Nonviolent Crisis Intervention: A Practical Approach for Managing Violent Behavior

Introduction

Managing aggressive and violent behavior has become an essential skill pertinent to all staff providing human services. What was once a skill reserved for those who worked on locked psychiatric units, now is in demand for emergency room staff, outpatient counselors, educators, security and law enforcement personnel. The demand for safe, effective techniques to manage the potentially assaultive person is no longer limited to those who work with the "mentally ill." The clerical admissions worker feels the same fear in today's human service setting as does the security officer.

This is not an illusion or difference in perception of potential dangerousness. We live in a more violent society. Violence pervades every aspect of our society. The typical comment heard from today's professional is, "We are treating more and more violent people these days." This is in part a reflection of the very violent state of our society.

To add to the problem, the deinstitutionalization trend has now injected thousands of individuals who formerly were treated on an inpatient basis into a society which is not quite sure how to manage their behavior. The outpatient mental health facility is now being asked to service the individual who formerly had inpatient care. Many times the staff of the community based treatment center do not have the training or experience to manage the aggressive behaviors of a client who in the past had been institutionalized.

The reasons or causal elements of increasing violence are not the focal points of this article. The issues are complex and can be debated at length. However, the fact remains that today's human service professional will encounter the violent person and needs safe, effective behavior management training designed to maintain the care and welfare of all involved in the intervention process.

Nonviolent Crisis Intervention

Nonviolent Crisis Intervention is a safe, nonharmful behavior management system designed to aid human service professionals in the management of disruptive and assaultive people, even during the most violent moments. It has been developed and taught by the Crisis Prevention Institute, a training organization devoted solely to training staff in the safe management of violent individuals. The program has several primary objectives:

1. Training staff with the techniques effective in approaching and reducing the tension of an agitated person.
2. Focusing on the alternatives if a person loses control and becomes violent.
3. Instructing staff in techniques to control their own anxieties during interventions and maintain the best possible professional attitude.
4. Providing nonverbal, paraverbal, verbal, and physical intervention skills to allow the staff to maintain the best possible care and welfare, as well as safety and security, for all involved even during the most violent moments.

The training program has been taught to over 3 million human service professionals throughout the U.S. and Canada. This article will outline the highlights and general philosophies of the program, in an effort to convey to the reader the key points which have made it so successful.

Editor's note: Use of the generic "he" and "him" pronouns throughout this article are for easier reading purposes only and do not reflect any biases on the part of the author.

Two Forms of Aggressive Behavior

As a general rule, there are two ways a hostile person will vent his or her aggression or hostility: verbally and physically. This is one of the essential tenets of managing aggressive behavior which at first seems obvious, but upon closer examination is a critical key to intervening. Clarification of this point allows the staff member to begin formulating concrete guidelines regarding the procedure utilized during interventions. These two types of "acting out" behaviors often become somewhat muddled or confused and are not separated from each other. This leads to inappropriate actions on the part of the staff intervening in the situation.

For example, let us assume that we have an agitated person in an emergency room and his agitation escalates to the point of verbal screaming and yelling at select staff who are present. Occasionally one will see staff overreact and attempt to use a "hands on" (physical intervention) strategy in an effort to calm down the individual. This staff action may actually precipitate a "physical acting out" episode. In attempting to use a hands on approach, the staff has escalated the person's behavior into a more difficult and more dangerous level. An appropriate analogy is running up to a fire and throwing gasoline on it in an attempt to put the fire out. It does not work, and makes matters more difficult to manage.

On the other side of the coin we have the staff who may attempt to utilize verbal intervention to safely manage the physically acting out person. Words are an ineffective means of intervening when a person is hitting, biting or choking you. In many cases the person's auditory channels shut down and they cannot hear you during the peak of the violent outburst. The analogy here is attempting to use a squirt gun to douse a bonfire; it is ineffective.

Therefore, the first principle which must be established is: Avoid overreaction and underreaction. Use verbal intervention skills to intervene with a verbally acting out person. However, when the aggression becomes physical, you must also have in your repertoire of skills, safe physical intervention techniques to control the physical acting out behavior.

