duty doctor for restraint and medication. Although the staff were in a position to begin restraint they continued talking instead; however, Karl attempted to strike one of them so they finally moved in. After a brief struggle that caused no apparent injuries, the patient was placed face-down on the floor. At that point the staff member who was holding Karl's head heard him say "I'm choking, I'm choking," in a soft voice. No obstructions to his breathing could be observed and he seemed to settle down, but shortly after he appeared cyanotic. They immediately rolled him over and a registered nurse began CPR. An emergency call was sounded, and within five minutes the duty doctor arrived and pronounced the patient dead.

Comments: Despite its tragic ending, this incident was deemed to have been handled as competently as possible by those involved. Inquest findings absolved the staff of responsibility for Karl's death. It was determined that they had done everything within their power to prevent a physical altercation, and when the patient turned it into one anyway,

they had used only the minimal force necessary. This example emphasizes how unexpected things can happen, and the importance of staff always following proper procedure so that if something does go wrong they they will not automatically be assumed to be at fault.

Example Seven

One weekday evening a group of patients was watching television in the lounge area of a medium-security unit of the hospital. They complained to the afternoon staff on duty that their 11:00 p.m. curfew meant they couldn't watch the news, which ended at 11:20. The staff agreed to a compromise, saying that for tonight they could stay in the lounge until 11:20, and informed the incoming night shift — three female nurses — of this understanding before going home.

At 11:20 p.m. the patients were still up. When the nurses reminded them of their agreement several went to bed, but a group of five males in their late teens and early twenties refused to leave, saying they were going to stay up to watch a movie. The nurses were adamant that they should go to bed, and the patients were adamant that they wouldn't. To the accompaniment of jeers and catcalls, the staff withdrew to the nursing station to decide what to do. The nursing shift supervisor was called, but when she arrived the noise level only went up. Any displays of authority were met with derision, and attempts to turn off the television set were blocked. The young men refused to be separated from each other, and the mood became one of frustration for the nurses and belligerence from the patients. Male nursing staff were called in from other units, and their arrival on the ward produced a challenging, aggressive atmosphere. Whenever staff members approached the group the patients threatened to lay assault charges should any of them be touched; if they withdrew, they were mocked. For the next three hours, the staff considered a number of interventions from turning off the electricity to bringing down a team of Oak Ridge attendants who would physically restrain the whole group. Shortly after 3:00 a.m., the patients went to bed on their own accord.

When the unit director was told of the incident the next morning, he made immediate arrangements for those patients who were court remands to return to the legal system, and for those who could be released to the street to be discharged. This incident produced a great deal of lingering frustration in the staff, who felt they had been abused by the patients but had had no options to deal with it. Over the next several years, role plays of this situation (i.e., as course exercises; these are described further in Section II) inevitably ended up either with the group of "staff" wading

in to physically restrain the "patients," or at an impasse, with "staff" feeling helpless and frustrated and "patients" feeling powerful and provocative.

Comments: With this particular incident, one wonders about the atmosphere on the ward in the preceding days. Were there signs that these five patients were forming a dangerous clique? Second, although the official rule was that bedtime was 11:00 p.m., it may not always have been enforced. It seems unfair to the evening shift that the afternoon shift gave the patients permission to stay up past 11:00 when they weren't the ones who would be around at that time. Furthermore, by being acceded to on this one point, the patients had been given the idea that they might be able to get away with other rule violations.

The staff did manage to have the incident end peacefully and it is hard here to recommend that they should have done anything differently. However, it was extremely unpleasant for them and they had had to put up with a lot of abuse. They ended up feeling unhappy, saying that they felt frustrated that the patients got away with it (even though several were discharged). This is a good example of the kind of stress that can result from working with difficult patients. Even when an incident is prevented from becoming physical through the use of verbal interventions, staff members can end up feeling abused and frustrated and require much support afterwards to help their morale.

One wonders about what would have happened if the nurses had attempted to resolve matters quickly by, for example, turning off the electricity. While it may have worked, it is also possible that it would have provoked the patients to physically assault them.

Example Eight

Tim had been held in Oak Ridge for 15 years after having been found not guilty by reason of insanity on a charge of murdering a fellow prisoner while in jail. His primary diagnosis was personality disorder, antisocial, but otherwise he was an intelligent high-functioning man in excellent physical condition. His pre-hospitalization record had included several assaults, while his institutional history included several assaults on other patients. There had been no violent episodes in the two years immediately preceding the present incident; however, because of his frequent hostile and belligerent behavior, Tim was considered to be a management risk and was assigned to a special handling program that clearly outlined his rights and responsibilities, as well as the sanctions that would be applied to inappropriate behavior.

One day Tim's clinical team decided that he was to be put on low privilege status, and gave instructions to the ward staff to remove his possessions from his room. This included a computer that he was particularly fond of, and Tim requested to be allowed to pack it away for storage himself. Ward staff agreed and he went down to the storage room to get a box. While there, he took a lot of time to empty out a box of clothes. Eventually the attendants who were watching this became frustrated, and said that his time was up and they would take care of things. Tim unexpectedly lashed out at the nearest staff member, striking him hard in the face, and then attacked a second one who was standing nearby. Two more staff arrived, and all four restrained Tim and returned him to his room.

Later that day one of the assaulted staff members went to the general hospital for x-rays and reported the incident to police, who after an initial investigation charged Tim with common assault. In the following weeks Tim laid a countercharge against his accuser, and arranged for a legal-aid lawyer to plead not guilty to his own charges. The staff member received encouragement from the police to drop the proceedings, but co-workers encouraged him to proceed.

Several months later, as the court date approached, Tim dropped his countercharges and, on the day of his court appearance he unexpectedly changed his plea to guilty with an explanation. The staff member later felt that Tim did this so he could tell the court his own side of the story and at the same time prevent him (the staff member) from testifying. Tim was found guilty and sentenced to one day, which was decided to have already been spent.

The staff member reports that he and Tim had reconciled even as the court case was proceeding, and that the verdict did not impair their relationship. Hospital administrators considered assigning him to work on another ward to prevent further conflict, but he successfully argued against this.

Comments: This incident provides another example of the danger involved in imposing sanctions on an upset patient. No details were available about exactly what was said, but the staff were no doubt frustrated by the inordinate amount of time the patient was taking to unpack the box, and it is quite likely that when they told him his time was up they did so impulsively and without giving too much thought as to what to say or for their own physical safety. Although Tim had not been violent in the recent past, his extensive and serious assault history was something that should have been kept in mind when reprimanding him.

The staff member who had proceeded with the charges was pleased afterwards that he had done so. Even though his assailant received a very minor sentence, he was satisfied that he hadn't gotten away with it entirely, inasmuch as the conviction was on his record.

Example Nine

Bob, age 32, had been a patient at the Mental Health Centre for several years and had spent virtually all of his life in institutions. A large, strong man, he was diagnosed as mentally retarded with a secondary diagnosis of schizophrenia. No one had ever reported him to exhibit any of the classic signs of schizophrenia (or any other psychotic disorder), but he nevertheless received large doses of neuroleptic drugs every day.

Bob's behavior showed an interesting cyclical pattern. At times he would behave extremely well, and staff would report that he was pleasant, cooperative and fairly calm and quiet. Later however they would report that he was demanding more and more of their time and attention, mostly seeking reassurance and approval. Ward notes show that these demands would become persistent and annoying, and Bob would then be ignored and avoided as much as possible. Under such circumstances calmness and cooperativeness could earn no staff approval, and Bob's behavior would become more and more agitated, noncompliant, and irritable. Then, staff would attempt to intervene in an attempt to help him calm down and relax. Unfortunately, such interventions were very slow to work (sometimes requiring an hour or more) and, if anything, seemed to increase the frequency of such upsets.

Months before the incident described below, Bob was noted to be doing well; cooperative and pleasant with a high standing in the ward program. Over the next several weeks this deteriorated, with the usual slow, steady increase in bothersome "attention-seeking" behavior, agitation and noncompliance. One night, he began yelling that someone had stolen his tobacco. Staff administered a sedative injection, but on returning to his room Bob threatened to bang his head and then did so, causing a small abrasion. A nurse was called to dress the wound, and ward staff remained with Bob, talking to him and encouraging him to calm down. He did so, but over the next several days his behavior became even worse and he received almost daily medication. Suddenly he improved dramatically and was reported to be friendly, cooperative and quiet for two weeks — then, just as suddenly, again became loud, demanding and noncompliant. A few days later, he locked himself into another patient's room and threatened to beat up the occupant. Staff entered the room and restrained him, with four members receiving minor injuries in the process, and placed

him in seclusion where he remained for three days. He was apologetic when released, but his loud, demanding behavior continued as before. In addition, he began to experience a series of minor injuries and medical problems — a burnt finger, a bite inflicted by another patient, some hair inexplicably pulled out, a sore throat, diarrhea. Each required at least one visit by a nurse and another by the physician, and some required several return visits for dressing changes, etc. He also began a weight reducing diet.

On the evening of the incident, Bob had demanded his regular tobacco ration and when staff told him he would have to wait he became extremely angry and began to threaten them. He went straight to his room, closed the door and barricaded it with his bed, and started a small fire with some scraps of paper in a styrofoam cup. When staff gathered outside his door, he climbed onto the window sill and screamed that he would jump head-first onto the floor if they came in. They entered quickly and Bob did dive to the floor, landing on his head. Staff attempted to restrain him, but before they could do so he lashed out with a sharp pork chop bone that he had saved from supper, slashing one attendant across the face and leaving an eight inch cut that narrowly missed the right eye. This attendant also received other cuts and bruises, and later experienced headache and blurred vision although he lost no time from work. A second attendant whose arm was bruised in the struggle lost five days. Bob himself received several cuts to his head and was hospitalized overnight. Following this, he was placed on constant observation for several days as a precaution against a more serious head injury. Through this period he was noted to be very subdued and passive and presented no further management problem for several days thereafter.

Comments: This example provides many illustrations of the trap that staff often fall into with highly institutionalized patients. It often seemed as though the only way the patient could get attention was by misbehaving, and then he frequently was given sedatives and medical attention with very little verbal intervention. When he was compliant and socially appropriate, he obtained little staff attention.

In the incident in question, there seems to have been little justification for entering the patient's room. The fire had been lit only for attention-seeking purposes and posed no danger on the concrete floor. The possible injury to the patient in the event that he carried out his threat to dive onto the floor, as well as the high risk always involved in going into a patient's room for purposes of restraint, should have deterred the staff from doing so.

The other noteworthy aspect of this incident was the patient's use of a pork-chop bone as a very effective weapon. It is interesting that staff were strongly opposed to the introduction of plastic knives for patients, yet had never voiced security concerns about serving meat with sharp bones. It seems that a determined patient, even a mentally retarded one, can use readily available objects to make a weapon if he or she so desires.

Example Ten

Jed, a 26-year-old Canadian Indian, had been a patient in the maximum security institution for a year, having been transferred there from a less secure psychiatric hospital. He was diagnosed as schizophrenic and often received neuroleptic drugs, but experienced serious side effects so he usually was given low doses. At the referring institution he had initially settled in well and, with encouragement, took an active part in a number of programs. Apart from this Jed kept very much to himself, except that on a number of occasions he was reported to exhibit unpredictable violence towards women. Once he had seriously assaulted a female clerical staff member — a complete stranger to him — as she walked by him in the main corridor. Another time he assaulted an elderly nurse while her back was turned, knocking her to the floor and then kicking her repeatedly. On neither occasion (or after other assaults on female staff) did Jed give any explanation, but it was suspected that he was experiencing auditory hallucinations at the time. After one of these attacks Jed had been charged with assault, convicted, and placed on court probation.

In the maximum security facility, Jed was a good patient: he did chores willingly, and although he was noted to be extremely quiet and seclusive he never exhibited any problem behaviors or management difficulties. He attended many off-ward activities, and, while he never spoke to anyone there unless spoken to, he reported when asked that he enjoyed the activities. Eventually he was admitted to a regular half-day, off-ward recreation program. Here too he was noted to be very quiet and withdrawn, but when encouraged was willing to attempt the activities suggested.

After many weeks of unvarying behavior, Jed committed a very uncharacteristic assault. For administrative reasons his recreation program had ended early one afternoon, and the participants were returned to the ward. On arrival, Jed kicked another patient in the groin. He was restrained and placed in seclusion, but neither party would give any explanation for the altercation. Jed spent two very quiet days in seclusion, and when he emerged his behavior was again noted to be characteristically quiet and cooperative.

A week after the assault, he returned to the ward from the recreation program visibly upset, having just received a notice from the Review Board which he thought implied he was a "stupid Indian." One of the ward staff talked to him about the actual purpose of the notice and Jed seemed satisfied. A week later, he was reported to be "smiling and laughing inappropriately," and staff hypothesized that he was experiencing auditory hallucinations. These reports are fairly typical of patient behaviors in a maximum security psychiatric institution, and no special actions or precautions were taken. They were, however, strikingly atypical of Jed's nearly invariant behavior over the past many months.

Five days after the report of hallucinations, Jed attended his recreation program as usual, but during the afternoon coffee break he requested permission to return to his ward. When asked why, he replied that he was tired of people calling him an Indian, and he pointed toward four other staff seated at the staff lunch table. He then suddenly lunged and struck the only female staff present very hard in the face with his elbow. He was immediately restrained, returned to the ward and placed in seclusion. Interviewed later, Jed was calm but not remorseful. He stated that he committed the assault because he was "mad, mad inside," but insisted that he was not angry at his victim. He would give no other reason for attacking her, saying, "I don't know; she just got in the way." The recreationist Jed assaulted was visibly pregnant at the time, and lost 13 days' work due to a black eye and a concussion.

Staff later reported that Jed had been observed "smiling inappropriately" during the yard period that had ended only minutes before the assault. It was hypothesized that he had again been hallucinating and that this had contributed in some way to the assault. Jed spent four very quiet days in seclusion afterwards. When he emerged his behavior was just as before — quiet and cooperative, and although this continued for months thereafter, staff reported Jed to be "unpredictable and dangerous."

Jed was interviewed by local police and charged with assault. After several remands, he was tried four months later, convicted of assault and sentenced to one day plus three years' probation.

Comments: It is of interest to note that there had been a very definite change in the patient's behavior in the three weeks immediately preceding this incident. However, because such behavior is not unusual in a maximum security hospital, no one paid it too much attention.

Another aspect to note was his choice of victim. Although it appeared to some that he picked her at random, a study of his file revealed that he had assaulted female staff at other institutions. Details of these assaults came to light only at the time the authors decided to include this incident

in this book. Obviously, this information should have been known to all staff during the patient's stay in hospital. In fact, it could be argued that hospital authorities had a duty to warn all female staff that they might be at particularly high risk.

Finally, this incident serves as an example of how problems can arise even under what would appear to be secure circumstances: here, the patient had little difficulty in assaulting his victim even though she was sitting across a table and was surrounded by four other (male) staff members.

Example Eleven

Martin, a tall, heavy man (102 kg) had lived in the maximum security institution for over 12 years. He was finally transferred to a less secure unit specializing in the treatment of patients diagnosed as suffering from mental retardation plus some other psychiatric disorder. The ultimate goal was to transfer him to an institution for the mentally handicapped, because, in fact, his only psychiatric diagnosis was mental retardation.

Martin's adjustment to his new setting was difficult. Although friendly and helpful to staff and obviously enjoying many of the new opportunities afforded, he seemed to miss the environment, routines and staff of his former unit. He was very poor at handling frustration, and his attachment to his old home presented some problems. One day when denied a request he ripped a telephone off the wall, and then told staff that he expected to be returned to maximum security where he would be punished by being placed in mechanical restraints. Instead, he was told that he would just lose his privileges for one day and miss the weekly bus trip. It seemed to staff that Martin was anxious and that some of his behaviors were a form of testing limits.

Martin was allowed to use the telephone to call his old staff acquaintances at the maximum security unit from time to time, but the new staff attempted to wean him from this practice and encouraged him to depend on them. His primary nurse tried to teach him acceptable ways to handle frustration, and encouraged him to work out on the heavy punching bag in the ward's recreation area.

About two weeks before the incident described below, Martin began to experience a series of minor problems. One evening he went to bed instead of eating supper, but staff insisted that he get up and eat; then he was scolded when discovered giving away food from his meal tray. Afterwards he was upset and anxious, reporting that he was afraid staff were angry with him. He declined evening activities, took an oral sedative and went to bed. He spent the next three days on the ward, very quiet and withdrawn. The following day in the recreation area he asked to use

the washroom. Within a few moments staff heard a loud noise and shouts, and found that he had broken a window in the washroom with his fist. Martin reported that he was angry because a co-patient had teased him. He returned to his room, took an oral sedative, and stayed in bed the rest of the day. The next day, he was told he would not be permitted on the weekly bus trip.

Martin's primary nurse talked about how he could better deal with anger and frustration, and again encouraged him to use the punching bag. The next day Martin began yelling at a co-patient (who staff thought may have been teasing him) and, visibly upset, approached staff saying, "You're my friend, aren't you?" He was given a sedative, and sat alone in the lounge for the rest of the evening. The next morning he was even more agitated than usual, sitting redfaced, rocking vigorously back and forth, twisting a knotted sock. An occupational therapy staff member told him he would not attend the program that day because he was upset. Martin protested, saying, "Not me, Jim! I'm okay!" He was given a sedative and remained on the ward. Two days later, he was reported to be very upset because he was "conned out of some money by another patient." Staff gave him an oral sedative to help him settle down. Later that evening he was again upset and complained that he had a toothache, and was given an analgesic and another sedative. At bedtime, his primary nurse again counseled him about how to handle frustration and Martin tried the punching bag for a while. This seemed to help and he was praised for employing this technique. He was also reminded that he would have to miss the weekly bus trip because of his upset behavior.

The next morning, ward staff approached Martin and told him that because of his recent behavior he would not be permitted to go for a walk that afternoon. Martin was upset; staff gave him a sedative. Fifteen minutes later the nursing team leader asked him to go to his room to settle down. He punched and slapped her across the head, then pushed her violently into a corner where her head struck the wall, cracking the plaster. She collapsed to the floor, and Martin was pulled away by another staff member who held him until help arrived. He was restrained and placed in seclusion. While there, he received another sedative, but paced continuously and shouted threats that he would continue to assault female staff until he was returned to maximum security. When asked about this incident, Martin repeated his threats and said, "She got mouthy with me so I hit her." The team leader lost five days' work due to head and knee injuries. Martin was transferred back to maximum security the same afternoon, and staff there reported that he seemed relaxed and happy to be back. A few days later, Martin was interviewed by local police and charged with assault.

Comments: In this example, one is struck by the number of times staff dealt with the patient's agitation by removing his privileges, giving him oral sedatives, and telling him to punch a punching bag, but, seemingly doing little else by way of verbal intervention. In many ways, it seemed that the only way he could get attention from staff other than his primary nurse was to misbehave. In the incident in question, the victim had told him to go to his room, again illustrating the danger involved in imposing sanctions on obviously upset patients.

The use of the punching bag is also worth commenting on. It is often believed that engaging in activity such as this will get rid of aggression by "blowing off steam." In fact, there is no evidence that that is the case and, in fact, this type of activity is more like practicing aggression, which may make actual violence more likely.

Example Twelve

Miles had been a patient in the maximum security division for many years, having being found not guilty by reason of insanity on a charge of murder. He was diagnosed as having a personality disorder and as a schizophrenic in remission. Eventually he was transferred to a less secure setting and initially did well, but was transferred back after revealing an elaborate and workable plan to take a hostage.

From the time of his return to maximum security, Miles experienced a series of serious problems. Shortly after his readmission he accused ward staff of assaulting him and other patients, as well as a variety of other forms of maltreatment. Although neither the police nor an internal investigation found sufficient evidence to charge or discipline the staff accused, within a few months all the workers on that ward were reassigned elsewhere and the ward was later closed. Miles eventually earned a transfer to one of the less secure, maximum privilege wards.

He continued to experience problems, however, becoming one of the most litigious residents the institution had ever known. He helped found a patients' rights group and spent a large proportion of his time and energy fighting for various causes. No issue was too small for his full attention: he frequently called the police over minor concerns about telephone privileges or meeting space for his rights group, for example. One day he was very upset because someone had placed a piece of cheese in his room, and he demanded a full investigation and insisted that his room door be locked whenever he was absent. When staff refused, Miles loudly demanded to see the administrator immediately or else he would call the police: then, when he was summoned to the ward front to receive a message from the administrator he shrugged and said he didn't care

anymore. As a result of such activities Miles experienced a great deal of friction with other patients and staff at all levels, yet persisted despite the fact that this was highly stressful (he often complained of tension-induced migraine headaches).

Miles' daily routine was marked by frequent meetings of the rights group and frequent suspicions about the behavior of other patients and staff. He was clearly unhappy and angry much of the time and, although he had a full time job in the typing and printing shop, most of his energies were spent on pursuing many, sometimes trivial, grievances. Ultimately he was informed by the unit director and senior nursing staff that because of his mental state he would no longer be able to work in the shop, and would remain on the ward on restricted privileges. Miles said, "I'm an angry person and I'm getting angrier." He stated that he would deal with his lawyer rather than hospital staff regarding his treatment, and added that he had launched a lawsuit against the printing shop. For several days thereafter he remained on the ward quietly, but in a discussion with his primary nurse he was obviously very unhappy, expressing doubts about his own perception and judgment and saying that he felt people disliked and rejected him. He also said that he felt more relaxed since his ability to participate in patients' rights activities had been restricted. In a subsequent meeting with his treatment team, Miles said he would refuse to sign anything and that any treatment plans could go straight to his lawyer. He declined any additional help, saying he was the same person he'd always been and no longer required institutionalization.

Two days later, Miles entered the patient lounge with a 12-inch metal rod, which was the handle from a video camera that he had removed from a locked but topless cabinet on the ward. He walked directly over to a co-patient (his former foreman in the typing and printing shop) who was sitting watching television, and began to stab him fiercely. A nearby staff member ordered him to stop and pressed an alarm button, but did not intervene physically. Miles continued to stab away, until his victim (who received numerous puncture wounds, primarily to his legs, arms and chest) scrambled over his chair and escaped. He was dragged into a room by another patient who closed the door, locking Miles out.

When other staff arrived, Miles surrendered without a struggle, and was restrained and immediately placed in seclusion. In seclusion he was calm and quiet, but would give no reason for the attack.

Comments: Here, the patient's litigiousness presented a formidable barrier to treatment and seemed to have both himself and the staff tied up in nonproductive endeavour. He himself admitted it was doing him harm, yet no one was able to stop him from pursuing every last legal avenue.

In the incident itself, the one attendant present did not intervene even though it certainly appeared that the victim's life was in danger (and in fact he had to save himself by escaping). In this case she ought to have intervened even though she was the only one present and doing so would have put her in some danger as well. Perhaps the most sensible and safe move in this case would have been to have grabbed an object (such as a cushion) and used it to knock the patient off balance after she had pressed the alarm button. If more staff had not arrived by this time, at least it may have allowed both her and the victim to run away.

The other noteworthy point about this incident is the apparent ease with which the aggressor was able to find a suitable weapon.

As a footnote to this example, the authors discovered that long before this incident, at the last two institutions where he had been Miles had planned a hostage-taking and planned to kill a staff member, respectively. In both cases he had prepared and hidden weapons for use in the attacks. Neither of these incidents was known to the staff responsible for him, and neither was described in his patient record. Perhaps if these incidents had been adequately documented and known to the appropriate people, preventative measures might have been taken.

Example Thirteen

Ron was a 22-year-old who had been admitted to the maximum security institution two years before, having been found not guilty by reason of insanity on a charge of attempted murder. His diagnosis was of personality disorder, schizoid type. He showed a difficult adjustment, at times angry and resentful about his incarceration and presenting some management problems. Eventually, however, he was transferred to a therapeutic community ward and slowly became able to participate in the therapy groups there. Four months before the incident described below he was noted to be doing well, with adequate participation in groups and good relations with staff and patients.

A few weeks later, Ron surrendered a small bundle to staff. Inside it were 25 antidepressant pills that he said he had saved a year ago and had hidden in the lining of his jacket, stating that he had forgotten about them until discovering them that day. Staff immediately searched Ron and his room but found no other contraband, and reported that they believed his story about the pills to be truthful. The next morning, Ron suddenly threw his tape recorder onto the corridor floor, smashing it. He was immediately placed in restraining wrist cuffs and a special group was arranged so he could talk about his feelings. However, he was uncooperative and resentful, saying that he was bored and fed up with the

pointless group therapy, and asking to be transferred to some other ward. Later, he said that he was depressed and discouraged and had considered suicide over the last two weeks. He asked again for a transfer but was told by the ward supervisor that this was impossible. Ron replied he would get out "one way or another" but would explain no further.

Over the next several days Ron's behavior showed considerable ambivalence. At times he would be angry and even assaultive, demanding a ward transfer, and at other times he would state that he wanted to remain in the program and work out his problems. He was placed on antidepressant medication again, and within two weeks his moods stabilized, he ceased demanding a transfer, and participated somewhat in the ward program. A month before the incident however he was noted to be quiet and withdrawn, with barely acceptable participation in the group programs. When one staff attempted to ask him about how he was feeling, Ron merely smiled and said he was fine.

Without any apparent accompanying change in his state of mind, the following incident transpired one hot July night. At 2:20 a.m. Ron passed a note to one of the night staff making a routine check, which read: "Siege —This is the fucking real thing assholes! Shots will be fired, someone seriously hurt and myself dead if demands are not met. . . I'll give up peacefully once something's worked out with the police, I'll only talk to the police . . . . You have 48 hours then shit is going to fly jerks. Try me (enter my fucking cell) see what happens. I'm sick of life ready to die!!! I have other weapons, we want a settlement now!!! . . . Patient Rights Committee." The note was dated 11 days before. The staff could see Ron holding what appeared to be a black handgun, and the door of his room was secured with a T-shirt tied around and through the bars while he was crouching behind his up-turned bed in the opposite corner. He told them, "I have a gun and I know how to use it."

The ward attendants phoned the supervisory staff, who in turn notified local police and senior personnel (including the hospital administrator), calling them out of bed. The night staff meanwhile remained talking to Ron, who spoke freely, voicing many complaints about his treatment as well as that of other patients and saying he wanted several changes in the institution's programs and policies. When the police and senior personnel arrived they remained in the background, allowing the original staff to continue discussions. However, when the administrator arrived he took over. By all accounts, this prolonged the crisis and eventually the two original staff resumed negotiations. Two and a half hours after the incident began, Ron surrendered his gun, which turned out to be a fake. Other than promising that he would be trans-

ferred to a more secure ward and to listen to all of his concerns in the future, staff made no commitment to him about what would happen afterwards.

When Ron's room was searched a second note was found. This note had the same date as the first, and apologetically stated that the issues (more programs on suicide prevention, less abuse and punishment, smoke-filled group rooms, no forced program compliance, no shock treatments or needles, more recreation) were real but that he was not dangerous and that he wasn't sure why he was about to commit the "prank." Ron was also interviewed in seclusion the next day. He apologized for the incident and said that he hadn't expected to be taken so seriously, but that he hadn't known how to end it, saying that he got the idea for his actions from television and books.

As a direct result of this incident, although staff on the scene had brought about a successful conclusion, senior administrators decided that the institution needed a specially trained crisis negotiation team and five staff were sent away for specialized training.

Comments: In this example, it seems, the patient didn't really expect his "prank" to work as well as it did. Once it began however he was unsure how to end it, and from the staff's point of view it certainly had to be taken seriously.

The attendants who were on the scene at the time were according to all accounts handling things extremely well, keeping the patient talking and apparently calming him down. When the hospital administrator arrived and took over negotiations the situation began to escalate and seemed less in control. All agreed afterwards that this had been a mistake, and that the staff who had been handling matters originally should have continued. Thus, while the intensive training of a few staff in crisis negotiation skills might be a good idea, it seems that whatever workers happen to be on duty at the time an incident occurs need to have the skills to keep things under control until the special team arrives, and, in many cases, are still the best ones to handle the negotiations until the situation is resolved.

Example Fourteen

A prison inmate, John, was transferred from the penitentiary to a psychiatric unit after increasingly expressing thoughts of suicide. Upon admission he was placed alone in a room until a doctor could interview him. His personal possessions were taken away, including his cigarettes. For the next few hours John paced around the room but otherwise caused no

disturbance. Ward staff who attempted any conversation with him would be asked for a cigarette; their typical response was that he would have to wait for the doctor before any of his possessions could be released. This would end the conversation and the patient would resume his silent pacing.

Just before lunch, the doctor arrived and spoke to John through the locked door. Again John began with a request for his cigarettes, and the doctor promised to return them if he would agree to talk. The patient consented; however, when the cigarettes were brought and one was lit for him, he resumed his pacing and refused to talk any more. Instead he began chain-smoking, lighting one cigarette after another and refusing to relinquish the package.

The doctor then called the ward staff together and reviewed John's case with them. His record in the penitentiary had included numerous attacks against staff, and he was considered dangerous and unpredictable. The doctor decided to have him returned to prison, and instructed the ward staff to enter the room and give him a sedative injection.

One staff member opened the door and walked in two paces, while a group of six to eight more stood just outside the door. The patient was leaning against the far wall, looking away. The staff who had entered raised a can and said, "John, have you ever had mace?" — and then proceeded to spray mace in his face. John immediately began to hold his face and cry out, whereupon the rest of the staff rushed in, restrained him on the bed, stripped him, administered the injection, and then left the room. As they exited, one said, "Just lie still, John, and you'll feel better soon."

Comments: Standards of operating procedure vary remarkably from setting to setting, and a routine considered quite common in this particular institution would have resulted in formal investigations and severe staff sanctions in our own. Our staff would have felt the situation did not require such a forceful intervention. The patient in this case was not acting dangerously; his possessions, including the cigarettes, were not being used in any threatening manner; and his worst behavior lay in not talking to the doctor. Certainly time was on the doctor's side, and staff entry into the room was unnecessary.

Example Fifteen

Garth, aged 38, had been hospitalized in maximum and minimum psychiatric institutions many times, variously diagnosed as a personality disorder with antisocial and immature features and as a schizophrenic

with drug and alcohol abuse problems. He had a long history of assaultive and acquisitive criminal offences, and had recently been transferred from a maximum to a medium security psychiatric institution where he was being held on a Warrant of the Lieutenant Governor, having been found not guilty by reason of insanity for a very minor property offence. For some time prior to the incident described below, he had refused to accept his medication.

On the day of the incident, he had his regular annual interview by the Lieutenant Governor's Advisory Board of Review to determine whether his Warrant should be removed or its terms loosened. After the interview he disappeared, and the police were notified that he had escaped. This notification was rescinded as he was subsequently seen on the grounds of the hospital. In the late afternoon Garth was located wandering in a hallway, but he refused to return to his ward. A hospital psychiatrist was consulted, who advised staff to leave him alone in the hope that he would return voluntarily. Nearly two hours later, all available male staff were instructed that Garth was to be returned to his ward "peaceably if possible, but forcibly if necessary."

Garth was later observed in a parking lot near the power house. When he saw the staff approaching him he picked up some pieces of lumber and jumped onto the back of a truck, threatening anyone who came near. The attendant staff tried to talk him into dropping the wood and coming with them voluntarily, but failed. Some unsuccessful attempts were made to subdue him; then, since most of the dozen staff were standing around the truck, two attendants moved in to restrain him. The patient suddenly hit one of them on the head with a piece of lumber. This man subsequently died of his injuries. The other attempted to protect his co-worker and was knocked unconscious. Garth was then pinned by two powerful fire hoses and subdued.

Garth later pleaded guilty to manslaughter,and was sentenced to 10 years in prison, but was transferred back to the maximum security psychiatric hospital to serve his sentence. The union representing the hospital employees tried several times to have the hospital administrator charged with criminal negligence, but these efforts were unsuccessful.

Comments: As in one of the earlier examples, a review board hearing is implicated here. In this case it may have been especially stressful, because hearings for patients found not guilty by reason of insanity are usually held only once a year. Patients often have intense feelings before and after this event, and a staff member should always go to them afterwards to try to find out how they are feeling. It is possible that talking with a supportive staff member would have calmed the patient down in

this case, or at least would have alerted staff to the possibility that he was very upset and needed further observation and security precautions.

When the order was given to return the patient to the ward, it was ambiguous with respect to time. There was no real danger of the patient escaping, as there were many staff on hand, and because of the clear danger he posed to anyone who approached him while he was holding the lumber it would have been much safer to have simply waited until he tired of holding it, or until there was a clear plan about what to do. It appeared that no staff member was clearly in charge. For a time some of them had attempted to talk to the patient and talk him into dropping the wood, and although this failed in the short term, it would have been a no-lose strategy inasmuch as it posed almost no risk to any party and it may very well have succeeded in the long run had it been continued.

Example Sixteen

The following incident occurred at the State Hospital at Carstairs, Scotland, a facility for the treatment of persons who require special security on account of their dangerous, violent, or criminal propensities. It is included in our vignettes because it has been described in considerable detail (State Hospital, Carstairs, 1977), and because the ensuing investigation raised a number of issues that can be usefully considered by those in similar institutions. This case involved the deaths of a hospital staff member, a patient, and a police officer, all murdered by two patients as part of an escape attempt.

Both men involved in the murder were described as psychopaths. One was a 26-year-old who, following an argument with a chef, had returned to the restaurant with a shotgun and revolver and shot through a closed door, injuring the chef's wife. At the time of the present incident he had been in Carstairs for six years, and had shown increasingly cooperative and mature behavior. He was a good worker and had been employed in the paint shop for five years. The hospital had a system of internal parole, which he had been granted five months earlier, entitling him to move unescorted around the hospital grounds during daylight hours. He had been noted to be friendly with the other patient involved in the escape for about three years.

The other patient was a 28-year-old man described as being of above average intelligence, arrogant, supercilious, and argumentative. He had been sentenced to Carstairs eight years earlier following an incident in which he held a teacher and a number of children hostage, sexually assaulted some of the female pupils, and subsequently shot and killed the teacher. He had been granted full internal parole about two months

earlier, which enabled him to move about the hospital so that he could edit the hospital magazine.

Together, the two began to actively plan their escape about a year before it happened. The first patient manufactured or obtained escape equipment and a number of weapons. His normal method of obtaining the necessary materials was to request them openly for an innocent purpose. Thus, a rope ladder was made with cord stolen from equipment he was making for the drama group, its rungs out of wood from the woodworking shop, and a lead weight attached taken from a floor polisher that had been sent to the woodworking department for repair and discarded as not worth fixing. The ladder was either kept hidden in a loudspeaker cabinet or in the patient's room. False identity cards were made using old academic or technical certificates, Letraset sheets that he had access to in the paint shop, and a Polaroid camera that he was allowed to use there to take pictures of articles he had made (and which he said was in the custody of other staff whenever he was asked about it). In taking each other's photographs the patients used a false moustache of unknown origin, which was found in their possession when they were arrested after their escape. They also obtained outdated nurse's caps from equipment for the drama group. Materials intended to help them surmount the barbed wire on the top of the perimeter fence were taken from the Occupational Therapy (OT) Department, and kept openly among the props of the drama group until the evening of the escape. One patient stole some steel, which was available in the woodworking shop to manufacture sleigh-runners, to make three knives. He sharpened them on the shop's power buff, made steel guards and wooden handles, and concealed the blades in hollow pieces of wood screwed to the workbench so as to appear to be part of it. Another knife used in the OT Department for cutting leather was stolen and replaced by a very dissimilar-looking dummy knife, which was a stage prop for the drama group. A small axe was made out of a sharpened piece of metal stolen from an office in the OT Department, fastened to a wooden hammer handle. This was kept hidden either in a space between panels forming sides of a work bench, or in a hobby box that the patients carried around regularly so that staff were used to seeing it and no one thought of searching it. Sheaths for these weapons were made from material obtained in the OT Department and sewn on a sewing machine kept in the paint shop, which one of the two patients had been allowed to bring into the hospital so that he could make soft toys as a hobby.

Several additional weapons were manufactured but not used in the escape. One of the patients had begun to make a sword from a long metal bar that had been part of a clamp, with one end sharpened on the buffing machine. The sword was concealed in a hollow piece of wood, and

skillfully hidden in some shelving in the paint shop where it was missed in a search. Two garrottes were also made, one from violin string and the other from thicker wire taken from the OT Department, with handles of metal and of wood. These were first hidden in the box with the axe, then removed and hidden in the paint shop, where they were discovered in a search after the murders. Wooden replicas of pistols that had been used as stage props were obtained by one of the patients and painted to appear more realistic, but these, too, were left in the paint shop. Finally, the patients had intended to throw ammonia into the faces of the nurses to disable them. They were unable to get hold of ammonia, but obtained a liquid paint stripper in plastic bottles which, when squeezed, emitted a jet of caustic liquid.

The patients made their escape from the Social Club on a Tuesday evening. This was the night of the week on which they had observed that the volume of traffic on the road running through the hospital grounds was usually greatest, and they planned to make their getaway by stopping a car. They chose that location because the building was unoccupied (it had been decided to use it as a patients' social club after administrative staff there had been moved to new quarters), and stood in an isolated location with two other unoccupied former administrative buildings on one side. On the basis of past experience, the escapees calculated that there would be at most one staff member and one patient to overpower.

On the appointed evening, one of the patients packed the axe, the knives, the caustic liquid, and other escape equipment into his hobby box and took it with him to his room when he left work. It was not searched.

Later that evening, a male nurse who acted as the recreation officer (and who became one of the murder victims) assigned himself and a female nurse to supervise the drama group, which was to consist only of these two patients. He assigned the several other available staff to supervise a badminton tournament. As it was shortly after dark and parole privileges had ended, the recreation officer went over to the patients' wards to escort them to the social club. One patient carried two boxes, one of which was his hobby box and the other a box he sometimes took to carry an electric extension cord used in the social club for tape recording. No one inspected either the patients or the boxes as they left the wards.

On arrival at the social club it was discovered that a third patient, unconnected with the escape plan, had been granted permission to come to the social club that night. The female nurse then took off to take care of some business of her own. Before leaving she happened to notice a garden fork and a spade in the office that had, it turned out later, been borrowed by the recreation officer and not returned.

According to the account of the murderers, one of them then opened

the boxes, put on a belt that held the knives and the axe, and donned part of his disguise. Carrying containers of the caustic liquid, the two men then went into the office where the third patient and the recreations officer were, and threw the liquid into their faces. This had no immediate effect and both victims began to struggle. The patient victim was stabbed in the head, but managed to wrestle the knife away from his attacker. When the recreation officer saw this he escaped into the corridor, and was attempting to lock all three patients into the office when he was attacked with the axe. After a struggle he got the axe away, but his assailant then drew a knife, went after him again, and recovered the axe. The other escapee was meanwhile fighting with his victim, and his partner, annoyed at him for not helping in his own struggle, struck him on the back of the head with an axe. The latter grabbed the garden fork, stabbed the patient victim with this until he collapsed, and then went to help with the other attack in progress. He squirted more caustic liquid at the recreation officer without much effect; however, the staff member had been seriously injured in the throat by the knife attack and he fell to the floor with the patient on top of him punching and stabbing. There was no further resistance from either victim.

Despite the blow to his head, one escapee remembered to cut the telephone wires. The other gathered up the escape equipment, handed it to his partner, and then pushed him outside the door to keep watch while he went back in and murdered the victims, by now both unconscious and seriously injured, by striking them repeatedly on the head with the axe. He removed the recreation officer's keys, opened the safe in his office, took another axe from it, and rejoined his accomplice. Both donned their nurses' caps and walked to an unlit area of ground by the perimeter fence, where they threw the weighted rope over and secured it to a rail near the ground. They also tossed up some material designed to cover the barbed wire, but it landed in a position where it could not be used and it proved unnecessary in any event. They climbed the fence and escaped across some fields to the road.

It is of interest to note that the murdered staff member was a large and powerful man and had he counter-attacked with the available weapons or attempted to escape he may well have survived. Instead, he had courageously attempted to secure the patient victim and one attacker, and to disarm the second attacker and overpower him without injuring him. He could not have known the number of weapons there were, and there must have been a nightmarish quality to the way in which his attacker produced weapon after weapon to subdue him.

About 45 minutes had now elapsed since the two patients had been escorted off the ward, and no one at the hospital knew anything of what

was going on. The recreation officer had had a two-way radio in his possession, but was not wearing it at the time of the attack, and the cutting of the telephone wires did not register at the hospital switchboard or anywhere else.

The escapees flagged down a passing motorist by pretending there had been an accident. As fate would have it, a police car with two constables came along at just that moment and the motorist stopped and reported the problem, at which point one of the patients attacked an officer with a knife. The motorist jumped back into his car and drove to the gatehouse of the hospital, where he reported that two men who appeared to be nurses were fighting with the police on the road nearby. The staff member on duty was skeptical, but passed this information along to the police department. Meantime the two escapees had attacked the police officers with an axe, killing one and injuring the other. They left them there and drove away in their van. When the staff member at the gatehouse saw the police van pass by, he mistakenly thought that everything must be all right and took no one further action.

Using his radio, the injured officer reported the attack, and all local police were notified. The police now called the hospital to check if any patients had escaped, and the senior nurse on duty phoned each ward and patient area to ask staff to check on their charges. When he received no answer at the social club he asked someone else to call there, but they, too, received no answer. Finally, somebody was sent to check and the victims' bodies were found. In all the excitement and panic, no one called the police.

Meanwhile the patients, only one of whom had ever driven a motor vehicle, drove away along icy roads and soon slid off the road and down an embankment. One passing motorist who stopped to help them was struck on the head; another was stabbed several times. After getting the van back on the road, the patients soon went off again and got stuck. This time they walked to a farmhouse and, by threatening violence, coerced the owners into giving them their car. The owners' daughter slipped away unnoticed to call the police, and the patients drove off again with the police pursuing some distance behind. Yet again they drove off the road and another car stopped to help. As they were preparing to take possession of that car, they were apprehended by the police. They had been free for about three hours.

The next day, there was a meeting of about 300 hospital employees. One group said the tragedy occurred because patients were allowed to move too quickly and too far through a system of progressively less strict supervision and more privileges, while others blamed a too humanitarian approach. Both these groups felt security had been allowed to lapse. Staff

members who were already concerned about staff-patient ratios said the murdered recreation officer should never have been alone with three patients. Many workers were convinced that the hospital administrators and physicians paid too little attention to their concerns and views about patients. At the meeting, a resolution was passed calling for the suspension of the senior hospital personnel, and staff in attendance authorized the head of the union to call for a strike if the suspensions did not occur. After much negotiation, the strike action was put off pending a high-level meeting to be held a few days later. At that second meeting, concessions were made by both sides; however, union discontent continued and several senior management officials were prevented from entering the hospital, which they did not contest. A few days later, a third meeting was held and it was agreed that all strike action would cease and the excluded senior management officials returned to work.

On an interim basis, all internal parole privileges were suspended and staff-patient ratios for many off-ward activities were increased. Some of these changes were ones that had already been suggested in a review of staffing requirements the previous year.

In the subsequent inquiry, there was much discussion about a number of issues. People debated whether progressive patient care improved or reduced security. Without resolving the issue, it was agreed that as long as the law required persons including dangerous psychopaths to be treated in special hospitals, both treatment and security had to be provided. It was agreed that the balance between them could best be kept by having individual treatment plans, and by using a team approach in which all staff collaborated in determining each patient's treatment as well as the security implications thereof.

