AGGRIP®

Aggression Intervention Program Devoted to Mentally Challenged Individuals

Towards Non-violent and individual oriented Intervention

Manual

Robin Mindell

www.aggrip.net

Acknowledgments

Foremost I want to thank all of the mentally disabled individuals who - with so much heart - have taught me and my research team ways of supporting them better and more sufficiently.

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AGGRIP® Anti-Violence Model: Devoted to Mentally Challenged Individuals

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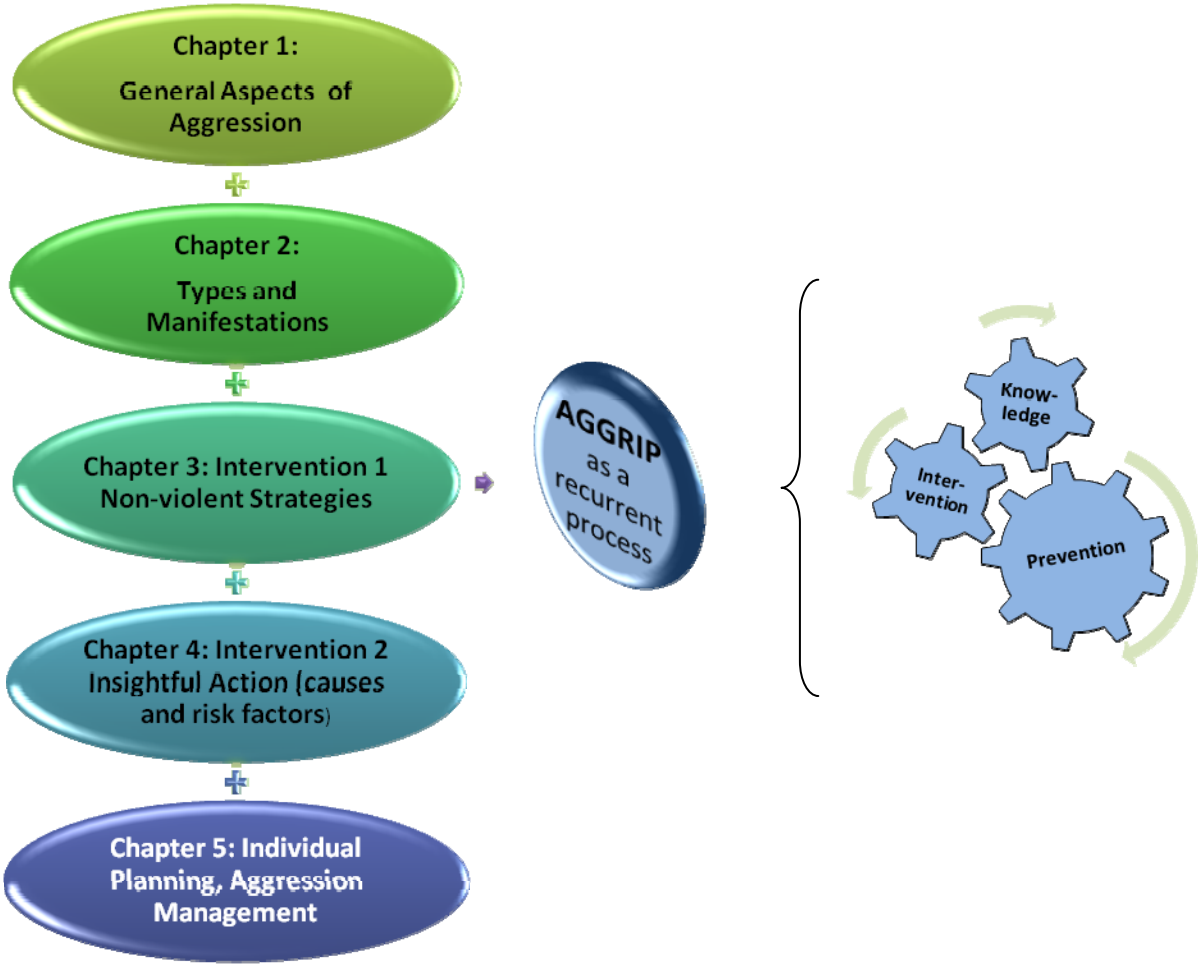
0. Introduction

The present guidebook constitutes the client-centered anti-violence intervention concept AGGRIP®. Its focus is to prevent and manage aggressive behavior, as it occurs in mild to severe mentally disabled human beings in homes and institutions. It contains non-violent systematic measures of intervention for service providers and simultaneously stresses the importance of comprehending residents aggression as a common phenomenon of human nature. Service provider hereby denotes care personnel such as caretakers, nurses, social workers or psychologists.

In consultation with the head of the Division of Services for Persons with Developmental Disabilities in the Ministry of Social Affairs and Services, Dr. Chaia Aminadav, this guidebook aims a) to instruct service providers at specific institutions to use AGGRIP® and b) explain how to use AGIM (AGgression Incident Measurement), an assessment tool for measuring the interventions efficiency.

Please note that the use of AGGRIP® in no way guarantees the absence of violence. It intends only to lead the service provider systematically through more efficient and safer ways of protecting oneself and others during aggressive incidents. Moreover it supports you to think about the resident as a human being and deal with the occurring situations in more creative yet responsible and secure ways. All intervention suggestions portrayed in AGGRIP® are however no warranty for the prevention of violence. Safe situations can be achieved – if at all - only by adequate training and you having full presence of mind, being flexible and responsible in surveillance as well as emotional empathy for all involved persons.

In order to Learn about the application of AGGRIP® as a tool, we will have to learn about five steps that together form the intervention concept. Later we will see that all parts within AGGRIP® are based upon each other and have to be applied like cogwheels …



0.1. Objective of Humanistic Intervention

Particularly with regard to dealing with aggressive behavior of residents there is a tendency to forget, that in all cases the service provider has the obligation to support human beings who generally have reduced capacities in coping with their own behavior. This obligation however can also be seen as a privilege! The long-term objective of any intervention program has to be to enhance competence and skills of service provider and resident. For the most part this involves maintaining and expanding the quality of care for the resident as part of the personnel's responsibility.

✓ Learning Matter: In brief the management of aggression forms a threefold task:

1. The act of intervention has to protect the service provider and create a safe place, i.e. health and security.
2. This "safe place" has to be dedicated to preserving the psychic and physical integrity of the beneficiary (home resident).
3. Both measures must be followed up by understanding the individual and the causing situation thereby preventing and enhancing life quality for both service provider and resident.

✓ Learning Matter: The Goal of successful intervention does not show by the absence of aggression but by…

1. increased competence and decreased fear showing in the caretaker,
2. increased life quality for both caretaker and resident as well as in the
3. decrease of injurious aggressive incidents.

1. General Aspects of Aggression

In order to take on the addressed responsibility, the caretaker has to dedicate heart and mind to the mentally disabled. Ultimately the nature of our theoretical attitude and practical intervention is an essential factor for treating and relating to other human beings. AGGRIP® provides a social psychological approach for intervention and a humanistic fundament for comprehension.

One part of the foundation of humanistic paradigm can be related to the UN human rights declaration. Looking at specific human rights, we can generally conclude that the mentally disabled human being has the right to be treated and respected just as any other human being. With reference to human behavior this mindset acts as a precondition, and obliges us to take an unbiased look at violence and aggression as "complex, yet alterable"[1], difficult human phenomena.

1.1. Common Definition

Aggression as used in common jargon, alludes to behavior whose intent is to harm another. We can differentiate 5 different connotations:

- Offensive intention; aggression as a disposition to behave aggressively,
- Hostile emotion; aggressiveness as a feeling that arouses thoughts of attack,
- Hostile action; aggression as violent action that is hostile and usually unprovoked,
- Animosity; aggression as the act of initiating hostilities and
- Hostile intentions: aggression as deliberate unfriendly behavior.

2. Caretaker's Encounter with Day-to-Day Aggression

„Knowledge ..."

Chapter two deals with types and manifestations of different forms of aggression that we can experience in institutions for individuals with retardation. The isolation of specific forms of aggression is a fundamental necessity prior to intervention and constitutes basic knowledge for service providers.

Later in this chapter we will have a look at the dynamic principles and that explain how an aggressive intention become to be an aggressive act and finally facts and requirements that we need to know for further intervention procedures.

2.1. Aggression Types[2]

- **Type A**: Emotional Aggression (Implosion, Resulting)

This type of aggression focuses on the causes and motivation for aggressive behavior such as frustration, anger, jealousy. The tension is relatively low, the physiological arousal can be controlled, and the consequences of one's behavior stay in the background. Treatment emphasis is prevention. We can find a forerunner, aggression being its result; "What lead to this aggression?"