Figure 1.
Two Types of Acting Out Behavior

Four Levels of Crisis Development

In any crisis development situation there are four distinct and identifiable behavior levels. The purpose of defining each level is to attempt to meet each level with the appropriate staff response to defuse or de-escalate the crisis development. The four levels model is not meant to oversimplify the complexities of the behavioral process, but rather functions as workable guidelines for the staff member who is intervening. Behavior is anything but neat and packaged. However, the following behavior patterns can be seen in most people who are escalating toward a potential violent episode. For the purposes of this article, we will be using a typical example of a person waiting for a visitor in a waiting area of any human service setting. As we point out the four crisis development behavior levels, we will also be outlining the four staff responses or staff attitudes to each behavior level.

The Anxiety Level

One of the first behaviors one will observe in the crisis development sequence is the anxiety level. Anxiety has numerous definitions in the fields of psychology and psychiatry, but for our example we will simply define anxiety behavior as a noticeable increase or change in behavior which is manifested by a nondirected expenditure of energy.

Let's assume the person is sitting in a waiting area and a visitor is due at 2:00 p.m. The person glances up at the clock and it is now 2:15. He proceeds to put down the magazine he was reading and begins to pace slowly back and forth, looking toward the window at the street outside the facility. Now,

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the clock reads 2:20. The person goes back to his seat and begins going through the magazine a bit more vigorously. He's not really reading, but using the magazine to expend some of his built up energy. Another glance at the clock shows the time to be 2:25. Now he tosses the magazine aside and gets up again, this time pacing more rapidly, and he begins to wring his hands and mutter to himself.

All of the previously described behaviors are classic examples of anxiety. It is the instance where one can tell by observing a person's behavior that something is "different" about them. You may not know the source of the anxiety, but you can clearly tell that something is causing him to expend built up energy and act different than normal.

The Supportive Staff Response

During the anxiety crisis development level, it is generally most effective to use a supportive staff response. The supportive approach requires the staff to be empathic and actively listen to what is bothering the individual. In this mode of intervention, the staff member should avoid being judgmental and avoid dismissing the person as a "constant complainer." The individual who is in the anxiety level does not need to be judged; he simply needs staff to listen.

Without even realizing it, here is where most potentially explosive situations are defused. As human service providers intervene on a daily basis, they become very adept at offering support. They also develop their own personal style of conveying this support. It is important, however, that staff understand that although this may seem a routine interaction experienced daily, it is often the key to "nipping the crisis in the bud" and defusing the situation at the onset of crisis development. One doesn't have to stretch his or her imagination too far to envision how a non-supportive approach at this point during the intervention can escalate the situation rapidly.

The Defensive Level

If the staff member does not intervene with a supportive approach, the individual refuses to accept the staff's support or the staff member arrives too late during the crisis development, there may be the possibility of the individual escalating to the second level, the defensive stage.

The defensive level signifies the beginning stages of loss of rationality. At this point the person begins to give you cues, verbally and nonverbally, indicating he is beginning to lose control. The defensive level is a highly volatile state and usually includes verbal belligerence and hostility. You will find the individual challenging you, your institution and your authority. The defensive person begins to respond or cue on different modes of communication. Often, at the peak of his defensiveness, he no longer responds to the rational context of your words. Instead, he may be more in tune with other types of communication such as your tone of voice, your proximity to him or your body posture.

Here is where we see power struggles and "button pushing" begin. Abusive language alluding to your race, weight, sex, and other sensitive areas is spouted. The person is testing you, and testing your limits. He may even solicit help with his verbal barrage from onlookers. Many times the verbal "acting out" strays far from the original issue that upset him, and staff may find themselves defending a completely different topic than originally precipitated the crisis.

This is an extremely critical time during the crisis development. At this stage the staff can make or break the intervention. If the individual's irrationality and "button pushing" affects the staff to the point where he loses his professionalism and becomes irrational, he has little chance of defusing the situation. Irrationality breeds irrationality. If the person senses you are not in control of your behavior, it will serve as further fuel for the fire.

The perfect example happens many times in larger institutions. A crisis alarm or signal which alerts security to report to a particular area is sounded. When security arrives on the scene they see two people in a heated shouting match, one more agitated than the other. Being a large institution, security's first task turns out to be determining who is the staff and who is the client. The point here is that during the defensive level it is very easy for the staff member to slip into his or her own crisis development. If this occurs, no one is in control and the situation is almost sure to escalate.