Another issue that was the subject of much discussion was whether there ought to be a staff member specifically designated to be in charge of security. Although it was agreed that security must be the concern of all, it was eventually recommended that a full-time security officer be appointed, and that a person well versed in modern security methods should sit on the most senior hospital management committee. The inquiry concluded that at the time of the murders the duties of senior nursing staff in relation to security in areas not staffed by nursing staff were ambiguous, that some well-recognized principles of security were ignored, that too much faith was placed in sloppily conducted routine security checks, that no one ever seriously tested the enforcement of security precautions, and that efforts of senior officials to maintain security were hampered by poor communication among staff of different disciplines and different levels.

A number of specific recommendations were made regarding security. Among these were: 1. There should be more control over the quantities of materials issued in workshops so that excessive quantities were not issued, and closer monitoring of the disposal of waste materials. 2. Junior nursing staff should assist in the occupational workshops but should not have the power to countermand the orders of the regular staff. 3. Irregular, unexpected, and thorough searches of patient rooms and work areas should be done at least monthly, and once or twice a week, random checks done of patients and anything they might be carrying as they leave work. 4. The internal parole system should be reintroduced, but staff should continually be informed about the kinds of patients who received such privileges. For some patients, seen as generally trustworthy, parole was a step on their way to release from the institution. For others, such as the two involved in the murders, it was something granted only to help make their lives more tolerable and was definitely not an indication of general trustworthiness. 5. Any parcel or gift brought by a visitor should be opened at the ward front, and searched in the presence of the recipient. In addition, visits should be sufficiently supervised so that articles could not be given to a patient without a staff member's knowledge, and patients searched after visits on an occasional and irregular basis. 6. Consideration should be given to installing alarm buttons that would set off alarms in the immediate area, the adjacent area, and in a central control room. 7. Staff should be clearly instructed about steps to be followed in various emergencies. 8. Staff should receive formal in-service training pertaining to security. 9. The 12-hour shift for nursing staff should be significantly shortened in order to allow better communication among staff, reduce fatigue among staff toward the end of their shifts, allow for increased staffing at critical times, and allow patients to be outside their rooms.

As a final conclusion to this episode, readers may be interested to know that the two murderers were found guilty and sentenced to prison. In the end, it seems, the sentiment that such individuals are too dangerous to be held anywhere other than prison prevailed.

Part II

Controlling Assaultive Behavior:

Description of the Staff Training Course

Introduction to Part II

Part II presents the material covered in our course. It includes the class notes that we hand out to our trainees, which are intentionally written in a simple style with few references. In addition, because some readers may wonder why a particular approach was selected over others and what evidence — if any — exists to support its use, we here include empirical support where available for the techniques advocated, and outline why we chose the methods we did in cases where such support does not exist.

The general philosophy of the course is that violence rarely erupts without warning, but that patients usually first go from a calm state, through an anxious state, to a hostile state. Chapter 4 discusses security measures and interventions to be used with calm or anxious patients. Our data have led us to believe that many violent episodes are preventable and, because the techniques involved in prevention entail little or no risk of physical or psychological damage, they are to be used whenever possible. Chapter 5 looks at defusing and restraint. Defusing involves verbal techniques that may work to settle problem situations nonphysically, because our data suggest that even when violence seems imminent, it may often be avoided solely through careful verbal intervention. The section on restraint describes techniques that minimize the risk of injury when physical intervention is absolutely necessary. Hostage taking is also discussed here. Chapter 6 reviews techniques of interviewing and conflict resolution that are intended to minimize the risk of problems happening again in the future. Finally, Chapter 7 details some other aspects of the course: the topic of job stress; some classic studies on institutional environments that we present in order to encourage students to think about how these issues may affect their own work; and the role-plays that are carried out in order to practice the techniques taught in the classroom.

For purposes of clarity and simplicity in writing, our discussion of crisis interventions will assume the violent individual to be a male psychiatric patient. However, although by far the majority of assaults are committed by males, females do commit them too, and the techniques described may be applied regardless of the patient's sex. Also, experience has shown wide applicability of these techniques in many settings and with many types of clients, whether patients in maximum security psychiatric hospitals, less secure psychiatric hospitals, or general hospitals; residents of homes for the mentally retarded; or prison inmates.

We begin the course with the following introduction. Psychiatric hospital staff have the difficult task of treating mentally ill persons, many of whom are being held against their wills because they are felt to be in imminent danger of causing harm to themselves or others. Some of these patients have acted violently in the past, and violence is something for which staff must be prepared at all times. One of its consequences is a high cost in work days lost through injuries. As mentioned, at the Penetanguishene Mental Health Centre between the years 1974-1979 over 500 work days were lost annually due to patient-caused injuries. Thus, even without considering injuries to co-patients, it may be seen that the problem of institutional violence is one of considerable magnitude.

Police forces have long been concerned about the number of injuries sustained by officers and civilians in the course of law enforcement duties, and several programs have been developed to try to reduce such injuries (e.g., Goldstein, Monti, Sardino, & Green, 1977). With a similar goal in mind, a course in crisis intervention was developed for staff at St. Thomas Psychiatric Hospital (St. Thomas Psychiatric Hospital, 1976). The course described in this section is based partly on these sources, partly on studies carried out at Penetanguishene over the past eleven years, partly on the combined wisdom of several nursing staff who have participated in its ongoing development, and partly on approaches used by staff at Penetanguishene, which were discovered in our search for effective techniques. The research on which it is based was done primarily in the maximum security division of the hospital, and it was first designed for use in that division. However, we have since expanded it to include methods appropriate for all psychiatric hospital settings. We believe we have developed and put forth here ways to prevent violent situations from arising, as well as safer ways to handle them when they are imminent or in progress. Our view is that violent episodes do not occur solely because of deficits or disorders exhibited by psychiatric patients, but often arise out of problems with their interactions with staff. Therefore, it should be possible to reduce institutional violence by *changing the ways in which staff interact with patients.*

Chapter 4

Preventing Violence

Violence can often be prevented by maintaining a secure environment. We will discuss two complementary ways of doing this. One method involves the development of and adherence to a set of security guidelines, and the other involves making use of verbal techniques we call "calming."

SECURITY

Levels of Security

Minimum, medium, and maximum security are terms that are often used when referring to correctional and psychiatric institutions. Very often, however, there is confusion about exactly what they mean. Usually, at maximum security institutions extreme precautions are taken to ensure that no one can escape; for medium security there are locked doors to prevent escapes but not a policy of "detain at all costs"; and for minimum security (at least in the mental health system) there are rarely locked doors to prevent escape. Beyond these very general divisions, however, the definitions vary widely. For example, while some maximum security institutions have double perimeter fences with guard dogs and armed personnel in guard towers, others have only a fence enclosing the yard area and video monitoring of the exits and grounds. Similarly, some allow physical contact between residents and visitors, while others allow visits only through armor-plate glass.

Definitions of what constitutes maximum, medium, or minimum security in correctional or health institutions are, for the most part, elusive (Rice,

1985). The Correctional Service of Canada recently revised its criteria governing security levels of its institutions (Final draft, Commissioner's Directives, 1986) as follows:

Minimum Security: The perimeter "will be defined but not directly controlled. Inmate movement and association will be regulated but with little or no staff supervision. Arms will not be retained in the institution."

Medium Security: The perimeter "will be well-defined, secure and controlled. Inmate movement and association will be regulated and generally supervised. Although arms will be retained in the institution, they will not normally be deployed within the perimeter."

Maximum Security: The perimeter "will be well-defined, highly secure and controlled. Inmate movement and association will be strictly regulated and directly supervised. Arms will be retained in the institution and may be deployed within the perimeter."

These criteria emphasize what most people consider when they think of security systems; namely, fences, grills, bars, locks, doors, weapons, and unbreakable fixtures (e.g., McGreevy, Steadman, & Way, 1984). Seldom are things such as rules, programs, or the interpersonal skills of staff members mentioned. Yet security in most institutions involves a combination of many types of control techniques.

Each institution seems to settle on its own precautions based on experience and historical precedent, and often the only pressure to change these comes from breaches or predicted breaches of security, such as successful escapes. The result is that most institutions have a hodge-podge of security measures that may or may not be necessary or sufficient. In our course, we encourage participants to consider the various security systems in place in their areas of work, to compare them to systems elsewhere, and to identify aspects that are over- or under-emphasized.

The following is a description of various means of maintaining security in institutions.

1. Security Through Static Physical Control

Many would argue that keeping high-risk residents contained is necessary before any other form of control can be exerted; therefore, perimeter security must be the overriding concern in maximum security. Static physical control refers to permanent structural aspects of an institution such as bars, fences, observation towers, etc. Within buildings, static control includes mechanical hardware and built-in features such as locks, doors, unbreakable glass, and surveillance by video monitoring, as well as time out rooms that can safely contain agitated patients. These are the features that are usually thought of when discussing "security." Although

most of the literature on static security concerns correctional institutions, we have found it useful in our course to get psychiatric hospital staff thinking about the kinds of measures present at their institutions and the effects these have on patients.

One advantage of static security measures is that they are, in most instances, effective in containing residents. Also, once a decision has been made to admit someone, the use of static security involves little further judgment on the part of staff, and therefore there is little room for complaints about unfair treatment with regard to this form of control. The disadvantage is that the high visibility of the control measures, while adding to the feelings of safety of those *outside* the institution, creates fear and anxiety on the part of those closed within. In addition, as the number of escapes from even "supermaximum security" institutions has shown, over-reliance on perimeter security does not necessarily mean better protection of the public. Static security can be easily undermined through inattention or neglect, as in leaving sensitive doors unlocked. Finally, the use of such things as segregation or time out rooms is a practice that is under constant public scrutiny for possible abuse.

"Security" in the physical hardware sense performs several functions. First, it is a deterrent to persons wishing to break in or out. (In the case of correctional or hospital facilities, the major danger is from the latter.) A would-be violator may inspect the measures in place, assess his capability of thwarting or breaching them, and decide he does not have the skills, time, or equipment to do so and thus not try. Alternatively, especially in the case of breaking in, he may be diverted to another, easier target, in which case he leaves the hardened target and attempts a penetration of the softer one instead. Even if they do not appear insurmountable, static security measures introduce a *delay factor* to any potential break-in or break-out. The target may have several "rings" of protection, like an onion, forcing an escapee to take a great deal of time to work through each ring. At each level of protection, if the time delay is sufficient and is combined with an effective method of detection and response, then he will be caught. The time delay factor alone may make residents too nervous to start or to continue an escape. Conversely, all the security in a hardware arsenal will be ineffective if escapees have unlimited time and tools, knowledge of weak points, and are sure that nobody will detect them. If they can work unimpeded, safe in the knowledge that they will not be detected, that the response will be severely delayed, or that personnel have insufficient strength or back-up, they will continue until the security is penetrated. Thus, no complete security system relies solely on hardware for full protection: there must be a human response system (police, security guards, patrol officers, etc.) built in as well.

The potential problems with any form of static physical control are too much reliance on hardware, failure to assess as carefully as a resident might all the potential escape scenarios, failure to regularly test all aspects of the system, failure to change or update necessary components of the system on a scheduled basis (usually changes are made only after breakdown, malfunction or successful escape), and failure to provide a sufficient level of detection or adequate response (Bruce Koffler, personal communication, December 19, 1986). Without a dedicated on-site security specialist who is able to see that equipment is maintained and that all staff have a security-minded attitude, equipment will deteriorate, wear out, or break down, and detection becomes hit-or-miss. The U.S. Government has undertaken studies of perimeter security measures such as fences in order to determine how effective various designs are against penetration. Their results show that no matter how strong a fence, how well it is anchored, or how much barbed wire it has on top, it can be easily climbed — in most cases in less than one minute— by physically fit persons with little experience in fence-climbing and with very little equipment (Fite, 1976). In the Canadian penitentiary system, despite the introduction of "super-maximum" security units called "Special Handling Units" with a very heavy investment in physical security, violence has continued to escalate (Porporino & Marton, 1983).

While security hardware provides some answers and solutions, it also creates problems. It often encourages a fortress mentality, emphasizes distinctions between those on the inside versus those on the outside, eats up a limited budget that might better go toward other necessary programs, and encourages reliance on hardware to solve what are essentially people problems (Bruce Koffler, personal communication, December 19, 1986). In recognition of this fact, engineers responsible for designing secure units in Great Britain were told not to take into account outside rescue attempts or to worry about determined absconders in designing their institutions (Williams, 1976). In newer institutions in the United States and elsewhere, there has been an increased emphasis on types of static security that are nonobvious and will not contribute to a fortress mentality (Schoen, 1981). It has been recognized that thoughtful attention to unobtrusive measures that both allow an environment that looks comfortable and attractive and provide for privacy can reduce the likelihood of violence (Nagel, 1976; Ward & Schoen, 1981; Wener, Frazier & Farbstein, 1987).

As far as the course described in this book is concerned, the important point about static security is that it cannot solve all security problems, and that it creates problems as well as solving them. Reliance on other forms of control (situational, interpersonal, etc.) cannot be avoided even in super-maximum facilities (Quinsey, 1984).

2. Security Through Dynamic Physical Control

Another physical way in which security is maintained is by the use of manual restraint such as holding a patient, or placing him in some form of material restraint such as wrist cuffs, leg cuffs, or a body bag. This type of control is termed "dynamic" because it is not a permanent feature of the environment but rather can be applied only when necessary. Its main advantage is that it allows patients maximal freedom at other times. However, it is dangerous in that it always involves a risk of injury to both staff and patient, it requires judgment to decide when it is absolutely necessary, and its safe implementation requires a high degree of skill and training. Many institutions require constant observation for those in material restraints. Dynamic physical control will be discussed in more depth in Chapter 6, when we present situations in which violence is imminent or in progress.

3. Security Through Pharmacological Control

Chapter 1 ("Drug Treatment") describes the improvements that can accrue from the long-term use of neuroleptics, lithium, antidepressants, and anticonvulsants. In addition to psychiatric drugs being administered for therapeutic reasons, some, such as phenothiazines, barbiturates, benzodiazepines, and neuroleptics, can also be used for security purposes because of their immediate sedative action upon any person regardless of psychiatric diagnosis. Often a patient will have a standing order for such a sedating drug to be used on a p.r.n. ("as needed") basis, with instructions that it is to be administered if he engages in some specified behavior that would be dangerous to himself or others (Stull et al., 1984).

To the extent that chemical agents reduce the likelihood of aggressive behaviors, they contribute to the safety and security of patients and staff. The advantages of pharmacological control are that it can be applied to only those who require it, dosages can be individually determined, many patients will take medication willingly, and it is usually much safer for staff than dynamic physical control methods.

However, numerous problems can arise. Many patients will *not* take medication willingly, and there is considerable risk of injury to both staff and patient when it is given intramuscularly to an unwilling recipient. Attempting to use manual restraint to force someone to take a drug could well represent more physical risk to staff and patients than did the behavior the drug is intended to reduce (Harris & Rice, 1986). Certain medications require time to take effect after administration, and therefore some other

form of control must be used in the meantime. Some patients' aggressive behaviors are reduced only when the drugs they receive reach stupefying dosages, which preclude the possibility of their learning to control their behavior while the drugs are in effect, and can result in permanent central nervous system damage. Some drugs can actually *increase* aggressive behavior, including neuroleptics (Liberman et al., 1981; Lion & Soloff, 1984), benzodiazepines, and other psychiatric agents (Mattes, 1986; Stull et al., 1984). Almost all individuals who take psychotropic drugs experience some undesired side effects (e.g., Enna & Coyle, 1983; Stull et al., 1984), which means that ward staff must constantly monitor the condition of patients receiving medication. In addition, problems relating to side effects may mean that a patient resists taking a particular drug or is not permitted to take it, regardless of his symptoms or behavior.

Another common problem lies in knowing which drugs at which dose levels are necessary and sufficient for reducing an individual's violent behavior. Ward staff commonly feel that aggressive patients are undermedicated, while physicians are commonly reluctant to increase medication levels because they have less faith in their efficacy to control aggression, and because they are concerned about the side effects, particularly when the drugs are administered over long periods. One solution is to try a patient on several different drugs sequentially, and vary the dosage level of each until a decrease in the frequency of aggressive behavior is observed. Unfortunately, there are a number of problems with this approach. The first is that assaultive behavior usually varies markedly in frequency over time whether or not medication is given; thus, when we observe a reduction in assault frequency, we can't conclude with any certainty that a medication change was responsible for the improvement. A further difficulty is that the medication records as usually maintained are not correlated with assault frequency, so that when a patient's file is reviewed we can tell when and what medication he has received, but not whether his assaultive behavior was modified (see Harris, 1989).

Finally, the use of psychiatric medication for an unwilling patient as a form of "chemical restraint" is fraught with legal and ethical difficulties for the physician, ward staff, and institutional administration (Tardiff, 1984b; Wexler, 1984).

4. Security Through Situational Control

Situational control is exerted through the selection of environments in which a patient is allowed to function. For example, someone with a predilection for hitting people with hammers would not be assigned to the

industrial therapy shop, while an elopement risk could be denied grounds privileges or could require an escort when outside the hospital.

Situational control is often handled by ward programs such as token economies, which have been developed in a number of psychiatric hospital and correctional settings (Bassett, Blanchard & Koshland, 1975; Gudjansson & Tibbles, 1983; Laws, 1974; Lawson, Greene, Richardson, McClure & Padina, 1971; Milan, Wood, Williams, Rogers, Hampton, Lee & McKee, 1974; Musante, 1975; Quinsey & Sarbit, 1975). Patients in these programs can only become eligible for greater freedom of movement and more privileges by exhibiting stable cooperative behavior, and lose points or tokens for misbehaviors such as being argumentative, threatening, or assaultive. In some programs, for example, patients must have fewer than a certain number of incident reports to go on to the next level in which the security restrictions are more relaxed (Andrasik, 1975). In another, individuals who have acted violently (and are thought to be likely to do so again) must spend time in seclusion and then start over at the minimum privilege level where they have few opportunities to be assaultive (Quinsey & Sarbit, 1975).

Token economy programs are not the only ones to make use of situational control techniques. Therapeutic communities often employ group sanctions to accomplish situational control of particular patients (Barker, Mason & Wilson, 1969; Maier, 1986). On the wards, patients who do well on more secure units are transferred to less secure ones where there are more privileges and greater freedom of movement. Point earnings and staff judgment control access to special events such as dances and outings. Patients who are very assaultive may be let out of their rooms or allowed to associate with particular staff and patients only with cuffs on. (This sort of manoeuver combines dynamic physical control and situational control.)

Another use of situational control involves designing an interpersonal environment that will be least likely to promote conflict. As outlined in Chapter 1, youthfulness, transience of population, and overcrowding have been related to violence within institutions. By creating suitable "mixes" of patients or inmates, and by trying to accommodate personal preferences in placing persons within a setting, the likelihood of violence can be minimized. Ward transfers may be indicated for patients who do not get along with certain peers or who have become paranoid about certain staff, as well as to break up cliques of individuals who appear to be plotting escape or other major misbehaviors. In correctional settings, youthful inmates generally prefer environments that promote social interaction, while older inmates prefer more privacy and more structure (Porporino & Morton, 1983). There is some evidence that an all-female staff may

decrease the level of violence relative to a staff comprised of both males and females (Levy & Hortocollis, 1976), and that the use of street clothing rather than uniforms may also have positive effects (Sterling, 1980).

The advantage of situational over static physical control is that when used properly it allows for individual variation. Patients who have demonstrated that they are capable of safe responsible behavior are allowed access to various areas, goods, and privileges, while those who have not are prohibited. Holmes and Miller (1976) emphasize that the careful development of a fair and just set of rules about who is allowed to do what reduces the potential for conflict by removing room for arguments over what the limits should be. Rules also make the setting of limits impersonal. Situational control may thus be seen by patients as more legitimate than interpersonal control (described below), because as long as staff enforce the same ward rules consistently with all patients, individuals will not feel they have been unjustly treated.

On the other hand, situational control is not necessarily an effective method to reduce violence if the rules imposed are seen as punitive. In an attempt to reduce prison violence in California, authorities increased situational control by reclassifying and reducing inmate assignments, cancelling evening activities, revising lockup times, and eliminating traffic in certain areas. Research showed that these stricter policies failed to reduce the rates of fatal stabbings and assaults on staff (Bidna, 1975).

5. Security Through Interpersonal Control

Interpersonal control is exerted through the behavior of others. Examples would be requesting a patient to go to his room because he has broken ward rules, listening sympathetically if he is upset, or asking him to help with an off-ward task in order to separate him from other patients who are teasing him. Its major advantage is that it can be applied to suit the needs of all patients at all times, and is thus extremely flexible. We all use it in our daily interactions with others, but its use requires a high degree of judgment and sensitivity. This method of control will be the subject matter of most of the course: the calming, defusing, interviewing, and mediation techniques discussed below are all based on the premise that security can be improved through interpersonal control techniques.

Interpersonal control relies on staff interacting with patients. However, in psychiatric hospitals there is evidence that nursing staff tend to avoid doing so (Rosenhan, 1974), whereas in correctional settings many

older institutions were designed on the assumption that inmates and staff should interact as little as possible. More recently they are being built so as to encourage it more, and there is evidence that this leads to fewer violent incidents (Wener, Frazier & Farbstein, 1987).

6. Security Through Self-Control

The five forms of control discussed above all have two features in common. First, they all *require judgment to implement:* for example, we must judge who is to be placed in (or released from) maximum security, when or how someone is to be restrained, who should approach and speak to an upset patient, etc. Second, they all are *short-term* in nature, meaning that they are only useful while they are in effect and have little influence on future behavior when they are not being applied. By the use of these methods, then, we have no reason to expect that patients will require either more or less security in the future.

In order to reduce the amount of control that we potentially exert over a given individual, that individual must *acquire control over himself.* Thus in the long term, the goal of security and treatment is to have patients become their own monitors — to achieve control over their aggressive behaviors and exercise this control responsibly. (The aim is not to eliminate aggressive behavior entirely, because aggression is sometimes useful and appropriate — as, for example, in resisting bullying attempts of others.) The function of psychiatric or penal institutions is to maintain short-term control over potentially violent persons while providing an environment conducive to their acquisition of self-control.

There are two broad methods of teaching self-control. The first is to place individuals in situations where they must form a meaningful and viable relationship with others. Many antisocial patients exploit others routinely, but predatory behaviors are counterproductive when the relationship is long-term (in the sense that there is no escape), and when group members have to cooperate with each other in order to achieve their individual objectives. Cooperative behavior often leads to the recognition that others are people, even friends. When others are viewed as people, antisocial behavior often results in guilt, which has powerful controlling properties. When they are viewed as friends, the motivation is to help them rather than exploit them. Milieu therapy and therapeutic community programs have been among the more popular of these approaches, and there is evidence that such programs can produce at least short-term positive changes in the behavior of the antisocial or psychopathic individuals who make up a large proportion of the populations of correctional institutions

and security hospitals (Angliker, Cormier, Boulanger, & Malamud, 1973; Gunn & Robertson, 1982; Whiteley, 1970). Long-term results, however, have been much less encouraging (Harris, Rice, & Cormier, 1989).

The other broad method of teaching self-control is to arrange an environment in which antisocial behaviors have little or no payoff or result in immediate punishment, while prosocial behaviors are immediately rewarded. This arrangement of consequences is the identifying characteristic of operant behavior programs, and is particularly suited to persons who exhibit overt impulsive aggression with some frequency. Other approaches include the modeling of prosocial behaviors, instructions, practice, and feedback regarding the appropriateness of social behaviors. In one of the most ambitious social learning approaches projects to date, Paul and Lentz (1977) showed that a token economy program could produce long-term positive effects on chronic mental patients. Among correctional populations (primarily juvenile delinquents), there have been demonstrations of long-term positive effects of token economy programs (Jesness, 1975; Phillips, Phillips, & Wolf, 1973). Social skills training techniques have also been used to teach self-control to delinquent populations (e.g., Chandler, 1973; Sarason & Ganzer, 1973). Stumphauzer (1972) used a peer modeling program to teach self-control to young prison inmates. Anger control programs (e.g., Feindler, Ecton, Kingsley, & Dubey, 1986; Goldstein & Glick, 1987; Novaco, 1976) and other therapies using cognitive approaches (Platt, Scura & Hannon, 1973; Platt, Perry & Metzger, 1980; Ross & Fabiano, 1986; Sperr, 1973) have also been shown to have positive effects with institutionalized correctional and psychiatric populations.

It is worth noting that efforts to teach long-term self-control help to accomplish short-term control as well. In psychiatric hospitals, the most highly assaultive patients have been found to be those who are the most disturbed, and it may well be that any treatment that reduces their psychiatric problems will reduce their assaultiveness. Also, the teaching of self-control involves patients developing friendly personal relationships with staff, which makes it less likely that they will act aggressively towards them. Finally, to the extent that patients believe they can secure their release through legitimate means (i.e., by getting better) they are much less likely to attempt to escape or cause other security problems.

Throughout the 1980s, Western society has placed more and more emphasis on individual human rights and rights to self-determination. This has been increasingly evident in psychiatric hospitals (e.g., Daes, 1986), where patients have been increasingly encouraged to demonstrate self-control in issues such as consent to treatment (Malcolm, 1986).

To summarize, then, staff members can maximize security within an institution by a careful combination of all forms of control techniques. Because of the fact that clients must eventually learn self-control techniques, the use of interpersonal and self-control techniques should be emphasized.

Security Manual

In order to train new members and to ensure that all staff are aware of security regulations and procedures, every area in a psychiatric institution should put out a manual outlining its security policies. All staff who work in that area should be familiar with the contents of this manual, and it should be reviewed at least annually and revised if necessary.

Unfortunately, we have found that there is a tendency in institutions for ever-increasing numbers of restrictions and regulations. Often the reaction to any real or even imaginable disaster is to tighten security, usually by increasing the static measures. While this is sometimes warranted, we believe that regulations should not be added without carefully weighing the advantages of added safety against the disadvantages of interfering with a therapeutic environment, because treatment may be severely hindered by excessive concern with security. Similarly, old regulations should be reviewed for possible deletion if they no longer serve a useful purpose.

People often think of a "security manual" as referring only to static measures. Such a manual however should describe procedures to be employed in the use of all types of security, including dynamic, situational, and interpersonal control. Much of this book constitutes the contents of a comprehensive security manual that could be applied in the majority of institutions.

For those interested in creating a manual specific to their institution, what follows is a list of questions that should be considered in its preparation. Most of these questions pertain to static and situational measures, but interpersonal security procedures should also be included. Obviously not all may apply to a particular institution; however, all are examples of factors to consider if not necessarily to endorse.

Inspection and Maintenance of Static Security Devices

a) Are security alarms necessary? If so, whose responsibility is it to ensure that all staff know where they are and are instructed in their use?
b) Whose responsibility is it to ensure that all security devices are maintained in working order?
c) Are regular examinations of windows, bars, locks, etc. required? If so, how often? Who is responsible? If such checks are deemed necessary, are they conducted at unannounced irregular intervals? When checking patients' rooms, is it safe to have just one staff member do this, or should there be a second staff outside the room to prevent a patient from surprising the first one or locking him/her in the room?
d) Are there rules about allowing staff an unobstructed view of bars or windows?
e) Is there a need for regular inspection of external walls, entrances, roof, and fencing? If so, how often? Who is responsible?
f) At the entrance to the building, is there a need for at least two locks, only one of which is open at one time?
g) Is there somewhere within the building (near the entrance, most likely), where a copy of the keys for all doors in the building are kept so that access can be had to all areas of the hospital?

2. Movement of Persons In and Out of the Area or Institution

a) Is there a need for all persons to sign in and out of the building?
b) Are any documents required of patients before they are allowed to leave the building? If so, the type of documents required for each type of patient should be identified.
c) When patients are outside the building, are escorts ever required? How many? Are additional security precautions ever required (such as cuffs, restraints, medication)? Who decides?
d) Where and by whom are new admissions to the area seen?
e) Are searches of patients required on arrival and/or before discharge? Who will conduct the search and how?
f) Should food and garbage containers be opened and inspected when they leave the building?

3. Visitor Regulations

a) Are there items that visitors should be advised may not be brought into the hospital (e.g., jewelry, knives, cutlery, scissors, knitting needles, razor blades, plastic bags, medicine, alcohol, cameras, cash)?

b) Are certain people not allowed to visit (e.g., ex-patients, children)?
c) Should incoming parcels, suitcases, briefcases, etc. brought in by visitors or staff from other areas or other institutions be checked by metal detectors or parcel scanners?

4. Staff and Volunteer Regulations

a) Are staff and volunteers screened with security concerns in mind prior to being accepted?
b) Are staff and volunteers checked prior to each entry to be sure they are not bringing in anything that might pose a security threat to themselves or others?
c) Are all staff who work in the area told what they should not bring or wear to work (e.g., knives, cameras, chain jewellery, etc.)?
d) Are volunteers asked not to give their last names, addresses or phone numbers, or money to patients?
e) Are staff clearly told specifically what to do in the case of bomb threats, fires, disasters, and hostage takings?
f) Are volunteers and staff told what to do if any problem arises while they are around (e.g., patients in a fight)?

5. Yard Security

a) Are patients counted as they leave the ward, enter, and return from the yard?
b) Are the yard staff instructed to remain in one position and be responsible for a particular part of the area?
c) Is there a set minimum staff/patient ratio for the yard?

6. Ward Security

a) Are all visitors escorted while on the ward?
b) Is an accurate count of patients maintained at all times?
c) Are staff instructed to keep keys out of sight?
d) Is a staff member always in a position to observe patients while they are showering?
e) Are patients escorted to off-ward areas such as the dispensary?
f) Are patients' parcels checked when they return from visits?
g) Is cutlery counted after meals?

h) Are staff told not to give or accept gifts from patients, or to buy items for or from patients?
i) Are staff warned not to gamble with patients?
j) Are patients allowed to have matches? Lighters? (Butane lighters and lighters with a pressurized fuel reservoir would be of the most concern.)

7. Workshop Security

a) Is someone responsible to ensure that all workshop staff know the location of fire alarms, security alarms, and emergency stop switches for all equipment?
b) Are there regular unannounced examinations of windows, bars, walls, locks, etc.?
c) Is someone responsible for keeping a record of all tools issued and returned?
d) Are patients counted while in the workshop?
e) Is there a list of all equipment kept in a safe place? If so, broken or obsolete equipment should be deleted from the list and caution should be used to ensure that it is removed safely from the building. Similarly, new equipment should be carefully reviewed as to its safety, and if accepted, should be added to the inventory list.
f) Are workshop staff instructed to carry keys out of sight? What keys should they have?
g) Are staff told not to give or accept gifts or money from patients?
h) Are staff told to communicate to ward staff any unusual behavior they observe?
i) Are patients escorted by workshop staff to and from the workshop?
j) Are regular unannounced searches made of patients entering or leaving the workshops?
k) Are maintenance personnel and contractors escorted while in the building?

CALMING

This section will discuss interventions to be used with patients who are moderately upset, or who are calm but showing signs of becoming upset. Calm states are essential to the maintenance of a therapeutic atmosphere as well as to the development of interpersonal relationships that can reduce the likelihood of greater upset and crises. By reducing a patient's disturbance early on through encouraging him to talk and by carefully listening, you will often be able to prevent further upset or agitation.

How can you tell if someone is becoming anxious, aroused, angry or upset? Signs to look for include: body tensed; fists clenched or other nervous hand gestures; eyebrows lowered and drawn together with vertical wrinkles between; ignoring others; either avoiding eye contact or staring; dysfluent speech; speaking loudly or very quickly; sweating; dilated pupils; "goose pimples"; pacing; fidgeting; "jumpiness" or the tendency to startle easily; rapid pulse and breathing; flushing; lips pressed together.

In addition to these physical signs of emotion, look for changes in usual behavior patterns, such as someone suddenly becoming either very quiet or very outgoing and noisy; showing a shift in energy level, either becoming more active or more lethargic; starting to talk to "unseen" persons; or seeming very sad or depressed (look for expressions of hopelessness). Finally, be aware of recent or upcoming events that can be seen as unusual, frightening, or frustrating. These include admission, visits, review board hearings, receipt of bad news, being teased, losing privileges, being about to leave hospital, or being about to return to court. Seeing a co-patient behave aggressively and be restrained by staff can also be upsetting: when this happens, other patients often need to be calmed and reassured that they are safe and will not be restrained themselves. The purposes of calming are:

- to *assess* the patient's current emotional state. Is he upset, angry, depressed or tense? If so, how strong is this emotional state?
- to *determine what is causing* the emotional state. Can the patient identify the cause?
- to *eliminate or reduce* the emotional level wherever possible by helping the patient arrive at his own solution, granting requests, providing information, giving reassurance, or making an appropriate referral to another staff member.
- to *temporarily remove the patient* from the vicinity of others to avoid upsetting them.

Steps in Calming

Most people find it reassuring just to have somebody listen to them, and "getting things off their chest" with an interested listener will therefore often have a direct calming effect. Additionally, by hearing a patient out you will know what grievances, resentments and problems he believes he has, which will often allow you to take corrective action such as granting a legitimate request or correcting misinformation. At a minimum, you will become aware of his mental state and of things that bother him that should be known to all ward staff (e.g., a firmly held delusion that certain staff members or patients are plotting to harm him; a persistent perception that he is not liked, etc.).

While calming and reassuring someone may seem simple, there are in fact a series of steps that should be followed in order to maximize the likelihood of a safe and effective intervention. These steps, as will be seen, are the same at every stage of crisis prevention and intervention: observation, preparation, approach, action, and follow-up.

Observation

Before you begin to talk with an upset patient, make careful observations. Of course, the more opportunity you have had to observe him in the past, the more accurate you will be in detecting behavior and mood changes that enable you to "read" his emotional state. If you have not observed him recently, reading his clinical file and discussing matters with other staff is informative. Familiarize yourself with his background so that you won't need to ask him questions he has answered several times before.

Accurate observation is important first in deciding whether it is necessary to approach a patient at all. Some of the cues that indicate that someone may be becoming disturbed or upset are listed above. In addition to these physical signs of emotion, attend to verbal and nonverbal behaviors. Listening to the *content* of what others say is quite straightforward, and as long as you listen carefully and can understand what is being said you can gain useful information about how they are feeling. However, research and clinical experience suggest that *nonverbal* aspects of communication often give additional information. By this we mean not *what* but *how* other people are speaking (e.g., voice tone, hesitations, stutters, etc.), and what they are doing with the rest of their body (e.g., are their hands relaxed or tense?). Nonverbal communication is thought to be less directly under conscious control and therefore to be an especially good indicator of feelings and emotions.

Preparation

If, based on your observations, it seems that calming procedures are indicated, prepare to intervene. Even if you are not certain, it is usually best to go ahead anyway. The procedures are simple and brief, the patient will likely appreciate any interest being shown in him, and through interacting with him you will know more precisely how he is feeling.

Safety. Before approaching an upset patient, be sure you can be seen by at least one other staff member. It is also desirable to tell the other staff what you are about to do.

Place. Calming is best done in a quiet, comfortable, private area. Ask other patients who are nearby to move, or ask the upset individual to come somewhere else.

Timing. In order to be able to calm someone else you must be calm yourself. It is difficult to appear this way if you are in a hurry or have to rush off to do something else in a few minutes. While calming need not take a long time, have at least ten minutes to spend with the patient.

Approach

Just as patients communicate through verbal and nonverbal cues, so do staff members. Here we briefly discuss the nonverbal cues that staff members transmit to patients and how they are likely to be interpreted.

Voice tone and quality and facial expression. You are primarily interested in drawing the patient out, and will therefore want to sound calm, friendly, and interested. You should not sound harsh, loud, sarcastic, or accusing. A smile will usually be interpreted as an indication of warmth.

Body posture. Your body posture should show calm interest. Avoid seeming aggressive, overly assertive, or afraid. Because a face-on, straight and rigid posture (especially standing with hands on hips) may be interpreted as threatening, avoid this posture. If you must stand, it is best to do so at an angle to the patient or to lean against a wall. Whenever possible it is better to sit. Sit at an angle to the patient keeping your body relaxed: this position is nonintimidating and is also safer for you because less target area is provided should the patient decide to act violently. Keep your hands out of your pockets: in the unlikely event that the patient attacks, you would not be able to react quickly. (On the ward, you should never have your hands in your pockets.)

Physical distance. Standing or sitting too close may be interpreted as crowding or an aggressive invasion of personal space. On the other hand, standing too far may be interpreted as either fear or dislike. You should therefore maintain a distance of at least three to four feet. If you

are much taller than the patient you may want to keep back a little further, or he may experience a feeling of being overpowered by your presence and react negatively.

Eye contact. Eye contact should be maintained as in normal conversations. Look frequently into the patient's eyes, but avoid staring since this may be interpreted as threatening. Avoiding eye contact altogether may be interpreted as fear or lack of interest.

Opening remarks. As you approach, plan your opening remarks. Sometimes it is advisable to ask the patient if he wants to talk by saying "John, you look upset. Would you like to talk about it?" On other occasions you may not want to give him the chance to say "no," in which case an opening such as "John, you look upset and I'd like to talk to you. Shall we go for a walk or stay here?" may be better because it still gives the patient some choice.

Action

Once you have approached the patient, encourage him to talk. *Listen carefully to what he is saying.* The mere fact that another person is showing interest can exert a powerful effect on his willingness to speak about what is bothering him, and discussing matters that are bothersome, frightening, or confusing with an interested listener will by itself do much to calm him down.

In your exploration with the patient you can use any and all of the techniques covered in the course section on interviewing (see Chapter 7). However, because exploration is most effectively conducted as a conversation (in contrast with more formal interviews), techniques that draw out the patient, show that you are interested, and show that you are *listening* are the most appropriate and effective. The following three basic techniques are particularly useful.

Open questions may be used to get a person to open up, be expansive, and talk more. These are neutral-sounding queries that, unlike closed questions, do not lead to "yes" or "no" one-word answers, and encourage patients to explore their thoughts and feelings without feeling they are being interrogated. Sometimes their use can allow patients to talk about things they might simply deny if asked a closed question. For example, asking "When you said that he stole it, what did he do?" is much more likely to elicit an honest answer than asking "Did you say that he stole it?" which is likely to elicit a simple denial.

Open questions typically begin with "what," "how," "could," or "why." Some examples are: "What happened this morning?" or "How did that happen?" "What" questions are most often associated with facts and

gathering information; and "how" questions with feelings. "Could" or "would" questions allow maximum freedom, even allowing the patient the implied right not to answer. "Why" questions are often associated with reasons, but because they sometimes make patients feel defensive they should be used sparingly. Sometimes the same question can be asked without using the word "why." Thus, instead of saying "Why did you hit . . . .?", say "What happened between you and . . . ?" Instead of speculating about an issue, leave it for the patient to answer. For example, instead of saying "Do you think that . . . ?" you might say "What do you think about that?" Instead of "Do you feel . . . ?" followed by "why," you might say "How do you feel about that?" Similarly, instead of saying "Do you have a problem . . . ?", you might say "What's the problem?"

Be careful to ask only one question at a time, as double-barrelled questions often confuse the patient and elicit answers that are of little value. Also, it is important to try to begin the interview with very general questions and then move to more specific (but still open) ones as the conversation proceeds. Sometimes a question might even be implied rather than direct, in which case it might better be called an "open invitation to talk."

The use of *listening responses* is another useful technique. These are small gestures such as nods or brief comments like "Uh huh," "I see," "Go on," "Oh yes," etc., that we use to show someone that we are listening to them and that we want them to continue. Most people need some feedback or indication that they are being listened to. Listening responses offer encouragement to the patient without intruding on his train of thought. Thus, the chances of the interviewer "leading" the direction of the conversation are reduced. Other listening responses include neutral phrases such as "And then?", "Tell me more," "Right," etc., as well as *echoes* (simple repetitions of the speaker's last few words), which encourage people to clarify or expand on something they have just said.

Another useful skill is *paraphrasing*, stating in your own words what the patient has just said. Often it involves a simple summary of his train of thought, and is a very good way to be sure you have understood what was meant. Paraphrases are similar to echoes but involve restating the important content of what was said in your own words. They show the patient that you are really trying to understand him, and thus help build a relationship. Moreover, if you have misunderstood what he has said, tthese give him a chance to clarify his meaning.

All of the above techniques are very simple and effective in encouraging patients to talk. If successful in making them comfortable by your approach, you will find that many patients will not only express what is bothering them, but will likely be calmer afterwards.

Closely observe the patient throughout the intervention to see whether he does seem to be becoming less agitated. You should especially try to determine whether certain topics (e.g., the mention of specific people, events, etc.) are associated with more signs of disturbance than others. These topics are likely sensitive ones, and careful inquiry about them may help you determine what concerns underlie the disturbed behavior.

What specific actions you take during or after exploration will vary depending on the circumstances. If nothing can be done about the situation the patient is upset about, you can only listen and empathize, but often this alone is helpful. Other times, you may be able to help find a solution to a problem by helping to explore alternative courses of action. If a patient expresses unrealistic concerns (such as fears of being put out on the street at the end of his hospital stay without help), he can be reassured. If he has a reasonable request, either grant it or inform him when it can be granted (if he wants to write a letter, for instance, you should state when this may be done and what to do to get writing material). If he is upset in part because of misinformation (e.g., a belief that patients are not allowed to have visitors), give the correct facts. If he can be referred to someone else on the treatment staff who might better be able to help, promise to do so (if there is a question that a social worker could best answer, make a referral to a social worker). If he makes an unrealistic or unreasonable request, carefully explain why it cannot be met.

Follow-up

Regardless of the outcome of a calming attempt, inform the ward supervisor, charge nurse, or team leader. This is just as important following a successful intervention as when you have been unable to calm a patient and are concerned that he is getting more agitated and disturbed. A note should be entered on the patient's file, and other staff should be informed. If you have promised to make a referral or find out some information, quickly do so and inform the patient when you have. If he has agreed to do something, get back to him to see if it has been done and give praise if he has taken action.The fact that he has not followed through may be important in later calming situations.

A last note: Although many times you will be successful following these techniques, there will be times when a patient will not want to talk. On such occasions it is advisable to let him be, but tell him that you will be available if he wants to talk later on. Sometimes a patient will express a desire to talk shortly after your first approach, or he may prefer to open up to another staff member.

Background and Rationale for Calming Techniques

Looking for Cues

Even psychotic or retarded people rarely become violent without reason or warning: our research has shown that patients almost always give a reason for aggression when interviewed afterwards (Chapter 2; Quinsey & Varney, 1977), while other research with psychiatric patients has shown that physical assaultiveness rarely occurs in the absence of verbal threats or abuse (Werner, Yesavage, Becker, Brunsting, & Isaacs, 1983).

An extensive literature implicates sympathetic arousal (especially catecholamine secretion) in the experience of anger (Hart, 1984). Some signs of sympathetic arousal that can be seen by observers are pupil dilation, sweating, "goose pimples", and rapid breathing. Observable signs of anxiety include pacing, fidgeting, jumpiness or the tendency to startle easily, tremor, limb and facial tenseness, rapid pulse and breathing, tearfulness, throbbing of blood vessels in neck, and flushing (Snaith, Baugh, Clayden, Husain, & Sipple, 1982). Signs of anger that can be seen in the face include pressed lips and eyebrows lowered and drawn together with vertical wrinkles between (Ekman, Friesen, & Tompkins, 1971).

Anger is known to contribute to the causation of verbal and physical aggression (Rule & Nesdale, 1976), while anxiety and arousal are in turn, related to anger (Deffenbacher, Demm & Brandon, 1986; Novaco, 1976). Thus, recognizing the signs of anxiety, arousal, and anger in patients and helping them to allay those feelings can be important steps in preventing aggressive incidents.

