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"I'M GONNA STICK YOU IN THE THROAT WITH A PENCIL!!!"

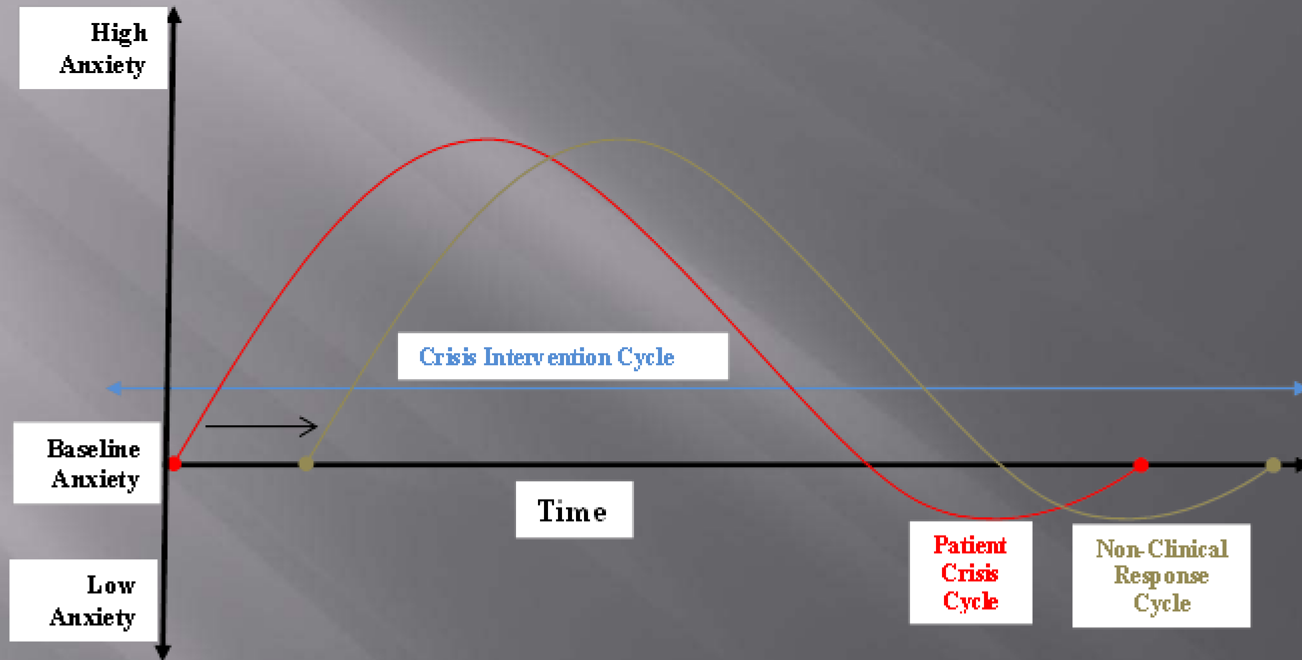
This guy is in front of you…

- You are a professional, obligated to provide a service
- There are regulatory standards by which you have to deliver those services
- You want to go home after work, uninjured
- What do you do?

Behavioral Crisis Cycle Diagram

"To Master these skills, you have to Master control of yourself"

C. Caracci



- Red curved line = patient crisis cycle
- Gold curved line = non-clinical response cycle
- Blue straight line = clinical response

I.N.S.E.R.T. algorithm

- **I**dentify Escalating Behavior – Hot or Cold Threat
- **N**eeds Assessment – Hot or Cold Threat's Origins & Gains
- **S**afely Approach – Tactical Movement/Thinking
- **E**ngage the patient – V.D.S.P.
- **R**einforce patient self-management and self-control
- **T**eaching moment for patient, staff, and team

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- **I**dentify Escalating Behavior
  - Cold Threat Behaviors are intentional, premeditated behaviors
  - Hot Threat Behaviors are impulsive, situational, reactive

Intentional Escalation a.k.a. "cold threat"

- May be preplanned with secondary gains
- Usually have little advance warning, by design
- More difficult to prevent or to stop
- Cold threats are often 'misdiagnosed' because the patient may not be viewed as a whole person or a credible source of information with a legitimate need...

Situational Escalation a.k.a. "hot threat"

- Aggravating circumstances occur – in many cases, a perceived aversive interaction due to a limit set, activity demand, or denial of request
- Patient is unsuccessful in coping with steady or escalating stressors
- Behavior gradually or rapidly escalates from calm to acting out
- Psychosis may be active, adding to agitation

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- **N**eeds Assessment – Cold Threat
  - Cold Threat Behaviors
    - History of preplanned actions
    - ***Secondary Gain***
    - Choosing their time (e.g. shift change, low staff)
    - Looking for the "right" victim (e.g. all female staff, etc.)
  - Cold Threat Needs
    - What is the unmet need patient is trying to satisfy?
      - Ask them!
      - What alternatives are available to meet the need?
      - Promise only what you can deliver.

I<u>N</u>SERT

- **<u>N</u>**eeds Assessment – Hot Threat
  - Hot Threat Behaviors
    - "Seemingly" unprovoked – "Out of Nowhere"
    - Threats of assault – unrealistic, disjointed, sometimes symptomatic *(i.e. "I'll kill you and everyone that knows you if it takes me the rest of my life")*

NOTE: Hot Threat Behaviors are generally easier to de-escalate then Cold Threat Behaviors

  - Hot Threat Needs
    - What is the unmet need patient is trying to satisfy?
      - Some needs may be hard for the patient to identify right away…(e.g. respect, security, safety, heard)
      - Validate and roll-with-resistance…
        - Spend adequate time with the patient-in-crisis…it may take some time to identify the unmet need, use patience, stay invested in a solution.

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- **S**afely Approach
  - Move tactically to the ‘zone of influence’ (close enough to engage the patient with a caring presentation, far enough to slip an attack)
    - Identify routes of escape, physical obstacles to movement and barriers to evade
    - Anticipate the physical mechanics of an attack (what arm or leg will likely be used by the patient first and how you will deflect or evade)
  - Be non-judgmental in language and non-verbal facial expressions…even ”smile” when indicated
  - Use a non-threatening interview posture – “cupped hands” or “jack benny”
  - Leave an egress route for the patient…don’t surround or block the patient with staff
  - Connect… Use the patient’s *NAME*
  - Establish that you want to help the patient get what he/she needs.

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- **E**ngage the patient – V.D.S.P.
  - **V**alidate patient's need and experience
    - Use Active listening – we call it the "Big Ear"…let the patient rant
    - ***Spend adequate time with the patient-in-crisis***
    - ***Reflect key talking points back to the patient***
    - ***View the patient as a whole person…not a diagnosis or their index crime***
  - **D**efer to treatment programming, standards, or policies
    - The guiding principle is deferral to an authority bigger than you or any one person…the law, a court order, a policy
    - Highlight the principle, not the messenger

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- **E**ngage the patient – V.D.S.P.
  - **S**uggest an alternative
    - EXAMPLE: *"I appreciate that you think that you are being poisoned by the Doctor…the Court has required that you take psychiatric medications while you are here…the Hospital has to obey the Court. It has no choice. However, you can choose from some options that might have less side effects. Would you be willing to try a different medication and keep on track with your treatment program?"*
  - **P**ositive Prompt
    - Express faith in their ability to solve the problem and regain control – "Great choice in accepting this new medication…thanks for working with us on that alternative! Now, let's get to work at earning that next level"
  - **Repeat V.D.S.P when resistance is presented, adapting to the resistance as the patient moves through the procedure.**

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- **R**einforce patient self-management and self-control
  - EXAMPLE: *Make environmental changes and provide comfort items during the crisis as practicable that support success*
    - *E.G. Separate aversive parties, reduce stimulation, set the stage for the person to self-regulate*
  - Provide encouragement and hope for discharge/future
- Remind them of past successes
- Reframe the patient's experience of the crisis to an outcome that prevents recurring crisis
  - Example: "The right medications and TRC classes can make all the difference Laura! You did a great job working with us on that medication issue. The quicker we can nail down a program that works for you, the quicker we move toward getting back to the community!"

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- **T**eaching moment for patient, staff, and team
  - Feed de-escalation data to the Tx Team
  - Successful de-escalations deepen rapport and can make subsequent ones more successful
  - Helping a patient regain self-control is far more meaningful than controlling them
  - Success models recovery to the Culture of Safety

Levels of Validation

Level One Validation – Listening & Observing

This level of validation allows the staff to understand where the patient is in the moment through listening to and observing the patient's words, feelings, and actions. The staff is interested in the patient and actively attending to the patient's verbal and non-verbal output.

Examples: "Can you explain that?" "Tell me more." "What were you thinking just then?"

Level Two Validation – Accurate Reflection of What is Stated

This level of validation is accurate reflection using a nonjudgmental stance. This allows the patient to know that he or she has been understood in a deep and meaningful way.

Examples: "So you were saying that…." "In other words…."

Level Three Validation – Articulating the Unverbalized

At this level of validation, the staff "reads" the patient's behavior and articulates emotions and meanings that the patient has not expressed. This does not mean that the staff uses consequences of behavior as proof of intent. This allows the patient to know that his or her responses to events are justifiable and for the patient to know him- or herself better than before.

Examples: "It sounds like you were very upset/angry/hurt." "This must be really difficult for you."

Levels of Validation Con't

Level Four Validation – Validating in Terms of Sufficient (but Not Necessarily Valid) Causes
This level of validation is viewing the patient's feelings, thoughts, and actions as justified and understandable in light of the following: 1) historical antecedents, 2) invalid current antecedents, and 3) disordered antecedents due to biological factors. Validating means highlighting and reinforcing the adaptive aspects of the patient's behavior, without emphasizing the inherent dysfunction of the behavior. This allows the patient to make sense of his or her behavior.
Examples: "So when she turned you down, you were angry and embarrassed. You were thinking of every other woman who had ever rejected you."

Level Five Validation – Validating as Reasonable in the Moment
At this level of validation, the staff communicates that behavior is justifiable, reasonable, well-grounded, meaningful, or efficacious in terms of current events, normative biological functioning, and the patient's ultimate life goals.
Examples: "You were really confused by that. I think most of us probably would have felt confused at that moment."

Level Six Validation – Radical Genuineness
At this level of validation, the patient is responded to as a person of equal status, due equal respect. This requires the staff to be genuine, and to respond spontaneously and completely in the moment. At this level, the staff communicates that the person is valid.
Examples: "Being here is really difficult. I don't think I'd like to live here either." "What you did really scared people. I would have been scared too if I had been there."

The End!
Questions, Comments, etc.

Recent relevant references to 'Best Practices for Interacting with Residents'

Newbill et al. (2010). Direct observational coding of staff who are the victims of assault. Psychological Services, 7, 177-189.

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Berry, K., Barrowclough, C. & Haddock, G (2010). The role of expressed emotion in relationships between psychiatric staff and people with a diagnosis of psychosis: a review of the literature. *Schizophrenia Bulletin*, 37, 958-972.