The Directive Approach — Setting Limits

The best staff response during the defensive level is a directive approach which entails

setting behavioral limits for the individual. It is quite clear that a supportive empathic approach is not very productive when a person becomes irrational and is testing limits. In many cases, support merely feeds into the irrational person's defensiveness. The individual needs, and at times is actually seeking, structural limits to regain rational control.

There are several critical keys in setting limits. First, make sure that your limits are clear to the person. Don't assume that he or she understands why the directive is being issued. Second, be sure that your limits are simple. Don't make them overly complex. When a person is losing rationality, he does not need five or six options to process. The most critical key is to ensure that any limits you impose are enforceable. For example, if you tell someone he must calm down or you will have to remove him from the area, you had better be prepared to do so. You can almost guarantee that any limits you impose will be tested.

Limit setting should be done as objectively as possible and should not be delivered in a threatening manner. Your goal is to make the person realize that the consequences of his behavior are up to him. The limits you impose on the individual should not merely be enforceable either; they have to be reasonable. Avoid getting yourself into a no win situation by issuing limits which cannot be enforced.

Behavioral limits do not have to be issued negatively. The "do it this way or else" ultimatum can be the spark which ignites the dynamite in a volatile situation. Inform the individual of the positive consequences resulting from his compliance. Let him make the choice.

For example, if the person is getting too loud, the first step is to let him know why his behavior has to cease. A simple explanation of the fact that the noise is disturbing others can often be enough to calm him down. If it is not, there is no need to threaten the person into compliance. Instead, point out the fact that he can remain in the area if he quiets down. Also inform him that he will have to be escorted out of the area if he continues the behavior. Make the individual feel as though he has a choice; i.e., the consequences of his behavior are determined by his decision. This approach will avoid getting yourself into a "no win" power struggle. You must keep in mind that you are there to enforce the consequences of the individual's choice and not to make the person choose one option or the other.

Limit setting is a skill which requires practice and a calm, professional approach. Verbal abuse by anyone can be frightening, not to mention insulting. It is critical however that you maintain your professionalism. A verbal loss of control at this moment may be the reaction which escalates a person into a total loss of control.

The Acting Out Person

If you do not impose and enforce reasonable limits, the individual simply refuses to follow your directives, or you arrive too late during the crisis development process, you may encounter the third level of behavior - the acting out person.

This behavior level is defined as total loss of control which usually involves physical aggression. The individual is no longer able to control himself and verbal aggression turns into physical assault. The person may assault staff, other people or even attempt to harm himself.

Nonviolent Physical Crisis Intervention

At this point and no sooner, you must physically control the person's behavior until he can regain control on his own. Nonviolent physical control and restraint should be used only as a last resort. You have now reached the point where all verbal means of managing the situation have been exhausted. The person is no longer responding to reason, and he may present a danger to himself, staff or other people in the area.

You want to avoid physical intervention for several reasons. First, there are the obvious legal implications of physically restraining someone. Also, physical intervention can be dangerous to the individual and staff. But equally important, you don't want to use a hands on approach until it is absolutely necessary because you run the risk of escalating a situation which might have been defused through verbal means.

It should be stressed that physical intervention, used appropriately and used as a last resort, can be as therapeutic as any other intervention tool. By utilizing safe, noninjurious restraint techniques you are providing the ultimate care and welfare for the individual by initiating physical control for his or her own safety. What could be more therapeutic? If physical restraint is utilized with the interests of care in mind, in most cases the person will realize this and it will aid

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you in your therapeutic treatment plan.

Physical intervention should never be utilized as a punitive measure. Unfortunately, pain compliance techniques are still a part of the restraint technique repertoire in some agencies and institutions. Besides the ethical questions, pain compliance produces negative feelings between the individual and staff. When a person loses total control he often does not remember what happened during his outburst. If the first sensation he experiences when regaining control is pain, he will remember that pain. This will lead to difficulty in managing the individual's behavior during future interactions.

Staff must remember that losing control of one's behavior is an unpleasant and frightening experience. It is sometimes difficult to keep this in perspective when the aggression or violence is directed toward you. However, most physical acting out in human service environments is not premeditated violence, but simply an explosion of pent up energy. The staff are simply the object of the explosion because they happened to be present at the time.