Step-by-Step Procedure

A step-by-step procedure is advocated for intervention at each stage of the escalation process, consisting of observation, preparation, approach, action, and follow-up. There are two main reasons for our emphasis on following these steps even for situations in which the possibility of physical aggression is remote. First, the literature on memory and learning supports the view that over-learning will help staff remember and perform the steps even when they are under stress (e.g., in the face of a patient who has escalated to the hostile stage). Learning is particularly enhanced when the repetition takes place in different relevant contexts (Morris, Bransford, & Franks, 1977). Second, breaking down every topic into the

same set of smaller steps encourages course participants to think of all relevant considerations for each component. Most of the techniques advocated in here are based on common sense and experience. For some, however, there is in fact empirical evidence of their validity.

For the approach and action steps most of the material presented comes from the literature on counseling and psychotherapy, as does much of the material on interviewing and mediation discussed in Chapter 7. This does not mean that the course is intended to teach trainees to be psychotherapists, but rather that the skills involved in calming upset patients, helping find out what is bothering them, and helping them to reach a resolution are some of the same skills that are involved in counseling. The aim here is to provide only the most fundamental counseling skills that we consider staff members must have in order to do this effectively. There is evidence that psychotherapy, irrespective of the particular type or training of the therapist, is effective in helping troubled individuals (Brown, 1987; Glass & Kliegl, 1983; Martin, 1983; Smith, 1982; Smith & Glass, 1977; Stiles, Shapiro, & Elliot, 1986), and that persons who possess qualities rated as therapeutic by counselors can have marked positive effects upon those with whom they interact (Shapiro & Voog, 1969). There is also general agreement about the value of variables such as warmth, empathy, interest, respect, and acceptance in helping relationships (Alexander, Barton, Schiavo, & Parsons, 1976; Goldstein, 1973; Martin, 1983; Mitchell, Bozarth, & Strupp, 1973; Krauft, 1977; Sweet, 1984; Truax & Mitchell, 1971). For example, in one particularly convincing study (Alexander et al., 1976) it was shown that therapist warmth, among other variables, was related to better outcome as measured by both subjective ratings and lowered recidivism among delinquent clients. The skills we teach in the calming, interviewing, and mediation sections of the course are those that have been found to be related to warmth, empathy, interest, respect and acceptance. We have chosen skills that are relatively easy to learn: there is evidence from other research that relationship skills can be taught (Haase & Dimattia, 1970; Martin, 1983; Mitchell et al., 1977; Truax & Mitchell, 1971), and that this learning need not take a long time (Ivey & Authier, 1978; Toukmanian, Capelle, & Rennie, 1978). A discussion of some of the specific skill dimensions taught in the approach and action phases of calming follows.

Approach. Two things to consider when approaching patients who may be upset are the angle from which to approach, and how close to get physically (i.e., how much personal space to allow). Generally speaking, when approaches are made from an angle or with the head turned, less anxiety is aroused than when they are made from a direct head-on position (Hayduk, 1983). *Personal space* refers to the area individuals maintain

around themselves into which others cannot intrude without arousing discomfort (Hayduk, 1978). Distances can be uncomfortably large as well as uncomfortably small; on average, most white North Americans begin to feel uncomfortable when someone approaches closer than 70 cm (Hayduk, 1981, 1983). People prefer more space when they are in a corner or under a low ceiling. There is evidence that more space is also preferred with persons who are feeling anxious, under stress, are expecting a hostile encounter, or are having an encounter with another person of differing social status. Intrusions on personal space can result in increased stress and physiological arousal (Hayduk, 1983). Several studies have shown that violence-prone individuals (most studies have used inmate populations) require more personal space than nonviolent ones (Booraem, Flowers, Bodner, & Satterfield, 1977; Curran, Blatchley, & Hanlon, 1978; Gilmour & Walkey, 1981; Hildreth, Derogatis & McCusker, 1971; Kinzel, 1970; Roger & Schalekamp, 1976), and there is evidence that schizophrenics require more space than nonschizophrenics (Horowitz, Duff, & Stratton, 1974). Personal space increases with age up to the early 20s (Hayduk, 1983). There is some evidence that it may decrease during adulthood, at least among incarcerated males (Wormith, 1984). All these findings suggest that when staff approach patients, especially upset and/or psychotic ones, they should consider that the patients may desire more personal distance than they would themselves. The more upset a patient is believed to be, the more nonthreatening should the approach be. At the same time not too great a distance should be kept, as closeness is an indication of concern, empathy, and liking (Haase & Tepper, 1972; Mehrabian, 1969).

Body posture. Throughout the course we emphasize the importance of maintaining a body position that conveys warmth, caring and empathy without unduly compromising safety. A forward trunk lean has been found to be one indication of therapist empathy, warmth, interest, and liking (Bayes, 1972; Haase & Tepper, 1972; Mehrabian, 1972). For this reason, sitting on the edge or arm of a chair leaning toward the patient is advocated as conveying interest and concern while allowing quick action if necessary. It is important to look relaxed, as a tense posture can have detrimental effects (Mehrabian, 1969). Hand movements have also been found to be related to conveying warmth (Bayes, 1972). For this, as well as for obvious safety considerations, it is recommended that staff not keep their hands in their pockets.

Eye contact. Because frequent eye contact (not staring) has been found to be positively related to empathy (Haase & Tepper, 1972), we emphasize looking at the patient. Although eye contact has frequently been measured by the number of breaks in eye contact, Ivey and Authier (1978) note that it is frequent, variable eye contact that is important.

Voice Quality and Facial Expression. There is a great deal of evidence to show that people have a tendency to imitate others, particularly those who are in higher status positions (Bandura, 1969), and thus we teach staff that they should model the behavior they wish the patient to perform. Individuals who exhibit calm behavior by using gentle, soft, unhurried voice tones will be likely to have a calming influence on patients who are speaking loudly, quickly, or harshly. In addition, smiling on the part of therapists has been found to be the best single indicator of warmth (Bayes, 1972), and also provides a model for patients that is incompatible with hostility.

Action. Using a person's first name in an interviewing situation has been found to increase liking for the interviewer by the interviewee, as well as greater perceived liking for the interviewee by the interviewer (Kleinke, Staneski, & Weaver, 1972).

Obviously, for a person to feel they have been listened to they must have had a chance to talk. Cox, Hopkinson and Rutter (1981) found that interviewers who use open questions have more talkative informants. As well, open questions are useful in eliciting feelings from clients (Hopkinson, Cox, & Rutter, 1981), are perceived by them as helpful (Ehrlich, D'Augelli, & Danish, 1979), and contribute to the rated empathy of the counsellor (Rennie, Burke, & Toukmanian, 1978). Listening responses encourage people to continue talking without interrupting their train of thought, as well as determining the flow of the conversation by keeping them on the area or topic immediately preceding (Ivey & Authier, 1978). They have been related to positive impressions of the counselor by clients (Mehrabian, 1969). Finally, we recommend frequent use of paraphrasing because it has been found to encourage client self-exploration and openness (Ehrlich et al., 1979).

Chapter 5

Explosive Situations

When patients become highly upset, it may be too late to use calming procedures. If someone is very close to acting violently the situation must be brought under control quickly and effectively if no one is to be hurt. Almost always, nonphysical intervention known as *defusing* should be attempted first. Usually this will work and the situation will quickly become one of calming. Only if defusing procedures do not work should physical intervention be attempted.

DEFUSING

Defusing means to de-escalate situations that are very close to becoming violent by using verbal techniques. In these situations, the very first thing you say is likely to be the most critical: if you say the wrong thing, the incident may very well end in violence. Unlike calming situations, there is not likely to be any second chance.

Defusing procedures are called for when it appears that a patient is escalating and losing control, or when a physical assault appears likely. Behaviors that indicate this include loud, jumpy, rapid speech, rapid pacing, banging or kicking of objects, wrinkled forehead, staring or squinting eyes, flared nostrils, lips pressed together or pulled back in a snarl, arms crossed or on hips, fists clenched. The patient will almost always be standing. Past history may be useful in identifying idiosyncratic signs that someone is losing control.

Examples of some typical situations that may require defusing are the following:

- a patient being highly argumentative with staff
- a patient threatening a staff member
- one patient threatening another
- two patients in a verbal argument and near fighting
- a patient being visibly very upset, as demonstrated by fast pacing, kicking furniture, etc.
- a new patient being hostile during the admission procedure
- staff asking an upset patient to do something he does not want to do
- a staff member telling a patient who does not like needles that he will be getting an injection
- a staff member imposing sanctions on an upset patient
- unannounced searches of patients' rooms and possessions.

NOTE: Depending on the circumstances, in some of the above situations you may decide right away that seclusion will be necessary. Seclusion is also called for when a physical incident is in progress, such as when two or more patients are fighting, or a patient is attacking a staff member, harming himself, or engaged in serious property destruction that creates a dangerous situation. In these cases, do not use defusing procedures but go straight to the procedures described in the next section, Restraint, Seclusion and Self-Defence.

Steps in Defusing

The steps in defusing are the same as in calming (observation, preparation, approach, action, and follow-up), but there are some important differences in execution. Preparation and coordination are more important, because usually more than one staff member must be involved. Approach techniques are also more critical, in that the approach must be quick enough to allow for intervention but not so quick as to trigger an incident by rushing the patient. Actions differ in that the first aim is to gain control of the situation, with exploration about why the patient was upset being of secondary importance. Follow-up is similar in that it should have the long-term effect of calming, but different in that sanctions may have to be applied.

Observation

Observation is very important when highly excited patients are involved. Referring to the list of typical situations that may lead to defusing, it can be seen that some are initiated by staff confronting an already-upset

patient (e.g., asking him to do something, telling him he will be getting an injection, or imposing sanctions). In these cases the staff often have considerable control over when to intervene, and should take time to adequately observe and prepare before acting. The interaction should also be initiated when conditions are most advantageous to staff in terms of the patient's position, location of other patients, etc.

Things to watch for with a highly upset patient include:
- the presence of weapons or potential weapons
- the presence of concealed weapons (for example, bulges in pockets)
- the presence of other patients who may be confederates (maybe staff members are being set up)
- the presence and location of other staff who may be called on for assistance as required
- alarm buttons if necessary
- escape routes if necessary.

On some occasions there may be much less time available for observation (e.g., when one patient is threatening another with a weapon). In these cases, observation must be done as you are preparing and approaching.

Preparation

In every case where defusing is required, a few moments spent discussing who will do what is well worth the time it takes and can often prevent disaster. Staff should discuss what they will do if the defusing attempt fails and physical intervention becomes necessary. Generally speaking, only one person should do the talking, while other staff act as backup. This individual should know the patient, be trusted by him, and be comfortable with the defusing procedures. Usually, less intimidating staff members will be more effective at this than authoritarian ones.

Approach

The patient should be approached calmly yet alertly by the person who will be doing the talking. While there are no hard and fast rules about what other staff should do, it is usually best for two backups to be behind the primary staff member and approach inconspicuously from opposite sides, so they will be ready in the event that restraint becomes necessary. They may also remove bystanders or obstructions if need be. Removing bystanders will help diffuse the situation immediately because the upset patient will no longer believe that he has to "play to the audience."

Remember that people who are angry require more interpersonal space. Giving the patient plenty of room not only minimizes the risk of escalating matters further, but is also safer should he strike out. It is also important not to make him feel cornered: if he is against a wall or in a corner, give him even more room. The choice of which route to use in approaching an explosive patient must be considered. Sometimes staff members will want to approach in such a way as to prevent the possibility of the patient escaping, whereas in other cases, one might deliberately want to open an escape route.

If there is a potential weapon in the vicinity that you are concerned about, stand between it and the patient: later, as you are talking to him, it may be possible for you or other staff to inconspicuously remove it. If there are other patients who may be confederates involved in a set-up, do not stand with your back to them. Keep your head turned toward the patient. Stand sideways with your feet shoulder-width apart and with equal weight on both feet; knees should be kept very slightly bent, while hands should be held at waist- to shoulder-height and towards your middle. You may want to stand slightly to the side of the patient rather than directly in front of him.

Action

Getting the patient to say "yes." A simple rule to remember in a defusing situation is to try to get the patient to say "yes" to things you are saying. It is hard for him to be angry with you while agreeing with you, and you can achieve this by asking questions that you know require a "yes" response. A second goal is simply to get the patient to talk about anything, based on the assumption that talking and striking are incompatible behaviors (two actions that are hard to perform simultaneously). Open questions should do this. Note that you are not so interested in *what* he says as just in getting him talking in the first place.

Remaining calm. Your tone of voice should be neutral — neither friendly nor unfriendly. It is very important to remain calm: it is hard to be angry at someone who is not angry in return, and by using a tone that is just slightly quieter and speech that is a little slower than the patient's, you provide a model that will be hard for him to resist imitating. At the same time, your voice should sound firm and controlled. Persons who are angry are eager to focus blame and insult on others, and if this is done to you it may be difficult not to get angry in return. To avoid this, try to establish a relationship in which you take his side as much as possible; for instance, agreeing with his statement of the problem or his feelings. By agreeing with him and enabling him to agree with you,

it is unlikely that he will continue to blame you. The object is to have him join you in defeating the problem rather than defeating you.

Once this part of the defusing is completed successfully, the situation becomes much more like a calming situation in which the goal is to find out what is bothering him. Open-ended questions, listening techniques, echoes and paraphrasing can all be used.

The light to heavy principle. Order the techniques you use from light (gentle persuasion) to heavy (strongly assertive). If a strongly assertive approach is used at the beginning (e.g., threatening to lock the patient up if he doesn't comply, instead of simply making a calm direct request) and doesn't work, it's too late then to try an easier-going approach. Be very careful not to burn your bridges. An overassertive approach can trigger violence. It is always easier to switch to a more assertive technique from a less assertive one than vice versa, which is seen as "backing down."

Saving face. One way to help the patient back off gracefully is by providing face-saving rationalizations if necessary. Having other staff get rid of uninvolved bystanders will help. You should control the pace of the patient's concession-giving by not asking for too much too fast; at the same time, do not negotiate or make concessions on substantive issues. Often you can help him save face by giving him a choice of actions, both of which are acceptable to you.

Humor. If a patient does not seem to be calming down by the use of the techniques suggested above, it may be possible to quickly ease the situation by the use of humor, especially with the sort of joke that makes fun of the target of his anger. This entails some risk, as an upset person may misinterpret joking remarks in a way that only provokes him further. Nevertheless, if it works it can quickly change the situation from one of defusing to one of calming. Thus, we refer to this as a high-risk high-gain technique.

Distraction. This technique has the advantage of not being especially high risk, but it will not be suitable in every situation. It is most useful when there are two patients involved and you think one of them might be happy to have an excuse to leave the scene. In such cases, distracting his attention from the other patient by asking him to do a small favor, telling him it's lunchtime, etc., might effectively separate the two until they calm down. Although this does not do anything to solve the problem causing the conflict, it at least allows time for the two parties to cool off, and staff can try to help them solve their dispute later.

Making requests of an upset patient. Sometimes when a patient is already upset,you must ask him to do something (go to his room, take medication, etc.). Usually the best way to do this is to calmly and politely state your request. If he refuses, listen to his arguments and use reflections

(see Interviewing, Chapter 6) and paraphrases to show you have heard them, but then calmly — and more firmly — restate your request. Other times, it may be possible to ask something implicitly via a factual statement rather than giving an explicit order. For example, the statement "It's time to get up" conveys the same message as "Get up," but is much less likely to be responded to with anger or violence.

Two upset patients. In defusing situations where two patients are arguing, breaking their eye contact and then separating them are the crucial first steps. *Never* step between them. Often it is possible to interrupt the argument and separate them by firmly but politely requesting one of them (usually the less upset one) to come over to you. Other times two staff will be required, each of you to talk to and control the attention of one patient while remaining visible to each other. One of you should try to take your patient around a corner or through a doorway so that the two antagonists cannot see one another but you and your fellow staff member still can. The importance of getting the patients physically separated so they are out of one another's eyesight and shouting range cannot be overemphasized.

Get the patient(s) sitting down. Whenever feasible, have him sit in a soft, deep chair or sofa. This may have a calming effect, and it makes the situation safer because it takes time to stand up from such a chair. Do not stand over the patient as this will be seen as threatening, but do not make yourself too comfortable either. Rather, sit down on the arm of a chair or sit forward so you can get up easily if you have to.

Errors to avoid. Be careful not to humiliate or belittle or challenge the patient in your defusing attempt. Especially if there are others around, this will only contribute to his anger and escalate the situation further.

Follow-up

The specific actions you take after defusing will depend on the situation. They will usually be the same as those discussed in the calming procedure; occasionally, however, a patient's behavior will have dictated the use of sanctions outlined by your program, such as going to his room or loss of privileges. After he has settled down, you should inform him that he will be losing privileges and explain why this is happening and exactly which privileges are being lost.

After defusing you should report to the ward supervisor what happened and what the patient's present mental state is, and put a note of the incident on the patient's record. It is also a good idea to complete an incident report form in the case of a successful defusing, as this may be instructive to other staff.

Background and Rationale for Defusing Techniques

Much of the material presented above is based upon our own research on assaults and staff injuries (see Chapter 2). The results of studies in other settings (e.g., Chapter 1; Conn & Lion, 1983; Dietz & Rada, 1982; Ruben, Wolkon & Yamamoto, 1980; Werner et al., 1983) point to many of the same conclusions. Of particular relevance are the findings regarding which situations pose a high risk for patient aggression.

Our list of situations for which defusing is appropriate comes partly from the review of the above literature, and partly from situations that were frequently mentioned in the incident report forms completed by staff at our institution. The list of behaviors that indicate if a patient is on the verge of physical aggression was also obtained by a review of incident reports and by talking with staff who worked on the wards where assaults were most frequent.

Steps in Defusing

Most of the material presented on the observation, preparation, and approach phases is based on the same theoretical and experimental background as that discussed for calming. In these situations, of course, because the probability of a physical encounter is much higher, factors such as allowing the patient more personal space and standing so as to to be in a good position to react defensively if necessary are more important.

In the discussion of the approach phase, the importance of not touching an upset patient unless absolutely necessary is emphasized. Although in other contexts a touch can be reassuring and calming (Riscalla, 1975), here the patient may interpret it as an invasion of personal space or an act of aggression, which puts staff at a high risk of being injured (see Chapter 2).

Some of the techniques described here have little empirical evidence for their efficacy, but we advocate them because they have some intuitive appeal. Talking and physical aggression are to some extent incompatible behaviors, and thus simply getting an angry patient to talk — and keep talking — should reduce the likelihood of violence. Helping a patient save face, breaking eye contact between two patients who are arguing, and the use of distraction have been recommended by others (Carney, 1976; Dutton, 1977; Goldstein, Monti, Sardino & Green, 1977; Goldstein & Rosenbaum, 1981; Guirguis, 1978; Lion & Reid, 1983; Miron, 1979).

The importance of remaining calm and of helping patients save face has been demonstrated in a study by Ruben, Wolkon, and Yamamoto (1980), in which they found that psychiatric residents who were assaulted more often were those who tended to be irritable and to favor physical fighting when threatened outside the hospital. In addition, an authoritarian, confrontative style in a therapist can be very damaging to the client-therapist relationship (Martin, 1983).

One of the problems that staff members carrying out defusing techniques must be prepared for is that a patient's anger, although not initially focused on them, may become so by the very fact that they are there. An upset individual often "projects" anger towards another as a way of defending his or her own self-image.

Havens (1980) suggests a technique called "counterprojection" to help avoid this. Instead of or after an empathic statement, rather than using questions to help the patient explore alternative courses of action (which might only make him react defensively), the staff member should try to make him feel that they both face a common enemy by agreeing with him as much as possible, and in a sense acting as a friend rather than an authority figure or therapist. Of course, one should never lie, collude, or undermine the program or other staff, but rather acknowledge and agree with the *feelings* the patient is experiencing. To facilitate this friend-like relationship, the staff member should stand at an angle to the patient rather than directly in front of him, and reduce eye contact compared to more relaxed encounters. Acting in this fashion minimizes the degree to which one will be blamed by the patient for his problem, which in turn reduces the likelihood of being drawn in and becoming angry at the patient in return.

There is evidence that people tend to think that others are responsible for their troubles rather than that impersonal or external factors are involved (Kelley, 1972; Miller & Norman, 1975), and this contributes to the likelihood that patients will become angry at staff members who are around when something upsets them. Moreover, it also makes it more likely that when a staff member asks a patient to do something, the latter will see him or her as being mean and arbitrary rather than simply enforcing a rule of someone else's making. Therefore, we teach that staff members can reduce the likelihood of being viewed in a negative manner by carefully phrasing their requests to patients as impersonally as possible.

Gradually increasing the coerciveness of techniques from gentle persuasion to strongly assertive has been found by social psychologists to increase the likelihood of compliance. Once someone can be made to comply with one request, the likelihood is much greater that he or she will then comply with a larger one (Freedman & Fraser, 1966). These

findings also suggest that one should be careful not to burn one's bridges by starting out with a heavier rather than a lighter technique.

We discussed the use of humor in the action phase as a high risk-high gain technique. That is, if it works, it may well change the situation immediately from one of defusing to one of calming; however, we recommend that it only be used as a last resort because in our opinion it is difficult to predict what will appear humorous to an upset patient. Some evidence for its effectiveness in reducing aggression and tension is provided by Singer (1968). In his study, black subjects listened either to a recording that was designed to make them angry towards segregationists or to a non-inflammatory control recording. Following this, subjects in each group listened to either a humorous or a neutral speech. Those who heard the humorous one, particularly if the humor was hostile towards segregationists, reported feeling less aggression and tension afterwards than the neutral-speech group. The difference between the types of speech was especially large for those who heard the anger-arousing recording first rather than the non-inflammatory one.

RESTRAINT, SECLUSION AND SELF-DEFENSE

Many times, efforts to defuse potentially explosive situations will succeed and no further intervention will be required. However, there will also be times when defusing is either inappropriate or fails when attempted. In these cases, restraint, seclusion and self-defence procedures should be followed.

What are Restraint and Seclusion?

In the Ontario Mental Health Act (1987 revision), the definition of "restrain" is to "place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient" (Revised Statutes of Ontario, 1980, Chapter 262, Section I(t)). In other jurisdictions it is defined differently, sometimes omitting chemical means of control.

In this section of the course we will discuss only restraint involving the use of manual physical force. The use of mechanical and chemical restraints, described briefly in the section on Security, will not be dealt with further here.

"Seclusion" refers to the supervised isolation of a patient in a special safe, locked room, empty except for a mattress, in order to prevent him from hurting himself or another person. In some cases, some or all of the patient's clothing would be removed to prevent self-harm. Although there are many issues of concern regarding seclusion, we will confine our discussion here to its use in emergency situations, with our primary focus being the process of getting patients into the seclusion room.

For purposes of this course, what differentiates a "defusing" situation from a "seclusion" one depends upon your decision as to what should be its minimal resolution. In some cases you will be content to allow it to end without incident, assuming the verbal intervention goes well, but in others you may have decided even before intervening that the patient will have to be secluded. Even in these cases, however, we still would advocate that you attempt a nonphysical resolution of the problem by requesting him to go voluntarily to the seclusion room before implementing restraint procedures. And even in situations where you do physically intervene, your verbal behavior is still important throughout.

Problems with Physical Restraint

One should not inflict unnecessary force on a struggling patient; on the other hand, insufficient force may mean he can escape and cause further damage. The critical factor is "minimal force," an issue that can be contested in future investigations. The Mental Health Act does not define "minimal" or "place under control," but staff involved in restraint can be asked to justify their actions with respect to the type and amount of force used. Examination of the Criminal Code provisions pertaining to assault and the use of force also indicate that staff are responsible for any "excess" force. Clearly they are entitled to use force to prevent serious injury or the commission of criminal offenses, which includes being entitled to protect themselves and others. However, the *unjustified* or *intentionally excessive* use of force constitutes assault and/or abuse.

Another problem with the use of restraint procedures is deciding who should carry them out. The official policy of most hospitals is that all clinical patient-contact staff are responsible. However, it seems that in some institutions the majority of restraint situations involve male ward staff only, and if none are around at the time, an agitated patient is left unrestrained until some arrive. Having only males responsible has produced a number of negative consequences. First, it means that situations may be handled by fewer than the desired minimum number of staff. Then, for the men, it creates the impression that they are always the ones to be called on to act as the "heavies," while for

women it can cause hesitation when faced with situations requiring restraint and, if unable to avoid them, feeling helpless to carry them out successfully and safely.

As with most difficult problems, both sides have legitimate arguments. Men generally are heavier, larger, more muscular and better able to take care of themselves in a physical confrontation. Female staff, however, are frequently in the majority and therefore need to be willing and able to participate. The best solution may be that a restraint situation should be handled by the most capable *and available* staff. Therefore, male staff may carry it out alone, or they may operate together with women, or women may carry it out alone, depending on who is there at the time. In order for this to be a workable solution, all staff must achieve a reasonable level of proficiency in restraint techniques: they must all know and practice the same techniques, they must all be familiar with the details to be considered during a restraint, and they must all know what the others are doing while they are carrying out their own role. They must act as a team. Such a condition will not come from reading the literature or spending one week practicing in the gym: it comes only with repeated experience and mutual cooperation in the workplace.

Steps in Restraining and Secluding Patients

Observation

As mentioned in the section on defusing, there are several situations in which you will know from the start that you are going to have to send someone to the seclusion room. These include a patient physically fighting with another, attacking a staff member, threatening someone with a weapon, harming himself, or engaged in serious property destruction. It may also apply to a patient in custody (involuntary, held on a warrant of remand, or found unfit to stand trial or not guilty by reason of insanity) who is attempting an unauthorized departure from the institution, if in your judgment the risk posed by his escape is great enough.

The decision about whether or not to use restraint should not be made lightly, and careful observation of the situation is crucial. To emphasize the point, we repeat that in many of the above situations you should first politely but firmly ask the patient to go *voluntarily* to the seclusion room. Other times, you will decide that you have no choice but to immediately initiate restraint procedures. In either case, you should carefully look around for any potential hazards (e.g., chairs), possible weapons, and other patients in the area before making your approach.

Preparation

The decision to carry out a restraint will most often occur right at the time of an incident. This requires quick, sound judgment as to what the outcome will be if restraint is and if it is not used; and if used, what form it should take. However, you will often have some time to consider how to proceed. Whenever possible you should make a plan of action that specifies what each staff member will do and how. If the decision is made to restrain, the person most experienced in restraint procedures should act as group leader in assigning roles and describing what the final goal is to be (e.g., escort to seclusion, restrain for injection of medication).

It is necessary to have sufficient staff available: physical restraint and seclusion procedures should not be attempted by fewer than two unless there is a victim in imminent danger of serious bodily injury. Preferably there should be three or four, plus another to clear the general area, open locked doors, or dispense medication. During the planning stage it should be discussed who will begin talking to the patient once the approach is made, which of you will approach him from which direction, and who will decide when or if to begin the restraint. If there is time, and when appropriate, the patient's relevant history should be reviewed (i.e., what are his assault characteristics). If possible, staff should remove jewellery, glasses, etc. When you all feel that you are prepared, approach the patient.

Approach

The purpose of this stage is to put yourself in a position where you can quickly put your hands on the patient. A second goal is to manoeuver him into an area where the restraint can most safely be carried out and where he has the least access to potential weapons.

You should be aware at this point that an agitated person may be very sensitive to others around him and his personal space may be larger than usual. A number of techniques can be used to reduce this provocation. While one staff member engages the patient in conversation, others can move around to the sides, keeping their bodies turned at an angle and appearing to be busy with other tasks such as moving away chairs or talking with other patients (and quietly asking them to clear the area). Once in position, staff should be ready to move in quickly.

Action

If you feel it might work to ask the patient to go voluntarily to seclusion before physically intervening, do so now. You should try as much as

possible to remain calm, use a neutral tone of voice, and avoid exhibiting anger, frustration, or annoyance. If you think it appropriate, state what misbehavior he has engaged in. For example, you might say, "I saw you throw that chair," then remind him of the rule and the consequences for breaking it. "Throwing furniture is not allowed. Please go to the seclusion room." Do not attend to his subsequent excuses, pleadings, or protests. Unlike the procedures recommended for calming and defusing, the patient's verbalizations in this case should be ignored.

Sometimes the show of force of having three staff approach along with a firm request to go to the seclusion room will suffice to convince a patient it is not worth struggling. In other cases, this last attempt to avoid a physical confrontation will fail and you must follow through with the restraint procedures described below.

Once the decision to restrain has been made and you are committed, you can do a number of things to ensure that the process will be safe and efficient. We have already discussed the importance of having a plan, and it is imperative that this is the procedure everyone now follows. Each of you will be counting on the others to carry out their roles. Second, you must not hesitate; it is speed that gives you an advantage over an aggressive patient, as you know what you intend to do and you know when. If one of you moves early or not with the others, you will lose some of this advantage.

A third essential feature is *necessary force*. As discussed above, one should be concerned about applying too much pressure; however, it is just as dangerous to apply too little. If a patient breaks out of a restraint he is a direct danger to you, and further, will not passively allow new restraints to be applied. On the other hand, new staff are especially prone to use too much force. Correct and sufficient force should be enough to maintain control and to constantly remind the patient that he is under your control. In some situations this may lead to him relaxing and then complaining about the discomfort you are causing; however, you should be sure to maintain control. Attempt to calm him by talking to him and explaining what is happening and what is going to happen (e.g., what medication he is receiving and what results are expected), but under no circumstances should you assume that he is no longer dangerous and that you can relax your grip.

Follow-up

Once the crisis is over, make certain the patient is adequately monitored in seclusion or material restraints. You and other staff members involved should review your actions to consider if anything could have been done

differently, and incident reports and file notes should be completed. You should also congratulate yourselves if the crisis was handled well, and take some time to calm yourselves before returning to normal duties.

Background and Rationale For Restraint

As discussed in Chapter 1, although much has been written about the use of restraint as a control procedure, most of the literature offers advice without much empirical support (Dubin, 1981; Guirguis, 1978; Gutheil & Tardiff, 1984b; Nigrosh, 1983; Soloff, 1983; Thackrey, 1987). Mostly, it consists of studies of the reasons for restraint (Roper, Coutts, Sather & Taylor, 1985) and of which patients are most likely to be restrained (e.g., Erickson & Realmuto, 1983; Evenson, Sletten, Altman, & Brown, 1974; Gutheil, 1984; Phillips & Nair, 1983).

The definition of restraint we use in the course comes from the Mental Health Act of Ontario (1986 revision), and includes the use of dynamic physical, mechanical, and pharmacological means of control. In other jurisdictions, it is defined differently. In the United States, Tardiff and Mattson (1984) surveyed authorities of each state regarding their regulations. Of 36 respondents, 23 offered no definition of restraint. Of those that did, most agreed it was a technique or the use of "a device" to restrict or control movement. Only four states included the use of chemical restraints in their regulations.

In the Ontario regulations, the definition specifies the use of "minimal" force; however, there are no guidelines as to what this comprises. Several authors point out the importance of choosing the "least restrictive alternative" among various techniques and offer their advice about which are less restrictive (e.g., Crain & Jordan, 1979; Dubin, 1981; Guirguis, 1978). However, as discussed in Chapter 1, there are very few data to support the contention that one technique is any less intrusive or restrictive than another (Thackrey, 1987; Wexler, 1984). Perhaps because of the acknowledgement that there is so little agreement among so-called experts in this area, Wexler concluded that courts will allow clinicians considerable flexibility in the use of restraint, especially in emergency situations.

Our definition of seclusion as the supervised isolation of a patient in order to prevent him from hurting himself or another, incorporates components of the definitions given by respondents across the United States in Tardiff's and Mattson's survey. The only major point in that survey on which states differed was whether there was a requirement that the door of the seclusion room be locked.

Legal Issues in the Management of Violent Patients

Our discussion of the laws regarding assault and the use of force are based on the Criminal Code of Canada. (Note: In some jurisdictions the law differentiates between "assault" and "battery," where battery refers to an act that involves actual violence, and assaults also can include attempts or threats. In all of our research, assaults were defined very similarly to the above definition for battery, and did not include threats or attempts.) In an emergency situation, it seems that courts tend to presume clinicians' judgments to be valid unless the intervention used was such a significant departure from accepted practice that it is questionable whether any judgment was exercised (Thackrey, 1987).

Just as courts are reluctant to find that a clinician used unreasonable force in subduing a violent patient, they are also reluctant to pursue allegations of assaults upon staff by patients (Appelbaum, 1983; Creighton, 1982; Thackrey, 1987). If the charges are upheld, the process may sometimes have long-term positive effects for both the patient and the victimized staff (Mills, Phelan & Ryan, 1985; Schwartz & Greenfield, 1978; see Example 8, Chapter 3). Staff must realize, though, that litigation often hinders their therapeutic relationship with the patient, and may also invite litigation by the patient in turn on another occasion (Gutheil, 1985). Thus, before charging a patient with assault, all clinical approaches should be tried and careful consideration given to the advantages and disadvantages of prosecution (Hoge & Gutheil, 1987; Miller & Maier, 1987).

Steps in Restraining and Secluding Patients

Observation: Our list of situations for which restraint and/or seclusion are indicated comprises those for which we believe there would be general agreement that there was no other way for the incident to end. Tardiff and Mattson (1984) found that in most states that responded to their survey, seclusion or restraint were to be used only to prevent harm to the patient or other persons. Several states included the prevention of substantial property damage as an indication, and two mentioned disruption of the treatment environment

Gutheil and Tardiff (1984b) concluded that there are three indications for restraint and seclusion: to prevent imminent harm to the patient or others when other methods are either not appropriate or have already been tried and failed; to prevent serious property damage or disruption of the treatment environment; and to assist in treatment as part of ongoing behavior therapy. In addition, seclusion may sometimes be indicated in order to decrease the amount of stimulation for a patient, and to accede to a patient's wish.

Only the first two indications pertain to emergency situations. We feel that all the situations described in the course would fall within these two.

Action: For the same reasons outlined in the rationale for defusing, staff should remain as calm as possible. Exhibiting emotions such as anger, frustration, or annoyance may only provoke a patient further or serve as a reinforcer for his angry outbursts. In agreement with Liberman and Wong (1984), we advocate that when attempting a last-minute verbal request that a patient go to seclusion on his own, one simply identify the misbehavior he has committed, request that he go to the seclusion room, tell him how much time he has to comply, and ignore any other verbalizations. If he is given an injection, he should be told what medication he is being given and why (Lion, 1983). During the entire restraint procedure, staff should make every effort to avoid the use of words (such as swearing), acts, or gestures showing disrespect or lack of concern for the patient. In several U.S. states, such things are specifically forbidden (Tardiff & Mattson, 1984).

Follow-up: In Tardiff's and Mattson's (1984) survey of regulations regarding the use of restraint and seclusion procedures, they found that most states required documentation to support their use. Whereas some merely mentioned that "a progress note" should be entered on a patient's record, others were very specific in what was required in the way of documentation, including the use of specific forms or logs in some cases. In cases where a patient alleges abuse, the clinical record or incident report may be admissable as legal evidence. In addition to information about the date, place, location, names of persons involved and witnesses, the report should include a complete description of the facts that caused the clinician to consider the situation an emergency, and a rationale for the choice of intervention used (Thackrey, 1987; Zillman, 1984).

PHYSICAL TECHNIQUES FOR SELF-DEFENSE AND RESTRAINT

It is important to realize that there is no such thing as a completely safe restraint technique. No matter how innocuous something sounds (and the methods presented below are the safest we have found), patient and staff injuries are always possible. Someone can fall unexpectedly, or may have a heart condition or some other disability that was not apparent (see

Example 6 in Chapter 3). These techniques do not come with guarantees of success, and should therefore only be used when necessary.

A survey suggests that the injuries most often resulting in lost work time are sprains and strains. It is well known that such injuries are more likely when joints are "cold," and since staff never go through a warm-up before a real-life physical encounter these are always a real possibility. It is wise, therefore, to exercise caution. Don't lay hands on an upset patient unless you have no alternative; if possible, wait until there is help. It is often possible to follow him around until reinforcements arrive. The verbal techniques described earlier can often be used to accomplish the same goals as the physical ones at much less risk of injury (for example, screaming or yelling for help can be an effective self-defence strategy).

Patients and staff are most likely to be injured by falls that occur during a struggle. The area that is most likely to be involved in serious injury is the neck: a blow or sudden pressure to the windpipe may collapse it and result in death. Occlusion of the carotid arteries very quickly leads to unconsciousness and brain injury. Any restriction of breathing is dangerous. A patient being restrained on the floor or on a bed constitutes a particularly dangerous situation: sitting on his chest or back may make him unable to expand his chest to breathe, and he may not even be able to speak to tell you that he can't breathe.

Although cases when self-defence will be required are very few, staff who are prepared will feel more confident and assured in their interactions with patients. The purpose of the physical training portion of the course is to teach simple but effective methods of dealing with assaults and restraint. The techniques that have been selected were chosen because they are easy to learn and unlikely to result in injury. Their effectiveness depends upon how well they are learned, as well as speed and coordination. Physical strength is not critical, although of course it helps. Being in good physical condition is more important, and becomes critical if the altercation lasts 30 seconds or longer.

The techniques described below cannot be learned by merely reading about them: they must be demonstrated and then practiced. It is also important to note that they deal only with the most common forms of assault. There is always the risk that a patient may employ some uncommon but dangerous attack, and clearly these descriptions will not prepare you for all types of situations.

In all situations, when engaged in restraining a patient, remember that what you say to him is still important. You should be telling him what is and will be happening to him in a calm matter-of-fact way.

Self-Defense Against Assaults

Stance

As shown in Figure 1, when talking to an upset patient one should stand slightly sideways to protect the vulnerable middle areas of the body. Hands and arms should be held ready to block an assault. Standing like a prizefighter, however, would be clearly inappropriate. Arms can be held (but not folded) across the chest with one hand resting on the chin. This position, with the body slightly turned and the knees slightly bent, is fairly safe and appears relaxed and casual. Never turn your back on or even take your eyes off a highly upset patient as long as he is within striking distance.

Grabbing Attacks

i) As shown in Figure 2, a one-hand cross-grab from the front can be removed with a rotary movement of the grabbed arm to the patient's outside. Keep the grabbed arm bent and its thumb upwards, and if greater strength is required, use two hands (clasped). If done correctly, the patient should end up partially turned away from you. An alternative technique that can be used when the patient's thumb is on top of your forearm is to grab your own fist and pull your forearm toward your shoulder.

ii) A two-hand wrist grab from the front can be removed with the confusion technique (Figure 3). This technique involves keeping your arms bent and moving them toward and apart from each other in an irregular fashion while moving backwards with your back straight.

iii) A hand choke from the front can be removed by clasping your hands between the patient's arms, so that one of your elbows is above one of his arms and the other is below his other arm. Then, as shown in Figure 4, quickly exchange the position of your arms so that his arms are simultaneously knocked upward and downward. If the patient is too strong for this, remove the choke by pushing his larynx (with only as much pressure as necessary) with outstretched fingers.

iv) A hand choke from the rear can be removed by stepping forward and rotating to the left or right with that arm held high (Figure 5A). Your shoulders will remove the patient's grip (Figure 5B).

v) A hair grab from the rear can be removed by grabbing the patient's hand so as to cup it, and pushing it hard against your head while dropping

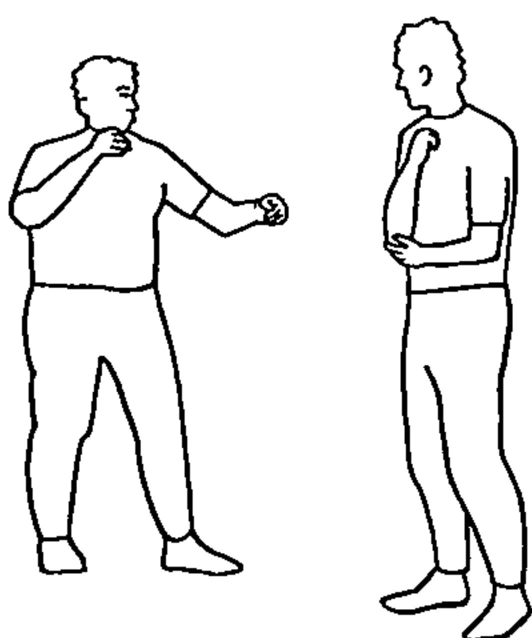


Figure 1:
Safe Stance

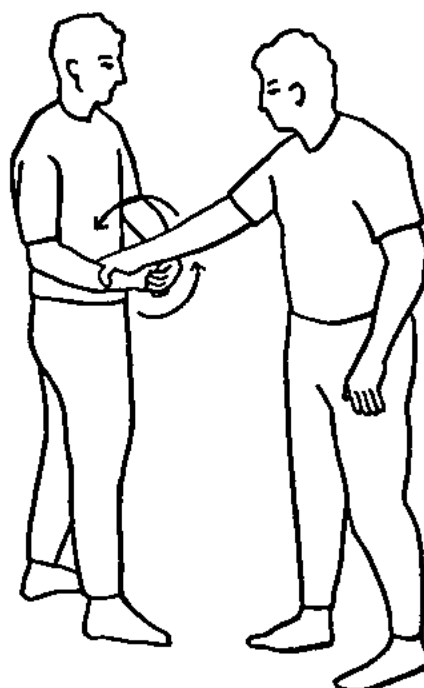


Figure 2:
Defense for one-hand cross-grab

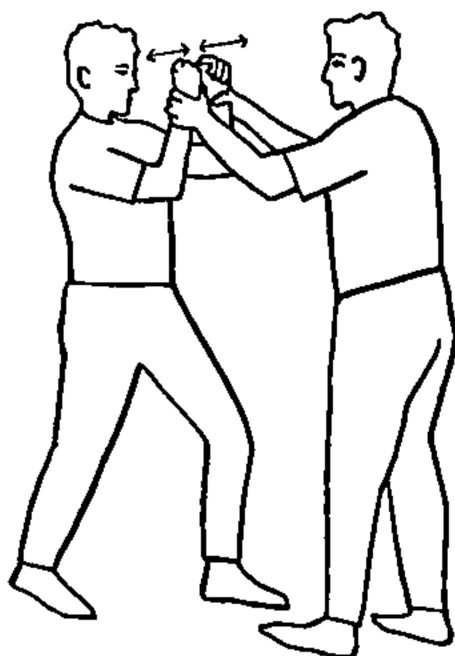


Figure 3:
Defense for two-hand cross-grab

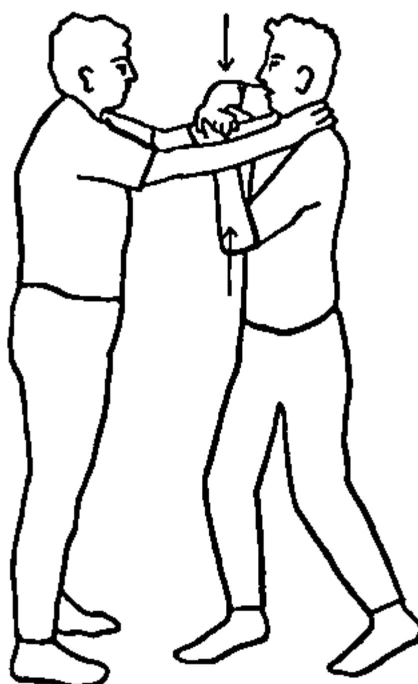


Figure 4:
Defense for front hand choke

your hips and rotating to face the patient while stepping toward him. See Figures 6A and 6B. A grab to long hair or to clothing from the front can be released by pressing your thumb into a pressure point located on the inner aspect of his upper arm just above the elbow.

vi) A rear choke with an arm is very dangerous. If possible, tuck your chin and bite the arm. If the arm comes under your chin, pull the arm frontwards and down to decrease pressure on your neck. Then rotate your neck towards the wrist of the choking arm in order to free at least one carotid artery from any pressure. Next, convert the choke to a head lock by stepping to the side and blocking the attacker's heel with your inside foot. Once the choke is converted to a head lock, the danger is greatly reduced because pressure on the front of your neck is largely relieved. Complete escape from the head lock can be effected, for example, by lightly grabbing the (male) attacker's groin, or by stepping quickly backwards while tugging sharply downwards on his holding arm.