- **Type B**: Functional Aggression (Direction)

Behavior that is induced to have a specific effect (gratuity, satisfaction, ease etc.). Accompanying emotions only somewhat control behavior; existing tensions are at the edge of being controllable. Treatment emphasis are sanctions and upgrading competence in decision-making. We can ask "what is the aggression directed towards?"

- **Type C**: Eruptive Aggression (Explosion, Self-serving)

During impulsive and continuingly increasing arousal individual self-control is lost and severe aggression is the consequence. Treatment emphasis is de-escalation, since causes and effects cannot sufficiently explain the dynamic. We can observe: "This aggression serves itself!"

2.2. Aggression Manifestations

While the frequency and type of aggression in different individuals can vary day by day, we can find the following most common manifestations. All manifestations can appear by themselves, or in combinations of the Type A (resulting), Type B (directed) and Type C (self-serving).

With respect to the manifestation-types that will be used in AGGRIP® in table 2 we have grouped the most common manifestations without making claim of containing all universally existing appearances in 2 groups with 4 types:

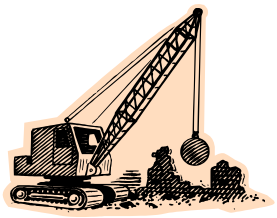
4 types of foreign aggression are differentiated:

1. verbal harm
2. psychic harm to humans
3. harm to objects and
4. physical harm to humans

4 types of auto- aggressive categories …

5. minor harm to subject
6. fair harm to subject,
7. severe harm to subject
8. self- destruction.

Finally a last type …



9. Demolition:
Demolition lies in the upper extremity of Type C “eruptive aggression”; it can neither be called self-, nor auto aggressive, because of its arbitrary expression, and its meaningless cause.

✓ Learning matter: The differentiation of these 8 different manifestations in groups is the first step of AGGRIP®. It will have an effect on your knowledge, on your selection of intervention technique and finally help you to reduce or prevent the occurrence of the next aggressive experience.

Table 1: 9 Categories of Aggressive Manifestations

Manifestation of foreign aggression

Verbal harm	**1**	• Spitting, screaming or cursing at others. • Laughing and insulting verbally, exposing, humiliating, frightening, pressuring and blackmailing.
Psychic harm to humans	**2**	• Provoking caretakers by refusing to cooperate or to fulfill certain requirements, by punching or fingering caretakers at genital areas and incapacitating them of action by extreme intrusiveness. • Pressuring caretakers by refusing the application of medication or food intake.
Harm to objects	**3**	• Throwing food, silverware and dishes at table Screaming or running riot in living quarters or class, demolishing chairs, tables, closets, windows and mirrors, electric equipment, tearing down curtains, decorations, pictures and paper-hangings. • Destroying or clogging toilets, setting rooms under water, ripping off electrical wires. • Ripping apart one's own or others' cloths or bedding or destroying personal items. • In specific situations of avoidance, wetting the bed, defecating, vomiting or smearing of feces.
Physical harm to humans	**4**	• Beating or hitting into the face, kicking, shoving (down the stairs or out of the wheelchair), knocking over or into and agitating. • Biting or scratching into the hand, arm, throat, face, pinching and twisting limbs, cutting others. • Pulling by the hair (to the floor), choking and hindering others to go their way by digging fingers into their clothes, entangling others in nasty fights.

Manifestation of self inflicted aggression

Minor harm to subject	**5**	• All types of compulsive, stereotype or self-stimulating behavior that causes wounds and is directed towards harming oneself.
Fair harm to subject	**6**	• Tear wounds or skin, ripping bunches of hair, hitting the head, face or one's body with hands, fist or other objects. • Reaching into closing doors or falling out of the wheelchairs or bed, or down the stairs.
Severe harm to subject	**7**	• Hitting the head intensively against the floor or objects, biting one's hand and limbs; regular surgical interventions are necessary.
Self destruction	**8**	• Suicide: actions that commonly have fatal consequences.

Meaningless aggressive manifestation

Demolition	**9**	• No specific cause, effect, direction function is visible in this deadly socio- and idiopathic[3] behavior.

2.3. Aggression as a Dynamic Phenomena

2.3.1. Aggression: From Feeling to Acting of Aggressive

Theories of aggression refer to a causal relationship between the *tendency* towards aggression, and the definite *act* of aggression. So "feeling aggressive" can be called A, and "acting aggressive" can be called B.

So the question is, how does

A lead to → B
(feeling aggressive) (aggressive act)

Aggression-as-Instinct

Ethnologists define aggression as being inherent behavior in man which is directed against members of the same species and aims at the struggle for existence: This theory can be compared to a "steam boiler model": Humans hold available a specific amount of aggressive drive energy (A) that releases aggressive behavior (B) according to the intensity of activating stimuli (C).

If only a small amount of instinctive energy is available, intense amounts of stimuli are needed to trigger aggression; if lots of instinctive energy has accumulated, it can release aggression as a spontaneous impulse discharge.

A triggered by C → B
(aggressive energy) (releasing stimuli) → (aggressive act)

→Discuss this theory with examples.

Externally-stimulated Aggression

The second theory of aggression moves from innate predispositions to external stimuli as sources of aggression. The central supposition is that aggression is a predictable reaction to defined stimuli, the defined stimuli being frustration.

C → B
(Frustrative stimuli) → (aggressive act)

→Discuss this theory with examples.

BERKOWITZ[4] modified this theory: Anger induced by frustration, or possibly motivated by expectations of gain, however, is a motivating force that leads to aggression

C leading to D → B
(Frustration) (Anger) → (aggressive act)

→Discuss this theory with examples.

Learning and Imitating Aggression

Finally it should not be forgotten, that aggression can be learned and imitated behavior. Supporters of this school point out both that there are many societies in which aggression is largely absent and that aggressive behavior will be imitated even when there is no frustrating stimulus.

- ✓ Learning Matter: For aggression to manifest in aggressive behavior a dynamic of tension buildup needs to come first. Aggressive incidents barely strike like lightning; aggressive impulses always pursue an individual development of increased emotional and physical tension before they erupt in active aggressive behavior. This fact allows us to observe symptoms and signs of evident, or increasing tension way ahead of the actual incident and is a crucial part of knowledge, when dealing with aggressive individuals (see Chapter 5.1)

Analyzing preceding signs of tension allows us to study natural ways of decreasing tension, or gives us starting points to interfere prior to a severe aggressive outburst. Since these tension curves usually follow individually common modalities, the caretaker has the chance to reorganize the course of development in a positive way.

2.3.2. Facts and Requirements to Know About

There are basic principles[5] which must be understood in order to approach effective intervention of aggression. It is important to understand these dynamic principles in order to achieve the proper state of mind for managing challenging situations.

FACTS about Aggression

Invisible Causes

All human behavior is actively dynamic. Aggression involves logical and illogical elements. Human beings, whether they are mentally disabled or not, behave according to inner and outer factors that are difficult to know in advance and not always visible immediately.

Predicting Aggressive Tension

Fully predicting aggression is impossible. We can however assess the risk of aggression to occur. Assessment and prevention imply understanding and analysis of behavior regarding the building of tension and the invisible components preceding the causes of aggression.

Aggression as communication.

Violence is an ineffective form of communication that becomes unnecessary when a person develops effective and positive methods of communicating.

Becoming a Role model

Be a non aggressive role model for the aggressor: For a change of the residents behavior to be accomplished physically, alternative behavior must first be continuously experienced and habituated to.

Warning Signals

Most aggression is preceded by numerous verbal, nonverbal, and physical warning signs, rising tension and by numerous opportunities for intervention.

Last Refuge

A person becomes violent when he believes there is no alternative for accomplishing his goals.

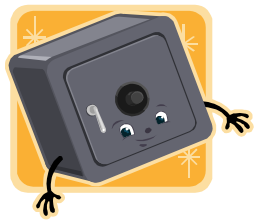
REQUIREMENTS in Dealing with Aggression

Nonviolent solutions
Self control and all actions of staff must be directed to leading the agitated person towards non-violent behavior in the best interest of the resident and oneself.

Preparedness.
Self-confidence and effective action are the consequences of mental, emotional, and physical preparedness and observation.

