

# Managing Challenging Situations

A resource guide for physical therapists

College of Physical Therapists of Alberta

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The College of Physical Therapists of Alberta (CPTA) is the regulatory body responsible for ensuring that physical therapists in Alberta provide safe, ethical and effective care. This Guide describes the CPTA's expectations of physical therapists in managing challenging situations that arise with patients, a patient's partner or family member or another health care provider when providing patient care. It serves to encourage physical therapists to reflect on their practice, develop additional skills and seek out other resources to assist when managing challenging situations. This Guide is a supplement to the CPTA's codes of ethics, practice standards and other ethics and practice advice documents found on the CPTA website. Physical therapists requiring additional information on managing challenging situations beyond that contained in this Guide are encouraged to consult the CPTA practice advisory service.

## Introduction

In the course of providing patient care, challenging situations arise. For the purpose of this Guide, a challenging situation is a situation that may interfere with a physical therapist's ability to deliver quality care culminating in achieving positive physical therapy outcomes. Many challenging situations involve interpersonal issues that arise in the healthcare system due to a variety of factors including the availability of resources, personal expectations and other environmental or contextual factors. Behaviours of the health care professional or patient, the healthcare setting where treatment is delivered or the service delivery model all contribute to creating challenging situations. Regardless of the cause, physical therapists are expected to manage each situation in a manner that promotes safe and respectful patient-centered care. This Guide discusses:

- why challenging situations develop;
- responsibilities and expectations of physical therapists; and
- strategies for managing challenging situations.

The Guide also provides supplementary information to assist with understanding and managing challenging situations and conflict.

## Why Challenging Situations Develop

Most challenging situations develop between a patient and a physical therapist; however, challenging situations can also arise between a physical therapist and another health care provider (Appendix A). When a challenging situation develops between a physical therapist and a patient, it is often because of differences in assumptions and expectations about the physical therapy care that will be delivered. In the case of challenging situations that develop between healthcare providers, the unequal and inherent hierarchical nature of the healthcare system may be a significant contributor. Different knowledge and experience in specific issues, both ethically and legally, imparts unequal responsibility and authority to those care providers with the most relevant knowledge and experience.<sup>26</sup> Sometimes the role of members on the team (e.g. supervisor, team leader) contributes to the inequality. Because of differences in training and experience, each member of the team brings different strengths and all need to work together to best utilize the expertise and insights of each other for optimal patient outcomes.

Challenging situations also can occur with a patient's partner or family member. Generally, partners or family members are interested in being an advocate for the patient. However, in some instances, their view of their role in the patient's health care and/or in their relationship with the physical therapist providing the care is not consistent with the physical therapist's view and this can lead to a challenging situation. The factors that can provide challenges between a physical therapist and a partner or family member are similar to those that arise between physical therapists and their patients. Given different personalities, competing values and varieties of experience, no two situations will be exactly alike.

## Responsibilities and Expectations of Physical Therapists

It is the physical therapist's responsibility to identify any interpersonal situation that may interfere with the delivery of safe, quality care and the desired physical therapy outcomes.<sup>7</sup> Physical therapists also need to consider other people in the environment who may be impacted. These include but are not limited to other patients, health care providers and administrative staff. When a challenging situation arises, physical therapists are required to be thoughtful in how they approach the situation and manage it in a purposeful and timely manner so as not to interfere with their ability to deliver quality physical therapy care (Appendix B).

When managing any challenging situation, the physical therapist should treat the other party in a respectful and professional manner. A *respectful exchange of views* may provide both parties with new information, and lead to further learning or a better understanding of the situation.<sup>26</sup> In the best situations, disagreement leads to a more complete discussion of a patient's care, resulting in a new consensus about the best course of action.