Striking Attacks

i) Punching attacks are typically to the head from a fair distance and to the body from close in. Note that people typically look first at the area they intend to strike. Most attackers will throw a right round house punch as their most effective weapon. Keep moving with your hands *high* as shown in Figure 7; punches to the body can be blocked by lowering the elbows. Punches to the head can be blocked by moving your arm between the patient's fist and your head; keep your arm bent and close to your own head.

ii) Kicks are rarer and much slower than punches. They are most often front snap kicks to the groin. If you are close, you should move in while twisting your hips to the side and raising your forward knee. You will thus block the kick with your shin on the patient's ankle (see Figure 8). If you are too far away or don't see the kick until late, step back and rotate your hips to the side while knocking the leg away with your forward hand (or, alternatively, grabbing the leg from underneath).

Biting attacks

Biting attacks are most unpleasant. To make the patient let go, do not try to pull his head away but instead, if possible, push the part of your body being bitten towards him and grasp his nose to close the nostrils; he will often open his mouth to breathe. Pressing (not striking) under

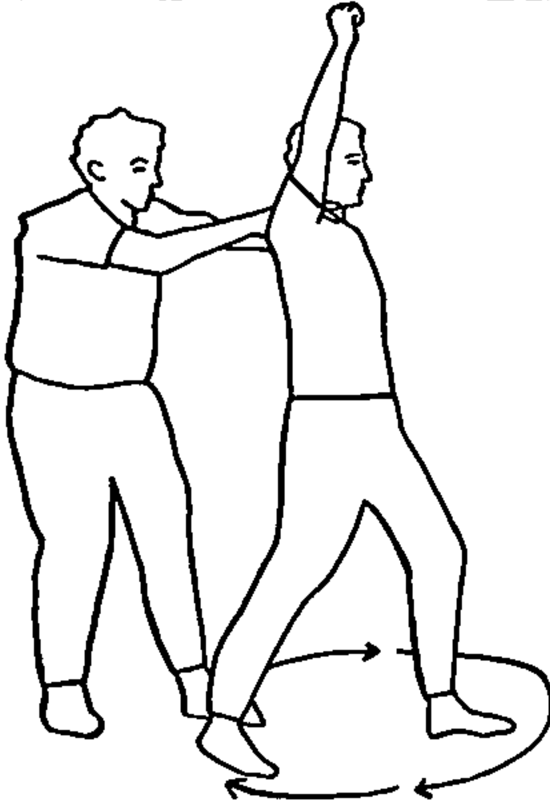


Figure 5A:
Defense for rear arm choke

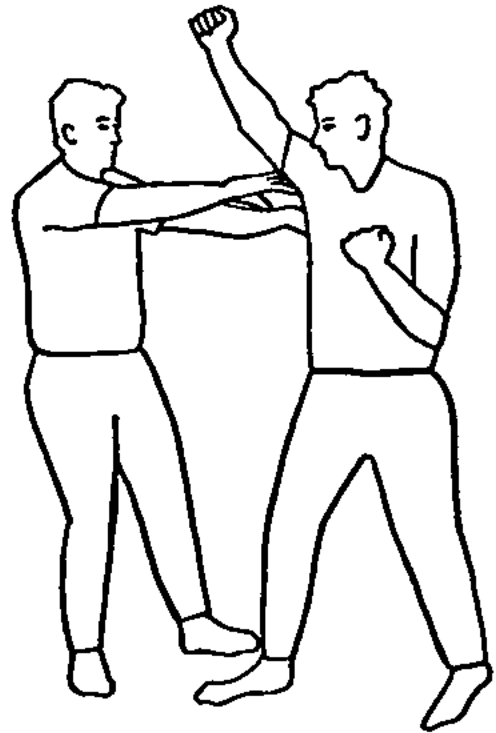


Figure 5B:
Removing grip

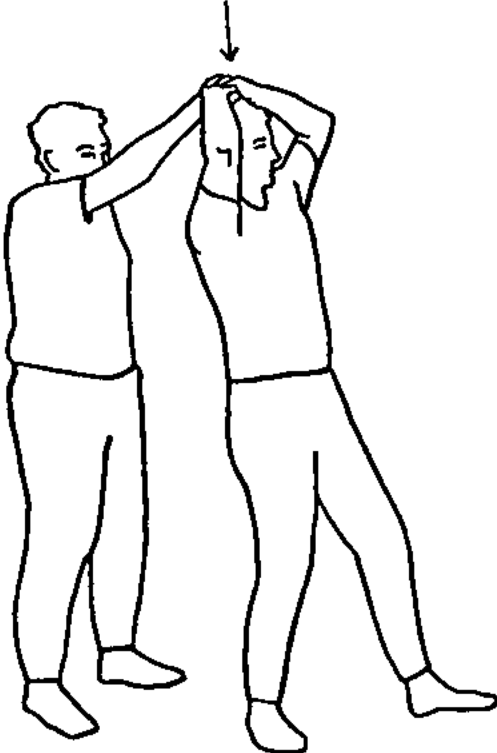


Figure 6A:
Defense for hair grab

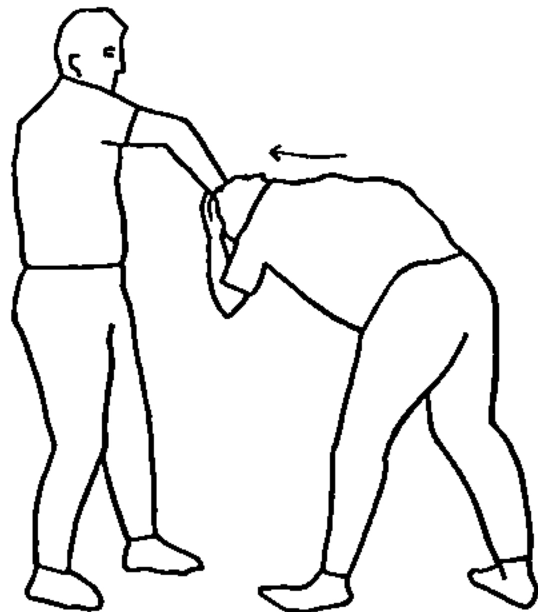


Figure 6B:
Rotate to face attacker

one or both ears with the middle knuckle(s) will often have the desired effect. Failing this, grab his ear firmly and pull him to the floor.

Weapon Attacks

Although it is highly unlikely that you will ever be attacked by a patient with a weapon, it's worth being prepared for. If you are alone, your primary concern is for your own safety. If possible, run away. If you are facing the patient, you should start running backward and suddenly twist your hips and run; the greater your distance from the patient when you turn, the better. If it is not possible to run, you should move backwards from side to side or even in a circle so as to maintain the distance between you and him. Keep your head a moving target.

As a general principle, you should try and get a weapon of your own to protect yourself. Light chairs are very suitable: pick one up by the front of its seat and the back and hold it so that one leg is pointed between the patient's eyes and the other at his solar plexus, as shown in Figures 9A and B. Your arms should be kept bent. Cushions can be thrust at the patient's face so as to block his vision. A belt can be wrapped around your hand so that it is about two feet long and, held at your side so that it can't be grabbed and with the buckle end furthest from your hand, rotated quickly toward the patient to keep him at bay.

If attacked with a stick or club held overhead, you should keep your head moving and try to get inside and close as the patient begins to swing. If you must block an overhead swing, keep your arm at an angle over the head so that (ideally) the weapon will be deflected or slide down and not break your arm. If you are close enough you can block his arm rather than the weapon. Remember that his striking distance is the length of his arm plus the length of the weapon.

Avoid heroics. The purpose of your weapons is for self-defence only: to stall for time, to back the aggressor into a corner, and/or to arrange for an opportunity to escape.

Offence

A patient is not to be struck unless someone is in imminent danger and there are no safer alternatives. A straight punch or pushing strike to the solar plexus is very effective and will temporarily incapacitate him. It is also fairly safe. The punch is difficult to block as it is in the midline of the body and is generally unexpected, being unusual in Western-style fighting. If it is off target, however, there is a danger of breaking his lower ribs.

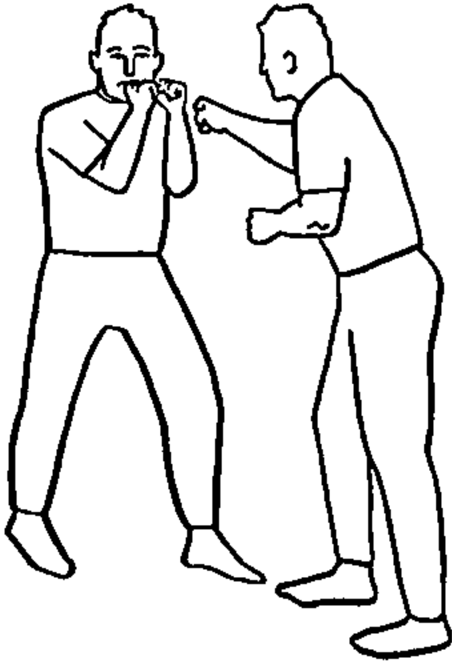


Figure 7:
Effective block for a punch

Figure 8:
Effective block for a kick

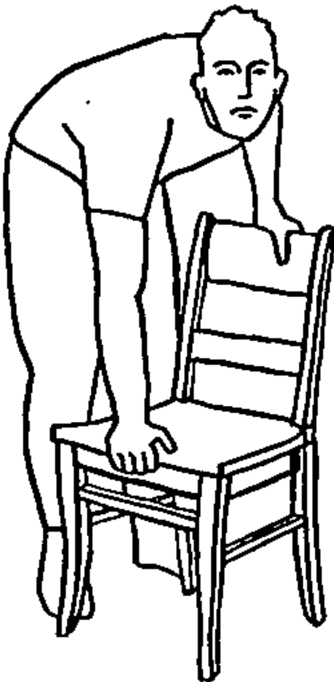


Figure 9A:
Use of a chair for self-defense

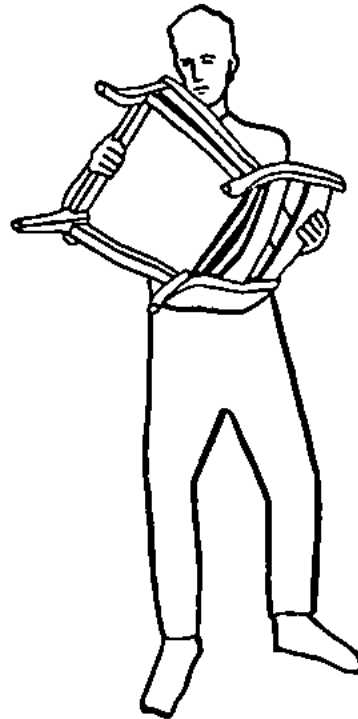


Figure 9B:
Point chair at attacker

Another self-defense strategy that can be employed is to lie on your back on the floor. If an attacker approaches you, kick sharply towards him. Kick rapidly with alternating feet, always keeping at least one leg bent as shown in Figure 10. If he circles, turn yourself with your hands so that he always faces your kicking feet. This "equilization" technique is useful to buy time while you yell for help. Finally, yelling for help or screaming can often be an effective self-defence strategy.

Breaking Up Fights Among Patients

Never step between fighting patients. Sometimes they will stop if you firmly order them to. If that doesn't work, or if someone is being injured and the fight must be stopped immediately, step behind one of the combatants and with one foot push (not kick) the back of his knee while pulling him backwards by the hair or collar, as shown in Figure 11. You will have to catch him as he falls to the floor.

Falls

Falls are common during physical altercations, and it is important to know how to fall without injury.

Falling forward: Keep your knees and body straight, and break the fall with your hands. Turn your face to the side. See Figure 12.

Falling forward or to the side while moving: Bend your neck and look at your belt, bend your knees and get close to the floor, make yourself into a ball, put your hand (on the same side as your forward foot) on the floor with your fingers pointing toward your feet, keep your elbow slightly bent, and convert the fall into a forward roll.

Falling backward: Bend your neck forward and look at your belt, keep stepping backwards while bending your knees to get closer to the floor, and break the fall with your hands (point your fingers forward). Let yourself roll backwards and if you are going fast, do a backward roll (slightly to the side, so as not to roll on your neck). See Figure 13.

Physical Restraint

Physical restraint is used primarily to control a patient so that he can be escorted to seclusion or receive a needle. As mentioned above, both staff and patient risk injury in any physical encounter. Patients may respond violently when grabbed because they are angry, confused or

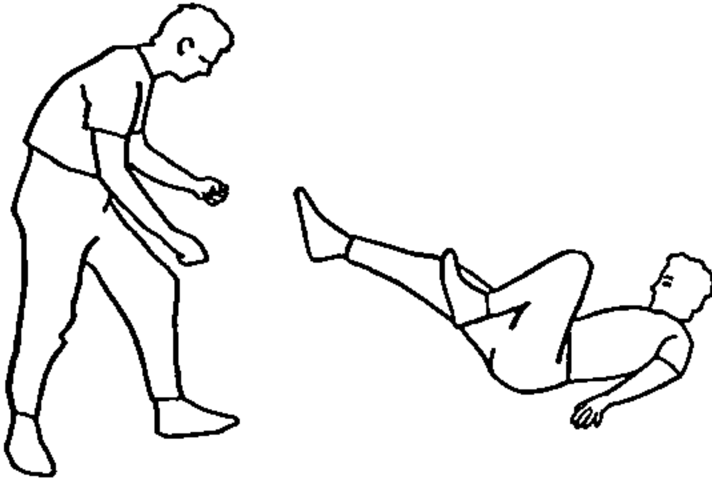


Figure 10:
Equalization technique

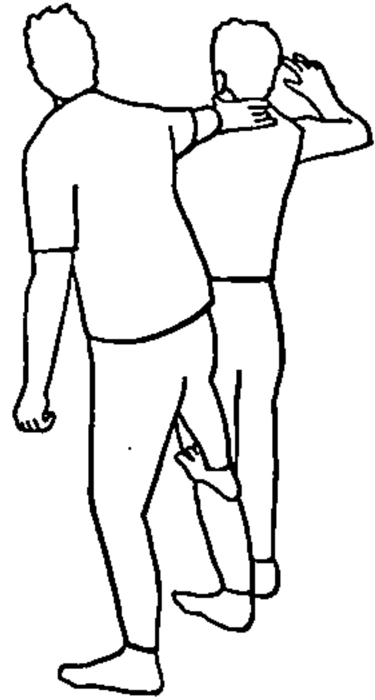


Figure 11:
Knee push used to break up a fight

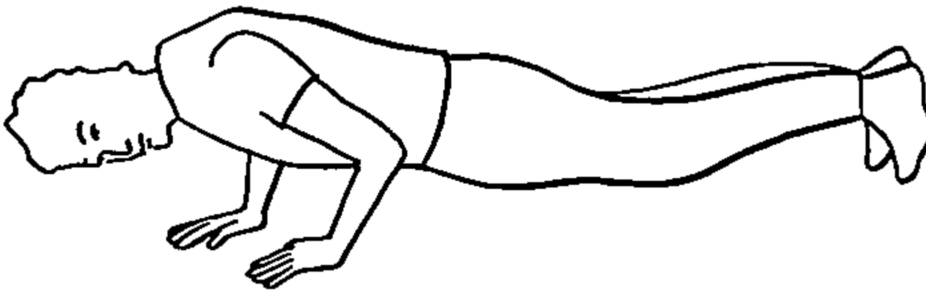


Figure 12:
Falling
forward

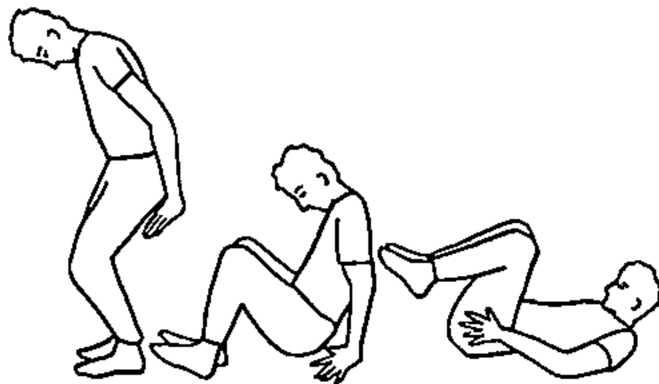


Figure 13:
Falling backwards

frightened. As the description below makes clear, it is extremely difficult to restrain a resistive patient alone, and if possible avoid doing so. It is usually possible to wait until help arrives.

Escort

Depending on the situation, a variety of restraint techniques can be used while escorting a patient to the seclusion room.

The *forearm bar with wrist control* is a two-person technique. As you stand beside the patient, bend his wrist toward him by holding his hand with your hand that is furthest from his body, as shown in Figure 14. His fingers should be pointing straight up. Place your hand that is closest to him on or slightly above his elbow. Your grip should always be firm: adjust the amount of pressure on his elbow and wrist depending on his resistance. In cases where he is very resistive, a third staff can arch his back by putting one hand on his forehead or grabbing his hair, being careful not to jerk his head back, and the other hand pressed into the small of his back (for example by grabbing his belt). Another technique for arching his back is to use a headlock where the pressure is applied to the chin. As an alternative, or if the patient's arm cannot be straightened, a hammerlock can be applied by holding his arm behind him with the pressure upward. Too much pressure can dislocate his shoulder, and you must also be careful that he does not fall.

The *support restraint* technique for escort is particularly useful if the patient will not walk or requires support. It also looks "natural" and may, therefore, be less disturbing to witnesses. As shown in Figure 15 (although this is a two-person technique, it is depicted only from the patient's right side for clarity), it involves hooking your right arm so that your elbow is to the inside of his elbow. With your right hand, grasp his right wrist while your left hand grasps your own right wrist. If the patient does not require support, keep his wrist in front of your belt, as this position is more effective (it keeps the patient's elbow against your side).

The *one-arm come along* is a one- or two-person restraint shown in Figures 16A and 16B. It is extremely effective but very difficult to apply, being hard to get into position. When standing on the patient's right side and facing in the same direction, turn his right hand so that his palm is facing upward and his thumb is on his side with the fingers pointing backward. Slide your left hand under the back of his hand and lightly grasp his thumb. Then place your right hand on his elbow and swing his arm forward so that it is vertically upright. Your left hand will exert a great deal of force on his wrist, so be careful. Keep your right hand on his elbow so that he cannot bring it upward.

Figure 14:
Forearm bar with wrist control

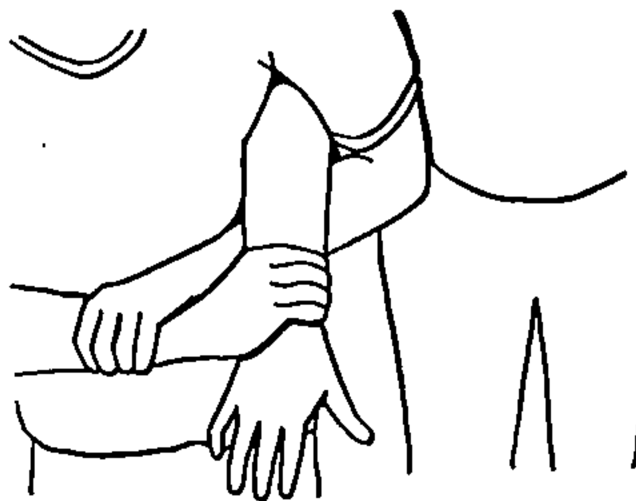


Figure 15:
Support restraint

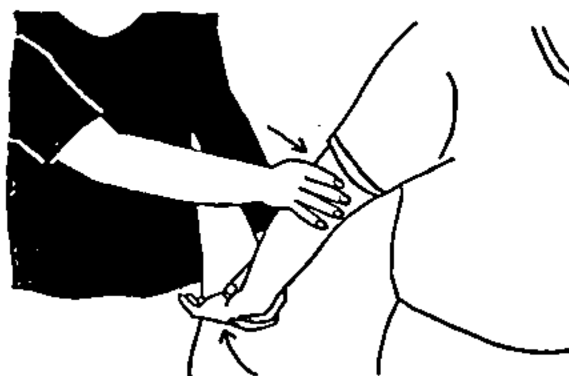


Figure 16A:
One-arm come-along

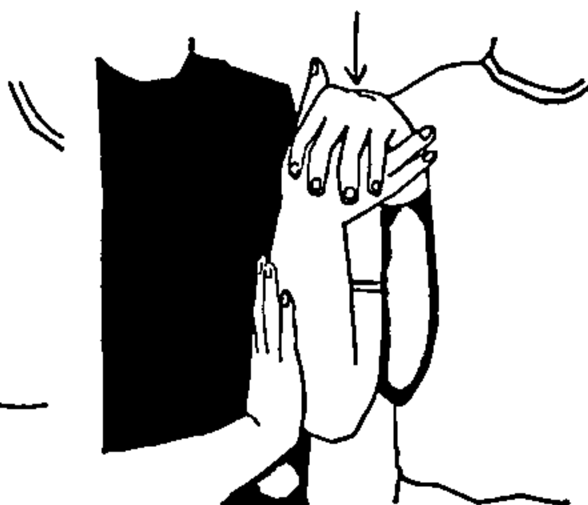


Figure 16B:
Swing attacker's arm up

A simpler one-arm come along can also be used. Hold one of the patient's arms — say the right — near his side with the elbow bent to 90 degrees, and bend his right wrist so that his palm is over his belt. Slide your left arm between his right arm and his body, and wrap your fingers over the back of his right hand. You can then apply the necessary pressure to his right wrist with your left hand and contain his right elbow with your body and right hand. Only the control you exert on his right wrist prevents him from attempting to assault you with his left hand.

Restraint Against the Wall

Note that it is always very difficult to restrain someone who is heavier than you, but this is especially so when restraining someone against a wall. The patient must face the wall. As shown in Figure 17, staff to each side of the patient can use a forearm bar or hammerlock and lean into him, forcing his front shoulders against the wall and blocking his legs and feet with their own. A third person can arch the patient's back using the same technique as for escort.

Restraint on the Floor

Restraint on the floor can more effectively immobilize a patient than restraint against the wall. However, it should only be used when he cannot be restrained against the wall or is already on the floor (or a bed), because of the awkwardness of getting him down and back up again. Most effective is to have the patient lie face down as shown in Figure 18. Two persons at his shoulders rotate his arms so that the palms are up and the arms straight out to the sides. The wrist should be bent so the fingers point upward. A knee can be placed on his triceps if necessary (be aware that this hurts). One person should control his legs. Kicking legs can be "captured" by holding your arms firmly crossed in a block until your hands can make contact. If possible, cross his legs and lean forward pressing his heels toward his buttocks. If his legs can't be crossed, lie across his knees and hang on. For a patient lying face up, rotate his palms down and place a knee on his biceps. His legs can be held down by lying on his knees. This is not as effective as when he is on his stomach.

Moving Through a Doorway

If you must go through a doorway with a patient under restraint, walk him through sideways. If he has been violent and is upset and you want to place him in a room alone, walk him under restraint to the open door

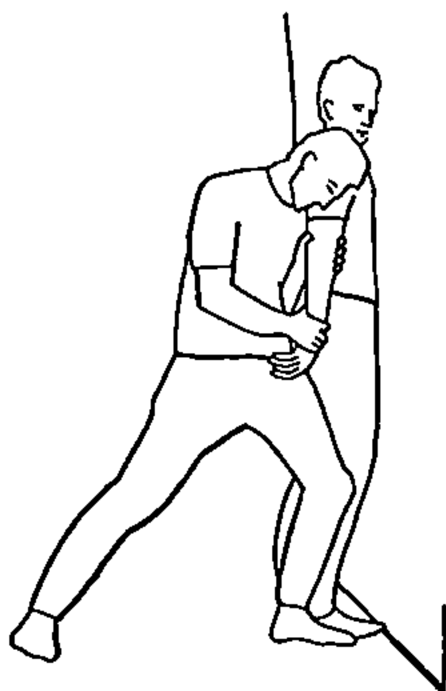


Figure 17:
Restraint against the wall

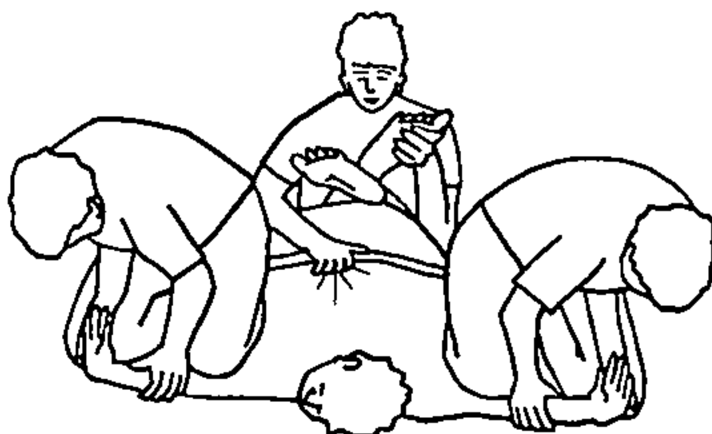


Figure 18:
Restraint on the floor

and push him into the room. You must adjust your force according to his weight, and ensure that he does not bang into the doorway or trip. The patient will be concerned with stopping his forward progress, which gives you time to close the door. However, if the room is very small and the door opens inward he may be able to stop himself, turn around and get to the door before it can be safely closed; in such circumstances, it is best to restrain him against the wall opposite the door (see above). On a visual signal, the staff should leave in a quick but orderly fashion, with the last one out closing the door. If the patient is first wrapped in a blanket, there will be even more time to leave. If the patient is not aware of the signal, you should all be able to exit before he can interfere.

If the patient puts his hands on the doorway, place one hand on his forehead pulling backward and the other hand in the small of his back and push forward. This won't work if his back is bent; under these circumstances, you should grab him by the collar and belt, pull slightly backwards, and angle him through the doorway with a push. Alternatively, you can push (not kick) on the back of his knee with your foot to break his stance before pushing forward.

Going into a Room

If a patient must be removed from a room but refuses to come out, the strategy depends on where he is. Usually three people will be required to handle the patient and a fourth to work the door. Staff should formulate a plan: ordinarily one will be assigned to the right side of the room, another to the left, and a third to the middle. Never assign people to the *patient*'s right or left side.

If the patient is in the doorway, you must push him backward so that the other two staff can help. The person with the longest arms should go first. Entry must be fast and be coordinated with the door opening. Use a two-handed push on the patient's chest, keeping your head tucked and your arms almost straight. A strong person can use one hand. Avoid striking collar bones, as they are fragile. After the patient is moved back, the other two staff can restrain him from the sides.

If the patient is in the middle, all staff can enter before attempting restraint. The staff member in the middle can attempt to distract the patient and perhaps draw a punch or kick while remaining just out of range. The people to the sides should simultaneously grab the patient while his attention is focused on the person in the middle.

An individual in a corner is most likely to kick, since he can't pull his arms back for a roundhouse punch. In this case, try to draw the kick while remaining out of range. As soon as he commits himself in one direction, the other two staff members should move in quickly. Keep turned sideways with your forward knee raised so as to smother or block a kick.

Background and Rationale For Physical Techniques

This portion of our course has a diverse history. The first techniques were taught by a karate instructor, but staff disliked this approach because it seemed completely esoteric and foreign (e.g., students were required to bow to the instructor). The course developers were also dissatisfied with it because it was clear that many hours of practice would be necessary for the martial arts techniques to be mastered. Consequently, only a few genuine karate moves were retained (e.g., blocks for kicks, solar plexus punch/push, rolls and falls, and some of the techniques for grabbing attacks).

The techniques now taught have been adopted from a variety of other sources. Some were obtained from police courses (e.g., equalization; Dutton, 1977); some from the St. Thomas (1976) course (e.g., the one-person "come along"); and some appropriated from published sources (e.g., defense against a bite, Thackrey, 1987). Some course instructors have maintained a personal interest in karate and, as students of the martial arts, have sought new useful self-defense techniques.

Generally, the evolution of both the restraint and self-defense strategies has involved the continual search for new simple and effective techniques. As far as we can tell, there are a large number of (nearly) equally effective methods to handle any physical situation. New techniques were added based on several interrelated criteria:

• Is the technique "natural", i.e., it is similar to what an untrained individual would do in a crisis situation?
• Is it simple: i.e., easy to teach to people unskilled in physical activities?
• Is it safe for patients and staff: i.e. are there obvious ways in which someone could be inadvertently injured?
• Is it useful in relatively common situations (noting that all situations requiring physical intervention are rare)?
• Does it work when there is a large height and weight difference?
• The most obvious criterion is overall effectiveness, but this is difficult for the course instructors to evaluate objectively. We advise against practicing in view of patients because techniques will be much less effective if it is known exactly what you will do during a physical altercation: much of the effectiveness of *any* technique lies in its surprise value. Thus, instructors have had to evalute the *potential* or *probable* effectiveness of techniques through staff members simulating the roles of patients (see Chapter 7).

Adoption of new techniques is usually preceded by considerable experimentation and testing by course trainers. For example, we first taught a sophisticated tactic for escape from a rear arm choke because we knew of no simpler method. (We needed a tactic for this form of attack because it is both relatively common and very dangerous for the victim.) Our tactic required the victim to perform several difficult and rather unnatural maneuvers in rapid succession: 1) turn the head towards the unseen attacker's elbow, 2) pull down on his arm, 3) place the right foot (usually) behind his left foot, and 4) from a standing position, quickly fall backwards at a 45-degree angle away from him (both victim and attacker fall to the floor). However, it became clear that while effective, this tactic was difficult to learn, relatively unnatural, and prone to cause injury.

Several years later we discovered the simpler tactic now advocated in the course: in only two rapidly executed moves the victim converts the choke hold into a much less dangerous head lock, and then has a wide variety of escape options. Before adopting this new strategy, however, we subjected it to some careful testing: we taught both techniques to several groups of trainees to assess relative effectiveness and ease of learning, and instructors practiced it with unsuspecting (but physically adept) mock attackers during karate classes. Finally, the second technique was adopted. A rear arm choke is probably so dangerous partly because there exists no natural effective countermeasure and a completely untrained individual would certainly succumb to a determined attacker.

The majority of the restraint techniques we advocate were those that had previously been used successfully by staff in the maximum security division of our hospital. The Assault Prevention Task Force (see Chapter 2) identified which techniques were safe and effective by asking staff to describe and demonstrate methods they had used in actual altercations with patients. Over the course of many interviews it became abundantly clear that some techniques were much safer, more efficient and more easily learned than others.

For example, we favor the use of restraint against a wall rather than on the floor because many of theTask Force interviews indicated that wall restraints are safer for the patient and permit the staff to more easily remove any potentially dangerous clothing, move him to another location, or administer injections, and often obviate the need to carry him while struggling. Although often recommended (e.g., Soloff, 1983), we believe that carrying a restrained individual puts staff members at undue risk for back injury (see Chapter 2). Some of our techniques were further refined by the ward staff who acted as the first course trainers, and who had been selected because they were widely regarded as competent in the use of physical techniques.

Some other considerations also affected our selection of restraint techniques. For instance, many staff used to employ neck/chin holds, but after a patient's death during an altercation with staff at another institution, our own administration banned their use. Consequently, course instructors now inform students of this ban and neck holds are not demonstrated. Also, we try not to use punishing or submission techniques (i.e., those relying on the application of pain), and instead favor those that require larger numbers of staff.

HOSTAGE TAKING

Although it is extremely unlikely that you will ever be involved in a hostage taking incident, it is important to be prepared in case it should ever happen. Hostage taking has become relatively common within correctional settings (Davies, 1982; Jayewardene, McKay, & McKay, 1976), and, although still rare, has been occurring with increasing frequency in health-care settings (Turner, 1984).

In any institution in which there is thought to be a risk of this happening, a policy should be developed and all staff should be aware of the procedure to be followed. In most correctional institutions and some psychiatric facilities there are specially trained hostage-negotiating teams that are prepared to act whenever they are called upon. In these cases, the job of staff who have not been so trained is to contact the team and attempt to control the situation themselves until it arrives. However, while in principle this plan is a good one, in practice there are many cases where it is not apparent for some time whether or not an incident is in fact a hostage-taking. When it is, the problem is that the first few minutes of such situations have often been found to be the most critical (Gilmartin & Gibson, 1985; Maksymchuk, 1982), and line staff must deal with the situation themselves during this time.

If you are the first staff member to encounter a hostage-taking incident, you will have to use the skills taught in this course to help you control the situation until the negotiating team arrives, or possibly to do the negotiating yourself in the event that your facility does not have such a team. In their early stages, hostage-takings may be dealt with through defusing interventions. Once the hostage-taker has been calmed to the point where he can talk normally, the interviewing and problem-solving techniques apply.

If you are taken hostage yourself, there are several things you can do to increase your safety. In general, it is not a good idea to try to fight with a hostage-taker or provoke him, as this will usually increase the risk of injury. Rather, it is important to try to remain calm. If he speaks to you, try to build a positive relationship with him by talking about things you both have in common, such as families, hopes, and plans. Try to make him see you as a human being similar to himself. Obey his instructions as much as possible. If food is offered, take it, and if the hostage-taker will accept a cigarette from you, give it. If you can sit down, do so. Remember that time is on your side — the longer the situation goes on, the more likely it is that you will get out of it safely.

Background and Rationale On How to Handle Hostage-Taking Incidents

Although much has been written about this subject, most of the literature concerns non-institutional incidents, and there is some evidence that hostage-takings that occur within correctional institutions differ in important ways from those occurring in other contexts (Marquis, 1985). Marquis (1986) examined 33 hostage-taking incidents in the Federal Correctional Service of Canada. He found that, unlike non-institutional hostage-takings, the majority of these incidents were planned. The most frequent demand of the hostage-takers was for transfer or release, with other common demands being for drugs, visits from loved ones (family members or sometimes pets), or access to psychiatric treatment programs. Often, then, these individuals are desperate people asking for things that are to varying degrees reasonable, which is quite different from outside situations where hostage-takers are often making demands that are totally unreasonable and impossible to grant. Other differences are that hostage-takers within an institution are known to the authorities, and that while weapons are almost always involved in both cases, the weapon is likely to be a knife, shiv, scissors, broken glass, or pencil rather than guns.

All of these factors mean that hostage-takings within institutions are usually less volatile and easier to resolve than those occurring outside, and therefore some of the advice given in training courses for negotiating with hostage-takers in other settings may not be applicable. For example, some courses recommend that drugs never be given to hostage-takers, that no hostage ever be exchanged for others, that family members not be brought to the scene, that no other outsiders be brought in, that the highest authorities not be brought in, and (more rarely) that it is acceptable to promise anything (Maksymchuk, 1982; Marquis, 1986). Yet according to Marquis (1986), drugs have frequently been given in hostage situations in Canada (codeine, morphine, minor tranquillizers), and there have been no adverse consequences (often the hostage-taker falls asleep, bringing the crisis to an end). There is no evidence that exchanging hostages or bringing in others such as a doctor, a lawyer, or the warden would have adverse consequences. Moreover, family members have occasionally been brought in or contacted on the hostage-taker's request, and most often this has not had detrimental effects.

Davies (1982), who studied 20 incidents of hostage-taking in the English Prison Service between 1972 and 1981, found results similar to those of Marquis. In addition, he noted that the duration of these incidents was generally quite short, ranging from virtually instantaneous to around

16 hours. Only one incident was politically motivated. Generally the perpetrators were serving long sentences (five years to life), and in the majority of cases the offense for which they were serving time involved violence. Staff were much more likely to be taken hostage than were inmates. In only one incident was the hostage harmed physically, and then the injuries were minor. In no case was there evidence of transference or the "Stockholm syndrome" in which the hostage shows support, sympathy, or liking for the perpetrator. Turner (1984), in a study of over 20 hostage-taking incidents in health care facilities, reported many of the same results that were found for correctional settings. He concluded that a recurring theme is a feeling of lack of power by perpetrators, who often believe they have exhausted legitimate avenues of complaint and have gotten no response from the institutional bureaucracy. Other times, he noted, incidents seem to be motivated by an attempt to reestablish relationships with significant figures in the hostage-taker's life.

Despite the differences between institutional and non-institutional hostage-takings, there are also many commonalities, and much of what has been learned about the general situation can be applied here. Studies of hostage-taking around the world have produced a few simple but definitive conclusions (Davies, 1982; Gilmartin & Gibson, 1985; Miron & Goldstein, 1979). Time is generally the most crucial feature of most situations: the longer a situation continues without the authorities initiating anything precipitous, the better the chances are of no one being harmed. Negotiating has proven effective regardless of the motivation of the hostage-taker, and has the additional advantage of giving authorities time to organize an effective physical intervention if the situation cannot be resolved this way.

Finally, most of the techniques advocated in courses in hostage negotiation procedures (March, 1983; Miron & Goldstein, 1979) are the same as those described in the calming, defusing, interviewing, and conflict resolution sections of our course. A step-by-step procedure involving observation, preparation, action, and follow-up is recommended. Dealing with a hostage-taking begins as a defusing situation, but, as it progresses it becomes one of calming, then interviewing, and finally mediation or problem-solving.

Although the general advice to a person taken hostage is to be passive, cooperative, patient, and nonargumentative (Bolz & Hershey, 1979; Crelinsten & Szabo, 1979; March, 1983), little is actually known about the role of hostages in resolving the situation. It is generally agreed that being taken hostage is a very stressful experience, and that preparation for the possibility of this happening and debriefing afterwards can be very helpful (Inwald, 1983; March, 1983; Strentz & Auerbach, 1988).

In any institution in which the possibility of a hostage-taking is considered to be real, even if low, there is a general consensus that there should be a hostage-taking policy and a specially-trained team of negotiators. However, there is little evidence to date that the use of such specially trained teams within institutions is a more effective strategy than training all staff — or, for that matter, that they do the job any better than untrained staff.

Chapter 6

Following Violent Episodes

After a crisis has subsided, it is extremely important to:

- identify those responsible and determine who did what to whom
- determine what sanctions are required
- determine if any environmental or program changes are required to prevent such an incident from recurring
- help patients work out a plan so that the incident will not recur
- provide an accurate account for the patient's record
- re-establish a relationship with the patient, and
- assess the patient's current mood.

Interviewing and conflict resolution are the two aspects of follow-up that will be discussed here. Follow-up techniques differ from defusing in that the patient begins the interview in a calm state. Thus, the statements you make are much less critical, as the patient is not likely to explode if a mistake is made.

INTERVIEWING

The area of interviewing is a very broad one. For purposes of this course we will discuss it only in the context of how to gather information from patients following the occurrence of a violent incident; however, most of the material covered will apply to more general situations as well. The main goal of interviewing following an incident is to gain information about why it occurred in order to prevent it from happening again. A well conducted interview need not take a long time; often ten minutes or less is sufficient.

If the incident involved two patients, they may be interviewed separately or together. The main advantage of seeing them together is that you end up with just one story instead of two conflicting accounts, and thus are more likely to obtain a more accurate view of what happened. As well, this often forces each patient to accept some responsibility. However, it requires considerably more skill than talking to each one separately, because controlling the interview and maintaining neutrality are much more difficult. Therefore it is recommended that you become confident in your abilities to interview patients one at a time before attempting this. If you are new at interviewing two patients together, you may wish to ask another staff member to sit in and help out if you seem to be having trouble. Often, he or she is much more able than you to see objectively what is happening because of lesser involvement.

Steps in Interviewing

Observation

Before an interview begins, you should carefully observe the patient to be sure he is calm. If there are two patients, ensuring that both are calm is even more important. It is often necessary to wait until a patient has been released from time out for a couple of hours or even a day to be sure that he has settled down, or until medication has worn off if any has been given. However, the interview should be done on the same shift on which the incident occurred whenever possible, so that the details do not get forgotten and so that staff members who may have knowledge about what happened are present.

Preparation

An interview is best conducted in a private room with another staff member sitting unobtrusively nearby. It could also be done in a patients' lounge with other staff in the vicinity: however, there should be no other patients close by. In a secure setting it is sometimes necessary to interview a patient through a door, with him inside the room or cell and you on the outside. In this case, the door should be slightly open (although secured) so that you can have direct eye contact with him. Try to pick a time when other patients are not around and the ward is relatively quiet. You may consider going into the patient's own room to conduct the interview sitting on his bed, with other staff outside the room but nearby. Co-workers should be notified before you begin an interview so they will be able to check that things are going all right.

Approach

While you should try to convey a calm, concerned, unperturbed, caring manner, it is important to remember that this must be balanced by a concern for your safety. Thus, always be sure the patient is seated so that you can leave safely if the interview gets out of hand (which is extremely unlikely). This is especially important if there are two patients.

If there is just one, the best arrangement is for you to sit in comfortable chairs facing at slight angles to one another, making frequent eye contact. If there are two, the best position is for you to sit between them, again making frequent eye contact with both. Having them sit on opposite sides of a table with you at one end contributes to safety by allowing the table to serve as a physical barrier in case the conflict escalates.

Action

Try to draw the patient out through questions. Talk just enough yourself to keep him talking and to keep control of the interview. A good guideline to aim for is for you to talk no more than 20% of the time, and let him do the other 80%.

Controlling the Interview. You should be in control throughout, directing the interview towards its goal, which is summarizing the major issues behind the incident. This involves disallowing rambling irrelevant talk, and preventing new flare-ups by demonstrating an interest only in relevant information. It is extremely important not to become embroiled in arguments, but just to get each involved person's version of what the fight was about. Do not contradict, argue, or state the patients' disagreements. Similarly, you should forget about getting at the "truth": each person's story is true to him.

It is important not to make judgments about who is right or wrong at this stage; rather you should simply try to get some agreement about the nature of the problem. This means remaining *impartial*, because taking sides will often cause one party to become extremely angry which will rule out any chance of the patients seeking a compromise solution. Although it is very difficult to resist the temptation, *never* indicate who you think is right or wrong or implicitly convey this judgment by suspicious questioning of just one party. You must make an attempt to hear both sides of the story.

Whenever possible, you should let each party speak for himself. If you are interviewing two patients at once, establish some ground rules: 1) both parties will have a chance to speak, and 2) no interruptions or

verbal attacks will be allowed. It may be necessary to remind patients of this rule during the interview. Ensure that they are at least hearing (although not necessarily agreeing with) each other by asking each to summarize the other's side of the conflict. Ask each person to begin by using a neutral question or statement such as "Sam, maybe now you could tell me what happened" rather than "Okay Sam, is what she said true? Did you do that?" because such questions will only put the patient on the defensive and make it likely that he will refute the other person's story.

A Few Interviewing "Don'ts". In conducting follow-up interviews, there are a few things that should be avoided. At this stage you are merely gathering information, so don't try to persuade the patient he was wrong and don't try to solve the problem. If you try to do this before the problem is stated this will convey that you are not listening or really interested. Also, you may end up in the awkward position of defending your own suggestions. Often you will make patients feel inadequate if you give them advice on personal problems: although the solution may seem clear to you, patients are a different situation than yours, and what would work for you may not work for them. Also, they are much more likely to follow up on their own solutions than yours. Thus, although it is a tough habit to break, you should be very careful not to try to offer solutions.