Self-reflection
Knowing your “crazy buttons”. A crazy button is a triggering event that is capable of getting you emotionally upset. It is essential that you know your crazy buttons and further, that you learn how to desensitize your reactions to those crazy buttons

Psychological dominance:
Intervention involves psychological stability: This stands for responsibilty and competence as well as for empathy and understanding. Dominance during crisis is not to be forceful but firm and yet as flexible as needed in searching for new solutions. Dominance should never imply an attitude of power.



Self control
To be able to control a situation you must first be able to control yourself. The primary behavior patterns that need to be controlled in a crisis situation are breathing, posture, thoughts, emotional reactions, and overt acting.

Promises and commitments
Trust is established by never making promises you cannot keep and by never misleading a person about your motives or the consequences of his behavior.

3. Intervention 1: Non -Violent Intervention Strategies[6]

„Protect and Secure“

Chapter three presents non-violent interventions techniques that are the first steps of intervention and aim at protecting and securing the service provider on the spot.

Previous to any other intervention action the safety of the involved person is paramount. Only safety and protection will give the service provider the safe space to take the second step in intervention

3.1. The Effective Use of Body Language

- ✓ Learning matter: “Protect” denotes your immediate safe-keeping from injury or damage on site. “Secure” labels the capability to avoid being harmed by any risk, danger or threat thereafter. “Protect” can be followed by “secure” within seconds. Practice the techniques. The effective use of body language lies within its value of calming a situation, and de-escalating a difficult setting.

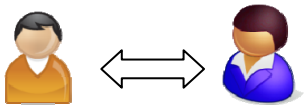
As about 70 per cent of all communication takes place at a non-verbal level, it is important for workers to be aware of the positive use of body language. Body language is a non-verbal form of communication which occurs between individuals. In humans, body language varies.

It is important not to signal 'victim' to the aggressor, as this will increase the feeling of power within her/him. Additionally, there is nothing more infuriating than the person on the receiving end of aggression becoming super-calm or super-cool, and giving off signals that indicate a lack of concern or involvement. The aggressor will perceive this as a challenge and will often become more aggressive to elicit a response.

1. Non-Confrontational Stance

Face-to-face stances will mostly be reacted to as confrontational. Try to stand at a slight angle to the aggressor, without turning away. Holding feet together can be perceived as 'victim' signals. When sitting, try to ensure that the seats are positioned at an angle of about 45 degrees. Alternatively, if the seats are permanently fixed in a directly opposed position, you can turn slightly to sit at an angle in the seat which can help indicate a non-confrontational stance.

2. Positive Use of Space



As already mentioned, the majority of individuals carry with them an imaginary area, which is their defendable space. The average space requirement between you and an aggressor is generally about two arm lengths if standing, and perhaps one-and-a-half arm lengths (at shoulder level) if sitting. Maintaining this distance between yourself and a person who is becoming aggressive can help to reduce the tension, while also providing a safer distance, should a punch be thrown.

3. Avoid Touching

Another general rule that concerns the use of touch: try not to touch the aggressor first, as it is usually instantly reacted to with hostility. In situations where the person is not known, or where the use of touch has not previously been identified and agreed upon as a calming device, the general rule applies.

4. Correct Appearance

What we wear is important. Sometimes our clothes can present an opportunity for an assailant to hurt us. Long dangly earrings through pierced ears may be snatched at and pulled, as may a nose ring; a non-detachable tie, or a necklace without an easy snapping clasp, will give a would-be assailant the opportunity to hold us. Flat shoes are easier to run with. Cotton will rip, allowing us to escape more easily, if grabbed. Replace glass lenses with plastic, as glass may smash, if hit by a fist.

5. Positive Head Movements

Repetitive head nods are reacted to as negative within aggression, as they are interpreted as a signal of not listening, or of wanting to be elsewhere. However, occasional head nods are perceived as active listening within many cultures, especially when reinforced with appropriate verbal comments or affirmations. Be careful of a side head tilt which can be reacted to as a 'victim' signal. While ensuring a non-confrontational position, try to keep your head straight-on to the aggressor.

6. Straight Facial Expression

Do NOT smile in the face of aggression as this will be reacted to as a sarcastic or arrogant grin. In order to stop the smile, take a deeper-than-normal intake of breath immediately upon being faced by aggressive behavior. This will then allow you to retain a committed facial expression.

7. Eye contact

Eye contact is usually important in most cultures and with most individuals. However, the type of eye contact will vary. A general rule, therefore, is: try to establish eye contact without staring. Staring will often be reacted to as a challenge.

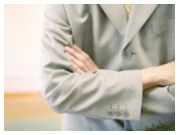
8. Relaxed Posturing

For many of us, a common reaction when facing aggression is to momentarily FREEZE. At these times the instinctive response is also to tense up and clench the fists. These body signals can be perceived as an aggressive response and will often escalate the situation. Slow down your breathing by inhaling and exhaling slightly longer, allowing the torso to relax and allowing you to regain personal control. Breathing more deeply will help to break the freezing process, allowing the muscles to relax. It will give you the opportunity to open the hands, lower the shoulders and regain inner control. Relaxing is one way of signaling non-aggression. But do not become too relaxed.

9. Positive Use of Hand Signals

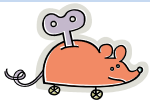
Aggressive acts usually involve a combination of tensing muscles, jabbing fingers or closed fists. The opposite of this, therefore, is to use gentle, free-flowing, open hand movements. Do not point at the aggressor, and avoid sudden, jerky movements. When giving a 'stop' sign, use one hand only, as it is less likely to be misinterpreted

10. Avoid Body Holding or Touching



Often when under verbal attack, we fold our arms, and sometimes either hold our arms tightly on the outside, or hold our body on the inside of the arm-fold. It is often instinctive, and although it may give comfort, arm or body holding can be reacted to as a 'victim' signal, and should be avoided, if possible.

11. Avoid Repetitive Movements

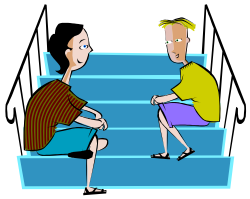


A lot of aggressive behavior is preceded by some form of repetitive body language. Therefore repetitive behavior is likely to be interpreted as a sign of increased tension and should be avoided.

12. Avoid Potential Sexual Signals

In order not to increase the potentiality for aggression, a general rule is: try to avoid sexual signals, especially in those situations where ongoing contact with a service user is involved. Hair touching or playing with hair: Usually a non-conscious act often performed as a means of comfort.
Tongue lip-wetting: At times of anxiety the lips can become dry and may need wetting. Try to do this when the aggressor is looking away or by bringing the lips together. Adjusting genital area: Often an unconscious act.

13. Talk and Explain



Talking empathically and upright to the resident during the build up of tension or in the worst case during the implementation of sanctions can make all the difference. Be sure to always talk and explain kindly even if you have to be assertive and even if the resident is non-verbal. Use your voice and your words to show your intentions and feelings. Even if it seems that you are not being understood; calm talking can restore confidence. Used appropriately it can show a resident that you are dedicated to listening and communicating. Never impose actions on a resident in silence.

3.2. Diffusion Techniques

Objective: Diffusion techniques are verbal and non-verbal methods of communication, designed to manage aggressive behavior while ensuring personal safety.

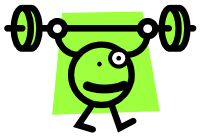
1. Maintaining Self- Control

Maintaining personal control is crucial when faced with aggression, though it is not an easy task. The aggressor may be breathing rapidly and shallowly, his movements are uneven and jerky, his tone hard and his sentences clipped. You, at this stage, can instinctively either become frozen with fear, or react with aggression. To change this instinctive reaction, take one deeper-than-normal intake of breath and gently exhale. This action will allow you to feel more in control, and will also give you enough time to think through, what you are going to say or do next.

2. Sitting Down

In many situations it becomes possible to judge the moment when the aggression is at the point of escalation - that moment occurs, when the behavior is moving from truculence into a more strident form. At this point, sit down and invite the aggressor to sit down with an open hand gesture. Only sit down if you feel confident. It is a demonstrative model which allows the aggressor to perceive de-escalation. The act is a clear signal of non-aggression and a sign of negotiation.

3. Identifying Past Strengths



Many people, who are in a hostile state, are in a state of negativity, and by reminding the person of the time, when they were in a positive state, we can allow them to refocus upon this. This is a technique that also rewards positive aspects, rather than criticizing negative behavior. If we have some prior knowledge of the person, referring to this information, can often help.

