AGGRIP®

Aggression Intervention Program
Menschen mit geistiger Behinderung gewidmet

Auf dem Weg zu gewaltfreier und Individuum zentrierter Intervention

www.aggrip.net

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Für den **Schweizer Heilpädagogik-Kongress 2011**
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Ein Projekt der Spielzeit Psychotherapie Zürich, www.spielzeit.ch

Merkmale des AGGRIP ® Interventionsprograms

- **Für Wen wurde das Program Entwickelt?**

  AGGRIP ist für die Betreuerin eine Anleitung für den Umgang mit Aggression vor Ort, in der Situation, während der Situation …

  und besonders eine systematische Auswertungsanleitung für nach dem Vorfall; in diesem Sinne also post-hoc Prävention.

- **Ein Farbiges Manual zum Teamwork**

  Der Fokus des Programs liegt ganz in der einfachen und sicheren Anwendung vor Ort in einer Institution oder Werkstätte.

- **Gedankengut; Verhaltenstheorie oder Tiefenpsychologie?**

  Die Anwender müssen selbst und dynamisch überlegen, die (den) Betroffenen und die Situation Verstehen lernen, danach mit Kreativität und Engagement handeln.

  → Aggressives Verhalten will verstanden werden.

- **Spezialitäten: Individuelle Lösungen im Vordergrund**

  …wo das Verstehen unsichtbarerer Dynamik menschlichen Handelns im Spiel ist, kommt niemals dasselbe Endprodukt zum Vorschein.

  → Jede Interventionsmassnahme bietet zum Schluss eine auf das einmalige aggressive Individuum und seine Betreuer massgeschneiderte Lösung.

Was AGGRIP® für Vorgaben hat:

- **Zielgruppe** sind Betreuer in Institutionen und Werkstätten für Menschen mit geistiger Behinderung.

- **Gewaltfreiheit**: Aggressives Verhalten verschiedenen Schweregrads soll nebst anderen Methoden gewaltfrei, individuell und menschlich angegangen werden; es soll nicht eliminiert werden!

- **Gleichberechtigung**: Die Interventionsmassnahme muss der Würde der Betreuerin ebenso wie der Würde des Menschens mit Behinderung gerecht werden.

- **Ebenbürtigkeit**: Die Sicherheit und der Schutz der Betreuerin muss ebenso gewährleistet werden wie derjenige des aggressiven Menschen und seiner Mitbewohner.

- Das Interventionsprogramm will alle Beteiligten zu **persönlichem Engagement** auffordern: Zu Verstehen und Verständnis ebenso wie zu Mitgefühl und professionellem Handeln.

- **Empowerment**: Das Erarbeiten einer möglichst angemessene Reaktion in gefährlichen Situationen soll allen Betreuerinnen Möglichkeit und Pflicht sein.

- Die **Wirksamkeit** der Anwendung soll empirisch überprüfbar sein. (Siehe hierzu den AGIM Erhebungsfragebogen): „Aggression Incident Measurement“ auf www.aggrip.net)

Von der Einzelpsychotherapie zum Interventionsprogram

Spielzeit Psychotherapie Zürich:
Workshop 2007 am Ministry of
Social Welfare Israel

Psychotherapy with Mentally Challenged Children and Adolescents

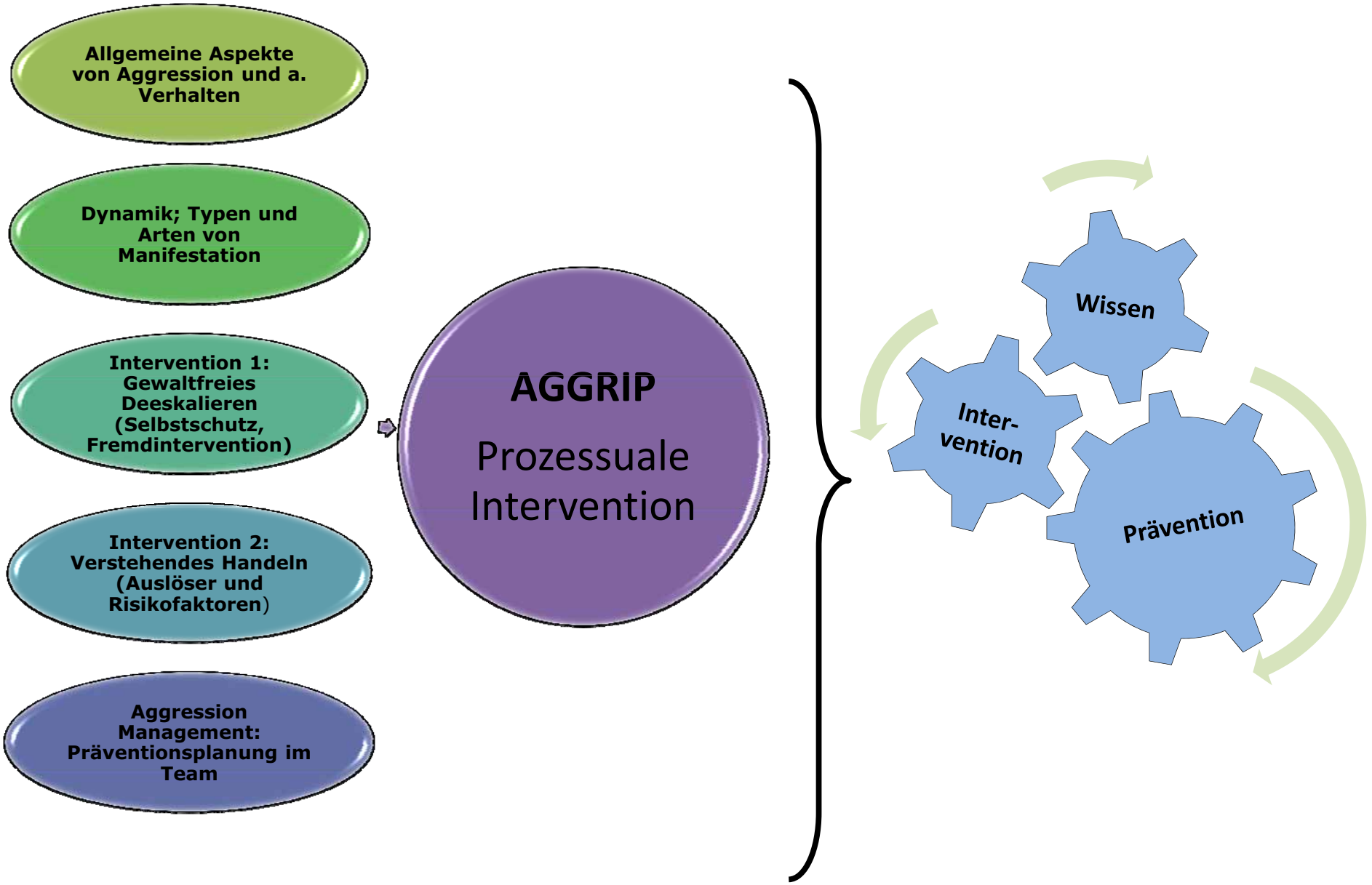
The Inferiority of the Seemingly Superior