Second, don't let the patient control the interview. Often you will be asked for personal opinions such as "Would you put up with that?" or "Isn't that true?" Responding to such questions can cost you your neutrality, giving the patient information that he can use to try and recruit you to his version of what occurred. Therefore, ignore these questions or, if they persist, state that you are simply there to find out what happened and your personal opinion is irrelevant. Another important point is to help patients concentrate on the present, and disallow talk about past or future injustices. Whenever you realize that this is happening, you should ask "How can that help us here?" or make some other statement that will bring things back to the present.

Another important point to remember is that you should try not to jump to conclusions and especially do not let patients think you have. Often patients can sound very convincing on emotional issues; however, A's version of what happened might be completely undercut by B's version. Therefore, always check your understanding of a situation with the person you are interviewing rather than assume you have it correctly, because there is a tendency to read in things that are not there.

Finally, do not continue an interview if a patient is getting out of hand. Instead, discuss it later when he calms down.

What to Say. There are several specific techniques one may use to facilitate the task of gathering information. Three of these have already been discussed in the calming section—open questions, listening responses, and paraphrasing. In this section, we will discuss some additional techniques.

Reflections. Reflections involve stating in your own words the feeling you are picking up from what a patient says. This often involves attending to the nonverbal aspects of his message as well as the verbal. By reflecting his feelings back to him, you help him talk about emotions that are often very important in understanding the problem.

Confrontations. The term "confrontation" is often used to accuse or blame somebody for an incident or present him with an evaluation of his personality, but this is not what is meant here. Confrontations are statements that bring discrepancies in one's actions and words to one's attention, and often lead to self-understanding and constructive change by setting a model for honest communication. They are especially useful in discussing crisis situations, because patients (and all of us for that matter) have a tendency not to see their responsibility in causing incidents. Confrontations can often help lead individuals to self-examination and acceptance of responsibility, and are useful in pointing out discrepancies related to their strengths as well as weaknesses. They must be employed very sparingly, and are best used when you have a positive relationship built up. Furthermore, they should be phrased tentatively so they do not arouse too much defensiveness. For example, a patient who says he gets along well with people but who gets into frequent fights might be told "I don't understand. On the one hand, you say you get along well with people, but on the other hand you've been involved in fights with three people this month."

Pauses. Pauses are another useful interviewing technique. Sometimes the best results come from maintaining silence for a while. A good interviewer knows when to wait out a response by saying nothing, leaning toward the patient, looking expectantly at him, maintaining eye contact, and *waiting.* Pauses are useful when a patient is reluctant or uncooperative (giving only yes/no answers), and with mentally retarded individuals. However, since they can place increasing pressure on interviewees, they should not be used when patients are hostile or volatile. They are most effectively used after good open-ended questions.

Closed questions. Closed questions are queries that can be answered with a "yes" or "no" or with just a few words. They allow the interviewer to obtain specific information regarding when, why, or how something happened, and are most useful late in an interview for completing the information necessary to close off a topic. If closed questions are used

BOX 1: SUMMARY OF INTERVIEWING TECHNIQUES

Interviewing Skill	Definition and Characteristics	Useful For	Cautions
Open Questions	Questions worded so that they will elicit *full responses (usually begin with what, how, could you)*	- Beginning interviews - After expression of negative emotion by patient and paraphrase by therapist to allow venting of anger - Getting silent patient to open up - Getting patient to elaborate - Eliciting concrete examples	- Be careful about using "why" to start your questions - Use sparingly with rambling patients as they may wander too far off topic
Listening Responses	Short prompts that show interest and encourage patient to keep talking (e.g., "mmm," "Go on," simple repetitions of parts of the patient's sentences)	- Eliciting further information without interrupting the patient's train of thought	- Only use to encourage topics you want to hear about, not to encourage rambling
Paraphrases	Restatement of content of patient's message in your own words (Don't introduce new topics)	- Showing attention and understanding - Building the relationship between therapist and patient	- Don't use patient's own words too much or you will sound like a parrot
Reflections	Statements of feelings picked up from patient's verbal or nonverbal behavior (contain "feeling words such as "confused", "hopeless")	- Dealing with silent patients - For hostile patients, allowing venting of feelings through nonphysical means	- Don't hurry to use this because if you're wrong very often, you will destroy rather than build rapport - Avoid overuse of "angry", "upset" and other common terms
Confrontations	Statements that bring discrepancies in patients' actions and words to their attention; honest expressions of therapist's observations related to both positive and negative aspects	- Promoting self-examination - Helping patient accept responsibility for his or her actions	- Don't use unless you have built up some relationship with the patient - Use very sparingly at all times - Phrase tentatively so as not to arouse too much defensiveness - Don't use as opportunities to blame, evaluate or give solutions

Pauses	Silences after patient has said something you think is significant, and you think he/she has more to say about it. Can also follow your statement if you think the patient is thinking about what you said. Put some pressure on patients to respond	- Allowing time to plan what to say - Allowing patient time to consider what's been said and to respond - Especially useful after open question - Useful with retarded patients or patients who are very slow to respond	- Don't be quick to end a pause for a patient - Don't use when patient is getting hostile or volatile, as it may put too much pressure on him/her
Closed Questions	Questions that can be answered "yes" or "no" or with just a few words Don't allow patient complete freedom to say what they want	- Closing off a topic - Getting necessary, but noncontroversial information, (e.g., "Is that everything then?" "When did it happen?") - Keeping a rambling patient on topic	- Don't ask rhetorical questions (e.g., "That was sort of silly, wasn't it?") - Don't use manipulative questions designed to "set up" the other patient ("Is it true that she said that?") - Don't use questions designed to make patient look foolish ("Who told you that?") - Use sparingly or you will not end up with the patient's account of what happened
Information Statements	*Statements of rules or reminders about* the constraints of the situation. Stated in neutral, matter-of-fact tone of voice. Concrete, impersonal	- Helps patients limit proposed solutions to those which are possible - Helps patient accept limits as set by program rather than by particular staff - Helps confused patients recall the sequence of events in an incident	- Don't use as opportunities to blame ("you know you shouldn't have done that"); evaluate ("It was silly to do that when you know the rule is..."); or give solutions - Make sure they are neutral and factual - Use only when necessary, or you will get *less information* rather than more
Summarizing	A brief review of all the important details of an interview up to that point. Contains key points of what patient said.	- At end, to be sure you have story straight - At any time to bring patient back on topic - Helping patients out of confusion - Especially good for psychotic patients	- Make sure you say what you heard, not what you wish you had heard

too early or too frequently, they will limit the amount and quality of information that the patient gives.

Information statements: These are simple statements of fact stated in a neutral tone of voice, which can be helpful when interviewing individuals who are confused about what has happened and need help in reconstructing an incident. Sometimes patients forget something they said earlier in an interview, while other times a staff member who saw an incident can describe what he or she saw in order to help the patient remember. They can also be useful in problem- solving, as patients will often come up with solutions that are not possible given the constraints of the program or ward rules. You should use information statements only when necessary, or the interview will end up being a recitation of events by the interviewer rather than by the patient.

When to end. Stop when you can summarize each involved patient's story back to him, and he agrees that you have understood it and stated the basic issues. This is a good self-correcting method: if he agrees with your summary, you may be assured that you heard him correctly; if not, interviewing should continue. It is not necessary that all patients involved *see* the problem the same way (in fact, this rarely happens). It is often useful to have patients summarize each other's stories, as this will indicate to you when miscommunication, misunderstanding, or poor listening has occurred. Summarizing is also a good way to get back to the main issues when someone is rambling or if you are getting lost.

Follow up

If you have been able to interview both patients after an incident between them, you will have had the opportunity to observe their attitudes towards each other as well as towards you and to have collected a large amount of verbal and nonverbal information. All of this is extremely valuable in helping you decide what to do next.

Sometimes after the summary of the interview you may want to continue the session by moving right on to the conflict resolution phase (discussed next). Other times, you may wish to schedule a break but plan to continue very shortly, in which case no follow-up other than informing other staff of what was accomplished may be required. On still other occasions, no further follow-up beyond the interview may be planned, or it may be some time before a resolution will be attempted. In these cases, you should inform other staff of the results of the interview and write a note for the patient's file. You may also wish to refer him to another member of the treatment team.

Background and Rationale for Interviewing Techniques

While it is generally acknowledged that interviewing two persons together is more difficult and requires more skills than interviewing one alone (Martin, 1983), it is also important that two people who have been in conflict learn ways to interact cooperatively with one another. For this reason, many of the techniques we advocate are the same as those recommended by marriage or family therapists (Gottman, Notarius, Gonso, & Markham, 1976; Jacobson & Margolin, 1979; Patterson, 1982).

Steps in Interviewing

Observation: Obviously, if a patient is upset at the outset of a discussion of sensitive or conflict-ridden subject matter, the likelihood of his losing control and becoming aggressive is higher than if he begins in a calm state. The importance of this is emphasized by those who work with people in conflict (e.g., Jacobson & Margolin, 1979).

Preparation: The interviewer should arrange for as much privacy as possible since the presence of others may needlessly raise the patient's level of anxiety, as well as increase his tendency to try to "save face" by painting himself in a positive light rather than trying to engage in honest self-exploration (Holmes & Miller, 1976).

Approach: The most comfortable arrangement is to have the patient and interviewer in comfortable chairs facing one another (Martin, 1983). Dutton (1977) points out that in order to balance this need with a concern for safety, the interviewer may want to sit on the arm of the chair or slightly at an angle to the patient so as to be able to get up quickly should the need arise.

Action: Since the purpose of the interview is to get the patient's version of what happened, it is important to make sure that he does most of the talking. Low levels of talking by the interviewer have been related to greater elicitation of feelings, more talking, and greater liking for the interviewer by the client (Cox, Holbrook & Rutter, 1981; Hopkinson, Cox & Rutter, 1981; Kleinke & Tully, 1979; Matarazzo, Wiens, & Saslow, 1966). Kelley (1971) found that with more highly trained interviewers clients participated more actively and talked more. Experienced interviewers have been found to talk less than 20 per cent of the time (Matarazzo, Wiens, & Saslow, 1966). The importance of remaining in control of the interview, asking neutral questions, and of not attempting to solve the problem oneself has been emphasized in many discussions about inter-

viewing skills (e.g., Dutton, 1977; Martin, 1983). Whenever there are two patients involved, the importance of making sure that each has a chance to tell his story and of the interviewer remaining neutral are emphasized by those working in marital therapy (Gottman, Notarius, Gonso, & Markman, 1976; Jacobson & Margolin, 1979).

Reflections are statements that convey empathy by showing that the therapist understands the client's feelings, both those communicated verbally and those conveyed through voice and postural cues (Rennie, Burke & Toukmanian, 1978; Truax & Mitchell, 1971). Reflections that involve the therapist verbally labeling the client's feelings have been found to be very effective in assisting the client's expression of emotions (Cox, Rutter, & Holbrook, 1988), and have been rated very highly by clients (Ehrlich, D'Augelli, & Danish, 1979).

A skilled interviewer uses *confrontation* to make people aware of discrepancies in their communication (Evans, Hearn, Uhlemann, & Ivey, 1979). It should be used only when a good relationship exists between interviewer and client, and people are often more receptive when confrontations are phrased tentatively rather than abruptly or directly (Evans et al., 1979). Tentativeness conveys to the client that he or she is the authority, rather than the therapist (Martin, 1983). On the other hand, therapists should not use confrontations as a means of evaluation, as studies have suggested that evaluative statements cause patients to show deterioration (Truax & Mitchell, 1971). Compared to less effective therapists, skilled therapists use confrontations more often, and are more likely to use those that focus on the patient's areas of strength rather than on liabilities or pathology (Truax & Mitchell, 1971).

Momentary *pauses* allow the client to think or explore or assimilate earlier material (Martin, 1983). In addition, they ensure that the client has finished talking before the interviewer formulates his or her own response, which avoids forcing closure on the client's message as well as missing some of it while formulating the answer. More experienced interviewers demonstrate pauses more often (Martin, 1983). Such pauses have been found to range from a low of one second to a high of slightly over four seconds for a patient-therapist pair, but experienced interviewers rarely wait as long as ten or fifteen seconds before responding (Matarazzo, Wiens, Matarazzo, & Saslow, 1968). Ivey and Authier (1978) emphasize that novice interviewers should generally try to lengthen their reaction time and thereby keep their own talking to a minimum.

Closed questions are an efficient way to elicit factual material (Cox, Hopkinson, & Rutter, 1981). On the other hand, they should be used sparingly as they have been found to be negatively correlated with counselor empathy (Rennie, Burke, & Toukmanian, 1978).

Information statements, neutrally expressed remarks about rules or reminders about constraints, have been defined by Truax and Mitchell (1971) as "didactic confrontations." They found that high-functioning therapists use these direct clarifications of misinformation or offering of information (as well as other positive types of confrontations) more than low-functioning ones, who tended to use more confrontations that pointed out weakness or pathology.

Evans et al. (1979) recommend the use of *summarizing* the points or feelings that have been expressed in order to help patients understand and deal with their emotions, to review what has been said, and to encourage exploration of particular themes.

CONFLICT RESOLUTION

In this section we will look at methods of resolving conflict between two people. The methods we will consider are negotiation and mediation. Negotiation refers to the process in which two people work through a process of offer, counteroffer, concession, and compromise until they reach a solution that both agree is the best one possible. Mediation refers to a process in which a neutral third party (the mediator) who has no authoritative decision-making power helps two parties in conflict develop a mutually agreeable solution. Both negotiation and mediation require considerable skill on the part of the staff member, but the reduction of stress and conflict on the ward that may result can make the effort required to learn these skills worthwhile.

If a conflict has been between yourself and a patient, it is very important to try to negotiate with him to find a mutually agreeable solution. This may be difficult as it is hard to be objective when a conflict involves oneself, but you should try to work out a compromise so that the same situation will not come up again in the future.

If the incident was between a patient and another staff member, it is probably best *not* to attempt to resolve the conflict yourself.

If it resulted from a patient violating program rules and did not involve another staff or patient, negotiating or problem-solving may help him come up with a solution or find a way to change his behavior so that he does not have cause to break this rule again.

If it involved two patients, mediation may help them to solve their problems by finding a mutually agreeable resolution. Usually, this is done

by sitting down with both together. The goal is to get them to commit themselves to a verbal contract that specifies what each will do to avoid further conflict, and to leave both with a positive feeling about that contract.

Note: Negotiation and mediation are almost always desirable after there has been a clear-cut incident, e.g., where one patient has assaulted or threatened another patient or staff, or where a major program rule has been violated. There are also times, however, when they may be used to *prevent* an incident from occurring in the first place. For instance, a patient may be following rules but only very reluctantly and with obvious signs of displeasure, or two patients may frequently disagree and have formed a strong dislike of each other. In these situations, it should be determined at the interview stage that the individuals involved agree that there is a problem that needs solving. If this agreement is not obtained, you should not attempt conflict resolution.

Steps in Conflict Resolution

If you are combining the interview and conflict resolution phases, the steps of observation, preparation, and approach obviously need not be repeated, but if they are being conducted separately observe patients to be sure calm is restored. Never begin a negotiation or mediation session if they are upset, as it will be extremely difficult to maintain control. It is important that both parties are motivated to solve the conflict, so point out the mutual advantages if need be. Unless they both agree there is a possible advantage to solving the conflict, you may wish to delay mediation until a future date when they are more motivated to do so.

Action

In negotiation, begin by eliciting from the patient his ideas as to how a situation could be improved. Often he may not be very clear as to what exactly he does want, and helping him clarify that in his own mind may be a necessary first step. Try to have him generate as many ways as possible to get what he wants before evaluating any of them. Very often the initial solutions proposed will be inadequate, but they may stimulate better ones. Avoid being critical at first; rather, just listen, paraphrase, and try to get him to come up with additional solutions while treating his ideas with respect. After he has given as many possible solutions as he can think of, you should summarize them, react to those that have an element of feasibility, and then put forth any additional possibilities

of your own. The patient should then summarize and react to *your* proposals, and put forth counterproposals. This process should continue until there is a solution that satisfies both of you.

When the problem is between the patient and some rule in the program, the procedure is the same but you must try even harder to get him to generate his own solution. Sometimes this might involve bringing matters up for discussion at a ward meeting: perhaps the rule is unfair or outdated, or maybe it should be clarified for other patients as well.

In mediation, unless you have come directly from the interview phase, the action phase should begin by reviewing the ground rules outlined for two-patient interviews. The next step is to have each patient summarize the issues or do so yourself, and then elicit from each his ideas as to how the problem situation could be improved. Say something like: "Well, what do you think you can do about this?", "How do you think you can handle this situation in the future?" or words to this effect. Be very careful not to *offer* solutions: these must come from the patients themselves. Many patients will resist this approach initially, often at this stage wanting you to make a suggestion because they see you as the authority figure and because it will appear to speed up resolution. For these reasons it may be tempting to offer a quick solution, but be careful not to fall into this trap. While any solutions you propose might work for you they might not work for the patients, and would often not be accepted or followed by them even though they asked for them. The mediator's responsibility is not to find solutions for other people's personal problems, but simply to help them come up with their own.

As the conflicting parties come up with suggestions, you should check each one out. Make sure that what is said is concrete and specific. If one patient says, "Joe keeps bugging me", pursue it until he turns it to something concrete such as "Joe asks me for cigarettes every day." If he says, "You treat me unfairly", question him until he clarifies his statement to something like "You don't give me as many points as the other staff do."

Obtain a reaction from the other patient as each suggestion is made. The process of checking out A's suggestions with B and vice versa should continue until a mutually acceptable compromise is reached. Often it may take several suggestions before this is obtained, so be prepared for this to take time. As much as possible stay out of the process of evaluating the solutions — let the patients evaluate one another's. Try to be very liberal in judging the solutions yourself, and especially hold back on giving negative feedback. It is not necessary to get the parties to agree on everything; getting some small concessions and agreements gives them an example of how this can be done. They may learn from the experience

and generalize the learning to other conflicts. Whenever an agreement is reached on any point, the mediator should emphasize this as it creates a positive bond between the two parties that did not previously exist. Once the patients have come up with a solution, encourage them to carry it out. Even if you think it is crazy, remember that it is their solution and it might work for them. Do not criticize it if it is mutually agreed upon. Making them feel good about having gotten this far (obtaining a compromise) will increase the chance that they will make it work.

At the end of the mediation, summarize and obtain a final commitment from both parties. The summary will ensure that vague issues are made concrete; will ensure that you have understood the patients correctly and that they have understood each other; will allow an opportunity to check once more for doubts about the solution; and will provide a chance to offer reassurances. Later, praise the patients if they are observed to be living up to their agreements.

Maintaining Control. Control is most effectively applied at the beginning of a negotiation or mediation session. Be sure to lay down the ground rules and enforce them as necessary. Do not let patients develop momentum in rambling on about irrelevant or inflammatory material; restate it using less emotionally charged terms. If there are two patients, you may want to gradually loosen control during mediation by allowing them to begin to address each other. If they are doing so constructively and working towards a solution, do not interfere but help them to consolidate (make specific agreements, summarize, and make commitments to agreements). If flare-ups occur, bring them back to their specific objective of finding a solution. Sometimes it may be necessary to summarize what has been accomplished so far. It is not always necessary to find a solution: if you have helped the patients to communicate the problem and started the process of finding a solution, you have accomplished something.

Other Useful Techniques. By *checking out*, or verbalizing what you have heard and asking if this is what was meant, you can ensure that both you and the patients are hearing and understanding each other's point of view. Stay with this process of clarification during interviewing and problem-solving until each party knows and can state the other's point of view.

Summarizing. As discussions progress, people often forget what each other have been saying. Frequent summary statements can help keep them on topic.

Role reversal. One method of clarifying perceptions is role reversal. That is, patient A is asked to present the case of patient B and vice versa. This allows A to find out if he has heard B correctly, as well as how B feels about A's behavior. Also, if there are discrepancies between what

B said and what A *says* B said, you can correct this communication problem immediately by simply checking with B after A has given his version of B's case. Does B agree that this is what he said? Point out similarities and differences missed by the patients.

Concentrating on the least cooperative patient. At various stages of the mediation, one or the other patient may be offering the greatest resistance toward moving toward a solution. You should direct your efforts primarily towards this person, reminding him if necessary of the potential advantages of the mediation process.

Helping patients save face. In order to maintain their self-esteem, patients need to feel that they have not completely lost in a conflict situation. You can help in this task by emphasizing the advantages to each party of any solution that is agreed upon and by emphasizing any concessions, no matter how small, each is making.

Errors to Avoid. All of the following are likely to either cut off communication or make the patient angry:

- Giving orders, directions or commands. Example: "What you need to do, John, is listen to staff."
- Warning or threatening. Example: "If you two keep fighting like this, we'll get you put in confinement (or in time out room) for a good long time." (Note: Sometimes it is appropriate to point out to patients the consequences of what will happen if they don't work out a solution. However, this should be done in a calm, nonthreatening manner, and should not be exaggerated.)
- Moralizing or preaching. Example: "This is not how good patients get along."
- Giving advice, finding solutions. Example: "You two should just stay out of each other's way."
- Judging or criticizing. Example: "Your behavior is disgusting."
- Shaming or ridiculing. Example: "Don't you feel ashamed of this behavior?"
- Interrogating or using probing questions. Example: "Jim, is it true that you are a homosexual?"
- Interpreting. Example: "You did it because you feel inadequate." Such statements may only anger or irritate the patient. Statements containing "because" should be avoided.
- Lecturing or using "logical" solutions. Example: "There's no logical reason for you to feel as you do, Tom. You're really over-reacting."
- Arguing.
- Interrupting.

Some other problems may arise in mediation sessions from what the patients say to each other. The mediator should not allow the following to occur:

- *Battering ram points.* If after one patient has made his complaint he keeps repeating it over and over to "drive it home," he is using a "battering ram" point. Cut him off and check to make sure the other person has gotten the point.
- *"Red herring" arguments.* These refer to points that are unrelated or irrelevant to the present situation. There is a strong temptation on the part of disputants to dwell on past injuries or to predict future catastrophes. These should be cut off and the patient returned to the present complaint. Patients may also tend to blame absent third parties for problems. Keep the discussion focused on issues between the two parties present.
- *Monologues.* If a patient appears to be on the verge of a long ramble, cut in and ask for a succinct, specific complaint. Control is required in these cases.

When to Stop: Once the patients have agreed on a specific course of action to follow, you have accomplished your objective and should end the negotiation or mediation session. Other times, the process will not be successful. If after about ten minutes nothing productive has happened, state that to the patients and end the session. Perhaps a referral might be appropriate, or perhaps conflict resolution will be possible at a later date.

Effects of Problem-Solving on Patients: Even if negotiation or mediation does not bring about a specific resolution of the conflict, two patients who have had longstanding problems in getting along may be helped by the process. You have provided a model for them in how they can attempt to resolve their differences.

Follow-up

After negotiation or mediation is completed, inform other staff members on your ward of the results. Often, the problem-solving process will reveal a flaw in the program that must be discussed. A note should be entered on the clinical files indicating what agreement was made. Be sure to check with the patients later to see if the agreement is being carried out, and, of course, be sure you carry out any promises that you have made yourself.

Background and Rationale for Conflict Resolution Techniques

Most of the direct care nursing staff who have taken our course are initially very unenthusiastic about the idea of acting as a mediator in the case of patient conflicts, typically favoring imposing a solution or arbitration. They often say that they will listen to each patient's side of the story separately and then offer a solution that they expect them to follow.

However, although we know of no data to support the use of mediation instead of arbitration in the case of patient conflicts, there are data from the labor relations area that suggest that arbitration has many negative consequences, some of which may be of relevance here. Lewicki and Litterer (1985) have found that most managers want to assume responsibility for resolving disputes among their subordinates. However, Kochan (1980) terms the "half-life effect" the tendency for disenchantment with the adequacy and fairness of the process to increase as the frequency of arbitration increases. With rising disenchantment is an increased likelihood of escalating to other means of resolving disputes such as strikes (Anderson & Kochan, 1977). Second, arbiters must be careful to maintain an image of fairness and impartiality, yet it is difficult in the long run not to show a systematic bias in favor of one party. Third, arbitration may lead to less commitment to a settlement than solutions in which the aggrieved parties have had greater involvement (Vroom, 1973). In our course, we include a brief discussion of the use of mediation and negotiation in labor relations contexts, as well as in the fields of divorce proceedings, business disputes, and international conflicts (Fisher, 1978; Moore, 1986; Reich, 1981; Saposnek, 1983).

Most of the approaches we advocate were adapted from courses designed to train police officers in dealing with domestic disputes and hostage-taking situations (Dutton, 1977; Miron & Goldstein, 1979). Our list of errors to avoid in interviewing and conflict resolution is adapted from similar lists (Gordon, 1972; Ivey & Authier, 1978; Matarazzo, Wiens & Saslow, 1966). While the problems inherent in making some of these errors are intuitively obvious, there are others that have been demonstrated in research on counseling techniques to be detrimental. For example, giving advice and interpreting have been found to be negatively related to counselor empathy ratings (Rennie, Burke, & Toukmanian, 1978). In our course, trainers include a short lecture, based on a chapter by Homes and Miller (1976), on theories of conflict development and escalation and outlining their relevance to methods of resolution.

Understanding some of the reasons of why conflicts arise and escalate allows one to better understand the issues involved in resolving them. *Realistic conflicts* are defined as struggles arising out of an objective conflict of interest (e.g., fights over food or money), while *autistic conflicts* have no basis in reality. To an outside observer there seems to be no reason for the fight and emotions appear to be totally out of line with the alleged grievance, but this is because the real issue is usually one of pride or ego. Autistic conflict is usually characterized by threat, distrust, and misperception. Often, what begins as a realistic conflict quickly becomes autistic. Realistic conflict is often difficult to resolve, but since most involve autistic components, conflict resolution techniques can be very helpful.

Social Exchange Theory

Our classroom description of social exchange theory begins with a consideration of research about the "prisoner's dilemma" game (Axelrod, 1984; Nemeth, 1973; Rapoport & Chammah, 1965), which provides some insight into the process of initiation, escalation, and resolution of conflict.

The game is based on the following premise. Two individuals have been accused of a crime. They are interviewed separately by the police and cannot communicate with one another. Each prisoner has two options: confess to the crime or not confess. If both confess, both will be convicted and receive a short sentence. If neither confesses, they will both be acquitted due to lack of evidence. However, if only one confesses, that one will go free and receive a reward for giving evidence against the other, who will receive a severe sentence. Consideration of the situation reveals that it is to each prisoner's advantage to confess regardless of what the other does, for if the other individual also confesses, both receive the lesser rather than the more severe sentence, and if the other does not confess, the one who does ends up free with a reward instead of just being free. However, the dilemma is that if both operate in this selfish fashion, they end up in a worse position than if neither confesses.

In a game, each player has these two possible moves on every turn. Players are told to earn as many points as they can. Neither is allowed to communicate or to see what choice the other has made until they have both made their decisions. The choices on each move are C (Cooperate) and D (Defect). If the game were to last for one trial only, the best strategy for each individual would be to play D, because no matter what the other does, defection yields a higher payoff. If we look at their best *collective* interest however, the best strategy is for both to cooperate because that

will yield the highest total payoff. The game is an example of a mixed motive, non-zero sum situation whereby each person is motivated to maximize his or her own interests at the expense of the other, but if both do this, each will end up with less than if they had cooperated.

Subjects typically play the "C" option on only approximately one-third of the trials, even though the most collectively rational solution is to play it on all trials. After all, if one player starts out by playing "D" due to short-term interest, the other may reciprocate that choice. The players thus end up in a joint "D" lock, which is very costly to both. Rather than being motivated solely to maximize gain, people play as they do for motives such as to save face, to gain revenge, or simply to beat their opponent (Nemeth, 1972). Even "expert" strategists make errors of being too competitive for their own good, not forgiving enough of their opponent, and too pessimistic about the likelihood that one's own "C" move will lead to a reciprocal "C" move by the other (Axelrod, 1984).This is exactly what is involved in autistic conflict: individuals are motivated by personal goals of revenge and retaliation rather than by concrete or material goals, and the opposing parties thus settle for little when they both could make a substantial profit by cooperating.

In real-life versions of this sort of situation, acting as a mediator or negotiator can be extremely helpful. Because the mediator is neutral, he or she can point out the objective consequences of the conflict (i.e., both parties are losing), and by helping the parties sort out their difficulties, can help them to move from a no-win to a both-win outcome. In real life, people do not have full knowledge about possible outcomes for the other party and themselves, and often are not clear even about their own preferences. Obtaining this information is part of the conflict resolution process. Of course, in real life it is hard to determine the exact payoffs of each possible outcome, and the number of possible outcomes can be quite large.

Working from an applied clinical perspective, social learning theorists have noted that whenever two people are involved in interactions over a long period of time, there is a tendency for them to exhibit reciprocity, or an equal exchange of positive and negative consequences (Patterson & Reid, 1970). Particularly when the pair involved in the interaction (e.g., a married couple) is having difficulty, there seems to be a very high degree of reciprocity in the exchange of negative consequences (Jacobson & Margolin, 1979). Patterson and Cobb (1971) describe "coercion" as a type of interchange between two people in which each controls the behavior of the other by the presentation and withdrawal of aversive stimuli. The process begins when one member presents what the other member perceives as an aversive stimulus,who in turn presents

an aversive stimulus back. The interchange continues until one member withdraws the aversive stimulus, at which point the second member withdraws his or her aversive stimulus as well. The negative reinforcement that results from this strengthens the behavior of both members of the dyad. After such an interaction the likelihood that a similar interplay will occur again increases, and thus over a series of interactions, the pair train one another to behave more and more destructively. Without outside intervention, the couple becomes locked into a series of attacks and counterattacks that effectively side-track them from any possible solution of the problem (Patterson & Hops, 1972).

Attributional Elements

Cognitive psychologists have examined the utility of attribution theory and research for understanding the initiation, escalation, and resolution of conflict (Doherty, 1981; Fincham, 1983, 1985). According to attribution theory (Heider, 1958; Kelley, 1972), people attribute causes to behavior because of their desire for control over the events occurring in their lives. In general, there is a bias towards explanations that emphasize internal factors such as personality traits, as opposed to explanations having to do with characteristics of the situation. There is also evidence that attributions differ depending upon whether one is attempting to explain one's own behavior or that of another (Jones & Nisbett, 1972).

In one study, couples were invited to list instances in which their explanations of each other's behavior disagreed (Orvis, Kelley, & Butler, 1976). It was found that people more often perceive their partner's negative behavior as being due to negative personality traits and their own as due to situational factors, than vice versa. Furthermore, there is a tendency for each person to view him or herself as an innocent victim of the other's behavior: each views the actions of the other as the causal stimulus and his or her own actions as simply the natural reaction to provocation, unaware that the sequence of events leading up to the current conflict has in fact been reciprocal (Watzlawick, Beavin, & Jackson, 1967). Moreover, people involved in a conflict may come to expect negative behavior from each other. When one partner exhibits negative behavior, the other blames it on his or her personality, whereas positive behavior tends to be dismissed as accidental or due to environmental influence. In a study of college student roommates, it was found that roommates tended to overattribute responsibility for negative behaviors to the other and underestimate their own contributions to conflict escalation (Sillars, 1981).

There is some evidence that people in extended or long-term dyadic relationships are biased in a self-serving manner in their apportioning of responsibility and blame. They tend to be willing to take credit for positive relationship events, but are likely to blame the other for negative ones. When experiencing conflict, this tendency is particularly pronounced (Berley & Jacobson, 1984). A mediator is likely to be able to see that each party's view makes sense to him or herself, and, by using role reversal or other techniques, can help each to see the other's point of view.

Goals and Relationships

Conflict is much more likely to arise in situations in which the goals of the two individuals involved are negatively rather than positively correlated: that is, when one individual attains his or her goal at the expense of the other. Research suggests that situations of this type are likely to be more characterized by mistrust, suspicion, the use of coercion, and efforts to block the other's goal attainment (Deutsch, 1973). In our course, trainers suggest that staff mediators point out ways in which the goals of the two parties in conflict can be shared rather than opposed.

When conflict arises out of competing goals (e.g., opponents in a tennis match), there is realistic competition between the two sides before the interaction begins. Autistic conflict is thus much more likely to begin in this case than it is when the roles of the two persons involve working towards a common goal (e.g., partners in in a tennis match). Many relationships involve a mixture of these two types of goals. Patient-patient role relationships versus staff-patient role relationships involve competing and conflicting goals, respectively. With one another patients may compete for attention or privileges, while with staff their goals may conflict, inasmuch as staff roles involve enforcing rules that patients would rather not obey. Mediators can reduce the level of conflict by pointing out ways in which the goals of the two parties in conflict are shared rather than in opposition.

Legitimate Power and Rules

Generally, the more formal the restraints that bind the participants and the more rules there are about how to behave in certain situations, the less likely it is that autistic conflict will arise. For example, in a fire, the more rules there are about who is in charge, who is to do what, etc., the less likely it is that there will be panic. Rules hinder the development of autistic conflict by depersonalizing interactions: things are done as

they are because of the rules rather than because of the personal whims of one person.

Generally speaking, the larger the power differential the less likely it is that conflict will develop. Similarly, once begun, conflict is most likely to escalate when the individuals involved are of the same status. For example, people are much more likely to get into a heated argument with their peers in a work situation than with someone much higher or lower in the power hierarchy. Conflict between two patients can arise easily both because of competition for attention, as discussed above, and because they are of equal status. Because staff members have more legitimate power than patients, their presence as mediators in a discussion will tend to reduce the amount of conflict. By laying down some ground rules about how the interaction will proceed, they can reduce it even further.

Personal Elements

The personality characteristics of the individuals involved in conflict resolution affect the decision-making process. People who are authoritarian or mistrustful are less likely than others to cooperate (Deutsch, 1960; Loomis, 1959; Terhune, 1971), as are those who are dogmatic, concrete, or intolerant of ambiguity (Druckman, 1967; Terhune, 1971). Our trainers emphasize that a good mediator is one who is flexible, open, and tolerant and who can help patients see shades of grey rather than simply black and white.

The more ego a person has invested in something, the more likely it is that his or her emotions will become heated. For example, confirmed golfers to whom the game is very important may become upset over fairly good shots, while inferior players who consider themselves simply "hackers" out to have a good time are quite happy about their poor shots. For psychiatric in-patients, perhaps because their world is so limited in terms of space, possessions, etc., they sometimes tend to be very ego-involved over things that may seem very unimportant to staff.

Traits of suspiciousness and dogmatism are other personal elements that can increase the likelihood of autistic conflict. Cognitive complexity plays a role as well: individuals who are limited intellectually tend not to see more than one possible solution to a problem, and mediators can help by encouraging them to do so. Some people tend to see the world in black and white, and in a dispute believe that they are totally right and the other person is totally wrong. A good mediator helps them to see shades of grey. In a negotiation situation, the negotiator should attempt to see the patient's side.

Other Factors

Presence of others. When an audience is present, parties in a conflict situation often feel that their egos are threatened and that they will look foolish if they are seen to back down. The conflict thus tends to escalate as each side makes its demands more firmly. In both negotiation and mediation, staff can reduce the amount of conflict quickly by getting rid of spectators.

Interruptions. Uninterrupted, conflict tends to escalate. While they are arguing, people are generally unable or unwilling to see things in perspective; for example, they rarely end an argument by apologizing even if they do so later. The longer an argument continues without interruption, the more likely it is that emotions will override reason. A mediator can help reduce the level of conflict by using short, strategically placed interruptions that simply restate (modeled in a calmer tone) what one of the disputants just said.

The blindness of involvement. When anxiety levels are high, as is usually the case during an argument, it may be difficult to recognize all the responses available: there is a tendency to "lock in" and only see one solution. Moreover, when conflict is heated, efforts are invested in managing one's emotions and in planning the next verbal attack. Later, when calm, one may wonder why another possible solution did not seem obvious at the time. A mediator who is not involved emotionally can help disputants explore solutions that may not be occurring to them on their own.

One issue or many? When people are in conflict, they tend to see the problem as involving one major issue. A mediator or negotiator can help by fractionating the main issue into several smaller ones. This allows compromise by letting each side give on some points and take on others, thus allowing both to save face and not be seen as losing.

Chapter 7

Other Course Topics

JOB STRESS AND BURNOUT

Staff working in psychiatric hospitals experience job stress for a multitude of reasons, not the least of which is from the constant threat of being assaulted or having to intervene in patients' fights. We will first look at the causes, signs, and effects of job stress and burnout, and then examine what can be done to prevent them.

Causes of Job Stress and Burnout

For direct care staff working in institutional settings, job stress and burnout are usually caused by the following:

- the possibility of being assaulted or having to intervene in assaults
- restraining patients
- wondering whether you will be supported by management for implementing restraint or seclusion procedures
- working overtime
- working long days or many days in a row
- shiftwork
- insufficient numbers of staff, especially front line personnel
- role conflicts
- promotion practices that are perceived as unfair
- abuse from patients
- status frustration
- caring for patients who refuse treatment

- significant changes in legislation and institutional policy affecting patient care
- concern about caring for patients who pose health risks (e.g., AIDS or hepatitus-B)
- staff differences in morale, enthusiasm, and productivity
- poor physical conditions
- too much or too little responsibility
- unfulfilled expectations regarding job

Signs and Effects of Job Stress

Job stress affects different people in different ways. In fact, some amount of stress and some types are positive influences. Stress can give you the motivation to achieve difficult goals and, like a vaccination, a little of it inoculates you against unexpected events that might otherwise incapacitate you. However, if it reaches excessive levels or remains at high levels over too long a period it will begin to impair your work proficiency and consequently your self-perception.

Signs that you are suffering from too much stress on the job include:

- job dissatisfaction
- accidents
- mistakes
- resistance to change
- feelings of hopelessness, helplessness, depression, or irritability
- dislike of co-workers and superiors
- physical symptoms such as headaches, ulcers, digestive problems, lack of appetite, inability to sleep, or chronic fatigue
- losing concern for, distancing oneself from, or depersonalizing patients
- negative self-image
- withdrawal and isolation in personal and social life
- marital, financial, or parental difficulties at home
- shortness of temper and anger with patients
- alcohol and drug problems

In addition to the destructive effects of job stress on yourself, there are effects on others. If you are suffering from too much job stress you cannot perform well, and this puts increased stress on your co-workers who must compensate by working harder themselves. Patients suffer if instead of being caring and tolerant in your interactions with them you are short-tempered and authoritarian — and needless to say, patients who are treated

this way become more difficult for the other staff to manage, again making their own jobs more difficult. Finally, high levels of job stress lead to high levels of absenteeism. At the Penetanguishene institute the average number of sick days lost by nursing staff in 1982 was 15.3, which was well above the average number of days lost by staff in most other departments. Of course, when some staff are off sick, the remaining ones have increased responsibilities.

In summary, job stress that affects one staff member takes its toll on co-workers as well. Thus, a vicious circle is created in which all staff on a ward may eventually suffer from too much job stress or burnout.

Alleviating Job Stress and Burnout

Strategies to reduce job stress are aimed at three different levels — the individual, the group, and the organization.

At an individual level, you can work to reduce personal stress levels by:

- Focusing on activities and friends outside the job
- Building competencies by attending workshops, conferences, etc.
- Changing your approach to the job by setting realistic limits for yourself
- Taking breaks or vacations
- Changing the job by introducing greater variety
- Focusing on positive aspects of the job
- Taking courses in relaxation training or stress inoculation training
- Talking to a coworker, a close friend, or a professional counsellor about your problem.

Within working groups, you can help one another reduce stress by:

- Developing mutual support systems to receive and give support, feedback, and assistance
- Listening without giving advice or making judgments
- Providing technical support by observing and commenting on your performance. Support and affirmation of competence from your co-workers is very important in preventing burnout.
- Providing technical challenge. Contact with a colleague who knows as much as or more about the job than you do can keep you from becoming stale. He or she can challenge you and encourage you to learn new skills.
- Providing emotional support. In a difficult situation, you need someone who is willing to be on your side even if he or she is not in total agreement with what you are doing.

- Sharing social reality. Sometimes you might need a friend to help you interpret social reality and decide on reasonable action, especially when you think you are losing your ability to evaluate accurately what is going on around you. Usually it takes just one other person who sees things as you do to give you useful advice.
- Forming support groups. These groups should allow discussion of stressful events; admission of feelings of inadequacy, depression, anger, and guilt; analysis of problems; and offers and acceptance of help. The support group leaders must model and encourage empathy and genuineness, and they must have administrative support as evidenced by the willingness of management staff to provide resources.

Organizational changes that may reduce stress include:

- Changes in authority and status structure
- Redesign of the division of labor
- Increased emphasis on career planning for staff
- Job enrichment. Techniques can include reducing the level of supervision while maintaining accountability, redesigning assignments so a person or team is given authority and discretion for a group of patients rather than all patients, and introducing more difficult jobs with increased feedback of results.
- Allowing short breaks from the job at regular intervals
- Allowing vacation days to be taken without long advance notice
- Organizing a quality-of-work-life committee to examine possible changes in the work environment
- Employing an employee counsellor who will talk to employees experiencing undue levels of job stress
- Offering training programs or sending workers to conferences
- Making goals clearer and more realistic
- Improving participation in decision-making
- Setting up support groups for staff.

Use of the above strategies will help not only you but your co-workers and patients as well. You will show an increase in productivity and morale, do work of higher quality, be in improved physical health, make better decisions, be more able to tolerate change, feel better about yourself, have a greater sense of commitment, cooperate better with other staff, and have more patience and tolerance in your interactions with patients. It is our hope that by carefully learning and applying the techniques presented in this book you will increase your feelings of mastery and competence and thereby achieve benefits for both yourself and those around you.

Background and Rationale for Alleviation of Job Stress

The section on job stress and burnout is included in the course for three main reasons. First, working closely and intensively with psychiatric patients or correctional inmates over a long period of time has been found to be very stressful (Dignam, Barrera, & West, 1986; Klitzman & Stellman, 1986; Pines & Maslach, 1978). Colligan, Smith and Hurrell (1977) studied the incidence of job stress as measured by the incidence of mental health disorders among those who practiced a given occupation, and found a disproportionate share of mental health problems among health care professionals.

Second, in the human services professions, direct care workers have been found to suffer most severely from job stress (Klitzman & Stellman, 1986). Often a worker feels that he or she is the only one experiencing difficulty and that everyone else is coping adequately. In discussions, participants have expressed great relief upon realizing that they are not the only ones suffering (Pines & Aronson, 1981).

Third, there is some evidence that physical assaults on staff by patients and inmates in institutional settings are both a cause and a result of high stress levels (Klitzman & Stellman, 1986; Ruben, Wolkon, & Yamamoto, 1980). There is also evidence that by learning techniques to manage the stress that comes from having to work face-to-face with aggressive clientele, staff can reduce the level of aggression on the ward (Feindler & Fremouw, 1983).

Definitions of Job Stress and Burnout

There have been many definitions of stress (e.g., Selye, 1956; Selye, 1974). The definition of job stress we have chosen for the course is adapted from French and Harrison (1982), who describe it as involving an objective or subjective misfit between a person's abilities and the demands of a job, or as something in the person's objective or subjective environment that is perceived as a threat. They and others (Adams, 1980; Selye, 1974) also define "strain" as a deviation from a person's normal state, including physiological, emotional, and behavioral aberrations. We have chosen to call these deviations signs and symptoms of job stress.