4. Appropriate Leaving

Leaving is a valid option and sometimes it is the only recourse available. The way we leave a situation is important, and there are a variety of options dependent upon the circumstances facing you. You can: Back away slowly without showing fear, walk away purposefully, taking any other vulnerable people with you (if possible), state that you are going to leave and do so, be called away by a colleague. Leaving must always be in the best interest of you keeping control over the situation and staying safe at the same time. “Showing weakness” can sometimes bring you into a position of acting more effective for the benefit of all.

5. Distraction

The energy of aggression is often sudden and loud, and is usually accompanied by the emotion of anger. Distraction is the use of similar energy, but without the emotion. Distraction may be a loud noise such as a shout or a scream, or it may be achieved by banging an object. In some instances it may be a vibration, a sudden movement or an instantaneous change of lighting. It is unexpected and shocking and can have the impact of momentarily freezing the aggressor. However, as the impact is short-lived, distraction must be accompanied by some other action(s) either to ensure personal safety or to regain control of the situation.

3.3. Physical Interventions

Physical intervention must be a last resort. Staff has a right to protect themselves and others. The aim for every residential and day-care staff member however must be to create an atmosphere where the use of physical intervention is not required. The use of physical measures to contain or control behavior is a controversial issue and often both dangerous and distressing for all parties. It should only be used in emergency to deal with a one-off situation, or within a strictly monitored individual program plan.

Where it is used, it must allow for maintenance of the resident’s dignity. Furthermore there is a lot of training and experience involved in the use of physical strategies. The following training program can be recommended due to its evidence based results:

PART2000[7] (Professional Assault Response Training). This program is an emergency intervention concept based on teamwork. The described elements are only to be used, when other possibilities that usually manage aggressive behavior fail.

✓ Learning Matter: Institutional resources should make sure, that there are at least two caretakers professionally trained for physical interventions available around the clock.

3.4. Medical Intervention

In any case that medication seems a possible solution, you have to consult the responsible psychiatrist and take into closer consideration all of the advantages and disadvantages. Never approach this issue unreflected and without exact documentation of all incidents.

- The advantage[8] of chemical control is the rapid control of aggressive behavior, which has been raging for some considerable time. Used as short term intervention it can allow different coping mechanisms and a management program such as AGGRIP® to get on track.

- The disadvantages of the use of medication for violent patients in an emergency situation include the possibility of having an inaccurate effect, as well as numerous side-effects of the drugs themselves: for example sudden death, respiratory distress, convulsions, tachycardia and arrhythmias, endocrine disturbances and so on.

✓ Learning Matter: Medication will never change the cause for aggression, but only suppress it. In case of aggressive manifestations of the Type C (see chapter 3.1.) such as idiopathic aggression (see table 2, Type IX) it may be indicated. Medication is used in short-term and longer-term therapeutic approach to the management of aggression

4. Intervention 2: Insightful Action

„Observe and Comprehend“

In chapter four common causes of and coping with foreign and self-inflicted aggression will be discriminated. The awareness of previous circumstances that lead to aggressive behavior is vital for understanding its formation, and thus important in order to anticipate future incidents and how they can be prevented. Typical situative, biographical and environmental causes will be presented.

Automatic Actions

The most natural way for a human being to respond to aggressive behavior is simple: freeze or react. These instinctive ways of reacting need no cause or effect, no reflection and no knowledge; they are universally present and constitute the basic system action – reaction. In the record of anti aggression strategies this basic bonding of action and reaction has lead to the dangerous model of teaching a receiver of aggression to react according to types of aggressive manifestations by defending oneself against the aggressor instead of freezing. This model does not include the fact that aggression in almost every instance communicates a history of elapse.

4.1. Insightful Actions Grow from Experience

Knowing about the causes of aggression enables us to assess the risk for possible aggressive behavior under certain conditions. Knowing about the dynamic and causes is therefore useful for understanding, as well as for appropriate risk assessment and prevention.

On the one hand aggression has a cause to be found in the present or preceding situation, as well as in the biographically influenced characteristics of the individual. On the other hand, aggression leads to a vicious cycle, if it is not prevented by a post-sequence analysis: The service provider needs to be taken care of with a chance to recover and process the experience in a debriefing group. Thereafter reflection needs to follow regarding the non- evident multi- causal factors, such as present condition of aggressor, individual character, biographical situation, pre- and per situational elements, the effectiveness of intervention strategy, recurrent behavior and relapse rate etc.

✓ Learning Matter:

Understanding the causes and dynamic of aggression will be the second step in order to control the situation, evaluate the individual and assess the risk for aggression to occur. It will give you self assurance and enable you to react more safely the next time.

4.2. Situational and Individual Causes as Risk Factors[9]

The following table suggests five groups of widespread causes for aggression. Knowing about the causes can help in two ways: First, these are risk factors that every caretaker should be aware of, when working with mentally disabled residents. Second, knowing about the risk factors is the first step to prevent the next aggressive outburst.

Group 1: Working Conditions, Group 2: Interactional Stimuli, Group 3: Environmental Stimuli,
Group 4: Situational Emotional Factors, Group 5: Biographical Causes.

✓ Learning Matter:

1. You are important and your personal safety is paramount. Aggressive assault is unacceptable, though it may be analyzable. There are a variety of techniques available to manage aggressive behavior.

2. Diffusion techniques and effective body language require both verbal and non-verbal skills. Sometimes nothing works. It is acceptable to leave a situation.

3. Suggested coping strategies linked to the described risk factors cannot be generalized and dogmatically implemented. There is never a guarantee that you can prevent aggression.

4. As a caretaker YOU are the most important link in the chain. Your spirit and knowledge, your inner stability, your willingness to devote your time to these residents and to learn from experience (failing can be part of this) mean top priority in dealing with aggressive behavior.

Table 2: 33 Risk Factors and Coping strategies

		Description of risk factor	Possible coping strategies
Working conditions	1	**LACK OF INFORMATION** It is vital that all relevant information about the resident concerned is made available to the individual staff member: This way a natural "risk assessment" can be completed. Staff fear is often a cause generating aggression, and providing information is one way of helping to reduce that fear.	Inform yourself about the resident as much as possible. It is important how the information is both recorded and provided, so that the worker is able to make use of it. Generalized statements often generate increased powerlessness and therefore more fear. [10]
Working conditions	2	**STAFF OVERSTRAINING** Staff being overburdened by residents can enhance aggressive behavior by residents. Caretakers face more abusive language or offensive behavior than any other professional group.	Even at times of financial constraint, debriefing sessions should not be cut. Staff development time and supervision are needed. The individual worker should not be left to find their resources alone.
Working conditions	3	**EMPLOYEMENT SATISFACTION** Fear, dissatisfaction with workplace condition, lack of time, time pressure and lack of communication within the institution will trouble staff and residents.	Make sure you have satisfactory work relationships with your superior (senior) and management.
Working conditions	4	**UNSTRUCTURED RULES** Daily expectations and rules on residents may aggravate aggression, if too rigid, not habituated or unclear; the same goes for misunderstandings or unpredictable performance requirements.	Create plain daily predictable routines; be prepared to have every member in your team communicate consistently the same contents. Keep to the structure and explain to the resident why it is necessary.
Working conditions	5	**STAFF FLUCTUATION** Too much separation and encounter with changing staff shifts. Not enough time for the resident to accustom emotional to fluctuation in staff members or new staff.	Advise your administration to create reasonable shifts; taking into consideration that high fluctuation will aggravate residents. Be polite and communicate visibly the changing of shifts in front of the resident.