Tension Reduction

The tension reduction behavior level is the fourth and final level in the crisis development sequence. Unfortunately this final stage is often forgotten in many models of crisis escalation, but it may be one of the most important.

During the crisis development process there is a tremendous build up of energy and tension within a person. At the third or "acting out" level a person experiences a total energy expenditure. Anyone who has had to restrain a struggling individual can testify to the fact that this is a total expenditure of energy. This cannot go on indefinitely; eventually there must be a tension reduction.

This tension reduction is both physical and emotional. The person "comes down" from the peak of energy output. If one happens to be restraining the person, he can actually feel the tension reduction in the muscles of the body. Often the individual is emotionally drained, as well.

Many times the person who moments ago was aggressive and hostile, now appears emotionally withdrawn. He may even feel remorseful and be apologetic. This change in behavior can often confuse staff and they may even become distrustful of this aftermath of the violent episode.

The key point to remember in the tension reduction stage is that this is the start of control, or a regaining of rationality. The individual who is experiencing tension reduction has been through a very frightening and traumatic experience, some or all of which he may not remember. When he enters tension reduction, he may be at a very vulnerable emotional level. Fear, confusion and remorse are typical emotions felt by the individual during this behavior level. Staff should remember that the act of "going out of control" is even more frightening to the individual than to the staff.

Therapeutic Rapport

The fourth and final staff response during the individual's tension reduction is therapeutic rapport or communication. This is one of the best times to attempt to talk with the person. Surprisingly enough, many times the person is actively seeking communication.

If the tension reduction occurs while the individual is being restrained, he should be told that he is O.K. and that staff is not going to harm him. Allow some time for him to fully calm down and regain rationality before transporting him to another area. Have him take a few deep breaths. This will serve two

Figure 2.

The Four Levels of Crisis Development

The crisis development model shown above is an extremely valuable tool that can be utilized to determine where a person is during an escalation process. Granted, human behavior is not an orderly 1-4 progression. Yet, determining the behavior level of a potentially violent individual can help professionals determine how to respond to the different stages of escalation and as a result, improve defusion and de-escalation efforts.

functions: deep breathing tends to relax a person, and if he complies with your direction to take deep breaths, he is proving that he has regained his rationality.

Be sure that you inform the individual what the sequence of events will be. If you are going to move him, let him know where he is going. Tell him why he is being moved. This is a good time to form a verbal contract with him and let him know that if he remains calm, you will not need to restrain him again. Within safe judgment, allow the person to "make his own choices," while staff still maintains full control, should another violent outburst occur. The more therapeutic communication you initiate, the quicker he will regain total rationality.

Nonverbal Communication

When dealing with potentially violent people, one cannot stress enough the importance of nonverbal communication and its impact on whether the situation escalates. When someone is losing rationality he tends to focus on nonverbal cues more than on rational communication, such as the context of words. At certain times during the intervention, it seems as if nonverbal communication is the only form of communication that gets through to the irrational individual.

Proxemics (personal space)

The proximity or distance between you and a possibly violent person is one of the most critical elements in defusing a potentially explosive situation. Even though you may have the best of intentions in moving close to the individual, you must realize that he may not feel the same. Your proximity can be perceived as a threat.

We all have an area surrounding our body which we consider an extension of our physical self. Any "invasion" or encroachment into that area tends to be perceived as a threat, or at least makes us feel uncomfortable. This is commonly known as our personal space. Personal space varies with each individual. The critical distance for most people is about 1½ to 3 feet. Even in nonthreatening social situations we can become uneasy when a person is closer than 2-3 feet.

Our personal space also varies from situation to situation, and there are several factors which determine how much distance we feel comfortable with. How large the room is, how we feel that day and the relationship with the individual approaching us are some of the key variables.

Frequently, as we near a potentially violent person, we tend to forget that his personal space may be much larger than ours. "Stay out of my face!" is a commonly used slang expression.

Interpreted it usually means: I feel threatened by you because you are coming too close to me.