**Respectful behaviour** *begins with listening to and considering the input of other professionals, evaluating each idea based on its merits, acknowledging and discussing the differences and similarities in views, and recommending and negotiating treatment options.<sup>11,12,26</sup> Respect is demonstrated through language, gestures and actions (Appendix C). Disagreement can and should be voiced without detrimental statements about other members of the team, and without gestures or words that impart disdain. Comments and remarks that draw attention to a person's unique characteristics should be avoided. The appropriate use of humour can facilitate communication, but it should never be used at the expense of another's identity or self-esteem. Both actions and language should impart the message. Disrespectful behaviour from a colleague does not justify disrespectful behaviour in return. It can be addressed using other communication techniques (Appendices C,D).<sup>5,9,22</sup>*

## Responsibilities and Expectations of Physical Therapists

The new consensus may require compromises from each individual. Physical therapists should always have their patient's needs as their primary concern and avoid placing the patient in the middle of a disagreement by suggesting that he or she "makes a choice" about which provider he or she prefers or by making statements that may diminish his or her trust in another professional. When members of a team cannot arrive at a consensus around what should be done, other measures may have to be adopted. Consultation with other professionals who are not directly involved in the patient's care team for objective input may be helpful.

In some situations a physical therapist may decide to discharge a patient from active treatment when, despite repeated reasonable attempts to manage the challenging situation over a reasonable period of time, the situation has not changed sufficiently and the physical therapist has deemed that the patient will not be able to achieve the desired physical therapy outcomes. Or when there is an immediate risk of harm to the physical therapist or other individuals.

When physical therapists decide to discharge a patient from active care, they must do so in accordance with their professional and regulatory obligations, code of ethics and any other applicable rule or policy.

## Strategies for Managing a Challenging Situation

### Be Proactive

One of the best ways of managing challenging situations is to try to prevent them in the first place.

Very early in the establishment of a therapeutic relationship, it is prudent for physical therapists to attempt to gain a broader understanding of the patient beyond the specific problems for which they are receiving physical therapy services. Often patients come to see a physical therapist with expectations around how treatment will be provided, the types of services they will receive and who will provide it to them.

Some of these expectations may arise out of previous experiences with other providers of physical therapy services, cultural differences or emotional state. Patient expectations can range anywhere from very reasonable and appropriate to unreasonable and inappropriate. Early identification and proactive management of behaviours or expectations that could escalate or interfere with achieving the desired physical therapy treatment outcomes is the responsible approach (Appendices B,D,E,F,G).<sup>15,22,27</sup>

*Early communication with the parties involved to clarify the role and responsibilities of the physical therapist in the patient's care is helpful in developing a common understanding.*

When physical therapists are aware that a partner or family member is actively involved in the care of a patient, it is prudent to determine the answers to the following questions prior to establishing a relationship with them.

- Does the partner or family member have legal authority to make decisions on behalf of the patient?
- If the patient is capable of giving consent and making his or her own healthcare decisions, has the patient consented to the release of their confidential health information to the partner or family member?

The response to these questions determines the boundaries or extent of the partner's or family member's involvement in the patient's health care and the level of disclosure of health information a physical therapist can provide. Whenever possible, physical therapists should establish parameters around matters a patient is comfortable having them discuss with his or her partner or family member. A lack of clarity among all parties regarding information that can be discussed and exchanged can contribute to the development of a challenging situation.

## Strategies for Managing a Challenging Situation

Another pro-active measure is to inform patients, at the onset of treatment, of any organizational policies or personal expectations with respect to their behaviour that may impact on achieving desired physical therapy outcomes. Examples include but are not limited to:

- Expectations/policies, written or unwritten, that have monetary or continuity of treatment consequences to the patient (e.g. policies relating to failure to attend an appointment without providing adequate notice or repeated cancellations).
- Expectations/policies, written or unwritten, that deal with appropriate behaviour or decorum in the treatment environment (e.g. policies related to arriving for an appointment under the influence of drugs or alcohol, or the use of language that is offensive, threatening or of a sexual nature).

Physical therapists who passively tolerate situations that arise out of inappropriate patient expectations or behaviour hoping that the behaviour will cease on its own, or that the patient will stop coming for treatment or will eventually be discharged, are not actively managing the situation (Appendices D,H).

