



Reminder to Trainers: *if needed, in preparation for the program, review the video on trainer's tips in demonstrating personal safety skills.*

Objectives

1. Participants will be able to demonstrate the escape moves from the different types of grabs and strikes.
2. Participants will understand the difference between escape moves and patient intervention techniques.

Let's discuss the difference between personal safety skills and self-defense moves. Personal safety skills are **designed for escape**, to get away from the situation. They are based on the notion of physically disengaging from a situation. The goal is to protect yourself, escape from the situation, and find help. Self-defense techniques are designed for defense not necessarily escapes. These techniques can involve engaging with the other person. Physically engaging with the other person can result in harm or injury to self and/or the other person.

Personal safety skills are weight based vs strength based techniques. In strength based techniques people tend to get hurt and typically the stronger individual tends to maintain control over the other individual. In weight-based techniques we develop skills that work for most people, most of the time, including people of all ages, sizes, abilities and limitations. The challenge for any personal safety technique is to provide the most utility and safety for staff and patients given the risks associated with working in health care.

LEVELS OF STRESS

Stress Level	Staff Action
Moderate Stress	Verbal Intervention
Severe Stress	Limit Setting
Panic	Personal Safety Skills or Therapeutic Containment
Tension Reduction	Therapeutic Rapport

Overview:

This session should begin with an overview of the events to follow, outlining the levels of stress and staff intervention, personal space, personal safety, and personal contact skills.

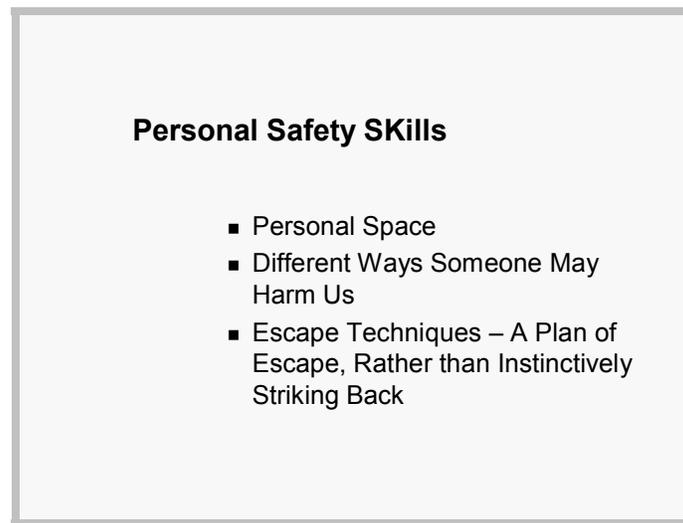
Ensure that all participants have read and understood the Acknowledgement of Risk and Statement of Health form. Only those participants that have been able to sign both sections of the form should participate in physical activities.

1. The following is a chart used to describe the four stages of increasing patient stress, an example, and the corresponding staff intervention for each stage.

<i>Patient</i>	<i>Example</i>	<i>Staff</i>
Moderate Stress	Pacing, Increased Motor Activity	Supportive Verbal / Nonverbal Intervention
Severe Stress	Threatening Harm	Limit Setting
Panic	Striking Out	Personal Safety Skills / Therapeutic Containment
Tension Reduction	Back to Baseline	Therapeutic Rapport

The explanation should begin with a description of a patient in the first stage, followed by a description of the staff intervention for that stage. You may proceed using this format to discuss stages 2, 3, and 4. The key to this presentation is the fact that staff intervention at stages 1 and 2 are verbal interventions, and stage 3 is the first point in which staff makes actual physical contact with the patient or the patient makes or attempts to make physical contact with staff.

The idea which must be conveyed to the participants is that a well-trained team approach to physical patient contact will provide staff with a feeling that if the worst thing that could happen, happens, they can control it! They will be better able to deal with a crisis at the verbal level (stages 1 and 2) and will most likely use Therapeutic Containment on the rarest of occasions.