Burnout is a syndrome of emotional exhaustion and cynicism that frequently accompanies intense and prolonged interpersonal interaction (Maslach & Jackson, 1981; Pines & Aronson, 1981). It may be seen as a

particular form of job stress that affects those working in "people jobs." It is characterized by a negative self-concept, negative job attitudes, and loss of feelings of concern for clients. Two self-administered tests for diagnosing level of burnout are the Maslach Burnout Inventory (Maslach & Jackson, 1986) and one given in Pines and Aronson (1981, p. 37). Of the two, the former has more demonstrated validity, but the latter is slightly faster and easier to score.

Pines and Maslach (1978) studied burnout among 76 mental health personnel by examining the simple correlations between indications of burnout and various aspects of the job, the clientele, and the worker. They found that the larger the ratio of patients to staff, the less staff members liked their jobs, the less likely they were to seek self-fulfillment or social interaction in their jobs, and the more likely they were to say that aspects such as money were the best things about their jobs. The higher the percentage of schizophrenics in the patient population, the less the staff said they liked their jobs, the more time they spent in administrative duties, and the more likely they were to recommend pharmacological rather than psychological interventions. The less seriously ill the patients and the fewer the hours worked, the better were the reported work relationships. When work relationships were reported to be good, staff members expressed more positive attitudes about their institution, said they enjoyed their work, and said they felt successful in it. Staff who could take time to withdraw from patient contact for short periods every once in a while when they needed to showed more favorable attitudes towards patients. Also, the more hours a day staff members worked, the less they liked their jobs and the more stress they reported. The longer they had worked in the mental health field, the less they said they liked working with patients and the more custodial rather than humanistic were their attitudes towards mental illness. Staff members who felt they had input into the institutional policy had a much more positive view of themselves than others. Those who had higher levels of formal education had entered the mental health field with higher expectations and, over time, tended to show the greatest degree of burnout. Of course, because this study involved simple correlations only, no conclusions can be drawn about causal relationships or about the effects of possible mediating variables.

DiMatteo and Friedman (1982) examined stress among health care professionals and identified a major source of stress for nurses as the gap that they perceived between their training and their professional lives. It was often a shock for nurses to find that the norms and values of school (e.g., talking with patients) did not fit with the bureaucratic norms set in institutions (time limits, etc.). In other studies, it has been found that

the existence of conflicting demands (for example, demands to do more paperwork and at the same time spend more time interacting with clients) is correlated with irritation about the job and with burnout (Caplan, Cobb, French, Harrison, & Pinneau, 1980; Schwab & Iwanicki, 1982).

French and Harrison (1982) examined job stress among 2,010 male workers in 23 occupations in four job groups: unskilled blue-collar (assembly line workers, forklift operators, and machine tenders), skilled blue-collar (tool and die makers), white-collar nonprofessionals (police officers, electronic technicians, air traffic controllers, supervisors, foremen, and train dispatchers) and professionals (engineers, scientists, professors, physicians, accountants and administrators). Using self-report data for all subjects and physiological data on a subset, they examined the interactions between several types of stressors (e.g.,workload, underutilization of abilities, job complexity, responsibility, ambiguity, future prospects, amount of participation in decision-making, and amount of social support) involved in various jobs, and workers' mental and physical health (measures of somatic complaints, blood pressure, cholesterol, uric acid and heart rate). They found that overall the unskilled blue-collar workers had the highest levels of job stress, reporting the greatest underutilization of their skills and abilities and the greatest discrepancies between their actual and desired levels of job complexity, responsibility, and role ambiguity. They also had high levels of uncertainty about the security of their jobs and low support from others. The skilled blue-collar workers frequently complained that their levels of responsibility did not match their abilities, and they also suffered from anxiety about the future security of their jobs. On the other hand, they were unlikely to complain about feeling underutilized. The white-collar nonprofessionals did not suffer more than any other groups from any of the stressors. They were also the least likely to complain of an excess workload. Finally, the professionals were the most likely to complain of an excess workload, but on the other hand, they rarely complained of being underutilized, of the complexity of their jobs, or of the level of responsibility they were given. They reported the highest workload, but overall showed the fewest signs of job stress.

In a study of the amount of job stress in 130 occupational categories carried out by the National Institute of Occupational Safety and Health in the United States, nurses' aides ranked 10th and registered nurses ranked 27th. A major finding of that study was that jobs high on the list, such as health technicians, secretaries, and nurses' aides, were frequently ones in which the individuals possessed information and skills that they weren't allowed to use. Again, the importance of a fit between the individual's skills and the requirements of the job are emphasized.

Of course, while the results of these studies show a relationship between unskilled jobs and high levels of job stress and strain, they do not indicate a causal connection. It may be, for example, that there is a degree of self-selection into particular positions that makes it more likely that some will have more workers who experience job stress. Occupations that require high levels of training, for example, may select out candidates who do not fit the job during the training process. Those that require little training (e.g., assembly line work) are less likely to screen people out ahead of time.

The implications of these studies for our class discussion is that staff in jobs that require less formal training (e.g., nurses' aides) are more likely to experience job stress than staff in jobs that require more training, such as registered nurses, psychologists, or administrators.

Symptoms of Job Stress

Physical exhaustion is one of the main signs of job stress and burnout. Nausea, muscle tension in shoulders and neck, back pains, changes in eating habits and weight, accident proneness, increased susceptibility to illness, nagging colds and frequent bouts of flu are common. Often there is a combination of being tired yet having difficulty in sleeping due to nightmares or tormenting thoughts. Consequences of burnout can include gastroenteritis and migraine headaches (Belcastro, Gold, & Grant, 1982), turning to alcohol, cigarettes, barbiturates, tranquillizers, hallucinogens, or overeating (Burke, Shearer, & Deszca, 1984; Maslach & Jackson, 1979; Pines & Aronson, 1981), and experiencing emotional exhaustion, including feelings of depression and hopelessness. The burned-out worker feels drained, yet irritable and nervous at the same time. Family and friends become another demand upon emotional resources rather than sources of support and satisfaction. Few relationships can tolerate irritability and lack of support for long periods, so marital and family conflict and deteriorating social relationships are common (Jackson & Maslach, 1982; Maslach & Jackson, 1979; Pines & Aronson, 1981).

Other symptoms may include negative attitudes towards oneself, one's work, others, and life in general; and feelings of inadequacy, inferiority, and incompetence. Human service workers may stop seeing the recipients of their services as having the same feelings, impulses, and thoughts as they do, and as a result are more likely to treat them as if they were not human beings (Zimbardo, 1970). Workers in correctional settings are particularly vulnerable to dehumanization (Dignam, Barrera, & West, 1986).

Yet other signs include arriving late, leaving early, taking extended breaks, missing work entirely, postponing or avoiding client contacts, and cynicism regarding clients (Maslach & Jackson, 1981; Pines & Aronson, 1981). Sometimes people experiencing high levels of burnout quit their careers entirely, while others stay but become "deadwood," do as little as possible, and look forward to retirement (Pines & Aronson, 1981).

Alleviating Job Stress

Strategies to alleviate job stress and burnout may occur at the level of the individual, the group, or the organization (Shinn & Morch, 1983).

Individual Strategies: At the individual level, there is a considerable literature on learning to cope through relaxation or stress inoculation training (e.g., Jaremko, 1983; Meichenbaum & Jaremko, 1983; Novaco, 1979). Feindler and Fremouw (1983) found that stress inoculation training reduced the frequency of aggression amongst child-care staff. Sharing job concerns with spouses or other persons unconnected with work can also be of help (French & Harrison, 1982).

Pines and Aronson (1981) suggest that the first step in coping with burnout is becoming aware of the problem, which involves changing the focus from blaming oneself to making a situational attribution and then beginning to take control over some aspects of it. In many cases this means tackling the source of stress directly (for example, confronting a supervisor), or setting realistic and achievable goals. Sometimes it involves changing some of one's focus from concerns about patients to concerns about oneself (Pines & Maslach, 1978). Another coping strategy is to build in a period of "decompression" after work to exercise or relax, in order to forget about work problems and make homecoming less stressful. Exercise has the additional advantage of helping one remain in good physical shape, which will enable one to better withstand the stresses.

Building self-esteem is encouraged by reviewing one's own performance at the end of a day or week and congratulating oneself on any accomplishments. This is made easier by setting short-term goals. In a related vein, it can be helpful to seek out a colleague who will provide technical support and affirm one's competence. This person should be someone who is an expert in the field, courageous enough to provide honest feedback, and who understands the complexities of the job (Pines, 1983), who can identify areas in which one could improve, and can be trusted to provide criticism in a helpful manner. This type of support can challenge one's way of thinking about things, and lead one to be more creative and enthusiastic.

Group Strategies: Scully (1983) emphasizes a support group of co-workers for preventing burnout. The group should have norms that permit talking about stressful events; admitting feelings of inadequacy, fallibility, depression, and guilt; giving feedback; problem-solving; and giving and receiving help. Letting co-workers know that their efforts are appreciated is another important task (Pines & Aronson, 1981). Very often, staff members get together in order to avoid direct contact with patients rather than to give each other support and confer about problems (Pines & Maslach, 1978). The leaders should model and encourage empathy, and be able to call upon administrative support. The group will be most successful if resources are provided as required to accomplish its goals.

Organizational Strategies: Underutilization of skills is one of the common causes of job stress (French & Harrison, 1982), and organizations that promote continuous job enrichment and encourage promotional opportunities can do much to help prevent this.

Patient-staff ratios might also be reduced: while large workloads and patient-staff ratios might save money in the short run, they can be very costly over time (Pines & Aronson, 1981). Organizations can also act to reduce the number of hours of direct contact any one staff member works by building in more breaks from direct contact with patients during the workday. These "times out" might include paperwork, attending meetings, or doing other non-patient contact tasks, as well as the usual coffee breaks or rest periods. Thus they need not result in fewer hours of work in total, but only fewer hours of direct patient contact for each individual staff member. Regular times-out may be even more important for those who work with the most severely schizophrenic or aggressive patients.

Another strategy is to prepare new employees for the stresses they will likely encounter, and to provide them with a realistic view of what they can expect to accomplish. They should also be taught the signs of burnout and how to take care of themselves when under stress. Learning how to work in a bureaucracy is also important (Pines & Aronson, 1981).

Continuing education is important as well: retreats, conferences, and workshops to learn new skills relevant to the job. Such opportunities provide a chance to get away from work and examine work pressures and clarify goals as well as to learn new skills (Pines & Aronson, 1981).

Staff clinical meetings are frequently positively correlated with burnout. Pines and Maslach (1978) speculate that the reason for this is that most such meetings employ a case presentation format in which patients are described solely in terms of mental illness, and thus enhance the dehumanization process by reducing them to labels and distancing them from staff. Meetings would be improved by focusing discussion on patients'

strengths and competencies as well as pathologies. In addition, Pines and Maslach suggest that some of these meetings be replaced by staff support group meetings.

Other strategies include making the physical environment as pleasant as possible by providing private, quiet, work spaces and allowing individual preferences to be expressed, as well as building in formal means of providing feedback that is specific and directly related to attainable improvements, in order to increase employees' feelings of significance at work (Pines & Aronson, 1981). In the course, we emphasize that only the individual level strategies can be undertaken alone, but that all staff members should initiate steps that may lead to the implementation of group or organizational-level strategies.

RELATED TOPICS FOR DISCUSSION

We here present summaries of two research projects that have found to be especially thought-provoking for staff who work in psychiatric and correctional facilities. Trainers may discuss these projects during the section on job-stress.

What if "Normal" People Were Admitted to Psychiatric Hospitals?

Study One

In a series of studies conducted in 1974 by psychologist D.L. Rosenhan, eight sane people —three women and five men—gained secret admission to different psychiatric hospitals in the United States. One was a graduate student in his 20s; the others were older and included a housewife, a pediatrician, a psychiatrist, and three psychologists. The mental health professionals claimed to belong to another occupational group, and all the supposed patients employed pseudonyms to avoid later embarrassment. Except in one case where the pseudopatient's role was known to the hospital administrator and the chief psychologist, none of the staff knew of the true roles of these patients or the nature of the research program. Twelve hospitals were involved in the study. Some were on the east coast and some on the west, some were old and some new, and ratios of staff to patients varied from very high to very low.

The subjects all called first for an appointment, and complained of hearing voices that were unclear but said things like "empty," "hollow,"

and "thud." Apart from this and their false identities, they told the truth about everything and acted normally: none described histories or current behaviors that were seriously pathological in any way. Most subjects were mildly anxious and nervous at first because they did not think they would be admitted so easily, expecting instead they would be exposed as frauds and embarrassed. Many had never even visited a psychiatric ward before.

What happened to the pseudopatients after admission? All but one were given an initial diagnosis of schizophrenia, and when discharged still had the same diagnosis but with the addition of "in remission". The participants had been instructed to get themselves discharged however possible, yet although all but one asked to be discharged almost immediately, length of hospitalization ranged from 7 to 52 days with an average of 19. This was despite the fact that the nursing notes uniformly indicated that they were cooperative, friendly, and behaved "normally" in the way they spoke to other patients and staff.

The pseudopatients reported that they were not very carefully observed. They responded to instructions from staff, and responded to calls for medication (but didn't swallow it). They spent time writing notes, secretly at first but then openly when it seemed no one cared. Once labeled as "schizophrenic" there was a tendency to view their histories as abnormal and their behaviors as irrational. For example, even slight problems within their families as children were interpreted as being indicative of the type of childhood upbringing that leads to adult pathology. Behaviors caused by boredom, such as pacing, were interpreted as indicating nervousness, while the note-writing was interpreted as an example of psychopathology.

Frequently, the participants reported seeing other patients being unwittingly mistreated by staff and thereby provoked into acting in a "crazy" fashion. When patients acted upset, staff rarely asked them what the problem was, but rather assumed it was occurring because of "craziness" or that the patient's family or visitors had caused the upset.

The hospitals were typically all structured in such a way as to minimize interaction between staff and patients, with the staff keeping mostly to themselves in what the participants called the "cage." The average amount of time spent by ward attendants outside of the cage was only 11 percent, including time spent folding laundry, supervising patients while they shaved, etc. For nurses it was much less, and for physicians (especially psychiatrists) even less. The pseudopatients felt as though the staff were afraid they could catch their patients' disorders by mingling with them.

The participants reported that they often had the feeling that as patients they were invisible or unworthy of being considered. Attendants delivered

verbal and occasional serious physical abuse in the presence of other patients, even though some others (the study participants) were writing down what was being said. On the other hand, this would terminate quite abruptly if other staff were known to be coming. Staff would adjust their undergarments openly in front of opposite-sex patients with no apparent intent of being seductive.

While no staff member ever questioned the pseudopatients' insanity, several other patients did, claiming they were journalists, professors, or someone checking up on the hospital. In fact, for the first three hospitalizations counts were kept of the number of times such suspicions were voiced, and it was found that 35 of a total of 118 other patients expressed doubts about the pseudopatients.

Study 2

In four of the hospitals used in the first study, the pseudopatient would approach a staff member with a polite and relevant request about when he or she would be discharged, eligible for grounds privileges, etc. Of 185 such questions addressed to psychiatrists, 131 received no answer at all: the psychiatrist simply moved on with head averted. On only 11 occasions was there any verbal response. Of over 1,000 such questions asked of nursing and attendant staff, 88% met with a similar response. Verbal responses to the question were given only 2.5% of the time. Questions were often dealt with by asking the patient how he or she was that day, for example, and then moving on without waiting for a reply.

Study Three

The staff at a research and teaching hospital were informed that some time during the following three months one or more pseudopatients would attempt to gain admission. Accordingly, during that time period each patient admitted was rated on a scale of 1 to 10 as to the likelihood that he or she was a fraud. Of 193 patients admitted, 41 were alleged to be frauds with high confidence by at least one staff member, 23 by a psychiatrist. In fact, none was.

These three studies allow the class to discuss psychiatric labeling and the implications the diagnostic procedure has for the way we treat patients. They also allow discussion of some of the stereotypes we all have about "mental patients," and how these stereotypes affect how we treat them, encouraging staff to consider the importance of observing and talking with their charges as people rather than as psychiatric patients.

What if "Normal" People were Assigned the Roles of "Guard" or "Inmate" in a Prison?

In 1971, psychologist Philip Zimbardo and his associates undertook an experiment to see what would happen if "normal" males were randomly assigned the roles of prison guard or inmate in a mock prison. An advertisement was placed in a Palo Alto, California newspaper calling for paid volunteers for a study of the psychological effects of prison life. Twenty-four college students at Stanford University were chosen from a larger group of volunteers. All scored in the normal range on a number of psychological tests. Subjects were assigned to be either guards or prisoners by the flip of a coin. There were no initial differences on any of the measures between the two groups.

A simulated prison was set up in the basement of the psychology department of the university by changing some of the doors, adding cell numbers, and boarding up the ends of the corridor. A small closet on one side of the hall became the "hole" or solitary confinement. There were no windows or clocks. The setting was intended to simulate a prison atmosphere rather than be exactly like an actual prison in its physical characteristics.

The subjects assigned the role of prisoner were picked up at their homes, spread-eagled against a police car, warned of their rights, handcuffed, put in the car and carried off to the police station. There, they were put in a detention cell after being blindfolded, booked, and fingerprinted. They were then brought to the "jail" and greeted by the warden. Each inmate was searched and then stripped naked and deloused. He was then given a uniform that consisted of a sack-like dress with his prison number on it, rubber sandals, and a cap made of a woman's nylon stocking. He also had a heavy chain bolted around his ankle. Prisoners were called only by number, and could refer to themselves and other prisoners only in this way.

Guards were given no specific instruction or training in how to act. They made up their own set of rules under the general instruction of the warden, who was also one of the undergraduates. All guards dressed in identical khaki uniforms, wore reflective sunglasses, carried clubs borrowed from the police, and wore whistles around their necks. When the study began, there were nine prisoners, three to a cell, and nine guards who worked three eight-hour shifts.

At 2:30 a.m. of the first night the prisoners were awakened for a count, one of several during the day and night. Push-ups were commonly used by the guards as punishment for rule infractions, displays of improper

attitude, etc. The second day of the experiment, the prisoners rebelled by removing their caps, ripping off their numbers, and barricading themselves inside the cells by putting their beds against the doors. The guards on duty responded by calling in all the other guards, using a fire extinguisher containing carbon dioxide to force the prisoners away from the doors, breaking into the cells, stripping the patients, removing their beds, forcing the suspected ringleaders into solitary confinement, and harassing and intimidating all prisoners.

After the rebellion was crushed, the guards had to figure out how to manage nine unruly inmates with just three staff. They did this by setting up a "privilege cell," and allowing the three inmates believed to have had the least to do with the rebellion to have their uniforms and beds back, to wash and brush their teeth, and to be given special food in front of the other prisoners who were denied the privilege of eating. By doing this, solidarity among the prisoners was broken. Then, to confuse the prisoners, the guards arbitrarily put the first three prisoners into bad cells again and gave three different ones access to the privileged cell. Some of the prisoners who had been the ringleaders of the rebellion thought the individuals in the privileged cell were informers, and this further broke down any feelings of solidarity or trust among the prisoners.

All aspects of the prisoners' lives were under the arbitrary control of the guards. Even going to the toilet was a request a guard could grant or deny as he wished, and he was free to push, trip, or do anything else to prisoners while he escorted one of them there. At night, the prisoners had buckets in their rooms and guards could refuse permission to empty them. The prison began to smell of feces and urine.

Less than 36 hours into the experiment, the first prisoner had to be released because he was crying uncontrollably, screaming, and appeared to be acutely emotionally disturbed. His thinking was disorganized. After some dispute as to whether his symptoms were real or whether he was just conning the experimenters, he was released.

On the third day, prisoners were allowed visits with their families. On the fourth day, a priest came to visit. That same day, one more prisoner had to be removed from the study after he broke down and began to cry hysterically. While the experimenters prepared to take him to a doctor and removed his stocking cap and chains, one of the guards lined up all the other prisoners and had them chant aloud about how "#819 was a bad prisoner."

By the fifth day, the guards had sorted themselves into one of three groupings. Some were "good guys" according to the prisoners. They seemed to feel sorry for the prisoners, tried to do favors for them, and never punished them. Others were tough but fair and followed the rules

of the prison. About one-third, however, were extremely hostile and arbitrary and seemed to enjoy humiliating and degrading the prisoners. None of the tests used in the beginning of the experiment to screen subjects predicted these extreme differences among the guards.

On the fifth day, the "parole board" met. Prisoners were chained together and had bags over their heads so they could not see or talk. Each prisoner was brought in one at a time and asked if he would forfeit all the money he had earned so far if he could be paroled. All but one said yes. Each was told to go back to his cell and his case would be considered. Not one objected, even though they had volunteered for the study and were, of course, free to withdraw at any time. Because of their experiences of the past four days, however, they believed they did not have the power to choose to leave. They had come to believe they were in a prison where they had to wait for parole to be granted.

All prisoners were denied parole. Each prisoner reacted in his own way; some by becoming rebellious and fighting with guards, others by breaking down emotionally, another by following every order to the letter. The prisoners no longer had any sense of group unity.

On the night of the fifth day, the prisoners were once again allowed to have visits. Some of their parents asked Dr. Zimbardo to contact a lawyer to get their sons out of the experiment, and the lawyer came and interviewed each of the prisoners. It became clear that the experiment had gone too far: the inmates were truly suffering, and some of the guards were enjoying behaving sadistically while all the others stood by and never interfered with orders of the sadistic ones.

On the sixth day of what was to have been a two-week study, the experiment was called off. A series of encounter groups was held in order to get everyone's feelings out in the open, and to recount what each had learned from the experience. Participants agreed that they could now understand how prisons and other total institutions could dehumanize people and make them feel helpless and hopeless. They could also see how prisons could foster the development of people who could enjoy dehumanizing others.

Discussion

This study offers the trainers a chance to stimulate discussion about the dehumanizing aspects of institutions, and how staff members as well as their charges are affected by the experience. Both research projects illustrate that the differences between staff and patients may be more apparent than real, and that many differences result not from the personal

characteristics of the individuals involved but from differences in power and absence of clear direction for staff. Often, trainers have found that class members are quite silent after this presentation and don't have much to say at the time. Later, when they have had time to think about it, they say that it was quite powerful and that it offered some valuable insights into experiences they have had in their own careers.

SIMULATIONS

One day is spent in role-playing situations designed to allow for practice of verbal and physical techniques learned in the course. Except for a hostage-taking simulation, these are chosen to illustrate typical situations that arise in our institution. One of the positive effects of such practice, especially for staff who initially view patients in a manner more custodial than therapeutic, is that behaving in a different manner during simulations might help change their attitudes (Cialdini, 1984). Another benefit is that it gives staff members a chance to experience the role of the patient. Many students comment that they come away with a better understanding of what it is like to be a patient and have to live within hospital rules, follow instructions, etc. Most enjoy doing this, and it is in fact usually easier to get volunteers for these parts than for the staff roles.

We conduct simulations in an unused patient sunroom for one half-day, and, when possible, use an unoccupied patient's room and the ward corridor and sunroom for the other half-day. The times for this must be scheduled around the periods when the patients are all off the ward.

The following simulations are some that we have been found to be successful. The basic details of many of the scenes used were drawn from incidents that have occurred in our hospital.

Simulations 1 and 2: Calming and Defusing

1) A newly admitted patient is pacing back and forth in the sunroom, not indicating any violent behavior, but looking very worried and upset because of having been told that all patients get ECT. The player is instructed to act in a psychotic manner and to make vague references to having his or her brain "blown up," but to respond by calming down if the staff do a good job of their task.

There are three staff roles in this scene. Other players can take the roles of additional patients who happen to be around.

2) In this scene, it is assumed that it is later the same day and that no one intervened earlier. The patient continues to pace but is now much more agitated, kicking furniture, etc. He or she is instructed to pick up a chair, mop, or broom to use as a weapon when staff begin to approach, but to allow them to successfully defuse the situation (i.e., put the weapon down) if good techniques are used. The roles in this scene are the same as in Scene 1, with different volunteers to play them in order to give more people a chance.

Simulations 3 and 4: Defusing and Interviewing

These two simulations are usually done one after another, with no discussion until both have been completed. They usually take about one hour, including set-up and discussion.

3) In this scene, two patients are arguing over some item of value (e.g., a book, tape player, etc.). One had lent it to the other who then lost it, and when the lender asks for it back the borrower eventually admits to losing the item but doesn't offer to do anything about it. The patients are instructed to get into a heated argument but not a physical altercation. Two more trainees play the parts of other patients who happen to be around at the time but are not involved. Four staff roles are used in this scene, but they do not necessarily all have to take part.

4) Later in the day, two or three staff decide to sit down with the patients and interview them together to try to find out what the earlier incident was about. The staff can attempt a mediation if they wish. Again, different volunteers are asked to take the roles from those who played them in Scene 1.

Simulations 5 and 6: Restraint

These two scenes take place with a patient alone inside a locked room who refuses to come out for an injection. He or she does not have a weapon.

5) In the first scene, the staff decide to go in to get the patient. There are five staff roles here, and players can decide among themselves who will do what. Two other players may take the role of patients who happen to be on the ward at the time.

Before this scene proceeds, students are cautioned about the possibility of injuries and warned to stop immediately if someone yells "Stop".

6) The scene is the same as before, but now the patient is to be talked out of the room voluntarily rather than having the staff go in. He or she will still be manually restrained for the injection. The roles are the same as in the first scene but with new players.

Simulation 7: Hostage-Taking

Although no staff have ever been taken hostage in our facility, we find that doing a hostage-taking simulation is a good way to involve students in a dramatic demonstration of the value of many of the techniques taught in the course. The topic is introduced with a brief review of the institution's official policy with regard to hostage-taking, and of what is known about the successful resolution of hostage-taking incidents (eg. Miron & Goldstein, 1979). It is emphasized that observation, talking the hostage-taker down, using defusing skills, and later, calming, interviewing and mediation skills are the recommended techniques (see Chapters 4, 5, and 6).

It is explained that although the participants' institution may have an official trained negotiating team that would be called in the event of a real hostage-taking, here the class members will do everything themselves and follow the incident through to its conclusion. Participants are told that in this and every other role play, they are to be sure that no one is injured; thus, if at any time anyone yells "Stop," the simulation is to cease immediately.

The role play takes place on a corridor just outside a side room, patient room, or any room off a larger area. Videotape equipment is set up somewhere down the corridor so it is out of the way. Nonparticipants stay in the sunroom next door where they can hear but not see what is going on. (For all other role-plays, the scene is enacted in full view of other class members.) This simulation, including the discussion before and after, usually takes about two hours. The roles are as follows:

First patient: hostage-taker. It works best if a trainer takes this role. This player will get behind one of the staff members and grab him or her quickly and firmly, holding a "knife" (a dull pencil or pen) against the hostage's neck as a weapon.

Second and third patients: These players will create a disturbance to distract the staff from noticing the hostage-taker. They argue over something (e.g., cigarettes), and the quarrel becomes sufficiently heated that the staff are obliged to intervene.

First and second staff: These staff are on the corridor with the patients. They know that one of them will be "taken hostage" and the other will be a witness and then act as the mediator, but which will be which is unknown until the event actually happens. They are told that the role of the hostage is to be generally quiet and docile, but if there is a chance to talk and establish a relationship with the hostage-taker, to go ahead and do so. The witness/mediator should observe as much as possible, try to defuse the situation and calm the hostage-taker down somewhat, find out any initial demands, and relay these to the ward supervisor.

Third staff: ward supervisor. This player stays in the sunroom with the nonparticipants. When the "mediator" comes out of the room where the incident has occurred, the supervisor finds out as much as possible about what happened, the state of the hostage and hostage-taker, and what the latter wants. He or she then asks the mediator to go back into the room and try to persuade the hostage-taker to give up and come out. The mediator is told to give in to minor demands in order to try to gain concessions such as putting down the knife and surrendering the hostage.

Background and Rationale for Role-Playing

The combination of modeling, instruction, role-playing, and feedback we use in our course are also important components of a number of skill-enhancement programs, including microcounseling, social skills training, assertion training, and anger control training. These techniques are described briefly below.

Microcounseling was developed to teach basic counseling skills to professional and lay counselor trainees (Ivey, 1971; Ivey & Authier, 1978). It uses role-playing as the focal point of training, with performances videotaped for later analysis and discussion by the peer group. Instruction and modeling are also used. Microcounseling has been shown to be an effective way to teach counseling skills to support personnel (Haase & DiMattia, 1970), teachers (Allen & Ryan, 1969), beginning counselors (Fyffe & Oei, 1979) and others (Higgins, Ivey, & Uhlemann, 1970). Role-playing, modeling, and feedback are also heavily emphasized and recommended in other interviewer training programs (Goldstein & Goedhart, 1973; Rappaport, Gross, & Lepper, 1973; Rutter, Cox, Egert, Holbrook, & Everitt, 1981).

Social skills training refers to a model of therapy that concentrates on having clients rehearse or practice prosocial behaviors. Modeling, instruction, role-playing and feedback are all involved. It has been found to be effective in increasing the social competence of mentally retarded clients (Bornstein, Bach, McFall, Friman & Lyons, 1980; Matson, Kazdin & Esveldt-Dawson, 1980; Meredith, Saxon, Doleys, & Kyzer, 1980), psychiatric patients (Bellack, Hersen & Himmelhoch, 1981; Foxx, McMorrow, Bittle, & Fenton, 1985; Monti, Curran, Corriveau, DeLancey & Hagerman, 1980; Rice, 1983; Rice & Chaplin, 1979; Rice & Quinsey, 1980), individuals suffering from dating anxiety (Bander, Steinke, Allen & Mosher, 1975), and offenders (Daigle-Zinn & Andrews, 1980; Spence

& Marzillier, 1981). A social skills model of training has also been used effectively for teaching job-related skills to mentally retarded clients (Grinnell & Lieberman, 1977), psychiatric patients (Furman, Geller, Simon & Kelly, 1979) and offenders (Twentyman, Jensen, & Kloss, 1978). The more modeling, role-playing, and feedback are used in the training, the more improvement shown in the clients (Bouchard, Wright, Mathieu, Lalonde, Bergeron, & Troupin, 1980).

Assertion training is similar except that the focus is primarily on the expression of negative emotions and standing up for one's rights. It has been used effectively with many populations (Field & Test, 1975; Rathus, 1973; Rimm, Hill, Brown, & Stuart, 1974). Anger control training is also very similar: modeling, role-playing, and feedback (and frequently additional components) are common ingredients that have been found to contribute to its effectiveness (Goldstein & Glick, 1987; Moon & Eisler, 1983; Novaco, 1977; Rimm, Hill, Brown & Stuart, 1974).

Despite the evidence that a combination of modeling, role-playing, and feedback is an effective way to teach new skills, much of the research has been criticized on the grounds that the improvements are short-lived, that they do not generalize beyond the training situations, and that the acquisition of new skills is usually evaluated in simulated rather than live situations (Gorecki, Dickson, Anderson & Jones, 1981; Higgins, Alonso, & Pendleton, 1979; Rich & Schoeder, 1976). Furthermore, because most training programs include a combination of procedures, it is not known which components are responsible for any improvements observed.

Nevertheless, there is evidence that each of the components (modeling, role-playing, and feedback) adds to the efficacy of the treatment package (McFall & Twentyman, 1973; Thelen, Fry, Fehrenbach, & Frautschi, 1979) and that treatment effects can generalize beyond the training situations (Goldsmith & McFall, 1975; McFall & Twentyman, 1973). In our course, in order to maximize the likelihood of this occurring, the simulations used are made to be as similar as possible to those that staff are likely to encounter in their work. This includes having them take place on wards that are very similar physically to the ones on which staff work, as considerable research has established that memory performance is optimal when the context of retrieval resembles the context of encoding or learning (Tulving & Thompson, 1973; Morris, Bransford, & Franks, 1977).

In an effort to check that students can generalize the skills they have learned to new situations, the simulations that we present in the tests of knowledge and skill (used to evaluate the effectiveness of the course; see Chapter 9) are all different from the ones described here.

Part III

Presentation of the Course:

Information for Trainers and Administrators

Chapter 8

Trainers' Notes

In this chapter, specific information is presented for the benefit of those developing their own courses and/or preparing to act as trainers. Here we give suggestions on how to present the material, describing a variety of techniques and classroom exercises that we have found to be useful.

INTRODUCTORY CONSIDERATIONS

Scheduling

We have found that the best way to present the course is by scheduling it for one full working week of five 7.5-hour days. This has several advantages over a schedule of one day per week for several weeks or some other noncontinuous timetable. First, it allows a group cohesion to develop, which is important in getting people to be comfortable enough to volunteer for the role play simulations that occur toward the end. Second, staff enjoy the course more when it means they have a whole week away from their regular duties. (To enhance this aspect, days off are usually scheduled so that they get the weekends off before and after.) Third, whenever we have taught a course that is not continuous we have found that participants frequently miss parts of it. By scheduling it for one continuous block of time, there are fewer problems of absenteeism.

We usually register groups of 8 to 16 at a time. Although groups of up to 24 can be handled quite easily, we have found that the nursing department of our hospital has difficulty scheduling coverage for the wards with so many staff absent at any one time.

The following schedule is the one used at our institution:

TIME	MON.	TUES.	WED.	THURS.	FRI.
8:30	Introduction to Course	Calming Procedures	Self-Defense and Restraint	Conflict Resolution	Simulations
10:30	Gym	Gym	Gym	Gym	Gym
12:00	Lunch break				
1:00	Security Measures	Explosive Situations: Defusing	Follow-up: Interviewing	Simulations	Job Stress Other Discussion Topics Wrap-Up

Preparation of Videotaped Material

Videotapes that illustrate the use of the techniques taught in the course are very powerful teaching aids. We use videos to portray the use of both recommended and inappropriate techniques. Some are played from start to finish; others are paused frequently in "freeze frame" to allow students to evaluate what has just occurred and to suggest what should be said or done next. The preparation of these videos requires a great deal of labor, because careful script writing, directing, editing, and acting are all required, but when successful they are invaluable in the presentation of the material.

Copies of one of these videos are available through the publisher (see information on page 294).

Introduction to the Course

Our first class begins with a brief description of the material that lies ahead, the history of the course, and the research that led to it. Students then complete the "Sensitive Situations Skill Test," which assesses their understanding of appropriate responses in difficult situations. This test, described in greater detail in Chapter 9, presents videotaped scenes of staff-patient interactions, followed by questions. It takes just over an hour, and participants usually find it quite interesting because it gives them an idea of the kind of material that will be discussed and sometimes stimulates curiosity about the appropriate answers. No feedback is given at this time.

The course notes (on which Section II of this book is based) are only handed out on the fourth day, after the classroom lectures are completed. Trainers have found that if these are handed out at the beginning, people often look for answers in the notes when asked questions, instead of thinking about their own experiences and forming their own answers.

Wrap-Up to the Course

At the end of the course, students are encouraged to ask questions about any part of the material that is not clear to them. Following this they are again given the same Sensitive Situations Skill Test that was presented on the first morning. This time the answers to each question are discussed as soon as each is completed; however, trainers ask that no one change his or her responses, because the purpose of the test is to help decide how effective the course was rather than assessing how much each person knows (the tests are handed in anonymously). There is some discussion at this time about the fact that often there is no one "correct" answer, but that it is important to be aware that the techniques advocated in the course have been approved by hospital administration.

Students also complete a questionnaire that asks how much they enjoyed each section of the course, how well it was taught, how useful it was, etc. (See Chapter 9 for a complete discussion of the evaluation of the course.) Finally, there is an informal discussion in which students are asked if they have any ideas for future courses, etc.

Trainers usually conclude the course by inviting the class to meet in a local pub where the events of the week are rehashed one more time. Often some very valuable information comes out of these meetings.

The remainder of this chapter contains our suggestions on how to present the course material.

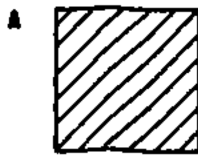
SECURITY

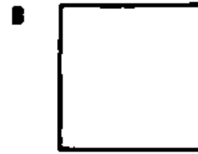
What is Security?

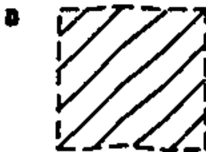
Begin by asking the class what is meant by security. Usually people identify physical aspects of the environment that make hospitals a place in which patients can be treated safely and prevented from eloping. Try to elicit other aspects of security.

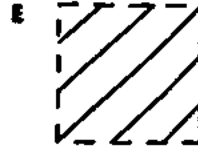
Have the class consider the following six models:

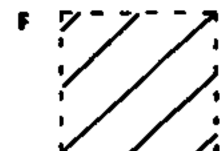
FIGURE 1
MODELS OF VARIOUS SECURITY ARRANGEMENTS











In (a), both perimeter and internal security are very tight. There is very strict control of who gets in and out, strict rules inside about access to various areas, etc. In (b) there is very strict perimeter security but very little security inside the building. This model, or something close to it, is often found in correctional institutions where inmates have very liberal access to one another — and to potential weapons such as razor blades. Both the above models would be considered to be maximum security. Models (c), (d), (e) and (f) represent various forms of medium and minimum security. In (c) there is no perimeter security, but internal security is tight. Some airports might be examples of this type of setting. Models (d), (e) and (f) show various blends of internal and perimeter security. Have the class discuss which model best describes their work area.

Methods of Maintaining Security

Go through each method of maintaining security described in Chapter 4, give a few concrete examples, and ask participants to give more examples used in their areas. Discuss the advantages and disadvantages of each type. Physical restraint need be discussed only briefly, as more time will be spent on that later.

Ask students to identify which types of security currently seem to be given most emphasis on their wards, and where the pressure is coming from to use or avoid those methods. Usually, staff say that all methods except for interpersonal ones seem to be actively discouraged. Discuss the implications of this and ask how interpersonal security techniques can be bolstered.

Security Crisis Simulations

In classes where more than two hours are available to spend on the topic of security, we have found simulation exercises such as the following to be useful. The class is divided into subgroups of three or four for 10-15 minutes. Each group discusses a particular crisis, and decides what types of security have lapsed and what they would do themselves in that situation. Following this, the groups present their topics to the rest of the class for general discussion. The examples of crises are designed to match the specific wards of the staff in attendance.

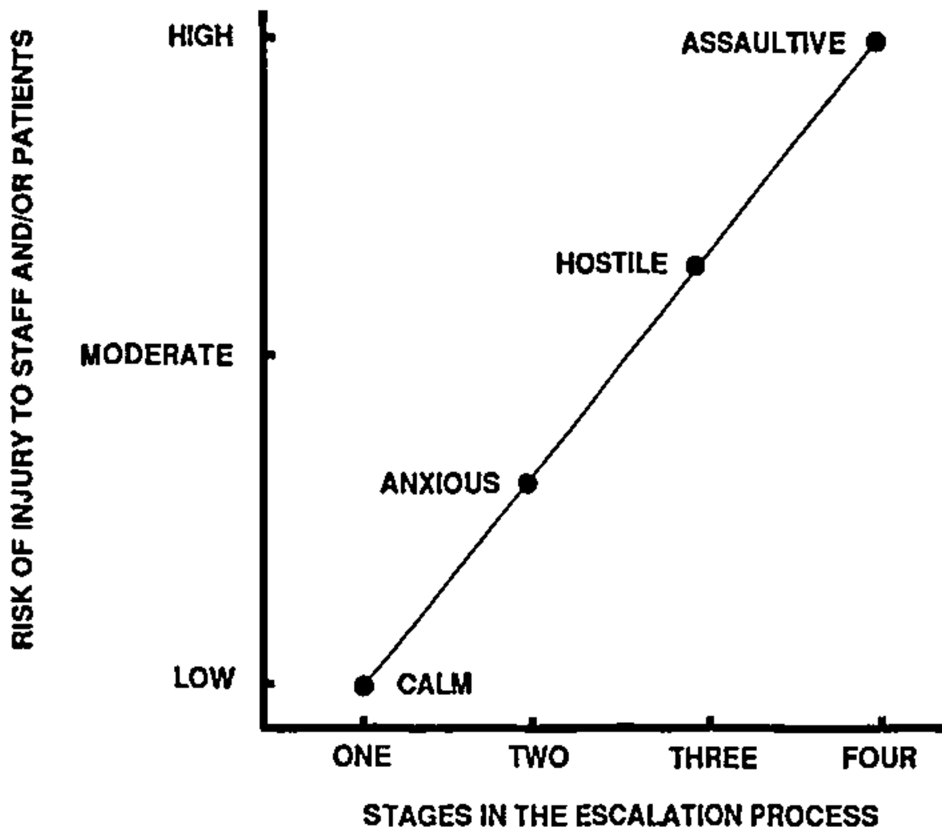
Example: A patient comes up to you and says he saw another patient on the corridor with a broken piece of glass. This patient has a history of self-mutilation and attacks against others. You are in charge. a) What type or types of security have lapsed? b) What actions will you take?

CALMING

Calm State Intervention

Open with a lecture on the escalation process in which a patient may proceed from calm to upset to hostile to attacking (see Figure 2). Definitions should be provided of the relevant terms (calming, defusing, aggression, etc.). The model of the escalation process is a major theme of the course, and should be reintroduced briefly at the beginning of each major section. Instructors should point out that the more a situation has escalated, the more control staff must expect to exert over an upset patient's behavior. Instructors should point out that the more a situation has escalated, the more control staff must expect to exert over an upset patient's behavior.

FIGURE 2
THE ESCALATION PROCESS



Follow this with a discussion of how crisis intervention can be applied when a patient is still calm. At first this may strike some students as an odd idea, but they quickly come to appreciate that many crises (or even mild upsets) can be avoided when patients and staff maintain friendly and positive interpersonal relationships. Point out that calming used as a reinforcer for already upset behavior could thereby contribute to *more* agitation and risk of danger, but that this is unlikely when it is used to reinforce peaceful behavior.

We next demonstrate bad ways to handle everyday interactions by presenting a videotaped demonstration of some very poorly handled situations. Students generally find these scenarios quite amusing and the mistakes made are obvious (e.g., a staff member at first appears aloof and uninterested, then suddenly begins to scold and preach at an upset patient). We elicit from the class the mistakes they noticed, and the problems that might occur later as a result of the poor handling of these relatively innocent interactions.

The Value of Early Intervention

Discuss how things can build up in the escalation process (i.e., if calming procedures are not used, tension may mount and defusing and/or restraint may then be required). Ask students to give examples from their own experience. Outline the advantages of early interventions, as listed below:

- They provide an opportunity for the patient to see staff members as human beings rather than as authority figures.
- They provide the staff with an opportunity to reward patients for desirable behavior.
- They provide an opportunity for staff members to develop a relationship with patients that may make the patients hesitate to act aggressively against them later on.
- They are relatively safe, meaning that if staff members make mistakes they can recover without risking an assault.
- Although the staff member involved might prefer the patient to act in a certain way in a calming situation, the patient does not have to immediately change his behavior, and staff therefore are not required to exert control.

The Step-by-Step Procedure

Present the main rationales for routinely following the step-by-step procedure: 1) that staff will have practiced using these steps in noncritical

situations and will be prepared to use them in more critical ones, and 2) being familiar with thinking in terms of the steps is useful after an incident, in that one can go over what happened in an attempt to identify what might be improved upon next time.

For the discussion of the "Observation" step, where one observes a scene and decides if one should intervene at all, have the class name the behavioral cues that indicate the need for calming intervention. List these on a flip chart for display. If any students suggest cues for which calming techniques are not appropriate (e.g., patient is making threatening gestures), explain why their answer is wrong; be careful however not to do this in a critical way that will inhibit future participation. Next, ask for a list of the sorts of situations that may cause patients anxiety.