### Implement Reflective Practice to “Know Yourself”

An awareness of one's values, emotional “hot buttons” and thinking style is a good way of choosing how to respond to certain situations. One way to influence your response to a challenging situation is to understand how you handle adversity in general (Appendix H). Do you listen well or jump to conclusions, do you have a set agenda or are you willing to discuss and compromise? Tools such as an RQ (Resilience Quotient) Test,<sup>20</sup> along with strategies to prevent and handle adversity (ABCs: Adversity-Beliefs-Consequences)<sup>20</sup> are techniques to learn how to:

- listen to your thoughts;
- identify what you say to yourself when faced with a challenge; and
- understand how your thoughts affect feelings and behaviours.

## Strategies for Managing a Challenging Situation

When considering your response to potentially challenging situations, it may also be helpful to be mindful of:

- how you responded to previous challenging situations or conflicts, and past experiences which may have contributed to those responses;
- what assumptions you bring to situations of conflict that may color your responses; and
- how secure you feel about dealing with challenging and conflicting situations.

Some authors suggest that during conversations with other people “we assume we know all we need to know to understand and explain things.” They suggest the benefits of a “learning conversation” in which “...you want to understand what has happened from the other person’s point of view, explain your point of view, share and understand feelings and work together to figure out a way to manage the problem going forward.”<sup>22</sup>

It is important for physical therapists to be aware of and understand their own biases, limitations and personality while managing their emotional responses to the behaviour (Appendix H). Members must be as professional and calm as possible, regardless of what the individual says or does.

In addition to the need to be aware of, and prepare for, the potential effects of emotions and thoughts in advance of challenging situations, it is equally important to do so after concluding difficult situations. Emotions such as anger, guilt, shame and embarrassment may result after terminating a challenging situation<sup>20</sup> and go on to cloud professional judgment and the ability to function as a professional. This isn’t to suggest that emotion is bad; however, physical therapists need to avoid emotion that clouds their judgment and over-personalizes the interaction. This takes practice. All challenging situations demand significant time and energy. But if you know yourself, know your patient, focus on the big picture, are compassionate and always set limits, the next challenging situation may not be so demanding.

## Strategies for Managing a Challenging Situation

### Develop a Plan

Formulation and implementation of a plan to address a challenging interpersonal situation are essential steps in actively managing the situation (Appendix B). A plan may have many components or may involve a single conversation with the party involved. When physical therapists develop a plan, they should consider:

- the severity of the behaviour;
- the reasonability of the plan in relation to the challenging behaviours to be addressed;
- safety issues;
- time frame; and
- the ability to achieve the desired outcomes.

### Communicate the Plan

The goal is to alter or accommodate the behaviour to the extent possible in order to provide quality patient care and achieve the desired outcomes.

Once a plan has been formulated, the next reasonable step is to engage in a focused and thorough discussion with the party involved (Appendix D) that provides the following information:

- identification of the issue(s);
- an explanation as to why it is presenting a challenge;
- the changes or modifications that need to occur; and
- the possible consequences associated with failure to make the necessary changes or modifications.

### Document It

Physical therapists understand the importance of creating and maintaining accurate and complete health records with respect to the physical therapy care they provide to their patients. In some instances, it is also very prudent for physical therapists to have accurate and complete documentation related to any challenging situation that arises during a patient's episode of care.

## Strategies for Managing a Challenging Situation

The decision to document in the health record should be based on a number of factors. For example:

- the inherent risk in the situation;
- the impact on the physical therapist's ability to provide quality patient care and achieve optimal physical therapy outcomes;
- the likelihood that the situation can be resolved in a collegial and respectful manner; and
- being in a position to explain one's actions if asked to account for them later on.

The documentation should contain:

- a description of the behaviour observed or statements made including date and context;
- the steps taken to address the behaviour including the substance of any conversations, if applicable;
- a description of a plan including the expected outcomes and dates by which they need to be achieved; and
- the consequences if the outcomes are not achieved and with whom these were discussed.

Prior to documenting information about a challenging situation in a patient's health record, it is prudent for physical therapists to review and understand their professional and regulatory obligations with respect to the health record, as well as any other requirements described in other relevant statutes that apply to their physical therapy practice.<sup>7</sup> Generally, the entry would be recorded in the patient's health record if it was clinically relevant. If it is not clinically relevant it might be recorded elsewhere. In all situations, it is prudent for physical therapists to document in a manner that demonstrates accountability for their professional conduct.