(Übs: "Psychotherapie für Menschen mit Behinderung: Die Unterlegenheit der scheinbar überlegenen Fachperson")

Werdegang des Interventionsprograms

- Ist es möglich, Menschen mit (schwerer) Behinderung psychotherapeutisch zu behandeln?
- Falls ja, was wären die **schwerwiegendsten Probleme** für das gegenseitige Zusammenleben, welche behandelt werden müssten? →Aggressives Verhalten
- Im institutionellen Setting wären die Kosten (zu) enorm!
- Es müssen Wege im Alltag gefunden werden, welche von den Fachleuten an der Front (und nicht den Experten im Hintergrund) **ad hoc angewendet** werden können.
- Ein **Interventionsprogram** muss her, das sicher, von Betreuern einsetzbar und effektiv ist.
- => AGGRIP: Prozessuales Analysieren, Verstehen und Verändern **ohne Einsatz von Psychologen**.
- Das **eigene Verhalten und die eigene Beziehung** zu dem herausfordernden Menschen bietet alle Mittel zur Intervention

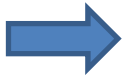
AGGRIP® Kapitel und Lerninhalte



Vom destruktiven aggressiven Verhalten zu Verhalten ohne destruktive Auswirkungen:

Problem-stellung zu Beginn

Lösungsfindung durch **selbst-regulierender** Feedback-mechanismus

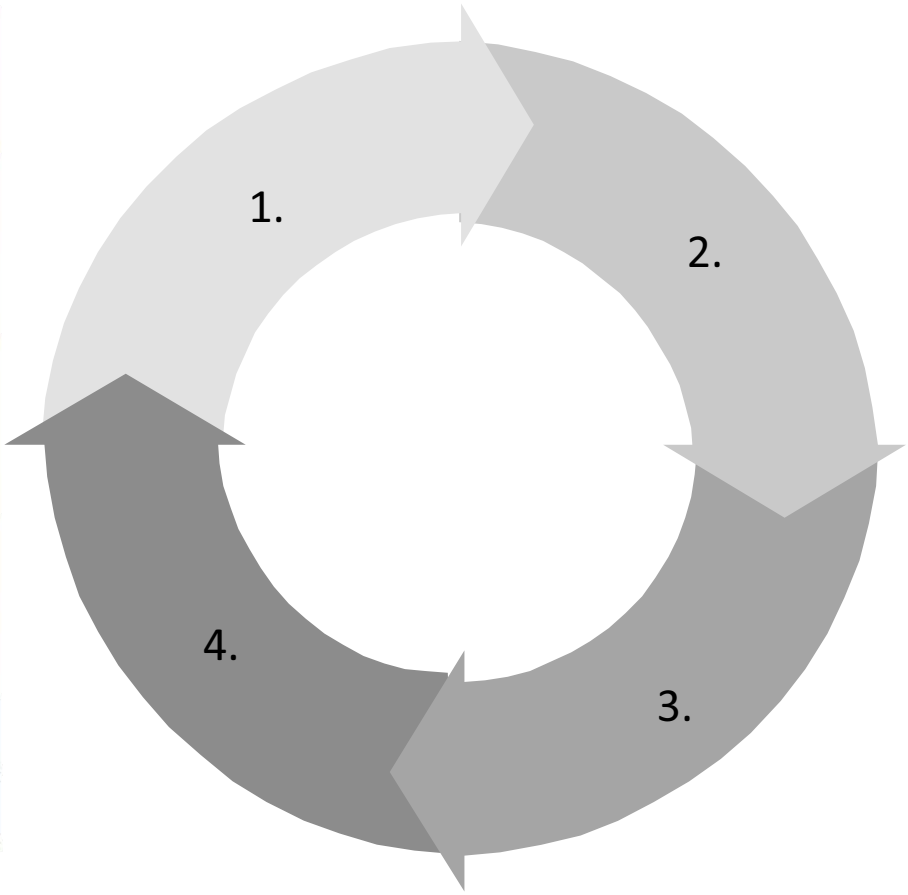


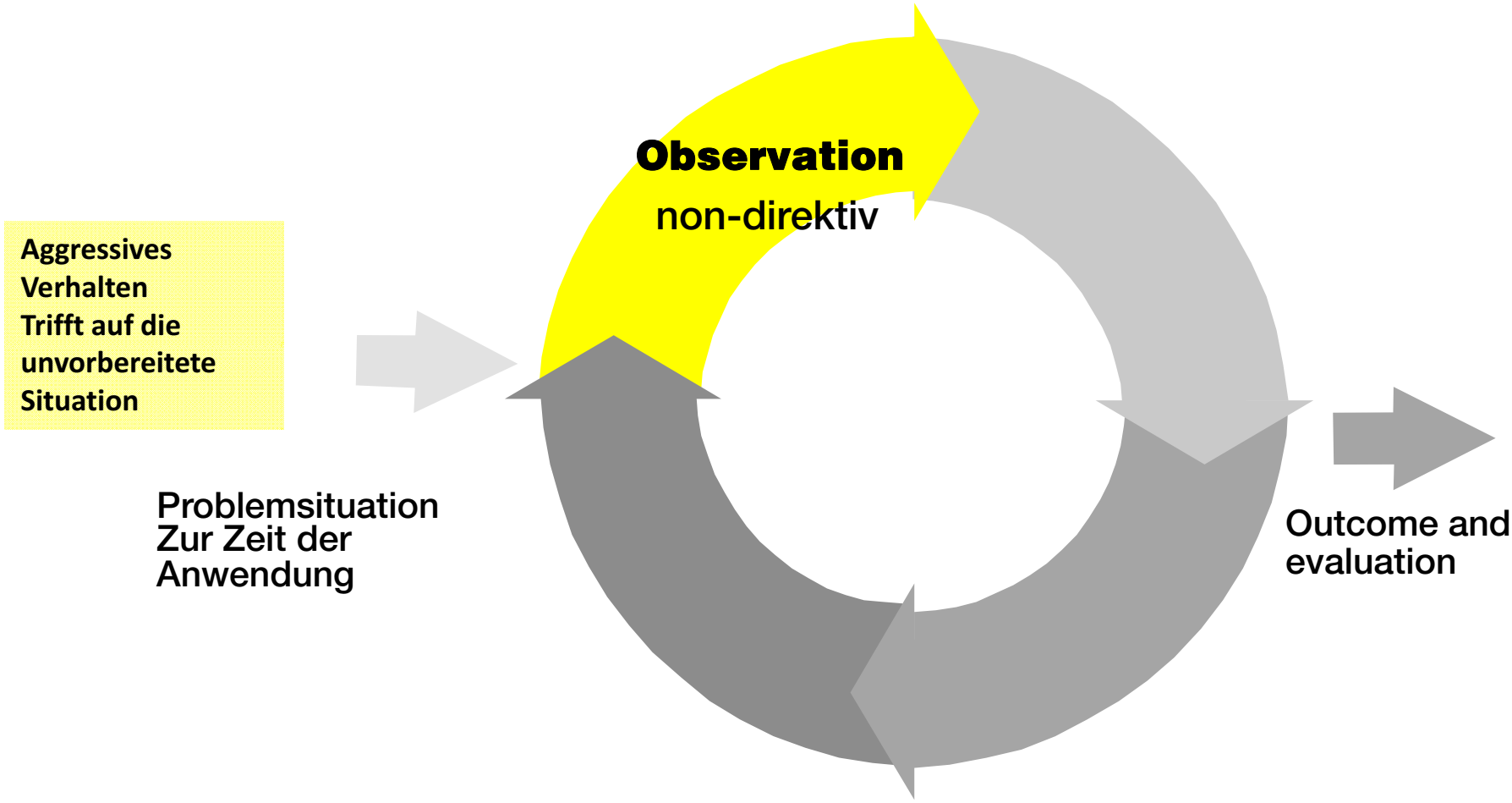
Ziel: Kontrollierbares Aggressives Verhalten **ohne destruktive** Auswirkungen