PROXEMICS

2. Next, a discussion of Proxemics and the role it plays in health care. People expend a great deal of energy to regulate and maintain personal space. There are many unspoken rules pertaining to interpersonal distances. The study of rules for personal use of space is called proxemics (E.T. Hall, *The Hidden Dimension*).

The nature of **proxemics** can best be demonstrated by exercises, which cause one person to invade the space of another. In these exercises, most people will show immediate signs of stress, anxiety and discomfort by giggling, talking, rocking, stepping back, or using various other forms of body language.

If these exercises are performed between good friends, the results will be less obvious, because rules governing personal space vary according to relationships, activities, and one's own personal comfort or discomfort with

closeness.

According to Hall, there are four basic zones of invisible boundaries, varying from 18 inches to 12 feet.

- Zone 1 **Intimate Space** is reserved for special people or circumstances. Lovemaking, comforting others, cuddling children, and massages take place within this space.
- Zone 2 **Personal Distance** is maintained in comfortable interactions with friends. This distance keeps people within arm's reach of each other.
- Zone 3 **Social Distance** is an impersonal business and casual distance used at social gatherings. It eliminates most possibilities of touching and formalizes conversation by the need for voice projection.
- Zone 4 **Public Distance** interaction takes on a formal quality. This distance is reserved for speeches, lectures, and business meetings.

Violation of personal space at each distance tends to cause the "invaded" person to move away or become defensive. It is important to stress to participants that other factors impact the four zones: gender, age, past experiences, culture, profession, and diagnosis. Typically staff are sensitive to the impact of these factors as they relate to the patient, however, it is important for staff to remember that they too contribute these factors in each situation. For example, a staff member who is male, a social worker, and maintains close ties to his Italian heritage would generally maintain close proximal relations with frequent physical contact during interactions with people that are friendly and familiar. It is KEY that this staff member recognizes that his approach may be threatening to others and not be received as warm and friendly.

When approaching a patient, it is advisable to maintain at least the social distance because, at this distance, you are least likely to invade his/her intimate or personal space boundaries. This is particularly true if the patient is anxious or agitated. In addition, this distance is safe for you as a staff member, because in order for you to be physically attacked, the patient must move forward to reach you, giving you an opportunity to defend or evade. The following exercises are designed to demonstrate the importance of understanding proxemics and the impact stress can have.

3. Next, we advise that you conduct the proxemics and personal safety exercises, stopping between each exercise for discussion. The following Trainer Tips will assist with this process.

Trainer Tips:

- Remember your personal space, arm/leg length distance. Trainers must pay close attention to properly demonstrating each technique paying attention to space, proper stance, using weight and not strength, and remembering to escape at the end of each technique as appropriate. **Demonstrate each exercise for group before asking group to practice.**
- In crisis situations creating space - creates time – time allows for choices.
- “Situational Awareness” - if you sense potential problems, remove yourself prior to occurrence if you can. Pay attention to Gut Feelings.
- Demonstrate and practice supportive stance - feet at a 90-degree angle and approximately shoulder width apart. This stance promotes balance, makes you less of a target, and positions you to escape.
- Ask group how many ways are there to be harmed by another person? – Create a list based on group feedback: kicked, bit, shot, object thrown, hair pulled, punched, stabbed, etc... Quickly the list becomes unmanageable for most health care workers. This is because most staff will want to have an intervention for each potential attack—this proves most difficult and tends to cause apprehension on the part of staff.
- Explain to participants that all the various forms of attack fit into TWO categories: STRIKES and GRABS. Ask them to categorize the list they came up with: Kick – Strike, Bite – Grab, Shot – Strike, Object thrown – Strike, Hair pulled – Grab... The goal is to therefore develop interventions for Strikes and Grabs, which is a less complicated way to address the problem. When using physical interventions, the less complicated techniques are less difficult to learn.
- Introduce techniques.

Reminder. All incidents requiring any use of personal safety skills need to be appropriately documented and reported to your supervisor/intervention team.