### Monitor the Situation

Monitoring the situation is important in order to identify and actively manage a possible recurrence of the issue(s). The level of monitoring and the strategies employed to monitor each situation will vary.

## Strategies for Managing a Challenging Situation

For each situation, it is prudent for physical therapists to assess the “risk” or likelihood that the issue(s) will recur prior to deciding how they will monitor the situation. For example, if a physical therapist has a patient with an acquired brain injury where the patient has a history of episodes of aggressive or violent behaviour, the physical therapist will develop monitoring and intervention strategies that are reasonable for these types of behaviours. In contrast, another patient who is consistently late for his or her scheduled physical therapy appointments will not require the same level of monitoring and strategy development. In the first instance, the physical therapist may decide to treat the patient in a location and at a time of day that provides the greatest amount of safety for all parties concerned. This plan could include developing a signal to cue staff for assistance. In the case where the patient is always late, a physical therapist may have a discussion with the patient explaining why he or she should be on time for scheduled appointments and the consequences if the patient is unable to comply with this requirement.

Whatever the case, the monitoring is a fluid and continuous process that is adjusted according to the observed changes in behaviour and the “risk” assigned to the situation at any given time.

### End the Relationship

There are instances when, despite reasonable attempts by a physical therapist to actively manage a challenging situation and provide quality care to achieve the desired physical therapy outcomes, the only option is to conclude the situation by discharging the patient from treatment. These situations often relate to but are not limited to the following:

- a high and immediate risk of emotional or physical harm to the physical therapist or any other party; and
- a demonstrated inability on the part of the patient to comply with the plan to address the challenging situation.

## Strategies for Managing a Challenging Situation

Physical therapists who decide to discharge a patient from treatment or transfer a patient to another health care provider, are required to do so in accordance with standards of practice and any professional and regulatory obligations that define their conduct or actions with respect to these matters. Failure to do so may, in some instances, constitute professional misconduct. For example, in most circumstances the physical therapist should provide the patient with information as to where he or she might be able to obtain further services if they are needed. Also, in cases where immediate discharge is not warranted (e.g. where safety or abuse is not in issue) and the patient needs ongoing care, a reasonable period of notice to the patient of the discharge date may be indicated.<sup>7</sup>

Where the patient is receiving **needed services** one or more of the following criteria should apply for discontinuation of services to occur:

- the patient requests the discontinuation;
- alternative services are arranged,
- the patient is given a reasonable opportunity to arrange alternative services;
- the physical therapist is unable to provide adequate physical therapy services because there are insufficient resources available to meet the needs of the community in question;
- the patient has failed to make payment within a reasonable time for physical therapy services received, and all reasonable attempts on the part of the physical therapist to facilitate such payment have been unsuccessful;
- the physical therapist has reasonable grounds to believe that the patient may abuse them, verbally, physically or sexually; or
- the patient's lack of co-operation or compliance with his or her treatment plan is such that the services are not effective.

## Example Scenarios

### **Addressing a Patient's Capacity to Participate in Physical Therapy**

**Example** A new patient arrives for her physical therapy appointment and checks in with the receptionist. The receptionist comes to you and tells you that she suspects that the patient may be intoxicated. She is “slurring” and has “alcohol breath”.

**Discussion** The receptionist at the clinic has already alerted you to the fact that the patient may be intoxicated but it is important for you to remain objective before you conclude that this is the case. There may be a medical reason why the patient is slurring and the smell on her breath may be from something other than alcohol. However, if during the course of your interaction with the patient you are inclined to agree with the receptionist's assessment of her condition, it is reasonable for you to sensitively discuss your concern with the patient.

Describing your observations provides the patient with objective feedback without labeling the cause. Informing the patient about your expectations with respect to her demeanor and ability to fully participate while attending future appointments and reviewing any relevant organizational policies help ground your expectations. It is helpful to include a brief note in the patient's record that summarizes the key points covered in the discussion.