When approaching the possibly violent individual stay in tune with his nonverbal behavior. He will often signal (by nonverbal means) the fact that you are getting too close. Clenched fists, tightening of the facial muscles and movement away from you as you draw near are very common nonverbal signals. Give him as much "space" as you can. If the person

Figure 3.
The Supportive Stance

The supportive stance offers several benefits to the staff. First, you do not encroach personal space nor do you present a kinesic "challenge position." Second, you offer the person a perceived "escape route" so he doesn't feel trapped. Finally, you allow at least one leg length (3 feet) as a personal safety margin. If the person does become physically aggressive, he must telegraph his motion by taking a step toward you.

feels threatened by your proximity, you increase the chances of the situation escalating and his behavior may progress into a level which is much more difficult to manage.

Kinesics (body posture and motion)

How you position your body can also have a significant impact on the nonverbal message you send to the potentially violent person. A face to face, shoulder to shoulder position is generally perceived as a "challenge position." You may be speaking to the individual with calm, reassuring words, but if your body is positioned in a challenging mode, you may be delivering a mixed message.

A better, less threatening position is the supportive stance which has the staff member at an angle to the person, keeping a distance of at least a leg length.

Another element of body posture is the positioning of your hands. Many times the individual will be focusing much of his attention on your hand placement. Avoid concealing your hands behind your back. This can be perceived as a threatening pose, but more important, the irrational person can imagine you have something dangerous behind your back. It is not unlike the irrational thought process to imagine even a gun or knife. Also, keep your hands out of your pockets. They will not do anyone any good resting inside your pockets if the individual escalates and becomes physically aggressive. Keep your hands out in plain view, at your sides if possible.

Paraverbal Communication

Communication experts seem to agree that only 10-15% of any given message we deliver to another person is verbal context. The other 85-90% of the message is interpreted from other sources of context such as nonverbal communication. Another component of communication is paraverbal communication.

Paraverbal communication involves three elements: the tone, volume and cadence of voice. These three elements make up most of the context of any message we deliver. Take for example the sentence "Is anything bothering you?" By altering the tone, volume and rate of speech, we can give this sentence various meanings. It can be a gesture of support or it can also be an insulting and sarcastic message. One only needs to alter the inflection to convey a completely different message.

Inflection becomes very critical when intervening with the potentially explosive or violent individual. Staff must be consciously aware of how they are speaking to the person (the paraverbal message), as much as they need to be conscious of what they are saying (the words they use). The best way to monitor your communication with someone is to focus on their feedback. Do not automatically assume that the individual has received the message you intended to deliver, rather listen to his response.

Team Intervention

All of the intervention concepts are best utilized when a team of professionals intervene. The concept of team intervention is not new. However, when it comes to intervening with the potentially violent person, the team concept tends to break down. Example: security personnel often feel as if a crisis gets "dumped into their laps" only after other staff have mishandled the onset of the crisis and now requires "brute force" to manage the situation. On the other hand, some staff feel security tends to intervene with too much of a heavy-handed approach.

This breakdown in teamwork occurs because there is frequently a fundamental lack of communication regarding exactly what a crisis intervention team is supposed to do and who should be involved in the team. Good "teamwork" is a product of two ingredients: communication and experience. The questions "Who should be on an intervention team?" and "What should the team do?" need to be answered before one can expect cohesive team intervention.

Why Team Intervention?

It is always advisable to intervene as a team of two or more unless the situation dictates or demands solo intervention. If you are alone on a unit and an individual breaks a glass and threatens suicide you may feel it is, in your best professional judgment, a wise decision

not to leave the scene to obtain assistance. Under all other circumstances, it is best to intervene as a team.

The first and foremost reason is that team intervention is much safer for all involved. Even police officers, when intervening in a domestic dispute, make every effort to intervene with a backup officer present. When dealing with volatile people you can never tell how far the situation will escalate and solo intervention can present a danger to you. Furthermore, it can be dangerous to the individual as well. If the person physically acts out toward you and you are alone in your efforts to manage his behavior, you may revert to self-defensive instincts. This is not uncommon and often is the cause of injury to the acting out individual.

Overall, team intervention is more professional. Solo interventions have the tendency to precipitate a confrontive atmosphere. Although you may have good intentions, the person may perceive the situation as a "one on one — you against me" scenario. With a team you are more likely to give the impression that "we are here to help you and keep you safe," as opposed to "I am here to confront you."

Finally, team intervention is safer from a legal standpoint. We live in the age of client's rights. If you intervene by yourself and an abuse charge if filed, it is your word against the client's regarding what happened during the intervention. Team intervention gives you added protection in a court of law due to the fact that witnesses can testify as to what actually occurred.