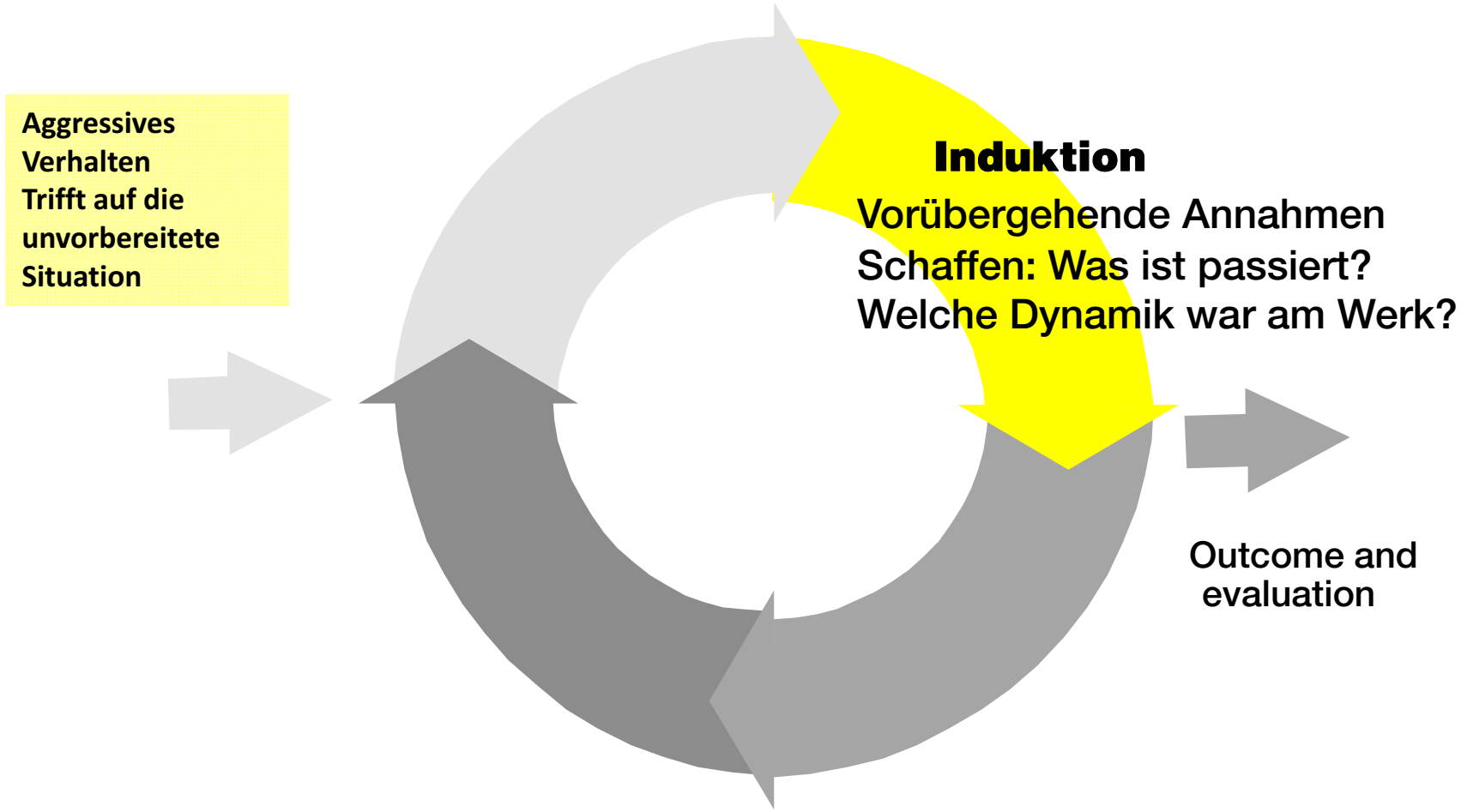
Empirisch Regulative Zyklen:

Selbsregulierende Intervention

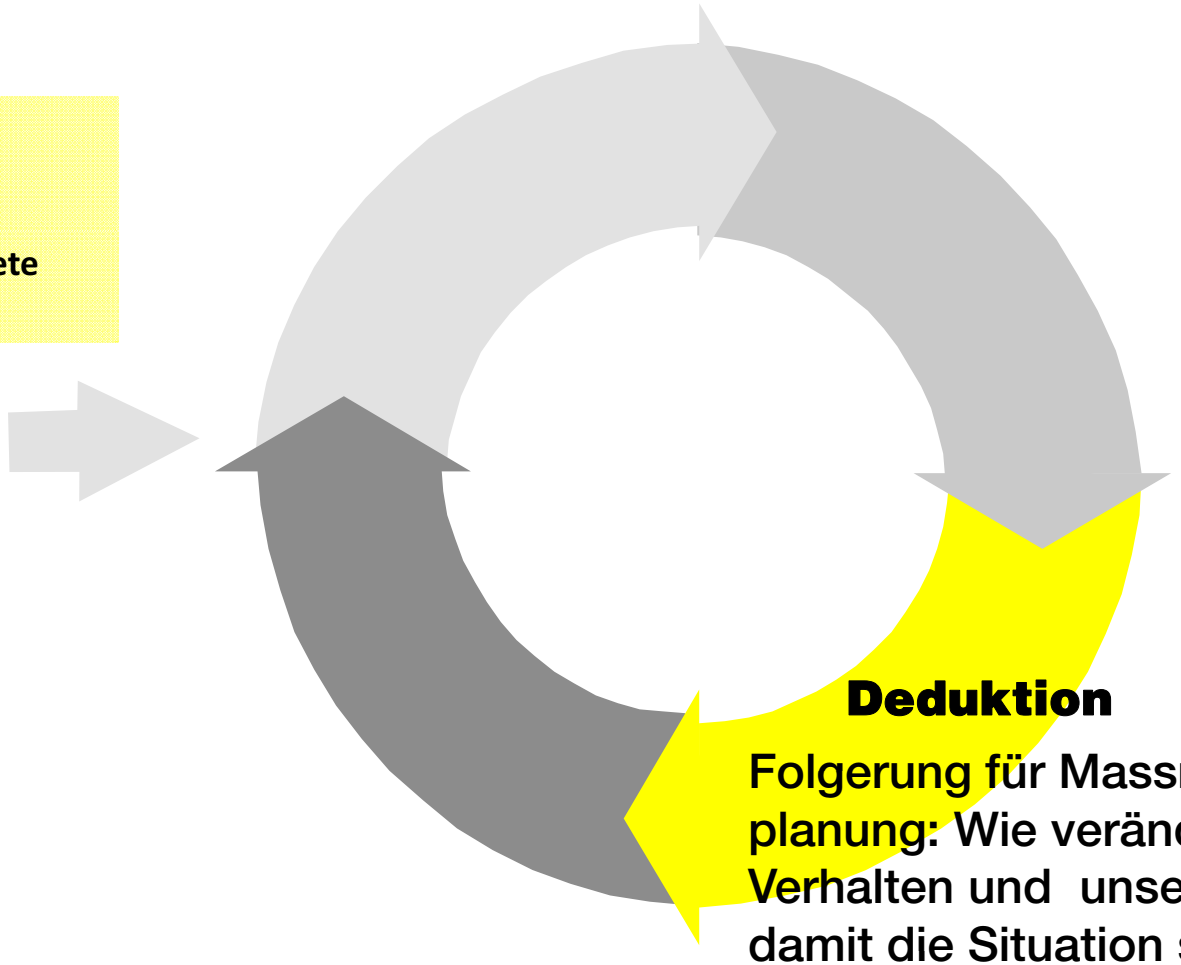
- **1. Phänomenologische Beobachtung**
- **2. Induktive Theoriebildung**
- **3. Deduktive Massnahmenplanung**
- **4. Zyklische Umsetzung von Massnahmen**