## Example Scenarios

### Managing Interprofessional Differences

**Example** A physical therapist assesses a patient for a shoulder problem. The clinical examination leads the physical therapist to suspect there may be a labral tear that requires further diagnostic testing to confirm the clinical impression. The physical therapist gives the patient a note for his physician that suggests further diagnostic testing would be helpful in establishing an accurate diagnosis of the shoulder problem. The physician writes the physical therapist a letter stating that the patient should have been initially directed to him for an assessment and it was the physical therapist's duty to direct the patient to the physician prior to seeing the patient.

**Discussion** The physical therapist is faced with a challenging situation that, if managed appropriately, is an opportunity to establish a respectful relationship with the physician and ensure that the patient receives the additional diagnostic testing required. Upon reflection, the physical therapist concludes that it may have been prudent to have spoken with the physician directly rather than send a note with the patient. A conversation between both parties provides an opportunity to immediately address any issues that may arise out of individual assumptions around the other person's behaviour or agenda. In this situation, the physical therapist would gain an understanding of why the physician expects his patients to see him before they access physical therapy services.

*While it is important for physical therapists to acknowledge their partnership with another health care provider, it is also reasonable to remind the other party that they are a trained professional with a set of skills and knowledge.*

Once this is understood by the physical therapist, he or she can develop a plan to manage the situation in order to achieve the desired outcomes of ensuring the best care for the patient and an ongoing respectful relationship with the physician.

## Example Scenarios

### Dealing with Family Members

**Example** A physical therapist working in the community is treating an elderly gentleman who lives with his daughter. The gentleman is capable of making all decisions with respect to his physical therapy treatment and personal care. The daughter is very attentive to her father and is often present during her father's physical therapy treatment sessions. The father freely speaks about his condition in front of his daughter and often includes her in discussions he has with you. He has told you that he is very comfortable discussing anything with his daughter present.

You receive a call from the daughter who tells you that she would like her father to be evaluated for a mobility aide that is different from what he is currently using because she believes it would be better for her father. She is calling to discuss this with you privately because she does not think her father will be receptive to this because "he doesn't like change."

**Discussion** On the surface, this situation may not present itself as being challenging. However, it should prompt the physical therapist to consider whether or not he or she has clarified with the patient what the daughter's role is in her father's care. This includes an understanding of the limits to and the type of information that can be shared between the physical therapist and his daughter. Discussions with all parties present where there is "free exchange" of information does not necessarily imply that private conversations between the daughter and the physical therapist are sanctioned by the patient. However well meaning the daughter may be, she may be making assumptions about her role that need to be actively managed by the physical therapist. For example, the physical therapist cannot agree to withhold information from the patient. This situation could escalate into something more challenging if assumptions are not discussed openly and a common understanding among all parties is not achieved.

## **Conclusion**

Challenging situations are an inevitable part of working in the health care system. Physical therapists are expected to manage each challenging situation in a calm, methodical and professional manner and, when appropriate, document the situation in the patient's health record, including the actions taken to resolve the situation. Where possible, physical therapists should reflect and develop an awareness of their conflict management style and strive to address the personal, interpersonal and systemic factors that may impact upon the delivery of quality patient care and the achievement of positive patient outcomes.

Most physical therapists are able to manage challenging situations and complete treatment with positive outcomes. Whether or not treatment can be completed, a challenging situation can be a valuable learning experience. Physical therapists can use the experience as an opportunity to reflect on their practice and develop new strategies to meet their responsibilities in situations that may arise in the future.

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## Appendix A

Challenging Situations  
That Occur Within Organizations

## Challenging Situations That Occur Within Organizations

In managing any challenging situation, it is helpful to view the level of conflict from a system's perspective. The following framework classifies the types of conflict that occur within organizations. When there is a recurrent theme to a challenging situation, the physical therapist is advised to discuss the situation with management.

**Intrapersonal** This involves a physical therapist having conflicting feelings about a personal course of action with a patient or colleague. The physical therapist may feel conflicted about supporting a patient's choice to forego a treatment (e.g. a patient refuses the recommendation to add acupuncture to her physical therapy treatment program).