The Team Leader

Every team needs a leader. This is obvious; but until the duties of the leader are specified, the leader's role becomes ambiguous and this defeats the purpose of having one.

The choice of a team leader should not be restricted to senior ranking staff. Years of service do not necessarily equate to competence in intervening in a crisis situation. There are several criteria which should be examined regarding who the team leader should be.

One of the best team leaders is simply the individual who arrives first on the scene. Because of practicality, this is often the case. The first person on the scene has the most information available as to what has happened. He or she may also have initiated good defusing efforts. If another person comes by and says "I'll take over now," the rapport established between the client and the first person on the scene may be destroyed. The individual may even have animosity toward the staff who "interrupted" the intervention.

A secondary consideration in choosing a team leader is looking for a person who has a great deal of confidence. This does not imply you choose the largest, strongest male on your security staff. The individual needs overall confidence in his or her ability to remain calm, and set and enforce limits. Size has very little to do with confidence. Confidence is a quality which exudes from certain people. You must remember that losing control is unpleasant and clients are often seeking control from another person. In most cases a calm, confident staff member gives the individual the nonverbal and verbal reassuring message that the situation is under control.

Lastly, if the team leader knows the potentially explosive person, he will have an added advantage. Having some degree of rapport with the individual can be beneficial in defusing the situation. This is not always possible, but in certain instances can be utilized to the team's advantage.

Should the team leader be predesignated, or is the team role a spontaneous process? It is, of course, a good policy to have a predesignated leader. If a particular staff member is proficient in handling crisis situations, he or she should be in charge during the intervention. However, the team intervention process should be flexible. The predesignated team leader may not be around when the crisis erupts. Team leaders often emerge as a function of group dynamics, without any prior predesignation. If team intervention is going to work successfully, this point must be understood by all staff on the unit — anyone can have the potential to assume the team leader role.

The Team Leader's Duties

There are several basic duties of the team leader. If the intervention is to operate smoothly it is beneficial to the team if the following functions are carried out by the individual in charge.

The first duties of a team leader are assessing and planning the intervention. Preferably this is done prior to arriving on the scene, but at times must be done "on the spot." Assessing involves a quick evaluation of the facts. Is the individual alone? What behaviors have been demonstrated? Where is the person? Planning the intervention is usually done simultaneously during the assessment process. How many

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staff do we need? What are the basic roles of each staff member during the intervention? When we enter the room, should we all enter or should a few remain outside? If we have to restrain the individual who will be involved? What will we do after the person is restrained?

All of these steps seem very basic; however, it is surprising how often there is no assessment or planning. In many facilities the typical scenario is a large number of staff rushing down a hallway without the slightest idea of what to do once they arrive on the scene. This leads to confusion. It also excites other staff and other clients, and ends up being a "show" with many onlookers. In addition to causing chaos, a lack of quick assessment and planning causes anxiety among staff. Participating in an intervention and having no idea what you are supposed to do is frightening.

The team leader should also be responsible for directing or cuing the intervention. There should only be one person who gives directions to the others involved. This applies both prior to and during the intervention process. This is not the time to solicit opinions, especially while you are on the scene. If the individual senses disagreement or confusion among staff, it will serve to escalate his behavior.

The last duty of a team leader is communicating with the individual. We find it very difficult as human beings to process more than one source of auditory stimuli at one time. If more than one person is talking to a potentially violent person it may be distracting, and may even lead to his behavior escalating.

Team intervention is a process which requires communication among all staff. An excellent way to foster communication is to conduct brief postvention meetings with the staff involved. As an intervention team works together over time, they will, like any good team, begin to develop an unspoken understanding of the most effective process to utilize during interventions. This can be difficult if facility politics and hierarchy interfere. However, if position and rank can be temporarily "suspended" for the brief period in which staff must manage a potentially violent person, all of the staff as well as their clients will benefit.

Why *Nonviolent Crisis Intervention*?

In conclusion it is appropriate to examine the basic philosophy of *Nonviolent Crisis Intervention* and why it works so well in managing aggressive and violent behavior.