Inter-actional stimuli	6	**CHANGE (OVER-STIMULATION)** Due to the fact that most residents are strictly habituated to specific timeframes, structures and daily rituals, such as social network, spaces, food, staff etc., their stable psychic conditions depends on it too much. The psyche arranges its organization rigidly with the help of these structures. Abruptly change these structures and you will create psychic confusion and frustration. Residents who are being suddenly dislocated or have their daily habits suddenly altered, can fall into a condition of *de-individuation*. They feel a loss of self-esteem, and an unconcern for consequences; they are more likely to respond to aggressive triggers.[11]	Always keep structures and rigid as necessary and as flexible as possible. Do not change resident's common habits without proper briefing and preparation of the staff team. Never impose change without appropriate advanced notice to resident. Take time to communicate change as adequate as possible, verbally and non-verbally. If this is not possible, be flexibly to creative solutions concerning aggressive reactions[12].
Environ-mental physical stimuli	7	**NATURAL PHENOMENA** Phases of the moon and climatic factors (thunderstorms), environmental particles etc.) can aggravate residents.	Take this into special consideration and prepare the use of effective body language.
Environ-mental physical stimuli	8	**SUDDEN MAN-MADE STIMULI** Sudden noise such as caused by construction, airplanes, explosions etc. can aggravate residents.	Prepare and habituate resident to upcoming changes in environment. Role-play and communicate; show your own frustration about these causes.
Environ-mental physical stimuli	9	**LIVING SPACE** Resident will tend to be aggressive more quickly in environments that are enclosed and provide only one exit, …monotone in color or colored in a tone that is either depressing - e.g. grey, brown, etc. - or dazzling vivid, such as white, yellow, orange, etc. …have poor or no exterior light, extreme interior lighting (strip) or dim lighting, are uncared for dirt, noise or smell.	Improve institutional inventory; create projects with residents involved in decision making. Make sure that once a day residents get to spend time in a place of their personal choice and personal comfort; Help them to find a place of their choice that feels soothing. Create differently stimulating environments that are under- and over-stimulating in color and physical stimuli.
Environ-mental physical stimuli	10	**SAFE SPACE** Staff invades the natural "territory" of resident. Resident cannot experience a "safe space": The majority of us need defendable space: The invasion of personal space is known to raise anger levels. The average space required between you and an aggressor should be approximately two arms' length. This amount of space is generally considered enough to allow you and the aggressor to feel less on edge, and it will give you enough opportunity to avoid a fist.	If sitting, the safe space can be relaxed to about one-and-a-half arms' length at head level, once again taking into account non-confrontational positioning. Do not touch the aggressive person first. Even though your need may be to comfort, contain or control, that is your need. Make sure, that important and frequently used institutional pathways are wide enough to ensure safe spaces for all.

Situational emotional factors	11	**SAVING FACE** In situations of shame, humiliation and defeat resident tries to "save face": Violence can occur in an attempt to "save face". Staff concentrating on the negative aspects of the resident, stressing these on every occasion, intimidating, laughing or not treating them as individuals can be aggravating.	Actively support the finding of constructive channels to "save face" for the resident. Never stress residents' negative characteristics in order not to humiliate them.
Situational emotional factors	12	**EXPERIENCED INJUSTICE** Staff acts unjust towards resident due to aggression of another resident.	Be aware of your state of mind and do not generalize your own frustration.
Situational emotional factors	13	**EXPERIENCED RUDENESS** Staff attitude of rudeness enhances aggressive respond by resident. There are a variety of ways of being rude. The way we communicate is important and if we are perceived as arrogant, superior or patronizing the potential for aggression is greatly enhanced.	Don't ignore the resident and talk to your colleague, while attending to him. On a bad day, be aware of your emotional state and try not to be abrupt, offhand or rude.
Situational emotional factors	14	**UNPREPARED WAITING** Insufficient staff communication and preparation can keep residents waiting. In social care we often need to keep people waiting whether it is waiting for transport, to have breakfast, to be helped out of bed or a chair, and so on.	Communicate directly and openly about waiting; keep promises. This way you can reduce frustration. If we have to keep people waiting, it becomes important to have a way to help manage some of the fear generated: Prepare distraction.
Situational emotional factors	15	**INCONSISTENCY** Staff not doing what they say, they will do: Broken promises can be devastating, especially within situations where the person on the receiving end has a low self-image, feels inferior, or by circumstance is forced to rely upon others.	Only promise what you can keep, try to act as consistent as possible. If this is not possible be polite and apologize openly. This way you can reduce frustration.
Situational emotional factors	16	**MUTUAL RESPECT** Experienced staff dignity is as important as the resident's dignity. It is important that staff feels respected as professional human beings with limits; nobody needs to be "superhuman". Insulted staff will tend to aggravate residents.	Monitor your feelings during work and make sure you feel that you are being treated well by residents. Always treat them as respectful as you wish to be treated.
Situational emotional factors	17	**TENSION** Natural physical and emotional tension prior to special holidays and celebrations increases the risk of aggressive behavior.	Staff can only to be aware of this fact and be prepared especially before holidays and festivities.
Situational emotional factors	18	**PHYSICAL COMPLAINTS** Suffering side effects of medication, pain, lack of sleep etc. increase the risk of aggressive behavior.	Take this into consideration when incomprehensible aggression arises. One superfluous visit to the doctor does not hurt anyone but can show care and consideration.

Bio-graphical causes	19	**ATTENTION SEEKING** A resident might be looking for ways to seek attention. If the result is frustrating because staff is occupied with tasks, the resident might modify his behavior and try out (auto) aggressive behavior, because this will seek attention effectively. Take into consideration that certain residents might find it humorously to be aggressive.	Make sure there are enough activities and specifically stimulating environments such as workplaces for handcraft, music, art, singing, sports, movement and recreation. Help resident to get attention, i.e. to act out and show humor in autonomous and constructive ways, such as theaters, role play, etc. …
Bio-graphical causes	20	**SENSORY DEPRIVATON** Sensory and higher cerebral capacities are of different physical nature. It is possible that full sensory capacities coexist with the reduction of intellectual capacities (skills). Outcome is that some residents don't have the skills to search for environments that can stimulate their natural need for sensory experience and become deprived. Auto aggressive behavior will commonly follow.	Don't resent the resident for this behavior, since it is a secondary problem in sequence to the mental disability. Make sure there are enough activities and specifically stimulating environments such as workplaces for handcraft, music, art, singing, sports, movement, recreation and trained staff to teach skills.
Bio-graphical causes	21	**TRAUMA** Psychic injury through traumatic experiences will always increase the risk of aggressive behavior. The traumatized residents will interiorize the experienced aggression and can unpredictably act it out. (Also see "ABUSE" as a type of traumatic experience)	Be aware of case history and study it carefully: Trauma leads to splits and disruptions in the personality. The resident thereby will more easily act instable, unpredictable and seemingly aggressive seemingly out of the blue.
Bio-graphical causes	22	**ABUSE** The experiences of physical, sexual and emotional abuse are much more widely spread among human beings with mental disability, than in the rest of the population. Different authors estimate the prevalence of abuse of women at 60 %[13].	Be aware of resident's case history and study it possibly together with a psychologist. A form of cautious physical therapy or psychotherapy might be indicated.
Bio-graphical causes	23	**DISPOSITION** If a person has a tendency towards aggression, then it can be said that they are likely to have developed this trait over a long period of time, probably from childhood.	Be aware of resident's case history and study it possibly before your first encounter. Never approach resident alone.
Bio-graphical causes	24	**IMPULSIVITY** Childhood tendencies towards impulsivity, hyperactivity, over-emotionality and independence are antecedents of aggression.	Be aware of resident's case history and study it possibly before your first encounter. Never approach resident alone.
Bio-graphical causes	25	**PARENTING FACTORS** Parental deviance, marital conflict, indifference from parents, reduced supervision by parents, and parents who are impulsive, violent, harsh, punitive and erratic, are contributing factors to violence.	Be aware of resident's case history and study it possibly before your first encounter. Address the issue with empathy.

Bio-graphical causes	26	**MISTRUST** Lack of the ability to trust enhances aggressive outbursts: Mistrust emerges from the inability to feel (evidenced in acting-out in place of processing feelings); lacking of empathy; lack in learning skills.	Be aware of resident's case history. Build up trust by acting consistently and emphatic. Help to act out simple feelings, teach socially accepted reactions by showing them openly.
Bio-graphical causes	27	**ANGER AND FRUSTRATION** Anger over a period of years can become a trait of the personality. Mentally disabled residents just like all other humans have basic emotional needs that do not always find good ways of satisfaction. Long term deprivation of need-satisfaction can easily create anger and fury.	Be aware of resident's case history. Never approach resident alone. In some cases search for ways of understanding the resident's basic needs and look for constructive ways, skills and projects to teach the resident how to satisfy these needs.
Bio-graphical causes	28	**SELF-ESTEEM** Differences in self-esteem are seen as antecedent of aggression.	Avoid situations of humiliation.
Bio-graphical causes	29	**SOCIAL SKILLS** The level of social skills is seen as antecedent of aggression.	Be aware of resident's case history. Build up skills in group activities and art therapy.
Bio-graphical causes	30	**INTELLECT** Social cognitive disabilities influence the resident's capacity to process information from their world around and can lead to impatience.	Be aware of resident's case history. Exercise patience with yourself and resident; show openly how difficult this is.
Biogra-phical causes	31	**POWER ATTITUDE** It is possible, that aggressive residents fundamentally experienced human relations as revolving around the exercise of power.	Be aware of resident's case history and try not to repeat unnecessary exercise of power. Never approach resident alone.
Bio-graphical causes	32	**EXCESS OF SELF-CONTROL** Over- controlled aggressive individuals have strong inhibitions, and aggress only when the arousal of anger is sufficiently intense. They are therefore expected to attack others rarely, but with extreme intensity, if they do so. (see Cold Emotion)	Be aware of resident's case history and always evaluate excess or lack of control in residents. Never approach resident alone.
Bio-graphical causes	33	**NATURAL MANIPULATION** Certain residents may use aggressive behavior to achieve effects and products that may not be attained otherwise. Knowing that aggressing will lead to specific consequences such as medication, punishment, isolation etc. the resident may be manipulatively act out aggression only to achieve the hidden goal. These goals imply more gratification than the possible.	Try to look for and expose possible effects of aggressive behavior by closely observing reactions of relief and feelings of gratification. Rechanneling: Help the resident to find alternative ways of asking and approaching these goals without aggressive behavior.