EXERCISES

- Walk towards your partner. Partner raises hand and says, "Stop" when they start to feel uncomfortable.
- Walk up to your partner and stand nose to nose until told to stop.
- Walk up to your partner and stand in the supportive stance outside of the patient's striking distance.
- Punch at your partner's nose stopping short of contact.
- Practice blocking punch.
- Show grabs

Hint: Begin these exercises with your participants in two equal lines facing each other from opposite sides of the room. Identify one side to play the role of Patient and the other side to play the role of Staff. Place yourself in the middle while demonstrating techniques or while addressing the group.

These exercises can get quite loud and typically do as participants get closer. The best way to regain control of the class, for your critique of each exercise, is to ask the partners to separate again back to their original positions. Once separated it will quiet down and become much easier for you to critique.

- A. Walk towards your partner. Partner raises hand and says; "Stop" when he/she starts to feel uncomfortable.
- B. Walk up to your partner and stand nose to nose until told to stop.
- C. Walk up to your partner and stand nose to nose, then get into a supportive stance.
- D. Walk up to your partner and stand in the supportive stance outside of the patient's striking distance. Punch at your partner's nose stopping short of contact.
- E. Practice blocking strikes.
- F. Practice releases from grabs.

Instructions:

Exercises A – F will be demonstrated in pairs. Please pick a partner who is approximately your own size and, if possible, someone you don't know well. One person will be the patient and the other the staff. Participants typically pick a partner they know and this can lead to increased chattering during the exercises. Trainers are encouraged to let each participant line up, as they desire. Once the lines are established and you have had the opportunity to understand the dynamics you can simply move one participant from one end of a line to the other end thus giving each participant a new partner. This is accomplished without drawing attention to the overly talkative pair.

- A. For the first exercise, the staff member walks toward the patient shoulder to shoulder, with hands to their sides, maintaining eye contact. When the patient begins to feel uncomfortable he/she should raise his/her hand and say, "Stop". When beginning this exercise partners should be facing each other, standing as far apart as the room will allow. The patient should be alert to any feelings of anxiety or discomfort as the staff member approaches. As soon as the patient feels any discomfort he/she should extend his/her hand forward, telling the staff member to stop. Take note of the approximate distance between the patient and staff member when the patient says, "Stop." You will note that this distance is approximately just outside the length of the patient's leg. Now, instruct the partners to switch roles and repeat the exercise. What you have just demonstrated is that there is a certain area around each individual, which he/she considers personal space. When someone enters that area of privacy, tension, stress, and anxiety generally result.

In addition, when the patient is approached directly from the front and you stand in his/her path, you present a barrier to him/her. You are non-verbally saying to the patient, by your shoulder-to-shoulder approach, that he/she must go through you in order to keep going forward. A patient generally does not want to attack you but how you position yourself in front of him/her can influence (1) how he/she will attempt to proceed, and (2) the degree of escalation during the crisis situation.

- B. In this exercise, the staff member will approach the patient as in exercise (A): however, this time the patient will not be allowed to stop the staff member's approach. The staff member will proceed into the patient's personal space and stand nose to nose. Instructions to participants are:
 - 1) Stand nose to nose with your partner---as close as possible
 - 2) Maintain eye contact
 - 3) Do not giggle or laughInstruct participants to maintain this position until you ask them to BREAK.

Instructor's Note:

Note the reactions of the partners to the invasion of their personal space. You will observe, clasped hands either in front or behind the body, shifting of weight from side to side, breaking eye contact, and, of course, laughing. These behaviors are reactions to the increased stress caused by the encroachment of personal space. It is important to mention that patients who are angry or anxious may feel this same degree of tension when a staff member enters the room.

- C. In this exercise the staff member will approach the patient just as she did in exercise (A). This time, when instructed to do so, staff member and patient will assume a supportive stance. This is done by moving one foot to the rear approximately shoulder-width distance from the front foot and at a 90 degree angle (perpendicular) to the front foot. By assuming a supportive stance, participants will gain an immediate understanding of how creating space can reduce stress and create time, which allows choices.