Aggressives
Verhalten
Trifft auf die
unvorbereitete
Situation
Problemsituation
Zur Zeit der
Anwendung
Observation
non-direktiv
Outcome and
evaluation


Aggressives
Verhalten
Trifft auf die
unvorbereitete
Situation
Induktion
Vorübergehende Annahmen
Schaffen: Was ist passiert?
Welche Dynamik war am Werk?
Outcome and
evaluation

Aggressives Verhalten Trifft auf die unvorbereitete Situation

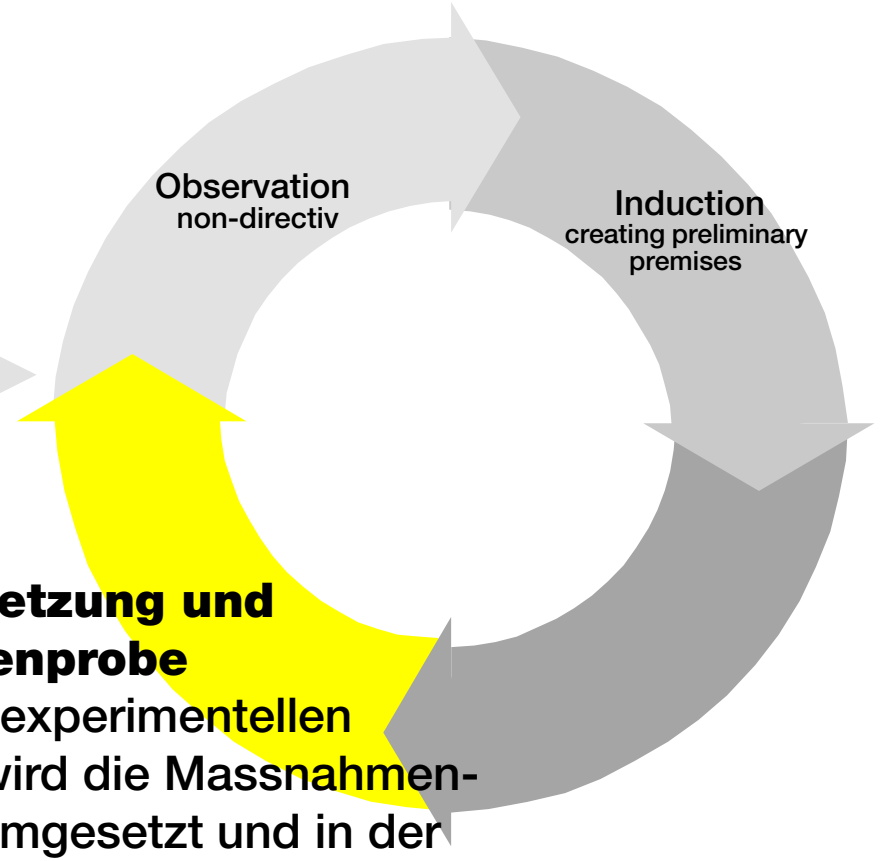


Deduktion

Folgerung für Massnahmen planung: Wie verändern wir unser Verhalten und unsere Einstellung, damit die Situation sich verändert.

Empirical Regulative Cycles
4th phase: Implementation and Control

Aggressives Verhalten trifft auf die geplanten Massnahmen und verhält sich dadurch anders, im optimalen Fall verbessert es sich undkann deeskaliert werden.