Keep in mind: There are many techniques to manage aggression. But one important factor cannot be overlooked, - there are some behaviors that are unmanageable and no matter how skilled, knowledgeable or experienced you are, SOMETIMES NOTHING WORKS. In situations where nothing works, it is important to leave. You will have to also consider this option and the conflict that may occur with the need to ensure your personal safety and the difficulty of achieving it, when at the same time by leaving a situation other service users may be placed at risk.

✓ Learning Matter: Always take into consideration the level of tension, i.e. aggression Type A, Type B or Type C (see chapter 2):

- **Type A aggression** in almost all cases can be approached by non-violent techniques and de-escalated.
- **Type B aggression** can be approached non-violently accompanied by safety measures (such as at least two caretakers on site).
- **Type C aggression** sometimes cannot be approached at all. Try de-escalation techniques only for your safety or give resident a timeout to calm down before intervention. For more Information see Chapter 4.4. Caretaker Endangerment Assessment Scale (**CEAS**)

4.3. Cause for Self-Inflicted Violence (Auto-Aggression)

Causes for self harm[14] are foremost a psychopathological subject matter. They will therefore only be shortly outlined in this manuscript. All forms of treating or intervening in severe cases of self-injury should be conferred about with a clinical psychologist or psychiatrist.

✓ Learning Matter: There are main motives for self injuries and by understanding the motive you can sometimes help to achieve to fulfill the motivation with an alternative, nonviolent mode of behavior.

- Self-Distraction: Commonly there are thought to be two main motives for self-injuries: “attention seeking” and “anger”. Self-injuries however allow the affected person to dissociate while separating the mind from feelings that are causing pain. Physical pain therefore acts as a distraction from emotional pain.

- Self-Punishment: Another possible source of self-injury can be self-disgust, often as a means of punishment for having strong feelings that were expected to be suppressed in childhood abuse, and the feeling that the abuse was deserved.

- Under- stimulation: Self-injury can also compensate under-stimulation, or the feeling of emptiness, even if the sensation is unpleasant and painful. Those who self-injure describe physical pain as being a relief from these feelings.

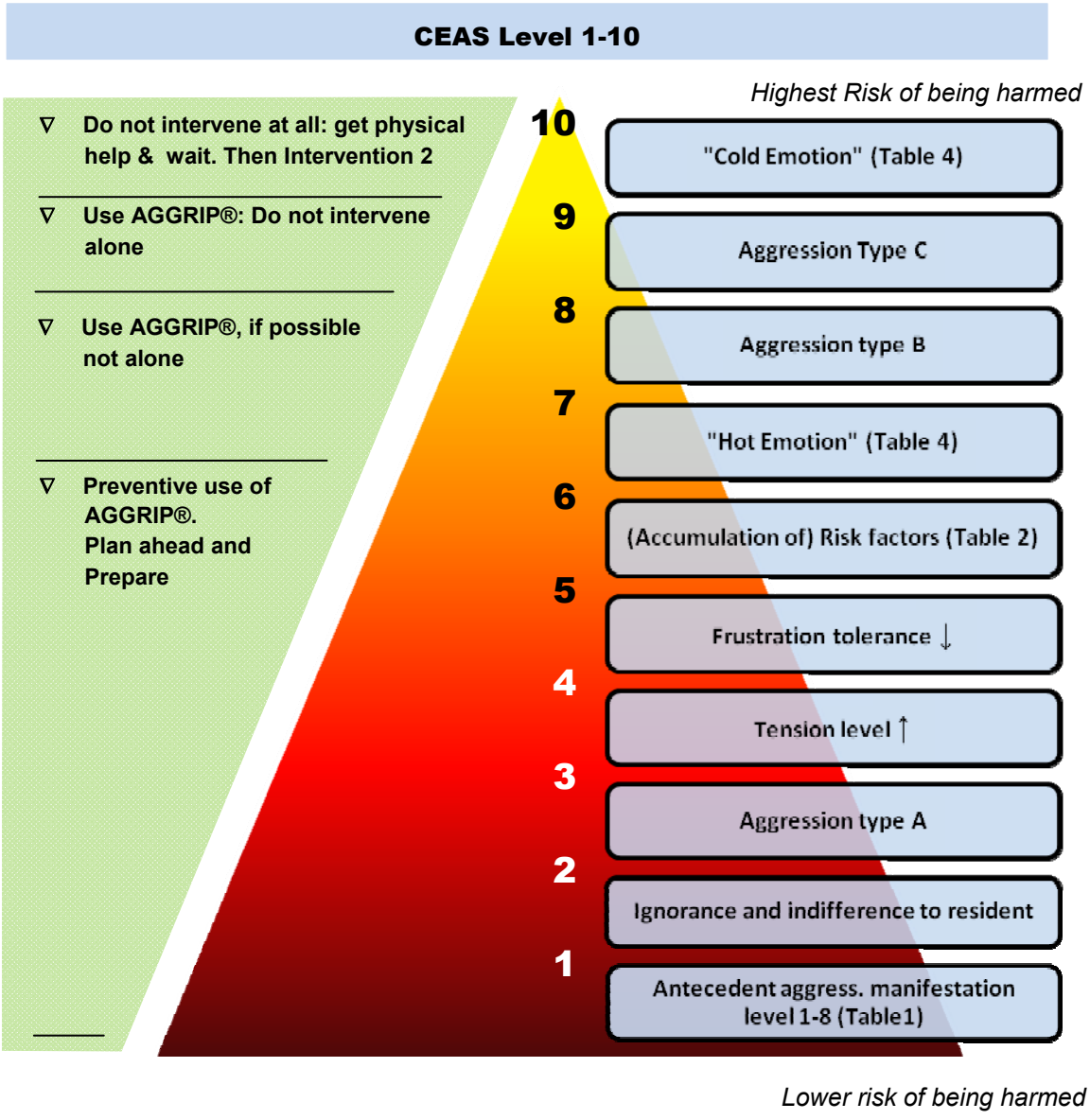
- Reduction of pain: It can just as well serve the holding off feelings, emotional pain and mental agitation. A way to deal with unwanted feelings of sexuality, or as a means of punishing sexual organs, that may be perceived as having responded in contravention to the person's wellbeing. (Responding to childhood sexual abuse the sexual organs may be deliberately hurt)

- Relief: It is actually medically possible that self-injurers feel very little or no pain, while self-harming. For some self-injurers the post-relief is primarily psychological, whilst for others this feeling of relief comes from the beta endorphins released in the brain. These act to reduce tension and emotional distress and may lead to a feeling of calm. Self-injury can be an addictive coping mechanism, because it works fast; it enables him/her to deal with intense stress in the current moment.

4.4. Caretaker Endangerment Assessment Scale (CEAS)

The following diagram shows the risk for caretakers of being harmed in levels 1-10 during intervention.

- On the right there are the 10 main factors (BLUE), on the left there are hints for coping (GREEN).
- In all cases the CEAS has to be considered in decision-making such as choosing possibilities to manage aggression. Even at level 1 you are at risk of being harmed!
- If multiple levels are evident then the ad at least one level to the higher of the two Never forget:



Examples:

1. If a resident is at high tension level (4) and accumulated risk factors are evident (6), you can add one level to the higher **CEAS = 7**
2. I If a resident is at low frustration level (5) and Aggression Type B is evident (8), you can add one level to the higher **CEAS = 9**

5. Aggression Prevention: Individual Intervention Planning

„Learning from Experience is Prevention …“

The Individual in the Center: Chapter five focuses on the final step of AGGRIP®, namely the individual team intervention planning and management of future aggressive incidents. Aggression management implies summarizing all the information collected and learning from experience with the team of caretakers. In the view of warning signals, the situational and environment factors, it has to be evident, that the management aiming at preventing further aggression has to be individually adapted. This goes generally for crisis intervention with mentally disabled human beings[15].