For "Preparation," ask the class what they would do themselves in the situations described above. Would they just go over and talk to the patient, or would they do anything else first? If people say that they would just go over, point out the potential risks. On the chart, write down recommendations on: a) which staff members should intervene, b) how much time should one allow, c) where should calming be done, d) the need to review the patient's background, and e) safety considerations.

Under "Approach," discuss the importance of nonverbal aspects of communication. What messages are conveyed by body language such as pointing a finger, standing with hands on hips, etc? Physically demonstrate how sitting down to talk with a seated patient differs from standing; the effects of height differences; the effect of a table between oneself and the patient, etc. How close should one stand or sit from the patient? Demonstrate some variations to stimulate discussion of personal space. The need for more personal space for someone who is upset should be brought up, as well as how cultural and gender differences affect body language and personal space. Emphasize the importance of using a calm, quiet, gentle voice tone, and the staff member's influence as a model. Discuss the advantage of opening with the patient's name, and whether or not to give him the option of refusing to speak with you.

Demonstration Videos

We then show some videotaped calming simulations and ask students to identify flaws and make suggestions about better ways to handle the situations. The steps can be identified, and use of various techniques pointed out. Stop the tape at various points to ask such questions as:

- How did the patient look to you?
- What made you infer that?

- How effective was the staff member's statement?
- What did you just see?
- As the patient and staff talked, what happened?

Mini-Simulations

Break the class into groups of three to practice calming situations. Within each group one student plays the role of the patient, one the staff, and the third takes notes and observes such things as body posture, eye contact, opening remarks, the use of open questions, listening responses, and paraphrases. Trainers should go around to each group to help them get started. The first simulation should be quite simple and should last only about five minutes before being cut off and discussed with the rest of the class. If there is time for more than one simulation, have students switch roles.

The behavior of the trainers is extremely important here in setting the tone for the later, more difficult, simulations. Give praise for participation and use of appropriate techniques, and at this stage simply ignore inappropriate ones. If one student questions the use of another's methods, ask what he or she would have done instead. The focus should always be constructive and positive.

We employ a number of different simulations, each with its own set of instructions. The observer and the person playing the role of the staff member both receive a sheet containing a general description of the situation at hand, while the one who plays the patient gets some additional information as well. Two examples are described below.

Example One

- General information: A new patient is sitting in the sunroom looking quiet and withdrawn. No other patients are around. A staff member decides to come over and talk.
- Information for patient: You have never been to a place such as this before and you are embarrassed to be here. You are depressed because your whole life seems to be falling apart around you. You're not sure if it's safe to tell the staff how depressed you really are, because they might just increase the medication you're on and which you don't like.

Example Two

- General information: A patient the staff knows quite well and who is usually quite cheerful today looks agitated. A staff member comes over.
- Information for patient: You are feeling angry because you just received a notification from the Review Board that they have denied your discharge request. You are frustrated and feel you have done the best you can.

DEFUSING

The discussion of defusing again begins with a brief review of the escalation process. It is discussed how, unlike calming situations, defusing situations are short, occur during a crisis, and the first remark made by the staff is likely to be crucial. In defusing situations, staff exert more control over patients' behavior than in calming. Ask students to generate a list of contrasts between calming and defusing.

Next, a discussion of within-hospital assaults may be presented. We present the long-term study described in Chapter 2, and ask the class to guess or predict a number of its findings (e.g., what time of day do assaults occur? Where do they occur? etc.). Students are then asked to predict what reasons staff and assaulters give for such incidents. Experienced staff usually accurately predict the reasons most often given by the patients; less often, it is realized that the perspective of the staff who were assaulted is that they were attacked for no apparent reason. The point of this discussion is to make the class aware that assaultive people usually believe they have some motive for their acts, and that asking a patient who is already upset to do something or imposing sanctions on him can be dangerous. The analogy with police officers intervening in domestic disputes can be discussed here. Ask students to:

- list situations in which a patient is likely to be very upset and explosive. (Often they list too many situations, including many that likely require calming only.)
- list behavioral signals that indicate that a patient is explosive and close to violence.
- suggest crises in which defusing would be inappropriate and stronger measures are needed immediately. There are only a few: serious suicide attempts or when someone is being physically attacked. The point to make is that defusing is almost always worth trying before employing restraint.

Discuss the steps involved in defusing. Staff often believe that explosive situations occur so quickly that there is no chance for planning and preparation. Emphasize that a plan need not require extensive discussion: a statement to co-workers such as, "I'll talk to him first. You guys stand back a little. Watch out, he likes to kick," can constitute a valuable plan.

In our video examples, the first scene shows a patient mopping the ward along with some other patients. Suddenly, he shouts and swings his mop as if preparing to use it to strike someone. The trainer stops the

tape in "freeze frame" and has the class break into groups. Each group quickly plans the first few things that should be said and done, and then reports its plan to the class at large for discussion. The rest of the tape is then played (showing the staff successfully defusing the situation and getting the patient to drop his weapon), and the class goes over the pros and cons of all the proposed actions.

Our second tape shows a poorly executed defusing, in which one staff member abandons another who is taking sides in a heated argument between two patients. Students usually find this example amusing and readily identify most of the glaring errors made. In the follow-up discussion about the special problems associated with defusing patient-patient altercations, emphasize the importance of separating disputants so that they cannot see each other, while keeping staff in view of other staff, and the use that can be made of maneuvering around corners and doorways.

Finally, the same altercation is shown again, with the staff this time attempting to do a good job. The tape is stopped frequently and the class is asked to make suggestions about how the staff should proceed. Whatever the action taken by the actors, alternate strategies (and their strengths and weaknesses) are discussed.

To sum up, discuss how defusing is a low cost/high benefit technique, even if it is used only to stall for time until help arrives. Emphasize the importance of maintaining a calm, controlled voice tone and quality (even if in such a situation one is sure to feel anything but calm and controlled!), and how short these interactions are and thus how important is the first thing said.

If there is time, a number of brief defusing situations can be enacted. The task for the class is to quickly decide on a course of action: What would you do? How would you move? What would you say? Two examples appear below:

Example 1. You witness patient A taking a package of cigarettes from B's room while B is not there. Patient A has been upset today and his level of agitation seems to be escalating. He is now sitting in the sunroom smoking B's cigarettes. There are three other patients present, and two staff. What would you do?

Example 2. A newly admitted patient is sitting in the sunroom watching TV. There are a few other patients there and one other staff in addition to yourself. Suddenly the new patient stands up, picks up a chair, and says: "I want my clothes — right now." What would you do?

RESTRAINT

Refer again to the figure illustrating the escalation process, and discuss how incidents that end with restraint have run the entire course of this process. In many cases, the fact that restraint is necessary indicates a failure to have used appropriate procedures earlier. (Of course, acknowledge that there are many times when there are no observable signals to alert one earlier or when, despite the use of appropriate procedures, the escalation continues.)

Next, review the data on assaultive incidents and the types of situations that may cause such incidents to occur. This should serve to alert students once again to the situations in which they should be extremely careful about what they say and do so as to prevent an assault. It also emphasizes the fact that as these situations arise they should begin to prepare themselves for such intervention should it become necessary.

Restraint and the Law

In our course, we display on a flip chart or overhead projector relevant portions of the Criminal Code of Canada, the Mental Health Act of Ontario, and the Manual of Corporate Policy and Procedure of the Ontario Ministry of Health. Trainers presenting courses elsewhere should obtain the codes and laws pertaining to their respective jurisdictions. As each section is presented, the class discusses its interpretations. We here describe the particular aspects covered in our course, as an example of what points are important to cover.

I. Restraint and Authorization to Restrain

The Mental Health Act of Ontario, Section 1(4), (Revised Statutes of Ontario, 1980; Chapter 262, 1986 revision) gives the following definition: "'Restrain' means place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means or chemicals as is reasonable having regard to the physical and mental condition of the patient."(Students are reminded that the key word in this definition is the word "minimal"; and a discussion as to what constitutes minimal ensues. The Act itself is silent on this question, as well as on what it means to "keep under control.")

The Act also specifies in Section 14(4) that *involuntary* patients may be "detained" and "restrained." Staff have no authority under the Act to restrain *voluntary* patients.

(Note: Although chemical restraint is included in the legal definition, we restrict any discussion of pharmacological control techniques to the security measures section of the course. They are not be discussed further here unless there are specific questions.)

II. Use of Force

The Criminal Code of Canada (Part I) contains the following statements:

Excessive Force. "Everyone who is authorized by law to use force is criminally responsible for any excess thereof according to the nature and quality of the act that constitutes the excess" (Section 26).

(Trainers point out that staff are entitled to use force under the Mental Health Act, but not entitled to use "excess" force.)

Use of Force to Prevent Commission of Offence. "Everyone is justified in using as much force as is reasonably necessary a) to prevent the commission of an offence i) for which, if it were committed, the person who committed it might be arrested without warrant, and ii) that would be likely to cause immediate and serious injury to the person or property of anyone; or b) *to prevent* anything being done that, on reasonable and probable grounds he believes would, if it were done, be *an offence*" (Section 27).

Use of Force in Self-Defense Against an Unprovoked Attack. (1) "Every one who is unlawfully assaulted without having provoked the assault is justified in repelling force by force if the force he uses is not intended to cause death or grievous bodily harm and is no more than is necessary to enable him to defend himself. (2) Every one who is unlawfully assaulted and who causes death or grievous bodily harm in repelling the assault is justified if (a) he causes it under reasonable apprehension of death or grievous bodily harm from the violence with which the assault was originally made or with which the assailant pursues his purposes, and (b) he believes, on reasonable and probable grounds, that he cannot otherwise preserve himself from death or grievous bodily harm" (Section 34).

Use of Force in Self-Defence Against an Attack Which Was Provoked. "Every one who has without justification assaulted another but did not commence the assault with intent to cause death or grievous bodily harm or has without justification provoked an assault upon himself by another, may justify the use of force subsequent to the assault if a) he uses the force i) under reasonable apprehension of death or grievous bodily harm from the violence of the person whom he has assaulted or provoked, and ii) in the belief, on reasonable and probable grounds, that it is necessary in order to preserve himself from death or grievous bodily harm; b) he

did not, at any time before the necessity of preserving himself from death or grievous bodily harm arose, endeavour to cause death or grievous bodily harm; and c) he declined further conflict and quitted or retreated from it as far as it was feasible to do so before the necessity of preserving himself from death or grievous bodily harm arose" (Section 35).

"Provocation" is defined in the Code as including ". . . provocation by blows, words or gestures" (Section 36).

Use of Force to Prevent an Assault. (1) "Every one is justified in using force to defend himself or any one under his protection from assault, if he uses no more force than is necessary to prevent the assault or the repetition of it. (2) Nothing in this section shall be deemed to justify the wilful infliction of any hurt or mischief that is excessive, having regard to the nature of the assault that the force used was intended to prevent" (Section 37).

Use of Force to Prevent a Breach of the Peace. "Every one who witnesses a breach of the peace is justified in interfering to prevent the continuance or renewal thereof and may detain any person who commits or is about to join in or to renew the breach of the peace, for the purpose of giving him into the custody of a peace officer, if he uses no more force than is reasonably necessary to prevent the continuance or renewal of the breach of the peace or than is reasonably proportioned to the danger to be apprehended from the continuance or renewal of the breach of the peace" (Section 30).

With the exception of the section on excessive force, all of these laws pertaining to the use of force apply to all citizens and have nothing to do with whether or not the individuals involved are patients or staff at a psychiatric institution. Of course, the interpretation of the law and the burden of proof required to convict someone might be different depending on the individual's status as staff or patient.

III. What is an "Assault"?

In this book we employ a more restricted definition of assault, but the Criminal Code of Canada (Part VI) defines it as follows (Section 244):
"(1) A person commits an assault when

(a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;

(b) he attempts or threatens, by an act or gesture, to apply force to another person, if he has, or causes that other person to believe upon reasonable grounds that he has, present ability to effect his purpose or

(c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs.

(2) This section applies to all forms of assault, including sexual assault, sexual assault with a weapon, threats to a third party or causing bodily harm and aggravated sexual assault.

(3) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of

(a) the application of force to the complainant or to a person other than the complainant;

(b) threats or fear of the application of force to the complainant or to a person other than the complainant;

(c) fraud; or

(d) the exercise of authority.

(4) Where an accused alleges that he believed that the complainant consented to the conduct that is the subject-matter of the charge, a judge, if satisfied that there is sufficient evidence and that, if believed by the jury, the evidence would constitute a defence, shall instruct the jury, when reviewing all the evidence relating to the determination of the honesty of the accused's belief, to consider the presence or absence of reasonable grounds for that belief."

A discussion should ensue about what constitutes assault, and how the law might be interpreted differently according to whether the victim or aggressor was staff or patient. We cite cases at our own facility and examples in the literature of both staff charging patients with assault (Phelan, Mills & Ryan, 1985; Schwarz & Greenfield, 1978) and of patients charging staff.

IV. Patient Abuse

The Manual of Corporate Policy and Procedure of the Ontario Ministry of Health (3-2-14) contains the following statements regarding patient abuse:

a) "dismissal is mandatory in cases of proven patient abuse, and criminal offences relating to the employee's duties."

b) Patient abuse is defined as "the wilful injury or mistreatment of a patient." At our Penetanguishene institute, abuse is further defined as:

a) the unwarranted and/or inappropriate use of physical force;

b) intentionally inflicted psychological trauma;

c) any deliberate act of omission such as ignoring a patient's need or knowingly allowing patient abuse to occur.

d) racial abuse.

Incidents of abuse may be regarded as minor or major and treated accordingly for disciplinary purposes.

Some examples of minor abuse are:

a) excessive teasing - verbal and physical (horseplay);

b) verbal attacks - this may include derogatory tones, profanity, sarcasm, and/or shouting;

c) failure to provide the necessities of everyday living, depriving a patient of human dignity (e.g., allowing a soiled individual to remain in that condition), recognizing that temporary deprivation for medical reasons (e.g., safety of self or others) may be necessary from time to time;

d) threats;

e) unauthorized or unnecessary use of physical restraints and/or seclusion, and/or segregation;

f) deliberate failure to carry out any reasonable order resulting in minor patient abuse as above.

Some examples of major abuse are:

a) physical - striking, slapping, choking, kicking;

b) supplying drugs and/or alcohol outside hospital policy;

c) sexual involvement or abuse;

d) failure to report incidents of abuse;

e) stealing from a patient or intentionally damaging a patient's private property;

f) deliberate failure to carry out any reasonable order resulting in major patient abuse as above;

g) repeated incidents of minor abuse will be treated as a case of major abuse.

The discussion of the Criminal Code, the Mental Health Act, the Manual of Corporate Policy and Procedure, and the hospital policy on patient abuse is intended to point out the following issues to students:

a) that under the law they have the legal right and responsibility to protect themselves and others from assault, and to use force to do so,

b) that the law considers a variety of acts to be assault (including, in some cases, restraining or threatening to restrain),

c) that, although the law may be vague, there are limits on the amount and type of force that may be used, and that staff must be prepared to justify the force they employ.

Situations in Which Restraint is Necessary

Point out that according to the legal definition, even touching a patient might constitute restraint or assault. Have students generate a list of

situations that they believe must end in a patient's seclusion or manual restraint, but hold off at this point on discussing it. In our course, we point out that practices differ in various areas of the hospital (e.g., in some areas, manual restraint is used routinely to take blood samples; in other areas it is not).

Ask why staff are reluctant to use restraint. Reasons given should include: a) staff do not always consider themselves to be well enough trained to use it safely, b) there is always the risk of an investigation, c) it may hinder the development of a therapeutic relationship between the staff and patient involved (in other cases it may be therapeutic for a patient to know that his aggression will be controlled), d) there is a risk of injury even if staff are well trained. For all of the above reasons, we point out that it is best to keep the list of situations in which restraint is used to a minimum.

Initiate a brief discussion about who should carry out restraints (all staff versus ward staff only; all staff versus male staff only, etc.). Our trainers briefly discuss the study carried out on staff injuries (Chapter 2) and present the results using an overhead projector. The implications of this study are that restraint should be avoided unless it is absolutely necessary, and that it *may* even be better to risk being assaulted instead of carrying out restraint.

Step-by-Step Procedure

We first demonstrate the step-by-step procedure in a video that shows a poor restraint. The discussion that follows should include the following:

Observation: Review the list of circumstances in which students said they would use restraint. If their suggestions include inappropriate situations (e.g., routine use for escorting new admissions onto the ward from the front gate, or for restraining a patient for blood work no matter how compliant he is), go over the advantages and disadvantages of using restraint. Also discuss the issue of whether to touch a patient who is very upset, such as by putting hands on his shoulders. Stress that before proceeding with a manual restraint it is worth thinking about what verbal strategies can be used to avoid it (for example, firmly instructing somebody to go to seclusion on his own).

Preparation: Students will often say there is no time to prepare, but the trainer should stress that usually there is some time and that even a few seconds spent in doing so can prevent injuries. The list of points to consider should include: How many staff are required? How many are available? Who will be the leader? Who will give the order to begin? What part of the body will each person go for? What is the final goal

(i.e. seclusion, manual restraint)? Is there time to remove glasses, jewellery, (especially with pins), watches, etc., before proceeding?

Approach, Action, Follow-up: Ask such questions as: How much force should you use? (Point out that new staff frequently have a tendency to use too much.) What talking should go on during the restraint? When do you relax your grip? What should be done after the restraint is over?

Restraint Techniques

Elicit a list of situations in which a staff member should attempt manual restraint when he or she is the only one around. Point out that a physical altercation under these circumstances should be avoided at almost any cost: the main object should be to get away if being assaulted oneself, or to go for help if someone else is being attacked. Probably the only cases in which it would be recommended would be those in which either oneself or a member of the public is under attack, or in which a suicide attempt is in progress. Emphasize that it is not recommended in cases of one patient assaulting another, unless the victim is unable to defend him/herself. If it must be done, the best thing to do is to try to wrap yourself around the patient.

Illustrate the techniques presented on escorting patients under restraint, including the desirability of using three staff members and the role of the third staff. In discussing the head lock, explain the risks involved in neck holds. For restraint on the floor, emphasize the importance of avoiding putting pressure on the patient's back, and discuss the role of the third staff member, if available. Ask for opinions about the practice of routinely stripping patients before putting them in their rooms, and the risks involved. Stress that stairs can be very dangerous, and that thought should be given to releasing a struggling patient rather than trying to maintain control on the stairs. (The recommended technique is to walk him up backwards, always staying one step above him. Under some circumstances staff may carry the patient.) If a patient initiates a one-on-one attack, explain the use and risks of solar plexus punches and chokes.

Stress that staff are legally entitled to do whatever they must to prevent grievous bodily harm, but that the amount of force must be measured against the harm being done by the patient. If students say it is against the law to hit a patient, our trainers refer to the Criminal Code provisions on the use of force, and emphasize that staff members still have their rights as citizens to consider.

At the end of the class we show videos of a good restraint and of a demonstration of all the physical techniques taught in the gym portion of the course.

PHYSICAL TECHNIQUES

The purpose of the gym classes is certainly not to encourage the use of physical interventions. Their main goal is to instil self-confidence in being *able* to carry them out, even if they are never used. It should be emphasized that verbal techniques are less risky and generally more satisfactory, but if one is too frightened of a possible physical interaction, one may be too terrified to remember what to say. In addition, of course, no one can be certain that they will never need to use self-defense against an attack.

Students often think that the techniques should cover all situations and will occasionally ask such questions as "But what if I'm attacked by three patients with chain saws?" Emphasize that the course deals with a limited range of more common situations and that no physical technique comes with a guarantee of success.

Tell participants to wear sneakers and loose clothing suitable for exercise. (Some always show up with inappropriate dress on the first day, regardless of instructions.) Ask about any disabilities that may interfere with exercise (e.g., heart disease, joint or back problems). With people over 40, the prevalence of disability is amazing. Students should be instructed to participate in only those exercises that they think will be comfortable and safe for them.

Gym Schedule

Day 1: Introduction; demonstration of stance, distance, hand position, danger signals; warm-up; restraint against a wall slowly (a good "ice breaker"; grabbing attacks; falling and rolling cautiously; blocks for punches.

Day 2: Warm-up; patient restraint against a wall (faster than before), on floor, moving a patient under restraint; solar plexus punch; blocks for punches and kicks; grabbing attacks.

Day 3: Warm-up; blocks; running away; ducking; equalizing; defense against biting attacks, defense against weapon attacks; entering room with patient at door, in middle of room, and in corner (lots of practice with quick repetitions); one-to-one fights.

Day 4: Warm-up; entering room, restraining and moving patient to another room; necessary force; self-defense strategies; floor restraints; neck holds; stairways.

Day 5: Review: practice in applying techniques quickly: videotape demonstrations.

Warm-ups

It is very important to limber up adequately before practicing the physical techniques for restraint and self-defense. The warm-up exercises emphasize stretching and have no jerking moves. Use them to identify participants who are particularly clumsy or not in reasonable physical condition (typically there is a great deal of variability within a class, with some individuals who may not have exercised properly in twenty years, while others are ardent dancers or runners). Pitch the warm-ups toward the less fit end of the spectrum. However, we find that it is often a good idea to include some exercises that everyone in the class finds difficult, so that no one will be embarrassed by being the only one not to succeed. Try to make the exercises fun. We have found the following warm-ups to be useful:

- Standing on toes, raise hands and stretch toward the ceiling. Hold for five seconds and relax. Repeat.
- With legs straight, bend at the hips and hang forward, then bend the knees and stand up. Putting hands on hips, arch the back and look at the back wall.
- With feet together and hands on knees, rotate knees ten times in one direction and reverse.
- Take a long step to the right and sink with right knee bent and the side of the left foot on the floor. Pivot to the ball of left foot, pushing the hips down and forward. Reverse to the left. Hold each for five seconds.
- With legs straight and feet as far apart as possible, try to get the elbows on the floor while bending forward. Hold for five seconds.
- With feet shoulder-width apart, twist to the right as far as possible and hold for five seconds. Repeat to left.
- With feet shoulder-width apart, rotate at the hips to the right touching floor (or close to the floor). Maintain the rotation with the back arched and come right around to the front again. Reverse to a count of 10, alternating sides.
- Arm rotations: swing arms forward at the shoulders to a count of 10 and then backwards. A much more difficult variation is to rotate one arm forward and the other backwards while bouncing in place.
- Neck rotations: Gently drop chin onto chest, then roll head slowly sideways until left ear is on the left shoulder, then gently let the head fall back as far as possible. Roll the right ear onto the right shoulder and then roll the head back to the front. Keep shoulders down and back.
- Kneel with back of feet on the floor, hold for five seconds. If flexible enough, arch backward until the head is on the floor.

- Lie on back on the floor with knees drawn up and feet flat on the floor. Tilt the pelvis down arching the back, and then press the back onto the floor tilting the pelvis up. Hold for a few seconds. Repeat 10 times.

The above exercises constitute a minimum warm-up. Their purpose is to provide some initial activity for the main muscle groups in the legs and arms, and to ensure that the back is as flexible as possible by including gentle twisting/rotation and some forward, backward and sideways bending. If the group is very fit, we sometimes add aerobic exercises. The count for all exercises is speeded up depending on the fitness of the group, except for the stretches which are always slow because it is better to err on the side of holding them too long.

Safety

Never schedule the gym section right after a meal.

As much as possible, one instructor should take all classes. Many people are shy in physical situations and benefit from the rapport that develops if the same instructor is always present.

Take some precautions to help avoid injuries. Explicitly tell students that all physical simulations (including struggling, etc.) are to cease immediately when a key word ("stop!") is used. Injuries most often occur to necks and shoulders during falls and rolls, and students are often reckless and land much too heavily. Thus, make sure that training proceeds very cautiously and gradually with "hands-on" guidance. Training in the falling and rolling techniques should proceed very gradually from kneeling positions to standing and then to moving.

When restraint techniques are practiced, try to keep the simulation confined to as small a space as possible to prevent losing control over the interaction. For the most dangerous exercises (e.g., defense against weapon attacks) the trainer should only demonstrate the techniques: do not have the students practice them.

Finally, exercise caution in the use of the solar plexus punch. A straight punch to the midsection is difficult to deliver accurately and with appropriate force. An open-handed push (with the heel of the hand and the fingers up) is easier and less dangerous.

Special Techniques

Teach techniques by having the class first observe and then practice the moves. Students often cease repetitions when they feel they "have the

idea"; this is a mistake, and they should be encouraged to practice as much as possible so they can be done quickly and automatically when necessary. Remind them that almost all techniques rely to some extent on surprise, and that few will work if the attacker knows exactly what the defender intends to do — thus, they must be practiced until they are instinctive.

When demonstrating proper stance, use a volunteer to demonstrate the impossibility of blocking or evading a punch when standing within arm's reach of an attacker with one's hands at one's side or in pockets. (Pull the punch about two inches from the volunteer's jaw.)

Following a demonstration of how to defend yourself from a grabbing attack, have students each practice with a partner. We find that it is best to switch the partners so that everyone gets to practice with someone stronger. Both sides (arms) are practiced at least ten times. If students complain of sore wrists, make a point of praising them for practicing in the correct manner. These self-defense techniques (take-offs) work unless there are vast differences in weight and strength. If a technique is not working, check to see if it is being performed correctly; if the problem is strength differential, the "grabbee" is instructed to begin the escape manoeuver before the "grabber" has established a firm grip. The most common problem in the rotary removal of a one hand cross grab is that students do not keep their fist in an upright (thumb side up) position. Also, they typically do not hold their arm high enough in the swing around to remove a rear hand choke.

Punching attacks are practiced by having the instructor aim at the students. The punches are started very slowly and are right round house punches to the jaw (pull the punch a few inches). Students often use a block that is much too soft. The punches are then speeded up according to the students' proficiency in blocking and evasion.

Kicks are practiced in the same manner, using a right front kick to the groin or knee area. Pull the kick, of course.

Restraints are usually practiced in groups of three (two restrainers and one restrainee). The restraint is first applied with the "patient's" cooperation, who then resists *slowly*. Each person takes part from both sides. It is important for the students to know both what it feels like to be restrained (it's uncomfortable!) and that it is difficult to apply (particularly if the patient is heavier than the restrainers). Attempt to ensure that appropriate practice makes the students reluctant to employ physical techniques unless necessary.

It is important for students to know to never jerk anyone's head backwards, either in practice or in a real situation. Also emphasize the dangers involved in choke holds, and in applying weight to the chest or back.

When practicing forcing a patient into a room, a simulated "room" is defined by mats that form its floor. Stop the interaction as soon as the restrainers have laid hands on the patient. Do not permit wrestling matches, as they may cause injuries.

Moving a patient out of one room into another is best practiced by having the "patient" kneel and not move until the restrainers have laid hands upon him or her. Thereafter, the patient is instructed to resist *slowly*.

It is very important for the instructor to maintain control of these interactions and to terminate them immediately if the interaction becomes too strenuous.

Good quality mats are essential for teaching falls. All falls are started from a kneeling or crouching position; as the fall is mastered, it is then practiced from a standing position. For the straight forward fall, some students do better if they bend at the hips before falling (this is also a good technique for those who cannot fall with the body straight). The forward roll is the most difficult. Start it on the right side with the left knee on the mat and the right knee bent with the right foot on the floor. For backward falls, ensure that students have their fingers pointing forward and that they don't roll backward on their necks. Manually guide participants through the first few rolls.

Point out that, although the other physical techniques may never actually be used, people inevitably fall and knowing how to fall properly can avoid significant injury.

Most of the techniques mentioned above are described more fully in Chapter 5. In the section on self-defense, discuss "common sense" strategies (e.g., keep the hands high and block downward rather than hold them low and try to block upward; keep your head a moving target.; try to use an attacker's momentum against him by moving sideways or by dropping and rolling; if attacked by a weapon, keep constantly moving; don't forget to call for help; and when restraining, the most important thing is to hold on tight).

The equalization techniques can be effectively demonstrated by taking one of larger men in the class aside aside and telling him that in a few moments he is to attack and immobilize a much smaller victim, usually female. The instructor then takes the "victim" aside and demonstrates the equalization techniques (falling to the floor, alternating kicks, etc.). The victim does not know of the attacker's instructions to immobilize him or her until the attack begins, but responds with such vigor that no "attacker" in our course has ever been successful!

Students are often shy and reluctant to participate, and it may be necessary to build up their confidence. For large individuals, the instructor

can emphasize their obvious strength and reach advantage. For smaller ones, emphasize their natural advantage in speed, quickness, and coordination.

As a note of caution, we have found that smaller male participants are sometimes more dangerous because they seem to have "something to prove," and behave recklessly. Finally, a small proportion of trainees seem like "hopeless cases," i.e., completely physically inept. The instructor should conceal frustration and realize that the effects of a lifetime of inactivity cannot be reversed in a few hours. Nevertheless, even these people such often show remarkable improvements during training, and concentrated efforts should be made to ensure that they participate in the training and do not stand idly on the sidelines. Playful encouragement usually works best.

Instructor training

Trainers must know the techniques to be taught extremely well. A background in the martial arts is helpful but not essential. The techniques are all described in this volume but are, of course, very difficult to acquire from a written presentation

INTERVIEWING

Introduce this topic by explaining that the techniques used for post-incident interviewing are similar to those used in any interview situation. Ask students to generate a list of why it is important to follow up after problem incident, noting that all these reasons involve gathering information. Point out that interviewing differs from defusing in that the patient is now calm, so one's comments are not so critical (in the sense that the patient may explode if a mistake is made). Interviews are thus a good time to try out new techniques.

We recommend beginning by showing a videotaped presentation of a deliberately bad interview where the errors are glaring and amusing. Elicit comments from the class regarding things to avoid and write these on a flip chart posted on the wall. Emphasize that the common trait of the items on this list is that they interfere with the main goal of gathering information.

Hand out a summary of interviewing techniques. Those that have already been discussed in the Calming section need only be briefly reviewed, but new ones should be covered in more detail.

The next video should contain the same scenario as the first (same patient, background information, etc.), but here the interview is conducted more skillfully. For this exercise, divide the class into groups of three or four (try to have one person known to have good interviewing skills in each group). Play the tape from the beginning of one interviewer statement to the end of the patient's response, stopping it after each segment and asking the groups to state what they think the interviewer should say next. Before showing the first segment have the groups consider what they would look for and do before starting (i.e., preparation) and how they would begin (approach). Give them a few minutes to discuss what they would do, and then have a spokesperson for each group report to the rest of the class what its consensus is. The techniques they agree on are written out and labeled according to what was discussed on the handouts. Then, play the video up to the end of the patient's first statement, and compare what was said and done here to the class's recommendations, including how the seating was arranged, posture, etc. Next, have them assume that they have just said what the interviewer on the videotape did, and now must react to the patient's response. The video is then played to show what the interviewer said and what the patient's next lines were. This process is repeated several times, with students asked each time to decide what to say next based on what has just happened. After each stoppage there is discussion about the effectiveness of each of the various ways.

Ask the class to consider the variety of techniques that they have proposed, and point out the value of such variety. If any groups have suggested approaches that are not recommended (for example, preaching or moralizing), label these and acknowledge that all interviewers use these techniques sometimes, but say they should not be used too often. Try to focus on what the other groups said. If at least one staff with good interviewing skills has been placed in each group, it is unlikely that any group will end up advocating the techniques on our list of "Don'ts."

A technique we have found useful requires the class to become involved in a simulated interview. One of the trainers plays the role of a usually well-behaved patient who has suddenly refused to attend his/her vocational therapy program and has threatened bodily harm to any staff who attempts to force this, while the other trainer plays the interviewer who will find out why this change has occurred. The "interviewer" elicits suggestions from the class about how to proceed, selects from these, and relays them to the "patient" who then responds. Throughout, the interviewer chooses from the suggestions offered so as to illustrate a variety of both good and bad techniques. The patient's role is to react

to each so as to illustrate its usefulness (e.g., responding to preaching by arguing and to open questions by giving information), while the interviewer's role is to point out the results (e.g., "See that: he responds to 'belittling' by refusing to talk"). Eventually, when proper techniques are applied the full story emerges (the patient is afraid to attend the program because of another patient there who is being threatening). Typically, students enjoy this exercise because they are not "on the spot" and there is usually no shortage of suggestions from the group. It takes about 30 minutes.

Discuss with students how they feel about interviewing two patients together. Usually none or very few have ever attempted this, especially in the case of two patients who were involved in a dispute or altercation. The initial reactions are usually negative towards this idea, with people correctly stating that maintaining control of such interviews is difficult. Ask the class if they can see any benefits of doing two-patient interviews, and then go through the recommended techniques. We show a videotaped interview with two patients who had allegedly been involved in an altercation earlier in the day, to illustrate the use of good techniques. The tape is stopped frequently to illustrate how the interviewer maintains control.

Simulations

These are conducted in a fashion similar to that done in the calming section. Divide the class into groups of three. Two participants play the roles of patient and interviewer, respectively, while the "observer" is given a checklist that lists both good and bad techniques and checks them off each time the interviewer uses one. All three players are given general information about the situation, and the "patient" and "interviewer" are each given separate, additional information. The interview lasts ten minutes, and group members then discuss it among themselves for about another five, with the observer commenting on the techniques that were used and the "patient" describing why he/she had reacted to them. A spokesperson from each group then summarizes what information was gained for the rest of the class. Examples are presented below.

One-Patient Interview

General information. A staff member had found a patient in the washroom with a towel around her neck trying to strangle herself. The staff broke her hold on the towel, and the patient became hostile and physically aggressive. Other staff came onto the scene and the patient

was manually restrained, given medication to calm her down, and placed in seclusion. She has now settled down, is out of seclusion, and has been in the lounge for about an hour. The staff member who initially found her wants to find out more about this incident and what may have precipitated it. The patient is middle aged, and looks depressed.

Additional information for patient. General background: You are a widow of middle age with grown children. Your youngest son just left home for university this year, and you are lonely and depressed without him. Your daughter lives in the area. Specific background to incident: You were feeling very depressed because your family seems glad to be rid of you, and the staff aren't paying any attention to you either. If pressed, explain that your daughter usually comes to see you every Monday but didn't come last night, and an underlying issue is that you wish that her family would ask you to live with them and you are hurt that they haven't, especially since you babysit for them all the time. Then, a staff member asked several other patients if they wanted to take part in groups, but didn't ask you. You've trusted this particular staff member and talk with him fairly regularly. When stopped in your suicide attempt, you got angry because the one time you get attention, you didn't want it. You really did intend to kill yourself.

Additional information for staff member. This patient was severely depressed; it was a suicide attempt that brought her to the hospital. Her family seems to have been supportive. She is a widow and her children are married. Her youngest child is away at university; and she's been very depressed and lonely since he left. He has been to see her twice in the last month. Her daughter lives in the area and usually comes to visit her frequently. She trusts you, and you talk with her pretty regularly whenever you are on.

Two-Patient Interview

Here there are three roles, so there can be an observer only if there are four in a group.

General information. Earlier, one patient had approached another for a light for his cigarette and was refused. Patient One then punched Patient Two in the eye. There was no further altercation.

Additional information for Patient One (the aggressor). *You had approached* Patient Two for a light because he has a lighter and you don't. You think that Patient Two is always picking on you and teasing you for being fat (lazy, short, skinny ... pick one you like) and you resent him for always making comments about it.

Additional information for Patient Two (the victim). You feel that Patient One is basically fat, lazy, and/or selfish, and you don't feel like

giving him a light because he won't do any small favors for you when you ask. Why should you cooperate when he won't? Also, he had kept bugging you for a light even after you had said "no."

Additional information for Interviewer. These two patients have been seen quarrelling over next to nothing on several occasions. You don't really know what, if anything, is at the bottom of it.

Practice in Using Skills

An alternative to the above simulations is to present some examples of patient statements and ask the class to suggest what they might say in response. The use of these vignettes is especially helpful to practice such skills as confrontations, which occur very infrequently in actual interviews. For this exercise, we display the patients' statements on an overhead screen so that they are visible while people consider their responses. The responses are labeled, and if more than one technique is suggested, the possible advantages of each are discussed.

Some examples are presented below:

1. Patient (who is always late for interviews): "I really enjoy these sessions with you. You're really helping me to get better."

This example is designed to show the use of confrontation. A good response would be "You say you really enjoy these sessions, but yet you're always late. I don't understand."

2. Patient : "My husband and I don't get along. We're always arguing. He doesn't even like to talk to me. It's no fun."

This example is designed to show the use of open questions. A good response would be, "What sorts of things do you argue about?"

3. Patient (who has indicated that he makes friends easily and gets along well with others): "I want to change work areas again. It's impossible to work with Jim. He's just as hard to work with as Bill was at my last job."

Another example of confrontation. A good response would be "You say you're easy to get along with, yet you've had trouble getting along with people in your last two jobs. That confuses me."

CONFLICT RESOLUTION

Begin a brief lecture about conflict resolution by asking the class what is meant by mediation and negotiation and why staff might want to use them. Outline the use of techniques for patient-patient conflicts, patient-

staff conflicts, and patient-program conflicts. Stress that conflict resolution must only be used when patients have calmed down.

Next, review the steps of observation, preparation, approach, and action, and follow this with a video that shows a mixture of good and bad techniques. We use one that illustrates how the therapist gains and loses control, the use of role reversal, the consequences of loss of neutrality, and the use of "red herrings" and "battering ram points." Stop the tape frequently and ask such questions as "What just happened?" "What do you think about what the staff said?" etc.

Talk about the reasons why conflicts arise and escalate, in order to better understand the issues involved in resolving them, emphasizing the distinction between realistic and autistic conflicts. Go over social exchange theory and the escalation of conflict.

Sometimes we relate the topics of negotiation and mediation to the field of labor relations. Many institutional staff are union members and have some understanding of the importance of conflict resolution in labor-management disputes. Almost all the important concepts and techniques of conflict resolution discussed above have direct analogues here. That is, labor mediators do not arbitrate (i.e., impose solutions) but attempt to get disputants to reach a compromise; act as neutral referees to ensure that labor relations laws are obeyed; elicit proposals and counter-proposals; assist disputants to formalize and summarize agreements in the form of a contract; attempt to ensure that disputants do not use red herrings and battering ram tactics; remind disputants about their real interests (i.e., materialistic rather than autistic); and attempt to avoid having parties lose face by keeping negotiations as secret as possible. Sometimes, labor mediators attempt to avoid the problems caused by uninterrupted disputes by encouraging breaks in marathon negotiations, separating disputants to reduce ego involvement, and exercising control to ensure that issues are dealt with one at a time. They also use role reversal and confrontation to help reach a compromise.Thus, many of the important components of conflict resolution and the concepts raised in the course can be illustrated in an area of human conflict with which the students are very familiar. It must be confessed that labor mediation has a checkered record in avoiding strikes and compulsory arbitration. However, many of the conflicts between labor and management are primarily realistic rather than autistic, and thus may not be as amenable to mediation as are most patient-patient conflicts.

Following the lecture, we show another simulated interview and mediation video that is designed to be a demonstration of good techniques, stopping the tape frequently to illustrate points raised in the lecture and in the course notes.

Negotiating with One Patient

Discuss how many of the techniques that are used in mediation can be applied with just one patient, who, say, is having problems with you or in following his treatment program. We show a short videotape illustrating the use of negotiation techniques in a case where a patient continually has trouble with one particular ward rule (getting up by 10:30 a.m. on weekends).

Simulations

End the class with a simulation exercise as was done with interviewing.

Example: Two patients are constantly bickering over changing the TV channel. You have seen this happening and decide to try to find out what the problem is.

Information for Patient One: Patient Two has more privileges and more time with staff members, so you feel that he is favored and is always getting his own way. In addition, he likes watching sports but you don't, and you think he is getting to watch more than his share. You believe others on the ward feel the same, because you've talked to one or two other patients and they agree with you.

Information for Patient Two: You think that Patient One is basically disagreeable and hard to get along with. As evidence, you are doing much better in the program than he is and have more privileges because you have worked hard to get them, which he is not willing to do. You really enjoy watching sports programs, and believe that most patients and staff on the ward prefer them too.

JOB STRESS

Begin by explaining that job stress is discussed in the course because it may lead to an increase in the number of violent incidents (i.e., because of decreases in staff efficacy and empathy, increase in absenteeism, etc.). Increased violence in turn raises the level of stress for other staff on a ward, so a vicious circle is created in which all may eventually suffer.

Elicit definitions of job stress and burnout, discussing the concept of discrepancy between the actual (objective) or perceived (subjective) demands of the job, an individual's actual and perceived abilities to meet these demands, and a job's demands, rewards, and the motivation to obtain the rewards. Point out that sometimes a discrepancy between the demands of a job and one's abilities to meet them can be positive, motivating one

to learn new skills and achieve new goals. However, excessive or prolonged stress can impair work efficiency. These definitions are discussed along with examples of some of the ways a misfit can occur. What are some of the job frustrations staff experience at this setting? Ask for some of the signs of suffering from too much stress and burnout on the job.

Describe the French and Harrison (1982) survey of job stress and strain in different occupations (see Chapter 7). Before presenting the findings, ask students to predict which of the various stressors affected each of the occupational groups and which groups suffered most. Emphasize that being underutilized or having too small a workload can be as stressful as the reverse: what is important is the fit between the person and the job.

Give the class members self-rating questionnaires to diagnose their own levels of burn-out. Two scales that we have found useful are the Maslach Burnout Inventory (Maslach & Jackson, 1981) and one given in Pines and Aronson (1981, p. 37).

Elicit suggestions for the alleviation of job stress. Often students suggest things that have little or nothing to do with the job, such as hobbies, taking medication, drinking, etc. Try to encourage them to think of ways to improve the fit between the job and themselves through individual, group, and institutional approaches. Pick one of the causes of job stress from the list generated earlier (try to choose one that seems to be uppermost in the students' minds), and help the class find possible ways of alleviating the stress caused by that source. Try to leave students with the idea that they should not be content merely to complain about stress-producing aspect of their jobs, but can and should use problem-solving techniques to bring about changes.

SIMULATIONS

The object of the simulation section of the course is to give students an opportunity to try out what they have learned in the classroom, stressing that this is a good chance to practice something new in a safe environment where one need not fear the consequences. The "single role-plays" (Wohlking, 1976) performed here involve a few people acting out parts in front of the rest of the class. By this time, students will have already experienced the classroom "multiple role plays" or mini-simulations, where they broke into small groups for brief role-plays. Since everyone took part in these, and often individuals who were initially reluctant to do so found the experience both valuable and fun by the end, this participation usually relieves anxiety about the single role-plays carried out now.

Stress that the single role-plays are voluntary and no one will be forced to take part, and that most people really enjoy them as they are intended to be fun. It is very rare for people to refuse to participate. Participation is very important, as individuals who may seem quite competent in the classroom at identifying and discussing the skills taught may often have a hard time using them in the simulations. It is one thing to recognize and understand a technique; quite another to incorporate it into one's repertoire in the place of those that have been used for many years. Unless staff can actually use the skills, the course has not had the desired effect.

It is very important to achieve a supportive climate in the group, which is usually not difficult because the members know one another quite well by the end of the week. Role players who sense they did poorly in front of the class may feel embarrassed, and the trainer should always attempt to make them feel good about some aspect of their performance, no matter what the outcome. This can be done by setting certain ground rules. We suggest giving students the following instructions regarding evaluating each others' performances:

- Make your comments in a self-oriented manner. That is, comment on how you felt or would have felt when one of the players said something. For example, "I would have felt very threatened if I were the patient when the staff said that to me."
- Avoid evaluative comments such as "The interviewer tended to be too condescending." Instead, try to follow the rule outlined above and say something such as "If I were the patient I might have felt talked down to."
- Avoid giving advice such as "She should have done it this way." Instead, describe what you observed, or suggest alternative ways of behaving in a tentative way, such as "I wonder how the patient would have responded if the interviewer had said....?"
- Focus your feedback on the positive aspects of the role-play as much as possible. Comments such as "I really liked the way the staff positioned themselves before they attempted to intervene," are encouraged.

