THE NATIONAL ANGER MANAGEMENT ASSOCIATION

PRESENTS

CRISIS INTERVENTION SPECIALIST CERTIFICATION (CCIS)

Andy Prisco, CCIS-V

Laura Moss, CCIS-IV

RESPONSE TEAMS

(PERT & CIT)

A BRIEF HISTORY ON SUPPORTING PEOPLE-IN-CRISIS

THE NATIONAL EMPATHY CRISIS

WHY STANDARDIZE BEST PRACTICES IN CRISIS INTERVENTION?

OUTCOME DATA

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Direct Observational Coding of Staff Who Are the Victims of Assault

William A. Newbill
University Behavioral HealthCare and Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey

Dean Marth
Truman VA Medical Center, Columbia, MO

James C. Coleman
Austin VA Mental Health Outpatient Clinic, Austin, TX

Anthony A. Menditto
University of Missouri School of Medicine and Fulton State Hospital, Fulton, MO

Sarah J. Carson
University Behavioral HealthCare, University of Medicine and Dentistry of New Jersey

Niels C. Beck
University of Missouri School of Medicine and Fulton State Hospital, Fulton, MO

Staff members in psychiatric hospitals are frequently assaulted by patients. When asked what events triggered specific assaults on staff, staff and patients disagree. Staff members usually say that symptoms of psychosis led to the assault, whereas patients usually say aversive interactions with staff triggered the incident. For years, experts have called for direct observational research to address this issue and possibly resolve the discrepancy found in the verbal-report data. Over 26,000 hr of direct observational coding of staff activities, including staff–patient interactions, was collected across 10 years by independent, noninteractive raters on Social Learning Program units. Eight of nine kinds of aversive staff–patient interactions occurred more frequently among staff members who had been assaulted. One possible interpretation of these data is that aversive interactions lead to assaults on staff, but other possibilities must be considered. Practical recommendations for reducing likelihood of assault are detailed.

Keywords: schizophrenia, aggression, limit setting, staff assault, risk factors

As measured by days away from work due to on-the-job injury, the three most dangerous occupations in the United States are (1) professional athlete/sport competitor, (2) psychiatric aide, and (3) mining roof-bolter, a job that requires operating machinery to install roof supports in underground mines (U.S. Department of Labor, 2006). Psychiatric aides' risk of injury on the job, then, puts them somewhere between professional athletes, who intentionally test the physical limits of their bodies, and those who work in the cross-section of two of the most dangerous broader classes of employment: mining and roofing.

During the 10-year period from 1995 to 2004, assaults on nursing and psychiatric aides represented nearly 30% of the total number of workplace assaults occurring in all of America (including police, taxi drivers, and all other professions). This was the highest proportion of assaults associated with any broad occupational group (Hoskins, 2006). Assaults are not limited to line-level staff. According to the Department of Justice's National Crime Victimization Survey for 1993 to 1999, the average annual rate for

William A. Newbill, Division of Schizophrenia Research, University Behavioral HealthCare, and Department of Psychiatry, Robert Wood Johnson Medical School, University of Medicine and Dentistry of New Jersey; Dean Marth, Department of Veterans Affairs, Truman VA Medical Center, Columbia, MO; James C. Coleman, Department of Veterans Affairs, Austin VA Mental Health Outpatient Clinic, Austin, TX; Anthony A. Menditto, Department of Psychiatry, University of Missouri School of Medicine, and Director of Treatment Services, Fulton State Hospital, Fulton, MO; Sarah J. Carson, Division of Schizophrenia Research, University Behavioral HealthCare, University of Medicine and Dentistry of New Jersey; Niels C. Beck, Department of Psychiatry, University of Missouri School of Medicine and consultant, Fulton State Hospital, Fulton, MO.

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Correspondence concerning this article should be addressed to William A. Newbill, University Behavioral HealthCare and Robert Wood Johnson Medical School, UMDNJ, 151 Centennial Avenue, Piscataway, NJ 08854. E-mail: newbilwa@umdnj.edu

3 COMMON CONDITIONS THAT CAN LEAD TO ASSAULT

- Activity Demand – get a person to do something that they don't want to do
- Denial of Request – when goods or privileges are refused
- Limit Set – get a person to stop doing something they want to keep doing

The Relationship Between Nurses' Limit-Setting Styles and Anger in Psychiatric Inpatients

William J. Lancee, Ph.D.
Ruth Gallop, R.N., Ph.D.
Elizabeth McCay, R.N., Ph.D.
Brenda Toner, Ph.D.