**Interprofessional** Differences of opinion on patient care are to be expected; however, recurring differences of opinion between team members may indicate the need for clarification about roles or inappropriate interaction that requires a third party mediator (e.g. a physical therapist has a difference of opinion with another health care professional as to whether oxygen is considered a drug as a result issues

have arisen around the physical therapist's role in adjusting the flow of oxygen while the patient is exercising).

**Intragroup** Several parties or subgroups within a team may be in conflict with each other (e.g. within a physical therapy department there are differences in opinion on the frequency of treatment visits to be provided to patients residing in long term care who have been assessed to receive "maintenance" physical therapy).

**Intergroup** Most teams practice within a broader organization that may impose external pressures that produce conflicts between programs and teams (e.g. an outpatient services team united in opinion against a medical services team over required staffing levels).

Adapted from the American Geriatrics Society 2001.

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## Appendix B

Managing a Challenging Situation:  
a Decision Tree

## Managing a Challenging Situation: a **Decision Tree**

The physical therapist assesses the urgency of the situation, determining whether safety is an issue and if immediate action is required.

### IF YES

Acts immediately to **ensure the safety** of his/herself, the client and/or others. This requires creating a safe environment or removing self and/or others to a safe environment.

Once safety ensured, **reassesses the situation** identifying desired behaviour(s) to be addressed or concludes the relationship.

### IF NO

**Identifies the behaviour** leading to the challenging situation.

**Analyzes the factors** leading to the challenging situation considering:

- personal factors (values, assumptions, personality);
- other party's perspective (values, expectations, beliefs, personality); and
- systemic, contextual factors (resources, system in which care is provided).

**Develops a plan** for resolving the challenging situation.

**Manages the situation** proactively by:

- describing objectively the behaviour contributing to the challenging situation;
- explaining why the behaviour presents a challenge;
- describing the changes that contribute to a positive outcome, listing the explicit consequences if changes do not occur; and
- listening to the other party for clarification, negotiating the plan to achieve the desired outcome and reaffirming the consequences for achieving the desired outcome.

**Documents** all interactions, including the following, in the appropriate record:

- description of the behaviour that is challenging;
- desired outcome and proposed goal and action plan for achieving desired outcome;
- consequence for achieving or not attaining the outcome;
- resources used to support change; and
- indication of whether the situation was resolved.

**Reevaluates the situation** determining if the desired outcome has been achieved and asks if the situation was appropriately managed.

### IF YES

**Continues** the therapeutic relationship.

### IF NO

**Reevaluates** the action plan and acts accordingly OR **concludes** the therapeutic relationship.

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**Appendix C**  
Establishing Rapport

## Establishing Rapport

Active listening is the act of consciously participating and applying oneself to hearing what another person is saying. Active listening is an important component in establishing rapport with another individual. Physical therapists can use the FIBER checklist below to further develop their active listening skills.

### Establishing Rapport using Neuro-linguistic Programming

Neuro-linguistic programming (NLP)<sup>4</sup> is playing an emerging role in enhancing communication effectiveness in health care settings. Simply put, it is the art and science of establishing rapport. Neuro-linguistic

<b>F</b> ollowing	Are you attentive and following the other person?	programming is based on the idea that neurology, language and behaviour interact and specific techniques can be used to influence these systems. <sup>9</sup> NLP techniques can be used in everyday and challenging situations to establish rapport with others. The techniques involve verbal cues and non-verbal gesture, eye contact and postures to impart a message to another person. In communication, most of the messaging comes from non-verbal cues and tone of voice rather than the actual content of the message.
<b>I</b> Care	Are you showing that you care and are interested in what the other person is saying?	
<b>B</b> ody Posture	Does your body posture let the other person know you are alert and involved in the conversation?	
<b>E</b> ye Contact	Do you make appropriate eye contact with them while they are talking?	
<b>R</b> esponse	Are you responding with open-ended questions that generate future discussion? ( <i>Open ended questions encourage speakers to express their thoughts and feelings more thoroughly than closed ended questions.</i> )	

Adapted from McAffer, Effective and Value-Based Leadership Workshop 2004.