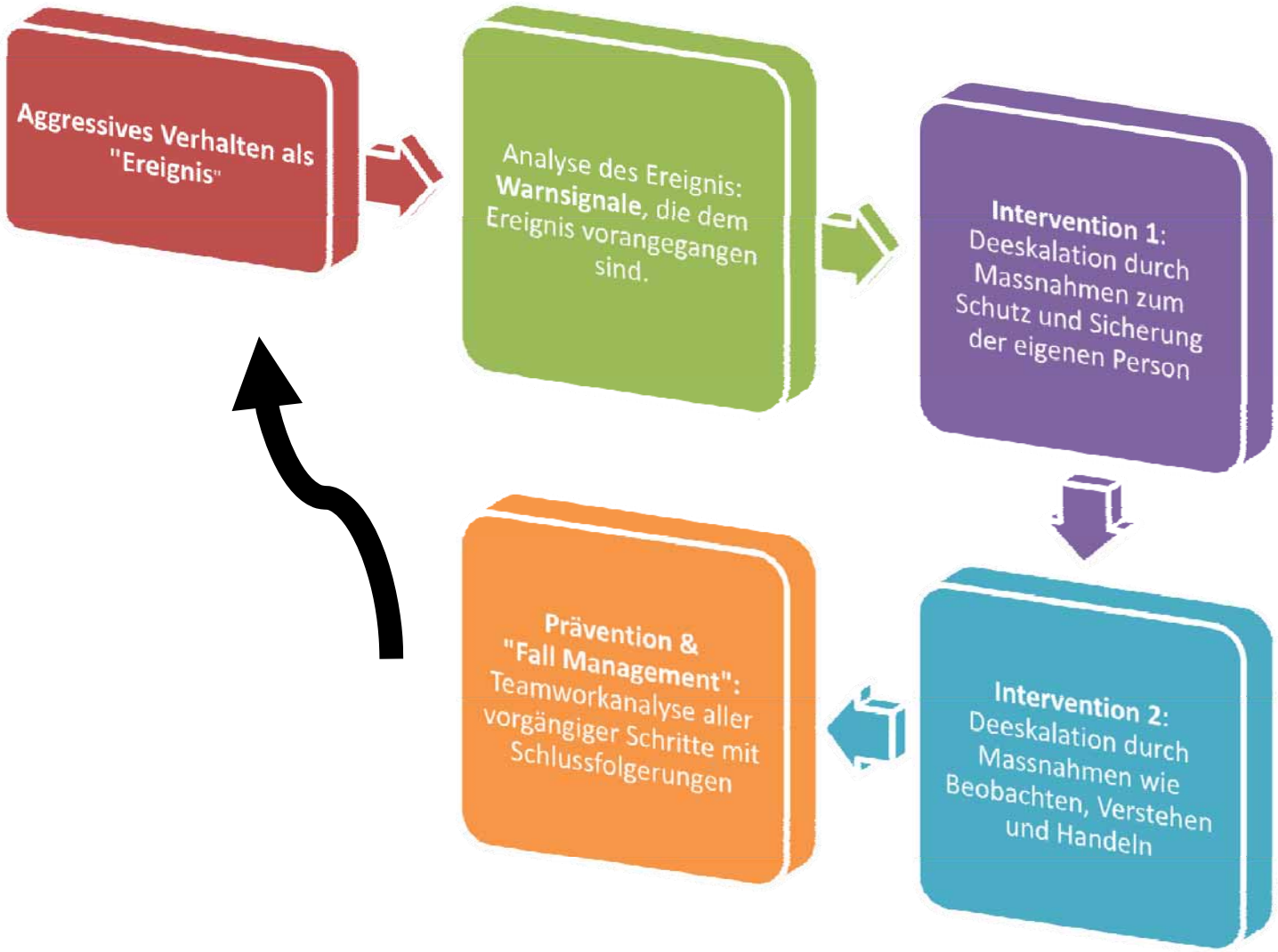


Nach einigen Anwendungen von ERC kann das Ziel erreicht werden.

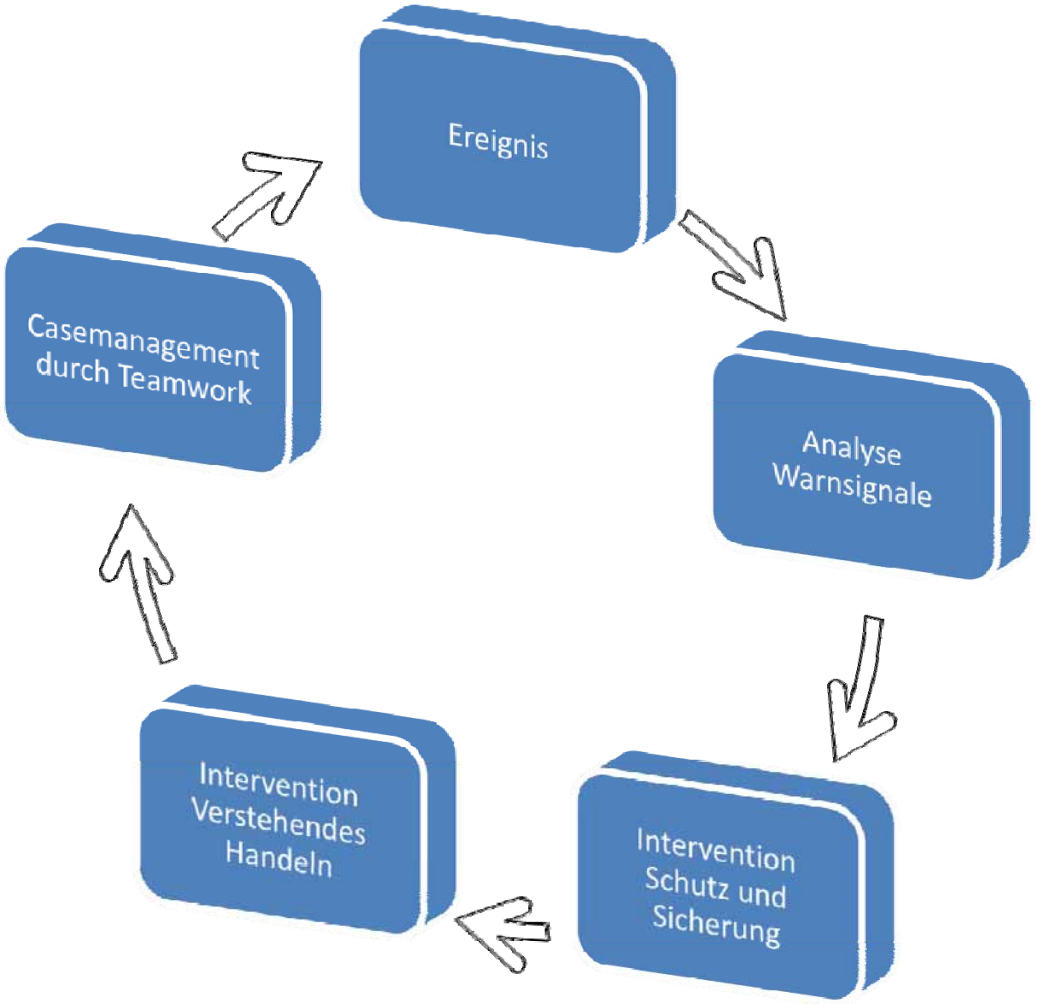
Umsetzung und Gegenprobe

Im Quasiexperimentellen Setting wird die Massnahmen-Plaung umgesetzt und in der Nächsten Situation angewendet

Intervention-Prozess als Flussdiagram:



Intervention-Prozess als kontinuierliche Zyklen:



AGGRIP® Intervention Procedure Flow Process Chart

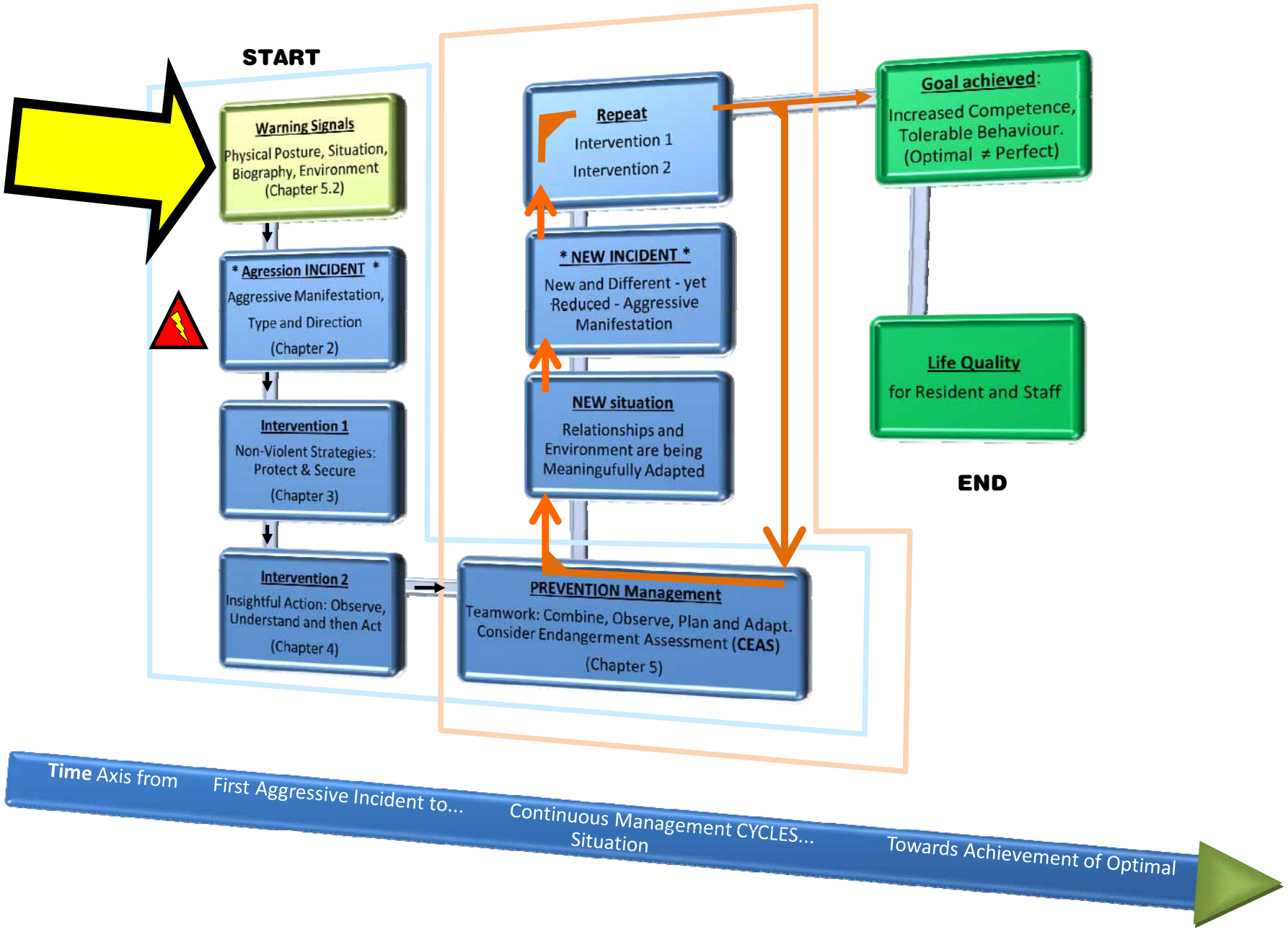


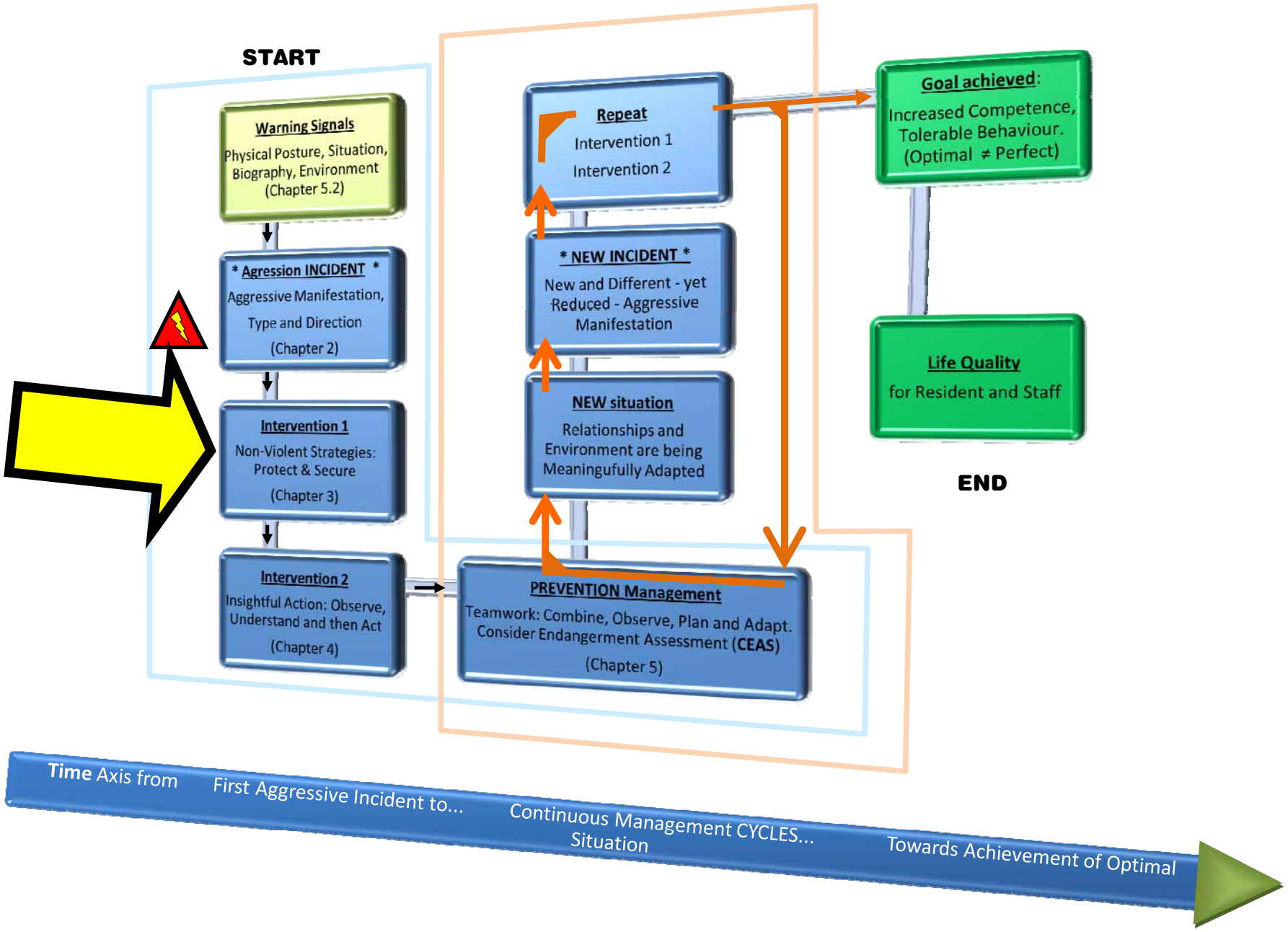
Table 3: Warning Signals

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

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.

AGGRIP® Intervention Procedure Flow Process Chart

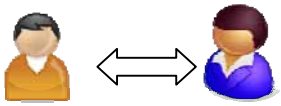


AGGRIP Intervention 1; Körpersprache im Einsatz zur Deeskalation …

1. Non-Confrontational Stance

Face-to-face stances will mostly be reacted to as confrontational..

2. Positive Use of Space



the majority of individuals carry with them an imaginary area,

3. Avoid Touching

try not to touch the aggressor first, as it is usually instantly reacted to with hostility.

4. Correct Appearance

What we wear is important. Sometimes our clothes can present an opportunity for an assailant to hurt us.

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.

6. Straight Facial Expression

Do NOT smile in the face of aggression as this will be reacted to as a sarcastic or arrogant grin.

7. Eye contact

Eye contact is usually important in most cultures and with most individuals.

8. Relaxed Posturing

body signals can be perceived as an aggressive response and will often escalate the situation.

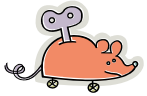
9. Positive Use of Hand Signals

The opposite of this, therefore, is to use gentle, free-flowing, open hand movements.

10. Avoid Body Holding or Touching

Often when under verbal attack, we fold our arms…

11. Avoid Repetitive Movements



A lot of aggressive behavior is preceded by some form of repetitive body language.

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.

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

AGGRIP Intervention 1: Zerstreuungstechniken …

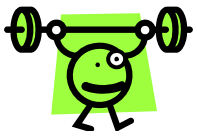
1. Maintaining Self- Control

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.

2. Sitting Down

In many situations it becomes possible to judge the moment when the aggression is at the point of escalation. At this point, sit down and invite the aggressor to sit down with an open hand gesture. Only sit down if you feel confident.

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.

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.

AGGRIP® Intervention Procedure Flow Process Chart

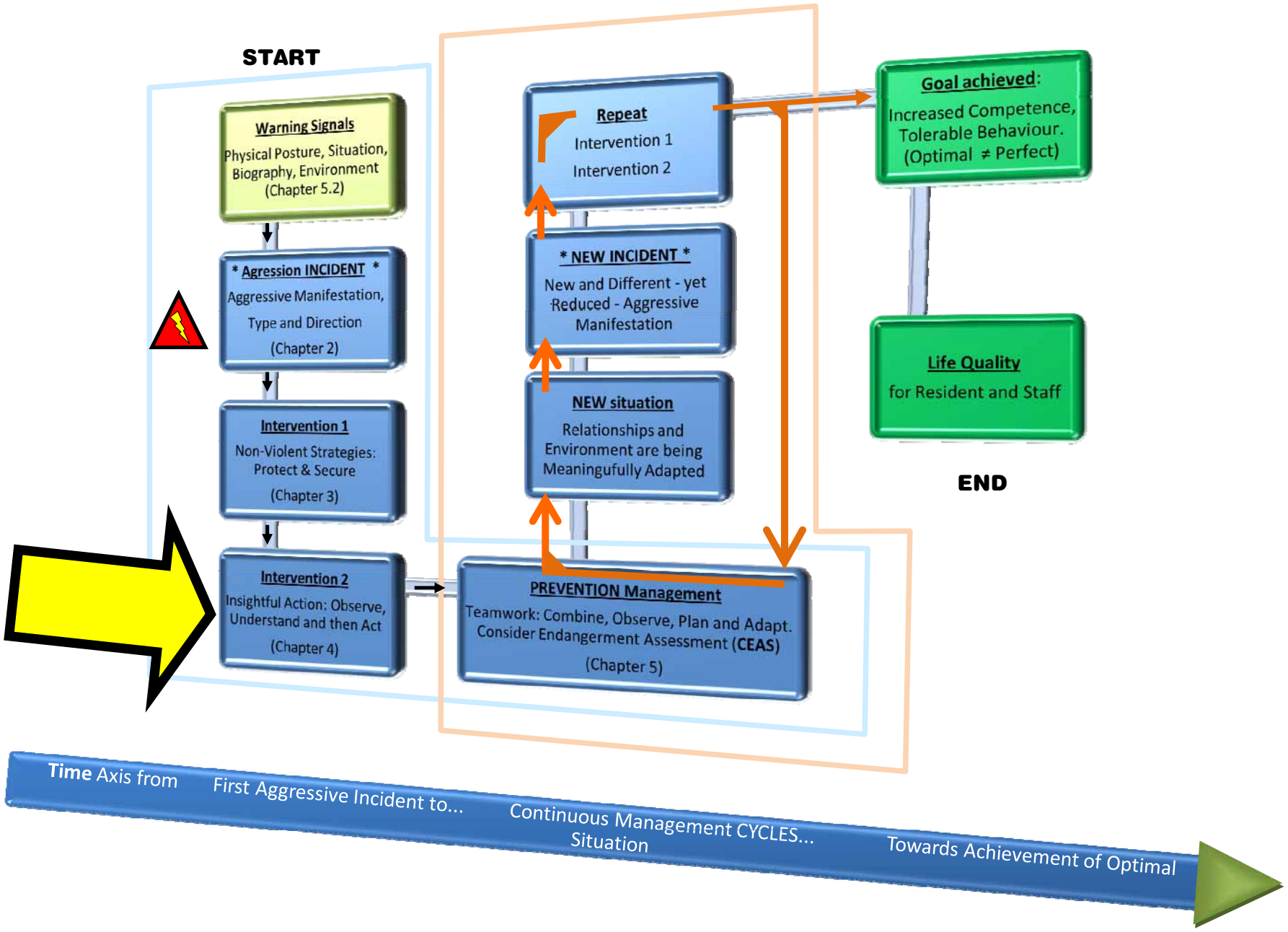


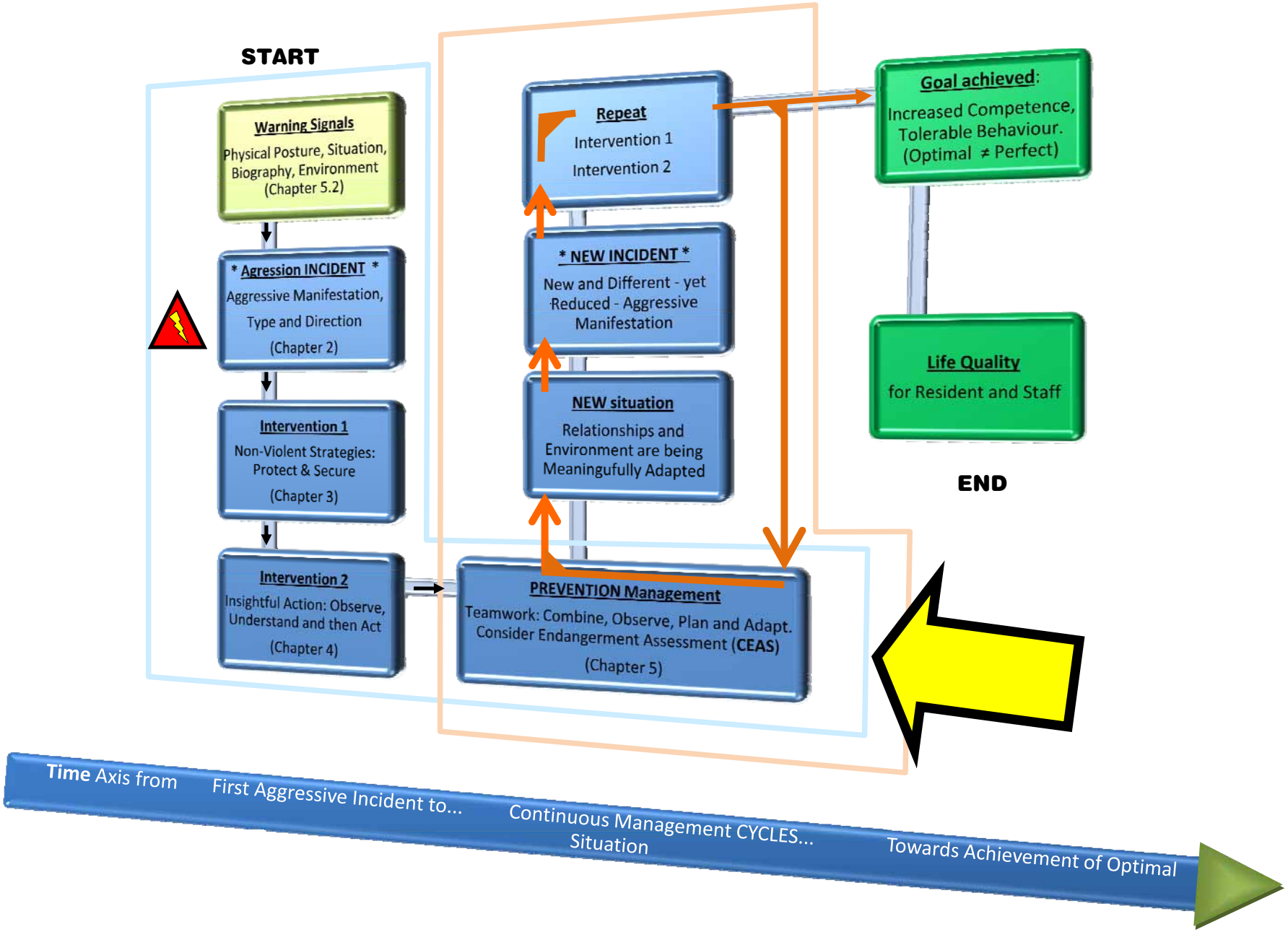
Table 2: Risk Factors and Coping strategies