Instructor's Note:

Note the relief expressed by both staff and patient when the **Supportive Stance** is utilized. The Supportive Stance should be maintained when approaching a patient. This stance is supportive for three reasons:

- (1) When standing perpendicular to the patient you present less of a target, should the patient decide to strike out at you (flank portion of body is more exposed than is the front of the body).
- (2) It is difficult to lose your balance with your feet shoulder-width apart and the back foot at a 90-degree angle to the front foot.
- (3) It is much easier to turn and run if the patient lunges for you. Also, you should always maintain this stance outside of a leg length away from the patient. This provides you with the opportunity to move away from a potential strike or grab.

- D. Partners should stand face-to-face. The patient will make a fist and measure an arms length plus two inches to the staff member's nose. Next, instruct the staff member to stare at the patient's fist as it slowly approaches the staff member's nose, stopping just prior to contact. Repeat this punch several times increasing speed, **but stopping just prior to contact.**

Most staff members have excellent verbal skills until a patient becomes angry or disruptive. If the patient makes a fist it usually elicits many reactions to the staff's own increasing stress and anxiety. This tends to decrease the effectiveness of our verbal skills. Verbal intervention becomes less effective as a result of our fears. The threatening patient provokes a normal fear. The fear is a fear of the unknown, or the anticipation of what will happen, and the assumption is that it won't be good.

Note that as the punches continued and no contact was made, the staff's stress and anxiety began to decrease. This is a lead in to the next exercise, the block. If we know that we can intervene when being punched, we can control our fear and thereby increase our verbal skills during the verbal intervention stage.

THE BLOCK

- E. The block is a reflexive move performed by raising the arms in a crossed manner starting at the waist and proceeding over the head. The staff should be in the supportive stance so that while blocking the punch they are turning to run. The block embraces the theory behind the strike.
- (1) Put something between the striking force and the target. In the case of the punch it was the crossed arms. In the case of a kick it could be crossed arms if being kicked to the chest/head area.
 - (2) Change direction of the strike. In the case of the punch or a kick, the crossed arms were moving up from the waist, changing the direction of the strike to pass over or to the side of the head. If being punched or kicked to the mid-section of the body it is important to change the direction of the strike so that it does not make contact with any other part of the body---either over the head or off to the side.
 - (3) Remove the target. After blocking the strike we turn and run.

The reflexive nature of the block is important to stress. Previous exercises have demonstrated the difficulty associated with responding when exposed to stress and anxiety (nose to nose exercise). It is worth pointing out to participants the difficulty they experienced attempting to follow three simple instructions. The stress and anxiety created when being struck at can be significantly more powerful than when standing nose to nose in a classroom setting. The more reflexive the intervention one uses in this situation, the better. Most martial arts techniques rely on muscle memory for maximum effectiveness---thus creating a response that mimics a reflexive response. Trainers can demonstrate the reflexive nature of the block by pretending to toss a quarter (key or other object) to a participant. Going though the motions without throwing the quarter will cause the participant to raise their hands in an effort to catch the quarter. The goal is to catch the quarter; however, the reflex is intended to prevent the object from hitting the face. This works from early in childhood until late in adulthood.

BLOCKING THE PUNCH AND KICK

Encourage participants to practice blocking both the punch and kick. Remind participants that while a kick is a strike, it is a bit different than a punch. The length of the leg is longer than that of an arm. The leg is generally twice as strong as the arm and if used appropriately can cause significant injury. The best defense for a kick is SPACE---be far enough away that the kick will not reach. If,

however, one is within striking range, the preferred intervention is the block. If one is unable to use the block, the next best technique may be to use the flank of the body and walk into the kick.

The reason this technique can be effective is two-fold: 1) the notion of balance, if one were to walk into an individual attempting to kick, it could cause the loss of balance on the part of the kicker; 2) the notion of force----force is mass X speed. In a kick, force is generated by combining the ability to generate momentum/speed with the mass of the body channeled through the leg. The kick is most forceful at the further most extension of the leg. By walking into a kick prior to the further most extension of the leg, staff can reduce the force of the kick.