5.1. Warning Signals: How to Observe Aggression

We have seen how to non-violently de-escalate aggressive tension and protect ourselves from being aggressive in the face of violence. The most dangerous thing that can happen during aggressive incidents is becoming aggressive ourselves: This enhances the escalation and puts ourselves and the resident at risk of fair to severe harm.

The precondition for prevention however starts with knowing about the “face of aggression”, the warning signals in our counterpart. We need to summarize what we know and expand our knowledge. How can we observe aggressive tension in residents?

Table 3: Warning Signals

Body posture	• Muscles are tense and rigid. • The upper body is positioned closer to us than the legs, head towards the front. • Body is in “confrontative” stance directly aiming at you at 180°. • The physical surface tends to be expanded (not contracted).
Head and Face	• Forehead is positioned closer to you or lower head (jaw) is clearly extended towards you. • Head position is in an angle (towards shoulders). • Eyebrows are raised (frowning) and slightly compressed; edges are lifted. • Eyes are confronting you either widely spread or twitched together (pupils must be directed towards you). • muscles beneath eyes are tense thereby opening nostrils. • Lips are pressed together, widely spread to left and right (teeth are showing) or contracted to a round mouth with lips tilted to the front. • Teeth are compressed behind closed or open lips (jaw muscles are visible).
Arms and Shoulders	• Arm(s) is moving up and back or arms are being folded with the elbows directed towards you. • Muscles in lower and upper arm are tense. • Shoulders are tilted towards the front and lifted towards the head. • Arm is fully directed towards you with fist or half-closed cramped hands. • Hands are tense, cramping, like a fist or tensely open in a “ready to choke” position. Hands are tensely holding the head or pulling hair. Person might also be pulling on their own clothes with a fist..

5.2. General rules and Examples to allocate warning signals

Table 4: General Observation Rules

Exceptions	Many mentally challenged individuals have their fully personal characteristics for showing aggression: These can never be generalized but only noted as to fit that particular resident.
Hot Emotion	The more open aggressive tension shows, the better; what is visible can be dealt with and studied. Prevention will be possible.
Cold Emotion	The colder the aggression is, the more dangerous it becomes, because unpredictable. (Mad and idiopathic aggression can be lethal without a fair warning).
Defense	There are defensive passive aggressive positions (approximately type A and B): You can protect yourself. Depending on tension and muscle power of resident this can be dealt with by AGGRIP® on site, i.e. non-violent intervention, and de-escalated.
Offense	There are offensive active aggressive positions (type C): You can usually protect yourself by non-violent techniques (or by leaving) but usually have to get help and wait before intervention for tension to build down. This type has to be carefully studied and planned in advance what to do. AGGRIP® comes into use as a subsequent tool and will help the next time round to prevent the situation.

- Exercise: Learn the warning signals and observation rules, add your own experience and allocate different signs within the 23 photos attached. Try to approximate tension level; look for warning signals and aggression types; assess risk of being harmed, suggest non-violent protection and speculate about the causing motives for the aggressor's behavior.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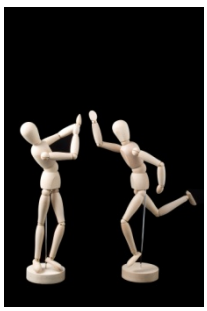
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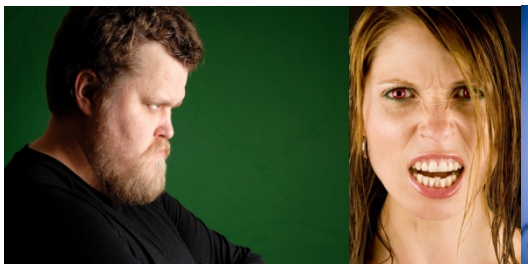
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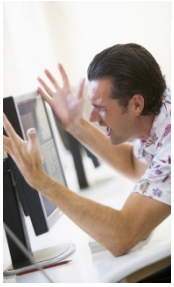
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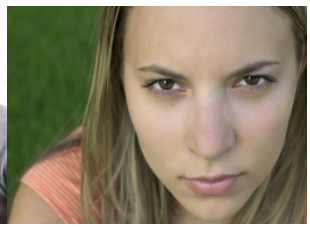
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Your own notes:

5.3. Management Worksheet: Teamwork and Organization

The 5 procedure modules in Table 5 (attached "Management Worksheet") make up the AGGRIP® individual intervention planning[16]. One worksheet constitutes one cycle of multidisciplinary team work. In reviewing violence and aggressive episodes, the team of caretaker needs to stay objective during the analysis of the facts.

✓ Learning Matter: One full cycle of 5 modules should always be answered on the "Management Worksheet" in writing. The answers constitute the preventive value of AGGRIP® and are the foundation of effective aggression management!

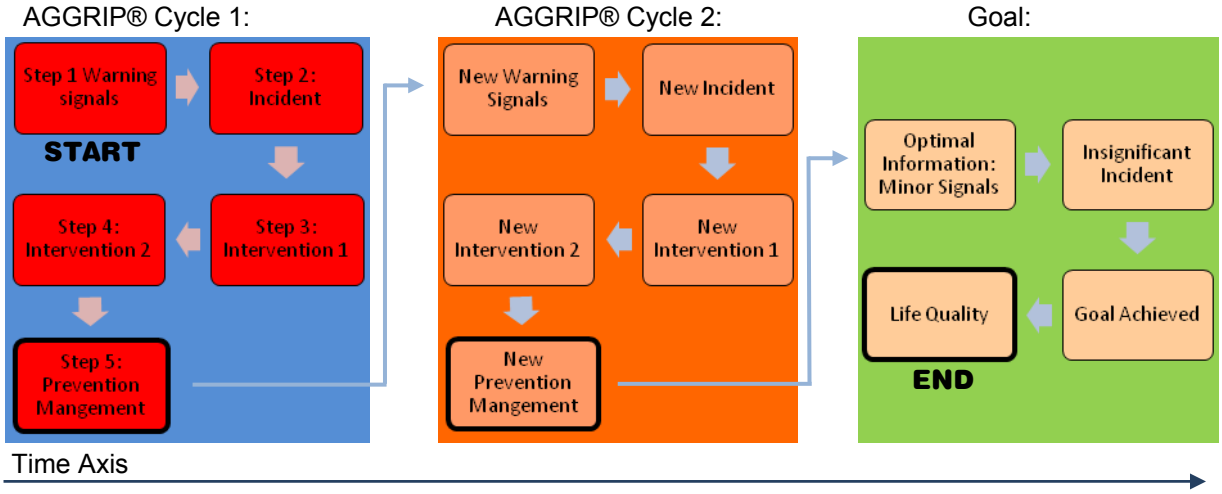
Each person should explore his own role in contributing to the outbreak of violence and reflect upon whether any action, or inaction on their part, contributed to the present violent incident.

For the effective use of the worksheet please read the "worksheet introduction" carefully.

6. AGGRIP® Procedure: Continuous Cycles

The chart below spotlights the recurrent AGGRIP® procedure as a flow process. It shows how a team of caretakers step by step can analyse and implement the modules mentioned in chapter 5.3. in a concrete situation of recent aggressive behavior. It is a precondition that all chapters of this manual have to have been read, spoken about and practiced in instructed caretaker training groups.

In the graphic below at the bottom is a time axis showing the sequence of procedure steps from **START** to **END**: Starting in the first Cycle, the first "Warning Signals" to the first "Aggressive Incident" and its preceding conditions. What follow are "Intervention 1" (protect and secure) and "Intervention 2" (insightful action). Then the "Prevention Management" of aggression follows. This subsequently leads to a new situation and new environmental conditions to go through the next Cycle 2 until we achieve the defined goal.



Since one cycle (blue shaded area) of intervention and prevention will never change the environmental conditions sufficiently, this intervention-management-situation cycle has to be continuously repeated (indicated by orange cycles in the orange shaded area). Each time around the caretaker team can achieve more optimal information and personal competence. The objective of an optimal goal is signified by the caretakers' reduction of feeling threatened and helpless in the light of aggressive behavior.