Objective: *Violence by patients in psychiatric settings is frequently associated with the quality of staff-patient interactions. Impulsivity has been identified as a high risk factor for anger and aggression. This study was designed to test the influence of nurses' limit-setting styles on anger among psychiatric inpatients grouped by high or low levels of impulsivity.* *Methods:* *Ninety-seven patients with various diagnoses and either high or low levels of impulsivity participated in role-play scenarios in which nurse actors played out six limit-setting styles, ranging from belittlement to explanations of rules to empathy linked with a presentation of an alternative course of action. Patients' level of anger in response to the acted scenario was assessed using the Spielberger State-Trait Anger Scale.* *Results:* *Patients' level of anger was highest in response to unempathic limit-setting styles, moderate for explanations, and lowest for empathic styles. Impulsive subjects were more likely to respond with anger than nonimpulsive patients, regardless of the limit-setting style.* *Conclusions:* *Although many current intervention programs focus on reducing patients' anger after it occurs, the study results suggest that it may be possible to prevent some of patients' anger by improving nurses' limit-setting styles.* *(Psychiatric Services 46:609–613, 1995)*

Dr. Lancee is senior scientist in the department of culture, community, and health studies, Dr. Gallop is senior researcher in the nursing department, Dr. McCay is clinical nurse specialist, and Dr. Toner is director of the women's mental health program at Clarke Institute of Psychiatry, 250 College Street, Toronto, Ontario, Canada M5T 1R8. Dr. Lancee is also assistant professor and Dr. Toner is associate professor in the department of psychiatry at the University of Toronto. Dr. Gallop is also associate professor on the Faculty of Nursing at the University of Toronto.

Over the past two decades, clinical and empirical attention has been paid to the problem of violence and assault by patients in the psychiatric setting (1–5). Explanations for the occurrence of violence—the physical manifestation of aggression and anger—have centered on patient characteristics and interpersonal factors in interactions between patients and staff.

Patient characteristics have been the main foci in the study of predictors of violence. Studies indicate that the best single predictor is a history of violence (1,6). Other predictors include verbal aggression (1,7), low self-esteem (1,8), anxiety (7), substance abuse (1), severity of pathology (2), and being in the acute stage of illness (1). Some studies have investigated diagnosis, age, sex, and socioeconomic status as predictors of violence; however, the results remain inconclusive (1).

Rossi and associates (2) have suggested that patients' impulsivity may be a high-risk factor and may more reliably explain aggression than age, gender, and other demographic characteristics. Eysenck and Eysenck (9) have defined impulsivity as action without thought, planlessness, intolerance for routine and rules, restlessness, impatience, and incautiousness. Berkowitz (10,11) found that impulsive individuals were more likely than nonimpulsive individuals to transform their anger into aggression.

Staff attitudes, such as fear and the expectation of violence, have been associated with increased violence (1,7,12). Rigid intolerance and authoritarian style have been linked to assaults (13–15). Katz and Kirkland (12) found that staff and patients on wards with increased violence had few interactions and that those interactions involved manipulative and fearful behavior.

More recently, studies focusing on the context of assaults have reported that assaults by psychiatric patients generally involve interpersonal factors and are in some way provoked by the situation (1,7). Frequently, assaults occur while staff members are setting limits, administering medication, or placing a patient in restraints (1,7,12). Sheridan and associates (7) reviewed events preceding 73 incidents of physical restraint and found that the most common explanation offered by patients for violence was conflict with staff. Issues involved in such conflict included enforcement of rules, denial of privileges, denial of requests, and denial of discharge.

Gallop and associates (16) examined patients' impulsivity in a phenomenological study that included interviews with nurses and chart reviews. They found that impulsive behavior by psychotic patients was not internally driven by hallucinations or delusions but was rather the consequence of interpersonal events

LIMIT SETTING STYLES THAT WERE STUDIED

- Belittlement
- Platitudes
- Solution without options
- Solutions with options
- Affective involvement without options (empathy)
- Affective involvement with options (empathy with options)

ARE YOU SURPRISED?

Affective involvement with options (empathy with options)

PRIMUM NON NOCERE

FIRST, DO NO HARM

PRACTICE GUIDELINES:

CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

CRISIS FROM 3 ANGLES

UNDERSTANDING OURSELVES

UNDERSTANDING THE PERSON-IN-CRISIS

UNDERSTANDING THE CRISIS

MODULE I

UNDERSTANDING OURSELVES

FIGHT-FLIGHT-FREEZE

DURING

HOSTAGE/SUICIDE/ASSAULTIVE SITUATIONS

+ WHO YOU ARE AFFECTS THE OUTCOME
AND HOW WELL YOU CONTROL AN INCIDENT

+ REGULATING YOUR SNS RESPONSE, FEAR.

+ REFRAMING WHAT IT IS TO BE ***POWERFUL***

+ LIFESTYLE PRACTICE

MODULE II

UNDERSTANDING THE PERSON-IN-CRISIS

+ TRAUMA

+ PSYCHOPATHY

+ ATTACHMENT STYLES

+ VAGUS NERVE

MODULE III

UNDERSTANDING THE CRISIS

INSERT©

CRISIS INTERVENTION PROCEDURES

IDENTIFY THE ESCALATING AGGRESSION TYPE

NEEDS ASSESSMENT

SAFELY APPROACH

ENGAGE USING I.R.P.D.©

ISSUE A VALIDATION STATEMENT

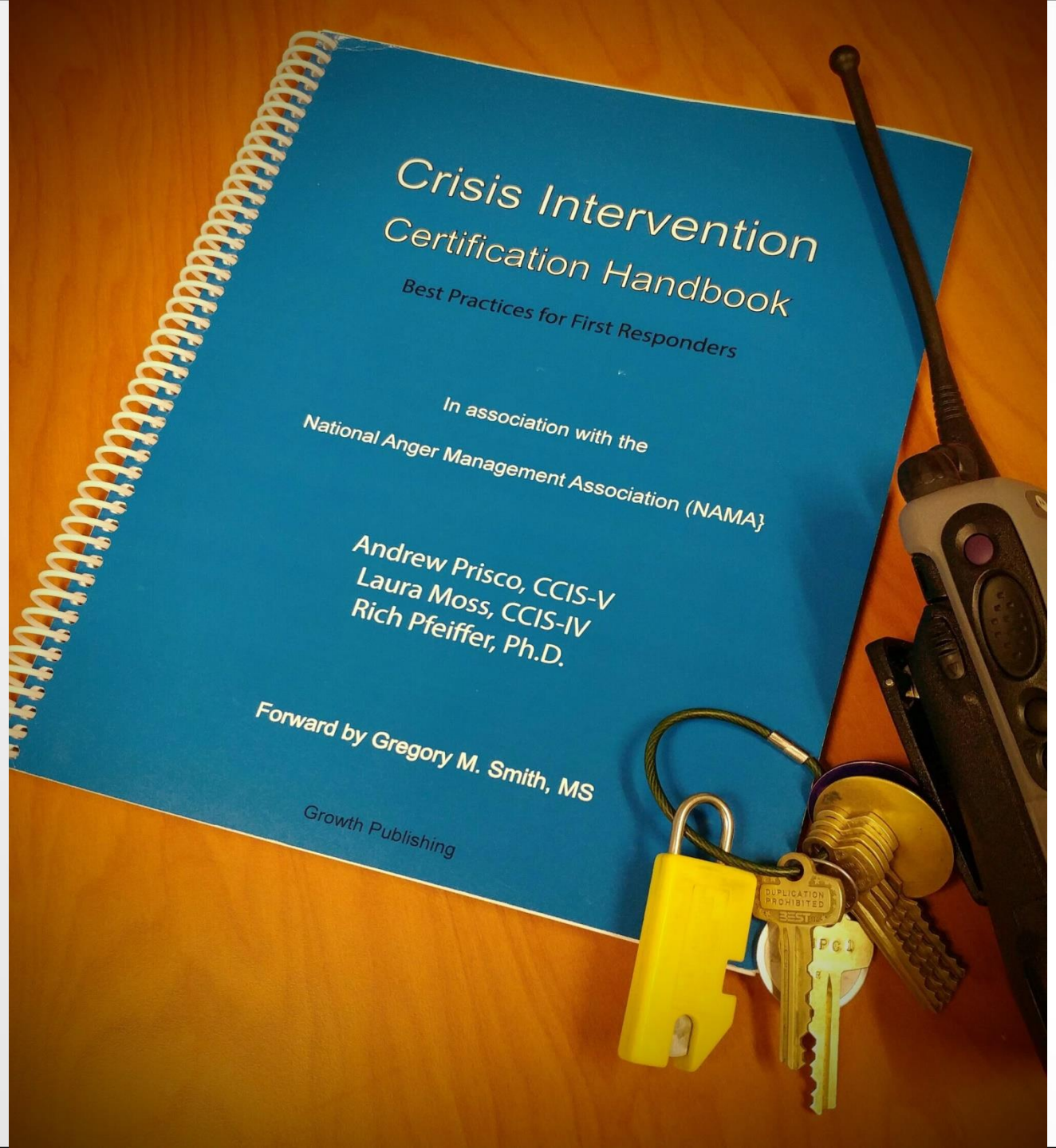
REFER TO A POLICY, LAW, RULE, STANDARD

PROPOSE A CHOICE

DESCRIBE A DESIRABLE OUTCOME

REINFORCE THE SELF REGULATION PROCESS

TEACHING MOMENT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Certification Handbook
Best Practices for First Responders
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Andrew Prisco, CCIS-V
Laura Moss, CCIS-IV
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CERTIFIED CRISIS INTERVENTION SPECIALIST (CCIS) TRAINING PROGRAMS, LEVELS 1 - 5

THIS IS A SKILLS CERTIFICATION IN CRISIS INTERVENTION FROM A PROFESSIONAL MENTAL HEALTH ASSOCIATION, THE NATIONAL ANGER MANAGEMENT ASSOCIATION, WWW.NAMASS.ORG

RESOURCES:

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WWW.NAMASS.ORG
NAMASS@NAMASS.ORG

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INFO@CRISISINTERVENTIONPARTNERS.ORG