OTHER POTENTIAL STRIKES

Staff must pay attention to other potential strikes. In a health care setting, patients often times possess items designed and intended to provide medical benefit but can be used as weapons: crutches, canes, walkers etc... These items increase the distance that one is able to strike. In blocking a strike, staff can also use various items available in the environment. For example place a chair between the strike and the target. A door, a desk, a chart rack, a bed, any item in the environment can be used as something to place between the striking force and the target.

As mentioned earlier, there are only two ways that we can be attacked, a strike or a grab. If we learn the theory behind the defense of a strike, we can defend ourselves against any form of a strike. If we learn the theory behind the defense of a grab, we can also defend ourselves against any form of a grab. It is worth noting that in most cases a strike is used to cause injury/pain whereas a grab is generally used to gain control---the choke and bite remaining the exceptions. Understanding the intent of the action can aid when implementing an escape technique.

GRABS

1. Single wrist grab
2. Double wrist grab
3. Two hands grabbing one wrist
4. Wrist grab with startle reflex – **Demo Only**
5. Choke (front & rear)
6. Hair pull (front & rear)
7. Kick
8. Death Grip (Headlock) - **Demo Only**

D. The theory behind the grab is threefold as well.

- (1) Look for the weakest point of the grab.
- (2) Find the weakest link.
- (3) Rotate the narrowest part of the body out over the weakest point, toward the weakest link.

Roll/twist/rotate over the thumb! An easy way to help staff remember is to think, **“RULE OF THUMB”** The thumb is the weak link in a grab because it is one (single) whereas the rest of the grab consists of four fingers. Some participants will pull away from the grab and may actually be successful in escaping. The danger in using this technique is that it is strength-based and when being grabbed by someone stronger, they may not be able to get away. It is important that trainers closely observe during practice to make sure participants are using the proper technique.

It is also important that participants understand the notion of using their weight to assist in escape, particularly when a larger male staff is grabbing a smaller female staff. Only by employing ones weight in the technique can the escape be successful. Trainers must demonstrate appropriate ways to use body weight to aid in escaping from various grabs.

1. Single wrist grab
2. Double wrist grab
3. Two hands grabbing one wrist
4. Wrist grab with startle reflex - **Demo Only**
5. Choke (front & rear)
6. Hair pull (front & rear)
7. Death Grip (Headlock) - **Demo Only**

1. The single wrist grab: The patient grabs your wrist with one hand. Keeping the theory behind the grab in mind, the staff member looks for the weakest point. In this case the weak point is between the thumb and four fingers. Next, we find the weakest link which would be the thumb. And finally, we rotate/twist the narrowest part of our wrist out between the thumb and four fingers and toward the weakest link, the thumb.
2. Double wrist grab: The patient grabs both your wrists. If you are able to rotate/twist out over the thumbs do so. If the grab is too strong for you to accomplish this, remember that typically the patient is grabbing you in an attempt to control you. Attempt to put your hands together, interlocking your fingers and quickly bend forward slightly and pull out towards the weak links---the thumbs---using your body weight to help escape. Turn as you pull, so that when the release occurs you are ready to run. If the patient tries to prevent you from putting your hands together, simply push outward---remember the control issue---the patient will generally push your arms back together thus aiding you in your escape. Quickly put your hands together and pull out as described above.
3. Two hands grabbing one wrist: To escape this grab; reach over the top of the patient's arms (between the two arms) grabbing your fist. Bend forward quickly as in the previous release and pull out. Turn as you pull so that you are ready to run---this also introduces your body weight to the momentum and facilitates your escape. Also be sure to locate the patient's thumbs---if the thumbs are on top then staff will need to Pull in an Upward motion, however, if the thumbs are placed towards the ground staff would want to pull in a Downward Direction.
4. Wrist grab with startle reflex - **Demo Only**: Same as the previous release, however you are still over-powered. Shout in the patients face as you simultaneously pull-out. The startle should affect your release. Make sure to pull at the same time you shout as you won't get a second chance with this technique.
5. The chokehold: Raise your arms as if to say hallelujah (from the side as if attempting to clap ones hands above ones head). With the arms outside the patient's arms, twist your body. This action will facilitate your escape. The key here is to trap the patient's hands between staff's neck and shoulders. When in this position, the patient is unable to maintain a choking grip and by twisting the body, staff is applying their momentum and body weight against the patient's hands.
6. Hair pull (front & rear): The worst part of this grab is the pain. Often times people try to pull away from the grab.

This is the worst thing to do as it will not only hurt but also leave you partially bald. To escape this hold, place both of your hands over the patient's hand, interlocking your fingers and push the patient's hand tight against your head. This doesn't get you out yet, but at least it stops the pain and eliminates the ability of the patient to continue to pull. In fact, pushing the patient's hand down on your head causes the patient to experience some pain---as the fingers are now being pressed against your head. While tilting your head toward the patient and holding the hand tightly against your head, turn and straighten your body. This will bend the wrist and cause enough pain to the patient that they release the grab. This works when your hair is pulled from behind as well. Trainers must caution participants to perform this technique slowly during training to reduce the chance that someone may become injured. If participants are having difficulty trainers should assist so that participants understand the technique and are proficient using it.

Note: It is important to mention that **long hair** puts you at a much higher risk, as it is nearly impossible for the novices to escape. **Ties, scarves, and long earrings** are also dangerous as they can be used to harm you. It is important to recognize the increase risk and develop solutions prior to emergency situations. If wearing a tie is required to perform ones job possible strategies to reduce the injury resulting from having the tie pulled could include: using a clip-on or once the tie is appropriately tied, consider cutting the tie in two just behind the neck—once done attach Velcro on each cut end and reattach the tie with the Velcro so that if pulled, the tie will come off. Long hair has cultural significance in some parts of the country and it is reasonable to expect some staff to have long hair. It is important for staff with long hair to realize that they are at an increased level of risk for getting their hair pulled. Again, consider solutions that reduce the risk of having your hair pulled: put long hair in a bun on top of the head, male with long hair may consider placing the long hair inside the collar of the shirt thus making it more difficult to get at---and provide staff with a bit of extra time should someone attempt to pull the hair out of the shirt.

In the event staff are having their hair pulled in such a way that prevents them from being able to use the aforementioned technique, staff should remain calm, grab their hair between the patient's hand and their own head. This will provide a bit of control to staff and reduce the pain from the pulling of their hair. Attempting to pull away may cause increased pain and not result in escape, staff should consider moving back into the patient. By doing so the staff may place the patient in a position of being off-balance, which can facilitate escape.

7. Death Grip (Headlock) - **Demo Only:** I refer to the headlock as the death grip as it is virtually impossible to escape if it is done properly. As a result, we show staff how to survive this grab rather than how to escape. If someone is coming up from behind or reaching around you

from behind, quickly grab your ear lobes. This move prevents the patient from getting their arm under your chin and placing your neck in serious danger. As a result you have bought time, enabling other staff members to come to your assistance. If this grab is done properly, time is of the essence as the patient could break your neck in less than a few seconds.

NEVER LET STAFF TRY THIS TECHNIQUE, IT IS TOO DANGEROUS.

Instructors Note:

Mention here that you must be **aware** of your surroundings as many times staff could prevent these attacks. Know who is walking behind you, turn and look if necessary. Awareness of your surroundings could prevent many incidents from ever occurring.

It is important to emphasize that the best approach to personal safety is a careful **assessment of the environment**, so as not to allow yourself to be attacked or trapped in an area with no egress.

Another important point; personal safety techniques are **escape** techniques only and should not be used to control an acting-out patient, particularly when the staff member is alone. No technique will teach the typical staff person a one-on-one physical intervention with a disruptive patient. Escape so that you can secure adequate help. If you neglect to alert others of the danger and you are attacked, there may be no one en route to come to your assistance.