The trainer has a difficult job during the simulations. Problems are occasionally encountered: sometimes participants, especially those in patient roles, overplay their parts or make a caricature of them. Other times, they confuse the facts they were given or make up facts not in the role. Most often these do not seriously affect the simulation; if they do, however, step in and get things back on track by asking how the role-play is

proceeding, what the problem could be, and what might be changed (Wohlking, 1976), or by simply clarifying some of the key facts. Another problem occasionally encountered is that a player will stop in the middle and say that he or she would do it differently in real life. Most often, a firm request not to step out of the role and to discuss it later will suffice to put things back on track. Sometimes a player performs so poorly in terms of demonstrating desirable skills that it is best to stop the simulation temporarily. This occurs only rarely, and usually when it does the person performing knows that there is trouble. Break in and ask the player for suitable suggestions on how to improve the role, or solicit the opinions of other class members. The role-player may then be able to complete the performance satisfactorily.

Something we advocate strongly is the use of videotape equipment, an extremely powerful feedback technique. Mention to the class earlier in the week that videotape will be used during the simulations and do not make an issue of it when the time comes. It is usually accepted without question as being part of the routine. Often participants are too quick to criticize themselves and overlook what they have done well, and trainers can direct them to parts done well by stopping the tape for feedback and by modeling positive comments.

In order to evaluate the effectiveness of the course, we used four sets of measures. The first set were designed to evaluate knowledge and skills learned during the course. Both verbal and physical measures of behavior in simulated crisis situations were included. These were: the Sensitive Situations Skill Test (written answers to questions about video simulations); the Audiotaped Simulations Test (verbal responses to audiotaped scenarios); the Self-Defense and Patient Restraint Test (a paper and pencil measure) and the Physical Test (actual demonstration of self-defence and restraint techniques). To determine the generalization of what was learned, some of the tests required participants to apply the knowledge gained to situations different from those encountered during the course itself.

On all four measures, we were able to demonstrate statistically significant increases that could confidently be attributed to the course. The experimental group showed significant improvements in their abilities to respond verbally in potential crisis situations, to recognize effective and ineffective ways to deal with crises, to defend themselves in the event of attacks, and to restrain patients safely and effectively. A control group of staff who did not take the course also completed all the measures, and served to rule out practice effects during the testing as a possible alternative explanation. This and the finding that very similar results were obtained from staff who took the course at different times make it unlikely that the observed improvements could be attributed to extracourse variables.

A second set of measures had to do with the acceptance of the program, and consisted of a feedback questionnaire given both immediately after the course and six weeks later, and a follow-up questionnaire administered about 15 months later. The results indicated that the course clearly met with the approval of the staff, who judged it to be relevant and useful in their daily work with patients. We were particularly encouraged by the finding that staff still rated the course as very useful 15 months after taking it, and that most stated that it had definitely or probably saved themselves or co-workers from being injured. These data, as well as informal comments, suggested that the course led to increased levels of self-confidence, which lessened the atmosphere of fear that may seriously interfere with treatment (Paul & Lentz, 1977). The course also met with the approval of the hospital management staff, who expressed support for the project throughout its duration and instituted the course as a regular component of staff training after the completion of the project.

A third set of measures of course effectiveness evaluated whether its effects were detectable by patients on the maximum security wards where the trained staff worked. On a global measure of affect, we found that patients rated themselves as having significantly more positive affect six weeks after the course than six weeks before, compared to control patients

on wards where staff did not receive the training. For the patients as well as the staff, then, the ward atmosphere seemed to have changed so that they felt better about themselves.

Finally, a fourth set of measures comprised direct assessment of the incidence of violence before and after the course on wards where the staff received the course compared to control workers. In the maximum security division, our data on the assaults on wards involved in the study were gathered by having a research staff visit the ward every weekday to read the ward notes and talk to staff; in the lesser security divisions, ward notes were checked only once a week, along with the reports that staff had to complete after each assaultive incident. In both cases, periodic reliability checks were made by having two raters independently collect the same information (see Chapter 2). A second assault-related measure was the number of staff workdays lost due to patient-caused injuries. These data could be obtained for staff on both study and nonstudy wards, and were available for several years prior to the initiation of the study. During the period of interest for analyses reported here, records were kept by the business office and later checked by a psychometrist unfamiliar with the study; in cases of disagreement, the psychometrist's ratings were used. A third measure was the number of times sedative medication was administered on an "as needed" basis to upset patients.

TESTS OF KNOWLEDGE AND SKILL

Sensitive Situations Skill Test

The Sensitive Situations Skill Test was designed to measure the accuracy of staff members' observations and interpretations of patient behavior, and their ability to discriminate effective and ineffective social and physical methods of dealing with potentially explosive situations. It consisted of four videotaped scenes of simulated interactions between patients and staff, with the staff displaying both effective and ineffective procedures. The scenes portrayed were designed to cover all aspects of the course, and had been judged by nursing and psychology staff to be highly realistic and typical of problematic situations on the ward. Scenes were broken up into short segments, and subjects answered questions (multiple choice and brief written answers) about each immediately after viewing it. For experimental subjects, the test was administered immediately before the course and again immediately after. Control subjects took it on two occasions approximately one week apart.

A scoring key was developed on the basis of responses by panels of experts (course trainers and nursing management staff), and only those questions on which there was unanimous agreement about the best response were retained.

Scene 1

1. A patient holding a cribbage board approaches a male staff member who is seated at a desk. He says, "I'm going to hit you." The staff member says, "I wouldn't like that."
2. The staff member gets out of his chair and moves closer to the patient while talking calmly.
3. The patient puts down the cribbage board and they both return to the desk.
4. The staff member challenges the patient, and when the latter raises his arm as if to strike, the staff member reaches for it. A female staff member arrives on the scene and assists in a restraint.
5. The two staff escort the patient to the seclusion room under restraint.
6. The patient is mildly resistant during the escort.
7. The staff hold the patient at the doorway while a third staff member unlocks the door.

Scene 2

1. Two patients, George and David, are sitting at a table arguing. A staff member calls David away.
2. Another staff member joins George to try and find out what the argument was about.
3 . The staff member and George discuss the job training program George is currently in, and George's goal of entering another program instead.
4. The discussion continues.
5. The scene ends with the staff member recommending a course of action and George refusing.

Scene 3

1. Anne and Dan are arguing over her playing a record over and over. A staff member intervenes.
2. He sits down with the two patients in an attempt to settle the dispute.
3. He sits placidly while Dan gives his side of the story.
4. He then questions Anne.

Scene 4

1. A patient appears upset after a visit from her parents. A staff member begins talking to her in front of a group of other patients.

2. The staff and patient discuss the patient's problem.
3 and 4. The discussion continues.
5. The staff member ends the conversation by minimizing the patient's problem and suggesting that she think about something else.

Typical questions include: Scene 1 — Should the staff member have immediately called for assistance? What risk did he take by standing up? Was moving back to the table a good idea? How adequate were his self-defence techniques when the patient tries to attack him? How well was the restraint carried out by both staff members?

Scene 2 —What was George's apparent emotional state? Should the staff have sat down with both patients together? What could have been done to make the interview with George more effective? How should the issue of George's work program be dealt with?

Scene 3 — What could the staff member have done first in order to facilitate the subsequent mediation? What is Dan trying to accomplish? Was it a good idea for the staff member to agree with Dan that it would bother him too to hear the same record over and over? Was it a good idea to ask Ann, "Do you play your record all the time?"

Scene 4 — What could the staff member have done at the very beginning to make it more likely the patient could speak freely and comfortably? Is the staff member's physical positioning appropriate? What could he have done other than offer reassurances in this situation?

Audiotaped Simulations Test

The Audiotaped Simulations Test presented tape-recorded scenarios that involved dealing with upset patients. A situation would be described, the "patient" would then say something, and then a tone would sound. The subject was instructed to respond in an appropriate manner to what was said. Three practice situations were presented, and then the test situations. This test was given on the same schedule as the Sensitive Situations Skill Test.

We developed a scoring system in which points were given for certain components and deducted for others. The system was derived by using good and deliberately poor responses provided by the trainers (who were considered to be experts in the handling of such situations), in order to extract components of "good" and "bad" responses, and then refined by using a sample of responses from pilot subjects. It was further refined by using a sample of actual experimental and control

subjects' responses, in which the judges were blind as to group assignment or test occasions. (This last step was taken because a few responses were given that could not be scored reliably by the existing scoring system.)

The validity of the Audiotaped Simulations Test was checked by giving it to senior nursing staff who had neither taken the course nor participated in its development, but had all been promoted into their positions because of their demonstrated skills in handling patients. These individuals obtained very high scores, thus providing evidence of the test's validity.

Situations

1. You are busy behind the nursing station filling out forms for a new admission when Bill walks up to the desk and asks for a cigarette. He is permitted to smoke and now is a reasonable time for him to ask for a cigarette, but you want to get your forms finished before the shift changes in 15 minutes. Bill says: "Cigarette, please."

2. Doug has refused to go back to work after lunch. You tell him that part of his treatment plan is to develop steady work habits, but he continues to refuse. The patient says: "I know my rights. You can't make me."

3. Two patients are loudly arguing over who gets to use a certain chair in the lounge. Bob insists he should get it because he was there first; Randy argues that that was because Bob elbowed his way past. Bob turns to you and says: "Do I get the chair or not?"

4. Jim frequently gets into arguments with other patients on the ward as well as outside the hospital. In a conversation with you, Jim says: "I get along pretty well with most people. I'm a pretty easy-going kind of guy. But if someone pushes me around, they're in trouble. I don't let anyone push me around."

5. Some friends have been visiting with Gord, and you notice they are about to leave and the patient appears to be going with them. Although Gord is a voluntary patient, he has expressed suicidal thoughts and you feel he may be a serious danger to himself. As you approach the group, he says: "You can't stop me from leaving. You can't keep me here against my will."

The scoring criteria below apply to all situations. Following these general instructions are additional, more specific criteria that apply to each situation individually.

Give 1 point for:
- using the patient's name (even if the respondent gets it wrong). If two patients are involved, both names should be used.
- reflection of content — repeating what the patient said or restating it in the respondent's own words
- reflection of feeling (e.g., "You're upset.").
- open question or statement— "Maybe you could tell me why you feel that way". (Avoid questions beginning immediately with "why.")
- invitation to talk — either an open or closed question or statement, as long as it specifically refers to talking.
- giving factual information about the patient's program or hospital routine, checking factual information with a third party, or acknowledging factual information (i.e., not doing a selling job on the program or rules, but merely stating them).

Give 0 points for:
- exhorting, moralizing, preaching: e.g., "You should try to get along with people", "You shouldn't......."
- giving a contrary opinion that shows that the respondent thinks the patient is wrong or shouldn't feel as he does.
- giving someone else's (usually a doctor's) opinion.
- giving suggestions or personal opinions, e.g., "why don't you...", "I think..."
- asking a closed question (one that can be answered yes/no or with just a word or two). However, if it can be seen as an invitation to talk, give it 1 point. For example, "Is something bothering you at work?" is a closed question, but it would get 1 point for being an invitation to explore a problem.
- asking a "why" question, such as "Why did you do that?" The only exception would be if it could be categorized as an invitation to talk: thus, "Why don't we talk about it?" would get 1 point.

Subtract 1 point for:
- ordering or directing the patient to do something, such as "You'll have to" unless qualified by "Perhaps," "I'm sorry, but," or some other positive term.
- telling the patient that his statement is not true.

- warning, admonishing, threatening (e.g., saying one will make the patient do something if he doesn't cooperate).
- solving the patient's problem beyond just offering suggestions — e.g., telling him or her what to do. However, if it is politely worded or tentative, count it a suggestion.
- ridiculing or shaming the patient.

Note: Any one statement counts only once unless there are two distinct clauses or a distinct combination of two skills in one sentence. The same point made twice still counts only once.

Special Scoring Instructions

Points	Response
Situation 1:	
+ 2	giving the patient the cigarette right away - e.g., "Here you are."
+ 1	making a polite request to wait up to two minutes, or a statement that one will be right with him, or getting someone else to give him the cigarette. A specific amount of time must be mentioned.
- 1	telling the patient that he is going to have to wait longer than five minutes.
Situation 2:	
+1	explaining the program, unless it is done in a negative manner.
+1	saying that one is not going to make the patient go to work.
0	any question (open or closed) or statement about the patient's rights.
0	saying that it's not a question of making the patient go.
-1	saying it will have to be discussed with the doctor.
Situation 3:	
+1	a clear indication that one intends to discuss the issue with both patients. 1 additional point for encouraging calm talk (as long as it involves both patients).
0	saying that they shouldn't argue.
0	talking to just one patient, unless it appears that the respondent intends to talk to the other one as well.
0	questions, open or closed, about the chair per se.
0	ordering the patients to discuss it.

Situation 4:

+ 1 pointing out the discrepancy in what the patient is saying.
0 preaching, such as "You should learn to control your temper", or "You're not supposed to push anyone around."

Situation 5:

+1 reflection of content regarding suicidal thoughts.
+1 saying that one cannot make the patient stay.
0 telling the patient that it has been decided that he should stay.
0 stating that one thinks that he should stay, or the doctor wants him to stay.
0 saying that both oneself and the patient should talk to the doctor.

Self-Defense and Patient Restraint Test

This paper-and-pencil test was designed to measure the understanding of principles of safety in violent situations. It consists of the following 13 items:

1. The principle most often involved in breaking a patient's grip on your arm or wrist is:
a) twisting your arm or wrist
b) working against the thumbs
c) striking the patient's hand with sufficient force
d) using your forearm against the patient's grip
e) none of the above.

2. When a patient swings at you, your best two defenses are:
a) ducking the blow and grabbing the patient's waist
b) stepping back and ducking
c) grasping the patient's wrist and stepping back
d) stepping back and blocking the punch with hands high
e) none of the above.

3. When a patient appears upset enough to strike you, which of the following ways of standing is wrong?
a) hands about solar plexus height
b) midline of body turned slightly away from patient
c) at least arm's length from patient
d) feet about shoulder-width apart
e) none of the above.

4. The safest and most effective area of the body to strike is:
a) the solar plexus
b) the xiphoid process
c) the stomach
d) the groin
e) none of the above.

5. In self-defense, the most important element of your behavior is:
a) strength
b) surprise
c) coordination
d) flexibility
e) balance.

6. Hitting a patient is justified when in your judgment:
a) the patient deserves it
b) it is by far the quickest alternative
c) you get really angry and there is danger of someone being hurt
d) there is danger of someone being hurt and you can think of no safer alternative
e) you have a weight and strength disadvantage
f) none of the above.

7. Before entering a room to restrain a violent patient staff need to have:
a) a blanket
b) at least three large men present
c) a plan
d) medication ready
e) all of the above.

8. When avoiding or blocking a kick one must be careful not to:
a) bend forward
b) use only one hand to block
c) step sideways
d) step forward
e) none of the above.

9. In a one-to-one situation where you have nothing to defend yourself with, no chance of escaping, and a weight and strength disadvantage, you can equalize the situation to some degree by:
a) getting on the floor
b) grabbing the patient's wrists

c) distracting the patient
d) running straight at the patient
e) none of the above.

10. In restraining a patient with a grip on his neck area, which of the following should you be most concerned about (i.e., which is the easiest to do accidentally):
a) cutting off air for too long
b) cutting off brain blood supply for too long
c) damaging the trachea
d) breaking the neck
e) b and c above
f) a and d above.

11. In restraining patients, the general principle is to:
a) use your weight effectively
b) control their joints
c) get behind them
d) control their large muscle areas
e) none of the above.

12. In entering a room to restrain a violent patient, it should be agreed that if one staff is to approach the patient from the front the other two should:
a) wait for an opening
b) try to get behind the patient
c) be assigned to control the patient's left and right side
d) be assigned to approach the patient from the left and right side of the room
e) try to knock the patient down.

13. List five things you should know about or look for in your surroundings when dealing with an upset patient who may become violent.

Scoring Key

1 (b); 2 (d); 3 (e); 4 (a); 5 (b); 6 (d); 7 (c); 8 (a); 9 (a), 10 (c); 11 (b); 12 (d); 13; escape route; objects patient could use to attack staff; objects staff could use to defend self; other staff nearby - where are they?; any other patients behind staff; location of alarm buttons, phones; any objects behind the staff.

Physical Test

The Physical Skill Test, which was administered individually, was designed to sample skills taught in the physical section of the course. It consisted of eight situations that might be reasonably likely to occur or in which a clear physical solution existed for a specific type of assault. With the trainer playing the patient's role, the subject is asked to either fend off a simulated attack or carry out a restraint. Subjects are told that it is only their initial response that counts: that they should do what they think is most effective (without, of course, hurting the "patient") and that they should stop immediately when told to.

Mats are placed on the floor for safety purposes. Two chairs and a length of pipe or a stick about two feet long are also required.

Situation 1
The subject is grabbed from behind in a choke such that the patient's right elbow is in front of his/her larynx. Points are awarded for (a) pulling on the arm and/or turning the chin into the elbow, (b) stepping behind the attacker, (c) converting the choke hold to a headlock.

Situation 2
The subject is grabbed by the hands from the back in the neck area (rear choke). Points are awarded for: (a) stepping forward, and (b) swinging the arm and shoulder over the patient's hands.

Situation 3
The patient grabs both subject's wrists from the front, attempting to do this with one thumb on the bottom and one on the top (one hand up and one down), although this is not always possible. Points are awarded for: (a) stepping back without bending over, and (b) using any rotational technique that works against the thumbs. The "confusion" technique where the arms work in different directions simultaneously is best.

Situation 4
Right roundhouse punch to the chin (at moderate speed) after stepping forward. This is a telegraphed punch and comes from the hip. Points are awarded for (a) stepping back or to side, (b) hands up, (i.e., elbows or forearms protecting face and head), and (c) blocking punch or hands in very good position if block unnecessary. Full points can also be awarded if the subject moves into the punch, but *only* if the block is effective; if block is ineffective, score zero.

Situation 5

Right front kick after stepping forward. This is a snap kick delivered at moderate speed toward the belt area (this simulates a groin kick but is safer). The kick is telegraphed by the patient looking at the area where he will kick. Points are awarded for: (a) stepping back or to the side, (b) not bending forward, (c) blocking with one arm or leg (an "X" block is unacceptable). Note that the kick is delivered from too far away for moving in to be effective.

Situation 6

Subject stands in a corner, facing the room and leaning against the wall. A kitchen-type armless chair is nearby. The "patient," about 25 feet away, suddenly produces a length of pipe from a concealed place and runs at the subject as fast as he can with it raised over his head. This situation must be a surprise one for the subject. Sometimes subjects will ask what the chair is for or whether it is real; the trainer replies that chairs are for sitting on or that everything is real. Points are awarded for: (a) picking up the chair, (b) rotating its legs such that one middle leg points at the patient's face and the other at his stomach, and (c) taking the initiative by moving forward quickly. Note that these manuevers can usually only be accomplished if one hand is placed on the front seat of the chair and the other on the back, as the chair is unwieldy if picked up by the back.

Situation 7

The purpose here is to restrain the patient's one free arm and hold him against a wall to receive a needle. One staff will control the patient's left side (patient faces wall) and the subject is to control the right. The "patient" holds out his arm and does not struggle unless he must assess whether he is being held properly. Points are given for: (a) elbow control, (b) wrist control, (c) blocking patient's foot, and (d) putting weight (usually hip) into patient. Items (a) and (b) are usually accomplished by a straight arm bar or hammerlock.

Situation 8

An assaultive and angry patient must be restrained in his room. Two chairs are positioned to represent the sides of a door. The patient stands with his fists up about two feet inside the doorway; the subject stands just outside it. The subject will be the first staff to enter and others will follow: thus, it is only the subject's initial approach that is of interest. The idea (not explained beforehand) is to push the patient back so that the other staff can help. Points are awarded for: (a) no hesitation, (b) hands up in front, and (c) pushing on the chest area with hands flat.

SELF-REPORT MEASURES

The Course Feedback Questionnaire, given at the end of the course and again six weeks later, asked participants to rate how much they had enjoyed the course, how good it was in relation to others they had taken at the hospital, how useful each topic was, how useful the course was in their daily work, the degree to which they felt their personal job effectiveness was (or would be) increased, and whether they would recommend the course to other staff.

A follow-up questionnaire was given 15 months later to all staff who had taken the course and who were still working on one of the study wards. It included many of the same questions on the original questionnaire, as well as whether the course had prevented themselves, their co-workers, or patients from being injured.

Course Feedback Questionnaire

I. How much did you enjoy participating in the course?
1. very much
2. quite a lot
3. some
4. slightly
5. not very much
6. not at all.

II. This course was . . .
1. one of the worst offered here
2. one of the poorer offered here
3. about average compared to others here
4. one of the better ones offered here
5. one of the best offered here.

III. How good a job did the instructors do?
1. very good
2. good
3. fairly good
4. not especially good or bad
5. fairly bad
6. bad
7. very bad.

Comments? (e.g., what was done well or poorly? How could the instructors improve?)

IV. How well organized did you think the course was?
1. very poorly organized
2. not well organized
3. fairly well organized
4. well organized
5. very well organized.

V. Rank order the topics of the course in terms of their potential usefulness in your performance of your duties.
- Calming techniques
- Defusing techniques
- Restraints and security
- Prediction of patient behavior
- Social skills in dealing with patients
- Interviewing patients
- Mediation
- Self-defense
- Job stress.

VI. How useful do you think the material learned in the course will be in doing your daily work on the wards?
1. very useful
2. useful
3. somewhat useful
4. a little useful
5. hardly at all useful
6. not at all useful.

VII. Can you think of anything that should have been covered in the course, but either wasn't covered at all or wasn't discussed enough?
- Yes
- No

If "Yes", what?

VIII. Do you think there was anything taught in the course that was useless or unnecessary?
- Yes
- No

If "yes", what was it, and why do you think it was useless?

IX. How much do you feel that course attendance may increase your effectiveness in your daily work?
1. not at all
2. a little
3. some
4. quite a bit
5. very much.

X(a) Would you recommend that new attendant staff take the course?
1. yes, I would recommend it very much
2. yes, I would recommend it
3. yes, I would recommend it, but with some reservations
4. no, I would probably not recommend it
5. no, I would definitely not recommend it.

X(b) Would you recommend that attendant staff with one or two years experience take it?
1. yes, I would recommend it very much
2. yes, I would recommend it
3. yes, I would recommend it, but with some reservations
4. no, I would probably not recommend it
5. no, I would definitely not recommend it.

X(c) Would you recommend that senior attendant staff take it?
1. yes, I would recommend it very much
2. yes, I would recommend it
3. yes, I would recommend it, but with some reservations
4. no, I would probably not recommend it
5. no, I would definitely not recommend it.

XI. What were the most important things you learned?

On-Ward Job Reactions Scale

The On-Ward Job Reactions Scale asked staff to indicate how confident and comfortable they had felt in their interactions with patients over the preceding four weeks, in a variety of different contexts. It was administered before and again six weeks after the course. Respondents were asked to circle the number next to the statement that most closely describes their feelings and experiences during this time period.

I. Compared to eight weeks ago, when dealing with difficult patients, I now feel . . .

1. much more competent
2. more competent
3. a little more competent
4. just as competent
5. a little less competent
6. less competent
7. much less competent.

II. When working (escorting, supervising) with new patients, I generally feel . . .

1. very tense
2. tense
3. somewhat tense
4. just a little tense
5. not tense at all.

III. I like . . . of the patients with whom I work.

1. all
2. most
3. many
4. quite a few
5. few
6. very few
7. none

IV. With big aggressive patients, I . . . wish that I were bigger and stronger than I am.

1. very often
2. often
3. sometimes
4. occasionally
5. rarely
6. never

V. How difficult is it for you to know what to say to a patient who is very depressed and suicidal, and who wants to talk to you about his feelings?

1. extremely
2. very
3. quite

4. somewhat
5. a little
6. not at all

VI. When a patient flatly refuses one of my requests, I feel . . .
1. very annoyed
2. annoyed
3. somewhat annoyed
4. a little annoyed
5. not at all annoyed.

VII. When escorting a patient who was placed in the time-out room about one hour ago for an assault on staff, I feel . . .
1. very calm
2. calm
3. only a little tense
4. somewhat tense
5. tense
6. very tense.

VIII. When talking with an obviously psychotic patient, I . . .
1. always know what to say
2. usually know what to say
3. am sometimes not sure what to say
4. am often not sure what to say
5. am very often not sure what to say.

IX. When I talk to patients, I find . . . of them offensive.
1. most
2. many
3. some
4. a few
5. very few
6. none

X. How often during the last four weeks would you say that you felt uncomfortable with a patient?
1. never
2. rarely
3. occasionally
4. often
5. very often.

XI. It seems that most patients . . . want to talk with me.
1. often
2. fairly often
3. sometimes
4. rarely
5. never

XII(a) When a patient wants to talk about personal problems (e.g., relationships, the future), and I have the time, I am generally. . . to talk with him/her.
1. very agreeable
2. agreeable
3. fairly agreeable
4. only slightly agreeable
5. not at all agreeable

XII(b) In such situations, I . . . encourage the patient to talk.
1. always
2. often
3. sometimes
4. rarely
5. never

XIII. When two patients are arguing, I feel . . . to try to break it up.
1. very reluctant
2. reluctant
3. somewhat reluctant
4. a little reluctant
5. not at all reluctant

XIV. I have . . . conversations with patients.
1. very many
2. many
3. some
4. few
5. very few
6. virtually no
7. no

XV. In dealing with recently assaultive patients, I feel . . .
1. very uncomfortable
2. uncomfortable

3. somewhat uncomfortable
4. only a little uncomfortable
5. not at all uncomfortable.

XVI. When talking to patients, I find . . . of them interesting.
1. most
2. many
3. some
4. a few
5. very few
6. none

PATIENT QUESTIONNAIRES

Patients were asked to rate their self-esteem and moods so that we could see whether staff were changing their interactions with them to help them feel less depressed, less anxious, and have more self-esteem. We therefore had every literate patient who consented to do so complete three questionnaires: a modified version of the Coopersmith Self-Esteem Inventory developed for an adult corrections population (Bennett, Sorensen, & Forshay, 1971), the Self-Rating Feeling scale using adjectives selected from the Adjective Check List (Gough & Heilbrun, 1965), and the Feeling Checklist, which was a slight modification of a scale designed to measure positive and negative affect in clinical populations (Bradburn & Caplovitz, 1965). Each questionnaire was given three times, approximately one week apart, six weeks before and six weeks after staff on each ward pair were given the course.

Self-Rating Feeling Scale

Instructions
Below are eleven word pairs. Each pair is made up of opposites such as cheerful-sad. Show how you feel today by placing a check mark (✓) in one of the spaces. Put only 1 check mark on each line. For example: if you feel very cheerful today, put a check mark in the space next to "Cheerful".

Cheerful ✓: :: :: :: :: :: :: Sad

If you feel very sad , put a check mark in the space next to "Sad"
Cheerful :: :: :: :: :: :: ✓: Sad
If you feel cheerful but not very cheerful
Cheerful :: ✓: :: :: :: :: :: Sad
if you feel sad but not very sad
Cheerful :: :: :: :: :: ✓: :: Sad
If you feel slightly cheerful
Cheerful :: :: ✓: :: :: :: :: Sad
if you feel slightly sad
Cheerful :: :: :: :: ✓: :: :: Sad
If you feel neither cheerful nor sad
Cheerful :: :: :: ✓: :: :: :: Sad

1) Cheerful/ Sad
2) Afraid/Not Afraid
3) Quick/Slow
4) Unwanted/Wanted
5) Happy/Unhappy
6) Weak/Strong
7) Liked/Disliked
8) Tired/Not tired
9) Safe/Unsafe
10) Nervous/Calm
11) Active/Inactive
12) Good-looking/Ugly
13) Confused/Clear-headed
14) Generous/Selfish
15) Pleasant/Unpleasant
16) Stubborn/Not stubborn
17) Miserable/Not miserable
18) Unreasonable/Reasonable
19) Kind/Unkind

Score each item by assigning it a 1 if the check is in the right-most box, etc., up to 7 if the check is in the left-most box. Then reverse the scores for the following items by changing a 1 to a 7, etc.: 2, 4, 6, 8, 10, 13, 16, 17, 18. Then add the scores for all items.

Feeling Checklist

Indicate how often during the past week you have had the feeling described in each of the statements below: 1. Never 2. Hardly ever 3. Sometimes 4. Quite often 5. Very often.

During the past few weeks, how often did you feel:

1. Particularly excited or interested in something?
2. So restless that you couldn't sit long in a chair?
3. Proud because someone complimented you on something?

4. Very lonely or remote from other people?
5. Pleased about having accomplished something?
6. Bored?
7. On top of the world?
8. Depressed or very unhappy?
9. That things were going your way?
10. Upset because someone criticized you?

Add the scores for items 1, 3, 5, 7, and 9 to obtain the Positive Affect score, then those for items 2, 4, 6, 8, and 10 for the Negative Affect score. Substract the Negative Affect score from the Positive Affect score to get the Total Affect score.

A further aspect of the effect of the course on patients that we had we hoped to measure was the perceived atmosphere on the wards before and after the course. After searching the literature, we chose the Ward Atmosphere Scale (WAS) (Moos, 1974; 1975). The WAS consists of ten scales to be completed by patients, and measures aspects of the staff-patient relationship, amount of staff control, personal problem orientation of staff, and degree to which staff tolerate the expression of anger and aggression (with items such as, "The staff very rarely punish patients by restricting them," and "Patients are careful about what they say when staff are around"). While we realized this was a "long-shot" in the sense that the course would have had to have a very profound effect for us to find changes on this measure, we wanted to include it because it seemed to be the best way to gather data from the ultimate consumers of our course.

However, although this measure has been used frequently by other investigators, we encountered severe problems when we tried to implement it. The problems stemmed from an indignant reaction on the part of staff toward having patients rate their behavior, even though we stressed that they would not be rating specific individuals but rather the staff on their wards in general. A further problem was the fact that psychology and research staff would have access to these data. Thus we had to abandon this measure, and settle instead for the patient questionnaires of mood and self-esteem described above.

Another measure we had planned to use was a time-sampling of actual staff behavior on the ward. The technique we chose for this was an adaptation of the Staff-Resident Interaction Chronograph, or SRIC (Paul & Lentz, 1977). The SRIC is designed to allow the systematic collection of data on interactions between attendants and patients on the ward, and was developed and used successfully by Paul and Lentz with staff and

chronic mental patients. In our study, trained observers were to have objectively coded the presence or absence of discrete instances of staff activity in response to patient behaviors. The use of this measure required a research staff to follow individual attendant staff members around the ward and code their behaviors for each six-second interval. Not surprisingly, the ward staff were not at all comfortable with this. Despite our misgivings, some individuals on the wards where we were piloting this measure allowed us to do it, and it didn't seem to affect their interactions with patients as much as we had feared it might. However, due to political factors mostly unrelated to us or our research, the attendants were very dissatisfied around this time and morale was at a low ebb. Many began to be very suspicious of our motives in following them around. Just after this, again for reasons unrelated to our project, the attendant staff went on strike and management staff (including one of the authors) were called in to run the building. This led to further bad feelings between the research and the attendant staff, and interrupted the collection of our pre-course data for the first wards where we planned to run the course. To have continued to collect these data after the strike seemed politically unwise and also would have set our project back by a considerable period. We therefore abandoned this measure as well.

MEASURES OF ASSAULTIVE BEHAVIORS

For both the assaultive incident data and the number of workdays lost, the data revealed immediate post-course decreases, but these were then followed by increases (see Figures 1 and 2). Also shown are the best-fit lines for each set of data. Although this was disturbing, we believe that two factors were operating to reduce the positive effects of the course.

From a research point of view, we would have been more likely to have found a positive effect if we had been able to look for reductions on assaults on the specific staff members who took the course. Our records were originally intended to have included the names of the individuals involved. However, some staff were very upset and suspicious about this idea, and the unions that represented them made it clear from the beginning that they would support the study only if we did not keep such records. Since in order for the course to be effective we needed the union's full support and cooperation, it became obvious that the entire project would have to be abandoned if we forced the issue. Thus, we therefore had to content ourselves with simply keeping records about the *wards* on which

FIGURE 1
ASSAULTS ON STAFF AND PATIENTS & TOTAL ASSAULTS BY 30-DAY PERIODS PRE- AND POST-COURSE (STRAIGHT LINES INDICATE LINES OF BEST FIT)

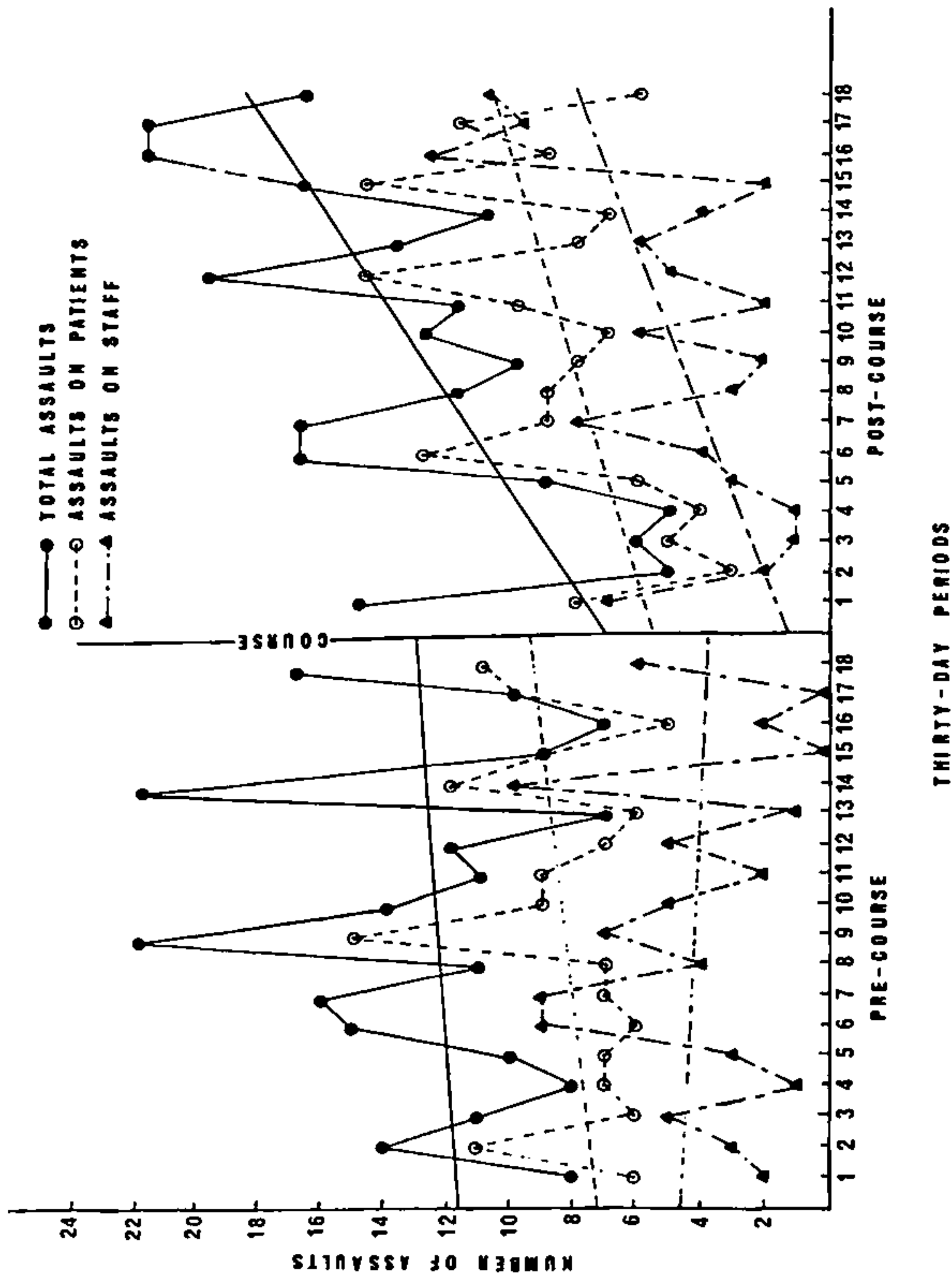
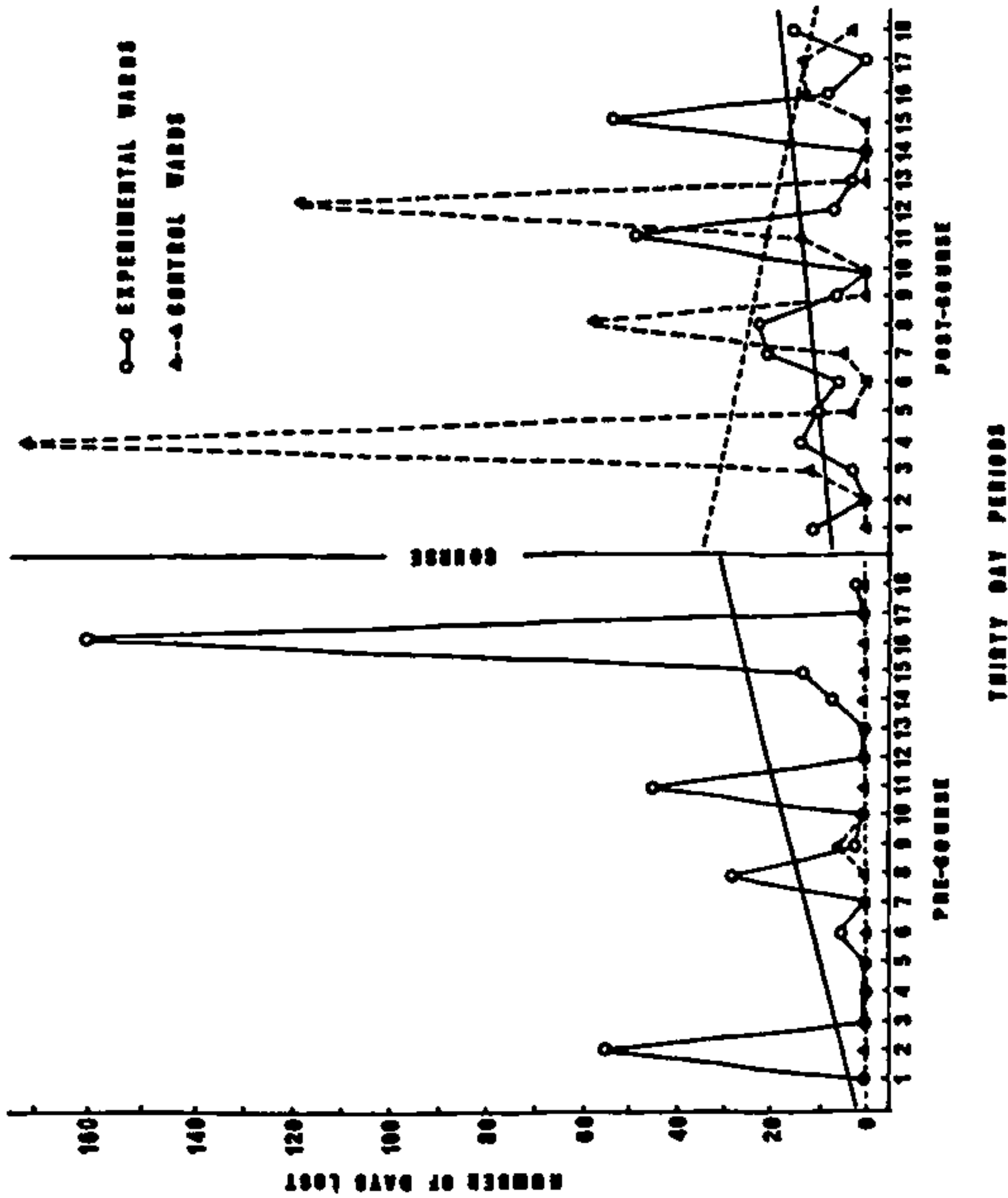


FIGURE 2
WORKDAYS LOST DUE TO PATIENT-CAUSED STAFF INJURIES ON EXPERIMENTAL AND NONSTUDY WARDS (STRAIGHT LINES INDICATE LINES OF BEST FIT)



an assault occurred. Because staff turnover was believed to be very low, ward data appeared to be acceptable at the time. Unfortunately however, despite assurances from nursing management that no staffing changes would be made on the wards involved in the study unless absolutely necessary, many were in fact made over the period of our data collection. In fact, while almost all of the original staff on the study wards took the course, a year later just over half of these individuals remained. Thus, we believe that staff turnover may possibly account for the fact that the post-course drop in assaultive incidents was not permanent, and made it difficult for us to evaluate the effect of the course on reducing the number of assaultive incidents in which trained staff were involved.

A second explanation suggested by several of the staff (also see Chapter 2) was that patients entering the hospital during the post-course period were more difficult and more assaultive than those admitted earlier. While we have no way of verifying these reports, it was noted that the number of incident reports (filled out on all wards whenever any difficulty was encountered) showed very large increases over the post-course period in *all* areas of the hospital. This explanation is also supported by the finding that the number of times medication was ordered for upset patients went up on all wards, and that the number of workdays lost by staff on the nonstudy wards was near zero in the pre-course period but was substantial afterwards.

For the days-lost measure, there were significantly fewer days lost in the post-course period on the study wards relative to the changes on control wards. However, because these data were highly variable, and because of the large *pre-course* difference of days lost on the study and comparison wards, we believe this result should be interpreted cautiously.

In summary, the combined results of all our measures support the conclusion that a course such as ours is an important component of an assault reduction strategy in psychiatric institutions. Trainees learned relevant skills; their morale and that of patients improved; and there was an improvement on assault-related measures. We believe our data should provide encouragement for others who are interested in developing programs to reduce institutional violence.

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Instructional Videotape Order Information

A videotape of approximately 30 minutes' duration is available to assist those interested in developing their own courses. The tape consists of three parts:

1) The Simulated Situations Skill Test which is described in Chapter 9,

2) Illustration of the physical techniques taught in the course,

3) An example of a video used in the course, which illustrates the use of interviewing and mediation techniques.

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- **What is the safest way to intervene in a hostage-taking incident?**

- **What strategies exist to alleviate the job stress that can result from working with violent individuals?**

- **How should you defend yourself against a hand-choke from the rear?**

- **Which verbal approaches work best when acting as mediator between two antagonists?**

This book reviews the research on assaultive incidents within psychiatric institutions, and describes a staff training course designed to reduce the problem. The premise of the course is that violent acts are often the outcome of poor staff-patient interactions, rather than patient pathology *per se*. Therefore, if front-line staff members are at times inadvertently inducing assaultive behavior in patients, they can learn how to change their own behavior in order to avoid doing so.

Part I represents a concerted effort to understand the etiology of institutional violence. It discusses the issue in various settings, both psychiatric and correctional; reviews what is known about the characteristics of perpetrators, victims, and assault-prone environments; and critically evaluates the various methods in use for dealing with the problem.

Part II describes in detail the course developed by the authors, which has been in operation at their institute for many years. It covers the complete range of topics discussed in the classroom, including empirical support for the approaches advocated. The last section is addressed to readers planning to conduct similar courses themselves, providing tips on how to present the material and describing measures used to evaluate course effectiveness.

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