	Description of risk factor	Possible coping strategies
Working conditions	**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.	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.
Working conditions	**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	**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	**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	**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	**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.	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.
Environ-mental physical stimuli	**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	**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..	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.

….. Risk Factors and Coping strategies continued….

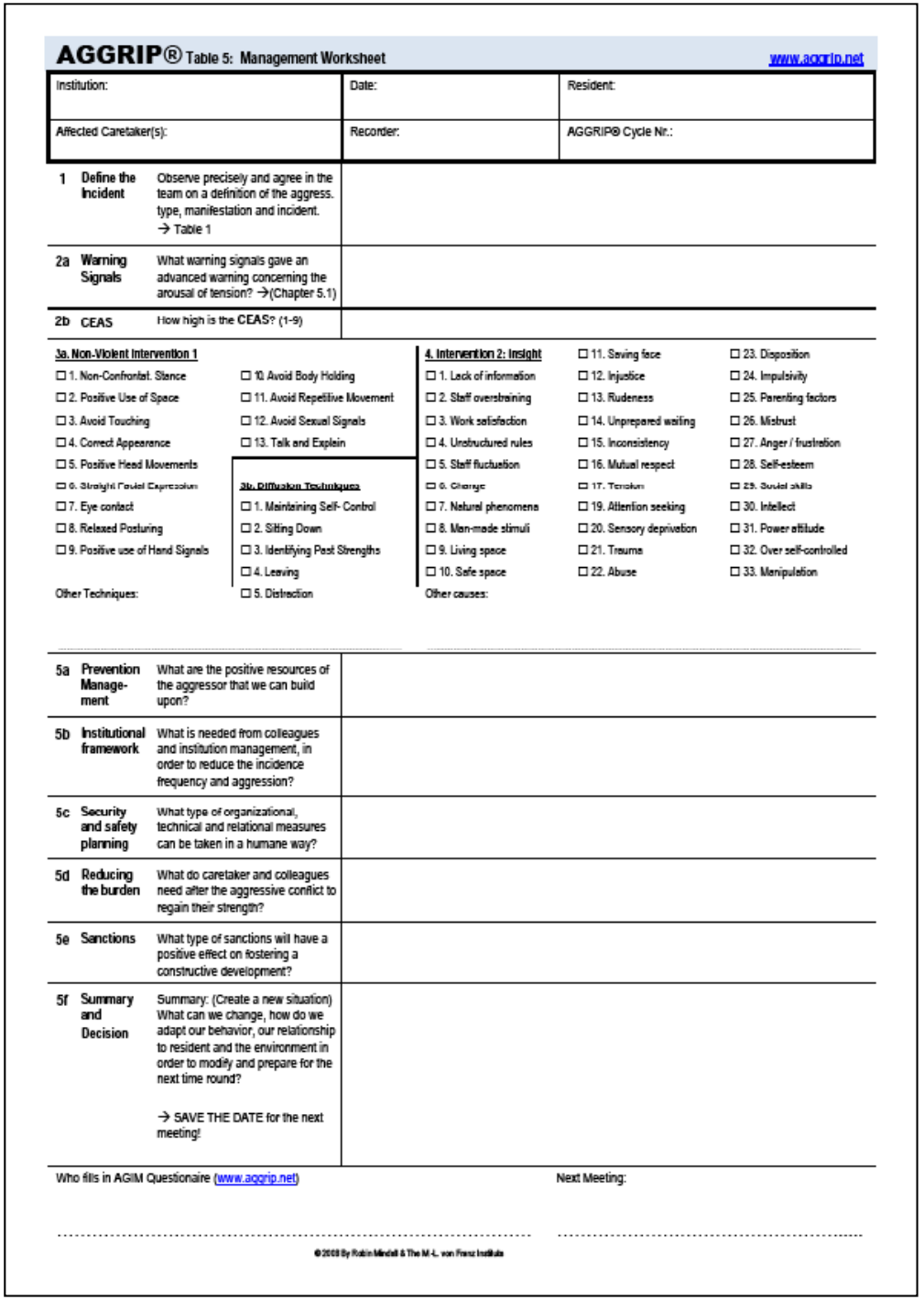
Environ-mental physical stimuli	**SAFE SPACE** Staff invades the natural "territory" of resident. Resident cannot experience a "safe space": The majority of us need defendable space: The invasion of personal space is known to raise anger levels.	If sitting, the safe space can be relaxed to about one-and-a-half 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.
Bio-graphical causes	**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	**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).	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	**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.	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	**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 %.	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	**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	**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	**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	**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.

AGGRIP® Intervention Procedure Flow Process Chart



AGGRIP Arbeitsblatt zur präventiven und post-hoc Anwendung:

Jedes ausgefüllte Blatt stellt Einen AGGRIP-Cyclus dar, welcher solange wiederholt wird, bis das geplante Ziel mit gewaltfreier Intervention erreicht werden kann



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

3b. Diffusion Techniques

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

Other Techniques:

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:

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Oberer Teil des Arbeitsblatts ……

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

3b. Diffusion Techniques

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

Other Techniques: .....

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: .....

Unterer Teil des Arbeitsblatts …

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!	

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Für den **Schweizer Heilpädagogik-Kongress 2011**
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