UNIVERSITY OF CALIFORNIA

Santa Barbara

Managing Patient Aggression in Healthcare: A Training of Competent Accommodation to Prevent Workplace Violence

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Communication

by

Rachyl Leonor Pines

Committee in charge:

Professor Howard Giles, Chair

Professor Bernadette Watson

Professor Karen Myers

June 2020

The dissertation of Rachyl Leonor Pines is approved.

_____

Karen Myers

_____

Bernadette Watson

_____

Howard Giles, Committee Chair

April 2020

ACKNOWLEDGEMENTS

I am extremely grateful to all of the people and organizations that have been a part of helping me achieve this life milestone. To my advisor, Howie Giles, thank you for believing in me and providing unending guidance and support. To my committee, Karen Myers and Bernadette Watson thank you for the feedback, advice, and conversation. Thank you to Jarrod Schwartz at Just Communities Central Coast, and Cottage Health Research Institute for the involvement that made Study 1 of this dissertation possible. Thank you to the clinics in Study 2 and to the International Research Centre for the Advancement of Health Communication at Hong Kong Polytechnic University for the invitation to replicate the workshop there. Thank you for the friends who volunteered to be "aggressive patients." Thank you to my research assistants for your countless hours of data entry on this dissertation, and insightful reflections: Eli Behar, Stephanie Dam, Sarah Stephens, Laurent Wang and Vivian Chen, Amber Klein. Thank you to Bryan Whaley, Liz Jones, Scott Reid, Cindy Gallois, and Bernadette Chevalier for the additional guidance on this project. Thank you to the McCune Foundation for my fellowship that made this project possible and thank you to the McNair Scholars Program for making me going to graduate school a possibility in the first place. To my family, thank you for your encouragement when I needed it, and for your celebration of my accomplishments. To my graduate school colleagues and friends, especially Matt Giles and Camille Endacott, thank you for the ample hours of conversation as we learned how to navigate this experience together. I would not have made it this far without you. Finally, to my partner Will Barring, thank you for your daily encouragement and love. To all who have helped me in any way, I am forever grateful.

VITA OF RACHYL LEONOR PINES
April 2020

EDUCATION

Doctor of Philosophy in Communication, University of California, Santa Barbara (2020)

Master of Arts in Communication, University of California, Santa Barbara (2016)

Bachelor of Arts in Communication Studies, University of San Diego, California (2014)
Summa Cum Laude, Distinguished Student Award, Spanish Minor

RESEARCH

PUBLICATIONS

Pines, R. & Watson, B. (in press). Theories of interpersonal communication. In T. Thompson & P. Schulz (Eds.), *Health Communication Theory.* Hoboken, NJ: Wiley.

Giles, M., Pines, R., & Giles, H. (in press) Testing the communication model of intergroup interdependence: The case of American and Canadian relations. *Journal of Multilingual and Multicultural Development. Advance online:* doi: 10.1080/01434632.2020.1720220

Pines, R. & Giles, H. (2020). Dancing through the lifespan: The social and health benefits of ballet for aging women. *Anthropology and Aging, 41*, 83-94.

Jones, L., Sheeran, N., Pines, R., & Saunders, B. (2019). How do health practitioners decide whether an interpreter is needed for families in neonatal and pediatric units? *Patient Education and Counseling, 102,* 1629-1635.

Pines, R., Jones, L., & Sheeran, N. (2019). Using family members as medical interpreters: An explanation of healthcare practitioner's normative practices in pediatric and neonatal emergency departments in Australia. *Health Communication.* Advance online: doi:10.1080/10410236.2019.1598740

Giles, M., Pines, R., Giles, H., & Gardikiotis, A. (2018). Toward a communication model of intergroup interdependence. *Atlantic Journal of Communication, 26,* 122-130.

Kam, J. A., Pines, R., & Bernhold, Q. (2018). Using a theoretical model of communal coping to understand changes in language brokers' coping patters: Implications for Latina/o early adolescents' brokering stress and efficacy. *Communication Monographs, 85,* 263-283.

Kam, J. A., Gasiorek, J., Pines, R., & Steuber, K. R. (2018). Latina/o adolescents' family-undocumented-status disclosures directed at school counselors: A latent transition analysis. *Journal of Counseling Psychology, 65,* 267-279.

Pines, R., Harwood, J., & Giles, H. (2018). Communicating intergroup matters: The Encyclopedia in context. In H. Giles & J. Harwood (Eds.), *The Oxford Encyclopedia of Intergroup Communication.* (Vol. 1, pp. xvii-xxviii). New York, NY: Oxford University Press.

Pines, R., & Giles, H. (2018). Dance and intergroup communication. In H. Giles & J. Harwood (Eds.), *The Oxford Encyclopedia of Intergroup Communication.* (Vol. 1, pp. 263-278). New York, NY: Oxford University Press.

Pines, R. L., Kam, J. A., Bernhold, Q. (2017). Understanding Latino/a language brokers' strategic identity goals in association with parent-child relational quality. *Journal of Social and Personal Relationships, 48,* 168-183.

Kam, J.A., Guntzviller, L., & Pines, R. (2016). Language brokering, prosocial capacities, and intercultural communication apprehension for Spanish-speaking mothers and their adolescent children. *Journal of Cross-Cultural Psychology, 48,* 168-183.

ORGANIZATION REPORTS

Pines, R. & Caputo, S. (2019). *Managing patient aggression during registration: An analysis of implementing the Affordable Care Act (ACA) 1557.* University of California, Santa Barbara and Cottage Health Research Institute.

Watson, B., Callan, V., Gallois, C., Leach, L., Hewett, D., Schwarz, G., Seoane, L. (2018). *Caboolture Emergency Department task management and training research.* Caboolture Hospital, Queensland Australia.
Pines, R. Completed and oversaw data analysis for compilation in the report

Jones, L., Sheeran, N., Pines, R., Saunders, B., Abbondanza, D. (2017). *Lost in Translation: What gets communicated, by whom, and who decides?* Griffith University and Gold Coast University Hospital.

CONFERENCE PRESENTATIONS

Pines, R., Benedetti, M., Sheeran, N., Jones, L., Pamoso, A., Watson, B., & Ying, B. (June 2020). Understanding the role of culture in decision-making preference patients have with their provider. Presented at the 70th Annual International Communication Association Conference. Gold Coast, Australia.

Pines, R., Jones, L., Sheeran, N. (June 2020). Improving doctor-patient communication in intercultural healthcare interactions. Presented at the 70th Annual International Communication Association Conference. Gold Coast, Australia.

Pines, R., Giles, H., & Watson, B. (July 2019). Addressing patient aggression and violence in a hospital setting: Developing competent accommodation among health professionals.

Presented at the Asian Association of Social Psychology 13th Biennial Meeting. Taipei, Taiwan

Giles, M. Pines, R., & Giles, H. (June 2019). Tensions between the United States and Canada: Testing Intergroup Interdependency Theory. Presented at the European Association of Social Psychology Meeting on Intergroup Communication. Bologna, Italy

Pines, R., Giles, H., & Watson, B. (June 2019). Managing patient aggression in hospitals: A training of competent accommodation to prevent work place violence. Presented at the European Association of Social Psychology Meeting on Intergroup Communication. Bologna, Italy

Sheeran, N., Jones, L., Pines. R. (June 2018). Communicating with LEP patients in Australia: How do health professionals decide what should be communicated and by whom? Presented at the 16th International Conference of Language and Social Psychology. Edmonton, Canada.

Giles, M., Pines, R., Giles, H. (June 2018). Toward a model of intergroup interdependence. Presented at the16th International Conference of Language and Social Psychology. Edmonton, Canada.

Pines, R., Jones, L., Sheeran, N., Saunders, B., Abbondanza, D. (May 2018). Explaining healthcare practitioners using family members as interpreters in pediatric and neonatal departments in Australia. To be presented at International Communication Association annual conference. Prague, Czech Republic.

Giles, M., Pines, R., Giles, H. (May 2018). Towards a communication theory of intergroup interedependency, To be presented at International Communication Association annual conference. Prague, Czech Republic

Pitts, M., Watson, B., Jones, L., Stewart, C. O., Imamura, M., Zhang, Y., Gasiorek, J., Stewart, C. Pines, R., Dragojevic, M. (May 2018). International Association of Language and Social Psychology: A roundtable discussion on the role of language in communication research. To be presented at International Communication Association annual conference. Prague, Czech Republic

Bernhold, Q., Rice, R., & Pines, R. (February 2018). Relational life in an era of multi-media communication: Toward an integrated model of online communication attitudes, communication frequency, and relational closeness. Paper presented in the Media Studies Division of the annual conference of the Western States Communication Association. Santa Clara, CA.

Pines, R., Sheeran, N., Jones, L. (November 2017). Using family members as medical interpreters: An exploration of healthcare practitioner's normative practices in Pediatric units in Australia. Presented at Gold Coast Health Research Week Conference

Kam, J., Pines, R., Bernhold, Q. (November 2017). Assess changes in language brokers' communal coping patterns: Testing a theoretical model of communal coping. Presented at the annual National Communication Association conference. Dallas, TX. *Top Paper Award*

Giles, M., Pines, R., Giles, H., & Gardikiotis, A. (June 2017). Epilogue: Towards a theory of intergroup interdependencies. Presented at the 1st International Symposium on Intergroup Communication. Location: Thessaloniki, Greece.

Sheeran, N., Jones, L., Saunders, B., Pines, R., Watson, B. (June 2017). *Lost in translation: What gets communicated, by whom, and who decides?*. Presented at the 1st International Symposium on Intergroup Communication. Location: Thessaloniki, Greece

Pines, R., & Giles, H. (June 2017). *Dance and intergroup communication.* Presented at the 1st International Symposium on Intergroup Communication. Location: Thessaloniki, Greece.

Pines, R. L., Kam, J. A., & Bernhold, Q. (May 2017). *Understanding Latino/a language brokers' strategic identity goals in association with parent-child relational quality.* Presented at the International Communication Association annual conference. Location: San Diego, CA.

Kam, J. A., Guntzviller, L., & Pines, R. (November, 2016). *Language brokering, prosocial capacities, and intercultural communication apprehension for Spanish-speaking mothers and their adolescent children*. Presented at the National Communication Association annual conference. Location: Philadelphia, PA.

Pines, R. & Chung, L. (August, 2014). *The identity (re)construction of the female MilSo.* Presented at the University of California San Diego Summer Research Conference

Pines, R. & Chung, L. (August, 2014). *The identity (re)construction of the female MilSo.* Presented at the USD TRiO McNair Scholars Summer Research Colloquium

INVITED TALKS

Invited presenter in UCSB Comm 128 – Intergroup Communication. Explained how intergroup theory can be applied for interventions in order to improve healthcare communication. (September 4, 2019)

Invited workshop leader at the International Research Centre for the Advancement of Health Communication (IRCAHC) at Hong Kong Polytechnic University in Hong Kong. Title: *Learning how to manage patient aggression to prevent work place violence in healthcare.* (July 7, 2019)

Invited presenter in UCSB Comm 594CE – Community Engaged Research. Discussed doing a community engaged dissertation as a graduate student to give advice to fellow graduate students. (February 4, 2019)

Invited as an early career speaker by CRiSP – Centre for Research in Social Psychology at the University of Queensland, Australia. Title: *U.S. Immigration, Language Brokering and Healthcare.* (August 19, 2016)

TEACHING

Santa Barbara City College – Adjunct Instructor
University of California, Santa Barbara

AWARDS

2019	School Research Project Enhancement Scheme at Griffith University
2019	New & Early Stage Investigator Award from Santa Barbara Cottage Hospital
2019-2020	McCune Dissertation Fellowship
2018	Cottage Hospital: Star Volunteer Award
2017	NCA: Family Comm. Division Top Paper Award
2016-2017	Graduate Research Mentorship Program Fellowship

ABSTRACT

Managing Patient Aggression in Hospitals: A Training of Competent Accommodation to Prevent Workplace Violence

by

Rachyl Leonor Pines

Workplace violence (WPV) perpetrated by patients against healthcare staff is abundant in healthcare settings. Many interpersonal communication skills trainings have attempted to equip staff to be better able to de-escalate patient aggression and prevent WPV. Nurses have received the most attention in trainings, as opposed to other types of healthcare staff. However, previous research has found that WPV is most likely to occur in the first hour of a patient visit meaning that the frontline staff should be of focus, and have not been to this point. Experiencing WPV has important consequences for staff and for patients. For staff, experiencing WPV is associated with staff burnout, low self-efficacy, low patient cooperation, low job satisfaction, more stress at work, more absent days, and higher turnover. For patients, the implications of poorly managed interactions are grave. They will experience poor care including but not limited to restraint use, seclusion, or antipsychotic drug use. Skills trainings have been insufficient and have been largely atheoretical. This dissertation ultimately aims to decrease WPV by developing a better training for healthcare staff generally.

To achieve this decrease, a first step was to conduct a pilot study by interviewing approximately 30 staff members in Australia about what training they receive about WPV and who typically perpetrates WPV. Study 1 then completes an interpersonal skills training intervention and three-month follow-up mixed-methods survey with approximately 180 frontline staff in a Central California hospital. Third, and of most focus, Study 2 of this dissertation develops and tests a communication competence training to prevent WPV framed by Communication Accommodation Theory using longitudinal mixed methods surveys. Study 2 trained all staff at a Central California clinic (approx. 170 employees) including dental staff, frontline staff, administrative staff, and primary care staff.

Although experiences of WPV were quite low at pre-training for both populations in Study 1 and Study 2, results of this dissertation show that attitudes and approach to patient aggression are the strongest predictors of use of communication strategies and successful de-escalation. Overwhelmingly, those that are more understanding of patient aggression and make external attributions for patient aggression are much more likely to use competent communication and achieve de-escalation. As more staff are successful in de-escalation by holding positive attitudes and using competent accommodation, the more they impact organizational norms by encouraging others to do the same. The trainings in both Study 1 and Study 2 were successful insofar as they increased staff efficacy in managing patient aggression and increased patient cooperation. The training in Study 2 is the first de-escalation training to be theory driven and is therefore replicable across contexts. Results of Study 2 help to refine CAT in two ways, first by refining its principles, and second by showing the applicability of the theory to function in creating successful interventions that can lessen WPV and therefore positively impact healthcare contexts.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

Preface

The following dissertation presents data about managing patient aggression in healthcare to prevent violence. The goal of this dissertation is to learn what replicable and generalizable strategies or orientations to patient aggression are most successful in preventing WPV in healthcare settings. The data for this study were collected from two different countries and three different healthcare locations. Study 2, the bulk of this dissertation, is longitudinal and uses mixed methods. First, this dissertation overviews the theoretical framework of the research by summarizing healthcare communication research and highlighting the strengths of the theory chosen for this work above other interpersonal adjustment theories. Next, this dissertation overviews the practical problem that these studies address. Specifically, previous research and definitional issues of workplace violence perpetrated by patients against healthcare staff in healthcare are highlighted. After, a pilot study with data collected from an interview study completed with Australian health staff is presented to better grasp staff understandings of patient aggression, its causes, and staff they learn to handle it (or not). Then, Study 1 presents information collected from a hospital in Central California that specifically addresses patient intake, where aggression most commonly occurs, thereby focusing mainly on non-medical staff performing a non-medical task in healthcare. In Study 1 over 180 staff members were trained. Study 1 used an existing interpersonal skills approach but moves existing knowledge forward by focusing on intake interactions.

Study 2, which is the main thrust of this dissertation, undertakes creating a new training that is theory driven using Communication Accommodation Theory (CAT) to address prior critiques of the interpersonal skills approach for managing patient aggression to

prevent violence. Study 1 findings help inform Study 2 training development. In Study 2, all healthcare staff at a clinic with approximately 170 employees in Central California ranging from front desk staff, call center staff, mental health professionals, medical assistants, primary care practitioners, and dentists were trained. Study 2 pushes de-escalation trainings to include dentistry and call centers, and also fuses theory with training on managing aggression and preventing violence. Of note, this dissertation generally and Study 2 specifically do not aim to add or test new constructs to broaden CAT. Instead, Study 2 carries the already established theoretical breadth of CAT forward both into the applied arena, and into creating an intervention. By so doing, findings from Study 2 refine the theoretical principles of CAT in valuable ways described in the general discussion. Study 2 brings CAT into the applied intervention health arena by not only considering the interpersonal interaction between a healthcare worker and a patient, but also focusing on the overall context, sociocultural histories between parties, and the norms in the healthcare organization as shaping and shaped by the interactions of focus.

Chapter 1: An Overview of Intergroup and Health Communication

As summarized by Teh (2014), the field of health communication started in late 1960's with work on HP-patient interactions in an interpersonal framework. Then, in 1989 the inaugural issue of *Health Communication* was published. Next, health communication research moved into interest in health campaigns with a media focus, then into power in the HP-patient relationship (Baker & Watson, 2015; Watson, Jones, & Hewett, 2016). Particularly regarding power when using an intergroup framework, researchers placed a special focus on interpersonal control strategies. The main outcome variables of interest regarded effectiveness of interactions, particularly focused on patient satisfaction (Watson &

Gallois, 1998, 1999, 2002). Although much research in healthcare communication has sought information regarding how to improve health practitioner training, especially communication skills to increase effectiveness of interactions (e.g., Kane & Sands, 1998; Carrard & Mast, 2015), it is not sufficient (Watson, Manias, Geddes, Della, & Jones, 2015). A skills-focused approach paints healthcare-communicative interactions (e.g. doctor-patient, doctor-nurse) as interpersonal in nature, which ignores many of the communicative issues stemming from healthcare's intergroup context (Watson & Soliz, 2019).

In light of the complicated context of healthcare settings and the nature of patient care in general, if we are to help improve patient care, we need theories that are able to provide robust predictive power and conscious processes that we could use to help improve training and hospital policy. Some scholars have turned to theories of interpersonal adjustment to achieve improved care. It is no secret that interpersonal adjustment is fundamental to human communication and occurs across a wide variety of domains. According to Gasiorek (2016), interpersonal adjustment is "the process of changing or adapting one's verbal and nonverbal behavior in an interaction in context" (p. 13). This act is largely an unconscious shift as will be demonstrated by the theories and constructs that follow. The large amount of interpersonal adjustment research across disciplines, and the profound undetectability of some forms of adjustment described below suggests that interpersonal communicative adjustment may be the mechanism that makes interaction possible at all. This notion is supported by the two main functions that interpersonal adjustment serves.

First, interpersonal adjustment helps interactants share cognitive frameworks, and allow for the co-creation or negotiation of shared meaning in interaction in a coherent fashion (Gasiorek, 2016). When successful, this can mean increased feelings of similarity, thus

associating with the outcomes of the similarity attraction principal (e.g., increased liking, trust, social support; Byrne, 1971). Second, they allow interlocuters to manage social distance and group memberships between one another. This management of distance is associated with consequential outcomes like social support (Burleson, Albrecht, & Sarason, 1994), resources, and social capital (e.g., Chi & Suthers, 2015), which may even mean increased chances of survival according to evolutionary scholars.

Comparing Theories and Constructs of Interpersonal Adjustments

There are several constructs that consider ways in which we shift our communication to be more similar to that of our interlocutor. First, Argyle (2017) describes response matching as person A communicating a message, immediately followed by person B responding in a very similar, almost identical fashion. A strength of this construct is that it proposes possible mechanisms for the adjustment including imitation and reciprocity (Argyle, 2017). A limitation of response matching is that the research does not address clearly the function of this adjustment, and it does not discuss what the effects of response matching are, negative or positive. Response matching has been determined to be either conscious or unconscious.

Very similarly, mimicry is mirroring or imitation of an interlocutor's verbal or nonverbal behaviors (Chartrand & van Baaren, 2009). Mimicry functions as a tool to build rapport, facilitate empathy, and generate social support (Thomsen & Brier, 2014). Chartand and Van Baaren (2009) state that mimicry can have intergroup effects. For example, interlocuters like people more who mimic them that are from their ingroup, and this helps with understanding the other's emotions. Mimicry is considered to be unconscious. Lastly, linguistic style matching is focused on language in terms of the synchronized use of function

words like prepositions, articles and conjunctions (Ireland & Pennebaker, 2010). Previous research has found that linguistic style matching is positively correlated with engagement. Some research has also found support for a positive association between linguistic style matching and mutual romantic interest because it means that the interlocuters are sharing the same cognitive framework (Ireland et al., 2011). Linguistic style matching is considered to be totally unconscious, as it is very difficult to detect it unless using linguistic analysis such as discourse transcription (see Bucholtz & Du Boise, 2020 as a resource for an explanation of discourse transcription methods).

Another set of constructs focuses on interpretability as the result or cause of interpersonal adjustments. First, an interpersonal adjustment called "grounding" refers to the focus on reaching a mutual belief that each party understands each other well enough for the purposes of the conversation, thereby providing evidence that speaking is a "bilateral process" or a processual joint activity (Clark & Krych, 2004; Gasiorek, 2016). The process includes trying to achieve coordinated activity and content so that information can be conveyed. Next, code-switching, or the alternation of using two (or more) languages by a bilingual speaker (i.e., Czech and English) in discourse with another speaker can be done to express disidentification or disaffiliation, or to include or exclude different people (Gardner-Chloros, 2009). Most research using this construct considers switching dialects or languages. This process is largely considered to be unconscious.

Recipient design is largely a linguistic theory focusing mainly word choice that facilitates (or not) the accessibility of information. Previous research in this framework has also considered rate of speech-change depending on perceived traits of the receiver (i.e., cognitive abilities of children; Newman-Norlund et al., 2009). There is no specification as to

whether this is a conscious or unconscious process. Very similarly, audience design, which may include code-switching as one type of audience design, is defined as accommodating one's audience. Audience design adjustments are impacted by the environment, but scholars in this framework consider environmental impact to be quite small (Bell, 1984). Environmental impact is instead called overhearer design, and is considered to be a very macro effect, not detectable in quantitative micro-variables. This process can be reactive or proactive. Due to the word "design" scholars consider this to be a conscious adjustment (Coupland, 2007). One limitation of audience and recipient design is that the model is descriptive and does not addresses causes. Lastly, Bell (1984) explains that using language that is uninterpretable to someone means that receiver is out of the audience, thus suggesting some notions of intergroup communication generally.

A final set of two interpersonal adjustment constructs is concerned with expectations. First, discrepancy arousal theory, born out of labeling-arousal model states that adjustment follows from a discrepancy between expectations and reality (Cappella & Greene, 1982). A moderate level of discrepancy may be pleasant while a heightened level is not. A positive violation is associated with approach or convergence whereas a negative violation is associated with distance or divergence. This is an unconscious adjustment and includes nonverbal behaviors. A limitation of this perspective is that it is focused on mechanisms and does not offer consequences or functions of the adjustments. Second, interaction adaptation theory, born out of expectancy violations theory, states that an interaction position is formed by a person's requirements for the conversation (R), their expectations (E) and their desires (D) (RED; Burgoon & Hubbard, 2005). A violation more positive than RED is associated with convergence, whereas a violation more negative than RED is associated with divergence

or maintenance. Interaction adaptation theory proposes consciousness as a moderated by type of need in the conversation such that if the conversation is about a basic human need, then adjustments are unconscious. If the conversation regards social or personal factors beyond basic human needs, then conscious adjustments may be made. A limitation of this perspective is that is does not specify functions or effects of the adjustments.

Using Communication Accommodation Theory for Health Communication Research

Using theories of interpersonal adaptation for healthcare communication research and intervention would be insufficient and inappropriate for several reasons. Namely, theories of interpersonal adaptation are insufficient because they are largely descriptive-level theories that explain adaptations that are unconscious. They also show very small effects sizes generally. Several researchers have acknowledged the lack of information that theories of interpersonal adaptation offer. However, the value of an intergroup framework in healthcare has increased. One theory that has received special focus in healthcare communication is Communication Accommodation Theory (CAT). CAT offers an intergroup theory of interpersonal adjustment that fills in the limitation gaps of those preceding theories (and therefore will be framing this dissertation). Generally, CAT posits that speakers can adjust their speech toward (converge) or away from (diverge) their communicative partner to maintain a desired social identity (Giles, 2016). The perspectives of interpersonal adjustment described heretofore are not specific about or *only* focus on explanatory mechanisms. CAT, however, is very specific with social identity and personal identity being one of the main the motivators of interpersonal adjustment (Soliz & Giles, 2014). Thus, CAT addresses both individual and group level interactions and adjustments (Dragojevic & Giles, 2014). Social identity is defined as "that part of an individual's self-concept that derives from his

knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership" (Tajfel, 1978, p.63). Social identities are activated when circumstances make some group-level identities more salient than others (Hogg, Terry, & White, 1995). To maintain a positive social identity, individuals engage in communicative adjustments, both verbal and nonverbal, to either converge toward a desired social identity or diverge away from an undesirable social identity. Having a strong explanatory mechanism for interpersonal adjustment is a main strength of CAT above other theories of interpersonal adjustment.

In addition, CAT offers other strengths beyond the other perspectives. Like all those perspectives listed above, CAT is consistent with the notion that interpersonal adjustment is fundamental to interaction. Yet, CAT complicates the notion further to say that we can simultaneously converge and diverge toward and away from a speaker (Giles, 2016). For example, a physician may wish and even intend to accommodate a patient (i.e., psychological convergence) but may do so by assuming a competent and direct speaking style using complex medical terms in describing their health plan (i.e., linguistic divergence). In addition, CAT is less explicitly tied to methodological approaches as the others above (i.e., linguistic style matching requiring rigid linguistic methodological tools). CAT is also superior to the above in that it is more equipped to be and has been invoked in applied contexts more than others (see Farzadnia & Giles, 2015 for a review of patient-provider studies invoking CAT). This is a large benefit for healthcare research and intervention.

Perhaps the most important of strengths of CAT is that it questions appropriateness of the adjustment. Although the other frameworks of interpersonal adjustment studying expectations have touched on this notion, they position adjustment as the outcome. Research

using CAT generally focuses on adjustments as the mediating or independent variable and subsequently focuses on outcomes of those adjustments such as patient compliance, for example, when a healthcare professional (HP) accommodates or not. Not only does CAT question the appropriateness of, but also considers information about, objective and subjective adjustment, taking into account the attributional process including the socio-historical context of the interaction. Although, to date, no firm stance has been taken by CAT scholars on whether interpersonal adjustments are conscious or nonconscious, it is speculated to be similar to expectancy constructs in that if individuals' attempts at some conversational outcome (nonconscious) fails then they may make conscious efforts (Gasiorek, 2016). Or, that speakers who are engaging in conscious behaviors to converge toward their interaction partner hold a specific intention such as facilitating liking or building rapport. Rather than attempting to determine whether communicative acts must be conscious or nonconscious to "count" as (non)accommodative, theorists in recent years in this arena have focused on when and why different forms of (non)accommodation are (non)conscious (Bernhold & Giles, 2020).

Other affordances that intergroup frameworks offer health communication researchers are an understanding of how an interaction may have gone wrong or resulted in miscommunication. By viewing a communicator's initial orientation to a conversation, we can understand categorizations and associated attitudes through which a person interacts with the others. Initial orientation forms for a person based on their relative salience of identities of those in the interaction. This includes interpersonal history, sociocultural norms, values and current and past state of intergroup relations (Gallois, Ogay, & Giles, 2005). If interactions are only thought of in only an interpersonal framework, researchers would only

generate questions that focus on the encounter itself, and largely miss out on issues of attitudes and pre-existing goals and histories as people enter into interaction. What is more, invoking an intergroup perspective is not a tradeoff between interpersonal and intergroup research. Instead it has been well demonstrated that that communication and can be both high or low in intergroup and in interpersonal dimensions simultaneously (Dragojevic & Giles, 2014). Recognizing the affordance of CAT for healthcare communication research and intervention, research has since taken two main pathways, interprofessional practice in hospitals including teams, or HP-patient communication.

Interprofessional practice

Research in an intergroup framework regarding interspecialty communication has shown the siloed nature of interprofessional practice in hospitals (Watson et al., 2018). For example, a study on patients with upper gastrointestinal bleeding showed that doctors' specialties were their most salient identities in the interaction. This can be seen as they refer to one another by their specialty name rather than their actual names. This is also an example of interpersonal control strategy (Hewett, Watson, Gallois, Ward, & Leggett, 2009). Although just one example, interspecialty communication in hospitals is often highly intergroup, which can be detrimental for patient care. For example, HPs report experiencing professional identity threats due to differing values between professions and conflicts, which impacts their care delivery (McNeil, Mitchell, & Parker, 2013). Collaboration is a highly necessary component of patient care in the hospital setting for the many groups to meet a common goal. Interprofessional practice requires effective communication for members of each group to be able to contribute their expertise to the situation (Watson, Heatley, Gallois, & Kruske, 2016). Invoking CAT to view interprofessional practice and interspecialty

communication can help us better understand the complexities of the hospital setting and thus design interventions that go further than a skills-based approach.

HP-patient interactions

Invoking a CAT framework, research in recent years has begun to use this intergroup framework to replace the interpersonal skills approach. For example, a recent study developed a learning experience using CAT accommodation strategies to create a training for pharmacists. Their results showed that participants realized the need to have actual conversations with their patients, and that the learning experience did in fact change the way pharmacists communicated with patients for the better (Chevalier, Watson, Falconer, & Cottrell, 2017). Otherwise, attention has been given to interpersonal control strategies in various specialties of medical care including palliative care, geriatrics, pain communication, neonatal and psychiatrics.

Although not overtly stated, studies of interpersonal control strategies in those arenas suggest two main things. First, that there is a struggle for control in interactions, especially in neonatal care where the caregiver desires more control. Second, they suggest that HPs manage discourse better than patients (Farzadnia & Giles, 2015). Another key finding of healthcare research in an intergroup frame is that Watson and Gallois (1998), regarding patient satisfaction and compliance, found that patients perceived HPs to be attending to controlling the interaction. Some of this type of behavior was perceived as satisfying. However, there is a delicate balance to accommodation and nonaccommodation (Williams, 1999). Other researchers have found similar results in that HPs rated higher in typicality were rated as more satisfying, moreover the researchers did not differentiate between justifiable and unjustifiable nonaccommodation because it is so context dependent in healthcare.

(Gasiorek & Giles, 2012). Taken together this means that not only is accommodation important in certain aspects in the HP-patient relationship but also nonaccommodation can be important for the appropriateness of the communication in these interactions. Achieving complementarity in these interaction with power discrepancies may be even more important. Complementarity refers to following expectations for an appropriate blend of accommodation and nonaccommodation based on the situational expectations of the interaction (for a review of studies of accommodation in relationships with power differences and defined hierarchies see Thakerkar, Giles, & Chesire, 1982). Of course, when the balance is not ideal and includes too much nonaccommodation healthcare delivery and patient care suffers.

Overaccommodation occurs when an interactant overdoes their adjustments to the extent that they are no longer considered accommodative (i.e., slowing down speech too much such that the receiver perceives an insult to their intellect). This may be done with positive or malicious intent. Overaccommodation in cases where patients can understand the HP but are unable to communicate their understanding can be a detriment to satisfying encounters. For example, research regarding these types of patient interactions has found that patients feel more discomfort, depression, and helplessness (Hemsley, Baladin, & Worral, 2012). Similarly, too much underaccommodation in HP-patient interactions using convergent interviews has shown that HPs do not sufficiently account for patient's interpretive competence, instead using technical jargon unintelligible to the patients. In turn, patients are more likely to underaccommodate by not sufficiently describing their symptoms in a way the HP can understand (Baker, Gallois, Driedger, & Santesso, 2011). Aside from issues of

general nonaccommodation unspecified if due to motivation or ability, there are some HP-patient interactions in which an HP is unable to accommodate.

Situations of multilingual medical interactions in which the HP does not speak any of the same language(s) as the patient are a special case of troubling interactions. Gasiorek and colleagues found that health nonaccommodation due to inability occurred in a multilingual medical context (Gasiorek, Van de Poel, & Blockmans, 2015). In these situations, HPs tried to adopt more nonverbal accommodation by using more gestures. In these scenarios, again inferences about motivation for nonaccommodation mattered such that if the patient thought that the HP was not putting in much effort then that is more egregious (Gasiorek et al., 2015). Specifically, when the HP was unable to accommodate, exacerbated by patient perceptions of HP lack of effort, it led to more patient perceptions of social distance. This resulted in experiencing more negative affect after the medical encounter. Despite there being a growing body of research on dissatisfying or difficult medical encounters in an intergroup frame in which the *provider* may not be able to accommodate, very little research has been done regarding accommodation with *patients* who may be unable or unwilling to accommodate. This dissertation lessens this gap by better understanding patient aggression as possibly nonaccommodative in medical contexts, and training staff to manage it. Ultimately this aims toward preventing workplace violence as overviewed in Chapter 2.

Using CAT to Study Difficult Healthcare Interactions

Research regarding difficult patient encounters have included several types of encounters, of which patient aggression is only one. In the healthcare context, challenging clinical encounters refer to "frustrating and demoralizing episodes in which forging a therapeutic relationship between health care providers and patients is difficult, if not almost

impossible" (Marcum, 2014, p. 405). For these interactions, HPs no longer only rely on the patient to adequately communicate their symptoms or medical complaint. Instead policies now implicate the clinician to help in the encounter, especially with continued expectations of patient centered care. Another study implicates attitudes as the reason an encounter is challenging – such as hostile sexist male patients toward a female physician (Cronauer & Mast, 2014). Studies in this arena go so far as to name the categories or types of patients that are challenging including "the denier", and "entitled demanders" to name a few. Often these types of patients also have a mental disorder (Marcum, 2014, p. 405). This naming of categories of difficult patients in challenging medical encounters indicates a highly intergroup encounter. HPs enter into the conversation with an initial orientation of preconceived ideas based on stereotype or group membership of the type of patient they encounter, which may include instances of encountering an aggressive patient.

Adverse Encounters

The term adverse is often used in health communication research to refer to difficult encounters that result in some sort of harm to a patient (i.e., adverse medical events). For example, Hemsley and colleagues (2012) found that communication disability such as developmental disabilities in patients that affect their communication or patients with little to no functional speech, or complex communication needs often was associated with adverse and preventable undesirable events in hospital. When ability is the barrier to communication thereby creating a problematic talk encounter, more creative forms of communication may be required such as using a whiteboard or communicating with photographs, using interpreters or gestures found (Hemsley et al., 2012). At times, adverse can also be used in medical

settings as a term that is ambiguous enough to avoid placing blame for the harm that befalls the patient and is used after the fact.

Problematic Encounters

Pittam and Gallois (1999) as also discussed in Williams (1999) explain problematic encounters in the context of accommodation dilemmas as situations in which participants do not agree or perceive the position taken by themselves to not match their interlocutor. Coupland and colleagues offer a typology of miscommunication with six levels. (Coupland, Wiemann, & Giles, 1991). Overall, problematic talk would be categorized into the highest level of the miscommunication typology as it centers on a mismatch of social power or ideology with an essential unawareness of that fact. Indeed, Boggs and Giles (1999) conceptualize problematic talk as a cycle of nonaccommodation, a level VI issue in the typology with "reinforcing socio-structural power imbalances between groups" (p. 226). This work was a seminal piece to pushing research in sexual harassment training into an intergroup arena. Previously, research in his domain was focused on the interpersonal skills of women dealing with harassment, instead of focusing on intergroup level characteristics of gender in the workplace. As mentioned by Gasiorek (2016) when nonaccommodation continues without correction or question, it may become institutionalized. Although we are offered these definitions of problematic encounters, labeling them as such can be subjective.

Although one group may label the communication as problematic, the other party may define it as something else. For example, Watson and Gallois (1999) characterize problematic talk as patients finding a miscommunication with their physician unsatisfactory. This leaves much room for the physician perspective to be very different in that they may find the interaction frustrating or a waste of time, rather than problematic. Those who do not

or wish not to see the interaction as problematic use this blindness to benefit themselves. In addition, some scholars (e.g., Williams, 1999) have discussed problematic talk, sometimes mislabeled as a miscommunication as unavoidable and inevitable. In this sense, there may not be any strategies to which we can assign to problematic encounters as a remedy. Instead interlocutors, depending on their conversational goal, may engage in strategic ambiguity in an attempt to save face and escape the problematic encounter. Research on problematic encounters may require critical approaches to research.

Taken together, these types of encounters can overlap or turn into one another. For example, problematic encounters may become adverse in the medical setting (Hemsley et al., 2012). Also, conflict with problematic subject matter may produce a stalemate, or an unresolvable problem. Challenging encounters may even be embodied by any of the other types of encounters listed as above as one can imagine that attitudinal issues or initial orientation in CAT terms, may play a key role in any of the other encounters.

According to Soliz and Bergquist (2016), some robust findings from CAT associated with accommodative behavior are increased well-being (i.e. self-esteem, life satisfaction and mental health), compliance (message agreement and persuasiveness), credibility and trust, quality of contact (communication satisfaction and evaluation of the conversation) and relational solidarity (relational satisfaction closeness, common ingroup identity and intimacy). Findings such as these suggest that with an increased understanding of interactions with aggressive patients and which accommodative behaviors matter in those settings, we may be able to remedy various types of difficult interactions by increasing and improving accommodation. In addition, with its focus on group level characteristics giving researchers a

better understanding of *why* people are adapting the way they are and *how* they are adapting, CAT may be the best suited theory to address interactions with aggressive patients.

Using CAT as an Intervention for Improved Communication with Aggressive Patients

Very little research has invoked an intergroup framework like CAT to examine difficult patient-provider interactions in terms of cognitive impairment or patient aggression for a variety of factors. Previous intergroup and health research has focused on older adults in care who experience some sort of cognitive degeneration, who may be in an altered mental state or who experience some type of delirium. When these older adults experience nonaccommodation like patronizing speech and interpersonal control, they report reduced perceptions of quality of life (Lagacé, Tanguay, Lavallée, Laplante, & Robichaud, 2012). More specific to mental health issues in medical care, Teh (2014), in a doctoral thesis using CAT, studied doctor and patient discordant explanatory models (EM) to understand how EM impacted their communication, particularly the extent to which the communication was empathetic and effective. This research showed that the way that patients develop their EM has to do with self-stigma internalization such that they view themselves negatively as they internalize negatively stigmatized issues of depression.

In terms of the communication, from the patient point of view, if they present with a cooperative accommodative stance then communication was more effective. Interactions were deemed especially helpful when doctors attempted to understand their patient EM and treat from their perspective, rather than using their own EM expecting that the patient match theirs. Taken together with issues of nonaccommodation in aged care and disparate EMs of depression, it becomes clear that communication with patients with mental disabilities (transient or permanent) pose a special difficulty for medical interactions. Clearly

experiencing lessened feelings of life quality, and internalizing depression stigma are undesirable correlates of inappropriate accommodation and dissatisfying medical encounters. However, in cases of aggressive patients the outcomes contributed to by inappropriate communication may be even graver, including patient violence and abuse of HPs. Issues of this type, due to their grave nature and their lack of research require more attention.

CAT provides the most robust and complex framework for studying patient aggression and violence issues to better understand effective and ineffective interactions and their outcomes via CAT strategies and dimensions. Research in aggression or difficult patients in emergency departments specifically has been largely a-theoretical (Roberton, Daffern, Thomas, & Martin, 2012). Separately, Pitts and Harwood (2015), in their epilogue of discussing ways forward in CAT, say we should start working toward communication accommodation competence. In other words, we should work to establish competent relations which can only be done in taking into account context, and identity of the communicators. In terms of taking identity into account, one new/burgeoning form of accommodation within CAT in the family communication arena mainly is identity accommodation, or the communicative affirmation (actual or perceived) of an interlocutor's identity or heritage in interaction (e.g., ethnic or religious identity).

When done competently, identity accommodation has been associated positively with relational satisfaction and shared family identity (Colaner, Soliz, & Nelson, 2014; Soliz, Thorson, & Rittenour, 2009). In a medical setting, successful identity accommodation may look like affirming a patient as "not crazy" or "not homeless" as they come in describing their symptoms and refusing resources and explaining that they are "not crazy" and "not homeless." Therefore, responding to the call by Pitts and Harwood (2015) and the critique of

previous ED research by Roberton and colleagues (Roberton et al., 2012), taking this construct into the medical context, along with the five other approximation strategies, may help provide HPs with a better or more competent way to communicate with aggressive patients to prevent violence.

Chapter 2: An Overview of Patient-Perpetrated Violence in Hospitals

Violence and aggression in hospitals, particularly emergency departments (EDs), has long been and still is a global and largely underreported yet common concern for both those who work there, and researchers alike (Lavoie, Carter, Danzl, & Berg, 1988). In 1991, around the time that workplace violence (WPV) and its under-reporting became of interest to the International Council of Nurses, more research was undertaken regarding the nature and causes of this violence. In terms of prevalence, Blank and Mascitti-Mazur (1991) found that 25% of teaching hospitals in Philadelphia, Pennsylvania, in their sample reported at least one incident of verbal aggression per day, and one threat of physical aggression with a weapon per month. Since that time, the problem has not improved. Incidents of violence in subsequent studies have included verbal (e.g., being sworn or yelled at) and physical violence, like being pushed or having some object thrown at healthcare worker (Crilly, Chaboyer, & Creedy, 2004). What is more, a 2017 review of violence against emergency medical personnel compared the non-fatal injury rates of HPs in ED as similar to, or higher than that experienced by police and firefighters, making the injury rate of HPs in ED higher than the national U.S. average of all occupations (Maguire, O'Niell, & Brightwell, 2017; Maguire, & Smith, 2013). Although WPV often occurs within the first hour of a patient's visit (Crilly et al., 2004), it may be the case that violence occurs after dissatisfactory interaction. Therefore, interactions between healthcare staff and aggressive patients may be

arenas of violence prevention. If healthcare staff are better able to communicate with acutely aggressive patients, they may be able to de-escalate scenarios and prevent WPV.

Previous research has attempted to not only define the parameters of WPV, but also explain how to best manage and prevent it. In addition, hospital policies have called for different orientations toward said violence. In what follows, I will define WPV and delineate consequences of WPV for staff and patients. Next, I will describe the prevalence of WPV as associated with patient factors. I will also identify staff-associated factors, such as attitude and knowledge that can be consequential for the patient-HP interaction. Regarding this, I will describe a pilot study I conducted as part of a larger project to gain a better understanding of staff training and knowledge of communicating with aggressive patients. I will then summarize existing strategies that have been identified in the literature. Despite previous research focusing on strategies of WPV management, very little research has gone beyond describing the nature of the problem. To address this gap, I will propose Study 1 which will systematically test strategies previously identified in the literature that are apparent in communication focus (e.g., not including seclusion, restraints, or antipsychotic drug administration). Strategies of this sort have been skills-focused, however, and by themselves are inadequate. In addition, previous research has lacked a theoretical basis. Study 2 will address the limitations of Study 1 by proposing a communication competence focus, framed by Communication Accommodation Theory, on interactions between aggressive patients and HPs.

Defining WPV and its Consequences

To demonstrate the variety of violent incidences that can happen in the workplace, Perrone (1999) identified 21 acts that constitute violence and noted that it is on the rise. It is

also important to point out how the hospital is unique in terms of WPV because general definitions and policies regarding WPV include only staff-staff violence whereas the overwhelming majority of violence or near violence that occurs in hospitals is from service users (i.e., patients and their family members; Beech & Leather, 2006). Researchers have considered violent instances to be, "adverse events and near misses – an incident being any event or circumstance which could have led, or did lead, to damage or harm" (Benveniste, Hibbert, & Runciman, 2005, p. 348). This definition adds near misses to our understanding of violence in the workplace, which should not be overlooked. Near misses of violent events may include "any client [patient] – initiated incident in which an employee [nurse] is physically attacked or threatened in the workplace" (International Labour Office et al., 2002). This definition falls short because it does not consider the instances in which a family member of a patient may initiate the violence.

Although many definitions of WPV exist in the literature, this dissertation will opt to use "any incidents where staff are abused, threatened or assaulted in circumstances relating to their work…involving an explicit or implicit challenge to their safety, well-being or health" (Mayhew & Chappell, 2005, p. 346). Hence, incidences of WPV include verbal abuse, physical threats, assault and emotional abuse (Lyneham, 2000). This definition is sufficiently broad to include all types of aggression and violence, committed against health staff by any person receiving services in the hospital. Previous research, to my knowledge, has not considered different mechanisms that regularly underlie different forms of WPV. Nor has previous research considered common forms of WPV that different types of patient, or their family members perpetrate. Instead, research has focused on prevalence of all types of WPV taken together and who is likely to perpetrate them. The most common type of aggression

experienced by HPs is verbal in kind. One study in Australia reported that about 80% of nurses have been subjected to it (Pich, Hazelton, Sundin, & Kable, 2010) and, another in Florida, reported that 100% of nurses in ED experienced it in the last year (May & Grubb, 2002).

Previous research has shown that the emergency nurse is the most likely HP to experience violence or aggression in the ED (Crilly et al., 2004). Although long wait times can contribute to patient or even family member aggression toward ED nurses and staff (May & Grubbs, 2002), violence and aggression mainly occur upon arrival, or within the first hour spent in the ED (Crilly et al., 2004). Frontline non-medical staff interact with patients immediately upon arrival and interact the most frequently with patients in the waiting area (unless patients arrive by ambulance). Therefore, frontline non-medical staff are included as individuals at high risk of experiencing patient-perpetrated aggression and WPV in the ED and other departments in a healthcare setting.

WPV has detrimental consequences for staff, healthcare received by patients, and for the hospital more broadly, especially when perceived as preventable or handled poorly. Effects of experiencing WPV, or threats to safety that can befall HPs, including frontline staff who experience WPV, may be short- or long-term. Staff experiencing WPV is associated with burnout (obtained through interviews), feelings of incomprehension (Erickson & William-Evans, 2000), anger and helplessness (Chambers, 1998), fear (Hislop & Melby, 2003) and, long-term, could even experience PTSD (Laposa, Alden, & Fullerton, 2003). These effects on staff can have larger impacts for the department and hospital more broadly, such as increased absenteeism (Hastings, Suter, Bloom, & Sharma, 2016), loss of productivity, increased sickness absence, increased turnover, and early retirement through

disability (Martini, D'Ovidio, Ceracchi, & De Santis, 2012). There are also undesirable outcomes for patients when patient aggression preceding violence is not handled well including increased use of restraints and antipsychotic drugs – which can also be very expensive for the hospital (Coburn & Mycyk, 2009) - dissatisfactory care, and increased likeliness to return to the ED (Feinstein, 2014).

Clearly, it would be beneficial to be able to prevent WPV for HPs, the hospital, and the patients. In agreement and addition, Kinkle (1993) asserts that it is crucial that HP staff be trained in the identification of pre-violent behaviors such as loud talking, profanity use, clenched jaw, and rapid pacing (Tishler, Reiss, & Dundas, 2013). Identifying the precursors to violence will help ready HPs to employ strategies to ensure that the situation does not escalate. The prevalence of WPV and existing knowledge on the topic necessitates proactive training for healthcare staff, especially frontline staff, to enact WPV prevention. This type of plan requires a focus on the interaction between the HP and patient that precedes and can prevent WPV. Given this, this dissertation conducts a pilot study and two substantive studies that refine, implement and evaluate de-escalation training informed by CAT for HPs on how to prevent WPV.

Patient-Associated WPV Indicators

In order to understand how to prevent WPV, we must first acknowledge the major patient-level factors that are associated with an increased likelihood to perpetrate WPV (see Table 1 for a summary of factors and associated behaviors). Broadly, previous research has conceptualized that there are three main categories of *causes* for WPV (Gerdtz et al., 2013). The three categories that have received scholarly attention separately often appear

concurrently in practice. The three main categories are: cognitive impairment, being under the influence of substances, and long wait times.

Regarding cognitive impairment, some of the major types of mental illnesses of interest to researchers as linked to WPV are schizophrenia, major depression and bipolar disorder (Pich et al., 2010). This link can be as strong as those with the aforementioned disorders being up to two-to-three times more likely to exhibit violent behavior than the general population (Friedman, 2006). In addition, drug and alcohol abuse in patients with a mental illness of these sorts increases the potential for violent behavior (Gillies & O'Brien, 2006). With this wide variation of disorders and substance use, some scholars have opted to altogether not study patients with mental illness when exploring the effectiveness of de-escalation techniques (Price & Baker, 2012). However, with research showing that mental illness is potentially the foremost patient-indicator of WPV, it should *not* be ignored.

Similarly, a better understanding of substance use patients as related to WPV is essential. Bunting, Fulde, and Forster (2007) examined different types of drug users and found that methamphetamine users were significantly more agitated, violent, and aggressive than other patients presenting with issues related to or caused by toxicology. Patients were also less alert, communicative, and cooperative. These users were more consistent users, and not people who seemed to be using methamphetamines as a "party drug." Alcohol is also another common substance-related presentation in ED. Most often, when patients arrive in the ED due to alcohol, they arrive by ambulance and they are so intoxicated that they lie in the hospital bed until they sober up, at which point some patients get impatient and want to leave. Alcohol abuse likely becomes of interest if it is combined with another substance or mental illness in terms of contributing to WPV.

Alongside this list of presenting factors, it is also the case that some patients will be known to the hospital staff while others will be presenting for the first time. Patients that appear frequently in ED or other departments - such that the staff know them or find them familiar – are, at times, referred to as "frequent flyers" by some ED staff at the Central California Hospital in Study 2. According to HPs in one study, a lack of a strong mental health system and lifestyle factors (i.e., insecure housing, social isolation or loneliness, and complex mental and physical health needs) were the main perceived reasons for which people become "frequent flyers" (Kahn et al., 2016).

Despite prior knowledge of the patient, perhaps being helpful in terms of knowing what triggers them and what their presenting issues are, there may also be reasons why a "frequent flyer" may be even more challenging than patients unknown to staff. For example, previous research has found that "frequent flyers" have some knowledge about the capabilities of the security guard(s). Namely, they may know the walking patterns or limitations of what actions a security guard at a given hospital is or is not allowed to take (Gillespie, Gates, Miller, & Howard, 2012). For example, in some hospital settings, the security guard is the one to apply restraints whereas, in others, that is the job solely of the nurse. This highlights the importance of gaining understanding of the training received and capabilities all staff in a given research setting.

Taken together, there are indicators of violence that are both more or less severe and more or less prevalent in hospitals. In terms of prevalence, previous research in Australia described the most common contributing factors to WPV. The most common patient-related factors were mental health conditions contributing to 40% of incidents; dementia to 15%; pathophysiological factors to 13%; confusion to 9%; alcohol or drug intoxication to 6% of

incidences (Benveniste et al., 2005). In light of understanding primary patient associated causes of WPV, previous research has aimed to lessen patient agitation and prevent WPV by understanding HP training, and developing trainings.

Table 1. *Types of aggressive patients and outcomes*

Type	**Sub-types of interest**	**Characteristics**	**Likeliness to perpetrate compared to general population**
Cognitively impaired	Schizophrenia Major depression Bipolar disorder	Likely to use substances	Up to 2-3 times more likely Most prevalent type of patient
Substance users	Methamphetamines	Less alert, communicative, and cooperative	More agitated, aggressive, violent
Frustrated			Likely to become violent

Previous Efforts to Prevent WPV

Most hospitals have a policy about how to handle distressed or aggressive patients to prevent WPV. Generally, in hospital policies, using restraints and administering antipsychotic drugs are discouraged and often are even a last resort (Chan, Taylor, Knott, Liew, & Kong, 2012). Clinical antipsychotic drug administration is a last resort because of the direct (i.e., expensive medicine) and indirect costs to the hospital (i.e., absenteeism of staff due to administering pills that agitated patients refuse). Despite these policies, nurses and staff often do not receive adequate training or experience in handling these situations using other means. Other researchers have highlighted and attempted to bridge this gap. However, much of this research has been criticized for being largely a-theoretical (Roberton, et al., 2012). The main framework that researchers have used is called the frustration-aggression hypothesis (Berkowitz, 1989; for an example, see also Fida et al., 2018). This

states that when someone is frustrated to a certain extent, in this case with their care or illness, they will resort to aggression. Lyneham (2000) maintained that when a patient is under the influence of a substance, or by extension in an altered mental state due to cognitive impairment, their frustration is likely to be worse, thereby increasing their aggression. This framework offers a description of the process of frustration preceding WPV, but does not offer an explanation or suggestion of what HPs should do about that process to slow it down or cut it off before WPV occurs.

In addition, Benveniste et al. (2005) also found that staff-related factors contributed to WPV. Specifically, the most common contributing staff-related factors were insufficient or inadequate staffing, so-called communication problems, and inadequate knowledge or experience. In what follows, I will discuss the importance of understanding these communication issues, and the extent to which staff knowledge, training and experience may help to prevent WPV.

Staff Training

The majority of training that staff traditionally receive is skills-based. Street (2003), in a literature review studies of interpersonal skills in healthcare, explains that clinicians are often taught to recognize the individual needs of the patient, and clearly deliver information. In the patient aggression arena, for example, a study on education in paediatrics for HPs included training and encouragement on quelling parental distress, using scripted phrases, case scenarios, and discussion with written documentation (Frazier, Liu, & Duak, 2014). Despite the apparent communication focus of several of these skills trainings, there is a lack of a description of what those phrases are, and how to best deliver them. In addition, health communication researchers have begun going beyond a skills-based focus for improving care

delivery because it is insufficient (Watson et al., 2018). A skills-focused approach paints healthcare communicative interactions (e.g. doctor-patient, doctor-nurse) as solely interpersonal in nature, which ignores many of the communicative issues stemming from hospitals' intergroup, organizational, and institutional contexts (Watson & Soliz, 2019).

Pilot Study

In light of previous research, and after noticing, in my volunteer role at a Central California Hospital in the ED, that patients who were in what the hospital called "an altered mental state" were often aggressive, I conducted a preliminary pilot study in a large tertiary ED in a hospital in Queensland, Australia. Patients in an altered mental state included those who were under the influence of drugs or alcohol, or had some cognitive impairment or psychosis. This pilot was part of a larger project to understand ED workflow, particularly focused on facilitators and barriers to effective communication in EDs. Interviews with 21 participants in all positions in the ED were conducted in the department at a time convenient for the employees. Of the participants, 61.90% were nurses (n = 13), 23.81% were clinicians (n = 5), and 14.29% (n = 3) were in administration. Interviews lasted approximately 20 minutes. The questions asked of employees focusing on communicating with potentially violent patients were: "What training do you receive to communicate with patients with cognitive impairment (mental health disorders) or altered mental states in triage?" and "What communicative strategies do you use to communicate with patients who have altered mental states due to substances or mental health disorders?" Probing questions time permitting included "How effective do you think those strategies are? How did you learn them?"

Results echoed previous findings regarding common patient-associated WPV in ED. A few HPs in the pilot study reported that it is common for mental health patients to also

become substance users. One participant said that “they all go together… so you’ve got the whole thing and it’s very challenging. I would like to see us not segregating quite so much” (V015, Nurse). Findings also echoed the variation in patient violence by drug-type findings of previous studies. For example, one nurse said that “if you get someone with ICE addiction… yeah they are very, very aggressive” compared to someone with prescription drug addictions (V015, Nurse). Most participants in the interview study explained that they may have had some type of training, but that it tends to either be a one-off, or optional online training. A nurse (V008) mentioned that casual or part-time nurses do not tend to go to trainings at all. Many participants admitted that, in reality, they gain this type of experience on the job. For example, another nurse (V006) remarked that they do what they think is best and it “comes with experience.” This finding aligns with previous theorizing by Miller and Jablin (1991) as they explain how newcomers to organizations use observation and surveillance tactics to gain information about their role and how to execute it. New healthcare staff may observe veteran staff as they attempt to gain skills to communicate with aggressive patients.

Participants in the sample also stated that some staff are better at communicating with aggressive patients than others, and fellow staff are good to use as a resource for learning. Previous research in clinical education has echoed the value of peer learning. Lincoln and McAllister (1993) theorized that peer learning helps encourage both deep and reflective learning for clinical staff. Deep learning may be facilitated through observing one’s peers, discussion and problem-solving with peers. Reflective learning encourages discussion following an event, especially events that produce negative emotions (which are likely to occur when interacting with aggressive patients). Lastly, peer learning may have benefits

such as encouraging staff to be enthusiastic life-long learners from one another, respecting each other's expertise thereby promoting collegial relationships, all the while remaining independent in their practice.

There were several instances where participants described learning from their peers. For example, one participant told of how other nurses come and get her when they need help with a patient in an altered mental state, because she seems to be able to handle those scenarios (V009, Nurse Unit Manager). Another Nurse (P14) mentioned that they tend to use seclusion when a patient is in an altered mental state or aggressive. In general, when participants did mention actual ways to communicate with patients in an altered mental state, they all underlined the need to show respect to the patient, yet also be firm with the patient about what they will and will not tolerate. Even with its limits on generalizability given one setting and a small sample, this pilot, nonetheless, offered me a better understanding of what hospital staff receive as training, and how they use communication to diffuse situations with patients in an altered mental state. Previous research has also attempted to identify effective strategies for preventing WPV with these types and generally aggressive patients.

Chapter 3: Study 1: Testing the Effectiveness of Existing Techniques

De-escalation and limit-setting have attracted scholarly and HP attention particularly in mental health departments. De-escalation strategies refer to the use of communication skills, both verbal and nonverbal, to diffuse potentially aggressive and violent situations by redirecting the patient to a calmer personal space (Cowin et al., 2003). Limit-setting broadly refers to establishing boundaries of what behaviors are desirable and acceptable/unacceptable (Roberton et al., 2012). These two strategies are often discussed in HP training regarding preventing WPV. Despite the majority of hospitals strongly agreeing that training for WPV

prevention is important and should be available or even required for staff, this is not often the case (Frazier et al., 2014). What is more, due to heterogeneity in understanding and use of these two tools, it is not clear what is included in training across hospitals that do require such trainings (Beech & Leather, 2006). Although these de-escalation and limit-setting techniques are helpful, very little research has been conducted about their effectiveness. Research that has been done has not been adequately theoretically grounded, if at all (Johnson & Hauser, 2001). Therefore, Study 1 will test effectiveness of existing de-escalation and limit-setting strategies for healthcare staff who perform patient intake.

De-Escalation Strategies

Scholars have identified behaviors that call for healthcare staff to use de-escalation strategies. See Table 2 for a summary of patient behaviors that indicate aggression and call for use of de-escalation strategies. Some behaviors identified in previous research include, "confusion, irritability, boisterousness, physical and verbal threats and attacking objects…provocative behaviour, angry demeanour, pacing, loud speech, tense posture and frequent changes in body position" (Hodge & Marshal, 2007, pp. 63). However, this research does not discuss which behaviors are most prevalent, or most commonly identified by health staff. To make more concrete what staff at this local community hospital in Central California identify as common behaviors, this study poses the following question:

RQ1: What behaviors do health staff identify as pre-violent behaviors?

Despite de-escalation strategies gaining popularity, there is much discrepancy and vagueness in terms of what is considered a de-escalation strategy, both in the scholarly literature and in staff understanding (Price & Baker, 2012). This variability has led some scholars to question what we know about interventions (and their generalizability) that train

HPs to use these strategies. Because de-escalation skills may be developed on the job, thereby occurring as tacit knowledge, we cannot be sure what training they have received, and how to teach it to others (Richter, Needham, & Kunz, 2007).

According to Roberton et al. (2012), de-escalation is established through the use of therapeutic communication that is rooted in respect, rights, and dignity of the patient. This definition is, arguably, rather vague, but some scholars have identified actual strategies they consider to be de-escalation techniques. Some examples of de-escalation strategies include: "providing adequate personal space; using open body language; speaking in a low and calm tone of voice; using open-ended sentences; and avoiding punitive or threatening language" (Roberton et al., 2012, p. 97). Other techniques include: "manage others in the environment; explain to the client what the staff member intends to do; give clear, brief, and assertive instructions; ask for facts about the problem; encourage reasoning; and ensure that nonverbal communication is nonthreatening and nonprovocative" (National Institute for Clinical Excellence, 2005, p. 188)

De-escalation strategies have gained popularity in mental health settings especially in hopes that HPs can use them instead of resulting to using seclusion and restraints (National Alliance on Mental Illness, 2003). Indeed, Hodge and Marshal (2007) contend that the benefits of staff using these strategies are that they are the least restrictive means of controlling potential WPV. Not only this, but another benefit of using these strategies is that it helps the HP formulate strong HP-patient cooperation. This cooperative relationship can then improve staff self-efficacy and job satisfaction, highlighting the interdependent nature of care delivery (Hodge & Marshal, 2007):

H1: The more staff report using de-escalation and limit-setting strategies, the more they will experience: a) higher self-efficacy; b) job satisfaction; c) patient cooperation; and d) less stress at work and e) less incidences of WPV.

Limit-Setting

Although limit-setting may include using communication similar to that of de-escalation strategies, this technique is broader. The scope of limit-setting can include all patient behavior, not just behavior of aggressive patients (see Table 2 for a summary). Indeed, some scholars have referred to limit-setting as *all* attempts to regulate patient behavior that includes planned options like hospital policy and responses to disruptive and non-disruptive patient behaviors (including aggression and violence; Vatne & Fagermoen, 2007). Taken in this light, limit-setting equates to policies about how hospitals enforce rules, including, but not limited to, arenas where a patient may become aggressive/violent. However, like de-escalation, there are discrepancies in terms of what is meant by limit-setting across research and hospital settings. Like de-escalation, despite heterogeneity in training and actual techniques, nurses in mental health departments in hospitals tend to receive some training in these techniques.

Limit-setting, thought of as hospital rule enforcement, includes two main values, the need for order and discipline in the hospital and society, and respect for the patient (Vatne & Holmes, 2006). This means that not only is it important that the patient feels understood and respected, but the hospital must also maintain a sense of order. When a sense of order is violated by rules being broken, there is often some type of discipline. At times, the aforementioned two values may be perceived to be incompatible. It may be the case, for example, that the patient is disrupting order and the discipline that ensues for the patient is

the use of antipsychotic drugs, which undermines the first value of showing respect to the patient.

Paralleling these two values for the hospital, there are two main approaches to using limit-setting techniques. The first is correcting in which the patient is seen as a deviant, whose behavior the HP should strive to control. This approach holds the discipline and order value highly. The second is acknowledging, which focuses more on compassion through which the HP attempts to be cooperative and achieve cooperation. This approach holds the respect value highly. Limit-setting strategies in the acknowledging perspective includes using empathic statements (i.e., "it sounds like you're in pain and confused") and showing genuine concern for the patient (i.e., "you're here to get help, and we're going to try to figure out what's going on"; Petit, 2005, p. 708). This perspective has traditionally been more successful in preventing escalation and disruptive behavior and patients feeling powerless (Lyneham, 2000).

H2: Staff who report having an acknowledging perspective toward patient aggression will experience: a) higher self-efficacy; b) job satisfaction; c) lower stress at work and d) less incidences of WPV than those who adopt a correcting position.

Table 2. *Indicators of likely patient aggression and de-escalation strategies*

Indicators	De-escalation strategies	Limit-setting techniques
Pacing	Provide adequate personal space	Give warnings to patients
Confusion	Use open body language	Demand relatives leave
Irritability	Low, calm voice tone	Show authority
Threats	Open ended sentences	Hospital policies on WPV
Attacking objects	Avoid punitive or threatening	Maintain order
Angry/grumpy demeanor	language	Discipline for broken
Pacing	Manage others in the environment	rules
Loud Speech	Explain what you intend to do	Empathetic statements
Frequent changes in body	Assertive, brief instructions	Show genuine concern
position	Ask for facts about the problem	
Tense posture	Encourage reasoning	
Squinting the eyes	Nonthreatening NV Comm	
Not giving eye contact	Empower patients to feel in	
Penetrating staring	control	
Shouting	Show concern and empathy	
Whispering or mumbling	Move patient to less	
Coercive behavior	confrontational space	
Crying	Mirror patient's mood	
Rocking	Active listening	
Wringing hands	Validate patient feelings and	
Defensiveness	concerns	
Shaking fists	Ask questions	
Increased sarcasm		
Dilating pupils		
Poor concentration		
Blocking escape routes		

Hospital Policy on Handling Patient Aggression

Some scholars have called for hospital policies on WPV to be unambiguous. At times, scholars have even suggested that there should be a zero-tolerance hospital policy on WPV (Beech & Leather, 2006). However, a zero-tolerance policy would also mean that patients with rightful irritation or frustration from any legitimate subpar delivery of care may, instead, be viewed as unable to voice those experiences and be considered intolerable. Previous research has found that a zero-tolerance policy could be undesirable as a norm because then, when HPs blame the patient and project intolerance, a patient is more likely to

self-empower in the face of feeling controlled by the HP (Hodge & Marshall, 2007). Self-empowering, in this case, may mean escalating aggression. This suggests that aggression management is a desirable or even competent position to take as an initial orientation to the patient, rather than intolerance.

H3: Staff who embody a zero-tolerance stance toward patient aggression will experience more WPV.

Study 1 Method

Data were obtained as part of a larger program evaluation of the implementation of the Affordable Care Act 1557 requirement of a new intake questionnaire. Questions included in this new patient data collection require healthcare staff to ask about sensitive topics such as patient gender identity, sexual orientation, race and ethnicity and disabilities to every patient, every time they seek medical attention at the hospital. All non-medical frontline staff or registration staff at a community hospital in Central California in every department underwent a three-hour training called "Respect & Care". Materials used in the "Respect & Care" trainings are included in Appendix B (p. 195). To better understand the size of the Central California hospital, the following are some publicly available metrics: 582 beds, 113,516 outpatient visits and 19,840 patients admitted in 2018 (citation not included to maintain confidentiality of study location). According the health needs assessment conducted by this organization in 2016, the patient population has overall good health in the desired range, does not have high incidents of alcohol use or smoking, and has appropriate levels of oral health, and physical activity. The health indicators not at a desirable level included a higher than desired amount of uninsured patients, patients lacking a primary care provider, patients who find cost to be a barrier to care, experience food insecurity, and high levels of

depression. In terms of the demographics of the patient population served, the area that this hospital serves is a relative affluent community that is concerned with having good health.

The community hospital in Central California contracted with a local non-profit to facilitate this training to provide more high-quality and patient-centered care. This training discussed why these questions were crucial to higher quality care, and how to best ask them. Even so, staff expected that some patients may not like being asked these new intake questions, and may become aggressive. I delivered a 50-minute portion of the training on eight different occasions in November and December 2018 to groups of 20-30 participants discussing de-escalation strategies from the literature described above which included role-playing aggressive patient scenarios.

Participants and Procedure

Following approval from a local IRB, and recognition by UCSB, on March 13, 2019, an email containing the survey link was administered by a staff member at the community hospital in Central California through an internal email address created for the purposes of this training. The survey was received by 189 staff members who attended a "Respect & Care" training approximately three months prior. The email address was created especially for the trainings that were delivered to serve as a place where staff could ask questions. Data collection stopped on March 29, 2019. Reminder emails to staff were sent out by the sub-investigator who worked at the community hospital in Central California twice during the two-week time period. Staff were not compensated for their participation.

Of the 189 people who received the invitation to the survey after attending a Respect & Care training, 122 people responded. Of those 122, 20 people declined to participate and did not fill out the survey after reading the consent information pages. Of the remaining 102

people, 28 people selected some combination of "agree" and "disagree" options in the 6 consent question pages, and proceeded to fill out the entire survey, including qualitative comments in the open-ended questions. After extensive consult with a local IRB, and UCSB IRB, it was determined that those 28 cases could not be included in this dissertation. This resulted in a final sample of 74 participants.

Of the final sample, 21.6% were male (n = 16), 77% were female (n = 57), and 1.4% (n = 1) did not report their gender identity. Participants ranged in age from 22-70 years old (M = 42.5, SD = 12.9), and worked at this hospital ranging from five to 492 months (M_{months} = 94, SD = 102.4). Regarding employment amount 10.5% were part-time employees (n = 8), 78.9% were full-time employees (n = 60), 7.9% were per diem employees (n = 6), and 2.6% did not report their employment amount (n = 2). When asked if they had taken a limit-setting or de-escalation training before, 42.1% reported never taking a training before (n = 32), 46.1% reporting taking a training at the same community hospital in Central California where this study took place (n = 35), 9.2% reported taking a training elsewhere (n = 7), and 2.6% did not respond (n = 2). Participants were employed across 23 unique departments at the hospital (i.e., laboratory, spiritual care, occupational therapy, interpreter services, outpatient surgery, administration, pediatric clinic, endoscopy, imaging center, etc.)

Measures

See Appendix A (p. 199) for a full inclusion of measures for Study 1.

Staff stress at work (Appendix A, Q# 13-18)**.** Six questions adapted from Laposa et al. (2003) measured staff stress at work. This scale was originally intended for ED staff, but was used for all healthcare staff. Questions were measured on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) and included "Following an aggressive patient

interaction: you've considered changing jobs; felt adequately supported by your immediate hospital administration." After examining reliability of the adapted scale, one item (i. e., "I have felt adequately supported by my immediate hospital administration") had low and negative inter-item correlations with the other items. As such, the final scale resulted in a 5-item scale (α = .74).

Self-efficacy (Appendix A, Q# 20-23). A 4-item scale adapted from Afifi and Afifi (2009) that originally measured communication efficacy regarding engaging in conversations with their parent about their parents' turbulent relationship was used. Measures were adapted to probe how confident staff feel about communicating with an aggressive patient (i.e., "I can communicate with an aggressive patient to de-escalate the interaction"). Items were measured on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*) (α = .75).

Job satisfaction (Appendix A, Q# 24-28)**.** A 5-item scale was adapted from Stamps, Piedmont, Slavitt, and Haase (1978). The original scale consisted of 37 items intended to capture the attitudes of hospital nurses regarding their occupational satisfaction. The original scale included pay, professional status, doctor-nurse relationship, administration, autonomy, task requirement and interaction components. This study did not measure issues of pay, doctor-nurse relationship, administration or autonomy. Sample items of this measure include "What I do on my job is important" and "I am satisfied with the types of activities that I do on my job." Items were measured on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). After examining reliability of the adapted scale, one recoded item (i. e., "I think I could do a better job if I didn't have so much to do all the time") had low inter-item correlations with the other items. The final scale resulted in a 4-item scale (α = .71).

Attitude toward aggressive patients (Appendix A, Q# 29-30)**.** Participants were asked about their attitude toward patient aggression in an open-ended manner. They were asked "What is your attitude toward aggressive patients?" and "Please describe how you think patient aggression should be handled."

Experience of WPV (Appendix A, Q# 31)**.** Participants were asked to list the number of WPV events they have experienced since the training. Then, in an open-ended response, participants were asked to describe managing patient aggression. They were provided with the definition of WPV included in this study to read first. The prompt then read "With that in mind, how many experiences of workplace violence have you experienced since the training? Please describe what happened in the most memorable of these interactions. Try to include quotations of things you and the patient said to one another, and the way you both communicated using your body language."

Managing patient aggression (Appendix A, Q# 32-33)**.** In an open-ended response, participants were asked to list as many de-escalation or limit-setting strategies they can remember using since the training. They were asked to report on which strategies they have found to be the most effective in managing patient aggression.

Analysis

Bivariate correlations for quantitative variables can be found in Table 3. For the attitude variable, responses were approached deductively to be coded into the three main approaches to managing patient violence described by prior literature (i.e., correcting, acknowledging, Petit, 2005; and zero-tolerance, Hodge & Marshall, 2007). However, upon coding, there were several responses that did not fit into any of those three categories. As such, a qualitative content analysis was undertaken to both maintain the benefits of

quantitative content analysis, and qualitatively expand and preserve other categories, without rashly including them in the deductive, a priori categories (Mayring, 2004). Coding reliability was ensured by having a research assistant code the data with the coding scheme developed by the researcher. The research assistant coded 94% of the responses in the same way as the researcher. For de-escalation and limit-setting variables, open-ended responses were quantified by counting the number of strategies participants report. For H1 and H2, data were analyzed using the quantified variables in SPSS 24. H1 employed bivariate correlations. Although an ANOVA would have been the appropriate analysis for H2 and H3, sample sizes for each level of the categorical approach to aggression variable were too small and cell sizes were extremely uneven. As such, H2 and H3 were tested by comparing means.

Table 3. *Study 1 descriptive statistics and bivariate correlations for quantitative variables*

	M(SD)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10
1.EmpTyp		---									
2. Gender		.11	----								
3. Age	42.51(13.94)	-.03	-.13	----							
4. PTrain		.02	.27*	-.05	----						
5. Length	93.97(102.36)	-.15	-.30*	.47**	-.13	----					
6. Confide	3.97(.80)	.04	.14	-.11	.01	-.19	----				
7. Effic	3.94(.52)	-.05	.03	.03	.10	-.16	.54**	α=.75			
8. JobSat	4.16(.55)	-.04	-.10	.24*	-.05	-.06	.21	.22	α=.71		
9. Stress	2.28(.82)	-.07	-.18	-.20	.00	-.06	-.05	-.15	-.43**	α=.74	
10. StratN	3.15(2)	.07	.37*	-.25	.07	.08	.30	.25	.23	-.24	---
11. WPV	.58(1.03)	.01	.06	-.03	.40**	-.28	.14	.27	-.14	-.04	.31

Note: *$p < .05$; **$p < .01$, ***$p < .001$. 1. EmpType = employment amount, 4. PTrain = prior de-escalation training, 5. Length = time at the hospital, 6. Confide = job confidence, 7. Effic = efficacy, JobSat = job satisfaction, 9. StratN = Number of de-escalation and limit-setting strategies listed, 10. WPV = number of workplace violence experiences since the training.

Results

How staff describe aggressive patients

RQ1 probed what are common behaviors staff identify as pre-violent indicators. Staff in this study responded to the question about what aggressive patients are like with physical and behavioral descriptions of aggressive patients. The answers to this question suggest that as a result of the training, staff are more knowledgeable and adept at identifying indicators of possible violence and aggression. Common descriptors of patient behaviors included tense posture, vocally loud, emotional (i.e., frustrated, angry), under the influence, repetitive or "making the same points over and over again" (P14, Nursing Administration), "disruptive to others" (P17, Front desk), agitated facial expressions, "many have mental health problems or are altered" (P24, Front desk), confused, and "anxious, fidgeting, red face" (P38, Front desk). These responses closely mirror the findings from previous research in two ways. First, they mirror that staff recognize "altered" patients who are under the influence, and those with a mental health disorder as commonly aggressive. Second, staff responses align with the indicators of violence summarized by Table 2 and taught to staff in the Respect & Care trainings.

Importantly, several respondents also explained that they recognize that the patient may have been upset by something prior to entering the hospital. For example, P74 who works in physical therapy said that aggressive patients are "hard to please, no matter how much you bend backwards. Regardless, we like to be friendly with them and feel confident sometimes they come in already upset for other reasons so we don't take it personal". This response shows that when staff made external attributions for patient aggression, they were likely to not take it personal and continue to try to be friendly.

De-escalation and limit-settings in association with key outcome variables

H1 predicted that staff who used more de-escalation and limit-setting strategies would experience a) higher self-efficacy; b) job satisfaction; c) less stress at work and d) less incidences of WPV. In order to measure how many strategies staff used, they were asked to list strategies they have used since the training to manage patient aggression in all situations, including during the intake questionnaire (which was the main focus on the training). Although only 33 people responded to this question with strategies, common responses included using more active listening, eye contact, calm voice tone, and giving explanations of what they are about to do to ensure patient understanding. The number of strategies listed by staff ranged from 1-11. All strategies listed in response align with strategies taught in the training and represented in Table 2. Nineteen participants said they had not used any of the strategies since the training because they had not encountered any patient aggression. Due to the very small number of people who responded with a list of strategies, bivariate correlations were run between number of strategies used and each outcome variable to test H1.

For self-efficacy, there was a positive, non-significant correlation between number of strategies and efficacy ($r = .25$, $p = .16$). For job satisfaction, there was a positive, non-significant correlation between number of strategies and job satisfaction ($r = .23$, $p = .20$). For stress at work, there was a negative, non-significant correlation between number of strategies and stress ($r = -.24$, $p = .19$). For experiences of WPV, there was a positive, non-significant correlation between number of strategies and WPV instances ($r = .31$, $p = .13$). Apart from experiences of WPV, the other results were in the expected direction. However, none of the associations are significant. Therefore, H1 is not statistically supported.

Prevalence and experiences of WPV at this community hospital in Central California

After learning of the unexpected direction of the associations with WPV prevalence in H1, and to gain a more detailed understanding of the setting of this study, additional analyses were run to understand the prevalence and experiences of WPV at this particular hospital. Of the 45 participants who responded to the question about their experiences with WPV, 19 people reported no experiences of WPV. The people who reported *no* experiences with WPV since the trainings had similar average amounts of stress (M = 2.36), job satisfaction (M = 4.17) and efficacy (M = 3.94) as the overall sample (See Table 3). Of the people who did experience at least one instance of WPV since the training, there were some similar descriptions of the experience.

Participants only explained instances of verbal aggression; there were no descriptions of physical aggression. Of those descriptions, common experiences included "using profanity and being disrespectful" (P3, Pediatrics), "making snarky comments" (P31, Lab), and "calling me names" (P49, Front desk). Several respondents also explained how although they "try to stay calm but I can feel my blood pressure rising" (P51, Lab). Three participants described a time they successfully de-escalated aggression. For example, P10 who works in the Eye Center, described a time when they feared a patient was going to become physically violent, but by remembering it was not about them but rather was about the situation, thereby making an external attribution for patient aggression, they were able to de-escalate the situation:

> Patient …got very close to my face, I thought he was going to hit me, … I felt my blood was going to boil, but remembered that he was not upset with me, but was angry at the situation. After calming him down, I found out he has been having

numerous surgeries, and that day he found out he needed an eye surgery, so he blew up. That was the reason why he was upset. The next day, he came back and apologized for yelling at me.

Those who reported experiencing WPV, also reported on strategies they use or have used to manage patient aggression.

Approaches to managing patient aggression

To understand how staff approached managing patient aggression, they were asked how they think patient aggression should be handled in an open-ended question. Coding of responses resulted in five categories; acknowledging (n = 36), acknowledging and correcting (n = 8), avoiding and acknowledging (n = 1), correcting (n = 5), and zero-tolerance (n = 3).

Responses were deductively coded as *correcting* if they mentioned maintaining control and being firm. In this category, participants said that management of patient aggression should be done by "Set a limit somehow that they need to remain calm and respectful in order for the interaction to continue. Otherwise, ask them to take a seat so you can get help" (P3, Pediatrics). Although participants were helpful to patients, ultimately they saw patient behavior as something to be controlled.

Responses were deductively coded as *acknowledging* if they included thoughts about listening, empathy, respect, acknowledgment of emotions, or compassion (Petit, 2005). Participants explained that patient aggression should be handled "In a calm but consistent manner, providing listening presence and acknowledging their feelings and concerns" (P20). It is promising that the majority of participants held an *acknowledging* management strategy, as that is what was taught in the training. Based on research previous research, responses were deductively coded as *zero-tolerance* if they mentioned refusing service (Hodge &

Marshall, 2007), as the small number of responses in this category said that they "should be able to make patient responsible for aggression by being able to refuse service" (P74, Physical Therapy).

The inductive categories that emerged from the data were *avoiding and acknowledging* and *acknowledging and correcting*. One participant said that they handle patient aggression "by not engaging as much as possible, maintaining physical distance, validate feelings if possible" (P4, Interpreter Services). It seems this participant's strategy would be to avoid the aggression if possible. However, they also mentioned they would be sure to validate patient feelings as well, suggesting an acknowledging perspective. Participants in the second inductively coded category, *acknowledging and correcting,* explained some combination of being firm and controlling patient behavior, while also being sure to show respect and empathy. For example, participants said things like "A patient should always be treated with respect and empathy. Also we can calmly let the patient know that we can help them, but they would also need to treat us with the same courtesy that we extend to them" (P71, Front Desk).

Lastly, a serendipitous finding emerged from the data where participants explained that when patient aggression or verbal violence escalated to becoming physically violent, they said they would back away or avoid the patient and call security. Of the 51 participants who responded to this question, 15.69% (n = 8) said they would get help from another person if the patient aggression escalated to physical violence. For example, one person said "If physical need to call Security. But otherwise, trying to find the reason why they are upset, and deescalating the problem" (P8, Eye Clinic). Future research could probe who they would get help from, and how they make that decision.

Approach on managing patient aggression and associated outcomes

H2 predicted that staff who report having an acknowledging perspective toward patient aggression will experience: a) higher self-efficacy; b) job satisfaction; c) lower stress at work and d) less incidences of WPV than those who adopt a correcting position. Those with an acknowledging approach worked at the hospital for an average of 106.36 months, were on average 41.79 years old, and 80.60% (n = 29) were full-time employees. In addition, those with an acknowledging approach were 72.2% (n = 26) female, and 58.4% (n = 21) of them had received a prior de-escalation training course. Those with a correcting approach worked at the hospital for an average of 112.63 months, were on average 48.13 years old, and 62.5% (n = 5) were full-time employees. In addition, those with a correcting approach were 75% (n = 6) female, and 77.5% (n = 7) of them had received a prior de-escalation training course. Those with an acknowledging and correcting combination approach worked at the hospital for an average of 49.20 months, were on average 40.60 years old, and 80% (n = 4) were full-time employees. In addition, those with a combination approach were 80% (n = 4) female, and 60% (n =3) of them had received a prior de-escalation training course.

Although this study lacks sufficient power and equivalent amounts in each approach to aggression to be able to test for significant differences between groups and include covariates, on average, those who had an acknowledging approach had the highest amounts of self-efficacy (M = 4.01) compared to those in the correcting (M = 3.8) or correcting and acknowledging combination (M = 3.6) approaches. They also had the highest levels of job satisfaction (M = 4.17) compared to those in the correcting (M = 4.05) or correcting and acknowledging combination (M = 4.05) approaches. Regarding stress at work, those in the acknowledging approach had the lowest levels of stress (M = 2.19) compared to those in the

correcting (M = 2.70) or correcting and acknowledging combination (M = 2.36) approaches. Regarding instances of WPV since the training, those taking an acknowledging approach had the lowest levels of WPV (M = .50) compared to those in the correcting (M = .71) or correcting and acknowledging combination (M = 1.4) approaches. Therefore, H2 is supported.

Zero-tolerance approach and associated outcomes

H3 predicted that staff who embody a zero-tolerance stance toward patient aggression are more likely to experience WPV. The three people who held a zero-tolerance approach to patient aggression came from all different departments and had worked between 53 and 97 months at this location. All were full-time, and female. Although this study lacks sufficient power and equivalent amounts in each approach to aggression to be able to test for significant differences, on average, those who had a zero-tolerance approach had the same amounts of self-efficacy as those with an acknowledging approach. However, they had the lowest amounts of job satisfaction (M = 3.92) and the highest stress at work (M = 2.80), and experienced one instance of WPV since the training. This is higher than those in the acknowledging (M = .50) and in the correcting approaches (M = .71), but lower than those in the acknowledging and correcting combination approach (M = 1.4). Overall, is partially supported.

Discussion

Broadly, Study 1 trained medical and non-medical staff completing non-medical tasks (i.e. patient registration) in existing de-escalation strategies found by previous research. Intake is one of the first points of interaction with a patient upon arrival to the hospital before medical attention is received. This study helped to diminish the ambiguity of what is meant

by de-escalation strategies by identifying which strategies staff use and if they were, in fact, effective. Overall, staff reported paying attention to the indicators of violence, and de-escalation and limit setting strategies outlined by Table 2. These results suggest that staff, as a result of this training, are better able to identify indications of patient aggression, and know what strategies to be able to deploy in order to de-escalate the situation.

However, and optimistically, it seems that most the staff have not had to deploy these strategies, as only 26 people reported having experienced WPV since the training. Due to this study lacking a pre-training survey, it may be the case that staff are communicating very well with patients already, such that they do not experience WPV. Of the people who reported experiencing at least one instance of WPV since the training, they reported only verbal aggression from patients. Generally, the more strategies staff reported using were associated in the desired direction with more efficacy, job satisfaction and lower stress, suggesting effectiveness of the strategies taught in the training. Importantly, respondents reported the importance and success of using de-escalation strategies when they made external attributions for the patient's behavior and did not take it personally.

Regarding approaches to patient aggression, an approach in addition to the two explained by prior research (i.e., acknowledging and correcting, Petit, 2005) emerged from the data as a combination of correcting and acknowledging. Generally, and as expected, those who held an acknowledging approach toward patient aggression had the most positive outcomes. Those who held a correcting, acknowledging and correcting, or zero-tolerance approach exhibited worse outcomes. The acknowledging approach, as staff were taught in the training encourages understanding, listening and compassion, it is other-centered, or in this case, patient-centered. It may be the case that holding an acknowledging approach

encourages making external attributions for patient aggression, understanding their situation and frustrations. Therefore, it may be the formation of external attributions that is the underlying mechanism by which patient aggression is best managed.

The notion of external attributions to patient aggression aligns with and extends previous research about attributions of nonaccommodation. Findings from prior research in an intergroup framework have shown that people who infer the motivation for non-accommodation – insufficient communication adjustment - to be motivated intentionally and personally, are most impacted by the nonaccommodation (Gasiorek, 2013; Gasiorek & Giles, 2012). In a 2-part study on inferred motive of nonaccommodation, Gasiorek and Giles (2012) tested the moderating and mediating effects of egregiousness of nonaccommodation. The authors explain that perceptions of communicator behavior in interactions lead to attributions. Those attributions help inform individual's interest in engaging in future interactions. Gasiorek and Giles (2012) found results consistent with principals of CAT. Essentially, people are much more forgiving of others when they perceive that the others did not mean to communicate in a way that we perceive as inappropriately adjusted, or if we think they couldn't have known better. This follows from Reeder's (2009) multiple inference model which suggests that when behavior is perceived as unintentional, we use the information available in the context or situation that a speaker is in to interpret the reasons speakers did what they did. In addition, Gasiorek and Giles (2012) found that motivated underaccommodation was more egregious than motivated overaccommodation. Generally, in terms of valence of the motivation, as long as people don't think there was intended harm, then the inappropriate adjustment is acceptable.

Although staff were not directly asked if they thought so, a patient becoming aggressive toward a healthcare staff person can be considered nonaccommodative. Those who experienced aggression in this sample experienced verbal aggression (i.e., name calling, yelling, disrespect). As the receiver of such nonaccommodative communication, if staff were to infer the motive to be intentionally negative and personally motivated by the patient, they would take it much harsher. The staff who held an acknowledging approach to the patient aggression, which were the majority, made an external attribution for the nonaccommodation such as blaming external experiences of the patient as them having a bad day or being in pain. By doing so, they were able to make the motivations for the nonaccommodative aggression more unintentional and therefore less negative and not personal. The staff who explained this type of thinking were successful in de-escalating aggression, at times even receiving an apology from the aggressive patient after they calmed down. Staff who thought this way also deployed more de-escalation strategies they were taught in the training. As such, staff should continue to be reminded that patient aggression is not personal, nor is it because the patient has some sort of negative character trait. Instead, if staff can be reminded and encouraged to make external attributions for patient aggression, they may be more likely and able to calmly deploy de-escalation strategies, and successfully prevent WPV.

Limitations

Although this study had rich data from a hard to reach population, there are two main limitations. First, the sample size is very small due to difficulty with the consent process of the survey, and very busy healthcare professionals who completed the survey during work hours. As such, very few analyses were feasible for these data as statistical power was very limited to run more sophisticated analyses. With a larger sample, the data could have been

analyzed accounting for control variables and it would have been more appropriate to run a MANCOVA to test H2, for example. Instead, descriptions of variables that would act as control variables have been explained to demonstrate other factors that may account for the results.

Second, and similar to previous research, although this study helped staff in patient aggression management, it lacked a theoretical framework. This study was interpersonal skills focused. To address this limitation, and further extend the finding regarding making external attributions, Study 2 provides a theoretically grounded approach to training healthcare staff in managing patient aggression. Study 2 goes beyond a skills-focused approach to more broadly effect organizational norms in aggression management, and attitudinal shifts that predict likelihood of effectively communicating with an aggressive patient.

Chapter 4: Study 2: A Communication Competence Approach to Preventing WPV

A skills-focused approach including training in de-escalation and limit-setting paints healthcare communicative interactions (e.g., doctor-patient, doctor-nurse) as strictly interpersonal in nature and gained attention as patient-centered care became of interest. Since then, many books have been written, especially for skills training for nurses (e.g., McCabe & Timmins, 2013; Arnold & Boggs, 2015; Sully & Dallas, 2005). Particularly, teaching communication skills helped doctors no longer focus on a controlling and executive-style delivery of healthcare. Instead, learning skills such as listening, showing concern, and allowing patient participation helped facilitate patient-centered care. Street (2003, p. 912) defines interpersonal healthcare communication skills as "participants' ability to produce communicative responses that enhance both the quality and outcome of medical

consultations." Although these are important considerations for consultations in healthcare, an interpersonal focus ignores many of the communicative issues stemming from hospitals' intergroup and organizational contexts (Watson et al., 2018).

Dragojevic and Giles (2014, p. 29) stated that "intergroup communication occurs when either person in a social interaction defines self or other in terms of their social identity rather than their personal identity". Social identity refers to the perception of self that is tied to the ideals and norms of a social group and is the perception of belongingness to that group (Tajfel & Turner, 1986). Gudykunst (2005) clarifies that intergroup communication occurs when people use cultural or sociological data to make predictions about the other's behavior. Thus, intergroup theory affords information about identity as related to cultural and sociological perceptions of interlocutors that purely interpersonal theories do not. Nonetheless, little to no research has invoked theory of either type to improve or even prevent HP-aggressive patient interactions. Study 2 of this dissertation invokes intergroup theory broadly, and CAT more specifically, to develop a training to address HPs interacting with aggressive patients. Due to social identity being an explanatory mechanism for which people adjust their communication behaviors in CAT, the theory is sufficiently broad to consider interactions that range in levels of interpersonal and intergroup communication. Figure 1 below displays a conceptual model of competent accommodation by staff with aggressive patients to be developed and tested by this study.

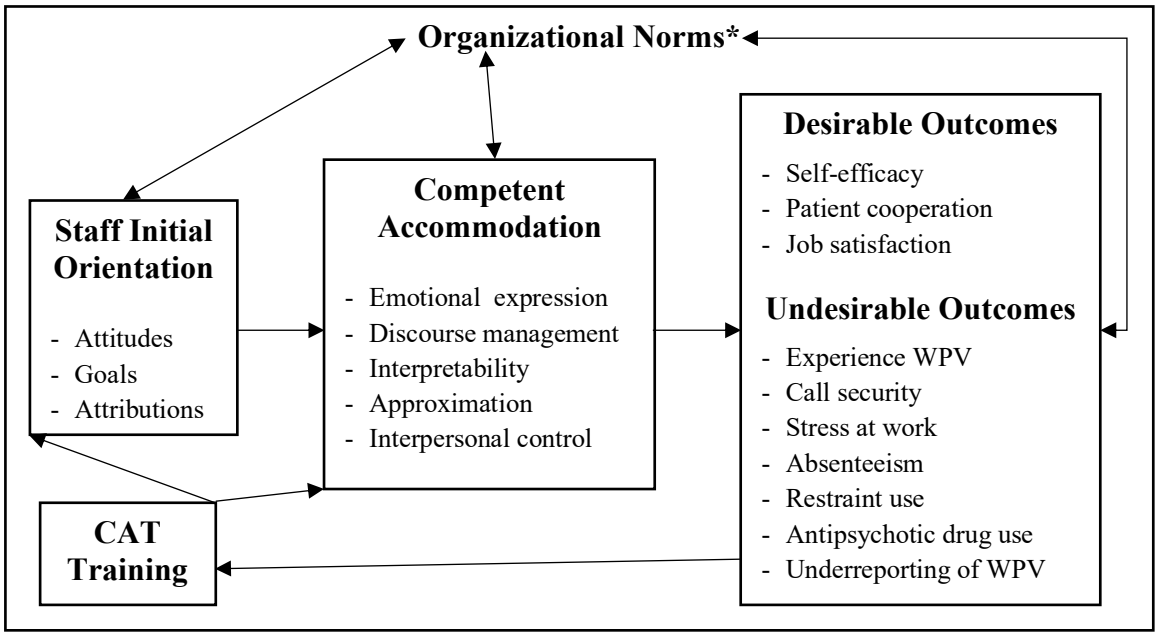


Figure 1. Conceptual model of training for improved staff-patient interactions

* Organizational norms refer to nature of experience of WPV including timing and location, and peer norms including what staff talk to and advise one another about managing WPV, and lastly the extent to which staff recognize their contribution to the environment in which WPV occurs.

To summarize Figure 1, Study 1 found a link between attitudes and outcomes such that the more positive and understanding the approach to patient aggression, the more successful they were in de-escalating aggression, preventing WPV, and experienced desirable outcomes like higher job satisfaction and efficacy. This model shows the conceptual components of CAT broadly that impact specific outcomes in the aggressive patient interaction. Beginning with staff initial orientation, staff hold certain attitudes toward patient aggression, attributions for causes of the patient aggression, and goals for how staff discuss this with their peers and how that aggression should be handled. This initial orientation impacts organizational norms, and likewise organizational norms set expectations for initial orientation of staff. This initial orientation impacts the way that staff accommodate patients

(or not), such that the more generally positive and understanding staff initial orientation is, the more they will accommodate patients. The more that staff accommodate patients, the more they will experience desirable outcomes, and the less they will experience undesirable outcomes that are known associations with experiences of WPV (as summarized in reviewing literature for Study 1). The extent to which staff experience these outcomes (desirable and undesirable) will impact organizational norms and feed back to the initial orientation of staff. Competent accommodation is central to this conceptual model and Study 2. Therefore, we now turn our attention to overviewing CAT as framing Study 2.

Competent Accommodation

Generally, CAT posits that speakers can adjust their communication to maintain a desired social and personal identities (Giles, 2016; Soliz & Giles, 2014). Thus, CAT addresses both individual and group level interactions and adjustments. As such, "when a particular social category becomes salient, it not only changes self- and other-perceptions but also influences how people adjust their communicative behaviors to their interlocutors" (Dragojevic & Giles, 2014, p. 35). As this passage indicates, the intergroup nature of most interactions to varying degrees fundamentally changes the nature of interpersonal adjustment. CAT suggests that interlocutors adjust toward (converge) or away from (diverge) their interaction partner based on various motivations, constrained by abilities. An interlocutor may also sustain one's level of communication, with no shifts toward or away from their interaction partner, thereby engaging in so-called speech maintenance (Dragojevic, Gasiorek, & Giles, 2016). Health staff may adjust along any of the dimensions of accommodation. Likelihood to adjust or not toward a patient is associated with attitudes held by staff, and organizational norms as discussed in a later section.

At an abstract level, Pitts and Harwood (2015) conceptualized CAT as a theory of communication competence. Communication competence is defined as being effective and appropriate. Specifically, Wiemann (1977) defines communication competence as "the ability of an interactant to choose among available communicative behaviors in order that he may successfully accomplish his own interpersonal goals during an encounter while maintaining the face and line of his fellow interactions within the constraints of the situation" (p. 198). To achieve this, interactants must have knowledge (understanding requirements of the situation), motivation (genuine desire to communicate competently), and skill (ability to enact competent communicative behaviors; Cupach & Spitzberg, 1983; Street, 2003). Competent communication considers context and the characteristics of the communicators involved in order to adapt communication to the situation or environment. Useful qualities that assist a communicator in enacting competence include a large repertoire of communicative behaviors, empathy, descriptive delivery of feedback, perceptual sensitivity and behavioral flexibility (Wiemann, 1977).

Indeed, previous research in health communication in an intergroup setting has called for researchers to first gain knowledge of the overall context in which the communication events are occurring. Specifically, knowing the context gives understanding of the antecedents of the adverse communication events, in this case instances of patient aggression and violence (Watson, 2019). As such, and in order to move beyond an interpersonal skills approach to healthcare in Study 2 and learn about contextual antecedents, this study poses the following research question:

RQ1: What is the nature of the context in which WPV typically occurs?

Competent accommodation broadens the traditional notion of what is accommodative by focusing instead on how interlocuters using CAT strategies can be effective and appropriate in conversation. Traditional notions, at their simplest level, of what is accommodative considers convergence as accommodative and divergence as nonaccommodative. However, converging to one's interaction partner may not be effective or appropriate, especially in the HP-patient interaction. For example, a staff member may need to set limits firmly and be blunt in the matter to effectively and appropriately do their job safely. At first glance, these acts by the HP may seem nonaccommodative, and yet they may help both the HP and the patient achieve their goals. Indeed, scholars underscore that communication competence is a dyadic construct such that the communicator should be accomplishing both instrumental and relational goals while simultaneously assisting their interlocutor do the same (Street, 2003; Wiemann, 1977). In the above scenario, the HP acting in this manner helps them to achieve their goal of completing their job safely while also helping the patient achieve their goal of receiving appropriate care.

Previous research has shown that the dimensions along which a person can be competent are affiliation/support, social relaxation, empathy, behavioral flexibility and interaction management. Interaction management was deemed the most important dimension where receivers judge a speaker to be communicating competently and managing anxiety in the interaction (Wiemann, 1977). This dimension includes the speaker guiding the conversation smoothly in terms of turn-taking, and maintaining control of the interaction, similar to the accommodation strategy of interpersonal control. However, results from the aforementioned study also indicated that there must be a blend of the dimensions, which was supported when in analysis, the dimensions suggested a single factor solution. For the HP-

aggressive patient interaction, competent accommodation may include more interpersonal control in combination with other strategies than a standard notion of being accommodative may otherwise encourage. However, accommodation, competent or otherwise, is influenced by the attitude held by the staff member toward the patient.

HP Initial Orientation toward Patients

Staff attitudes toward patients is a component of their overall initial orientation, shaped by the hospital department context. Initial orientation includes people's perceptions of the sociohistorical context, their identification with their ingroup, perception of potential conflict and threat from outgroups, personal values, and any interpersonal relationship history that exists with their interlocutor (Gallois & Giles, 2015). Although previous work considering gender and ethnicity of each party has been considered as a key social identity and component of initial orientation, this dissertation focuses mainly on staff and their experience with all patients. Future work can more closely examine how ethnicity and gender factor into the HP-aggressive patient interaction.

CAT contends initial orientation is especially consequential for motivation to accommodate or not. For example, cooperative accommodation is motivated by a desire for social approval and to reinforce or foster a particular social/personal identity (Dragojevic, et al., 2016). When faced, for example, with an interaction with a patient who the HP believes to be challenging, the HP may have no desire for social approval from the patient, thereby lacking motivation to accommodate to the aggressive patient. Similarly, communicators may engage in "reluctant accommodation" out of respect or obligation due to cultural or social norms (see Soliz & Bergquist, 2016). For example, although a staff member may not be motivated to accommodate the patient out of a desire to share a social identity with or please

the patient, they may reluctantly accommodate to achieve social approval from their peers or superiors. Despite converging in communication, this type of accommodation lacks genuine motivation and is often evaluated negatively by the receiver. To further probe the contextual antecedents to the interaction of focus between the HP and aggressive patient, the following RQ probes:

RQ2: What initial orientation (e.g., motivation to accommodate, goals, contextual norms) do staff hold toward patient aggression?

Staff perceptions of the context, including the normative attitudes toward individuals with mental illness or addiction, may matter for how they approach a patient, perhaps in a reluctant manner. This component is included as organizational norms in Figure 1. This encompasses and sets the tone for the HP-aggressive patient interaction. In addition, the extent to which they identify with their ingroup of other HPs, and the norms that those HPs hold, shape HP initial orientation toward patients. For example, if other HPs in their department with whom they identify hold negative attitudes toward patients who use substances, they will likely be much less accommodative. If they perceive the patient to be of an outgroup (e.g., patient identity generally and the inherent power differences therein, high maintenance patient, or naive patient), and threatening to their safety or image as a good HP, they may be less likely to accommodate. Previous research has recognized the need for a focus on norms when considering intergroup communication in a variety of contexts, and especially in health (e.g., Gallois & Callan, 1991; Watson et al., 2018)

RQ3a: What are the normative attitudes staff hold toward aggressive patients?

More extreme than adhering to accommodating out of obligation, non-cooperative accommodation, on the other hand, occurs when a communicator is motivated to emphasize

distinctiveness from relevant outgroups, thereby affirming their social identity ingroup (Dragojevic et al., 2016). It may be the case the staff wish to distinguish themselves from aggressive patients. A negative attitude toward aggressive patients may mean that staff are more likely to engage in non-cooperative accommodation or nonaccommodation, highlighting their distinctiveness by appearing competent and professional as compared to the aggressive patient.

RQ3b: How are staff attitudes toward aggressive patients associated with their reported accommodative behaviors toward patients over time?

HPs Nonaccommodating Patients

It may be the case that negative attitudes and poorly managed emotions manifest in HPs non-accommodating their patients. The ideal situation for any HP-patient conversation - shown by previous studies of police accommodation - would be an accommodative climate in which both people are polite, pleasant, treat one another with respect, listen well, and perspective-take. In so doing, intergroup sensitivity (i.e., heightened attention to group-level identities) is likely lessened (Myers, Giles, Reid, & Nabi, 2008). However, the conversation between an HP and aggressive patient is likely instead to not include these characteristics, and may present an accommodative dilemma. An accommodative dilemma is a situation where the HP is dissatisfied with the patient's unpleasant or problematic aggressive behavior. When faced with a dilemma, the speaker can decide to either tolerate or accommodate the undesirable behavior or take a punishing stance toward the behavior (Yum, 2004). Previous research has found that in situations like these, there is an increased risk of low respect and nurturance (Williams, 1999). Respect is important as almost all nurses in the Pilot Study

above stated that even patients with altered cognitive abilities presenting in the ED need to be treated with respect.

However, in situations of accommodative dilemmas intensified by the ED or the general hospital context, mutual respect is especially difficult to achieve, no matter what the goals or position the HP holds. It may also be the case that when HPs perceive no desired communication options, and are under pressure to work quickly, they may resort to undesirable options such as nonaccommodating their patient, or at worst employing restraints and antipsychotic drugs as discussed in Study 1. Nonaccommodation is defined as the pursuit or unintentional result of some disaffiliation, disconfirmation, or emphasis of dis-identification or dissimilarity with one's interaction partner (Gasiorek, 2016). This notion encompasses both a speaker and a receiver focus in determining divergence. Nonaccommodation may have cognitive effects such as miscommunication, misunderstanding and communication breakdown or affective effects like less positive evaluations of people, lower contact quality, and lower relational solidarity or family identity (Colaner et al., 2014; Gasiorek, 2016). Generally, the outcomes of nonaccommodation demonstrate clearly that encounters filled with a lack of appropriate interpersonal adjustments are dissatisfying.

There are several reasons why staff may adopt a nonaccommodative stance. For example, previous research has shown that when staff blame the patient only, they are much more likely to use techniques like restraints, antipsychotic drugs, and seclusion which are clear behavioral examples of nonaccommodation (Gerdtz et al., 2013). Indeed, Mackay and Barrowclough (2005) found that feelings of irritation over a person not controlling their behavior are linked with decreased helping behavior. More specifically, when an interaction

partner perceives that the other intended harm through their nonaccommodative communication, this is perceived especially negatively (e.g., Gasiorek & Giles, 2012). This matters for the HP-aggressive patient interaction because from the perspective of the HP, if they perceive the motive for the patient not accommodating them as negative and target this as a *personal* attack, then their care delivery may suffer, and their ability to manage WPV may be altered. It may also be the case, however, that staff do not perceive it as a personal attack but, instead conceptualize patient aggression in more intergroup ways as attack on HPs or the hospital.

RQ4: When staff experience patient aggression, who do they view the patient to be attacking (i.e., them personally, HPs generally, the hospital generally)?

As found by Study 1 and previous research, experiences of WPV are associated with lower self-efficacy, lower job satisfaction, and higher stress at work. Given these findings, it may be the case that when staff perceive aggression to be a personal attack, they may be even more likely to experience these things given their perceived motive of the patient aggression, and then actually experience WPV even more.

H1: The more staff perceive patient aggression to be personally aimed at them, the more they will experience: a) lower self-efficacy; b) lower job satisfaction; c) less reported patient cooperation; d) higher stress at work, and e) more incidences of WPV.

Accommodating a Patient

There are five main strategies that a communicator can use to adjust toward or away from a speaker called accommodation strategies (Dragojevic et al., 2016). Adjusting toward one's communication partner along one or several of these strategies can result in an increase

in similarity (perceived or actual) between communicators. Accommodative strategies are used in varying degrees of consciousness to appear more similar to or to increase social distance with their interaction partner(s). These five strategies are included in the center of Figure 1 called "competent accommodation strategies". First, approximation strategies are verbal shifts and nonverbal shifts away or toward an interlocutor (e.g., increasing/decreasing rate to speech, increasing/decreasing volume, adopting similar terms as the other speaker or not). Next, interpretability strategies have to do with increasing or decreasing the level of comprehensibility (e.g., a doctor not using medical jargon a patient cannot understand, opting instead for everyday language). Discourse management strategies focus on macro-conversation, otherwise known as big picture, processual issues of a conversation, such as turn-taking and the process of selecting an interesting topic. Interpersonal control strategies refer to any communication that highlights the status and role of the other interlocutor in the conversation, such as the use of interruptions or honorifics.

Lastly, emotional expressions as a fifth strategy refer to the extent to which someone accommodates their interlocutor (or not) in terms of emotions. This occurs when a person in interaction "explicitly acknowledges, elaborates and legitimizes the other's feelings" which helps demonstrate empathy (Williams et al., 1990, p. 136). Generally, the receiver feels a sense of reciprocal trust and openness, self-control, and uncertainty reduction when accommodated to in terms of emotional expressions. Soliz and Bergquist (2016) showed that some robust findings associated with accommodative behaviors are increased well-being (i.e., self-efficacy, life satisfaction and mental health), compliance (message agreement and persuasiveness), credibility and trust, quality of contact (communication satisfaction and

evaluation of the conversation), and relational solidarity (relational satisfaction closeness, common ingroup identity and intimacy).

In healthcare domains, an appropriate blend of the various strategies is required to achieve patient trust and satisfaction. This appropriate blend would constitute competent accommodation. Previous research in healthcare has shown that patients prefer to be accommodated to especially along the interpersonal control, discourse management and emotional expression dimensions (Watson & Gallois, 1998, 1999, 2002). When communicating with an aggressive patient, emotional expression is likely of special importance. Achieving a competent accommodative blend of strategies with an aggressive patient is likely complex and requires complementarity given the role-bound scenario between patient and provider. There may be combinations where a patient is diverging from the HP as they emotionally share their frustration. A convergent response from the HP may be competent, such that they validate patient frustration and are more accommodative. There are many possible scenarios of competent accommodation that may not appear competent on the surface.

Given that competent accommodation is defined as being appropriate and effective (Pitts & Harwood, 2015), it could be the case that the HP appears divergent or even non-accommodative by firmly setting limits with patients who are aggressive. However, this may prompt a response from patients that is respectful, and the situation is de-escalated, thereby making the interaction effective. It may also be the case that the speaker's linguistic dimension, or choice of words is divergent from the patient, but that is socially expected and appropriate. For example, in the case of a HP and patient, linguistic divergence may not result in a dissatisfying interaction because it is psychologically convergent (Watson &

Gallois, 1998, 1999). In simpler terms, patients anticipate and prefer HPs to speak differently than them in their role as a HP.

In addition, Gallois (2015) explains that strategy use in a conversation is dynamic and that there is no clear delineation of behavior and which one strategy it is. Instead, one behavior may function as several strategies simultaneously, and even to be competently one strategy, and ineffectively another. For example, a healthcare professional may say "wow that sounds like you're having a really hard time, miss" which would be considered effective emotional expression at first glance. However, it may also be a form of interpersonal control as judged by the patient if they perceive the HP to be talking down to them in a patronizing way instead of from a place of genuine care. Given the complexity of the theory and strategies, previous research has successfully manipulated strategy use in experimental research. However, in applied research, it may not be possible to disentangle accommodation strategies. Given this challenge, Gallois (2015) encourages researchers to investigate strategy use in qualitative ways, such as discourse analysis, to capture the complicated nature of intergroup encounters in reality. To learn more about what combination of strategies HPs use in the HP-aggressive patient interaction, and the ways it is associated with outcomes of interest, Study 2 poses the following research question and hypothesis:

> RQ5: What accommodation processes do healthcare professionals describe themselves using in their a) successful, and b) unsuccessful encounters with aggressive patients?
>
> H2: Staff reporting using competent accommodation will experience: a) higher self-efficacy; b) higher job satisfaction; c) more patient cooperation; d) less stress at work and e) less incidences of WPV.

Using Training to Improve HPs Accommodation of Patients

We cannot, however, in light of CAT assume that people have the appropriate knowledge to make the appropriate interpersonal adjustments. Nor can we assume they will adopt a positive attitude and accommodative stance toward patients. In terms of ability, communicators may not cognitively have the communicative repertoire to accommodate in difficult encounters. Although they may switch to affective strategies of accommodating, this may be insufficient, leaving the interaction remaining as a difficult one. Although for some it might be intuitive, staff who lack training and experience may not be likely to appropriately accommodate. Lacking communication competence, staff may not effectively or appropriately interact with aggressive patients, showing the importance of developing a training program to lessen the astronomical amounts of WPV experienced by healthcare staff.

In other healthcare arenas, researchers have used CAT to develop intervention trainings to improve interactions and increase outcomes like patient compliance and staff confidence. For example, Chevalier et al. (2017) developed an intervention training for junior pharmacists in the final stages of their medical education by delivering a lecture about CAT followed by practicing strategies with one another. This training changed pharmacist communication for the better with patients. Improved communication between pharmacists and patients has the potential to improve patient compliance with medication use. In addition, follow-up interviews from intervention trainings in New South Wales, Australia, have indicated success of interventions improving staff attitudes about patients who are likely to perpetrate WPV. Trainings helped HPs realize the importance of the environment and listening in patient interactions. In addition, trainings have helped change department norms

as other staff begin to encourage each other to respond appropriately to patients rather than just blaming the patient (Gerdtz et al., 2013).

Gallois and colleagues explain four main ways that researchers should use CAT principles when creating these trainings, which have been taken into consideration in this Study. First, researchers need to analyze the training situation including the history events, goals and relevant stereotypes. Second, researchers need to foreground the nature of the context. Third, researchers should highlight the most relevant sociolinguistic strategies in this context including convergence and divergence, learning which are the most important for the desired outcomes. Fourth, researchers should train others in how they perceive the interaction. (Gallois, Gasiorek, Giles, & Soliz, 2016). The order of the aforementioned research questions and hypotheses in this study have followed points one through three. The following hypotheses address point four.

H3: As more staff are trained and accept the premises inherent in such training, norms for handling aggressive patients will change such that they will a) recognize their contribution to the environment, and b) encourage one another to listen.

What's more, if HPs have a better understanding of the patient, blame the patient less, and understand their own impact in the interaction, they may be less likely to take patient-delivered nonaccommodation personally. Therefore, they may continue to try to adequately and competently adjust their communication to the patient.

H4: Training about managing patient aggression framed by CAT will help a) reduce taking the aggression personally, b) increase the likelihood of staff to report using accommodation strategies, and c) decrease WPV.

Unfortunately, even though previous intervention trainings, some of which used CAT, have shown great promise in improving healthcare, improvements may not be lasting. Williams (2006) tested the effectiveness of a training for care nurses in a nursing home to improve their communication with patients (i.e., decrease elderspeak). Despite finding that the intervention was successful immediately following the training, effects dissipated after two months. Given this finding, it is crucial to not only develop interventions that improve interactions for desired outcomes (i.e., decrease WP) but also that have effects that endure over time. As such, Study 2 poses the following research question:

RQ6: What effects does CAT training to prevent WPV have on a healthcare organization and the staff over time?

Summary of Hypotheses and Research Questions in Study 2

Figure 1 overviewed the conceptual components of CAT that participants were trained on, and that were tested in Study 2. Given this conceptual diagram, Study 2 is organized by the order of a conversation. First, it is shaped by the context. As such, RQ1 asks about the nature of WPV in the context in Study 2. Next, a person enters into a conversation with an initial orientation. As such, RQ2 asks about that orientation followed by RQ3 a probing more specifically staff attitudes toward patient aggression. Then, how those attitudes are associated with accommodation prior to training. RQ4 also probes initial orientation by learning about what attributions staff hold about who the patient is attacking prior to training. Following on from initial orientation, are communication behaviors. RQ5 probes what accommodative behaviors staff use with aggressive patients. Next, this study replicated and again posed H1 as supported and drawn from findings from Study 1, predicting that the more favorable and understanding a staff member orients themselves to the patient aggression, the

more they will experience desirable outcomes, and the less they will experience undesirable outcomes. H2 then predicts that accommodation is associated with more desirable outcomes and less undesirable outcomes. Beginning with H3 and onward, Study 2 tests the effectiveness of the training over time. Particularly, H3 predicts that training will favorably impact organizational norms in the organizational context. H4 then predicts that training will improve accommodation, initial orientation, and reduce the undesirable outcome of experiencing WPV. Finally, RQ6 probes how these effects change the overall context over time to predict future successful prevention of WPV by accommodating patients.

Study 2 Method

Data were collected from a Central California clinic that provides mental, dental, and primary care. The following sections will explain more information about the location, procedure and participants from this clinic.

Study Location – A Central California Clinic

The clinic where data were collected is a registered 501C-3, non-profit organization. The mission statement of this organization reflects the values of providing high value, comprehensive care that is available to all people, not dependent on their financial means. They also state values of "respect, compassion and dignity" (Organization Blinded, 2017). According to the public tax documents for the clinic in 2016, the target population includes low-income, uninsured, homeless and underserved populations in the county where it is located. In the 2016 fiscal year, the organization provided service to 20,692 unique patients across medical, dental, and behavioral health encounters. There are seven clinic locations total, three of which provide dental services, and have a residency program with at least one attending dentist at each location. The remaining four locations only provide medical and

behavioral care. The locations that provide medical care have a behavioral specialist on site. Two clinics have a community wellness navigator on site. This position is dedicated to helping patients learn about and sign up for services they may need like subsidized housing, food stamps, MediCal or social security benefits. Community wellness navigators also work in the community at events to educate families about resources they have available through the government and local non-profits.

Before conducting the all-staff training, I spent a day at five of the seven locations in which I received a tour and had informal conversations with staff about their experiences with patient aggression. The other two locations did not allow me to spend a day there prior to the training. At times, I shadowed clinicians by sitting in on clinical visits. I also sat at the front desk and shadowed staff there during business hours. At each clinic, I had conversations with each staff specialty. Having staff give their input before developing the training was essential for several reasons. Not only could staff knowledge be incorporated into the training but also so that staff saw the training as more than just explaining a "soft skill," which communication is often referred to in medicine (Watson, 2019). Each of the clinics had a unique patient population (i.e., some clinics focus mainly on children while others focus mainly on those recovering from addiction). The clinics varied widely in size, with one clinic having only two patient rooms, and others having up to seven patient rooms. The clinics dedicated only to dental services had a very open layout, sometimes with four dental chairs in a room with little to no partition between them. All of the clinics were open Monday to Friday from approximately 8:00am to approximately 6:00pm and were open for a half-day on Saturday mornings. The clinics were not open on Sundays.

Procedure

Participants from all seven clinics attended a training at their monthly all-staff meeting in June 2019 that lasted approximately one hour. There were two sessions such that half of the staff attended the earlier training from 8:00 am – 9:00 am, and the other half attend a training immediately following from 9:00 am – 10:00 am. In total, there were 155 staff in attendance across both trainings. Similar to previous work by Chevalier, Watson, and Cottrell (2018) in Australia, the researcher delivered a competence training course about what CAT is, the importance and associations with accommodation and how to employ strategies in aggressive patient interactions. In the first phase, upon arrival, staff members were told about the research and purpose of the training. At this time, staff signed consent forms at their tables. At the training before learning new material, staff then filled out a pre-questionnaire regarding their knowledge, skills, and attitudes (Appendix C, p. 209). This will now be referred to as the pre-training time point.

Next, staff engaged in the first role play with one another at their tables. Role plays were included in the intervention for several reasons. First, healthcare staff regard this as an important way to learn new skills. It is normative for all healthcare staff to engage in role plays through their medical education regardless of specialty. In all research with HPs I have completed, staff request role plays or simulations to practice before interacting with real patients. In addition, practice scenarios were included in the intervention developed by Chevalier et al. (2017) when training pharmacists with a CAT training. Lastly, previous research has shown that role plays can help with perspective-taking and empathy, especially when the participant is the person playing the part of someone unlike themselves (Castro & Mineo, 2019; i.e., an aggressive patient). Scenarios for these role plays were created based on informal interviews with and shadowing of key informants at clinic locations including

clinicians, dentists, phone operators and management. After creation of the scenarios, key informants had the opportunity to make edits to them to make them as relevant as possible to the organization. To engage in the role play practice during the training, a volunteer that I recruited was given a scenario to enact where they were the aggressive patient – or parent of an aggressive patient – relevant to the staff at that table. Volunteers were my friends and department colleagues. One staff person at the table performed their normal job role with the volunteer aggressive patient. At this time, other staff at the table with a similar job functions who were observing the interaction rated the staff member's behaviors using the CAT scoring tool (Chevalier, Watson, & Barras, 2020) found in Appendix C (p. 209).

After that, I delivered a short lecture, (approximately 20 minutes) where I described each of the five CAT strategies, the importance of accommodation, and how to combine them in interaction. Participants then engaged in a second role play to practice their new skills. To complete the second role play, volunteers stayed in their assigned character scenario and shifted to another table of professionals in the same job function. The slides and scenarios used for this training course can be found in Appendix E (p. 237). Phase two, now referred to now as the post-training time point, of data collection occurred directly following the short lecture such that participants then responded to a near identical questionnaire after learning the material before leaving for the day (Appendix C, p. 209).

Phase three of data collection commenced on September 6, 2019 when the follow up survey found in Appendix F was emailed to all SBNC employees across all locations through their listserv by an administrative assistant. Follow-up surveys were conducted at this time for several reasons. First, findings by Williams (2006) that found that post-intervention effects after a communication intervention training with patients and care nurses in a nursing

home only lasted two months. Given these results, it was important that sufficient time passed between immediately post-training and a follow-up to examine how enduring effects were. Second, permissions to email the survey to participants were challenging to obtain. Ultimately, I waited until the organization was able to send the survey out which was about a month after I requested it be sent out. This time point is now referred to as the three-month follow-up.

Only 24 participants filled out the online survey. Owing to low response rates to the online survey distribution, I or one of my research assistants attended each of the clinic's September staff meetings, at which point the clinic manager allocated 10 minutes for their staff to fill out the paper survey. Only one of the seven clinics did not allow us to visit their September staff meeting. Two of the remaining six clinics did not have sufficient time in their meeting to allow for survey completion and agreed to send completed paper surveys to me via email at a later date. Despite several emails and phone calls to both the clinic manager and lead clinician after visiting their September meeting, asking for the completed surveys, they were never returned. As such, four of the seven clinics' survey data are represented at the follow-up time point. Data collection for phase three officially concluded on October 6, 2019.

Paper surveys combined with the online surveys and excluding duplicates resulted in a total of 74 responses at the three-month follow-up time-point. Of these 74 responses, only 45 were able to be matched to the other time points, based on their ID code. In conversations with staff members while being in the clinics for meetings and informal conversations, as well as for interviews for a study that goes beyond the scope of this dissertation, I was made aware of possible reasons why so many of the ID codes did not match up. First, I learned that

there is high turnover at this organization in the administrative staff. Second, I learned that people in this participant population change their phone number. I had several participants unable to remember what their phone number was in June, as opposed to the October time point because it had changed since then. Upon inspecting the data, many of the last four digits of the phone number were unique and matching the time point one, pre-training responses. Given this, it may also be the case that the ID code question that asked for the "first three letters of your mother's name" was not specific enough. Perhaps people wrote the first three digits of their mother's first or last name, or even their own name, in ways that did not match their prior response. As such, for quantitative analyses of all time points, 45 participants were used.

In sum, data were collected from staff members of the clinic across all job positions at three time points. The first time point was on the day of the training immediately preceding the training when staff entered the room after informed consent. The second time point was immediately post-training on the day of the training before staff left for the day. The final time point was a three-month follow-up survey completed either online from an email or on a paper survey when a member of the research team visited the clinic for their monthly meeting.

Participants

On the day of the training, 176 employees were expected to attend the training. Of the 155 who actually were in attendance, 140 people agreed to participate in the research[1]. Of these, 140 attendees agreed to be research participants. Of the participants, 15.71% were

[1] Although all-staff trainings at this organization are mandatory, some staff do miss for personal reasons or due to illness. No formal data was collected about those who did not attend, or who elected not to participate. Their reasoning for non-participation remains unclear.

male (*n* = 22), 81.43% were female (*n* = 117), and 0.71% (*n* = 1) reported other as their gender identity. Participants ranged in age from 19-77 years old (M = 34.73, SD = 13.22), and worked at this organization ranging from one to 458 months (M_{months} = 49.96, SD = 76.60). Regarding employment amount, 9.29% were part-time employees (*n* = 13), 89.29% were full-time employees (*n* = 125), 0.7% were per diem employees (*n* = 1), and 0.7% did not report their employment amount (*n* = 1). When asked if they had taken a limit-setting or de-escalation training before, 81.43% reported never taking a training before (*n* = 114), 14.29% reported having taken a training before (*n* = 20), and 4.29% did not respond (*n* = 6). Participants were employed across 11 unique departments at the clinic (i.e., Medical Administration, Dentist and General Clinicians, Dental Administration, Insurance Administration, Management, Referrals, Social Services, Lab Assistance etc.) The majority of participants worked in Medical and/or Dental Administration (35%, *n* = 51).

Demographic information was only collected at the pre-training time point. However, to understand the final sample, the demographic information for only those who completed the survey at all three time-points, the three-month follow-up description of participants is included here. At the three-month follow-up time point, 11.36% identified as male (*n* = 5) and 88.63% identified as female (*n* = 39). Participants ranged in age from 19-62 years old (M = 32.38, SD = 10.12), and worked at this organization ranging from one to 216 months (M_{months} = 40.91, SD = 46.86). Regarding employment amount, 9.09% were part-time employees (*n* = 4) and 90.91% were full-time employees (*n* = 40). When asked if they had taken a limit-setting or de-escalation training before the June training, 72.73% reported never taking a training before (*n* = 32), 22.73% reported having taken a training before (*n* = 10),

and 4.55% did not respond (*n* = 2). Employment across departments remained identical to the previous time point.

Measures

See Appendix C (p. 209), Appendix D (p. 214), Appendix E (p. 214), and Appendix F (p. 237) for a full inclusion the survey items. See Table 4 for variable descriptive statistics and bivariate correlations. Variables were measured in the following way:

Staff stress at work (Appendix C, Q#7-11; Appendix F, Q#1-5)**.** Five questions adapted from Laposa et al. (2003) measured staff stress at work. This scale was originally intended for ED staff, but was used for all department staff. Questions were measured on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) and included "Following an aggressive patient interaction: you've considered changing jobs; sought internal mental health services." After examining inter-item correlations, one item had low and negative correlations with other items, as such "I have reduced my work hours in the past year" was not included in the analysis. (Pre-training $\alpha = .54$; Follow-up $\alpha = .54$). Despite removing one item, and using an established scale, reliabilities for this variable at both time points were very low. As such, results should be interpreted with increased caution.

Self-efficacy (Appendix C, Q#12-15; Appendix D, Q#1-4, Appendix F, Q#6-9). A 4-item scale adapted from Afifi and Afifi (2009) that originally measured communication efficacy regarding engaging in conversations with their parent about their parents' turbulent relationship was used. Measures were adapted to probe how confident staff feel about communicating with an aggressive patient (i.e., "I can communicate with an aggressive patient to de-escalate the interaction"). Items were measured on a 5-point scale from 1

(*strongly disagree*) to 5 (*strongly agree*; Pre-training α = .78; Post-training α = .81; Follow-up α = .75)

Job satisfaction (Appendix C, Q#16-19, Appendix F, Q#10-13)**.** A 4-item scale was adapted from Stamps, Piedmont, Slavitt, and Haase (1978). The original scale included 37 items intended to capture the attitudes of hospital nurses regarding their occupational satisfaction. The original scale included pay, professional status, doctor-nurse relationship, administration, autonomy, task requirement and interaction components. This study did not measure issues of pay, doctor-nurse relationship, administration or autonomy. Sample items of this measure include; "What I do on my job is important" and "I am satisfied with the types of activities that I do on my job." Items were measured on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*; Pre-training α = .61; Follow-up α = .62)

Perceived target of patient aggression (Appendix C, Q#20-22; Appendix D, Q#6-8; Appendix F, Q#14-16)**.** Three items were created for this study which measured who participants perceive to be the target of patient aggression. Items included "When a patient is aggressive it is an attack on; me personally, healthcare professionals generally, the hospital." Items were measured on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Single items were sufficient for use for this variable given that it is not a latent construct.

Attitudes toward causes patient aggression (Appendix C, Q#23-27; Appendix D, Q#8-12; Appendix F, Q#17-21) An adaptation of the management of aggression and violence attitude scale (MAVAS; Duxbury, 2003) was used to assess the extent to which HPs blame the patient for their aggression. The original scale consisted of four domains (i.e., interactional perspective, external perspective, biological perspective, and the perceptions for clinical management) and 26 items. Although the scale has been validated and deemed

reliable in its entirety, that version of the scale was too long for purposes of this study. Therefore, one to two questions from each domain were included resulting in a 5-item scale. Sample items included "Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence" and "Other people make patients aggressive or violent." The final five items included in this scale were measured on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*; Pre-training $\alpha = .52$; Post-training $\alpha = .67$; Follow-up $\alpha = .55$). Reliabilities for this variable were very low, and results containing this variable should be interpreted with increased caution.

Patient cooperation (Appendix C, Q#28; Appendix D, Q#14; Appendix F, Q#22)**.** Participants responded on a 5-point scale from 1 (*strongly disagree*) to 5 (*strongly agree*) to the following question; "When a patient is aggressive, I am usually able to make the patient cooperate enough to complete my job tasks."

Experience of WPV (Appendix C, Q#29; Appendix F, Q#34)**.** Participants listed in an open-ended manner the number of WPV events they have experienced both at the time of the training and since then. Participants were asked to describe how they manage patient aggression. They were provided with the definition of WPV included in Study 2 to read first as shown in Appendices C and F. The prompt then read "With that in mind, how many experiences of workplace violence have you experienced since the training? Please describe what happened in the most memorable of these interactions. Try to include quotations of things you and the patient said to one another, and the way you both communicated using your body language."

Department normative practices (Appendix C, Q#30-31; Appendix D, Q#17; Appendix F, Q#39-41). To measure the extent to which HPs were aware of their influence in

their department's work environment, they were asked the following two open-ended questions. "What role if any, do you play in fostering an environment where patients do or do not become aggressive?" and "What do you talk about with your peers during work regarding your department experiencing aggressive patients? Do you give your peers any advice about how to handle it? If so what advice?" Interview questions regarding normative practices and policies in the department were also asked of participants in a study that goes beyond the scope of this dissertation.

Aggression context (Appendix D, Q#15a-c; Appendix F, Q#35-38). To determine where and when patient aggression typically occurs, staff were asked several questions in an open-ended manner including: "What contexts come to mind when you think of conversations you've had with aggressive patients? Where do they occur? What time of day do they occur?"

Accommodation (Appendix C, Appendix F, Q#23-33)**.** Originally, the accommodation scoring tool was a 10-item measure on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*) assessing pharmacists' accommodation toward patients in consults explaining new medications. As part of her dissertation, Chevalier, Watson, Falconer, & Cottrell (2017) trained pharmacists and used this tool to assess their improvements in communication with patients along the five accommodation strategies. The tool for this study was an adaptation of the same items reduced to eight items relevant to the aggressive patient interaction. It was also changed to a 1 (*strongly disagree*) to 5 (*strongly agree*) scale instead of a 7-point scale to remain consistent with the rest of the survey. This tool was used twice during the training to assess baseline and then changes to communication competence. Nine accommodation items were also included in the follow-up survey (Appendix F, Q#23-33) to

assess longitudinal communication competence effects. Sample items include "The staff member avoided the use of medical terms that the patient wouldn't understand [Interpretability strategy]" and "The staff member spoke to the patient in a respectful and courteous manner [Interpersonal control strategy]." (Role play #1 $\alpha = .92$; Role play #2 $\alpha = .93$; Follow-up accommodation scale $\alpha = .88$). Accommodation was also coded for in the open-ended responses where staff wrote about their experience of WPV[2].

Perception of Lasting Nature of the Training. To assess participant perception of the training, and thereby their motivation to use their new knowledge, participants were asked "How long-lasting do you think what you learned in the training will be?" in an open-ended fashion (Appendix C #16, Appendix F #42).

[2] Nonaccommodation was not explicitly measured. It was anticipated that in open-ended responses about managing experiences of patient aggression, staff would explain experiences that exemplified nonaccommodation. However, this did not occur. Likewise, low scores on the accommodation scale would demonstrate nonaccommodation, however the mean for this scale was quite high indicating no obvious or reported instances of nonaccommodation. Lastly, nonaccommodation is largely a receiver-determined variable. Given that patient perceptions were not included, nonaccommodation could not be thoroughly measured.

Table 4. *Study 2 descriptive statistics and bivariate correlations for quantitative variables*

Pre-training	M(SD)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1.Length	3.41(3.91)	---										
2. Age	32.38(10.01)	.57***	----									
3. Stress	2.01(.54)	.12	.10	α = .54								
4. Efficacy	3.69(.65)	-.04	.04	.13	α = .78							
5. JobSat	4.06(.64)	-.47**	-.09	-.16	.38**	α = .61						
6. Personal	1.79(.56)	-.04	-.21	-.04	-.34*	-.25	----					
7. HPs	2.38(.81)	-.18	-.18	-.16	-.20	.02	.42**	----				
8. Clinic	2.22(.73)	-.21	-.14	-.18	-.25	.12	.32*	.80***	----			
9. Attitude	3.45(.44)	-.11	.18	.09	.34*	.33*	-.10	-.15	-.03	α = .42		
10. Cooperate	3.43(.67)	-.36*	-.20	.12	.61***	.43**	-.30	-.30	-.33*	.49**	----	
Post-Training												
11. Efficacy	4.05(.43)	.04	.23	.17	.61***	.10	-.36*	-.34*	-.29	.31*	.34	α = .81
12. Personal	1.74(.79)	.07	-.15	.18	-.21	-.32*	.63***	.26	.12	-.25	-.26	-.21
13. HPs	2.06(.94)	-.03	-.05	.13	-.04	-.14	.50**	.33*	.23	-.01	-.09	-.04
14. Clinic	2.01(.83)	.01	-.07	.16	-.17	-.12	.54***	.50**	.36*	-.13	-.28	-.17
15. Attitude	3.81(.54)	.09	.33*	.17	.27	.08	.03	-.11	-.16	.47**	.23	.27
Three-month follow-up												
16. Stress	2.06(.70)	.10	-.05	.45**	-.26	-.26	-.01	-.03	-.07	-.14	-.10	-.10
17. Efficacy	3.90(.58)	.22	.40**	.24	.60***	.09	-.43**	-.25	-.27	.35*	.25	.66***
18. JobSat	4.13(.56)	-.03	.33*	-.30	.08	.48**	-.21	-.15	-.03	.30*	.12	.22
19. Personal	1.71(.69)	.08	-.03	-.02	-.36*	-.27	.62***	.34*	.37*	-.11	-.34*	-.12
20. HPs	2.16(.89)	.09	-.05	.01	-.19	-.22	.35*	.46**	.47**	-.14	-.35*	-.13
21.Clinic	2.07(.76)	.08	-.09	-.01	-.24	-.18	.42**	.44**	.42**	-.22	-.37*	-.19
22. Attitude	3.55(.47)	-.02	.29	.04	.15	.15	-.17	-.13	.03	.65***	.20	.30
23. Cooperate	3.75(.44)	.24	.28	.14	.28	-.15	-.11	-.26	-.18	.15	-.01	.36*
24. Accom|	4.22(.37)	-.14	.17	-.03	.36*	.31*	-.35*	-.16	-.12	.30	.21	.44**

Table 4 continued

Pre-training	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.	22.	23.	24.
1.Length													
2. Age													
3. Stress													
4. Efficacy													
5. JobSat													
6. Personal													
7. HPs													
8. Clinic													
9. Attitude													
10. Cooperate													
Post-Training													
11. Efficacy													
12. Personal	----												
13. HPs	.74***	----											
14. Clinic	.71***	.83***	----										
15. Attitude	-.02	.13	.08	α = .67									
Three-month follow-up													
16. Stress	-.01	-.02	.09	.25	α = .54								
17. Efficacy	-.22	.00	-.07	.49**	-.03	α = .75							
18. JobSat	-.18	-.01	-.16	.26	-.33*	.29	α = .62						
19. Personal	.46**	.52***	.64***	-.03	.09	-.23	-.17	----					
20. HPs	.40**	.58***	.55***	-.15	.03	-.09	-.07	.54***	----				
21.Clinic	.42**	.44**	.57***	-.13	.15	-.24	-.23	.64***	.85***	----			
22. Attitude	-.39*	-.23	-.23	.56***	.04	.49**	.25	-.12	-.18	-.23	α = .55		
23. Cooperate	.01	-.11	-.02	.19	-.18	.52***	.17	.04	-.08	-.02	.20	----	
24. Accom	-.19	-.07	-.18	.34*	-.31*	.47**	.55***	-.33*	-.34*	-.52***	.31*	.25	α = .88

Note: *p < .05; **p < .01, ***p < .001. Length = time at the clinic in years, JobSat = job satisfaction, Personal = aggression perceived as personal attack, HPs = aggression perceived as an attack on healthcare professionals generally, Clinic = aggression perceived as attack on the clinic, Attitude = attitude toward patient aggression, Cooperate = extent to which staff achieve patient cooperation, Accom = accommodation of the patient

Analysis

For qualitative data, following recommendations by Miles and Huberman (1994), I coded open-ended questions first by using line-by-line, inductive coding to develop a coding scheme. Variables were quantified by assigning a number to each code. I described this coding scheme to one research assistant who was very familiar with the research project through assisting in proofreading materials, attending the June training, and data entry of paper surveys into excel. After this, coding reliability was pursued and ensured by having the research assistant independently code the data with the coding scheme I developed. The variables that were coded and checked for reliability in this way were how lasting participants thought the skills they learned in the training would be (95% intercoder reliability), the role that they play in fostering an environment that prevents WPV, (pre-training and post-training intercoder reliability 92%), and the context in which the WPV occurs (intercoder reliabilities on each dimension; location in the clinic 95%, time of day 93%, and weekend or weekday 95%). Reliabilities were determined sufficient in accordance with the process described by Miles and Huberman (1994). Quantitative changes over time were analyzed using SPSS 26 to conduct repeated measures analyses (i.e., ANOVA, ANCOVA). Composite scores were created for each variable and used for analysis after assessing variable reliability.

Results

Initial quantitative analyses

Owing to the very small sample size at the three-month follow-up in the Central California clinic in comparison to the pre-training sample, the data were investigated for any patterns in the missing data. Although much of the missing data may be due to the ID Code

convention used as previously described, there may be statistical indications of missingness as well. To assess if there is any systematic way in which people dropped out of Study 2, a binary logistic regression (completed study at all three time points = 1, dropped out = 0) was conducted with each of the following continuous variables at pre-training to determine if any of the substantive variables significantly predict dropout of the study prior to the three-month follow-up: stress at work, self-efficacy, job satisfaction, perceived target of patient aggression, attitudes toward patient aggression, ability to achieve patient cooperation, and instances of WPV. Table 5 shows the associations and their levels of significance between each of these variables. None of the variables significantly predicted participant dropout. Having participated in a prior training approached statistical significance ($p = .06$), such that those who have participated in a prior training were 61% more likely to drop out of Study 2. As such, this variable is included in several analyses below, and explored further in the general discussion section. Results below should still be interpreted with the high level of dropout in mind as there could be an unmeasured variable beyond challenges with the ID Code that impacted results.

Table 5. *Logistic regression results investigating patterns of missing data in Study 2*

Predictor Variable	**Exp(B)**
Stress at work	.67
Self-efficacy	.74
Job satisfaction	.86
Perceived target of patient aggression	
- Personal attack	.84
- Healthcare professionals	.84
- The clinic	.49
Attitudes toward patient aggression	.55
Achieving patient cooperation	.78
Experiences of WPV	1.11
Prior de-escalation training	.39

Note: *$p < .05$; **$p < .01$; ***$p < .001$

RQ1: Pre-Training Contextual Factors

RQ1 probed the nature of the context in which WPV typically occurred at the Study 2 location prior to the trainings including prevalence, nature, and context (e.g., location and time of day). Study 1 results indicated the importance of the way that staff orient themselves to the aggression. As such in Study 2, staff were asked in an open-ended question about "What role, if any, do you play in fostering an environment where patients do or do not become aggressive?" Responses to this question provided an understanding of staff initial orientation to the aggression. Lastly, an understanding of participant thoughts about how long what they learned in the training would last helped to provide some information to determine staff attitudes about learning the accommodation skills, perceived ability about using the new accommodation skills and how motivated they were to enact those skills into the future. Motivation and ability are important to consider in CAT because interlocuters who are not motivated or are not able to accommodate one another are much less likely to do so (Giles, 2016).

WPV prevalence and nature before the training.

Results from Study 1 indicated that the overall prevalence and nature of WPV at the study location should be well understood before any other analyses. Given that very few participants in Study 1 had experienced any WPV since the Study 1 training, results for that study were not always in the expected direction. Similar to Study 1, participants in Study 2 reported generally low experiences of WPV. Of the 77 participants who responded to the question about the prevalence of their experiences with WPV during the pre-training time point, 24.68% (n = 19) reported no experiences of WPV at this organization. Of the people who reported at least one experience of WPV at the pre-training time point, 20.78% (n = 16)

of the respondents reported experiencing “multiple” or “many” or “several” experiences of WPV. One participant said, “too numerous to count, where do I start?” (DAR3716, Licensed Clinical Social Worker). As such, no discrete number was given to these types of responses. Of the remaining responses, participants reported experiencing 1.27 instances of WPV on average (SD = .80). The most common response at 40.26% of the sample (n = 31) was experiencing one instance of WPV. Only seven participants reported experiencing two or more instances of WPV. Given this, the baseline for experiencing WPV was already low with this population at pre-training.

Of participants who reported having at least one experience with WPV, there were some common descriptions of the experience. The majority of descriptions from participants were about times that a patient did not get what they were requesting, whether it be an appointment time or narcotic pain medication. This resulted in experiences where they perceived the patient to try and physically intimidate them, and patients using profanity or “foul language”. One person explained that a patient “ended up backing me into a corner and using his size/volume/body language etc. to dominate over me” (CAR9231, Dentistry). In another scenario, for example, one participant said a patient came into the clinic upset about an appointment cancellation and “was yelling at everyone saying “fuckyall!” (EVA6059, Medical Administration). The majority of responses regarded verbal attacks, ranging in intensity from suggesting staff incompetence like “Does anyone know anything around here?” (NIC0529, Medical Staff), to being serious threats like bringing a gun with them. Another example of a serious threat is the following experience: “A psychotic patient threatened to kill me and my family. It was like he was reading a script, totally deadpan” (KIN3232, Medical Staff). In addition, many participants (n = 9) explained they had only

experienced verbal aggression over the phone. Only one participant reported a physical attack, although they did not provide details of said attack.

> A patient who suffers from paranoia (diagnosed) locked me up in a room with her and was hysterious towards me. She physically attacked me (ALM7084, Dentistry)

Altogether, results from the pre-survey regarding prevalence of WPV indicate that at this location, physical violence was very uncommon and instead staff experienced verbal abuse that often made them feel unsafe.

Where and when WPV typically occurred pre-training.

Because a wide range of healthcare staff were included in Study 2 (e.g., front desk, referral, billing, dentistry, medical doctors, lab staff), a wide range of locations, in an open-ended manner, were reported of where WPV occurred. Several respondents listed more than one place in which the WPV typically occurred prior to the training, which explains why the responses below add up to more than 100%. Of the 102 people who wrote a response at pre-training, in order of prevalence, 37.25% said the WPV occurred at the front desk which is in the waiting area (n = 38), 16% of respondents (n = 16) said the aggression typically occurred over the phone, 15.69% (n = 16) said that it occurred inside the clinic often describing either the hallway area where patients are being taken back into the exam room, or the space where insurance claims or referrals are discussed, 15.69% (n = 16) of people said that the WPV occurred inside the exam room in medical visits and 7.84% (n = 8) said that it occurred inside the dental operatory while the patient is in the dental chair, 14.71% (n = 15) said that the WPV occurred anywhere in the clinic and did not specify a location, and 1.96% (n = 2) said the WPV occurs in the lab room. Given this general overview of location of WPV in the clinic, the experiences of WPV per location were proportional to the amount of staff at each

location. For example, the majority of staff at the clinic were administrative staff who worked the front desk, billing and insurance which means they often also received phone calls, and this was where the majority of staff reported WPV to occur. The second largest group of staff were medical assistants who escorted patients between the waiting area, vitals area, and into the exam room and this was the second most common response of where WPV occurred.

In addition to where in the clinic the WPV occurred, participants explained in an open-ended fashion, when it occurred. Similar to the location question, many people responded with more than one location which is why the percentages below add up to more than 100%. Of the 104 responses, the overwhelming majority of participants (53.85%, n = 56) indicated that the WPV occurred any time of the day saying that it varied. Of the remainder of responses, in order of prevalence, 18.27% (n = 19) of participants reported that the WPV occurred in the afternoons with 11.54% (n = 12) saying more specifically that it occurred in the late afternoons toward the end of the workday, whereas 13.46% (n = 14) said that it occurred in the mornings with 3.85% (n = 4) specifying the early morning. Lastly, 6.73% (n = 7) said it occurred at lunchtime. Given the near even spread of responses regarding time of day, it seems that indeed the WPV did occur at any time of day and not in any predictable pattern at these clinic locations. If anything, the WPV bookended the day, occurring in the mornings or afternoons and less so in the middle of the day. This slight increase in occurrences of WPV in the morning and afternoon was likely because the mornings and afternoons tend to be the busiest times for the clinics. The increase in occurrences in the afternoon may have been caused by wait times, as five participants who

said it occurs most in the afternoon described in their responses that the WPV occurred "usually when we are running late or have to be rescheduled" (ESP0431, Dentistry)

RQ2: Initial orientation to patient aggression in workplace role

Responses for the question "What role do you play in fostering an environment where patients do or do not become aggressive?" were analyzed inductively, starting with line-by-line coding. Line-by-line codes were then grouped together by similarity. This process resulted in eight main codes resulting strictly from the data. Reliability of these eight codes was established with a research assistant by coding responses independently in accordance with the process described by Miles and Huberman (1994). Upon re-examination of the data, many of the eight data-driven codes overlapped in theory-driven ways that suggested moving up a level of abstraction, resulting in three main themes that reflect the goals that participants hold aligning with multiple goals theory (Caughlin, 2010). Communication competence, and CAT generally, incorporates the underlying initial interpersonal goals that people have entering into an interaction (Pitts & Harwood, 2015). The goals that participants described reflected their initial orientation to interactions with aggressive patients. Ultimately, participants reported attending to multiple goals. Multiple goals theory outlines three main types of goals that interlocutors pursue in interaction that may overlap. Instrumental goals are whatever purpose the interaction is meant to achieve or initial purpose for initiating the interaction, which in this case are providing patient care. Relational goals are a consideration of the relationships of those in the interaction, in this case patients or fellow staff. Identity goals are how one conceives of or wishes to present the self in the interaction (Caughlin, 2010).

The instrumental goals that participants reported attending to included behavioral pursuits to prevent or de-escalate patient aggression. There were two sub-types of behaviors that participants reported: behavioral pursuits focused on the context in which the aggression may occur, and behavioral pursuits directed at the patient. Eighteen of the 56 participants (32.14%) who responded described their role as focused on the context for preventing WPV. Participants said that it was their role to prevent WPV by "promoting a calm environment" (ROS3583, Medical Staff). Others described their role as fostering a calm or welcoming environment for patients where they modeled the ways patients should behave. In addition to focusing on the context or environment of patient care, participants responded with behaviors that were directed at the patient. These patient-directed behaviors were intended to accomplish the instrumental goal of providing quality care.

Often times, the responses about behaviors they pursued in this arena attempted achieve typical tenets of patient-centered care (PCC). Patient-centeredness is an inherently relational (and instrumental) concept such that the patient and healthcare provider should jointly pursue patient needs and wishes in a reciprocal relationship (Guzley, Dunbar, & Hamel, 2002). Participant responses implied that when these instrumental behavioral tasks were achieved, they would be able to de-escalate aggression and prevent WPV. Of the respondents, 18 participants (32.14%) reported engaging in behaviors that logistically help the patient like addressing their problem, offering resources, or explaining medical information "to the best of my knowledge" (MAU6609, Medical Administration). For example, one participant reported their role as "pursuing the roots of their concerns" (PAU8545, Dentistry). Participants implied that if they were able to get to what the patient was really needing or complaining about in the interaction, then they would be able to de-

escalate the situation. Responses also implied that causes of patient aggression tend to be because the patient was not getting what they want or did not understand the situation. For example, one participant said that their role was "sometimes translate doctor's words and try to have the patient understand as well" (LUC3229, Dentistry). Although length of time at the organization, age, or gender did not impact likeliness to pursue this goal, interestingly, the majority of participants who attended to this type of instrumental goal were in dentistry. This may have been because, according to the dentists at this organization, they perceived most of patient aggression to be caused by either dislike of wait time, appointment time, or fear of the dentist. Perhaps they felt that if they were able to explain care and offer resources to the patient, they would be able to prevent patient aggression from this cause. Overall, the focus on the patient concerns and needs suggests that the participants recognized the role of providing PCC in preventing WPV.

Although patient-centeredness is inherently a relational concept, many participants more explicitly stated that their role in the environment was pursuing relational goals. The two main parties that participants pursued relational goals with were patients and fellow staff. Staff who reported relational goals with the patient as their role in preventing WPV described their efforts to provide social or emotional support and promoting feelings of solidarity. One participant said they give "hugs + smiles" (DEL0908, Medical Staff). This type of physical touch may communicate care. Another participant reported that, "I communicate to them they are not alone" (MAR9012, Medical Administration) which communicates the solidarity from the staff member to the patient. The majority of participants who focused on relational goals with patients in preventing WPV reported efforts to communicate understanding to the

patient. Many of the participants who responded in this way were in medical administration or reported communicating with patients this way mainly over the phone.

Several other staff responses (n = 5, 8.93%) explained the importance of the relationships they focus on with fellow staff in order to prevent WPV. Generally, these responses came from people in leadership positions such as a clinician or management staff. For example, one participant said, “I encourage staff to acknowledge goof-ups and move on” (KIN3232, Medical Staff) indicating that staff encouraged one another in their efforts to provide high quality care, acknowledging that they were not perfect. Other staff reported that they attend to relational goals with fellow staff by “assisting staff when they are not able to deal with patients who are angry” (MAR7314, Medical Staff). Based on informal conversations with staff in the clinics, often times this assistance was given without having be ask. This initiation indicated that a helping relational orientation toward fellow staff in the clinic was normative. Overall staff who reported attending to patient or staff relational goals often also reported attending to instrumental goals (n = 10, 17.86%).

Lastly, participant responses reflected identity goals in two main ways. First, participants reported conceiving of themselves in some sort of self-determined identity that prevents WPV. Second, participants reported that from their job position in the clinic, they played a certain role in preventing WPV. Overall, 20 participants (35.71%) responded in a way that reflected an identity goal. Those who focused on some self-concept that implicated them in preventing WPV often attached a name to the identity such as “the diffuser” (GOL8981, Dentistry) or “a peacemaker” (JOH5631, Medical Administration). Participants who responded in this way seemed to claim preventing WPV as part of their professional identity that was not prescribed necessarily by their job function. According to Davies and

Harré (1990), operating from this position suggests that participants created a role for themselves based on fragments of their lived experiences in the clinic.

However, others responded from their position as a certain job function in the clinic, suggesting that they see themselves in known "roles" in the clinic based on their professional title. They called on cultural stereotypes of their professional title as a resource that prescribed certain appropriate behaviors as part of this position. Although not asked directly in the question, participants who positioned themselves this way to pursue their identity goals responded first with their professional title by saying things like "As a…" or more simply listing their title, followed by a period before their response. For example, one respondent said, "As a dentist who provides care directly to the patient, I try to explain everything about the procedure and answer all questions in as friendly and calm of a manner as possible" (TRA4223, Dentistry). The positioning of the participant, in their view, led to whatever instrumental behavior they associated with their professional role. This shows that participants pursuing any identity goals led to their pursuit of and overlapped with their instrumental and relational goals.

In sum, the majority of participants responded in ways that showed their understanding of the importance of their role in preventing WPV. Many participants shared that generally they had "a very important role" (ELE8590, Medical Staff) before going on to explain further what that role meant or looked like. Only three participants (5.36%) said either not applicable or that they played no role in preventing WPV. As such, at baseline prior to the training, participants initial orientation to aggressive patients is that they actively conceive their multiple goals to prevent WPV through their professional position, their relationship with the patient and fellow staff, and through providing high quality, PCC.

Contextual Norms

To better understand the normative environment in the clinics in Central California, staff were asked to answer the following open-ended question, “What do you talk about with your peers during work regarding your department experiencing aggressive patients”. This was followed by the question “Do you give your peers any advice about how to handle it? If so, what advice?” Responses for these questions were coded line-by-line by a research assistant, using guidelines from me. This research assistant was involved in all phases of data collection, and coded responses to previous open-ended questions when establishing intercoder reliability. After coding several variables that I led the first round of coding, she expressed interest in learning how to do the first round of coding. I judged her as competent to take the lead. As such, I challenged her to do the first round of coding starting with line-by-line coding of the two questions described above. Using her coding scheme, I coded responses and we were 84.24% and 97.30% reliable on each question responses respectively. After viewing the coding scheme and making slight adjustments to responses to question one to better capture the data, four final themes were identified and agreed upon regarding what staff talk about at work regarding patient aggression, and five types of advice were identified in terms of advice they give one another.

Regarding what staff talk about at work, a total of 29 people responded with the majority of staff saying that they try and debrief the interaction to retrospectively gain understanding of the patient and ways to improve (44.83%, n = 13). When staff discussed the events that occurred during a debrief, they wrote about how “I usually discuss with my peers what happened during the incident, what the patient said, what the patient did, and how my peers responded” (TRA4223, Dentistry). Staff in leadership positions often viewed this as a

teaching opportunity to discuss how the more junior staff can handle situations like this in the future. Some staff said that they provide emotional support to their peers (31.03%, n = 9).

When staff described instances of providing emotional support, they were focused on their ability to vent and share frustrations with one another, at times focused on validating the feelings of the person who experienced patient aggression. One participant wrote that they told a peer "Your feelings are valid. Debriefing is part of team-care. There is no hierarchy of suffering" (MAR6347, Medical Staff). Other staff (13.79%, n = 4), responded in less specific ways that reflected a general orientation to patient aggression like "Roll with the punches" (SUN5303, Medical Staff) or "Communication is key" (MAG3473, Dental Administration). Finally, few staff said that they do not talk to other peers about it at all (10.34%, n = 3). Overall, at pre-training, staff were normatively supporting one another with both instrumental advice, and emotional support when their peers experience WPV. One noteworthy remark from a participant was that they said, "I generally try to help the staff understand that the patient's actions may be coming from another situation outside of the clinic environment" (TAN2084, Medical Staff). This response highlights that staff were making external attributions for patient aggression, which may mean they were more likely overall to be successful in de-escalation, as found in Study 1.

More specifically than conversation content, there were five specific types of advice that staff reported giving one another about how to handle patient aggression. At times, staff listed more than one of the six types of advice. There were no identifiable patterns in the ways these overlapped. Of the 23 participants who responded, the most common type of advice described was advising one another to "listen to the patients" (LUC9120, Medical Staff; 39.13%, n = 9). Staff commonly cited active listening as important. They also said that

clarity in responses to patients was important for objectivity. The second most common type of response was staff encouraging one another to be understanding (30.43%, n = 7), saying things like "I advise my peers to understand pt's with compassion" (CEC3468, Medical Administration). Third, staff reported advising peers to not let patient aggression heighten them saying things like "I tell them to remain calm" (OFE2118, did not list department; 26.09%, n = 6). Fourth, staff advised one another of ways to modulate their voice such as "try to lower your voices" (ESP8034, Medical Administration) or to "speak calm and slow" (LET8892, Medical Administration; 26.09%, n = 6). Lastly, two staff members (8.70%) said they encourage one another to not take the aggression personally. The normative focus on listening, understanding, using one's voice to manage the interaction in more positive ways, and to not take aggression personally are all desirable norms to have, as learned from Study 1. This means that staff started at a normative baseline that is prepared to enact accommodation strategies with aggressive patients. However, one must also consider motivation and ability to accommodate before assuming that people will do so.

Motivation and ability to accommodate in attitudes toward the training.

In the post-training survey, participants were asked in an open-ended fashion "How enduring do you think the skills you have learned today will be?" A total of 91 participants responded to the question. The majority of participants reported that they expected the skills they learned during the training to last "a lifetime" or "throughout my career" (64.84%, n = 59; TER9647, Medical Administration; ANN5819, Dentistry) or at least they said they would last "hopefully forever" (14.29%, n = 13; DEL0908, Medical Staff). Participants who responded in this way were fairly evenly distributed across functional areas. Others responded by saying that they could use them in everyday work (10.99%, n = 10). For

example, one participant said, “I think they will be applied to every patient I come in contact with in the future” (MAR693, Medical Administration). Several participants, in addition to their response pertaining to their workplace, explained they could see themselves using their newly learned accommodation skills in their everyday life (3.30%, n = 3). For example, one participant said they would use the new skills “life long, you could always incorporate these lessons in your daily life – ex: your husband. jk” (MAR1757, Lab). For well over half of participants, reception of the new accommodation skills that staff learned in June was positive, indicating that most staff were motivated to use their new skills with aggressive patients.

However, some participants were not as confident in their ability to enact the skills. Ten participants (10.99%), in addition to a response about length of lasting, reported needing more practice in order to get used to the skills they learned so that they would last. For example, one participant said “depends on how well I practice them. I hope they last a long time” (ELE8590, Medical Staff). The majority of participants who responded in this way were medical administration staff. A small group of participants explained that they were either unsure of how long-lasting their new accommodation skills would last (n = 3, 3.30%), or that they learned nothing new saying “good presentation but nothing new that we don’t already do everyday,” for example (n = 3, 3.30%; MAR2969, Dentistry). Given that the majority of participants thought that the new things they learned would be long-lasting, and at times even had behavioral intention to use the skills they learned that day, motivation to accommodate for this population was relatively high. Staff perceived ability to accommodate aggressive patients, however, was not as high.

RQ3: Attributions about patient aggression associated with accommodation

RQ3a asked about normative attitudes staff hold toward patient aggression. Both quantitative and qualitative data obtained at three time points answer this question. Quantitative results regarding participant attitudes below should be interpreted with caution given the low reliability of the scale. Forty-two participants responded to five Likert-type questions about their attitudes toward patient aggression prior to the training, post-training, and at the three-month follow-up. Higher scores on the management of aggression and violence attitudes scale indicated higher staff understanding of patient aggression and recognition of their role in the aggression (see Appendix C, D or F for items). Attitudes data were subjected to a repeated measures ANCOVA. Upon review of the following possible covariates (i.e., length at the clinic and age) and between subjects factors (i.e., department, gender identity, and prior de-escalation training or not), none were significant, nor had large effects sizes and therefore were excluded from the analysis; department F (2, 80) = .28, p =.60, partial η^2 = .02, length of working at the clinic, F (2, 78) = .86, p = .43, partial η^2 = .03, gender identity F (2, 80) = .26, p = .26, partial η^2 = .04, age F (2, 78) = .44, p =.44, partial η^2 = .04, and having received prior de-escalation training F (2, 78) = 1.11, p = .34, partial η^2 = .06. The aforementioned variables were important for examination to ensure they were not driving results. However, excluding non-significant covariates and between subjects factors allowed for more power in the model with the small sample size. This process is repeated in all subsequent quantitative ANOVA analyses reported below in Study 2.

Analysis of ANOVA results indicated a significant change in attitudes over time, F (2, 82) = 3.17, $p < .001$, η^2 = .36. Figure 2 shows the change in attitudes toward patient aggression over time. Post-hoc comparisons of time points indicate there was a significant increase in attitudes from pre-training (M = 3.45) to post-training (M = 3.83), $p < .001$. At

pre-training time point, many participants also responded to open-ended questions in ways that reflected their attitude toward aggression and its causes. At pre-training, these responses ranged from showing understanding for the cause like the following response "patients can occasionally become aggressive toward the dentist because they have dental phobia and had a bad experience in the past (DOR8234)", to a much more negative orientation like the participant who described patient aggression in the following way: "aggressive patients are going to be assholes to anyone and everyone" (AND5830)". Following the training participants more consistently said things like "Understand the patient and hear the patient on what they have to say (LOU8083)."

ANOVA results showed there was a significant decrease in attitudes toward aggression between post-training time point (M = 3.83) and follow-up time points (M = 3.56), $p = .002$. Although there was a slight increase, there was no significant difference between pre-training (M = 3.45) and follow-up (M = 3.83) time points, $p = .26$. This means that immediately following the training, staff had significantly more favorable attitudes toward patient aggression and its causes than they did before the training. However, although staff attitudes were slightly more favorable three months after the training, significant effects dissipated over time. At the three-month follow-up, participants' qualitative responses reflected a problem-solving focus instead of a subjective personal experience or opinion on patient aggression. Many participants responded with a problem-solving orientation to patient aggression about work tasks that they can do to lessen the aggression, rather than responding about causes or what aggressive patients are like.

Figure 2. Participant attitudes change over time

RQ3b inquired about how attitudes toward patient aggression were associated with accommodation toward patients, especially when attitudes are negative and may predict nonaccommodation. One of the several ways that accommodation was measured was in participant observations of their peers in role plays. Participants used the scoring tool to quantitatively rate their peers' communication and also provided qualitative observational comments pre- and post-training. Comments from the data collected at the pre-training role play suggested that prior to the training, staff made efforts to position themselves as part of the participant ingroup. One example of an accommodative skill that a staff member noted their fellow staff doing in the first role play, prior to any training about accommodation, was "Put herself 'on pt's side' by describing limitations on scheduling as system-related rather than individual" (ESP9586, Medical Staff). The notion of putting herself on the patient's side indicates she was already using communication to be able to best position herself as part of the patient's ingroup by using interpretability strategy, even before learning from the training

about this. Nevertheless, to understand the associations between attitudes and accommodation following the training, a correlation was run between the two variables at the three-month follow-up. At the three-month follow-up, accommodation was measured as a self-report scale. Results showed that there was a significant and positive association between attitudes toward aggression and accommodation, $r = .31$, $p = .05$. Results overall indicate that the more positive the attitudes a staff member holds toward patient aggression, the more likely they are to accommodate the patient.

These results mirror staff responses explained above about how long-lasting they thought what they learned that day was and their behavioral intentions to apply those communication strategies going forward like the following participant who said "I will apply the skills I have learned on a daily basis" (PEG6196, department not listed). Not only did participants say they would use their new skills, but the data show, according to participant self-reports, that they did in fact accommodate patients more following the training. However, at no time point did staff respond by describing their own or their peers' communication behaviors using the terms taught in the training (i.e., the names of the 5 accommodation strategies).

RQ4 & H1: Perceptions of target of patient aggression

RQ4 queried who healthcare staff perceive the patient to be attacking when they are aggressive. Staff were asked to what extent they perceive the patient to be attacking the clinic as a whole, healthcare staff in general, or them personally at each time point. Upon review of the following continuous covariates (i.e., age and length at the clinic) and between-subjects factors (i.e., gender identity, prior training and department) the following were not significant and therefore were excluded from the analysis; department F (24, 136) = 1.04, $p = .43$, partial

$\eta^2 = .16$, length of working at the clinic, F (4, 35) = .52, p = .72, partial $\eta^2 = .06$, gender identity F (4, 36) = .70, p = .60, partial $\eta^2 = .07$, age F (4, 35) = .49, p = .77, partial $\eta^2 = .05$. However, having received prior de-escalation training or not was a significant between-subjects factor that produced a significant two-way interaction with time, and was therefore included in analysis F (2, 37) = 5.10, p = .01, partial $\eta^2 = .22$. Attitudes data were then subjected to a repeated-measures mixed model 3 X 3 X 2 design with three time points, three perceived targets of patient aggression (i.e., personal, on healthcare professionals generally, and on the clinic), and a between subjects factor with two levels of if they had completed a prior de-escalation training or not. Figure 3 below shows participant perceptions of target of aggression over time who have received prior training, and figure 4 below shows participant perception of target of aggression over time who have not received prior training.

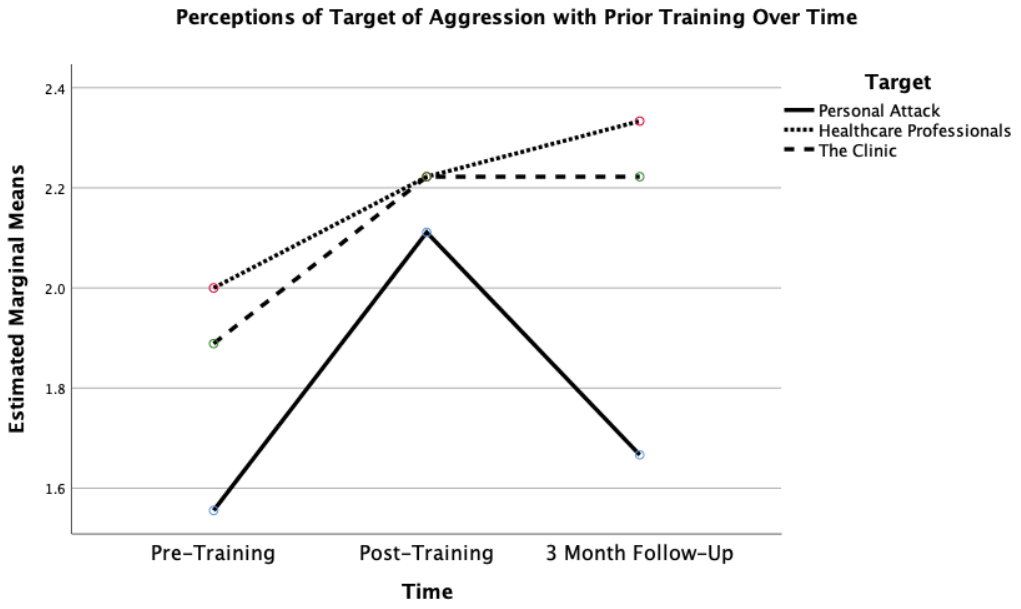


Figure 3. Participant perception of target of aggression over time with prior training

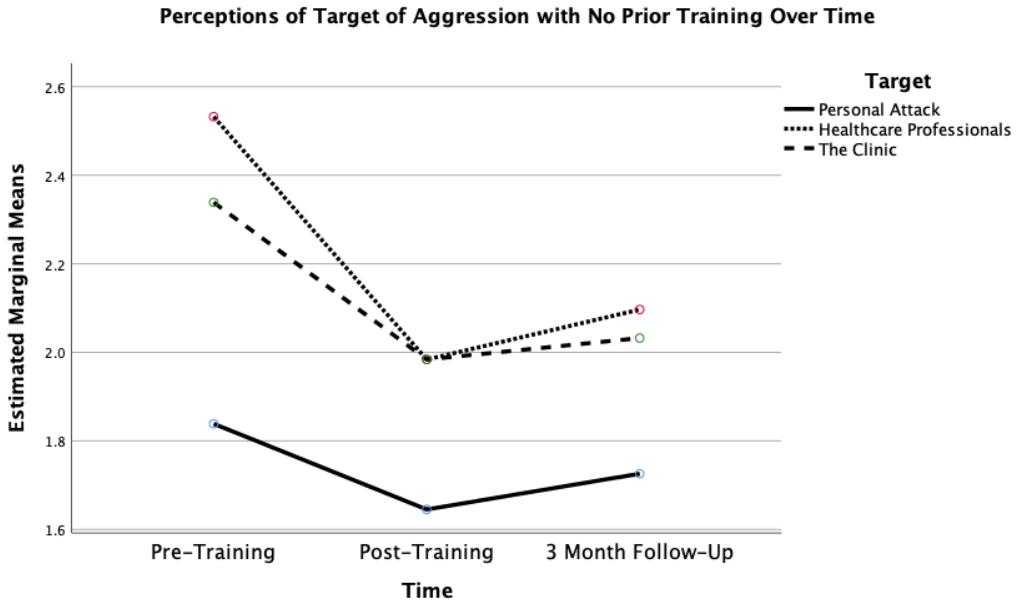


Figure 4. Participant perception of target of aggression over time without prior training

Analysis of results indicated no significant main effect for time, F (2, 37) = .01, p = .99, η^2 = .001. There was a significant two-way interaction, however, between time and if the participant had attended a prior de-escalation training or not, F (2, 37) = 5.10, p = .01, η^2 = .22. There was also significant main effect of perceived target of aggression, F (2, 37) = 9.48, p < .001, η^2 = .34. The two-way interaction between perceived target of aggression and having prior training or not was not significant, F (2, 37) = .05, p = .96, η^2 = .002, likewise the interaction between time and perceived target of patient aggression was not significant, F (4, 35) = 1.25, p = .31, η^2 = .13, nor was the three-way interaction between the variables significant, F (4, 35) = .80, p = .54, η^2 = .08. Because Mauchly's test of sphericity was violated for domain, p < .001, post-hoc analyses were conducted to decompose these effects using a Bonferroni correction for Type I error (Mauchly, 1940; Abdi, 2007; Field, 2013). Only significant results are reported below.

For those who had received prior training in de-escalation techniques, there was a significant increase in perception of the aggression being a personal attack from pre-training

(M = 1.56) to post training time points (M = 2.11), $p = .01$. All other results for those who had received prior training were not significant across time points. Comparing across targets of attack, at time point three, participants were significantly less likely to perceive the target of patient aggression to be a personal attack (M = 1.67) than an attack on healthcare professionals generally (M = 2.33, $p = .05$), and an attack on the clinic (M = 2.22, $p = .04$). This means that even though following the training staff perceptions of patient aggression as a personal attack increased, at the final time point, staff were the least likely to perceive patient aggression to be a personal attack as opposed to an attack on healthcare professionals or the clinic. Staff perceptions may have increased in this way due to either an artifact of a very small sample size, or due to training fatigue. It may be the case that staff experienced reactance upon being required to participate in another training that may have challenged the way they were already practicing, and were unwilling or not interested in changing (Lowery, 2011). This was exemplified in some of the qualitative responses from staff who have had prior training such as "I actually did not learn anything new" (MAR7324, Dentistry), and "Don't expect I will remember much from this training" (ESP9586, Medical Staff).

For those who had not received prior de-escalation training, which is the majority of participants, there was no significant changes in the amount that staff perceived aggression to be a personal attack over time. There was a significant decrease for perception of aggression as an attack on healthcare professionals from pre-training (M = 2.53) to post-training (M = 1.98, $p = .01$), and from pre-training (M = 2.53) to the three month follow-up (M = 2.10, $p = .02$). There was no significant difference between post-training and three-month follow-up indicating that staff perceptions of aggression as an attack on healthcare professionals decreased and persisted over time. Perceptions of aggression as an attack on the clinic

decreased and approached marginal significance between pre-training (M = 2.34) and post-training (M = 2.03, $p = .09$). At all three time points, participants were less likely to perceive the patient aggression to be a personal attack as opposed to an attack on healthcare professionals generally or on the clinic (pre-training personal attack v. healthcare professionals, $p < .001$; pre-training personal attack v. the clinic, $p = .003$; post-training personal attack v. healthcare professionals, $p = .01$; pre-training personal attack v. the clinic, $p = .02$; follow-up personal attack v. healthcare professionals, $p = .04$; follow-up personal attack v. the clinic, $p = .03$). There were no significant differences between staff perceiving patient aggression as an attack on healthcare professionals generally and the clinic at any time point.

Results for those who have had prior training suggest that staff are already very unlikely to perceive patient aggression as a personal attack. These results are exemplified in the qualitative comments at pre-training that persisted through to the three-month follow-up indicating it was already normative that they advise their peers to not take the aggression personally. For example, many participants said things similar to "Try to encourage staff to remain even-tempered + not take the incidents personally" (CAR9231, Dentistry) when asked what advice they give one another about experiencing patient aggression. The training decreased staff perceptions of patient aggression as an attack on healthcare professionals generally and as an attack on the clinic. This finding was also exemplified in this response about advice this participant gave their peers about handling patient aggression at the three-month follow-up "Be understanding, walk in the patients' shoes" (FIL6431, Medical Administration). This suggests that participants did not perceive it as an attack that was at all

about the clinic, and instead may have been something the patient was personally going through.

Although there were significant differences found between groups who had a prior training in de-escalation or not, there were no significant changes in perceptions of who the patient is attacking when they are aggressive. Based on these results, and given the contextual information, it is likely the case instead that the health staff were making external attributions for patient aggression, rather than perceiving the aggression as an attack that was associated with themselves as a cause in some way. As found in Study 1, making external attributions for patient aggression was associated with higher efforts to communicate effectively with the patient and higher likelihood of being successful in de-escalation.

Nevertheless, it may be the case that those who did perceive the aggression to be a personal attack would experience negative outcomes. Specifically, H1 anticipated that staff the more staff perceived patient aggression to be personally aimed at them, they would also experience: a) lower self-efficacy; b) lower job satisfaction; c) less patient cooperation; d) higher stress at work and e) less incidences of WPV. To test this hypothesis, correlations between variables were run for each time point they were measured. Quantitative results regarding participant stress at work reported below should be interpreted with caution given the low reliability of the scale. At pre-training, there was an inverse, nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their self-efficacy, $r = -.07$, $p = .44$. There was an inverse significant relationship between the extent to which staff perceive aggression as a personal attack and their job satisfaction, $r = -.19$, $p = .03$, indicating that the less a staff person took the aggression as a personal attack, the higher their job satisfaction. There was an inverse marginally significant relationship

between the extent to which staff perceive aggression as a personal attack and their reports of amount of patient cooperation lending support to H1, r = -.16, p = .06. This means that the less a staff member perceived aggression as a personal attack, the greater their reports of achieving patient cooperation.

There was a positive significant relationship between the extent to which staff perceive aggression as a personal attack and their stress at work, r = .21, p = .02 meaning that the less staff perceived aggression as a personal attack, the lower their stress at work. Lastly there was an inverse nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their experiences of WPV, r = -.10, p = .48. As such, prior to the training, all results were in the expected direction and significant for job satisfaction, their ability to achieve patient cooperation, and their stress at work such that staff who perceive aggression as a personal attack experience significantly lower job satisfaction, less patient cooperation and higher stress at work supporting H1.

Following the training at the three-month follow-up, the inverse, nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their self-efficacy persisted, r = -.23, p = .15. There was an inverse nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their job satisfaction, r = -.17, p = .28. There was a nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their reports of amount of patient cooperation, r = .04, p = .78. There was a positive nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their stress at work, r = .09, p = .57, and a nonsignificant relationship between the extent to which staff perceive aggression as a personal attack and their experiences of WPV, r = .10, p = .61. As

such, following the training, all results except for achieving patient cooperation were in the expected direction. Given the lack of significant results at the three-month follow-up, H1 was only partially supported.

Due to the marked differences in results in the Central California location pre-training and at follow-up, it may be the case that there were unique characteristics of people who dropped out of the study between the training and the follow-up time points, despite none of the measured variables in this study being significantly associated with study drop out (see Table 5). In addition, the extent to which staff perceive patient aggression to be a personal attack remained very low over time which means that there is very little room for staff to perceive the attack as personal any less than they already did prior to the training. One variable that may explain likeliness to drop out was peer norms in the organization about what they talk about regarding patient aggression. To assess impact on drop out, a chi-square analysis was conducted using the coded categorical peer norm variable to see if any particular normative conversations pre-training predicted study drop out, and there were no significant differences between peer norms, $\chi^2(5) = 8.35$, $p = .14$.

RQ5 & H2: Accommodation and managing WPV over time

RQ5 asked about the accommodation strategies staff described in their experiences of WPV over time. To address this question, I deductively coded the open-ended responses of staff as they describe aggressive patient encounters for which types of strategies staff describe at pre-training, and at the three-month follow-up using Atlas.ti 8.4.4. At times, responses to the question "How many experiences of workplace violence have you experienced?", followed by a request for the details of a memorable incident, were only a number or a small phrase about frequency, rather than a description of the experience. As

such, only responses including accounts of the experience were used in the analysis. In addition, responses from Study 1 were included as there were richer stories provided from staff due to having the ability to fill out the survey at their leisure at work. Although staff in Study 1 or Study 2 did not include any strategies by name, their responses highlight ways they (non)accommodated patients. Analysis results showed that very few participants gave full accounts of either their own actions in the interaction, instead explaining only what the patient did. Likewise, very few participants shared success stories in their written responses.

In Study 1 stories of experiencing patient aggression, of the total of ten stories provided by participants, two stories resulted in either having to call security or the situation escalating from dissatisfaction to name-calling. In these two stories, the participant did not describe any behaviors of theirs that were accommodative processes. This is not to assume that no accommodation occurred. However, the participant either did not explain their accommodation in their response, or did not consciously use accommodation to de-escalate the situation. One participant, for example, said that "Patient became impatient with the help I was providing. I could see he was upset physically, mentally, and emotionally. But he felt like things were going too slow for him to leave and he resulted to calling me names" (P49, Administration). It is clear the participant could see the patient was escalating, but the participant did not report having done anything about the situation. Instead, if the participant had used emotional expression or interpersonal control strategies to validate the patient's frustration with the process and tell the patient how the steps in the process would proceed, it is possible that the name calling could have been prevented. For example, a different participant shared a story that began with profanity and disrespect. They were able to de-escalate the situation by using interpretability and interpersonal control. They described the

situation as follows; “I picked up the phone and calmly let him know that I am getting a clinic coordinator. It will just be a moment” (P3, Pediatrics). In this instance, the participant used the two strategies in combination by using interpersonal control to let the patient know what they were going to do and demonstrate their legitimate role-prescribed power and used interpretability when they clearly explained what was going on.

The other stories from Study 1 were mainly during patient registration in which the participant was able to successfully de-escalate the situation when they combined interpretability, interpersonal control, emotional expression mainly, and to a lesser extent, discourse management and approximation. Due to the nature of the focus on patient registration in Study 1, it was expected that the majority of success stories would be about an instance where a patient was becoming aggressive during registration due to not understanding the new questions that some patients perceived to be personal and sensitive. For example, one participant recalled the following experience.

> After I explain why the questions are important, patients usually understand or decline to answer. I’ve had a patient say: ‘do I need to show you that I am a man?!’ to which I responded, ‘no sir you do not. If any of these questions make you uncomfortable you can always decline to answer’ (P29, Front desk).

In this instance, the participant used all of the accommodation strategies to de-escalate the situation. For example, allowing the man to ask his question and responding was effective discourse management, explaining to him what action to take about declining to answer was effective interpersonal control by encouraging him to exercise his legitimate power as a patient, recognizing his discomfort was effective emotional expression, explaining the questions’ purpose was effective interpretability, and responding to his self-description as

“man” with “sir” was effective approximation. There were three other similar stories regarding registration.

There were two other successful de-escalation recounts that were not during registration, one in triage and one in intensive care by using emotional expression by putting their arm around a drunk family member of a patient (P64, Spiritual Care). The participant describing the incident of aggression in triage below achieved patient cooperation and de-escalation. They did so by using discourse management allowing the patient to speak when they were ready, emotional expression by recognizing their unreadiness upon arrival to provide information, and interpretability by explaining in simple terms that were appropriate to the patient why they needed more information. They did this all while directing the patient of how they needed to provide information to be seen using effective interpersonal control:

> In a busy day within the Emergency Department, a patient approached myself to be checked in by opening with ‘I don't need your attitude’ and sat down. I responded, ‘When you feel ready, I will be able to collect your information to be triaged.’ The patient sat there, while our high foot traffic were triaged one after another, for about 20 minutes before approaching me again. Patient responded ‘Now look here, I'm not here to dilly dally and deal with your s****. I was recommended to coming here to be seen.’ I emphasized that we need to collect a little more information before he can be seen. I asked for name, date of birth, and the chief complaint for the initial visit. Patient cooperated and waited to be triaged (P65, Front desk).

Similar responses from Study 1 about successful de-escalation by combining all of the accommodation strategies were found in Study 2 data, despite the contexts of patient aggression differing.

In Study 2 data at pre-training, 15 participants gave accounts of their experience. Of these, eight stories were unresolved situations where the incident was not effectively de-escalated. In all of these unsuccessful recounts of the incident, the focus of the response was only on what the patient did, and not on what the participant may have attempted to do to de-escalate the situation. This suggested that the absence of any accommodative processes was an ineffective way to manage the situation. It could also have been that the staff member was more focused on allowing the patient space to be upset. Staff told me, in informal conversations, about the value of letting the patient vent or let out their frustrations before doing anything else. However, allowing the patient to vent without using emotional expression to validate their emotions, or perhaps interpersonal control to bound the situation and facilitate the visit, and interpretability to tell the patient what is going to happen and why, may be passively allowing the interaction to escalate. Nonetheless, the most common strategies identified at the pre-training in successful interactions was discourse management and emotional expression (n = 5, 30.00%). Staff cited their ability to listen to the patient, and to gain understanding highlighting both discourse management and emotional expression. For example, in the one success story written about at this time point, one participant said "I was able to speak to patient and understand what he needed. Patient left happy. If you just listen to them." (ANT6687, Medical Administration). No responses at pre-training were coded as including interpersonal control or interpretability.

In contrast, at the three-month follow-up, the most common strategy coded was interpersonal control. At this time point, 19 people described an experience with WPV. Of those 19, five participants (26.31%) used interpersonal control. For example, the following participant explained how they removed an aggressive patient from the clinic by using

interpersonal control; “asked patient to meet with me outside after he scared a co-worker” (MAR6347, Medical Administration) after which the participant described calling for help with removing the patient from the clinic. This interpersonal control use was effective in some ways. Particularly, it was successful in maintaining staff safety but was unsuccessful in providing high quality patient care. Also, in contrast to pre-training, participants described using interpretability strategies more often, which often overlapped with interpersonal control and discourse management strategies. The following participant explains an interaction where they were able to make sure a situation did not escalate by using interpretability and interpersonal control strategies.

> Patient came in and was in pain, but did not have an appointment. I explained that our emergency walk-in time were usually first thing in the morning…I used small words and minimal hand gesture in my explanations, as to not aggravate the patient. (CYN0741, Dentistry)

In this response, the staff member uses interpersonal control in explaining scheduling to the person. They also use interpretability strategy as they do this in saying they used small words, implying the importance of the patient being able to understand the words to remain calm. The strategic use of minimal hand gestures can also be considered an approximation strategy in which they were likely doing the opposite of what the patient was doing with their gestures in order to encourage the patient to calm down.

Only one participant cited emotional expression in their response, however they were citing how someone they had observed had successfully used this strategy to calm a patient. They described the scenario by writing, “The most memorable was over 25 years ago in a hospital where the patient was confused and threatened the team with a large pair of sharp

scissors. The physician is charge spoke in a reassuring voice and was able to validate the patients concern" (TAN2084, Medical Staff). Although the participant did not describe using the strategy themselves, they demonstrate metacognitive awareness of the value of using the strategy by being able to recall an instance where a fellow staff member was successful in de-escalation by using the strategy.

Although prevalence of strategies clearly changed over time in Study 2, many participants still shared unsuccessful stories in which the patient wound up leaving the clinic still very angry or started to yell and name call at times resorting to physical violence. The stories that were unsuccessful still concentrated only on the patient behavior and were heavily focused on how what the patient was requesting was not a reasonable task or something not within their capability to do. For example, the following participant shared an unsuccessful experience "Once a patient got upset because he had to wait to drop off his specimens. Well he got mad at me and my coworker and threw his specimens at us" (SYL1248, Lab). In this response, it is unclear what the participant said or did to attempt to de-escalate the patient who was upset because of his wait time. Perhaps if they had used accommodative processes to validate his frustrations with waiting, and interpretability to explain to him what was going on, they may have been able to prevent him throwing things at them. However, in the success stories described in the written responses, participants described their behaviors and appeared to report using at least three, if not all of the five strategies.

Also of note, all of the success stories came from staff in Medical Administration, whereas unsuccessful recounts came mainly from Dentistry, and only some from Medical Administration. This may be because dentistry broadly, prior to this training and study, has

not been the focus of any de-escalation training and research to my knowledge. Perhaps people who work in dentistry lack the skills and understanding that staff in other medical services have been trained in from the beginning. In other words, it may be more normative in other medical service contexts apart from dentistry to prepare professionals for how to manage patient aggression and WPV. As such, in cases of patient aggression, competent accommodation requires the use of all of the CAT strategies to increase likelihood of successful de-escalation and WPV prevention.

H2 anticipated that the use of competent accommodation would be associated with higher self-efficacy, higher job satisfaction, more patient cooperation, less stress at work, and less incidences of WPV. Self-efficacy was measured in such a way that it measures the extent to which staff feel able to manage patient aggression. To test this, given results of RQ3, accommodation items were not separated by strategy, and instead were included as one measure of accommodation. Regarding self-efficacy in managing patient aggression, 42 participants responded to four Likert-type questions at all three time points. Self-efficacy data were subjected to a repeated measures ANCOVA. Upon review of the following possible continuous covariates and categorical between-subjects variables, none were significant and therefore were excluded from the analysis; department F (12,70) = .84, p =.61, partial η^2 = .13, length of working at the clinic, F (2, 38) = .2.09, p = .14, partial η^2 = .10, gender identity F (2, 39) = 1.67, p = .20, partial η^2 = .08, and having received prior de-escalation training F (2, 38) = .44, p = .65, partial η^2 = .02. However, age was a significant covariate F (2, 38) = 3.84, p = .03, partial η^2 = .17 and was included in the analysis.

Analysis of ANCOVA results indicated a significant change in self-efficacy over time, F (2, 38) = 3.37, p = .05, η^2 = .15. Figure 5 shows the change in self-efficacy over time.

Post-hoc comparisons of time points indicate there was a significant increase in self-efficacy from pre-training (M = 3.66) to post-training (M = 4.05), $p < .001$. There was no significant difference between post-training (M = 4.05) and the three-month follow-up (M = 3.90), $p = .09$. There was a significant increase in self-efficacy in managing patient aggression from pre-training (M = 3.66) to the three-month follow-up (M = 3.90), $p = .02$. As such, the training delivered in June significantly increased staff self-efficacy in managing patient aggression, and this persisted over time.

To determine the association with accommodation, only data from the three-month follow-up required staff to complete CAT measures about their own behaviors. At the three-month follow-up, there was a positive, significant association between self-efficacy in managing patient aggression and accommodation, $r = .48$, $p < .001$ indicating that the more efficacious staff members felt, which increased as a result of the training, the more likely they were to report accommodating the patient.

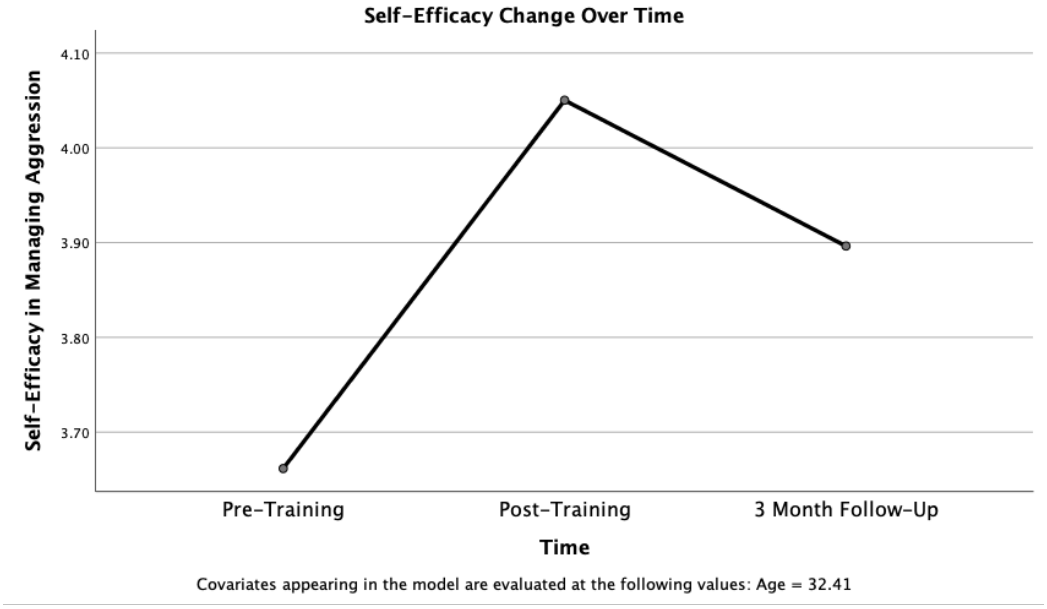


Figure 5. Participant self-efficacy in managing patient aggression change over time

To determine if competent accommodation was associated with job satisfaction, a paired samples t-test was run to first determine if job satisfaction changed over time. A t-test was run as opposed to an ANOVA because job satisfaction was only measured at two time points, post-training and at the three-month follow-up. Results indicated there was no significant change in job satisfaction over time, $t(42) = -1.00$, $p = .22$. However, at the three-month follow-up there was a significant positive correlation between accommodation and job satisfaction, $r = .55$, $p < .001$, indicating that the more staff accommodated patients, the higher their job satisfaction.

Regarding the extent to which staff reported achieving patient cooperation over time, there was a significant increase in staff ability to achieve patient cooperation from pre-training to the three-month follow-up, $t(41) = 2.93$, $p = .01$ and a positive correlation approaching significance between accommodation and patient cooperation, $r = .25$, $p = .10$. These results indicate that the more staff accommodated patients, the more they achieved patient cooperation which significantly increased after the training. Staff stress did not significantly change from pre-training to post-training, $t(42) = .26$, $p = .79$. However, there was a significant inverse relationship between accommodation and stress at the three-month follow-up, $r = -.31$, $p = .05$, indicating that the more staff accommodated patients, the less work-related stress they experienced.

Regarding experiences of WPV, there was no significant difference between amount of WPV experiences from pre-training to three-month follow-up, $t(12) = .84$, $p = .42$. However, there was a significant, inverse association between accommodation and experiences of WPV at the three-month follow-up such that those who reported accommodating patients experienced less instances of WPV, $r = -.42$, $p = .02$. Given the

significant associations between accommodation and higher self-efficacy which increased after the training, higher job satisfaction, more patient cooperation which increased after the training, less stress and less WPV at the three-month follow-up, H2 is supported.

H3: Changes in norms for managing aggressive patients over time

H3 predicted that training would make it more normative for staff to encourage each other to listen to patients and recognize their contribution to the environment. Pre-training data showed that at baseline, it was already very common for staff to encourage one another and make efforts themselves to listen to patients. Only participants who responded with a matched ID Code at all three time points were included in analysis. The trend remained that listening was one of the most common types of advice that staff gave one another at the three-month follow-up. Of the 20 participants that provided a written response about advice they gave peers about managing patient aggression, six participants said they encourage one another to listen (16%; e.g., “Listen to the patients, try to understand why they are frustrated” DIE3172, Medical Administration).

Regarding other types of advice that staff reported giving to one another about managing patient aggression, of the 20 people who responded, six people (30.00%) said they advised one another to remain calm, writing responses like “just stay as calm as possible” (MAR693). Four people (20.00%) said they advised their peers to be understanding in some way and perspective-take which suggests a focus on empathy. Four people (20.00%) said that they advise one another to not take the aggression personally, writing things like “just to try and let it go, not to take it personally” (MAR1757, Lab). Lastly, five people (25.00%) said that they do not give one another advice on managing patient aggression.

In terms of general topics of conversation about patient aggression that staff reported at the three-month follow-up, of the 24 responses, most commonly staff described their conversation of a debrief of a previous experience in order to try to gain some understanding of why the patient behaved that way and how they could handle it differently in the future (n = 11, 45.83%; e.g., "how we could improve de-escalation of the situation" NAN6197, Medical Administration). Another common response was that staff reported providing emotional support to one another in the conversations (n = 4, 16.67%). For example, one participant wrote "Just express the frustration I feel when patients go off" (ROS8938, no department listed). Four participants (16.67%) responded in more general ways about how they aspired to handle patient aggression like "I want to be a good listener to hear what the experience was like for them" (GAI5960, Medical Staff). Five participants said that they keep the experience to themselves, and do not talk to fellow staff about experiences with patient aggression. Responses from pre-training to the three-month follow-up remained very similar. Table 6 shows the percentage changes between participants in how they responded about topic of conversation overall and advice that they give one another.

Table 6. *Changes in peer norms for managing patient aggression over time*

Topic	**n = 29**	**n = 24**	**Advice**	**n = 23**	**n = 20**
Theme	**Pre-training**	**Follow-up**	**Theme**	**Pre-training**	**Follow-up**
Debrief to gain understanding	44.83%	45.83%	Listen to patients	39.13%	30.00%
Emotional support	31.03%	16.67%	Be understanding	30.43%	10.00%
General orientation	13.79%	16.67%	Remain calm	26.09%	30.00%
No conversation	10.34%	20.83%	Modulate voice	26.09%	10.00%
			Not to take it personally	8.70%	20.00%
			No advice		25.00%

There are several ways that norms for conversation and advice about patient aggression between peers changed following the training. In terms of topic of conversation,

staff did not provide as much emotional support to one another about their experiences with patient aggression which may mean they had less opportunities to share their frustrations. In addition to less emotional support, at the three-month follow-up staff reported generally talking about patient aggression experiences less. They either said they had no conversation or that they did not give each other advice about patient aggression. Although a focus on trying to understand patient aggression decreased, staff encouraging one another not to take the aggression personally increased. Although the decrease in being understanding was not desirable, with accommodation remaining high at the three-month follow-up it may be the case that staff were making efforts to accommodate patients and prevent WPV regardless of if they are able to understand why the patient is behaving that way. To assess if experience with prior training predicted norms for conversations about patient aggression, a chi-square analysis was conducted at pre-training for topic of conversation[3] ($\chi^2(4) = 7.62$, $p = .11$) and was not significant. As such, having prior de-escalation training was not associated with the types of conversation topics that staff had with one another.

The second portion of H3 purported that norms would change such that staff would recognize their contribution to the environment more. Table 7 shows the changes in ways that staff described their role in preventing WPV from pre-training to the three-month follow-up. Only those who participated in the training at all three time points were included in the follow-up analysis. At pre-training, many staff were already focused on how their behavior contributed to the environment. At the three-month follow-up[4], the most common response was the pursuit of an identity goal associated with one's professional position in the

[3] A chi-square was not conducted for type of advice due to the majority of participants providing more than one answer in their written response whereas participants only gave one topic of response.
[4] See above for explanation of analysis. Data were analyzed in the same way for this time point.

clinic (n =10, 37.04%). Similar to pre-training, although not specified by the question, participants started their responses to the question with either only their professional title, or their professional title followed by their instrumental pursuit that is prescribed by that role. For example, “lead clinician – can only organize the clinic; the best I can do to allow smooth running during the day and good communication with patients” (CAR9231, Dentistry). This suggests that participants were increasingly operating from cultural stereotypes for their position that prescribed appropriate behavior (Davies & Harré, 1990). Four participants (14.81%) explained their role in preventing WPV as an identity goal associated with a self-concept other than their professional position by calling themselves things like “I’m usually the patience role” (FEL5283, Medical Administration).

Regarding relational goals, three participants (11.11%) reported attending to their relationship with the patient in order to prevent WPV writing things like “I try my best to help, make the patient feel I relate” (ALM7084, Dentistry). Only one participant (3.70%) at this time point mentioned attending to their relationship with fellow staff with “compassion” in order to prevent WPV (FIL6431, Medical Administration).

Regarding instrumental goals, staff either reported efforts focused on the clinic environment, or efforts more specifically directed toward the patient to provide high quality patient care, often aligning with the tenets of PCC as described above. Six participants (22.22%) responded in ways reflecting high-quality PCC such as managing time well with patients and listening to their needs. For example, one participant said, “If I’m running behind I ask my assistant to make sure this is communicated to the patient” (GAI5960, Medical Staff). Seven participants (25.93%) responded in ways that referred to the environment, writing things like “help create an environment where patients are respected

and empowered to make their own healthcare decisions" (ESP9586, Medical Staff). This response in particular reflects the way that this staff member recognizes their contribution to the environment to facilitate PCC, which would lessen WPV.

Table 7. *Changes in role in WPV for managing patient aggression over time*

WPV Role Theme	**Pre-training (All) n = 56**	**Pre-training n = 19**	**Post-training n = 26**	**Follow-up n = 27**
Instrumental goal	64.28%	43.75%	53.85%	48.15%
Environment focused	*(32.14%)*	*(15.79%)*	*(19.23%)*	*(25.93%)*
Patient focused	*(32.14%)*	*(21.05%)*	*(34.62%)*	*(22.22%)*
Relational goals	30.36%	23.53%	11.54%	14.81%
Patient focused				
Fellow staff				
Identity goals	35.71%	52.94%	34.62%	51.85%
Self-concept				
Position in clinic				
No role	5.36%	0%	0%	7.41%

Note: The pre-training all column includes all participants who completed the survey at that time point and reflects results above. The middle "pre-training," "post-training," and "follow-up" column includes only those who participated at all three time-points.

Overall at the three-month follow-up, staff responses to their role in WPV still reflected their recognition of their contribution to a clinic that prevents WPV. However, staff responses became more focused on their professional position rather than communication and relational behaviors that they undertook in the clinic that prevent WPV (or worsen it). Compared to all those who responded at pre-training, the amount that staff pursued environment or PCC instrumental goals decreased, as did staff pursuits of relational goals with both patients and fellow staff. Owing to decline, Table 7 includes a column that describes the pre-training and post-training responses of only participants who participated in all three time points. Comparing the three-month follow-up results to only the columns that included participation at all three time-points, it appears that staff conceptualizations of their role in preventing WPV did not change. The main change was that across time points, staff

reported attending to environmental instrumental goals more over time. As such, it may be the case that staff who dropped out of the study were driving the difference[5].

Focusing specifically on H3's predictions about increased listening and focus on the environment. Listening did not increase across time points but was a very common response from the very start. Focusing on the environment increased slightly in the ways that people conceptualized their role in preventing WPV. Ultimately, H3 was supported.

H4: Effects of training on accommodation and WPV

H4 anticipated that taking aggression personally would decrease, accommodation would increase, and WPV experiences would decrease as a result of the training. Quantitative ANOVA results above demonstrated no significant change over time in perceiving patient aggression to be a personal attack for participants who had not received prior de-escalation training, which was the majority of participants. Instead, perceiving patient aggression as a personal attack was already very low at pre-training. Despite the lack of significant quantitative results, qualitative results suggest that taking aggression personally decreased due to the nature of the advice that staff gave one another with more occurrences of staff advising one another to not take aggression personally when they experience it.

Likewise, qualitative results showed that staff used more accommodation strategies in their experiences of WPV following the training suggesting that accommodation did increase. Staff likely recognized more ways that they could accommodate the patient. Lastly, although WPV experiences did not significantly decrease over time according to staff open-ended responses about WPV they experienced, staff reports of achieving patient cooperation did significantly increase from pre-training to the three-month follow-up. The disparity

[5] Participation in prior training was not assessed due to the nature of the coding of WPV role such that people responded in multiple ways in one response.

between reports of WPV and patient cooperation could be due to a measurement limitation of the question regarding WPV.

Even though a definition of WPV was included in the question for participants to understand what counts as an experience of WPV, several participants responded in ways that showed a misunderstanding such that they believed only physical violence to be WPV and verbal abuse was not considered an instance of WPV. For example, one participant wrote "I have not been in a physically aggressive altercation with a patient that is aggressive" (CYN0741, Dentistry). This response suggests that the participant only considered a physical altercation to count as WPV and therefore did not report on any verbal instances of WPV they may have experienced. Participants also reported on incidents that occurred prior to the training at the three-month follow-up suggesting that they were reporting lifetime occurrences which did not accurately capture any change in WPV due to the training. Despite the lack of significant quantitative results and the measurement limitation of WPV, given the nature of the open-ended responses, H4 garnered support. The measurement limitation of WPV is further elaborated in the general discussion

RQ6: Post-Training Contextual Factors Change

RQ6 probed what effects a CAT intervention training to prevent WPV has on an organization and the staff therein over time. In addition to the results explained above regarding changes at the three-month follow-up time point, the antecedents to accommodate patients may have changed due to the training. The main antecedents of interest were context and time of day in which the aggression occurred, and how lasting staff perceive what they learned in the training to persist. At pre-training, WPV typically occurred in the front desk reception area most frequently, followed by in hallways when patients were being roomed.

This trend did not change, as the majority of the 24 participants who answered the question about where aggression typically occurs at the three-month follow-up reported patient aggression occurring in the front desk reception area (n = 8, 33.33%). This suggests that staff who work in this context may need additional training that is more focused on their contextual experiences. Many staff who responded to their role in WPV who work in this context reflected their understanding of how important their role was in preventing WPV because they were the first person the patient sees. For example, one participant said, "I am the first person the patient sees so I have to set the tone" (MAR693, Medical Administration). Recognizing this importance and given that WPV occurs most frequently in the front desk reception area, staff in this context were well-positioned to be trained to manage patient aggression which may help prevent it in the entire clinic.

Regarding when the WPV occurs, at pre-training there was not a clear discernable pattern in what time of day WPV is most likely to occur. This trend remained at the three-month follow-up. The lack of pattern is described by the following participant who responded to the question "What time of day does WPV typically occur?" by sarcastically writing "at full moons, don't know, it's hard to specify a time" (ALM7084, Dentistry). This response suggests that like the pre-training responses, WPV was equally likely to occur at any time of day. Given this finding, all staff at this particular clinic should be continually and equally trained in managing patient aggression to prevent WPV, not only focusing on staff that work at a certain time of day. This may be different at an organization that is open later in the day, given that this study did not collect data from staff who work late hours in the day. Aggression trends may be different at those times.

Lastly, at pre-training, the majority of staff said that they expected what they learned in the training to last a lifetime, or at the very least a long time. At the three-month follow-up, 19 people responded to the question and the response of their skills lasting a long time remained the most common (n = 9, 47.37%). For example, one participant wrote "throughout my whole life" (LOU8083, Medical Staff). This response also captures how participants thought their new abilities would not be helpful in the clinic, but also in other areas of their life. However, a much higher percentage of people at the three-month follow-up responded by saying they did not learn anything new (n = 4, 21.05%). Although staff wrote that they did not learn anything new from the training, they did write that it still affirming or a good reminder by writing things like "I actually did not learn anything new. But it was good reaffirmation on my knowledge" (MAR7324, Medical Administration). Staff responses like this suggest that training should perhaps be more specified to job function so that staff are not only motivated to learn new strategies, but also so that staff feel they are in fact learning new things that will help them in their workplace. Going forward, given that most staff anticipate their skills to last a long time, motivation to continue to accommodate patients was high.

Results Overview

RQ1 asked what the nature of WPV in the Study 2 context was. Results showed that in this location, WPV was low and occurred at any time of day, mainly at the front desk/waiting area of the clinic. RQ2 asked about staff initial orientation in terms of motivation and ability to accommodate patients, based on their stereotypes of patients and/or conceptualizing the patient as an individual with unique experiences and needs. Results showed that staff were motivated to accommodate patients, although they were a bit unsure of their ability pre-training. In addition, staff held the goals of helping one another lessen

WPV in the clinic. RQ3a probed the nature of staff attitudes toward patient aggression. Results showed staff held attitudes that were generally understanding and desirable. At post-training, there was a significant improvement in attitudes, however this dissipated over time. RQ3b asked how those attitudes are associated with accommodation. Results showed that the more desirable and understanding attitudes staff held toward patient aggression, the more likely they were to accommodate patients. RQ4 investigated initial orientation by asking what attributions staff hold about who the patient is attacking prior to training. Staff generally did not view patients to be attacking them personally, healthcare professionals generally, or the clinic when they were aggressive; all mean scores on these variables were very low and qualitative results mirrored quantitative results. However, there were differences between staff who had prior de-escalation training and those who did not. This finding is further elaborated in the discussion.

RQ5 asked what accommodative behaviors staff used with aggressive patients. Results showed that the more accommodation strategies staff used in aggressive patient interactions, the more successful they were in de-escalation. Strategies were intertwined which is further elaborated in the discussion. Next, this study posed H1 predicting that the more favorable and understanding a staff member orients themselves to the patient aggression, the more they will experience desirable outcomes, and the less they will experience undesirable outcomes. H1 was supported. H2 then predicts that accommodation is associated with more desirable outcomes and less undesirable outcomes. H2 was supported. H3 predicted that training would favorably impact organizational norms in the organizational context. This was supported. H4 predicted that training would improve accommodation, initial orientation, and reduce the undesirable outcome of experiencing WPV. H4 was

partially supported. Finally, RQ6 probed how these effects change the overall context over time to predict future successful prevention of WPV by accommodating patients. Findings from RQ6 are elaborated in the discussion. Generally, results support the model offered by Figure 1.

Discussion

Study 2 trained staff in a WPV prevention training framed by CAT. In the Central California clinic where this study was conducted, all staff were trained. Staff ranged from front desk and call center, to clinician and dentists at a clinic in seven clinic locations that typically serves a low- income population. The training given to these participants was framed by CAT and was about managing patient aggression and preventing WPV in theory-driven ways, rather than a-theoretical ways that have been used in the past. The training was delivered at the June 2019 all staff training at which point staff were surveyed pre-training and post-training on the same day of the training. Staff were surveyed a final time three-months later. Results of this study suggest that the most important factors in de-escalating aggression and preventing WPV are the attitude that staff hold toward patient aggression, which predicts their likeliness to accommodate the patient and achieve cooperation.

Contextual antecedents

Before considering (non)accommodation that occurs in the interaction of interest, health research framed by CAT should better understand the context of the interaction that may foster or inhibit an effective interaction in which competent accommodation may occur (Watson, 2020). This helps move Study 2 beyond an interpersonal skills approach. The consideration of contextual antecedents for the Central California location were considered before designing the June training by visiting each clinic, learning the layout of the space, the

job titles of staff, and developing the content for the role plays completed by staff during their training. The contextual antecedents collected in the survey data included examining the nature and prevalence of the WPV occurring in these locations prior to the training, and also initial orientation including attitudes and goals, motivation and ability to accommodate, and norms in the organization. Generally at this clinic in Central California, prevalence of WPV as reported by participants was low. Most people reported never having experienced WPV. The average number of experiences of WPV was one. Of those who did experience WPV, it occurred at any time of day, and typically in the front-desk/waiting area. In addition, the WPV was verbal in kind, with very few people reporting physical abuse.

The low baseline of reported experiences of WPV pre-training was coupled with staff whose initial orientation to aggressive patient interactions was one that suggested a highly accommodative stance. In Central California, staff reported talking with one another about patient aggression in ways that demonstrated staff having several main goals in communicating with aggressive patients to prevent WPV. First, staff reported making efforts to understand the patient and their complaints. This understanding, according to staff, could be achieved instrumentally through providing high quality PCC. It is unsurprising that staff focused on high quality and PCC in this particular clinic, given that those are two of the seven main principles of primary care (Epperly et al., 2019). Should this training be replicated outside of a primary care clinic, those values may not be as commonly talked about among staff. At pre-training, staff also commonly wrote about the instrumental goal of impacting the environment of the clinic in ways that could prevent patient aggression. Staff also reported relational goals of having good relationships with not only patients, but with one another which would help prevent WPV. Lastly, staff identity goals showed that they

conceived of themselves in their professional role or as part of their personality as a person who has a big part to play in preventing WPV in the clinic.

In addition to pursuing these goals as part of their initial orientation to patient aggression, staff gave advice to one another that showed the normative environment of the clinic as one that was well-situated to accommodate patients and prevent WPV. The normative advice and help that staff gave to one another in Central California was that they encourage one another to listen to what the patient had to say, not take the aggression personally and provide a space for debriefing and venting about any experience of patient aggression. In the debriefing, staff reported providing emotional support to one another as they made sense of the WPV experience. The initial orientation and organizational peer norms of staff in Central California suggest that staff, prior to training, make external attributions for patient aggression and were motivated to help the patient and one another. In addition to staff norms suggesting high motivation to accommodate patients, staff responses to how long lasting they thought their new knowledge from the training would be demonstrated a high level of motivation and behavioral intention to use their new accommodation strategies with patients.

Attitudes, target of aggression, and accommodation

As a result of the training, staff attitudes toward patient aggression became significantly more positive and understanding, such that staff perceived external factors to be causes of patient aggression, rather than making internal attributions for aggression. However, these effects dissipated at the three-month follow-up. These results support previous findings in de-escalation trainings that although they are helpful for a time, without follow-up booster trainings, their effects are not lasting (Williams, 2006). This is further

illustrated in some of the responses of staff when responding to how lasting they thought the training would be such that they felt they were not sure they would be able to remember what they learned. They thought they would not be able to maintain their new knowledge without more practice. This finding highlights the need for regular trainings that remind staff what they learned or what they already know. Given the fast pace of the clinic, and the vast knowledge these staff already are required to hold, it is challenging to gain new information to put into practice in the clinic. One form of "booster" training that has demonstrated success in healthcare is training that occurs in situ. For example, Sutton et al (2011) found that students who were given feedback about the way they were giving CPR as they were giving it were more successful in appropriately administering the lifesaving technique. In the context of WPV, instead of having a classroom training where staff must attend that is outside of the context of the experience, training given inside the clinic may be more successful as staff are nearby where they may experience WPV.

Although attitudes toward patient aggression did not remain significantly changed, at the three-month follow-up, staff attitudes were still generally positive and were positively correlated with accommodating patients in interactions where they were aggressive. Given these findings that staff attitudes predict the extent to which they accommodate patients, it is crucial that staff are continually encouraged to hold understanding attitudes toward aggression, instead of blaming patients, so that they are more likely to accommodate their patients.

Another factor in addition to attitudes toward patient aggression that impacted staff likeliness to accommodate patients was who they perceived the patient to be attacking when they were aggressive. The extent to which staff perceived aggression to be a personal attack,

an attack on healthcare professionals generally, or an attack on the clinic both changed as a result of the training, and impacted likeliness to accommodate. In general, staff did not take aggression personally at any time point. However, as a result of the training, staff were significantly less likely to perceive patient aggression to be an attack on healthcare professionals generally. Staff likeliness to perceive aggression to be an attack on healthcare professionals generally being higher than perceiving it to be a personal attack reflects the intergroup nature of healthcare (Baker & Watson, 2015) where they think that the patient is communicating and treating them in ways that reflect their group membership, rather than their personal characteristics. These results support that healthcare interactions with an aggressive patient are not an exception to the intergroup context of health.

An important caveat, however, was that perceptions of who the patient was attacking for those who had prior de-escalation training changed in unfavorable ways. After the training, even though the perceptions were low over time, staff were significantly more likely to perceive patient aggression to be a personal attack at post-training. These effects dissipated at the three-month follow-up. This could have resulted from the small sample size of those who had prior training, but it also could have been a product of training fatigue. These staff members may feel like they already know all of the things they were taught in the training, as shown in the qualitative responses saying they learned nothing new, and are not interested in managing patient aggression in any other way. Their responses to the aggression being a personal attack could have been a form of reactance from the required nature of the training (Lowery, 2011). Taking the aggression as a personal attack had consequences. Supporting H1, the more that staff perceived patient aggression as a personal attack, the lower their self-efficacy over time, the lower their job satisfaction over time, the less patient cooperation they

achieved, and the more stress they had. Given the severity of the effects of perceiving aggression as a personal attack and that those who had prior training increased in their perception of aggression as a personal attack at post-training, should a "booster" training be given, it would have to be made extremely relevant and staff would need to be invested in the training prior to the "booster" occurring. An in-situ training may be the way for staff to be invested in their learning and recognize the need for the new information and feedback.

Accommodation and preventing WPV

Previous research using CAT in healthcare has tried to meticulously parse out which strategies are most successful for important outcomes such as compliance or are most favorable when used by HPs according to patients (see, for example, Watson & Gallois, 1999). However, these types of questions can only be answered using data that is easily manipulated like vignettes, for example. In reality, strategies happen simultaneously and do not have a clear beginning and end. Given the applied nature of Study 2, and staff being taught and encouraged to use all five accommodation strategies it would be unreasonable to treat accommodation strategies as separate and investigate their separate influence (For a discussion of separating strategies in research, see Jin & Watson, 2020). I encouraged staff in the training to use all of the strategies, thereby implying for them that competent accommodation is the blend of all of them. This instead comprises an accommodative stance, rather than the use of any one strategy. Results supported this notion such that when staff described their experiences of WPV in varying amounts of detail, those responses that did not include any accommodative strategies were also the least successful in de-escalation. Those who described using of more of the five strategies were more successful in de-escalation and patient cooperation. One strategy that was very rarely apparent in the data was

approximation. However, given the nature of this strategy of matching one's interaction partner, it may be the case that only interaction data with more detail, actual dialogue and turn-taking would be able to show this strategy in use. Recounts of experiences from only one party in the interaction were insufficient to be able to demonstrate this strategy fully. An accommodative stance that combined all of the strategies was also associated with higher staff self-efficacy in managing patient aggression, higher job satisfaction, less stress at work, and more patient cooperation as anticipated, thereby supporting H2.

Training effects on staff individual experiences and clinic norms

Not only did this training influence the attitudes and accommodation of staff, it had important outcomes for norms for the clinic through the conversations staff reported having with one another over time, as expected. The favorable ways that norms changed following the training were that staff increasingly encouraged one another to not take the aggression personally, which may explain the dissipation of results for those with prior training who increased in perceiving it as a personal attack immediately following the training. Listening also remained a common response about how to handle patient aggression. Lastly, recognizing their impact in the overall clinic environment increased overtime as expected, thereby supporting H3. However, there were some unfavorable changes in norms as well.

First, staff reported providing emotional support for one another less often, and reported having no conversations and giving each other no advice more often. This may also be a form of training fatigue such that staff may have felt that following the training, they should be able to successfully handle patient aggression and if they could not, they should not share it with others. It is possible that the amount of training could increase the likeliness of staff to remain silent and perceive the WPV to be just part of the job, as described findings

from the pilot study. However, staff keeping their experiences to themselves means they may be missing out on the benefits of peer learning theorized by Lincoln and McAllister (1993) to be achieved by observation, discussion and problem-solving with peers. Although the majority of staff reported debriefing their experiences with one another to reflect on how to improve in the future, staff who do not talk to one another may not be able to benefit from these conversations and make sense of their WPV experiences.

Despite staff discussing their experiences with one another less at the three-month follow-up, the training impacted the more individual-level experiences of staff in favorable ways. First, the training increased staff self-efficacy in managing patient aggression over time which sustained through the three-month follow-up time point. It also significantly increased job satisfaction from pre-training to the three-month follow-up. Lastly, staff reported that they were significantly more able to achieve patient cooperation at the three-month follow-up than at pre-training. The ability to achieve patient cooperation may be the most appropriate indicator of success of the training given a measurement issue of WPV further elaborated in the limitations section. Given that the more staff reported accommodating patients, the more patient cooperation they reported, and that patient cooperation increased over time, H4 was supported, and the training was successful.

Chapter 5: General Discussion

This dissertation aimed to improve de-escalation trainings that staff receive in hospitals to communicate with aggressive patients. In order to do this, a series of two studies addressed the limitations of previous trainings about WPV in healthcare documented by previous research. Limitations of prior work included that: a) it has not been tailored to experiences of non-medical or dental staff, and b) the majority of training has been vague in

terms of what is actually taught and referring to general communication skills and lacking theoretical frameworks. To address these limitations, Study 1 trained non-medical staff completing non-medical tasks (i.e., patient registration) in existing de-escalation strategies found by previous research. This helped to diminish the ambiguity of what is meant by de-escalation strategies by identifying which strategies staff use and if they are, in fact, effective. Although Study 1 pushed de-escalation trainings into a new arena, the training still lacked theory.

Study 2 addressed both limitations of previous work. Thus, it trained staff in a communication competence perspective informed by CAT. Using CAT helped to theoretically frame previously known de-escalation strategies to make them more accessible across hospitals and research studies. Of special importance was a focus on how training can change attitudes favorably in ways associated with higher accommodation. Indeed, Pitts and Harwood (2015, p. 93) argue that, "accommodation competence is a skill that can be acquired through training and experience." In addition, this training was given to all members of the clinic ranging from front desk staff, billing, call center, psychologists, dentists and primary care physicians.

Health communication research invoking CAT only started at the end of the 1990's. Prior to this, the main focus of healthcare interactions was on the communication skills that practitioners used to communicate more effectively with patients. Given the intergroup focus of CAT, it is appropriate to apply in the highly intergroup context of healthcare (Watson, Hewett, & Gallois, 2012; Watson, Jones, & Hewett, 2016). The highly intergroup context stems from hierarchies that are strongly formalized and that embolden professional social identities. They are deeply engrained, recognized, and respected due to high levels of

specialty trainings that often have their own sub-cultures of medicine (Hewett et al., 2009). Across the two main streams of research in healthcare that invoke CAT, namely in interprofessional interactions and in provider-patient interactions, the theory offers strengths that help to improve healthcare communication.

In the most general sense, using CAT instead of other interpersonal theories to improve healthcare communication offers a bigger representation of what causes interactions to be effective and what causes them to be *in*effective. In health, ineffective interactions have high consequences that could be as severe as death. Given that, it is essential that researchers understand the whole picture of the communication occurring in a healthcare setting. Often times when an adverse event does occur, those inside the medical setting, who have been trained to only view the present moment, try and interpret the event by picking apart what happened in that very moment (Watson, 2019). This causes them to miss information about what *led* to that present moment. PhDs who are not medically trained are well positioned to complete this research because of their training and ability to invoke theories that help probe antecedents, context, and the interaction itself. At present, research using CAT is increasing to understand how inter-professional practice impacts likelihood of adverse events in hospitals. In addition, research using CAT aims to understand patient perceptions of communication - and their satisfaction thereof - with their provider across various types of medical complaints. Despite the strengths of CAT that position it as useful for applied work (i.e., views the whole the interaction of interest, not methodologically tied), very few studies have used CAT as an interventional tool as this dissertation does.

In what follows, I will first overview the findings of the studies in this dissertation. I will then discuss limitations relevant to interpreting the findings of this dissertation. This will

be followed by proposed revisions to the most recent principles of CAT that made it well suited to be used in this applied health context. Next, practical implications will be summarized, including ways that the training can and should be changed in future research before concluding.

Overview of Findings

In general, findings from the pilot, Study 1 and Study 2 suggest that staff do not receive streamlined consistent information about how to effectively handle patient aggression. However, staff in the locations of these trainings did not often have to handle extensive WPV. Findings from the pilot study showed that some staff are good at or at least feel confident handling WPV, because they have some personal experience with someone in their life who has been aggressive due to many factors including confusion, substance use or cognitive disorders. In addition, findings from the pilot showed that staff typically either voluntarily or are called upon to help one another when a patient is aggressive. This finding was echoed also in Study 2.

Study 1 findings showed that frontline staff are nervous about handling patient aggression and would like to know more ways to be better at it. Staff were given more information about the rationale of new mandated intake questions that made them nervous. Because they understood with compassion the reasoning for asking such questions, they were highly motivated to ask the questions in the best way they could and learn to de-escalate where necessary. In fact, many participants in the trainings approached me after the training asking for more information or additional training for their specific departmental experiences. Results showed that after learning indicators of patient likeliness to perpetrate WPV, staff were better able to identify those behaviors in patients. Findings also indicated

that staff put the de-escalation and limit-setting interpersonal skills that they learned to use successfully. Findings also showed the importance of the way that staff approach patient aggression. As opposed to a correcting or a zero-tolerance approach to patient aggression, those staff who held an acknowledging approach, were more reportedly successful at managing WPV and less likely to experience it in the first place. An acknowledging approach is one that is from a place of compassion and understanding as they respectfully manage patient aggression (Petit, 2005). Because the importance of attitudes or approach found in Study 1, the training in Study 2 focused heavily on this in addition to the CAT strategies that framed the successful de-escalation and limit-setting techniques.

Results of Study 2 echo the vital role that staff attitudes play in managing patient aggression, such that those who hold a more understanding attitude are more likely to claim an accommodative stance toward patients, are more likely to wish to advise their peers to do the same, and are reportedly successful in preventing WPV. More than the key focus on preventing WPV, staff who have more positive attitudes toward patient aggression also experience more job satisfaction, higher self-efficacy, and less stress at work. Likewise, staff who accommodate patients more report experiencing more job satisfaction, higher self-efficacy, and less stress at work and more patient cooperation. These findings support the value of a CAT training on managing patient aggression, and support Figure 1 as an accurate depiction of variables important for consideration and CAT intervention trainings in this context.

Limitations

Although findings of this dissertation were exciting for improving WPV in healthcare, they are not without limitations. Given the applied nature of this dissertation, with

studies conducted with two different organizations that do not typically engage in social science research, there were some methodological limitations of the studies that resulted in small sample sizes. In Study 1 at the hospital in Central California, given the differences in the way that clinical trials are typically conducted, the consent process was lengthy and counterintuitive for the follow-up survey as required by the IRB. Specifically, six pages of consent information had to be clicked through by choosing "agree" before beginning the survey. Some of the pages of information did not make sense to require an "agree" statement (e.g., "You will not be paid for participating in this research study"). Participants responded "agree" and "disagree" to some of the six pages of consent information.

After extensive conversation with the IRB of record for the study, and the IRB of my home institution, they decided to allow only those who chose "agree" to all pages of consent information to be included in the study. This is normative process for higher risk clinic trials but for survey data, this was not the appropriate consent process. As such, and as explained in Study 1, many responses had to be thrown out of the study. Although this could be beneficial to Study 1 in the grand scheme, given that perhaps those participants were not reading the questions closely, their qualitative responses were substantive. In addition to the benefits of more qualitative responses to garner understandings of WPV at that location, a larger sample size in Study 1 may have meant that more sophisticated analyses could be run as more variation in approaches to patient aggression may have been present. In addition, Study 1 would have benefitted from a pre-survey to be able to more confidently assess the effects of the training on participants. Given the nature of access at that organization, a pre-survey was not feasible.

Although Study 2 is not limited by the lack of a pre-survey, it does have similar issues with a small sample size. The small sample size in Study 2 was due to participant dropout rates. Although there were no systematic substantive predictors of dropout in the study, some unobserved variable may be driving the high level of dropout. The dropout could also be explained by the use of paper surveys that required participants to write ID Codes on their survey before answering questions. Sometimes participants forgot to write in their ID Code. Owing to the short time window of data collection for the three-month follow-up, there was not an opportunity to return to participants to ask them to fill in their ID Code. This may have been solved by using an online survey and requiring a response to the ID Code question before participants could begin the survey. Another reason the dropout was high was because even of those who did fill in an ID Code in their three-month follow-up survey, it often did not match any of the records from pre-training. This was a curious issue because the open-ended responses of staff who did not have a matching ID Code suggested that they were in fact at the June all staff training. This could have been due to a phone number change, or not reading the question carefully at pre-training. A larger sample size in Study 2 could have allowed for more sophisticated analyses that could have better tested the causal and mediated relationships in Figure 1.

Although this ID Code convention of mother's first three letters of her name and last four digits of the participant's phone number was a convention previously used by and advised to be used by a professor in the Communication department, it may not have been the strongest choice. Participants may have confused their mother's name for their own name if they were reading too quickly or may have put the last four digits of their mother's cell phone number instead of their own, or even their home phone number. However, like the

consent issue in Study 1, the exclusion of the participants who did not have matching ID Codes at the three-month follow-up, despite their open-ended responses suggesting that they participated in the June all staff, could be a good thing for Study 2 overall. These participants may not have paid careful attention at any one of the time points, and therefore excluding their data means an overall high-quality data set even if that means it is a bit smaller.

In addition to high dropout in Study 2, likely due to the nature of data collection, participants gave short and often vague answers to open-ended questions that described their own behavior. In coding responses with the research team, the research assistants reflected that participant responses were still slightly vague about what exactly they actually do to manage aggression. Responses like "remain calm" are helpful in terms of orientation and attitudes, but do not describe replicable behaviors that can taught to others (i.e., how do they remain calm?). In a facilitated reflection exercise with the researcher, undergraduate research assistants said they were still left wondering exactly what it was that people did to manage aggression and their workplace? What exactly do they say to their peers? Despite the questions in the survey asking for examples of actual dialogue, this was often not provided by participants in Study 2. This could be because survey data collection was a bit rushed. Participants were given limited time to complete their survey and were required to complete it at a prescribed time. In other words, participants were not informed in advance they were going to be filling out the survey. Instead they were handed it during their staff meeting with time pressure to complete it very quickly. This is in contrast to Study 1 where staff could take the survey at their own leisure, any time during their workday and may have had more time to sit and reflect as they wrote their answers at a time convenient to them. This may explain why Study 1 open-ended responses were more detailed.

One next step that could address the above limitations of Study 2 is to have future trainings that are even more tailored in the role plays to be more specific to departments. One piece of feedback from the clinic in Central California in Study 2 was that they would have liked to have the training be of smaller groups of staff and to have them be more department-specific. Despite my efforts to do just that, organizational barriers meant that staff were trained in very large groups, and there was minimal time for department specific focus in the presentation. Currently, I am in contact with the clinic in Central California about doing a refresher course with the staff that is more department-specific, allows for more time, and is taught to staff in smaller groups.

Study 2 was also limited by several measurement issues. First, there were low reliabilities of the staff stress at work and attitudes toward aggression scale, despite those being previously validated scales. As such, quantitative results including those two variables should be interpreted very carefully. Another measurement limitation, that was also a conceptual and methodological limitation of Study 2, was that even though participants were given a definition of WPV for the purposes of the study, they clearly held disparate understandings of what does and does not count as WPV. Instead, participants responded with their own definition of WPV in mind at all time points. This was evident in participant responses that said things similar to that they had not experienced any WPV because they had not had any instances of physical violence, only name-calling or that because they only spoke with patients over the phone that they could not have experienced any WPV. However, instances of verbal abuse like name calling were included in the definition of WPV given to participants, which means that they could have experienced WPV even over the phone. This limitation perhaps should have been unsurprising given the definitional differences in what

counts as WPV in prior research as summarized in Chapter 2 of this dissertation. This issue, despite the efforts of this study to clarify it, remains.

An additional limitation of the way that WPV was measured in Study 2 was that even though the three-month follow-up survey asked how many instances people had experienced since the training, people still responded with lifetime experiences of WPV. This issue was evident in participant responses at the three-month follow-up that cited memorable experiences of WPV that occurred many years ago, not only since the training (see Bernhold & Giles, 2019 for an example of the impact of memorable messages on older adults to demonstrate the power of memorable experiences/messages). This made analysis of amount of WPV over time challenging.

This limitation could have been eliminated by adding a ratio-type question about how many instances of WPV people had experienced with response options ranging from 0-10, for example. The open-ended nature of the response, despite asking for a discrete number, made quantifying the experiences of WPV difficult. The issue of reporting on number of instances since the training was less of an issue in Study 1 because it was more specific to patient registration and intake experiences which only changed after their training anyway, rather than general instances. As such, participants had more specific events to report on that could have only been different after the training anyway given the nature of the focus of the training on implementing the new questions from ACA 1557. Nonetheless, both studies would have benefitted from having a ratio-type question, in addition to an open-ended question about prevalence of WPV.

A final limitation of this dissertation, that should be simultaneously a celebrated fact, is that the two Central California locations for this study already had very low instances of

WPV pre-intervention. The locations are very close proximity to each other and have an overlapping patient population. In addition, pre-intervention, both locations held initial orientations to patient aggression that foster understanding and accommodation. The setting, initial orientation, and norms of the study locations meant already increased successful de-escalation and WPV prevention prior to the training. The locations for these studies, then, did not have much variation in attitudes toward patient aggression, perceptions of blame of patient aggression, or even amount of experiences of WPV. This means that there were nonsignificant results in arenas where variables changed in expected directions (i.e., improved attitudes, less WPV). Because variables of interest began already in a desirable way and, there was not much movement that could possibly take place. This suggests that trainings should be highly domain-specific and conducted in locations that need them the most like places with high occurrences of WPV. For example, in a similar workshop I delivered in Hong Kong, all staff that attended experienced at least one instance of WPV in the previous month. This confirms the nature of the location driving the low instances of WPV rather than a globally low occurrence.

Even though WPV was very low generally in both Central California locations, even one instance of WPV could have a very lasting and severe impact on a healthcare staff member and should not be taken lightly. Different locations that are more rural or more urban may experience different patterns of WPV in ways not observed by this dissertation. The self-report nature of Study 1 and Study 2 may also be artificially demonstrating lower experiences of WPV than what actually occur. Indeed Thakerar, Giles, and Cheshire (1982) summarized several studies that demonstrate that despite objective linguistic changes and outside raters noticing linguistic changes, speakers rated no linguistic changes in their

speech. This demonstrates the importance of collecting observational data, or objective reports from organizations so that actual amount of WPV can be more accurately included in research. Future work could replicate this training and collect other forms of data that may provide a more accurate depiction of number of experiences of WPV (i.e., diary entries immediately after experiencing patient aggression, observations of staff while at work). Nonetheless, even one experience of WPV with a patient could be sufficient to cause psychological harm, and make one want to quit their job.

Theoretical and Methodical Implications for CAT

This dissertation has theoretical implications for CAT, including pushing applied health CAT research into new arenas, methodological considerations for how CAT strategies are understood and analyzed, and findings that give back to the core CAT Principles in ways that suggest revision. To date, limited research uses CAT in healthcare in applied ways. To an even lesser extent, research has used CAT to create interventions in healthcare. The main settings where this has occurred is in pharmacy interactions where Chevalier et al. (2017) developed a training for pharmacists in consultations with patients about new medications using CAT to increase medication compliance. Their training was successful in increasing medication compliance of patients, and satisfaction of patients with their pharmacist. This dissertation uses CAT to develop an intervention in a new arena of patient aggression and WPV in health. What is more, this dissertation pushes CAT and health research into more broad forms of care as this dissertation included participants in dentistry and call centers for the first time known to the researcher in a study.

CAT is a theory that focuses on many variables, not only those in the interpersonal interaction itself. However, the antecedents and contextual variables like norms and initial

orientation of interlocuters has been largely overlooked in empirical CAT research (Gallois, 2019; Watson, 2019). Findings from this dissertation highlight the importance of focusing on the antecedents of an interaction, especially in the context of WPV in healthcare. Indeed, the most important indicators of successful de-escalation are contextual and attitudinal in kind. Zooming in on the interaction itself, this dissertation shows that CAT strategies cannot (and perhaps should not) be separated in measurement. Likewise, strategies should perhaps not be parsed out when attempting to make predictions for successful outcomes. Previous research has focused on trying to parse out strategies to determine which are the most important, yet this is not how conversation actually occurs (Watson & Gallois, 1999).

Research that is applied and interventionist in nature should not separate strategies and different lines of inquiry, because that is not how they occur in natural conversation. There is value in conducting experimental studies that separate strategies meticulously in vignettes to understand what might need to be highlighted in different doctor-patient interactions. However, results from Study 2 of this dissertation suggest that the most effective combination of strategies is to quite simply use all of them; the more strategies used, the better off staff were in de-escalating patient aggression. When strategies are used effectively (avoiding over- or under-accommodation), there is no harm in using all of them to the extent that one does not overaccommodate. No instances of overaccommodation were glaring in Study 2. As such, it may be of less interest to find out which are the most situationally important when they are all good anyway. A focus on an accommodative stance and competent accommodation means that staff use all of their communication faculties to have high quality and effective interactions with patients (Gallois, 2019; Pitts & Harwood, 2015; Watson, 2019).

Extending and Revising CAT

Results of this dissertation suggest revisions and addition to the CAT principles offered by Dragojevic et al. (2016). CAT principles over decades of research and as the theory evolved from SAT have been refined and extended (see, for example, Gallois et al., 2005, and Thakerar et al., 1982). The nature of these principles position CAT to be well-suited for applied work in that they capture well the notions of intent and motivations. However, research has only begun in the last decade to do intervention work in healthcare using CAT. Given the foray into applied and intervention creation in health, CAT principles can be updated to include more, or perhaps return focus to goals, norms, and broadening of attributions of nonaccommodation.

The following updates are more nuanced to capture the sensitive and time pressured nature of healthcare conversations that are highly intergroup structurally. A strong attempt has been made to heed the cautioning of Gallois, Ogay, and Giles (2005) for keeping the propositions parsimonious. In their review of CAT evolution prior to 2005, they explain that "the extensive amount of research and theory development around CAT has made parsimony a major concern" (p. 5). Even though CAT is incredibly complex and broad in scope, the principles outlined by Dragojevic et al (2016) are indeed more parsimonious than any previous iteration. Due to the fine tuning that CAT has undergone across decades has meant that some relevant components of the intergroup interaction have lost focus as the expense of more contextually relevant ones. In the principles refined below, many of these components are brought back to the foreground by the findings of this dissertation.

For reader convenience and ease of interpretation, the original principles outlined by Dragojevic et al. (2016, p. 51) will be stated again here, followed by the proposed updated

revision/extension to the statement where merited. Findings from this dissertation do not encourage extensions or revisions of all seven of the principles outlined by Dragojevic et al (2016). As such, all are listed for clarity and comment, while five are refined. The refinement/extension is italicized. The proposed extension/revision of select principles will then be justified through an explanation based on findings of this dissertation. Lastly, Principle 8 is added to this list based on Gallois, Weatherall, and Giles (2016).

> **Principle 1.** Communication accommodation is a ubiquitous and fundamental aspect of social interaction that serves two major functions: first, it helps facilitate coherent interaction and, second, it allows interactants to manage social distance between one another.
>
> *Revision/Extension:* Communication accommodation is a ubiquitous and fundamental aspect of social interaction that serves three major functions: first, it helps facilitate coherent interaction, second, it allows interactants to manage social distance between one another, *third, it facilitates the accomplishment of instrumental conversational goals.*

Justification of revision/extension: The principle as stated in Dragojevic et al. (2016) is focused largely on relational and identity goals that are achieved through accommodation. Even though the proposition acknowledges completing a coherent conversation, it fails to highlight the ability of accommodation to be commonly used to facilitate accomplishment of instrumental goals. Accomplishing conversational goals has been of focus in past iterations of CAT Principles (Gallois et al., 2007). In addition, recent scholarship has acknowledged the assumptions that both CAT and multiple goals theory (Caughlin, 2010) share including that people pursue different types of interaction goals in conversation, and often that people

pursue multiple goals simultaneously in an interaction (Wilson, 2019). As CAT is becoming more commonly used as an intervention tool to facilitate competence, which is defined as being appropriate and effective, updated propositions should be refocused to include conversational goals, beyond understanding, as a central function of accommodation.

A focus on conversational goal accomplishment highlights the need for the interaction to be effective. Results of this dissertation support that accommodation facilitates the conversational goals, de-escalation of patient aggression to prevent WPV, and also to help staff maintain their safety in their work environment. Previous intervention research using CAT has demonstrated that accommodation can facilitate other conversational goals such as medication compliance following an interaction between patient and pharmacist (Chevalier et al., 2017). As such, future work should consider what other conversational goals accommodation helps achieve (For a recent review of accommodation competence, see Zhang & Pitts, 2019).

> **Principle 2.** Individuals have expectations about what constituted appropriate and desirable accommodation in context, and these expectations are informed by the sociohistorical context of interaction, interpersonal and intergroup histories and idiosyncratic preferences.

Expectations were not of focus for this dissertation, as such Principle 2 remains unchanged. However, results of this dissertation may loosely consider expectations insofar as they return attention to the propositions offered by Thakerar er al. (1982) where they focus more on cost and reward expectations as predictors of convergence and divergence. It may be the case that staff in Study 2 perceived too high of a cost in *not* accommodating patients. They expect that if they do not accommodate patients competently, they will be faced with

aggression and WPV. So, staff in this study may have accommodated out of avoidance of high costs and their expectations (i.e., their safety compromised, fears of appearing bad at their job). Although this is beyond the scope of variables tested in Study 2, findings do draw our attention back to reward and cost notions offered by both Speech Accommodation Theory and CAT.

> **Principle 3.** The degree and quality of individuals' accommodation in interaction is a function of both their motivation to adjust and their ability to adjust.

Results of this dissertation support this principle and demonstrate that CAT trainings can help improve or at least maintain high motivation and ability.

> **Principle 4.** Speakers will over time increasingly accommodate to the communicative patterns they believe characteristic of their interactants, the more they wish to affiliate (i.e., decrease social distance) with their interactants on either an individual or group level, or make their message more easily understood.
>
> *Revision/Extension:* Speakers will over time increasingly accommodate to the communicative patterns they believe characteristic of their interactants on either an individual or group level, *the more they are focused on approach goals* (i.e., to affiliate with/decrease social distance, signal positive face) *or on avoid goals, such as fear of the other person's reaction, out of role-bound prescription, or obligation will engage in accommodation.*
>
> *Justification of revision/extension:* At present, social identity is a strength of CAT and is theorized as a main explanatory mechanism, among others such as similarity attraction and uncertainty reduction, to the interpersonal adjustments made. However, results from Study 2, and emerging theory in the intergroup domain, suggest this notion should be broadened (see

for a discussion of social identity as the motivating mechanism and suggestion of addition of interdependence as a motivator of intergroup behaviors, Giles, Pines, & Giles, 2018). Results from Study 2 show that staff are motivated to and do accommodate aggressive patients based on their own experience of negative feelings they would like to avoid, like frustration or fear. They are also motivated to and do accommodate aggressive patients to terminate the conversation with the patient faster and avoid further escalation. Lastly, they were motivated to accommodate the patient not in order to share a social identity with them but, instead, out of identification with their role in the clinic or some other social identity in the clinic as the person who is patient or could handle it.

Previous meta-analytic CAT research has recognized how so-called obligatory or reluctant accommodation is evaluated negatively by receivers (e.g., Soliz & Bergquist, 2016). However, staff were not engaging in accommodation reluctantly or out of obligation only. Instead, their accommodation was due to strong identification with their role in the clinic that prescribed accommodative behaviors or motivated by avoidance. These motivations are qualitatively different than the approach goals that were originally in the 2016 version of this Principle.

> **Principle 5.** As a function of the intentions and motives believed to underlie a speaker's communication, perceived accommodation increasingly and cumulatively decreases perceived social distance, enhances interactional satisfaction and positive evaluations of speakers, and facilitates mutual understanding.
>
> *Revision/extension:* As a function of the intentions and motives believed to underlie a speaker's communication, perceived accommodation increasingly and cumulatively decreases perceived social distance, enhances interactional satisfaction, positive

evaluations of speakers, facilitates mutual understanding, *self-efficacy in future interactions, and self-esteem. When attributed to an external cause as opposed to an internal cause, perceived nonaccommodation is associated with the same outcomes.*

Justification of revision/extension: Results of this dissertation show that accommodation is associated with self-esteem and efficacy which have been added to the above principle. The first phrase of the proposition is about intention and motives. Beyond intent, results from this dissertation show that instead the focus of attribution of the nonaccommodation that is patient aggression as either internal or external is pivotal for staff satisfaction, self-esteem and accomplishment of their goals of de-escalation. Although the attribution regarding intent has been demonstrated to be vital to how nonaccommodation is reacted to (e.g., Gasiorek, 2013), it should be broadened to include a consideration of external or internal attribution-making. For example, when staff attributed patient nonaccommodative aggression externally, such as to the patient having a bad day or being in pain, staff were much better off in terms of the above relevant outcomes. When they, instead, attributed patient nonaccommodative aggression as internally, such as recognizing the patient who always approaches the clinic that way or assuming there are patients who are just like that no matter what, staff fared much worse in terms of the above variables.

Principle 6. Speakers will over time increasingly nonaccommodate to the communicative patterns they believe characteristic of their interactants, the more they wish to disaffiliate (i.e., increase social distance) with their interactants on either an individual or group level, or make their message more difficult to understand.

Revision/extension: Speakers will over time increasingly nonaccommodate to the communicative patterns they believe characteristic of their interactants *for social*

distancing goals, on either an individual or group level, make their message more difficult to understand *or out of necessity.*

Justification of revision/extension: The notion that speakers nonaccommodate largely for the purpose of social distancing has been well-established through CAT research (Giles, 2016). If social distancing can be considered a social/relational goal, results of this dissertation suggest revising this by broadening it such that people may nonaccommodate for necessary instrumental goals. For example, results from this dissertation showed that staff engaged in nonaccommodation of aggressive patients often as a last resort when their accommodation efforts did not suffice. For example, staff told stories of times they tried to help the patient but wound up having to dismiss them from the clinic because the patient was jeopardizing staff or their own safety[6]. This suggests that nonaccommodation is not always a wanted or desired action but may be *required* at times to satisfy other goals that are not social in kind.

Principle 7. As a function of the intentions and motives believed to underlie a speaker's communication and the potential consequences of associated outcomes, perceived nonaccommodation increasingly and cumulatively increases perceived social distance, diminishes interactional satisfaction and positive evaluations of speakers and impedes mutual understanding.

Revision/extension: As a function of the intentions and motives believed to underlie a speaker's communication and the potential consequences of associated outcomes, perceived nonaccommodation increasingly and cumulatively increases perceived

[6] Dismissal from a clinic is described by staff as "firing" a patient. Dismissal means the patient is no longer allowed to visit that healthcare location. This is taken very seriously by staff in Study 2 in Central California particularly because they often are the only place that patients are able to attend due to the nature of serving low income patients, who often lack insurance.

social distance, diminishes interactional satisfaction and positive evaluations of speakers, impedes mutual understanding, *and diminishes effectiveness of goal accomplishment in the interaction.*

Justification of revision: More than a focus on satisfaction or understanding which suggests an impact on attitudes of the receiver toward the sender, the actual effectiveness of the interaction is lowered. Results from this dissertation show that when staff made internal and negative attributions for patient aggression which can arguably be considered nonaccommodation, they experienced more WPV and were less successful in de-escalating the aggression and preventing violence. Although beyond the scope of this study, more research should be conducted to determine if staff also view patient aggression as nonaccommodative. Results also showed that the attributions that staff made not only affected them individually but flowed into the norms of the organization in the ways that staff spoke to and advised one another regarding patient aggression. A focus on effectiveness in terms of goal achievement (i.e., de-escalation, prevent WPV, patient cooperation) in the interaction should be incorporated into CAT principles not only due to the results of this dissertation, but also based on previous work that has called for a focus on competent accommodation that is both appropriate and effective (Pitts & Harwood, 2015).

Principle 8. The degree and quality of individuals' accommodation or nonaccommodation in interaction is a function of the interactional dynamics, including turn-by-turn actions, interactional accomplishment of immediate conversational goals, and the (mis)alignment of speakers in terms of the personal and/or social identities negotiated.

Revision/extension: The degree and quality of individuals' accommodation or nonaccommodation in interaction is a function of the interactional dynamics, including turn-by-turn actions, interactional accomplishment of immediate conversational goals, the (mis)alignment of speakers in terms of the personal and/or social identities negotiated *and contextual norms.*

Justification of revision/extension: This principle, like the proposed revision to Principle 1, includes conversational goals as a key function of accommodation. Although Giles (2016) does reference the importance of norms often, and they have been included in previous iterations of CAT principles (see Giles, Mulac, Bradac, & Johnson, 1987), they have lost focus in the set of 2016 CAT principles. As such they have been added to the additional 8th Principle above. Results of this dissertation suggest that CAT intervention trainings have value beyond improving communication competence insofar as they can encourage contextual norms to change, or at minimum remain favorable, such that they encourage accommodation over time. Specifically, results of this dissertation indicated that participants in Study 2, following the training were more likely to encourage their peers to listen to patients' needs, and recognize their contribution to an environment that either escalates or de-escalates patient aggression,

The above extensions and revisions of the above CAT principles not only point researcher attention to updated foci, but also return, in ways, to CAT's Phase 1 theorizing with Speech Accommodation Theory roots; for an overview of the three phases of CAT research, see Gallois et al. (2005). Namely, they return to the notion that speakers may change their communicative behaviors in order to "adopt a situationally appropriate speech pattern" (Gallois et al., 2005, p. 12). In addition, they draw researcher attention to situational

and contextual norms which have lost focus in recent years of CAT research. Norms in this case are exceptionally important when conducting intervention research. If norms are not addressed or at minimum queried, it is likely for skills trainings to fail (Gallois et al., 2005).

These updates also help to improve upon limitations of Phase 2 theorizing of CAT insofar as they do not think of speaker evaluation as the outcomes, but rather think about how speaker evaluations are associated with or even lead to more objective applied outcomes for healthcare organizations. Lastly, these propositions share in the parsimony goal set forth by researchers in Phase 3 theorizing of CAT. Perhaps and arguably, the findings of this dissertation combined with other applied intergroup health work suggest that CAT is entering into a fourth phase of theorizing in which researchers are returning to the very basic tenets of SAT and CAT that have not received quite as much attention in recent CAT research. In this fourth phase, researchers are focusing on antecedents to the interaction anew, are considering the complexities and constraints of norms, and are learning what new and consequential objective outcomes (non)accommodation is associated with.

Practical Implications

Given the applied nature of this dissertation focused on ameliorating the problem the high prevalence of WPV in healthcare settings (albeit a high prevalence not found in the locations of this dissertation), the practical implications of these findings abound. Any of the results above may be considered practical implications because they changed the organizations where the studies were conducted. However, there are some key practical implications that merit special attention here. Upon completion of Study 1, a report was created and given back to the Central California hospital, including recommendations for best practice given the findings from the study. The two main recommendations given to the

Central California hospital from Study 1 were as follows. Recommendations were received with excitement, and staff continue to be trained at that hospital by an outside vendor.

Recommendation 1. The hospital should continue to educate staff about causes of patient aggression, and encourage external attribution making. In all, external attribution making encouraged an *acknowledging* approach, and therefore staff used more de-escalation strategies to successfully prevent violence.

Recommendation 2. Future studies should probe staff about how they decide to get help in managing patient aggression when they fear that the patient may become physically violent.

Recommendation 1 focusing on the importance of making external attributions for patient aggression was integrated into the training in Study 2. Clearly one of the main ways that patient aggression is well-managed is by staff not blaming the patient for their aggression. This then leads to a positive attitude/acknowledging approach to patient aggression, which is followed by higher accommodation and patient cooperation. Recommendation 2 focusing on how staff help one another with experiencing patient aggression was of greater interest in Study 2, but in addition to the results from Study 2, healthcare settings should create guidelines or even a policy about how patient aggression should be handled in terms of who to call for help and when. The question remains at what point do staff determine they need help from fellow staff? A manager? Law enforcement?

A practical implication uniquely learned from Study 2 is that it is possible to have too much training on this topic. Results showed detrimental effects at times for those participants who had prior de-escalation training. It is critical to provide training to staff, yet there is a line at which it becomes too much and staff may have reactance that affects their work life

and ability to manage patient aggression in negative ways. Many staff who feel like they already know what they are being taught in the training (despite this being the first training including CAT they have received), and the training being mandatory, may feel offended by having to hear the advice again or may even feel misunderstood or undervalued for the great job they perceive themselves to be already doing. It may also be the case that the staff who already had training had reactance to this particular training because I do not work in the medical field/am not medically trained. As stated by Watson (2019), and through personal experience in many healthcare settings, it is challenging as an academic researcher to be accepted into medical settings as a credible teacher of information. Instead, medical staff often view the researcher to not understand what they experience at work.

To overcome this, researchers should increase the amount of presence in the healthcare setting prior to the training, over and above what was done in Study 2. This will help increase staff to view the communication training as central to their practice, rather than viewing it was a "soft skill" - as it is commonly called. An additional way that staff buy-in could be increased would be to collaboratively adapt the training for the particular organization or department of focus. Similar to findings from a culture-based approach to healthcare research, desired behavior change may not be brought about from the idea that sharing more information will change attitudes and then lead to behavior change (Dutta, 2008). Instead, the collaborative efforts of the population from which behavior change is desired and the researcher can help the population of interest achieve their own interests. In the case of WPV, no healthcare worker wants to experience it, so the researcher and the healthcare staff member can and should work together to that end to effect behavior change. In addition, a further focus on changing norms in the organization can predict the link

between attitudes and behavior change such that if ingroup norms reflect the desired behavior change in the clinic, it is more likely to occur (Crano & Prislin, 2006).

The main staff that need training in preventing WPV are staff who work at the front desk. This was demonstrated by this dissertation in several ways. First, previous research has indicated that WPV most often occurs in the first hour of a patient visit in the ED (Crilly et al., 2014). Second, the population of Study 1 were those who complete intake and mainly work at the front desk. Third, the results from Study 2 indicate the majority of WPV in the Central California clinic occurred in the front desk/waiting area. As such, context specific trainings should be developed to target this context and population. The ways that this could occur is to keep the theory-driven notion of accommodation strategies as the brunt of the training, but adapt any examples and role plays to be front desk situations. This requires researchers to spend time at the front desk, learning typical interactions that occur there that are common aggressive patient scenarios. Here again, volunteering at the organization to work the front desk can be illuminating and can help to gain trust of the staff that would be learning from the researcher.

Future Directions

This dissertation focuses on the actions only of the receiver of patient aggression, namely healthcare staff. However, the perspective of a patient would help to understand how their initial orientation including attitudes, goals for their interactions with their healthcare provider, and how the communication of their provider effects their (de)escalation. It may be the case, for example that patient aggression often recurs as a result of multiple interactions with their provider that they previously found dissatisfying (Watson, Jones, & Hewett, 2016). In this way, they may have experienced accumulated underaccommodation over time in

interactions with their provider, which has been shown to be associated in the context of older adults with lower perceptions of warmth and competence of the sender of the information (Gasiorek & Dragojevic, 2019). Given this, there is a need to observe WPV in situ.

In healthcare, patients may experience multiple visits in the clinic in which they perceive the staff to underaccommodate them (i.e., use jargon and acronyms they cannot understand, or rush them through the conversation). In turn, they may become aggressive in future interactions and perceive the healthcare provider to be less competent or even less credible as results of this dissertation show when patients asked staff if they knew what they were doing, or were even qualified to do their job. Future research should consider what patients perceive to be effective in terms of de-escalating their aggression. Given the sensitive nature of a study like this, the first forays into this arena may be best suited for a laboratory experiment in which a confederate is the aggressive patient and the participant is the healthcare staff member. The confederate could then reflect on what was effective from the healthcare staff member, what was not, and what could have been done differently to be more competently accommodative and prevent WPV.

A second future direction for this work is replication in a location that experiences more WPV. Given the limitation of very little variance in prevalence of WPV experienced in both Study 1 and Study 2, the training developed by Study 2 should be replicated in a setting where WPV is more common to test its effectiveness. One arena where this may be especially important is in the ED in a hospital. For example, one study in Florida reported that 100% of nurses in the emergency department experienced WPV in the last year (May & Grubbs, 2002). What is more, a 2017 review of violence against emergency medical

personnel compared the non-fatal injury rates of healthcare providers (HPs) in ED as similar to, or higher than that experienced by police and firefighters, making the injury rate of HPs in ED higher than the national U.S. average of all occupations (Maguire, O'Niell, & Brightwell, 2017; Maguire & Smith, 2013). Given the extremely high prevalence of WPV occurring in ED, Study 2 should be replicated there. Given the findings of this dissertation that most commonly WPV occurs in the front desk/reception area, combined with previous research findings that WPV most often occurs in the first hour of a patient visit (Crilly et al., 2014), future trainings in ED should target front desk staff the most.

A third future direction for this research is to assess training effectiveness using objective measures of success. Figure 1 shows the conceptual model including many outcomes of importance. Many of those outcomes were not tested in this dissertation due to organizational limitations. Namely times security was called, absenteeism data from the organization, restraint use, antipsychotic drug use and underreporting of WPV were not tested in this dissertation. Many of these outcomes would be data that is obtained from the organization, and not self-report in nature as this dissertation is. Having these types of outcomes by which to assess the training over time would be compelling and should be explored in future research. Similarly, future work should test the entirety of the model in non-healthcare contexts where the client is the perpetrator of violence to the staff person. Perhaps police-citizen interactions where citizens as the client become aggressive may benefit from CAT training to prevent violence in that arena (For an overview of accommodation and law enforcement, see Giles, Willemyns, Gallois, & Anderson, 2007).

A final future direction is a focus on emotion management and expression. Staff in Study 2 reported venting to one another about their feelings of frustration and annoyance

after experiences of WPV. Judging by the severity of some of the experiences of WPV, like threats or acts of physical violence, staff likely also feel anger and fear. Thus, in healthcare, emotional expressions as a CAT strategy merits special attention in future research. Supporting this notion, many medical residency programs are training primary care physicians in emotional intelligence which includes emotion management and emotional expression as a vital process with patients. Early theoretical work on emotional expression framed by CAT was proposed by Williams, Giles, Coupland, Dalby, and Manasse (1990) considering how providing emotional support is associated with positive health outcomes. Later, Watson and Gallois (1998, 1999, 2002) drew researcher's attention to emotional expressions strategy in healthcare delivery. Results of this dissertation show that managing patient aggression requires healthcare staff to manage their own emotions, and those of the patient while communicating with the patient.

This dual management of emotion, or double-faced emotion management, is "highlight likely in high stress emergency jobs where the client is experiencing strong emotions" (Tracy & Tracy, 1998, p. 407). The management of emotions in this way requires emotional labor. Emotional labor occurs when a worker experiences a mismatch between the emotion that they should display and the emotion that they genuinely feel due to trying to accomplish some interaction goal (e.g., provide good service to get a better tip; Mann, 2004). The labor or management component is when the worker conceals or alters their genuine emotion in favor of the more appropriate emotion to display as dictated by the context. For example, while attempting to simultaneously calm down a patient and provide patient centered care, a staff member may feel genuinely afraid or even upset when a patient is aggressive and showing cues of becoming violent. The staff member may engage in

emotional labor or emotion management by concealing feelings of fear and anger and instead display calm and empathetic cues to the patient.

Previous research has noted that emotion management is both a vital skill to people in the counselling or guidance professions and can also be a substantial source of work stress (Mann, 2004). In addition, emotional labor can be associated with burnout. Burnout includes feelings of being worn out by work, becoming depersonalized and negative when responding to others, and a decreased sense of personal accomplishment associated with work (Maslach, 1982). When emotional labor is considered by employees to be part a valid part of the job (good faith), workers experience less burnout than when they feel it should not be part of their job (bad faith; Rafaeli & Sutton, 1987). Previous research in healthcare has shown that many nurses in ED and mental health departments consider managing WPV to just be part of the job, suggesting a good faith orientation toward emotional labor. However, Tracy and Tracy (1998) show that it can be hard to disentangle good faith from bad faith emotional faking, due to employee norms and reinforcement of organizationally mandating emotions. This occurs such that workers may adopt a faking in good faith position as they are encouraged by fellow employees and organizational policy to do so. Future research should probe what norms staff enforce from the organization regarding appropriate ways to engage in double-faced emotion management and how staff feelings of obligation to engage in emotion management are associated with stress and burnout.

Previous research has recognized communicative ways that staff engage in emotional labor. Tracy and Tracy (1998) for example, identified seven strategies that 911 dispatchers used to engage in double-faced emotion management. Double-faced emotion management is the management of both a speaker's identity and emotions, while simultaneously

encouraging positive face and emotions for the other communicator. Engaging in double-faced emotion management is similar to a dyadic notion of communication competence, with a special focus on emotions. Strategies for double-faced emotion management have included ways that 911-dispatch employees took some control in the scenario in an otherwise powerless-feeling situation such as giving advice to the caller and upping the call's priority for police dispatch. Other ways that staff rely on each other as highlighted by previous research about frontline employees in health clinics are talking with one another in the backstage (Harrison, Smith, Greenwell, & Stephens, 2018).

There are many ways that healthcare staff may engage in emotion management. For example, when studying nurses, Hayward and Tuckey (2011) found that nurses used nine main strategies to manage emotions. One strategy, enduring across most scenarios, was the maintenance of emotional boundaries between themselves and the patient. Nurses described this as the extent to which they "let their guard down" with the patient. In addition, staff who are able to discuss experiences with one another, and even find humor in them, experience their job as less stressful (Tracy & Tracy, 1998). Future research should consider what communicative practices healthcare staff use to cope with their own feelings experienced during aggressive patient interactions.

Conclusion

Despite previous work recognizing that communication trainings can increase knowledge gain and attitude shifts thereby producing favorable results, changes on these types of variables may be insufficient. Indeed, Price and Baker (2012) comment that studies including interventions for HPs in handling patient aggression in various departments show that, despite staff confidence or knowledge increasing, actual violent incidences do not

decrease. Outcomes of interest associated with handling aggressive patients already explained above such as lower staff stress at work, higher job satisfaction, and higher self-efficacy are crucial to improving the lives and work of staff in healthcare. However, these outcomes may not reflect an actual improvement for the overall department and patient care. A truly successful training on handling patient aggression must also consider objective changes shown to be associated with experiences of WPV such as absenteeism, security calls, use of antipsychotic drugs and restraint use.

In general, if staff can communicate in ways that demonstrate the clinic is a safe environment, and that they are there to assist the patient, HPs should benefit in that their job can be a safer and more satisfying place, filled with less violence (Petit, 2005). In the setting of this dissertation, instances of WPV remained very low following the training and staff reports of patient cooperation in Study 2 increased following the training and sustained the change over a three-month period. Not only is ability to manage patient aggression beneficial in these ways for the healthcare staff, but patients benefit as well from better, more appropriately accommodated care where staff make efforts to understand their underlying concerns and help solve them.

Incoming editor to the flagship journal, *Communication Monographs,* Schrodt distinguished between great and simply good scholarship. I contend that in what was taught to staff, written in reports, conversed about with the organizational leadership personnel, and formally written into this dissertation adheres, modestly, to the standards by which Schrodt (2020) determines research to be "great". Schrodt (2020, p. 1) asserts that "good research addresses thoughtful questions, whereas great research addresses thought-provoking questions" that foreground the communication that answers the "so what?" of the inquiry.

Throughout the years of work on this dissertation, I focused on the "So what?" by constantly asking, "What communication strategies *work* to prevent WPV?" Second, Schrodt (2020) argues that great research advances theory, whereas good research only references it. In the pursuit of answering the "so what?" of this dissertation, not only did results show that accommodation works, but also results advance theory such that they refine Principles of CAT and push its research further into applied, intervention work for developing intergroup competence.

Third, Schrodt (2020) argues that great research uses the right method *well,* as opposed to good research using the right method just generally. This dissertation undertook complex methods including interventions, and longitudinal mixed-methods in an applied context with the goal of providing rich results and using mixed-methods to its full potential for helping to solve wicked problems, like WPV in healthcare. Fourth, Schrodt (2020, p. 4) states that "good research produces new findings, whereas great research produces newsworthy findings" such that the research has social applications beyond the advancement of knowledge. This dissertation uncovers much information about the nature and context of WPV in Central California and provides information sufficient for developing future effective trainings for keeping WPV low in the region. Fifth, Schrodt (2020) stated that great research is written for relatively broad and global audiences rather than a narrow and specialized audience. Although healthcare may seem narrow and specialized, this research has broader implications for patients as well, which all people have presumably been. Results of this dissertation also have potential for adaptation and replication in other settings where WPV is client perpetrated.

There is one final finding from this dissertation that merits special attention. Watson (2019), in an invited Memorial Lecture, urged researchers to celebrate what the healthcare staff do well when conducting research. One of the reasons why access can be difficult to negotiate in healthcare is due to mistrust of the researcher, or a perception that the researcher will come and point out everything that they are doing wrong. Instead, it is crucial that researchers also celebrate the strengths of the staff as they complete their studies. Staff at the organizations in Study 1 and Study 2 were already delivering excellent patient care with goals and attitudes that positioned them to competently accommodate patients and experience very little WPV. One participant, while tearing up, said to me in an interview conducted beyond the scope of this dissertation that this training helped them, and that they realized that the research team was there to help when they said the following regarding the training:

> Like um, just reminders, you know? Or, you know, just little things to teach us again and I think with the course that we had and the little interview that we're having here just kind of reminds you of all these things, you know? And it's just like, "Yeah, you're here to do a job, but you're here also to help. And enjoy it." (DOL8824, Medical Administration)

This participant recognized the research team goal of helping staff to grow in their abilities to manage challenging interactions with patients and was grateful. In showing participants that the purpose of the research was to help improve their work life and safety and asking for their input about what goes well already for them and their colleagues, I developed a trust with participants that has encouraged positive change in their lives and organization.

References

Abdi, H. (2007) Bonferroni and Sidak corrections for multiple comparisons. In Salkind, N.J. (Ed.) *Encyclopedia of Measurement and Statistics* (pp. 103-107) Thousand Oaks: Sage.

Afifi, W. A., & Afifi, T. D. (2009). Avoidance among adolescents in conversations about their parents' relationship: Applying the theory of motivated information management. *Journal of Social and Personal Relationships*, *26*, 488-511.

Argyle, M. (1969, 2017). *Social interaction: Processes and products.* New York, NY: Routledge.

Arnold, E. C. & Boggs, K. U. (2016). *Interpersonal relationships: Professional communication skills for nurses.* St. Louis, Missouri: Elsevier, Inc.

Baker, S. C., & Watson, B. M. (2015). How patients perceive their doctors' communication: Implications for patient willingness to communicate. *Journal of Language and Social Psychology,* 34, 621-639.

Baker, S. C., Gallois, C., Driedger, S. M., & Santesso, N. (2011). Communication accommodation and managing musculoskeletal disorders: Doctors' and patients' perspectives. *Health Communication*, *26*, 379-388.

Beech, B., & Leather, P. (2006). Workplace violence in the health care sector: A review of staff training and integration of training evaluation models. *Aggression and Violent Behaviour, 11,* 27-43.

Bell, A. (1984). Language style as audience design. *Language in Society, 13,* 145-204.

Benveniste, K. A., Hibbert, P. D., & Runciman, W. B. (2005). Violence in health care: The contribution of the Australian Patient Safety Foundation to incident monitoring and analysis. *Medical Journal of Australia, 183*, 348-351.

Berkowitz, L. (1989). Frustration-aggression hypothesis: Examination and reformulation. *Psychological Bulletin, 106,* 59-73.

Bernhold, Q. S., & Giles, H. (2019). Older adults' recalled memorable messages about aging and their associations with successful aging. *Human Communication Research, 45,* 474-507.

Bernhold, Q. S., & Giles, H. (2020) Vocal Accommodation and Mimicry. *Journal of Nonverbal Behavior*, *44*, 41-62.

Blank, C. A., & Mascitti-Mazur, J. E. (1991). Violence in Philadelphia emergency departments reflects national trends. *Journal of Emergency Nursing, 17,* 316-321.

Boggs, C. & Giles, H. (1999). "The canary in the colemine": The nonaccommodation cycle in the gendered workplace. *International Journal of Applied Linguistics, 9,* 223-245.

Bucholtz, M., & Du Bois, J. W. (2020, March 5). *Representing discourse*. *Resources for the representation of linguistic interaction.* http://transcription.projects.linguistics.ucsb.edu/representing

Bunting, P. J., Fulde, G. W., & Forster, S. L. (2007). Comparison of crystalline methamphetamine ("ice") users and other patients with toxicology-related problems presenting to a hospital emergency department. *Medical Journal of Australia, 187*, 564-56

Burgoon, J. K., & Hubbard, A. E. (2005). Cross-cultural and intercultural applications of expectancy violations theory and interaction adaptation theory. In W. B. Gudykunst

(Ed.) *Theorizing about intercultural communication,* (pp. 149-171). Thousand Oaks, CA: Sage.

Burleson, B. R., Albrecht, T. L., & Sarason, I. G. (Eds.). (1994). *Communication of social support: Messages, interactions, relationships, and community*. Thousand Oaks, CA: Sage.

Byrne, D. (Ed.). (1971). *The attraction paradigm.* New York, NY: Academic Press.

Cappella, J. N., & Greene, J. O. (1982). A discrepancy-arousal explanation of mutual influence in expressive behavior for adult and infant-adult interaction. *Communication Monographs*, *49*, 89-114.

Carrard, V., & Mast, M. S. (2015). Physician behavioral adaptability: A model to outstrip a "one size fits all" approach. *Patient Education and Counseling, 98,* 1243-1247.

Castro, A., & Mineo, E. R. (2019). *Reducing prejudices with stories: The role of transformative roleplay and immersiveness*. Presented at the EASP Meeting on Intergroup Communication. Bologna, Italy.

Caughlin, J. P. (2010). A multiple goals theory of personal relationships: Conceptual integration and program overview. *Journal of Social and Personal Relationships, 27*, 824-848.

Chambers, N. (1998). We have to put up with it-don't we? *Journal of Advanced Nursing, 27,* 429-436.

Chan, E. W., Taylor, D. M., Knott, J. C., Liew, D., & Kong, D. C. M. (2012). The pharmacoeconomics of managing acute agitation in the emergency department: What do we know and how do we approach it? *Expert Review of Pharmacoeconomics and Outcomes Research, 12*, 589-595.

Chartrand, T. L., & Van Baaren, R. (2009). Human mimicry. *Advances in Experimental Social Psychology*, *41*, 219-274.

Chevalier, B. A., Watson, B. M., & Barras, M. A. (2020). Assessing communication behaviours of hospital pharmacists: How well do the perspectives of pharmacists, patients, and an independent observer align? *Journal of Language and Social Psychology.* Advance online: doi:10.1177/0261927X20909867

Chevalier, B., Watson, B., & Cottrell, N. (2018). *Pharmacy student self-reported attitudes, beliefs, and behaviours about communicating with patients: Impact of theory-based communication tutorials.* Presented at the 16th International Conference of Language and Social Psychology. Edmonton, Canada.

Chevalier, B., Watson, B., Falconer, N., & Cottrell, N. (2017). Educating pharmacy students to speak with patients about their medications - a novel use of CAT. Presented at *International Symposium on Intergroup Communication*, Thessaloniki, Greece.

Chi, R., & Suthers, D. (2015). Assessing intercultural communication competence as a relational construct using social network analysis. *International Journal of Intercultural Relations*, *48*, 108-119.

Clark, H. H., & Krych, M. A. (2004). Speaking while monitoring addressees for understanding. *Journal of Memory and Language*, *50*, 62-81.

Coburn, V. A., & Mycyk, M. B. (2009). Physical and chemical restraints. *Emergency Medicine Clinics of North America, 27*, 655-667.

Colaner, C. W., Soliz, J., & Nelson, L. R. (2014). Communicatively managing religious identity difference in parent-child relationships: The role of accommodative and nonaccommodative communication. *Journal of Family Communication, 14*, 310-327.

Coupland, N. (2007). *Style: Language variation and identity.* Cambridge, UK: Cambridge University Press.

Coupland, N., Wiemann, J. M., & Giles, H. (1991). Talk as "problem" and communication as miscommunication": An integrative analysis. In N. Coupland, H. Giles & J. M. Wiemann (Eds.), *Miscommunication and problematic talk.* (pp. 1-17). Newbury Park, CA: Sage.

Cowin, L., Davies, R., Estall, G., Berlin, T., Fitzgerald, M., & Hoot, S. (2003). De-escalating aggression and violence in the mental health setting. *International Journal of Mental Health Nursing, 12*, 64–73.

Crano, W. D., & Prislin, R. (2006). Attitudes and persuasion. *Annual Review of Psychology*, *57*, 345-374.

Crilly, J. Chaboyer, W., & Creed, D. (2004). Violence towards emergency department nurses by patients. *International Emergency Nursing, 12,* 67-73.

Cronauer, C. K., & Mast, M. M. (2014). Hostile sexist male patients and female doctors: A challenging encounter. *The Patient: Patient-centered Outcomes Research, 7,* 37-45.

Cupach, W.R., Spitzberg, B.H., 1983. Trait versus state: a comparison of dispositional and situational measures of interpersonal communication competence. *Western Journal of Speech Communication 47,* 364–379.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behavior*, *20*, 43-63.

Dragojevic, M., Gasiorek, J., & Giles, H. (2016). Accommodative strategies as core of the theory. In H. Giles (Ed.), *Communication accommodation theory; Negotiating*

personal relationships and social identities across contexts (pp. 36-59). Cambridge, UK: Cambridge University Press.

Dragojevic, M., & Giles, H. (2014). Language and interpersonal communication: Their intergroup dynamics. In C. Berger (Ed.), *Handbook of interpersonal communication*, (pp. 29-51). Berlin, Germany: De Gruyter Mouton.

Dutta, M. J. (2008). Culture as praxis. In M. J. Dutta (Ed.), *Communicating health.* Polity Press.

Duxbury, J. (2003). Testing a new tool: The Management of Aggression and Violence Attitude Scale (MAVAS). *Nurse Researcher, 10*, 596-606.

Epperly, T., Bechtel, C., Sweeney, R., Greiner, A., Grumbach, K., Schilz, J, Stream, G., & O'Connor, M. (2019). The shared principles of primary care: A multi-stakeholder initiative to find a common voice. *Family Medicine, 51,* 179-184.

Erickson, L., & William-Evans, S. A. (2000). Attitudes of emergency nurses regarding patient assaults. *Journal of Emergency Nursing, 26,* 201-215.

Farzadnia, S., & Giles, H. (2015). Patient-provider interaction: A communication accommodation theory perspective. *International Journal of Society, Culture, and Language, 3,* 17-34.

Feinstein, R. E. (2014). Violence prevention education program for psychiatric outpatient departments. *Academic Psychiatry, 38*, 639-646.

Fida, R., Tramontano, C., Paciello, M., Guglielmetti, C., Gilardi, S., Probst, T. M., & Barbaranelli, C. (2018). 'First, do no harm': The role of negative emotions and moral disengagement in understanding the relationship between workplace aggression and misbehavior. *Frontiers in Psychology*, *9*, 1-17.

Field, A. (2013). *Discovering statistics using IBM SPSS statistics*, 4th ed. Thousand Oaks: Sage.

Frazier, E. R., Liu, G. C., & Dauk, K. L. (2014). Creating a safe place for pediatric care: A no hit zone. *Hospital Pediatrics, 4*, 247-250.

Friedman, R. A. (2006). Violence and mental illness-how strong is the link? *New England Journal of Medicine, 355,* 2064-2066.

Gallois, C. (2015). Intergroup accommodative processes. In W. Donsbach. (Ed.), *The International Encyclopedia of Communication* (pp. 1-5). New York, NY: Blackwell/Wiley.

Gallois, C. (2019). *Intergroup communication in health: War, welfare, writing.* Presented at the European Association of Social Psychology meeting on Intergroup Communication. Bologna, Italy.

Gallois, C., & Callan, V. J. (1991). Interethnic accommodation: The role of norms. In H. Giles, J. Coupland, & N. Coupland (Eds.), *Contexts of accommodation: Developments in applied sociolinguistics* (pp. 245-269). Cambridge, New York: Cambridge University Press.

Gallois, C., & Giles, H. (2015). Communication accommodation theory. In K. Tracy (Ed.), *Encyclopedia of language and social interaction* (pp. 159-176). New York: Blackwell/Wiley.

Gallois, C., Gasiorek, J., Giles, H., & Soliz, J. (2016). Communication accommodation theory: Integrations and new framework developments. In H. Giles (Ed.), *Communication accommodation theory; Negotiating personal relationships and*

social identities across contexts (pp. 36-59). Cambridge, UK: Cambridge University Press.

Gallois, C., Ogay, T., & Giles, H., (2005). Communication accommodation theory: A look back and a look ahead. In W. Gudykunst (Ed.), *Theorizing about intercultural communication* (pp. 121-148). Thousand Oaks, CA: Sage.

Gallois, C., Weatherall, A., & Giles, H. (2016). CAT and talk in action. In H. Giles (Ed.), *Communication accommodation theory; Negotiating personal relationships and social identities across contexts* (pp. 105-122). Cambridge, UK: Cambridge University Press.

Gardner-Chloros, P. (2009). Sociolinguitic factors in code-switching. In B. E. Bullock & A. J. Toribio (Eds.), *The handbook of code-switching. Cambridge handbooks in language and linguistics* (pp. 97-113). Cambridge, UK: Cambridge University Press.

Gasiorek, J. (2013). "I was impolite to her because that's how she was to me": Perceptions of motive and young adults' communicative responses to underaccommodation. *Western Journal of Communication*, *77*, 604-624.

Gasiorek, J. (2016). Theoretical perspectives on interpersonal adjustments in language and communication. In H. Giles (Ed.), *Communication accommodation theory; Negotiating personal relationships and social identities across contexts* (pp. 13-35). Cambridge, UK: Cambridge University Press.

Gasiorek, J., & Dragojevic, M. (2019). The effects of speaker group membership and stereotypes on responses to accumulated underaccommodation. *Journal of Language and Social Psychology, 38,* 514-522.

Gasiorek, J., & Giles, H. (2012). Effects of inferred motive on evaluations of nonaccommodative communication. *Human Communication Research, 38,* 309-332.

Gasiorek, J., Van de Poel, K., & Blockmans, I. (2015). What do you do when you can't accommodate? Managing and evaluating problematic interactions in a multilingual medical environment. *Language & Communication, 41,* 84-88.

Gerdtz, M. F., Daniel, C., Dearie, V., Prematunga, R., Bamert, M., & Duxbury, J. (2013). The outcome of a rapid training program on nurses' attitudes regarding the prevention of aggression in emergency departments: A multi-site evaluation. *International Journal of Nursing Studies, 50*, 1434-1445.

Giles, H. (Ed.). (2016). *Communication accommodation theory: Negotiating personal relationships and social identities across contexts*. Cambridge, UK: Cambridge University Press.

Giles, H., Mulac, A., Bradac, J. J., & Johnson, P. (1987). Speech accommodation theory: The first decade and beyond. In M. McLaughlin (Ed.), *Communication Yearbook, 10,* (pp. 13-48). Newbury Park, CA: Sage.

Giles, H., Willemyns, M., Gallois, C., & Anderson, M. C. (2007). Accommodating a new frontier: The context of law enforcement. In K. Fiedler (Ed.), *Social communication* (pp. 129–162). New York, NY: Psychology Press.

Giles, M., Pines, R., Giles, H., & Gardikiotis, A. (2018). Toward a communication model of intergroup interdependence. *Atlantic Journal of Communication*, *26*, 122-130.

Gillespie, G. L., Gates, D. M., Miller, M., & Howard, P. K. (2012). Emergency department workers' perceptions of security officers' effectiveness during violent events. *Work, 42*, 21-27.

Gillies, D., & O'Brien, L. (2006). Interpersonal violence and mental illness: A literature review. *Contemporary Nursing, 21,* 277-286.

Gudykunst, W. B. (2005). An anxiety/uncertainty management (AUM) theory of effective communication: Making the mesh of the net finer. In W. B. Gudykunst (ed.), *Theorizing about intercultural communication* (pp. 281-322). Thousand Oaks, CA: Sage.

Guzley, R. M., Dunbar, N. E., & Hamel, S. A. (2002). Telehealth, managed care, and patient-physician communication: Twenty-first century interface. In W. B. Gudykunst (26), *Communication Yearbook*, Mahwah, New Jersey: Lawrence Erlbaum.

Harrison, M. A., Smith, W. R., Greenwell, M. R., & Stephens, K. K. (2018). Frontline employees in the health clinic: Impression management multiplexing when performing in-the-round. *Communication Monographs, 85,* 309-330.

Hastings, S. E., Suter, E., Bloom, J., & Sharma K. (2016). Introduction of a team-based care model in a general medical unit. *BMC Health Services Research, 16*, 245-256.

Hayward, R. M., & Tuckey, M. R. (2011). Emotions in uniform: How nurses regulate emotion at work via emotional boundaries. *Human Relations, 64,* 1501-1523.

Hemsley, B., Baladin, S., & Worral, L. (2012). Nursing the patient with complex communication needs: Time as a barrier and a facilitator to successful communication in hospital. *Journal of Advanced Nursing, 68,* 116-126.

Hewett, D. G., Watson, B. M., Gallois, C., Ward, M., & Leggett, B. A. (2009). Intergroup communication between hospital doctors: Implications for quality of patient care. *Social Science & Medicine.* 69, 1732-1740.

Hislop, E., & Melby, V. (2003). The lived experience of violence in accident and emergency. *Accident and Emergency Nursing, 11,* 5-11.

Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling.* Berkeley, CA: University of California Press.

Hodge, A. N., & Marshall, A. P. (2007). Violence and aggression in the emergency department: A critical care perspective. *Australian critical care: Official Journal of the Confederation of Australian Critical Care Nurses, 20*, 61-67.

Hogg, M. A., Terry, D. J., & White, K. M. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly*, *58*, 255-269.

International Labor Office, International Council of Nurses, World Health Organization, &Public Services International (2002). *Framework guidelines for addressing workplace violence in the health sector*. Geneva, 2002. Retrieved from: http://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf

Ireland, M. E., & Pennebaker, J. W. (2010). Language style matching in writing: Synchrony in essays, correspondence, and poetry. *Journal of Personality and Social Psychology*, *99*, 549-571.

Ireland, M. E., Slatcher, R. B., Eastwick, P. W., Scissors, L. E., Finkel, E. J., & Pennebaker, J. W. (2011). Language style matching predicts relationship initiation and stability. *Psychological Science*, *22*, 39-44.

Jin, Y., & Watson, B. M. (2020). Playback: An investigation of the discursive implications and the pragmatic functions of repetition in traditional Chinese medical consultations.

Journal of Language and Social Psychology. Advanced online: doi:10.1177/0261927X20908614

Johnson, M. E., & Hauser, P. M. (2001). The practices of expert psychiatric nurses: Accompanying the patient to a calmer personal space. *Issues in Mental Health Nursing, 22*, 651–668.

Kahn, D., Lescz, M., O'Campo, P., Hwang, S. W., Wasylenki, D. A., Kurdyak, P., Harris, D. W., Gozdzik, A., & Stergiopoulos, V. (2016). Integrating care for frequent users of emergency departments: Implementation evaluation of a brief multi-organizational intensive case management intervention. *BMC Health Service Research, 16,* 156-164.

Kane, B., & Sands, D. Z. (1998). Guidelines for the clinical use of electronic mail with patients. *Journal of the American Medical Informatics Association*, *5*, 104–111.

Kinkle, S. L. (1993). Violence in the ED: How to stop it before it starts. *American Journal of Nursing, 93,* 22-24.

Laposa, J. M., Alden, L. E., & Fullerton, L. M. (2003). Work stress and post-traumatic stress disorder in ED nurses/personnel. *Journal of Emergency Nursing, 29,* 23-28.

Lavoie, F. W., Carter, G. L., Danzl, D. F., & Berg, R. L. (1988). Emergency department violence in United States teaching hospitals. *Annals of Emergency Medicine, 11,* 1227-1233.

Legacé, M., Tanguay, A., Lavallée, M. L., Laplante, J., & Robichaud, S. (2012). The silent impact of ageist communication in long term care facilities: Elders' perspectives on quality of life and coping strategies. *Journal of Aging Studies, 26,* 335-342.

Lincoln, M. A., & McAllister, L. L. (1993). Peer learning in clinical education. *Medical Teacher, 15,* 1-17.

Lowery, R. L. C. (2011). *Development and validation of the Crowell-Lowery multicultural training reactance scale (CL-MTRS).* (Doctoral dissertation). Retrieved from ProQuest. (UMI No. 3490562)

Lyneham, J. (2000). Violence in New South Wales emergency departments. *Australian Journal of Advanced Nursing, 18,* 8-17.

Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions and willingness to help. *British Journal of Clinical Psychology*, *44*, 255-267.

Maguire, B. J., O'Neill, B. J., & Brightwell, R. (2017). Violence against emergency medical services personnel: A systematic review of the literature. *American Journal of Industrial Medicine, 61,* 167-180.

Maguire, B. J., & Smith, S. (2013). Injuries and fatalities among emergency medical technicians and paramedics in the United States. *Prehospital and Disaster Medicine*, *28*, 376-382.

Mann, S. (2004). 'People-work': Emotion management, stress and coping. *British Journal of Guidance & Counseling, 32,* 205-221. doi:10.1080/0369880410001692247

Marcum, J. A. (2014). Caring for patients during challenging clinical encounters. *Journal of evaluation in Clinical Practice: International Journal of Public Health Policy and Health Services Research, 21,* 404-409.

Martini, A., Fantini, S., D'Ovidio, M. C., Ceracchi, A., & De Santis, A. (2012). Risk assessment of aggression toward emergency health care workers. *Occupational Medicine, 62,* 223-225.

Maslach, C. (1982). *Burnout: The cost of caring.* Englewood Cliffs, NJ: Prentice-Hall.

Mauchly, J. W. (1940). Significance test for sphericity of a normal n-variate distribution. *The Annals of Mathematical Statistics, 11,* 204-209.

May, D. D., & Grubbs, L. M. (2002). The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical center. *Journal of Emergency Nursing*, *28*, 11-17.

Mayhew, C., & Chappell, D. (2005). Violence in the workplace. *The Medical Journal of Australia*, *183*, 346-347.

Mayring, P. (2004). Qualitative Content Analysis. In U. Flick, E. von Kardorff, & I. Steinke (Eds.) *A Companion to Qualitative Research,* (pp. 266-270). Thousand Oaks, CA: Sage.

McCabe, C., & Timmins, F. (2013). *Communication Skills for Nursing Practice*. (2nd Ed.). New York, NY: Palgrave Macmillan.

McNeil, K. A., Mitchell, R. J., & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review*, *22*, 291-307.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd Ed.). Thousand Oaks, CA: Sage.

Miller, V. D., & Jablin, F. M. (1991). Information seeking during organizational entry: Influences, tactics, and a model of the process. *The Academy of Management Review, 16,* 92-120.

Myers, P., Giles, H., Reid, S. A., & Nabi, R. (2008). Law enforcement encounters: The effects of officer accommodativeness and crime severity on interpersonal attributions are mediated by intergroup sensitivity. *Communication Studies, 59*, 1-15.

National Alliance on Mental Illness (2003). *Community leaders identify mental health system as one of most overburdened community resources; Consequences include stressed emergency medical and education systems*. Retrieved from https://www.nami.org/Press-Media/Press-Releases/2003/Community-Leaders-Identify-Mental-Health-System-As

National Institute for Clinical Excellence (NICE). (2005). *Clinical practice guidelines for the violence: The short term management of disturbed/violent behavior in psychiatric in-patient settings and emergency departments.* (NCC-NSD Publication No. 22/02/05).

Newman-Norlund, S. E., Noordzij, M. L., Newman-Norlund, R. D., Volman, I. A., De Ruiter, J. P., Hagoort, P., & Toni, I. (2009). Recipient design in tacit communication. *Cognition*, *111*, 46-54. doi:10.1016/j.cognition.2008.12.004

Perrone, S. (1999). Violence in the Workplace. A.I.C. *Research and Public Policy Series. No 22*: Canberra, Australia.

Petit, J. R. (2005). Management of the acutely violent patient. *Psychiatric Clinics of North America, 28,* 701-711.

Pich, J., Hazelton, M., Sundin, D., & Kable, A. (2010). Patient-related violence against emergency department nurses. *Nursing and Health Sciences, 12,* 268-274.

Pittam, J. & Gallois, C. (1999). Negotiating a working consensus: Conversations about HIV and AIDS. *International Journal of Applied Linguistics, 9,* 207-222.

Pitts, M. J., & Harwood, J. (2015). Communication accommodation competence: The nature and nurture of accommodative resources across the lifespan. *Language and Communication, 41,* 89-99.

Price, O., & Baker, J. (2012). Key components of de-escalation techniques: A thematic synthesis. *International Journal of Mental Health Nursing, 21*, 310-319.

Rafaeli, A., & Sutton, R. I. (1987). Expression of emotion as part of the work role. *Academy of Management Review, 12,* 23-37.

Reeder, G. D. (2009). Mindreading: Judgments about intentionality and motives in dispositional inference. *Psychological Inquiry, 20,* 1–18.

Richter, D., Needham, I., & Kunz, S. (2007). The effects of aggression management training for mental health care and disability staff: A systematic review. *Psychiatrische Praxis, 34*, 7–14.

Roberton, T., Daffern, M., Thomas, S., & Martin, T. (2012). De-escalation and limit-setting in forensic mental health units. *Journal of Forensic Nursing, 8*, 94-101.

Organization blinded (2017). Organization 2016 tax returns. Retrieved from https://sbclinics.org/wp-content/uploads/2018/07/sbnc-990-ending-june-30-2017.pdf

Schrodt, P. (2020). What is the bar? Differentiating good from great communication scholarship, *Communication Monographs, 87*, 1-3,

Soliz, J., & Bergquist, G. (2016). Methods of CAT inquiry: Quantitative studies. In H. Giles (Ed.), *Communication accommodation theory; Negotiating personal relationships and social identities across contexts* (pp. 36-59). Cambridge, UK: Cambridge University Press.

Soliz, J., & Giles, H. (2014). Relational and identity processes in communication: A contextual and meta-analytical review of Communication Accommodation Theory. In E. Cohen (Ed.), *Communication Yearbook, 38*, (pp. 106-143). Thousand Oaks, CA: Sage

Soliz, J., Thorson, A. R., & Rittenour, C. E. (2009). Communicative correlates of satisfaction, family identity, and group salience in multiracial/ethnic families. *Journal of Marriage and Family, 71*, 819-832.

Stamps, P. L., Piedmont, E. B., Slavitt, D. B., & Haase, A. M. (1978). Measurement of work satisfaction among health professionals. *Medical Care*, 337-352.

Street, R. L. (2003). Interpersonal communication skills in health care contexts. In J. O. Greene & B. R. Burleson (Eds.), *Handbook of communication and social interaction skills* (pp. 909-933). Mahwah, New Jersey: Lawrence Erlbaum.

Sully, P. & Dallas, J. (2005). *Essential communication skills for nursing*. New York, NY: Elsevier Mosby.

Sutton, R. M., Niles, D., Meaney, P. A., Aplenc, R., French, B., Abella, A. S., Lengetti, E. L., Berg, R. A., Helfaer, M. A., & Nadkami, V. (2011). "Booster" training: Evaluation of instructor-led bedside cardiopulmonary resuscitation skill training and automated corrective feedback to improve cardiopulmonary resuscitation compliance of pediatric basic life support providers during simulated cardiac arrest. *Pediatric Critical Care Medicine, 12,* e116-e121.

Tajfel, H. (1978). The achievement of group differentiation. In H. Tajfel (Ed.), *Differentiation between social groups: Studies in the social psychology of intergroup relations* (pp. 77-98). London, UK: Academic Press.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worshel & W. Austin (Eds.), *The psychology of intergroup relations* (pp. 7-24). Chicago, IL: Nelson-Hall.

Teh, J. L. (2014). *Depression explanatory models of primary care patients and doctors: Relationship with self-stigma, communication effectiveness, and recovery.* Unpublished doctoral dissertation. University of Queensland, Australia.

Thakerar, J.N., Giles, H. & Cheshire, J. (1982). The psychological and linguistic parameters of speech accommodation theory. In C. Fraser & K. R. Scherer (Eds.), *Advances in the social psychology of language* (pp. 205-255). Cambridge, UK: Cambridge University Press.

Thomsen, O. N, & Brier, S. (2014). Total integrative evolutionary communication: Towards a cybersemiotic discourse pragmatics. *Public Journal of Semiotics, 6,* 22-57.

Tishler, C. L., Reiss, N. S., & Dundas, J. (2013). The assessment and management of the violent patient in critical hospital settings. *General Hospital Psychiatry, 35,* 181-185.

Tracy, S. J., & Tracy, K. (1998). Emotion labor at 911: A case study and theoretical critique. *Journal of Applied Communication Research, 26,* 390–411.

Vatne, S., & Fagermoen, M. S. (2007). To correct and to acknowledge: Two simultaneous and conflicting perspectives of limit-setting in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 14*, 41–48.

Vatne, S., & Holmes, C. (2006). Limit setting in mental health: Historical factors and suggestions as to its rationale. *Journal of Psychiatric and Mental Health Nursing, 13*, 588–597.

Watson, B. M. (2019). Good and bad in healthcare communication – Forget the consequences, let's explore antecedents. Presented at the 16th. Annual Bradac Memorial Lecture at University of California, Santa Barbara.

Watson, B. M., & Gallois, C. (1998). Nurturing communication by health professionals toward patients: A communication accommodation theory approach. *Health Communication, 10,* 343-355.

Watson, B. M., & Gallois, C. (1999). Communication accommodation between patients and health professionals: Themes and strategies in satisfying and unsatisfying encounters. *International Journal of Applied Linguistics, 9,* 167-184.

Watson, B. M., & Gallois, C. (2002). Patients' interactions with health providers: A linguistic category model approach. *Journal of Language and Social Psychology, 21,* 32-52.

Watson, B. M., Heatley, M. L., Gallois, C., & Kruske, G. (2016). The importance of effective communication in interprofessional practice: perspectives of maternity clinicians, *Health Communication, 31*, 400-407.

Watson, B. M., Hewett, D. G., & Gallois, C. (2012). Intergroup communication and health care. In H. Giles (Ed.), *The Handbook of Intergroup Communication.* New York, NY; Routledge.

Watson, B. M., Jones, L., & Hewett, D. G. (2016). Accommodating health. In H. Giles (Ed.), *Communication accommodation theory: Negotiating personal relationships and social identities across contexts* (pp. 152-168). Cambridge, UK: Cambridge University Press.

Watson, B. M., Manias, E., Geddes, F., Della, P., & Jones, D. (2015). An analysis of clinical handover miscommunication using a language and social psychology approach. *Journal of Language and Social Psychology, 34,* 687-701.

Watson, B. M., Zhang, Y. B., Gasiorek, J., Dragojevic, M., Pines, R., Imamura, M., Pitts, M., & Stewart, C. (2018) International association of language and social psychology

panel: The role of language in communication research. Presented at the 68th. Annual Conference of the International Communication Association. Prague, Czech Republic.

Watson, B., & Soliz, J. (2019). Communication accommodation theory in institutional settings: Opportunities for applied research. In J. Harwood, J. Gasiorek, H. Pierson, J. F. Nussbaum, & C. Gallois (Eds.), *Language, communication, and intergroup relations: A celebration of the scholarship of Howard Giles*. New York, NY: Routledge.

Wiemann, J. M. (1977). Explication and test of a model of communicative competence. *Human Communication Research, 3,* 195-213.

Wilson, S. (2019). Interpersonal accommodation and multiple goals frameworks. In J. Harwood, J. Gasiorek, H. D. Pierson, J. F. Nussbaum, & C. Gallois (Eds.), *Language, communication, and intergroup relations: A celebration of the scholarship of Howard Giles* (pp. 217-219). New York, NY: Routledge.

Williams, A. (1999). Communication accommodation theory and miscommunication: Issues of awareness and communication dilemmas. *International Journal of Applied Linguistics*, *9*, 151-165.

Williams, A., Giles, H., Coupland, N., Dalby, M., & Manasse, H. (1990). The communicative contexts of elderly social support and health: A theoretical model. *Health Communication*, *2*, 123-143.

Williams, K. N., (2006). Improving outcomes of nursing home interactions. *Research in Nursing & Health, 29,* 121-133.

Yum, Y. (2004). Culture and self-construal as predictors of responses to accommodative

dilemmas in dating relationship. *Journal of Social and Personal Relationships, 21,* 817-835.

Zhang, Y. B., & Pitts, M. J. (2019). Interpersonal accommodation. In J. Harwood, J. Gasiorek, H. D. Pierson, J. F. Nussbaum, & C. Gallois (Eds.), *Language, communication, and intergroup relations: A celebration of the scholarship of Howard Giles* (pp. 217-219). New York, NY: Routledge.

Appendix A

Respect and Care: Affordable Care Act 1557 Training Long Term Evaluation

1. In each of the consent sections below, please indicate "Agree" if you understand and agree to participate, or "Disagree" if you do not wish to participate.

Purpose of this Research Study:
You have been asked to participate in a research study because you have recently participated in the "Respect and Care" training about implementing new questions in the registration questionnaire as mandated by the Affordable Care Act 1557. Rachyl Pines, one of the facilitators from that training is engaged in a study to assess the effectiveness of the training you received, especially in regards to the de-escalation practice portion of the study. This data will also serve as a portion of Rachyl Pines' PhD dissertation research at UCSB about communicating with aggressive patients more generally.

- Agree
- Disagree

*2. **Study Procedures**:
If you agree to participate in this study, you will be asked to do the following: fill out a survey with a combination of closed and open-ended questions. The survey should take you about 10-15 minutes. By marking your consent on this form, you are also indicating your approval of the use of feedback you provided the day of your "Respect and Care" training to be used as part of the research data. You will complete this survey during normal work hours. There is no compensation for your participation in this study. All staff who attended a "Respect and Care" training (approximately160-200) will be invited to participate in this study.

- Agree
- Disagree

*3. **Participation in Research is Voluntary**:
You are free to decline to participate or to discontinue participation in the study at any time without any penalty or loss of benefits to which you may otherwise be entitled. There are no penalties if you want to change your mind. If you no longer wish to participate in this research project, you may contact (call or text) Rachyl Pines at (760) 275-3224. If you are opting out of the study, please choose "Disagree"

- Agree
- Disagree

*4. **Payment or Reimbursement**:
You will not be paid to participate in this study. w

- Agree
- Disagree

*5. **Confidentiality and Risks**:
Study related records will be held in confidence. Your consent to participate in this study includes consent for the investigators to review all of the study related documents as may be necessary for purposes of this study. Your study-related information may also be inspected by governmental agencies such as the Food and Drug Administration and the Cottage Health Institutional Review Board (CH IRB; a committee for the protection of research participants). Representatives from these groups may inspect your health information for study monitoring and/or auditing purposes, while maintaining your health information as confidential to the extent required by law. There is no physical risk to you by participating in this study, however some of the questions about your experiences asked about in this study may make you feel uncomfortable.

Confidentiality of your responses will be maintained in any research reports or publications. If publications result, your name will not be used and you will not be identifiable in any way. Instead, a pseudonym or number assigned to your responses will be used that does not link to you in any identifiable way. The investigator is required by law to retain your research-related data for six years.

- Agree
- Disagree

*6. **Consent**:
Participation in research is voluntary. By continuing onto the questionnaire, you are indicating that you have decided to participate as a research subject in the study described above. If you would like any additional information regarding your rights as a research subject, you may contact the Institutional Review Board at (805) 324-9255. w

- Agree
- Disagree

Thank you for agreeing to participate in this study. Below, you will answer questions regarding your experience interacting with aggressive patients. There will be several demographic questions, closed-ended questions and open ended questions. Your responses will help inform future trainings for healthcare staff on communicating with aggressive patients.

7. Which departments do you work in? w

** Participants were given a list of departments to choose from at the community hospital in central California where this study took place. Those options have been removed for confidentiality..**

8. How long have you worked at this hospital? (Please respond in number of months) w

9. Are you: w

- Part-time
  - Full-time
  - Per diem
- Other (please specify)

10. Please choose the response that best describes your gender identity:

- a. Woman
- b. Man
- c. Transgender Female (Male-to-Female)
- d. Transgender Male (Female-to-Male)
- e. Non-Binary
- f. Other
- g. Rather Not Say

11. Please enter your age: w

12. Have you participated in a limit-setting or de-escalation course other than "Respect and Care" before?

- Yes at this hospital
- Yes elsewhere
- No

In response to feelings stressed from work, to what extent do you agree with the following statements (13-18):

13. I have reduced my work hours in the past year.

Strongly Disagree Disagree Neutral Agree Strongly Agree

14. I have sought help outside of the organization's professionals for dealing with your stress reaction.

Strongly Disagree Disagree Neutral Agree Strongly Agree

15. I have sought internal services as help for dealing with my stress reaction. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

16. I have felt adequately supported by my immediate hospital administration. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

17. I believed the incident affected my ability to maintain the previous level of function/interaction with coworkers. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

18. I have considered changing jobs. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

19. I would describe my confidence level regarding asking the new questions on the intake form as: w

Not at all confident Not confident Neutral Confident Extremely confident

20. I am able to ask an aggressive patient what they are upset about. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

21. When patients are aggressive, I can validate their feelings. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

22. I can communicate with an aggressive patient to de-escalate the interaction. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

23. I am able to communicate with an aggressive patient and complete my job. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

24. I feel like what I do at my job is important. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

25. I am satisfied with the working conditions here. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

26. I think I could do a better job if I didn't have so much to do all the time. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

27. My fellow staff members pitch in and help one another out when things get in a rush.
Strongly Disagree Disagree Neutral Agree Strongly Agree

28. I am satisfied with the types of activities that I do at my job. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

29. What are aggressive patients like?
w
30. Please describe how you think patient aggression (e.g., verbal, nonverbal, or physical) should be handled.

For the following questions, work place violence is defined as "any incidents where staff are abused, threatened or assaulted in circumstances relating to their work…involving an explicit or implicit challenge to their safety, well-being or health" (Mayhew & Chappell, 2005, p. 346).

31. How many experiences of work place violence have you experienced since the Respect and Care training? Please describe what happened in the most memorable of these interactions. Try to include quotations of things you and the patient said to one another, and the way you and the patient both communicated using body language.

32. Please list as many de-escalation or limit-setting strategies you have used since the training. Please also note which ones may be new strategies you have developed from the training by placing an * next to the strategy like this " make eye contact*". w

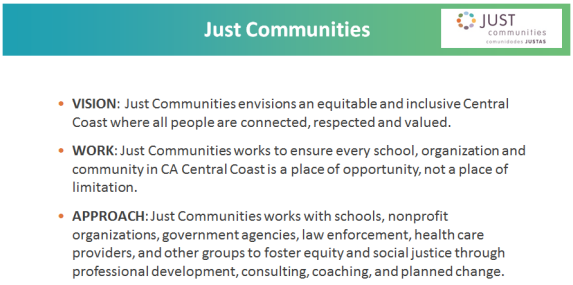
33. Which de-escalation or limit setting strategies listed in question 34 have you found to be the most effective in achieving patient cooperation?

Appendix B

Materials Used for Respect & Care Class

Facilitators

- **Jarrod Schwartz,**
  Executive Director, Just Communities
- **Dolan**
  Facilitator, Just Communities
- **Rachyl Pines,**
  Facilitator, Just Communities / UCSB
- **Hospital Staff**
  Spiritual Care, Organizational Development, Customer Care



Communication Goals

- Keep it Real: be honest, and Keep it here: what is said it here stays here and what is learned here leaves here.

Why Is This Important

Here participants were shown the mission statement for the hospital and their patients-first policy, not included in this document for confidentiality.

Who do we serve now and in the future?

Recent Demographics 2015

Groups	US	CA	SB County
People of color	36%	59%	**54%**
American Indian/Native American	1%	>1%	**>1%**
Asian/Pacific Islander	6%	13%	**5%**
Black/African American	13%	6%	**2%**
Latino/Hispanic	16%	39%	**46%**
White	62%	38%	**44%**
Bi-racial/Multi-racial	3%	3%	**2%**

Projected Demographics 2040

Groups	US	CA	SB County
People of color	45%	65%	↑ **64%**
American Indian/Native American	1%	>1%	**>1%**
Asian/Pacific Islander	5%	14%	↑ **7%**
Black/African American	12%	5%	**2%**
Latino/Hispanic	27%	45%	↑ **54%**
White	52%	32%	**34%** ↓
Bi-racial/Multi-racial	3%	4%	↑ **3%**

Health Disparity vs Health Equity

- **Health** and **health care disparities** refer to differences in **health** and **health care** between population groups.
- "**Health disparity**," generally refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group..
- **Health Equity**...ensuring access and quality care to all regardless of race, religion, language, sexual orientation, gender identity, income, or any other individual characteristic.

Can you identify examples of health inequities or scenarios involving a health disparity?

Cottage Health

Statistics Activity

JUST communities

Learning about HEALTH INEQUITIES...

Please read the Statistics Worksheet and select the statistic that affects, surprises, concerns, or interests you the most.

Discuss the one you selected and why you selected it with the others at your table.

Health Disparities Worksheet from Just Communities

Instructions: Please read through all of the health disparity statistics and findings. Place an "X" next to the one that most stands out to you, affects you, intrigues you, concerns you, or produces some kind of response inside of you. Be prepared to speak with others about why you chose the one you chose.

Disparities exist consistently • Across a wide range of disease areas and services • Across a range of clinical settings (e.g. public and private hospitals, teaching and non-teaching hospitals, etc.) • Even when access-related factors such insurance status and income are controlled • Even when clinical factors are taken into account (e.g. stage of disease presentation, co- morbidities, age, and severity of disease) • Associated with higher mortality among minorities (Source: *Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care*, Institute of Medicine, 2002)
Mexican Americans received 38% fewer medications than whites, ***even after adjusting for clinical and demographic characteristics***. Mexican Americans were less likely to receive almost all major medications, especially • antiarrhythmics, • anticoagulants, • and lipid-lowering therapy. (Source: *Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care*, Institute of Medicine, 2002)
"African American women are three to four times more likely to die from childbirth than non-Hispanic white women, and ***socioeconomic status, education, and other factors do not protect against this disparity***. Instead, sexism and racism are primary drivers." (Source: *The Healthcare System and Racial Disparities in Maternal Mortality,* Center For American Progress, 2018)
In a study based on actual clinical encounters, *van Ryn* and *Burke* (2000) found that doctors rated black patients as: • less intelligent • less educated • more likely to abuse drugs and alcohol • more likely to fail to comply with medical advice • more likely to lack social support • and less likely to participate in cardiac rehabilitation than white patients, ***even after patients' income, education, and personality characteristics were taken into account.*** (Source: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Institute of Medicine, 2002)

1528 Chapala Street, Suite 308 Santa Barbara, CA 93101 tel: 805.966.2063 fax: 805.246.1566 e: info@just-communities.org

"More than 886,000 deaths could have been prevented from 1991 to 2000 if African Americans had received the same care as whites. That means five times as many lives can be saved by correcting the disparities [in care between whites and blacks] than in developing new treatments." (Source: Dying for Basic Care, The Washington Post, 2004)
"Disparities in quality of care are not getting smaller. Over time, the gap between Whites and African Americans, Hispanics, Asians, and American Indians/Alaskan Natives has either remained the same or worsened for more than half of the core quality measures being tracked." (Source: Eliminating Racial/Ethnic Disparities in Healthcare: What are the Options?, Kaiser Family Foundation, 2018)
"Black and Latino adults are less likely to rely on a private physician for their medical care than White adults (62% and 44% vs. 77%)." (Source: Eliminating Racial/Ethnic Disparities in Healthcare: What are the Options? Kaiser Family Foundation, 2018)
More than 100 studies -- most published since 2000 -- document the effects of racial discrimination on physical health. Some link blood pressure to recollected encounters with bigotry. Others record the cardiovascular reactions of volunteers subjected to racist imagery in a lab. Racism, other research suggests, acts as a classic chronic stressor, setting off the same physiological consequences as job strain or marital conflict: higher blood pressure, elevated heart rate, increases in the stress hormone cortisol, suppressed immunity. Chronic stress is also known to encourage unhealthy behaviors, such as smoking and eating too much, that themselves raise the risk of disease. (Source: The Boston Globe, How Racism Hurts -Literally, 2007)
Latinx & Black patients seen in emergency departments receive less pain medication than White patients — all other factors being equal. (Source: EurekAlert, 2015)
White people are more likely to receive expensive and potentially lifesaving tests and treatments than Black & Hispanic people suffering from the same symptoms. (Source: Heins et al. 2006)
Enacted & anticipated stigma resulted in approximately 40% increase in delaying urgent & preventive care in a sample of 2,578 transgender men. Note: anticipated stigma begins with front-desk interactions, where a host of misgendering systems hit the transgender client hard. (Source: Reisner, Sari L., et al. Substance use to cope with stigma in healthcare among US female-to-male transmasculine adults. LGBT health 2.4 (2015): 324-332
50% of transgender patients reported having to teach their medical providers about transgender care. (Source: National Transgender Discrimination Survey Report on Health and Health Care, 2010
Bisexual people report higher rates of hypertension, higher rates of depression, anxiety, suicidal ideation and eating disorders when compared to gays and lesbians. (Source: San Francisco Human Rights Commission. Bisexual Invisibility: Impact and Recommendations. San Francisco: Author, 2011)
Lesbians and bisexual women less likely to get preventive screenings for cancer. (Source: Cochran SD, Mays VM, Bowen D, et al. Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. Am J Public Health. 2001;91(4):591 597
LGBT populations across-the-board have highest rates of tobacco, alcohol, and other drug use. (Source: 2015 National Survey on Drug Use and Health)

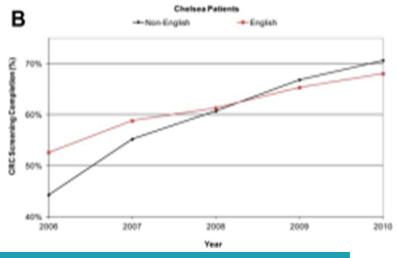
When does health equity happen?

Health equity happens when hospitals engage in the following:

- Collect patient level demographic data
- Identify and report inequities in care
- Implement solutions to reduce inequities

PROVE IT…

Evidence that collecting demographic data makes a difference…



- Patients are willing to share this information
- Demographic data collection has been occurring for years in US, Australia, and UK
- Collection of demographic data has led to well-documented positive changes in health care planning and delivery
- Collection is about sensitively, respectfully and genuinely asking key questions for the right reasons

Why do we want to collect patient demographic data?

- To identify who we are serving
- To ensure care and treatment responds to individual needs
- To make sure we know how to refer to people in ways that respect who they are
- To analyze criteria such as re-admission rates, incidence of diabetes, who participates in cancer screening, etc.
- To develop evidence-based quality improvements for reducing health inequities
- Collecting this information is part of legal and accreditation requirements

Current Questions

- What is your legal name?
- What is your date of birth?
- Since your spoken language preference is _____, please allow us to get a qualified interpreter for you at no cost.
- What type of housing do you live in?
- What is your address?
- What racial group best describes you?
- What do you consider your ethnicity?
- What is your religious or spiritual affiliation?
- Are there any special needs that we should consider during your hospital stay?
- Do you currently have difficulty hearing or use any assistive device for hearing?
- Do you currently have difficulty with your eyesight or do you currently use any assistive devices for seeing?
- What sex were you assigned on your birth certificate?
- Are you married?

New Questions

- What name would you like to be called?
- What language are you most comfortable using to speak with your healthcare provider? *(preferred language)*
- What language do you prefer for reading healthcare information?
- What is your legal sex?
- Do you want your care team to be aware of how you identify your gender? *If so, what gender do you identify yourself as?*
- Do you want your care team to be aware of your sexual orientation? *If so, how would you identify your sexual orientation?*
- What pronouns would you like us to use when speaking with or about you?
  - Him
  - Her
  - Them
  - Name
  - Other
  - Decline to Answer/Unknown

Improving Patients' Comfort Level

Patients feel more comfortable answering questions if they believe:

- The questions come from a place of concern
- The data serves a positive and valuable purpose
- Their care will not be negatively impacted
- They are not required to provide the information

Pre-empt, allow for, and address discomfort.

Some patients are likely to have experienced discrimination and harassment and may be reluctant to answer these questions at all. Be patient, be compassionate, understand that a allowing the patient to decline may actually build trust for the next encounter.

Developing a Common Language
Understanding the Identities & Terminology Behind the Questions
Race vs. Ethnicity :Questions 8 – 9

Race vs. Ethnicity (Practical)

- **Race** refers to a person's physical characteristics, such as bone structure and skin, hair, or eye color.
  e.g. brown, white, or black skin
- **Ethnicity**, refers to cultural factors, including nationality, regional culture, ancestry, and language.
  e.g. Chinese-American, German-American, "_____-American"

Race vs. Ethnicity (Practical)

- Biologically speaking, there is no such thing as race.
- It has become a political and social reality.
- People have varying levels of understanding of the concept, history, etc.
- But many people use it as an identifier.
- Some people don't and reject the concept altogether.
- Some Latinx people will define both their race and ethnicity as Latinx

Disability - Questions 11 – 13

American Disability Act (ADA)

A person with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activity…

- Sensory
- Motor/Movement
- Speech
- Cognitive
- Psychiatric
- Conditions such as diabetes/cancer/asthma

Anyone can become a person with a disability any time!

Disability Factoids

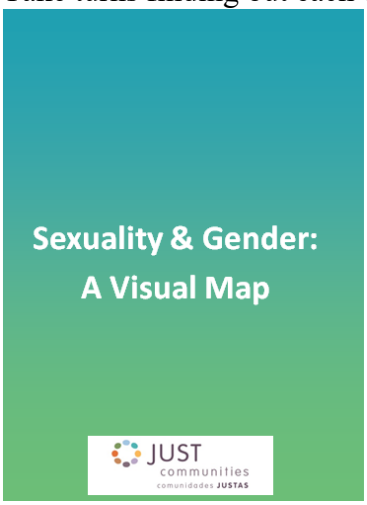
- All disabilities are covered by the ADA
- 20% of the population have a disability
- Not all disabilities are visible to others
- Communication must be equally effective for people with or without disabilities
- Auxiliary aids and services promote effective communication and/or mobility

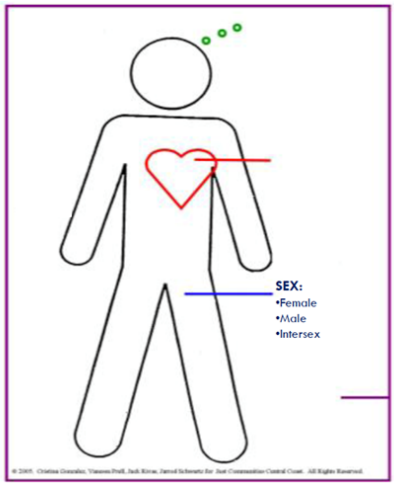
Examples of Auxiliary Aids you Might Enter into Free Text if "Other" is selected:

- Qualified Note taker
- Video Remote Interpreting (VRI)
- Qualified Reader
- Written Material
- Audio recording
- Magnification Software
- Open/Closed Captioning
- Braille
- Oral Interpreter/Tactile Interpreter
- Screen readers
- Large Print Assistive Listening system or devices
- Sip & Puff controls
- Telephone handset amplifiers
- Anything that helps a person do something they couldn't otherwise do

Developing a Common Language
Sexuality & Gender : Questions 14 – 18

Find a partner at your table.
Take turns finding out each other's favorite childhood toy or game

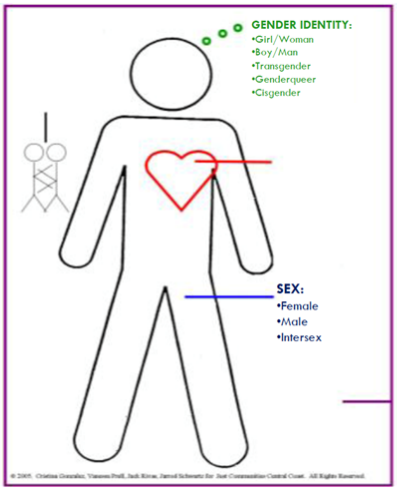




Sex: (assigned at birth)
The assigned identifier of biological criteria based on anatomical observation, chromosomes (DNA), and hormones.

- Female
- Male
- Intersex

Sexuality & Gender: A Visual Map



JUST communities comunidades JUSTAS

Gender / Gender Identity

An individual's internal sense of being a woman/girl, man/boy, or an identity other than woman/girl, man/boy.

Since gender identity is internal, one's gender is not necessarily visible to others.

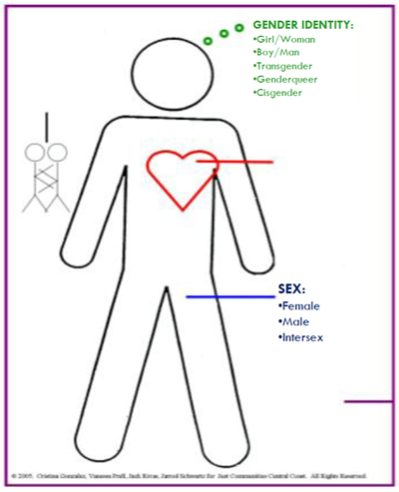
JUST communities comunidades JUSTAS

You can't tell genderjust by looking at a person

Gender vs. Sex

JUST communities comunidades JUSTAS

Sexuality & Gender: A Visual Map



Transgender	A term used to describe a person whose gender identity, expression, or behavior is different from those typically associated with the sex assigned at birth
Cisgender	A term used to describe a person whose birth sex matches their current gender identity: • CisWoman • CisMan • CisgenderPeople

Cisgender & Transgender

CIS-

- A prefix from Latin meaning on the nearside of; on this side of
- Cis = on the same side of:
  - Cisatlantic
  - Cisgender

TRANS-

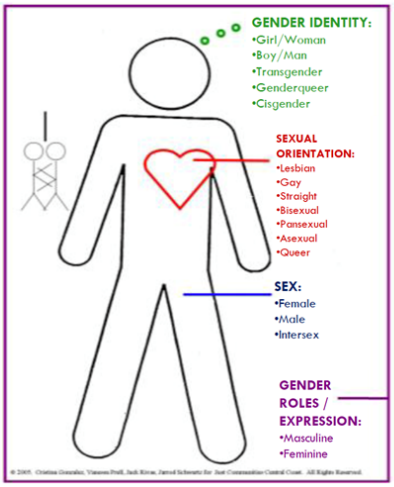
- A prefix from Latin meaning across, beyond, through, changing thoroughly
- Trans = across:
  - Transatlantic
  - Transgender

+ (ever-evolving language)

Agender	Neither	Trans Woman
Androgyne	Neutrois	Transfeminine
Androgynous	Non-Binary	Transgender
Bigender	Other	Transgender Male
Female to Male	Pangender	Transgender Man
FTM	Trans	Transgender Person
Gender Fluid	Trans*	Transgender Female
Gender	Trans Female	Transgender Woman
Nonconforming	Trans* Female	Transmasculine
Gender Questioning	Trans Male	Transsexual
Gender Variant	Trans* Male	Transsexual Female
Genderqueer	Trans Man	Transsexual Male
Intersex (sic)	Trans* Man	Transsexual Person
Male to Female	Trans Person	Transsexual Woman
MTF	Trans* Person	Two-Spirit

Sexuality & Gender: A Visual Map

JUST communities comunidades JUSTAS



The ABC's of Sexual Orientation, Gender Identity & Sex

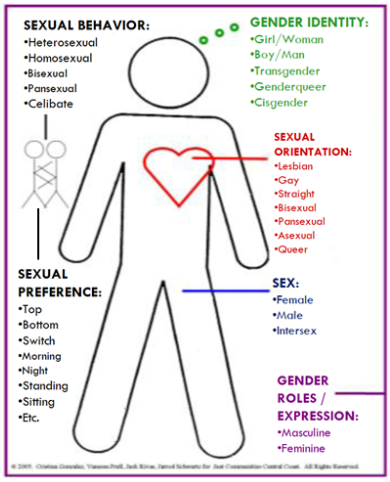
Sexual Orientation	Gender Identity	Sex
Lesbian	Transgender	Intersex
Gay	Gender Queer	Female
Bisexual	Genderfluid	Male
Queer	Gender Nonconforming	
Asexual	Nonbinary	
+ ...	+...	
Heterosexual/Straight	Cisgender	

L G B T Q I A + JUST communities comunidades JUSTAS

About the Word "Queer"

- Historically – a derogatory term.
- As an oppressed group, LGBTQ people reclaimed the word to use as a term of empowerment as opposed to a term of degradation.
- In some contemporary circles, it's become a term that is inclusive of gay, lesbian, bisexual, pansexual, transgender, intersex, genderqueer and asexual peoples.
- While widely accepted in academic circles, it's not readily accepted by the community as a whole, and still may be offensive to some.

Sexuality & Gender: A Visual Map



Putting it all together…

- ***Sex*** = *the parts you're born with*
- ***Sexual Orientation*** = who you partner with
- ***Gender Identity*** = who you are
- ***Gender Roles / Expression*** = how you dress / act
- ***Sexual Behavior*** = what you do with your partner
- **Sexual Preference** = how you like to do it

GROUP TALK

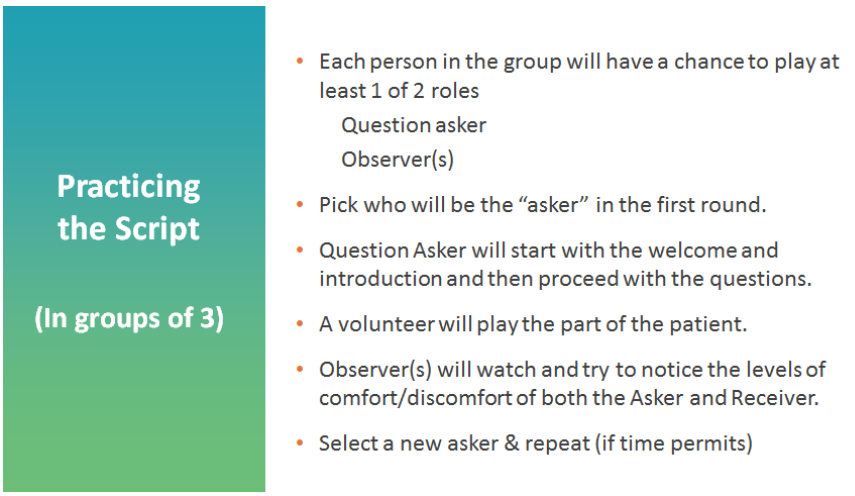
- What's your understanding of the difference between sex, gender, sexual orientation, and sexual behavior?
- What questions or additional knowledge do you have related to the terms and identities?
- Is there anything from the Visual Map that is interesting or helpful for your understanding?

- Are you thinking about any terms or identities differently than before this discussion?
- What questions do you still have?

Putting Things Together

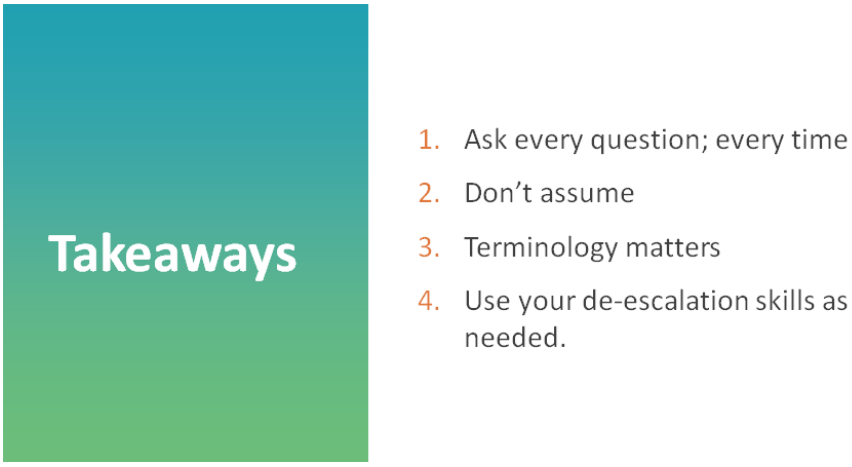
Tools

- Responding to Patients' Questions
- Patient Pamphlet



Asking the Questions:: Observation Round and Debrief
(Jarrod as angry patient and Rachyl as staff model the intake process)

- How did it feel?
- What did you notice?
- Did any questions / challenges come up?



Appendix C

Pre-Training Survey

Thank you for agreeing to participate in this study. There will be several demographic questions, closed and open-ended questions.

In order to link your data today with your post-training survey answers today and about a month from now, you will create an identification code, so that we can link your answers across surveys WITHOUT connecting your answers to your name. Your answers will be kept confidential.

This code is meant to keep your answers anonymous, so that no one will know how you personally responded.

To create your ID code, please write the first three letters of your mother's name AND the last four numbers of your cell phone number: _____.

Example: If your mother's first name is Maria, and your telephone number is 805-987-1234, your identification code would be: mar1234

Demographic questions:

1. Circle which type of department you work in? (choose one)w

   Medical Administration
   Medical Delivery
   Dental Administration
   Dentistry
   Insurance
   Home care

2. How long have you worked at the clinic? (Please respond in number of months) w

3. Are you: w
   - ○ Part-time
   - ○ Full-time
   - ○ Per diem
   - ○ Other (please specify) _____

4. Gender identity:
   - ○ Woman
   - ○ Man
   - ○ Non-Binary

Rather Not Say

5. Please write your age in years: w

6. Have you participated in a limit-setting or de-escalation course before?

Yes
- No

Closed-ended questions – please circle the response option that best represents your level of agreement with the following statements:

In response to feelings stressed from work, to what extent do you agree with the following statements:

7. I have reduced my work hours in the past year.
Strongly Disagree Disagree Neutral Agree Strongly Agree

8. I have sought help outside of the clinic professionals for dealing with my stress.
Strongly Disagree Disagree Neutral Agree Strongly Agree

9. I have sought internal the clinic services as help for dealing with my stress. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

10. I believe an aggressive patient incident has affected my ability to maintain my previous level of function/interaction with coworkers. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

11. I have considered changing jobs. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

12. I am able to ask an aggressive patient what they are upset about. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

13. When patients are aggressive, I can validate their feelings. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

14. I can communicate with an aggressive patient to de-escalate the interaction. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

15. I am able to communicate with an aggressive patient and complete my job. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

16. I feel like what I do at my job is important. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

17. I am satisfied with the working conditions here at my job. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

18. My fellow staff members pitch in and help one another out when things get in a rush.
Strongly Disagree Disagree Neutral Agree Strongly Agree

19. I am satisfied with the types of activities that I do at my job. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

20. When a patient is aggressive, it is an attack on me personally.
Strongly Disagree Disagree Neutral Agree Strongly Agree

21. When a patient is aggressive, it is an attack on healthcare professionals generally.
Strongly Disagree Disagree Neutral Agree Strongly Agree

22. When a patient is aggressive, it is an attack on the hospital.
Strongly Disagree Disagree Neutral Agree Strongly Agree

23. Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence
Strongly Disagree Disagree Neutral Agree Strongly Agree

24. It is usually situations that contribute towards the expression of aggression by patients
Strongly Disagree Disagree Neutral Agree Strongly Agree

25. There appear to be types of patients who frequently become aggressive towards staff
Strongly Disagree Disagree Neutral Agree Strongly Agree

26. Patients commonly become aggressive because staff do not listen to them
Strongly Disagree Disagree Neutral Agree Strongly Agree

27. Patient aggression can be understandable.
Strongly Disagree Disagree Neutral Agree Strongly Agree

28. When a patient is aggressive, I am usually able to make the patient comply with my task enough to complete my job tasks.
Strongly Disagree Disagree Neutral Agree Strongly Agree

Open ended questions

For the following questions, work place violence is defined as "any incidents where staff are abused, threatened or assaulted in circumstances relating to their work…involving an explicit or implicit challenge to their safety, well-being or health" (Mayhew & Chappell, 2005, p. 346).

29. With that in mind, how many experiences of work place violence have you experienced? Please describe what happened in the most memorable of these interactions. Try to include quotations of things you and the patient said to one another, and the way you and the patient both communicated using body language.

The following questions have to do with normative practices in your department and your interactions with your peers. Please respond with your work department environment in mind.

30. What role if any, do you play in fostering an environment where patients do or do not become aggressive?

31. What do you talk about with your peers during work regarding your department experiencing aggressive patients?
    Do you give your peers any advice about how to handle it? If so what advice?

Please Enter your ID Code: _____

Communication Assessment Tool – Role Play #1
As you observe the role play, please rate the following statements to indicate your level of agreement with each one.
For example, for the statement "The staff member allowed the patient enough time in their conversation to ask any questions they had.":

- If you feel they had enough time to hear the information given to them by the staff member and ask questions throughout the conversation, you might choose "Slightly Agree", "Agree" or "Strongly Agree" depending on how strongly you feel.
- If you feel that the conversation was too rushed and the patient did not have enough time to ask questions, you might choose an option in the "Disagree" side depending on how strongly you feel. If you are unsure about this, you might choose "Neutral".

1. The staff member made sure they matched the patient's way of speaking by adjusting their own speech rate or volume – so the patient could understand what they were saying.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

2. The staff member avoided the use of medical terms that the patient wouldn't understand.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

3. The staff member paid attention to and listened to issues raised by the patient.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

4. The staff member allowed the patient enough time to ask questions.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

5. The staff member allowed the patient to interrupt them with any questions they had.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

6. The staff member demonstrated that they thought the patient's worries/concerns were important.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

7. The staff member spoke to the patient in a respectful and courteous manner.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

8. The staff member made changes to the way they spoke to patient - to match the patient's manner of speaking – more casually or formally based on the patient's personality.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

Open-Ended:
What skills did you see the person use to manage the situation?

Appendix D

Post-Training Survey

Please enter your ID code: _____

Closed-ended questions – please circle the response option that best represents your level of agreement with the following statements:

1. I am able to ask an aggressive patient what they are upset about. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

2. When patients are aggressive, I can validate their feelings. W
   Strongly Disagree Disagree Neutral Agree Strongly Agree

3. I can communicate with an aggressive patient to de-escalate the interaction. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

4. I am able to communicate with an aggressive patient and complete my job. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

5. When a patient is aggressive, it is an attack on me personally.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

6. When a patient is aggressive, it is an attack on healthcare professionals generally.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

7. When a patient is aggressive, it is an attack on the hospital.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

8. Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence
   Strongly Disagree Disagree Neutral Agree Strongly Agree

9. It is usually situations that contribute towards the expression of aggression by patients
   Strongly Disagree Disagree Neutral Agree Strongly Agree

10. Patients who are aggressive towards staff should try to control their feelings
    Strongly Disagree Disagree Neutral Agree Strongly Agree

11. There appear to be types of patients who frequently become aggressive towards staff
    Strongly Disagree Disagree Neutral Agree Strongly Agree

12. Patients commonly become aggressive because staff do not listen to them
    Strongly Disagree Disagree Neutral Agree Strongly Agree

13. Patient aggression can be understandable.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

14. When a patient is aggressive, I am usually able to make the patient comply with my task enough to complete my job tasks.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

Open ended questions

15. What contexts come to mind when you think of conversations you've had with aggressive patients?

    a. Where do they occur?

    b. What time of day do they occur?

    c. Is it usually a weekday or a weekend day?

16. How long-lasting do you think the skills you have learned today will be?

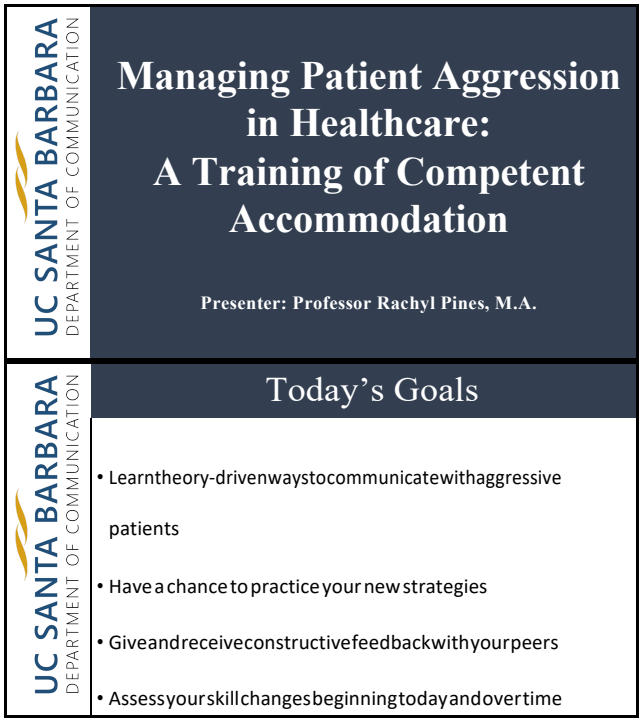
For the following question, please respond with your work department environment in mind.

17. What role, if any, do you play in fostering an environment where patients do or do not become aggressive?

If you are willing and interested in participating in a brief follow up *interview* at a later date, please write your email address here: _____
** Your email address will not be linked with your individual survey responses

Appendix E

Slides Used in the Training Course for Study 2 on June 11, 2019



UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Why this is Important

- Experiencing patient aggression, or work place violence perpetrated by patients is associated with
  - Higher stress atwork
  - Higher turnover
  - Higher absenteeism
  - Less workplacesatisfaction
  - Less self-esteem and self-efficacy

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Research Explanation

- **Purpose of this Research Study:** This training aims to improve management of patient aggression by increasing and improving strategies for healthcare professionals to communicate with aggressivepatients.
- **Benefits and Risks:** There is minimal to no risk involved in participating in this study. However, answering some of the questions may make you feel uneasy as I will be asking you to consider and recall your experiences communicating with aggressive patients. You will benefit from this study by gaining and subsequently reflecting on new skills learned in the training.
- **Confidentiality:** Absolute confidentiality cannot be guaranteed, since research documents are not protected from subpoena. Confidentiality of your responses will be maintained by using your study number as an identifier in any research reports or publications. All data obtained from participants will be kept in password protected files.
- **Right to Refuse or Withdraw:** You are free to decline to participate or to discontinue participation in the study at any time without any penalty if you want to change your mind.
- **Additional Information:** If you have any questions about this research study, please contact Rachyl Pines at (760) 275-3224. If you have any questions regarding your rights and participation as a research participant, you can contact the Human Subjects Committee at (805) 893-3807 or hsc@research.ucsb.edu. Or write to the University of California, Human Subjects Committee, Office of Research, Santa Barbara, CA 93106-2050.

Ifyouagreetoparticipate,pleasesigntheconsentformatyourtablenow

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Survey Time! (8-10 mins) "Pre-Training Survey"

For the next 8-10 minutes,
please fill out the survey at your table

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Give it a Try – Role Play Round 1 (5 min)

- **At yourtables:**
  - Choose one person to be the person working
  - A volunteer will play the part of the patient
  - The rest of you will observe
  - Workingthroughanormalworkconversationyouwouldhavewithapatient, talk with the volunteer at your table.
- **Observers:** Fill in the communication assessment tool

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Types of Patient Who Perpetrate Aggression

- Any patient could become aggressive/violent.
- The aggression is not personal – it isn't about you.
- The way we talk to them could prevent it, or lessen the intensity
- The cause may not be the patient, but the cause could be the nature of the interaction with the patient.

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Problems with Communication

- There are many reasons that good communication can be blocked with patients:
  - Differences in power
  - Personal agendas
  - Fear of 'loss of face'
  - Job position

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Indicators of Possible Patient Aggression: Things to look for

- Confusion
- Irritability
- Boisterousness
- Physical and verbal threats
- Attacking objects
- Provocative behavior
- Angry demeanor
- Pacing
- Loud speech
- Tense posture
- Frequent changes in body position

(Hodge & Marshal, 2007, pp. 63)

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Communication Accommodation Theory

People adapt their words and body language to seem either similar or dissimilar to the person they're interacting with, depending on whether or not they consider that person an ingroup member.

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Communication Accommodation Theory

- **Aggression Management Accommodation Strategies (I-IDEA)**
  - Interpersonal Control
  - Interpretability
  - Discourse Management
  - Emotional Expression
  - Approximation
- **Practice**:
  - In the following videos – which strategy is the character(s) failing to implement appropriately?
  - How does the receiver respond?

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

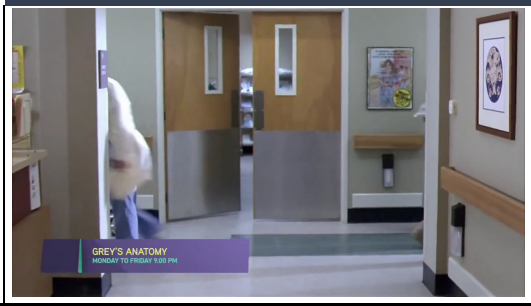
Which strategy did he fail at?

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Which strategy is she explaining?

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Which strategy are they failing at?



UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

What De-escalating Patient Aggression Looks Like

- provide adequate personal space
- use open body language
- speak in a low and calm tone of voice
- use open-ended sentences
- avoid punitive or threatening language

(Roberton et al., 2012, p. 97)
(National Institute for Clinical Excellence, 2005, p. 188)

- manage others in the environment
- explain what you intend to do
- give clear, brief, and assertive instructions
- ask for facts about the problem
- encourage reasoning
- ensure that nonverbal communication is nonthreatening and nonprovocative

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Give it a Try – Role Play Round 2 (5 min)

- **At your tables:**
  - Choose a different person to be the person working
  - A new volunteer will play the part of the patient
  - The rest of you will observe
  - Working through a normal work conversation you would have with a patient, talk with the volunteer at your table.
- **Observers:** Fill in the communication assessment tool:

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Survey Time!
"Post-Training Survey"

For the next 8 minutes,
please fill out the survey at your table.

UC SANTA BARBARA
DEPARTMENT OF COMMUNICATION

Thank you!
Questions?

Rachyl Pines – rpines@ucsb.edu

Scenarios Given to Aggressive Patient Volunteers

Director/MD/MA Table - narcotic pain medication seeking patient

Who You Are: You have been living at your friend's place for a while because you've had a rough time with money lately, and your friend said you could crash on the couch for a little while. You used to be addicted to heroin, but you've been clean for 10 years now and you're damn proud of that. A few months ago, you were working a construction job trying to make some money, and you hurt your shoulder but didn't have insurance, so you just took some of your friend's narcotic pain meds and you got hooked again.

The Situation: You are visiting the doctor because you want more pain medication. You know your shoulder is better, but you definitely aren't going to let them know that and you aren't planning to leave there until you get some meds. The doctor asks you what brings you in today and you tell them:

"Look, I hurt my shoulder and I'm in a lot of pain here." (you wince and maybe let out a groan)
Doctor says something about taking a look and you say,
"No way you're coming anywhere near my shoulder, it hurts too bad."
The staff person say something about not being able to help you then.
"Well I think some strong pain meds would really do the trick."
The staff person offers you other services – maybe refer to an x-ray or MRI or a cortisone shot.
You get upset because you realize this isn't going to be as easy as you thought. So, you get angry and you raise your voice and say,
"Just give me some damn pain meds and get me out of here! Can't you tell I'm in pain?! And what, you're just going to make me live like this?! I should sue you for malpractice for leaving me in so much pain."

Director/MD/MA Table - helicopter parent of a young patient

Who You Are: You are a working parent of a 13 year old son named Justin. You are VERY involved, and some may even call you a helicopter parent.

The Situation: Upon arriving to the clinic with your 13 year old son for his complaints of regular headaches at school, you recognize there are a lot of other patients in the waiting area. So, when you approach the window to check in, you declare to them that you're in a hurry to get back to work as soon as possible. When they FINALLY call you back into a room to treat your son, you INSIST on going back with him. The doctor asks what is his reason for visiting, naturally, you answer for him.

You tell the clinician:
"He has been having headaches while he is at school"
Every time the clinician tries to ask a question, you answer for him. As the clinician says they are going to go take a look and treat him, you say to them:
"Make sure you don't hurt him! He is very sensitive to pain!"
You say to Justin: "Does that hurt you sweetheart? You look like you're hurting Justin!"

Everything the clinician says next appears to question your knowledge of your son and your ability to parent appropriately because you know best. You become extremely offended at this point and raise your voice.

NP/PA/MA - mom and adult child-caretaker back pain

Who You Are: You are the full-time caretaker for your mother who has very minor dementia. Your mom has been complaining that her back hurts, and you know she has had a history of sciatic nerve pain in her back so *obviously* you know it's that, but she told you she thinks it's different this time so you take her to the clinic.

The Situation: The clinician asks your mom what brought her in today, and she tries to answer saying she has some weird new pain in her back.

You say, "I know she is going to tell you it isn't her sciatica but, look, I know it is, so can we just get some meds and get on with it. I have to go pick up my daughter from school."

The clinician will try and talk to your mom again, and you get aggravated and really tell them how it is.

"I have been taking care of this woman FULL-TIME for the last 10 years! How dare you question me?! Not to mention the history of sciatica that has run in my family for years. My sister has it. My brother has it. My great grandpa has it and was even hospitalized for it a few times it got so bad! Hell, I even have it some days. Obviously, I know how to take care of my *own mother*."

Clinician responds.

You say, "You have to be f****** kidding me. Just give us the meds! Stop wasting everyone's time!"

NP/PA/MA - high anxiety person who thinks there is something wrong

Who you are: You are someone who is very aware of your body and your health, and takes your well-being very seriously. Because you are so concerned about being healthy, you continuously read up online about your symptoms before visiting the doctor, you know, just to make sure they're doing their job right and covering all things that could possibly be wrong with you. You also go to the doctor at the first sign of anything that just seems, you know, a little off.

The Situation: You saw the doctor yesterday, but the doctor told you it was just a cold. But you *know*, just definitely know, there is something wrong with you. You had a headache the last few days, and a bit of stomach and back pain, so the doctor told you to rest. You know in the back of your head that the doctor might be right; it could just be something you ate, or maybe the flu. However, you are concerned it might be a kidney stone based on what you read on WebMD and what people say on blogs. You ***expect*** that your doctor will check ALL possible causes of your symptoms and do a better job than the day before:

The doctor greets you and ask what brings you in today

You say, “Hi, I’m here to figure out why my back, head and stomach have been hurting. I want to be checked for kidney stones.”

The doctor asks more questions about your symptoms.

You explain that online you read about these things and how doctors often miss kidney stones and how serious they can become.

The doctor says something about it not being likely.

You say, “Well I saw online that doctors just don’t believe people all the time when they say they think its kidney stones and I don’t want this to become worse and threaten my life! I’m not crazy!”

The doctor tries to explain.

Frustrated, you say, “What the hell are you going to do?! Let me walk out of here with a serious problem? You have got to be kidding me. Don’t you think I know my body?! I just know something is wrong! This isn’t the flu or just a migraine! I’ve had those before and I know this is different!”

If the doctor doesn’t do a good job calming you down, you start threatening to sue.

PAN/Billing - indignant person who says they were told something but weren’t

Who you are: You are an average patient with above average expectations for your health care. You tend to read up online about your medical complaints before visiting the doctor, you know, just to make sure they’re doing their job right and you get what you deserve. You have asthma and have had it for just a few years now.

The Situation: You are going into the clinic to get a prescription filled that was prescribed to you months ago by a different doctor and your prescription has expired. Based on what you read on WebMD and what people say on blogs, you believe that the person at the front desk can just quickly refill the prescription for you and send you on your way quickly and easily. You approach the front desk with your empty inhaler in hand and tell them what you know:

The staff person greets you.

You say, “Hi, I’m here to have my medication refilled for my asthma.”

The staff person asks questions about your prescription. You explain that a different doctor prescribed it for you, but no matter, you just need more.

The staff person says something about not being able to do it.

You say, “Well I saw online that clinics can just refill this sort of thing for you. Obviously my asthma hasn’t just magically gone away so why the hell would I need to see a doctor again to get this taken care of?”

The staff person tries to explain.

You say, “What are you going to do?! Let me walk out of here not being able to breath? You have got to be kidding me.”

If the staff person does not do a good job, you even start telling the other patients in the waiting area. “You hear that? I can’t breathe and no one here is going to do anything about it!” You even raise your hand to throw the empty inhaler at the front desk worker.

PAN/Billing - narcotic pain medication seeking patient

Who You Are: You have been living at your friend's place for a while because you've had a rough time with money lately, and your friend said you could crash on the couch for a little while. You used to be addicted to heroin, but you've been clean for 10 years now and you're damn proud of that. A few months ago, you were working a construction job trying to make some money, and you hurt your shoulder but didn't have insurance, so you just took some of your friend's narcotic pain meds and you got hooked again.

The Situation: You are going into the doctor because you're out of meds. You know your shoulder is better, but you definitely aren't going to let them know that, and you are not planning to leave there until you get some meds.

The front desk staff asks you what brings you in today and you tell them, "Look, I'm in a lot of pain here." (you wince and maybe let out a groan)
The front desk person says something about trying to schedule you for an appointment.
You say, "No you idiot, I don't want some appointment weeks from now. I want some pain meds NOW!"
The person then says something about not being able to prescribe those without seeing the doctor and you get upset because you realize this isn't going to be as easy as you thought.
You say, "Just give me some damn pain meds and get me out of here! Can't you tell I'm in pain?! And what, you're just going to make me live like this?! I should sue you for malpractice for leaving me in so much pain!"

PAN/Billing - wait time

Who You Are: A parent who takes care of your 3 kids at home, all under the age of 5, with a partner who works a lot. You do your best to be a "super-parent," but there just doesn't seem to be enough time in the day! You hate it when you get sick because how could you possibly find time to see a doctor? You finally found someone to watch the kids so you can go to the doctor, but your mother-in-law said she can only do it for an hour during her lunch break from work. Needless to say, it's near impossible to make time to get to the doctor so your visit better happen fast.

The Situation: Because you found out so last minute about the sitter, you didn't make an appointment. You decide to just walk in.

Admin: "Hi do you have an appointment?"
You: "No, but I'm so sick and I only have an hour cause someone is watching my kids and I really just need to be seen right now."
Admin says something about the lack of availability to see you at that time or asks for information from you.
You get increasingly stressed about getting back to your kids in time, and your head is absolutely killing you.

You begin to get aggressive so that you can be seen.
You say, in an angry and condescending tone, “I thought this was a medical clinic?! You know, a place where you help people! I mean, how long does a person have to wait to get some help around here?!”

PAN / Billing - high anxiety disordered person

Who you are:
You are someone who is very aware of your body and your health, and takes your well-being very seriously. Because you are so concerned about being healthy, you continuously read up online about your symptoms before visiting the doctor, you know, just to make sure they’re doing their job right and covering all things that could possibly be wrong with you. You also go to the doctor at the first sign of anything that just seems, you know, a little off.

The Situation: You saw the doctor yesterday, but the doctor told you it was just a cold. But you *know*, just definitely know, there is something wrong with you. You had a headache the last few days, and a bit of stomach and back pain, so the doctor told you to rest. You know in the back of your head that the doctor might be right; it could just be something you ate, or maybe the flu. However, you are concerned it might be a kidney stone based on what you read on WebMD and what people say on blogs. You ***expect*** that the admin staff will get you in to see your doctor ASAP so they can check ALL possible causes of your symptoms and do a better job than the day before.

The front desk person greets you and asks what brings you back in today.
You say, “Hi, I know I was here yesterday, and they said it was a cold, but I just know it’s something else. I want to be checked for kidney stones.”
The person asks more questions about your symptoms or something like that.
The receptionist might offer to go talk to your doctor.
You explain that online you read about these things and how doctors often miss kidney stones and how serious they can become. They say something about it not being likely, or your doctor not being able to see you.
You say, “Well I saw online that doctors just don’t believe people all the time when they say they think its kidney stones and I don’t want this to become worse and threaten my life! I’m not crazy!”
The staff person tries to explain.
You say, “What the hell are you going to do?! Let me walk out of here with a serious problem? You have got to be kidding me. Don’t you think I know my body?! I just know something is wrong! This isn’t the flu or just a migraine! I’ve had those before and I know this is different!”
If the staff person doesn’t do a good job calming you down, you start threatening to sue.

Dentist Table - “do you even know what you’re doing?” (mainly for residents)

Who You Are: You are an average patient with above average expectations for your dental care. You tend to read up online about your teeth complaints before visiting the dentist, you know, just to make sure they're doing their job right.

The Situation: You are going in to get a cavity filled for the first time. Based on what you read on WebMD and what people say on blogs, you know it might hurt a little bit but generally you don't expect to be able to feel any pain, since you expect your dentist to numb you correctly. You think your dentist looks timid, maybe they're even a resident and still in training. You're weary. During the procedure, you feel the slightest pinch in your mouth.

You say loudly and annoyed, "Ow!"

The dentist apologizes, but a few seconds later it happens again, this time you say louder, "OW! Stop doing that!" The dentist apologizes again.

You start to try and sit up and say "You know what, do you even know what you're doing? How hard it is to fill a cavity? Are you stupid? You hurt me twice!" The dentist responds somehow.

You say, "I want to be seen by a better dentist! Get your hands out of my mouth." As the dentist tries to help, you demand better care and even cite what you've read online.

Dentist Table - patient who exaggerates pain

Who You Are: You have an incredibly low tolerance for pain. In fact, it runs in your family. Everyone you know has a low tolerance for pain. You also know that your family has terrible teeth, and always talk about how much the dentist sucks and hurts.

The Situation: You are going in for this pain you've been having in your right molar for some time now. You really hope it isn't a cavity - those hurt so bad! You're really not looking forward to this, and you hope your doctor is gentle. You have to make it known that you don't tolerate pain well.

The dentist greets you and ask if they can take a look.

Before you open your mouth, you say, "I am in so much pain from this molar… I really need you to fix it right away. But, just so you know I have a very low pain tolerance, it's imperative that you are very careful."

The dentist says something.

Upon first opening your mouth you complain of pain even opening up. You start to try and refuse service.

If the dentist doesn't do a good job of calming you down, you just start to yell about their sloppy care and how they haven't fixed your pain so that nearby patients can hear.

Dentist Table - helicopter mom

Who You Are: You are a working parent of a 13 year old son named Justin. You are VERY involved, and some may even call you a helicopter parent.

The Situation: Upon arriving to the dental clinic with your 13 year old son, you recognize there are a lot of other patients in the waiting area. So, when you approach the window to check in, you declare to them that you're in a hurry to get back to work as soon as possible. When the staff FINALLY calls you back into a chair to treat your son, you INSIST on going back with him. The dentist asks what his reason is for visiting, naturally, you answer for him.

You tell the clinician, **"**His left molar has been bothering him"
Every time the dentist tries to ask a question, you answer for him.
As the dentist says they are going to go take a look and treat him, you say to the dentist, "Make sure you don't hurt him! He has a very sensitive mouth!"
You say to Justin, "Does that hurt you sweetheart? You look like you're hurting Justin!"
Everything the clinician says next appears to question your knowledge of your son and your ability to parent appropriately because you know best. You become offended at this point and raise your voice

Dental Registration - narcotic pain medication seeking

Who You Are: You have been living at your friend's place for a while because you've had a rough time with money lately, and your friend said you could crash on the couch for a little while. You used to be addicted to heroin, but you've been clean for 10 years now and you're damn proud of that. A few months ago, you were working a construction job trying to make some money, and you hurt your shoulder but didn't have insurance, so you just took some of your friend's narcotic pain meds and you got hooked again.

The Situation: You are going into the dentist because you're out of meds. You know your shoulder is better, but they don't need to know about your previous injury and you are not planning to leave there until you get some meds.

The front desk staff asks you what brings you in today and you tell them, "Look, I'm in a lot of pain here." (you wince and maybe let out a groan)
The staff person says something about trying to schedule you for an appointment.
You say, "No you idiot, I don't want some appointment weeks from now. I want some pain meds NOW!"
The staff person says something about not being able to prescribe meds without seeing the doctor and you get upset because you realize this isn't going to be as easy as you thought.
You say, "Just give me some damn pain meds and get me out of here! Can't you tell I'm in pain?! And what, you're just going to make me live like this?! I should sue you for malpractice for leaving me in so much pain."

Dental Registration - WANTS ALL SERVICES SCHEDULED FOR ONE APPOINTMENT

Who you are: An entitled patient who lives in Lompoc and drives here for your appointments. You have 3 jobs, so getting to town for a dental visit is very difficult to schedule. But, you have been having tooth pain for a while now, and you can't let it

go any longer. You EXPECT that they will be able to do your multiple treatments in one appointment. After all, you have to drive so far in order to be here anyway, they practically owe it to you!

The situation: You just finished this dumb check-up appointment they made you have before doing any real work on fixing the issues you're having in your mouth. You are checking out with the front desk staff and scheduling the *real* appointment now, but you need a root canal and a filling. When they try to schedule two separate appointments, you become very upset, raising your voice, standing up from your chair and even threatening staff saying:

"I'm not leaving here until you schedule my damn appointments in one sitting!"

Call Center & Call Center RN Table - WAIT TIME

Who You Are: A parent who takes care of your 3 kids at home, all under the age of 5, with a partner who works a lot. You do your best to be a "super-parent," but there just doesn't seem to be enough time in the day! You hate it when you have to go to the doctor because how could you possibly find time to do that? You finally found someone to watch the kids so you can go to the doctor, but your mother-in-law said she can only do it for an hour during her lunch break from work. Needless to say, it's near impossible to make time to get to the doctor but you can't stand the pain in your jaw any longer, so your visit better happen fast.

The Situation: Because you found out so last minute about the sitter, you didn't make an appointment. You decide to just call the call center and tell them your situation. You get upset when you find out it isn't going to go as planned.

Receptionist on the phone: "This is ____ how can we help you?"
You: "I'm in so much pain and I only have an hour cause someone is watching my kids and I really just need to be seen right now."
Admin says something about the lack of availability to see you at that time or asks for information from you.
You get increasingly stressed about getting back to your kids in time, and your jaw is absolutely killing you. You begin to get aggressive so that you can be seen.
You say, in an angry and condescending tone, "I thought this was a doctor's clinic?! Hell you have 6 different locations and you're trying to tell me I can't be seen at any of them right now?! You know, isn't this a place where you help people! I mean, how long does a person have to wait to get some help?!"
(if with the RN expect them to just diagnose you over the phone)

Call Center & Call Center RN Table - wants all services scheduled for one appointment

Who You Are: You are an entitled patient who lives in Lompoc and drives to Santa Barbara for your appointments. You have 3 jobs, so getting to town for a doctor visit is very difficult to schedule. But, you have been having tooth pain for a while now,

and you can't let it go any longer. You EXPECT that they will be able to do your multiple treatments in one appointment. After all, you have to drive so far in order to be here anyway, they practically owe it to you!

The Situation: You just finished this dumb check-up appointment they made you have the other day before doing any real work on fixing the issues you're having in your mouth. You are calling the call center to make the *real* appointment, but you need an x-ray for your hurt ankle and a flu shot and you want them to fill your old prescription, oh and you have these terrible migraines. When the staff person tries to schedule separate appointments, you become very upset, raise your voice, call them inept and threaten the staff saying, **"**I'm not getting off of this phone until you schedule my damn appointments in one sitting!"
(if the RN then expect them to at least fill your prescription over the phone)

Manager/Asst Manager Table - wants all services scheduled for one appointment

Who you are: you are an entitled patient who lives in lompoc and drives to santa barbara for your appointments. You have 3 jobs, so getting to town for a doctor visit is very difficult to schedule. But, you have been having tooth pain for a while now, and you can't let it go any longer. You expect that they will be able to do your multiple treatments in one appointment. After all, you have to drive so far in order to be here anyway, they practically owe it to you!

The situation: you just spoke to the idiot front desk staff, after they made you do this dumb check-up appointment they made you have *real* work on fixing the issues you're having in your mouth. So you demanded to speak to the manager. You tell them your situation about all of the care that you need and demand that you be seen by *their best* doctor. When the manager tells you why you can't do all of those treatments at once, and tries to schedule separate appointments, you become very upset, raise your voice, call them inept and threaten the staff saying, **"**i'm not leaving here until you schedule my damn appointments in one sitting!"

Manager/asst manager table – expects a certain doctor for their visit

Who You Are: You are an entitled patient who expects the very best care. You have a good thing going with Dr. Lawton. She really helped you out several months ago when you came in for your stomach pains. You will only see her, because well, you deserve the absolute best and that is what she is.

The Situation: You just spoke to the idiot front desk staff, they told you that Dr. Lawton doesn't have any time to see you next Tuesday. So you demanded to speak to the manager.

You tell them your situation about all of the care that you need and demand that you be seen by Dr. Lawton ONLY.

The manager explains that she can't see you, you take it personally.

"You mean to tell me that you expect me to see some *mediocre* quack who barely passed medical school? You really think that is all I deserve? I thought this place was about quality healthcare… quality healthcare my ass."

Lab Assist Table – Low Pain Tolerance

Who You Are: You have an incredibly low tolerance for pain. In fact, it runs in your family. Everyone you know has a low tolerance for pain. You also know that getting tested for STDs regularly is really important but requires a blood test…. You're absolutely dreading it, but you can't put it off any longer cause your partner asked you to get one.

The Situation: You are going in for STD test… You really hope it is over quick. What if they can't find your vein and have to stick you more than once?! You're really not looking forward to this, and you hope the lab person is gentle. You have to make it known that you don't tolerate pain well.

The phlebotomist greets you.

Before you roll up your sleeve for the blood draw, you say very nervously, "Just so you know I have a very low pain tolerance, it's imperative that you are very careful."

The phlebotomist says something.

Upon first touching your arm to find your vein you complain of pain even then. You start to try and refuse service. and say "you better only stick me one time…. Are you even any good at this?!"

If the phlebotomist doesn't do a good job of calming you down, you just start to yell about their sloppy care and how they can't do their job so other patients in the hallway can hear.

Lab Assist Table – Taking Too Much Blood Freak Out

Who you are: You are someone who is very aware of your body and your health, and takes your well-being very seriously. Because you are so concerned about being healthy, you continuously read up online about your symptoms before visiting the doctor, you know, just to make sure they're doing their job right and covering all things that could possibly be wrong with you. You also go to the doctor at the first sign of anything that just seems, you know, a little off.

The situation: You came to the doctor today because you need your blood levels tested, you know to ensure you are taking appropriate care of your cholesterol and that your white count isn't out of whack or anything. You read online that it is something you should do as a responsible person who cares about your health. Online it said that they need only a few vials for these tests but when you see the phlebotomist prepping, they have too many tubes! You couldn't possibly loose that much blood and still do the exercises you had planned for the rest of the day.

You question their abilities every step of the way, citing what you read online. Be aggressive about knowing your body and your health.

Tell them that it is way too much blood, but if they say they cant do the tests then, tell them they are wrong. “Do I look like an idiot to you? Don’t you think I can read??”

Referral Table – expects a certain doctor for their visit

Who You Are: You are an entitled patient who expects the very best care. You have to see a cardiologist for this annoying murmur you have going on with your heart. You only have MediCal, but you don’t think that should limit your options to the best of the best care! You will only see the best doctor (Dr. Pines), because well, you deserve the absolute best!

The Situation: You are about to speak to the referral person, they told you that you may have to be put on a waitlist for the first available specialist because your problem is getting worse. But, you demanded better for yourself! Surely they can get you in.

You tell them your situation about all of the care that you need and demand that you be seen by the best specialist, Dr. Pines, ONLY.

The referral person explains that your insurance doesn’t cover that provider you take it personally.

“You mean to tell me that you expect me to see some *mediocre* quack who barely passed medical school? You really think that is all I deserve? I thought this place was about quality healthcare… quality healthcare my ass.”

Referral Table - wants all services scheduled for one appointment

Who You Are: You are an entitled patient who lives in Lompoc and drives to Santa Barbara for your appointments. You have 3 jobs, so getting to town for a doctor visit is very difficult to schedule. But, you have been having GI problems for a while now, and you can’t let it go any longer, you know you have to schedule this referral appointment. You EXPECT that they will be able to do your appointment on the day you have off next week. After all, you have to drive so far in order to be here anyway, they practically owe it to you!

The Situation: You just finished this dumb check-up appointment they made you have before doing any *real* work on fixing your GI problems. You are speaking with the referrals person to make the *real* appointment, but you can only take next Tuesday off work and can only get here for the afternoon. When the staff person tries to schedule an appointment you can’t make, or tell you they aren’t even in charge of that, you become very upset, raise your voice, call them inept and threaten the staff saying, **“**I’m not leaving here until you schedule my damn appointment!”

Dental X-ray Table – Refuse X-Ray

Who you are: You really prefer natural treatments. You really pride yourself on not putting toxins in your body and you have an essential oil for everything. You’ve been going to a homeopathic doctor about your mouth pain, yet, your right molar has been really hurting so you figure you will give the traditional dentist a try.

The situation: You arrive for your appointment on time, and you're so nervous you have put lavender oil all over your neck. It isn't working well enough really.

The x-ray tech greets you to take you back. They ask "when was the last time you had a dental x-ray?"

Righteously you answer "oh never! And I don't want one today either."

They start to tell you about how the doctor needs one

You refuse more aggressively, raising your voice, scoffing at them, citing the damage you are absolutely not going to do to your body with that cancer causing machine!

Dental X-ray Table – Refuse for your Kid's X-Ray

Who you are: You really prefer natural treatments. You really pride yourself on not putting toxins in your body, and will fight for the health of your family! Vaccines… forget it! You have an essential oil for everything. You've been taking your child to a homeopathic doctor about their molar pain, yet, your little child's right molar has been really hurting. You have tried it all, peppermint tea bags, salt water rinse, garlic, vanilla extracts, you name it. Nothing is working so you figure you will give the traditional dentist a try and just have them take a quick look.

The situation: You arrive with your child for your appointment on time, and you're so nervous you have put lavender oil all over your neck. You put peppermint oil on your child's cheek to help with the molar pain but… it isn't working well enough really.

The x-ray tech greets you to take you back. They ask "when was the last time your child had a dental x-ray?"

Righteously you answer "oh never! And I don't want them to have one today either."

The x-ray tech starts to tell you about how the doctor needs one

You refuse more aggressively, raising your voice, scoffing at them, citing the damage you are absolutely not going to do to your child's healthy body with that cancer causing machine!

Wellness Navigator/Cancer Coordinator/Social Worker – Unreceptive to help

Who You Are: You have been living at your friend's place for a while because you've had a rough time with money lately, and your friend said you could crash on the couch for a little while. You used to be addicted to heroin, but you've been clean for 10 years now and you're damn proud of that. A few months ago, you were working a construction job trying to make some money, and you hurt your shoulder but didn't have insurance, so you just took some of your friend's narcotic pain meds and you got hooked again. Not to mention you're also out of a job.

The situation: You came in to the doctor to get your shoulder checked out, and they found some skin cancer. You're feeling completely beat when you're down, how did your life even turn out like this?! They send you to meet with the cancer coordinator. They start offering you all these services… but you're a responsible grown ass adult. You do not need them treating you like some homeless person.

They ask what happened

You say: “Ah they found some cancer and I don’t have a job right now so I need
to figure out how to get this taken care of. I’m not crazy or homeless or anything like that though.”
They offer you services, you find them offensive because those are for stupid people.
You say “What do you think I’m stupid? Do I look like I can’t figure this out? What the fuck?!”

Wellness Navigator/Cancer Coordinator/Social Worker – Unreceptive to help

Who you are: You just got out of an abusive relationship. You’re really proud of that! You and your kid left your abusive partner in the middle of the night, and you’ve been staying with your sister. Things have been tough because you don’t have a job, and lately you’ve been having crazy stomach pain and being so bloated. You’re in so much pain most days but who has money to go to the doctor?! hell you don’t even have anywhere to call your own.
The situation: You finally borrow the money from your sister to go to the doctor. They say you need a biopsy because they think its ovarian cancer. Everything from there is kind of a blur, all you heard was how much it would cost. They send you to talk to the wellness navigator about services. You know you should be thankful for their help, but you’re so embarrassed about where your life is that you lash out.
They ask you what you need (or to talk about how you feel)
You tell them about your situation and say “so look I don’t need your pity or whatever, I just gotta figure out how to pay for this.”
They start offering you services (saying there are mental health help options)
You reject them, offended you say, “That shit is for homeless people! Or like crazy people! I don’t want any of that trash, I’m not an idiot.”
Keep holding your ground and empowering yourself as not crazy, not stupid and not a loser asking for some *real help.*

Social Worker – Too proud to get help

Who you are: You have been an independent person your whole life. Your dad walked out on you and your mom when you were just ten and since then you haven’t needed help from anyone. Plot twist though, your mom just died and you’re not coping well at all. You recently got sent home from work for lashing out even! Your boss told you if you wanted to keep your job you had to go get some help coping with losing your mom.
The situation: In order to keep your job, you agree to get some help so today is your first appointment. You figure its only an hour, you’ll explain that you’re fine and they will send you home.
The social worker greet you and ask what brings you in.
You explain “Oh my dumb job made me come because I got a little mad the other day.”
They ask you something about the anger
You say “it was not even a big deal. Look I’m fine, can I go?”
They try to talk to you more

You say “Look I don’t want your help. This shit is for people who just are too weak to handle life. Yeah, I’ve been through some shit but I’m stronger for it.”
You continue to get defensive and louder with them.

Appendix F

Post-Training 3-Month Follow-Up Survey Measures for Study 2

Thank you for participating in the final follow-up survey of the training you attended in June where you learned about communicating with aggressive patients. By continuing on to the survey, you are indicating your consent to participate in this portion of the study. Responses will still be kept confidential as described previously in the training.

To begin the survey and provide consent for this portion of the study, **please enter your ID Code you made on the day of the training** (Enter the first three letters of your mother's name AND the last four numbers of your cell phone number)

In response to feeling stressed from work, to what extent do you agree with the following statements:

1. I have reduced my work hours in the past year.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

2. I have sought help *outside* of the clinic professionals for dealing with your stress reaction.
   Strongly Disagree Disagree Neutral Agree Strongly Agree

3. I have sought *internal* the clinic services as help for dealing with my stress reaction. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

4. I believed the incident affected my ability to maintain the previous level of function/interaction with coworkers. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

5. I have considered changing jobs. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

6. I am able to ask an aggressive patient what they are upset about. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

7. When patients are aggressive, I can validate their feelings. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

8. I can communicate with an aggressive patient to de-escalate the interaction. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

9. I am able to communicate with an aggressive patient and complete my job. w
   Strongly Disagree Disagree Neutral Agree Strongly Agree

10. I feel like what I do at my job is important. w

Strongly Disagree Disagree Neutral Agree Strongly Agree

11. I am satisfied with the working conditions here at my job. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

12. My fellow staff members pitch in and help one another out when things get in a rush.
Strongly Disagree Disagree Neutral Agree Strongly Agree

13. I am satisfied with the types of activities that I do at my job. w
Strongly Disagree Disagree Neutral Agree Strongly Agree

14. When a patient is aggressive, it is an attack on me personally.
Strongly Disagree Disagree Neutral Agree Strongly Agree

15. When a patient is aggressive, it is an attack on healthcare professionals generally.
Strongly Disagree Disagree Neutral Agree Strongly Agree

16. When a patient is aggressive, it is an attack on the hospital.
Strongly Disagree Disagree Neutral Agree Strongly Agree

17. Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence.
Strongly Disagree Disagree Neutral Agree Strongly Agree

18. It is usually situations that contribute towards the expression of aggression by patients.
Strongly Disagree Disagree Neutral Agree Strongly Agree

19. There appear to be types of patients who frequently become aggressive towards staff.
Strongly Disagree Disagree Neutral Agree Strongly Agree

20. Patients commonly become aggressive because staff do not listen to them.
Strongly Disagree Disagree Neutral Agree Strongly Agree

21. Patient aggression can be understandable.
Strongly Disagree Disagree Neutral Agree Strongly Agree

22. When a patient is aggressive, I am usually able to make the patient comply enough to complete my job tasks.
Strongly Disagree Disagree Neutral Agree Strongly Agree

Thinking about a time you communicated with an aggressive patient since the all-staff training in June:

23. I felt that I spoke clearly to the patient they could understand what I was saying.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

24. I avoided the use of technical terms that the patient wouldn't understand.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

25. I explained to the patient what I was doing in a way they could easily understand.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

26. I allowed the patient enough time to ask me any questions they had.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

27. I paid attention and listened to concerns the patient expressed.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

28. I allowed the patient to interrupt me with any questions they had.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

29. I felt that the patient's worries and questions were important.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

30. I spoke to the patient in a respectful and courteous manner.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

31. I felt I did a good job in helping the patient understand.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

32. I was satisfied with the experience I had with the patient.
    Strongly Disagree Disagree Neutral Agree Strongly Agree

33. This was an effective conversation with the patient. (I feel we both got what was needed from our conversation).
    Strongly Disagree Disagree Neutral Agree Strongly Agree

Open ended questions

For the following questions, work place violence is defined as "any incidents where staff are abused, threatened or assaulted in circumstances relating to their work…involving an explicit or implicit challenge to their safety, well-being or health" (Mayhew & Chappell, 2005, p. 346).

34. With that in mind, how many experiences of work place violence have you experienced since the training?
    Please describe what happened in the most memorable of these interactions. Try to include quotations of things you and the patient said to one another, and the way you and the patient both communicated using body language.

35. What contexts come to mind when you think of conversations you've had with aggressive patients?

36. Where do those conversations occur?

37. What time of day do they occur?

38. Is it usually a weekday or a weekend day?

The following questions have to do with normative practices in your department and your interactions with your peers. Please respond with your work department environment in mind.

39. What role if any, do you play in fostering an environment where patients do or do not become aggressive?

40. What do you talk about with your peers during work regarding your department experiencing aggressive patients?
41. Do you give your peers any advice about how to handle patient aggression? If so what advice?
42. How long-lasting do you think what you learned in the training will be?