6.1. Preventive Use of AGGRIP®:

How to plan a better way to deal with aggression that has already been occurring for a while…

Table 5	A team of caretakers get together and take "Management Worksheet" table 5:
Module 1-3:	The team starts by collecting general information about the past aggressive incident(s) according to "Management Worksheet" Make exact notes.
Module 4: Insight	Perceive and comprehend the causal chain of risk factors and aggressive manifestation. Understand cause and effect; what and why it was happening by combining biography and environmental information.
Module 5: Prevention Management	Assemble comprehensive management plan combing **CEAS**, techniques and environmental as well as relational adaptation. Talk about the elements and the redesigning of environments, needed to prevent the problem behavior by promoting naturally adaptive behavior.
Repeat	After your first "Management Worksheet" (note on it "cycle 1") the intervention and management will lead to a new situation and new environmental conditions for the next time. The aggressive manifestation of the resident however may still persist. Therefore analyze the situation over again as soon as possible with a new AGGRIP cycle. Take a next "Management Worksheet" (note on it "cycle 2") and repeat the procedure above until the goal of humanistic intervention (see chapter 0.1) is achieved. In chronic and persistent cases of aggressive behavior and self-injurious behavior form an intervention taskforce (including specialists in social work, psychology, psychiatry etc.) and plan as many recurrent management cycles as needed.

6.2. Post-Incident Use of AGGRIP®:

How to take care of a recently affected caretaker and form a team that thinks about the particular incident in order to find better ways to deal with the aggression the next time…

Debriefing	Take care emotionally and physically of the personnel involved in the aggressive attack by debriefing the person and team. Make them talk freely about their experience and feelings of helplessness, fear, terror, anxiety or pain. Insist and communicate verbally and in a structured way, trying that everything possible will be undertaken to prevent such an accident from happening the same way again. Be honest: Add, that there is no 100% guarantee to eliminate the behavior. Be sure to avoid verbal silence about the incident and the social withdrawal of the caretaker within the team. Consider involving a clinical psychologist or psychiatrist.
Documenting	Document all involved data, expand the record of the resident with data and inform institutional management about the incident.
Table 5	Create a team of involved caretakers (including the affected caretaker) and take the "Management Worksheet" table 5.
Module 1-2:	The team starts by collecting general information about the recent aggressive incident(s) according to "Management Worksheet". All points of view have to be taken into consideration. Make exact notes.
Module 3: Protect and Secure	Suggest possible techniques to protect and secure the affected caretaker for the next incident. Practice these techniques with the caretaker intensely according to risk assessment and **CEAS**. For the next two weeks do not let the affected caretaker approach the resident alone. Medication: If resident is in a chronically continuing state of high arousal or self- harming tension (high **CEAS**), contact a psychiatrist and consider short or midterm application of correct medication. Document this exactly and make sure that the use of medication, as well as the dose is being monitored by the doctor regularly. If possible, discontinue with medication as soon as indicated.
Module 4: Insight	Perceive and comprehend the causal chain of risk factors and aggressive manifestation. Understand cause and effect; what and why it was happening by combining biography and environmental information.

Module 5: Prevention Management	Assemble a comprehensive management plan combing CEAS, techniques and environmental as well as relational adaptation. Talk about the elements and the redesigning of environments, needed to prevent the problem behavior by promoting naturally adaptive behavior.
Repeat	The first cycle of intervention and management will lead to a new situation and new environmental conditions. The aggressive manifestation of the resident however may still persist. Therefore analyze the situation over again as soon as possible in a second cycle until the goal of humanistic intervention (see chapter 0.1) is achieved.

7. Measuring Efficiency: AGIM

AGIM is an assessment tool for measuring AGGRIP® intervention efficiency. Every institution using AGGRIP® should enter the information on **www.aggrip.net** into AGIM to ensure optimal effectiveness and feedback. Your Feedback is most important!

8. Bibliography

For the complete bibliography and further reading visit **www.aggrip.net.**

9. Attachments

On the next two pages you can find the following attachment:

Management Worksheet Table 5 with introduction

ENDNOTES

[1] Heinrich, J. (2007), p. 35.

[2] Heinrich (2007).

[3] *Idiopathic* is an adjective used primarily in medicine meaning arising spontaneously or from an obscure or unknown cause.

[4] Berkowitz (1980), pp.116-136.

[5] Compiled in reference to AGGRIP pilot survey (2007) (see chapter 1), Gorski & Miller (1981).

[6] Compiled in reference to AGGRIP pilot survey (2007) (see chapter 1), Braithwaite (2001), Gorski & Miller (1981) and Nolting (2007).

[7] Papenberg & Smiar (2004).

[8] Compiled in reference to Mason & Chandley (1999).

[9] Compiled in reference to AGGRIP pilot survey (2007) (see chapter original AGGRIP Manuscript), Braithwaite (2001), Mason & Chandley (1999), Heinrich (2007) and Mühl (2001).

[10] Example, statements like 'He can be violent' or 'She has violent outbursts' do little other than promote fear.

[11] For example, if one day the dining room location changes at lunchtime, 10 % of all residents can possibly become aggressive towards staff.

[12] Example 1: Do not have residents only consume food in one room for years at time. If they ever have to adapt to another room they will be furious. Try to establish rhythmical changes and involve the resident's autonomy to co-decide on simple topics.

Example 2: In individual cases be prepared to bring food to the resident or take more time to accompany him to the new location. Don't approach the resident alone

[13] Zemp et al. (1998).

[14] Also see Strong (2000).

[15] Wüllenweber (2001).

[16] Compare T.r.i.a.s. by Heinrich (2007b).

AGGRIP® Table 5: Management Worksheet

www.aggrip.net

Institution:	Date:	Resident:
Affected Caretaker(s):	Recorder:	AGGRIP® Cycle Nr.:

1	**Define the Incident**	Observe precisely and agree in the team on a definition of the aggress. type, manifestation and incident. → Table 1	
2a	**Warning Signals**	What warning signals gave an advanced warning concerning the arousal of tension? →(Chapter 5.1)	
2b	**CEAS**	How high is the **CEAS**? (1-9)	

3a. Non-Violent Intervention 1

- ☐ 1. Non-Confrontat. Stance
- ☐ 2. Positive Use of Space
- ☐ 3. Avoid Touching
- ☐ 4. Correct Appearance
- ☐ 5. Positive Head Movements
- ☐ 6. Straight Facial Expression
- ☐ 7. Eye contact
- ☐ 8. Relaxed Posturing
- ☐ 9. Positive use of Hand Signals
- ☐ 10. Avoid Body Holding
- ☐ 11. Avoid Repetitive Movement
- ☐ 12. Avoid Sexual Signals
- ☐ 13. Talk and Explain

Other Techniques:

3b. Diffusion Techniques

- ☐ 1. Maintaining Self- Control
- ☐ 2. Sitting Down
- ☐ 3. Identifying Past Strengths
- ☐ 4. Leaving
- ☐ 5. Distraction

4. Intervention 2: Insight

- ☐ 1. Lack of information
- ☐ 2. Staff overstraining
- ☐ 3. Work satisfaction
- ☐ 4. Unstructured rules
- ☐ 5. Staff fluctuation
- ☐ 6. Change
- ☐ 7. Natural phenomena
- ☐ 8. Man-made stimuli
- ☐ 9. Living space
- ☐ 10. Safe space
- ☐ 11. Saving face
- ☐ 12. Injustice
- ☐ 13. Rudeness
- ☐ 14. Unprepared waiting
- ☐ 15. Inconsistency
- ☐ 16. Mutual respect
- ☐ 17. Tension
- ☐ 19. Attention seeking
- ☐ 20. Sensory deprivation
- ☐ 21. Trauma
- ☐ 22. Abuse
- ☐ 23. Disposition
- ☐ 24. Impulsivity
- ☐ 25. Parenting factors
- ☐ 26. Mistrust
- ☐ 27. Anger / frustration
- ☐ 28. Self-esteem
- ☐ 29. Social skills
- ☐ 30. Intellect
- ☐ 31. Power attitude
- ☐ 32. Over self-controlled
- ☐ 33. Manipulation

Other causes:

5a	**Prevention Manage-ment**	What are the positive resources of the aggressor that we can build upon?	
5b	**Institutional framework**	What is needed from colleagues and institution management, in order to reduce the incidence frequency and aggression?	
5c	**Security and safety planning**	What type of organizational, technical and relational measures can be taken in a humane way?	
5d	**Reducing the burden**	What do caretaker and colleagues need after the aggressive conflict to regain their strength?	
5e	**Sanctions**	What type of sanctions will have a positive effect on fostering a constructive development?	
5f	**Summary and Decision**	Summary: (Create a new situation) What can we change, how do we adapt our behavior, our relationship to resident and the environment in order to modify and prepare for the next time round? → SAVE THE DATE for the next meeting!	

Who fills in AGIM Questionaire (www.aggrip.net)

Next Meeting: