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Relationship Security: The Dynamics of Keepers and Kept

REFERENCE: Maier, G. J., **"Relationship Security: The Dynamics of Keepers and Kept,"** *Journal of Forensic Sciences*, JFSCA, Vol. 31, No. 2, April 1986, pp. 603-608.

ABSTRACT: Hiring, training and supervising treatment staff who work closely with forensic patients at all levels of security requires careful planning. In particular, staff must identify and share feelings like fear and anger that are always generated when patients threaten or attack staff. Approaches to dealing with staff countertransference to patients are suggested in this article, and aids to breaking the aggression cycle are discussed. Relationship security is a working through of dynamics that are always in operation where there are keepers and kept.

KEYWORDS: psychiatry, security, prisons

The Initial Process

From 1981 to 1983 the Department of Health and Social Services (DHSS) in Wisconsin decided to convert a maximum security hospital into a medium security prison and at the same time develop a comprehensive forensic center embracing maximum, medium, and minimum security units at Mendota Mental Health Institute (MMHI) in Madison. They decided to do so without consulting the Madison community and knowing that maximum security patients would be residing within a mile of the Governor's mansion. Community and political concerns beyond the scope of this paper were ultimately addressed by an ongoing committee called The Forensic Advisory Committee.

MMHI was deeply concerned about its identity as a mental health institute and the impact that security would have on health units. Some believed that the aides would turn into "goons" and that patient abuse would be rampant. Some staff were convinced that parents would refuse to send their children to the Child/Adolescent Program because murderers and rapists were also on the same grounds. Staff were pessimistic that treatment and security values could coexist. Real and fantasy fears about intractably aggressive patients abounded.

On the bright side, MMHI had an opportunity to phase out a custodial program and develop an active treatment program for the hard-core 73 out of 250 patients. Key planners such as the Security Director and key Unit Chiefs were hired well ahead of phase out. Central to the planning was a conscious effort to design a maximally safe institution, and therein forge an administrative structure that would maximize smooth relations between security and treatment, giving emphasis to a therapeutic environment that remains highly humane, even when strict control is required. By 15 April 1983, the Joint Commission on Accreditation of Hospitals (JCAH) accredited program consisted of a 164-bed facility divided into 4 maximum, 2 medium, and 2 minimum security units [*1*].

Received for publication 17 May 1985; revised manuscript received 19 Aug. 1985; accepted for publication 26 Aug. 1985.

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The Kept (Patients)

The 73 forensic patients to be transferred were generally representative of patients in a maximum security hospital. All were male, with 50% diagnostically schizophrenic (all types); about 40% having character disorders; and 10% with organic brain syndrome, episodic aggressions, developmental disabilities, and other conditions. Legally most of the psychotics had been found not guilty by reason of insanity (NGRI). Most of the character disorders were sex offenses; there were six prison transfers, four of whom were repeatedly aggressive and civilly committed. There were three under guardianship and three who were voluntary. Most important, these patients were, by history, crime, previous illness, or current temperment, assaultive to others. Most of the patients did not look forward to the change in location or programming. Further, many of the patients were resistive to change; four or five had been confined for up to 23 h a day for two to five years.

As a group, they were dangerous to others and could ignite fantasy fears. To be truthful, many were also afraid of coming to MMHI. They were afraid of the program and the emphasis on constant surveillance.

The Keepers (Staff)

MMHI had the opportunity to hire, train, and supervise a new class of aides, the equivalent of the unit guards in a prison, so that they would feel secure and possess the interpersonal skills to engage with patients without being "conned" or heavy-handed. What follows is a description of the process and rationales used to select staff personnel.

Staffing with a Sexual Bias

The aides were hired in accordance with Institute guidelines established by a Bona Fide Occupational Qualification (BFOQ), 50% male and 50% female. Since the MMHI was serving an all-male population, it successfully argued that hiring aides in the ratio of three males to one female was more desirable. The rationales were as follows:

1. It was therapeutically sound to have a mixture of both male and female aides to deliver direct care to the patient population. While some characteristics of the patient group in maximum security may make the environment seem better suited for male staff, it was important to provide the patients with an opportunity to develop healthy relationships with adult females and to reap the positive security influence that female staff have in an all-male population [*2*].
2. It was clearly indicated that whenever a patient had to pass through the maximum security perimeter he would need to be accompanied at all times. More than one escort would be necessary. In no instance would the patient be allowed to go into a public toilet or other area where any intimate bodily activity could occur without full escort. Therefore, in order not to inconvenience, embarrass, or frighten anyone involved, the escorts must be male.
3. Since there was a high probability that on at least one of the maximum security units the patients would be so disturbed that they would spend considerable time in seclusion, both their need for staff assistance with personal hygiene and commonly accepted standards of propriety dictated a preponderance of male aides on that unit.

Hiring for Prevention

As part of the preemployment interview process, MMHI screened all levels of staff members to prevent future breaches of security. Initially each applicant was interviewed by a team of clinical staff and asked a series of standard questions on which the interviewers

made notes. The applicant was required to provide written answers to standard questions to check writing skills. Finally, the applicants were required to provide suitable references.

It was MMHI's view that staff are the most important management resources. In secure facilities staff are often abandoned, consciously and unconsciously, by senior administrators. Because of neglect, they can fall under the sway of powerful "sociopathic" patients. It is not surprising that staff are often the source of breaches of security in prisons, especially of contraband. MMHI was determined to care for its staff, and as part of this caring it carefully covered the following areas on interview:

(1) feelings about and reaction to potentially aggressive patients,
(2) feelings about and reaction to smooth talking con artists,
(3) sense of professional distance,
(4) attitude toward alcohol and drug abuse, and
(5) ease at discussing human sexuality.

While these examples are not exhaustive, they give a flavor of the issues covered. Applicants that appeared naive or easily swayed during the interview were questioned further. The applicants were required to satisfy the interviewers that they were aware that the job would force them to deal with fear and hatred. MMHI assured them that their supervisor would be open to discuss these feelings.

Physical Fitness as a Condition of Employment

Because the aides in the maximum security perimeter were expected to be able to manage repeatedly aggressive patients, common sense dictated that they be physically able to respond. Unfortunately, there was no previously established obligation for aides to be physically fit. But because police and fire departments had established such criteria [*3*], arguments were made that DHSS support the establishment of physical fitness as a criteria for employment. Aides selected on interview were then given seven weeks to pass four specific tests: push ups, sit ups, leg raises, and a 2-1/2-km (1-1/2-mile) run. The aides were given instructions and time to train weekly.

At the time of this writing, MMHI has not been able to persuade the Personnel Commission to make physical fitness a maintenance condition of employment. To hasten this desirable objective, aides must take a physical fitness test program each year, and records are kept on each aide. Aides who do not meet the physical fitness standards will be encouraged to do so, although at present there is no penalty for not remaining fit. Over the next three to four years MMHI will examine the impact of fitness on staff injury, illness, and workman's compensation cases. If an impact can be demonstrated, the Personnel Commission will be able to require physical fitness as a maintenance condition of employment.

Managing Aggressive Behavior

Developing expertise in identifying and managing aggressive patients was of special importance in our training [*4*]. Hours were devoted to theory and practice and special techniques, like Aikido, were explored.

Relationship Security

MMHI did not want a guard ethic in the maximum security units. Staff must be skilled in interpersonal communication, to both prevent and de-escalate aggression. Relating to the patients on a daily basis in a safe, humane way was the core issue to prepare line staff to face. *Relationship security then was seen to encompass the working through of dynamics that are always in operation where there are keepers and kept* [*5–8*]. To give structure to these im-

portant, ongoing dynamics, MMHI examined the reaction that staff members have to a threatening patient and agreed to the following interpretation of aggression dynamics. The immediate conscious reaction to a serious threat is fright or fear. On an unconscious level staff feel indignant and angry at having their homeostasis disturbed. Because of fright and fear, aides react in the short run with less composure than normal, and with denial and projection in the long run because of unconscious anger or rage. The aides, then, react poorly at the time of the potential or actual aggression and poorly over time because they wish to be vindictive or punitive toward the patient, who may aggress again, thus reactivating their fear and hatred. From this definition of aggression, dynamics emerged a training program designed to help the staff to understand that feelings of fear and rage are a normal reaction to working with aggressive patients and to equip them with the skills to meet actual aggression. In the long run aides must discuss countertransference issues and make strategies for the reentrance of chronically aggressive patients to the unit [*9–12*].

Me-Time

To facilitate ongoing discussion about fear and anger among the staff, MMHI developed a communication structure called "Me-Time." Every second week all unit staff are brought together for 1 h, and, in a semisupervisory manner, the Unit Chief and Head Nurse help the staff discuss what it is like for them to work on their unit at that particular time. This forum provides a means to identify and discuss the long-term feelings that aides develop for patients, especially excessive fear and anger, or warmth and love. These often hidden feelings are part of staff countertransference to patients and are, over time, the feelings that lead to patient abuse or breaches of security. At the same time, the polarities among the staff are open for discussion. Generally there are two approaches to working with confined patients: the overly authoritarian and the excessively benevolent ("hard ass" and "bleeding heart," in the vernacular). Both are necessary to maintain a semblance of balance on the ward. However, it is extremely important that both factions recognize the needs of the other and try to work in harmony with each other. The Unit Chief, in particular, is responsible for identifying these extremes and working them through with the staff collectively or individually.

Staff inservices alternate with Me-Time. Every week all a.m./p.m. staff on each unit explore their feelings about the patients, each other, the unit, or assemble for an inservice meeting on a topic relevant to their work.

Preventive Aggressive Devices (PADS)

As a response to the repeatedly aggressive patients who would be cared for in the Management Unit, MMHI decided to initiate ambulatory restraints, called PADS. These restraints are made of leather; one belt goes around the waist, and two wrist cuffs then connect to the belt so that patients have enough movement to smoke a cigarette or drink coffee. They can also protect themselves should they fall or defend themselves if attacked. But PADS prevent a patient from delivering a forceful blow. Further, they alert staff and patients who may be new to the ward to be mildly wary of these patients.

The main reason for the development of PADS was to break the traditional dynamics that result from serious aggression. When aggression occurs, the patient is usually subdued with appropriate counterforce. There is therefore a display of staff power that some patients enjoy evoking because it keeps their reputations as powerful threats intact. The patient is usually isolated in a seclusion room for a period of time, during which the staff and other patients, if frightened, live in fear of the patient getting out. The patient then gets out and holds the staff or patients or both psychologically hostage. The patient lives at an unacceptable psychological distance from other patients and over time may decide to live up to their expectations and aggress.

MMHI felt that it was imperative to break the cycle of aggression→isolation→fear induction→social distancing→aggression. Patients can be returned safely to their peer group much sooner if they are in PADS because staff and patients feel safer. PADS were presented to the State Committee on Behavioral Treatment Techniques (CBTT) for review as a behavior contingent treatment. CBTT now supports their use.

Legislative Support

Night Lockup—At the time the patients were transferred to MMHI's maximum security division, a U.S. Supreme Court decision was in force requiring toilet and water facilities in rooms in which patients would be locked overnight. Further, MMHI decided that its Management Unit of 14 beds would be the intensive care unit for repeatedly aggressive patients. Because these patients must be locked in their rooms overnight (as they were used to), one-piece toilet and water units were installed in each secure bedroom. Each of the other three maximum security units were equipped with four such rooms so that they could have the same option. Locking these patients up overnight would increase their safety and the safety of other patients and staff. While the architectural planning went on, MMHI began discussions with the staff of the Client Advocate Program (CAP) in charge of monitoring and enforcing patient rights. They agreed with MMHI's rationales and drafted legislation that the Governor signed one year later.

Continuity of Care Lockup—MMHI also felt that in the Management Unit it was important for the a.m. and p.m. staff to maximize communication unencumbered with the responsibilities of supervising potentially aggressive patients. The CAP found legislative support for this idea, an act called the Continuity of Care Lockup. Staff are allowed to lock up the patients for 1½ h at the change of the a.m. and p.m. shifts. The cross shift is 1½ h, which is enough time for the a.m. staff to discuss their impressions of the patients with the p.m. staff. Since cross shifts tend to be the major source of medical errors in general hospitals, we wanted to maximize staff interaction.

Conclusion

The security responsibilities of a staff guarding a secure hospital have developed into two separate specialities. Guarding the perimeter and environmental security require social training and differ from the interpersonal skills of relating directly to patients on an ongoing basis. Physical fitness, aggression management, and the ability to deal with the dynamics of fear and anger are the requirements of relationship security. Since these dynamics are always in operation when people live confined against their will, they must be constantly addressed. MMHI staff members expect to discuss these issues on a regular basis, in a structure called Me-Time. It is MMHI's view that separating security into two special areas has given prestige to both staffs. Although MMHI has been open only two years, morale is good through the program, patient and staff injuries are below those in other units at the Institute, and no successful escape or serious injury to staff or patients has occurred.

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