The fundamental premise of this system is that behavior escalation does not occur by itself. People don't "act out" in a vacuum. The staff member who intervenes with the potentially violent person must realize that his behavior has a tremendous impact on the individual. In many cases the subsequent escalation or defusion of the client's behavior may depend entirely on how the staff reacts. Crisis intervention is an integrated process. If the staff allows himself to become irrational or unprofessional, he will ultimately find his de-escalation attempts frustrated. Meeting anxiety with anxiety, defensiveness with defensiveness etc., only tends to accelerate the crisis development. In an effort to maximize the chances of calming down the person, it is best to balance or offset the person's behavior with therapeutic responses by staff.

The therapeutic milieu must be maintained continually, even during the most violent moments. Often when an individual becomes physically aggressive it is assumed that the therapeutic process should be abandoned. Quite the contrary. Taking physical control of a person when he has lost complete control of himself is the most therapeutic process possible, if the action by staff is carried out in a non-harmful, nonviolent manner.

In defense of today's human service provider, many do not have the technical skills necessary to manage violent behavior. This lack of skill and training produces normal reactions of fear and self-protection when confronted with violence. If one does not have the necessary skills to manage violence, he naturally reverts to instinctive responses. The challenge of managing violence in today's society can only be met by a commitment from administration to firmly confront the problem with quality training standards.

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POST-TEST

Date ____________

Name ____________ Title ____________
Facility ____________ Phone (   ) ____________
Facility Address ____________
City ____________ State/Prov. ____________ Zip/Postal Code ____________
Country ____________

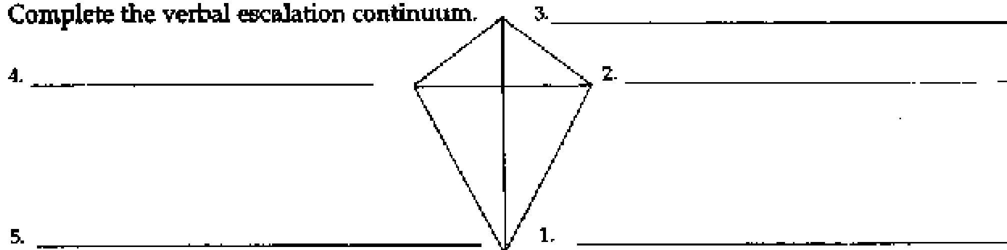
1. Name the two ways that an individual can act out.
   a. b.

2. Complete the following chart:

Crisis Development Behavior Levels	*Staff Attitudes*
a.	a.
b.	b.
c.	c.
d.	d.

3. What is the value of learning the four levels and corresponding staff attitudes?

4. Complete the verbal escalation continuum.



5. Circle the best example of CPI's supportive stance and list three reasons why you should use it.
   (Note: Circle represents personal space = 1 leg length; shaded ovals = feet of acting out person; blank ovals = feet of staff personnel; arrows represent direction individual is facing.)

   a. b. c. d.

   Reasons:
   1.
   2.
   3.

6. List the duties of a team leader.
   a. c.
   b. d.

7. When should you use nonviolent **physical** crisis intervention?

8. What is the purpose of this course?

PARTICIPANT EVALUATION

Date (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Instructor's Initials: ☐☐☐

First Name

Last Name

Did you pay for this program?

☐ Yes ☐ No

If yes, what fee did you pay?

☐☐ , ☐☐☐ . ☐☐

Directions

Please indicate your opinion related to each of the following items by marking an "X" in the box ... with 10 signifying the highest rating and 1 the lowest rating.

1. **How would you rate the program overall?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

2. **To what extent was the program content relevant to your needs?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

3. **The physical techniques in this program were designed to be safe, effective and therapeutic. Did the instructor teach them accordingly?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

4. **Did you find the role plays in the program useful as a teaching tool?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

5. **Did this course give you more confidence to manage aggressive individuals in a safe, therapeutic manner?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

6. **Was the instructor able to apply the course content to a variety of examples?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

7. **Did the instructor stimulate interest in the subject matter?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

8. **Did the instructor create an enjoyable learning atmosphere?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

9. **Was the philosophy of care and welfare, safety and security emphasized throughout every aspect of the program?**

   Highest 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1 ☐ Lowest

Additional comments on the program and /or the instructor:

Thank you for your input. It is both valuable and necessary in maintaining the quality of the program.

NCIEVA 9/00

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