## Establishing Rapport

The techniques of *Matching, Pacing and Leading*<sup>29</sup> have not only been used to successfully establish a therapeutic relationship in health care settings, but also to diffuse potentially volatile situations. Matching involves the subtle copying of the other person's posture, body weight distribution, small hand, head and body movements and breathing. It also can extend to voice tonality, speed, volume and rhythm of speech. Once a connection has been made with the other person, a physical therapist can change his or her behaviour and it is likely the patient will follow. Pacing and leading are techniques where once rapport is established, changes in the physical therapist's posture, verbal tonality, speed of speaking and phrase will lead the patient to unconsciously follow.

An example of NLP is using the other person's language style including their actual words, pronunciation, jargon and preferred terminology in similar phrases or sentence length and tonality.

**Patient:** *"Coming here is frustrating because I have to wait so long to get in to see you."*

**Physical therapist:** *"Okay, since waiting so long to see me is frustrating, let's have you start your exercises before I see you in the treatment cubicle rather than waiting to do them after the treatment."*

Another example is the use of positive descriptive statements that indicate the desired behaviour of the patient rather than behaviour you don't want. Positive descriptive statements help patients visualize the behaviour that is desired and increases the likelihood of them understanding what is required. "Keep your feet shoulder-width apart" is more effective than "don't cross your feet" for a patient with a total hip replacement learning about their post-operative movement limitations.

Adapted from Bandler and Grinder 1975, Davis 2006, McAffer *Conflict Resolution Workshop* 2004 and Young 2004.

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**Appendix D**  
Assertive Communication

## Assertive Communication

Managing challenging situations requires assertive communication skills. Assertive communication is a learned technique that involves getting your message across without offending others, using direct, congruent expression of thoughts, feelings, beliefs and opinions in a non-offensive way.<sup>9</sup> Assertive communication differs from aggressive (behaviour in which you get your point across but are perceived by others as hostile, angry, offensive, sarcastic or humiliating) and non-assertive behaviour (passive behaviour in which you fail to get your message across).

There are eight types of assertive responses that can be used in the health care setting:

- being confrontational
- saying no
- making requests
- expressing opinions
- initiating conversation
- disclosing self
- expressing affection
- entering a room of strangers, willing to get to know others and allow others to be known

### The DESC Response and Modified DISC Response

These models provide a framework for handling any interaction where an individual needs to express their point of view.<sup>5</sup> The DESC format is used when there is an established relationship with the other party and some confidence that the other party will respond in a mature, respectful manner.

In some situations there is greater risk and less certainty about the response from the other party. In this case, the “E” is replaced with an “I”: **Indicate** the problem the behaviour is causing<sup>6,9</sup>

**D Describe** the situation.

**E Express** your feelings about the situation: “I feel \_\_\_\_\_.”

**S Specify** the change you want: “I’d like you to \_\_\_\_\_.”

**C Consequences.** Identify the results that will occur: “In that way \_\_\_\_\_.”

There are some dos and don’ts of good DESC conversations. To be successfully expressed it is equally important to attend to the “Don’t” as the “Dos”.

## Assertive Communication

	DO	DON'T
Describe	describe the other person's behaviour objectively	describe the emotional reaction
	use concrete terms	use abstract, vague terms
	describe a specific time, place and frequency of the action	generalize for "all time"
	describe the action, not the "motive"	presume the other person's motives or goals
Express	express your feelings	deny your feelings
	express them calmly	unleash emotional outbursts
	state feelings in a positive manner, as relating to a goal to be achieved	state feelings negatively making a put-down or attack
	address the specific offending behaviour, not the whole person	attach the entire character of the person
Specify	ask explicitly for change in the other person's behaviour	merely imply that you'd like a change
	request a small change	ask for too large a change
	request only one or two changes at a time	ask for too many changes
	specify the concrete actions you would like to see stopped and those you want to see performed	ask for changes in nebulous traits or qualities
	take account of where the other person can meet your request without suffering large losses	ignore the other person's needs or ask only for your satisfaction
	if appropriate, specify which behaviour you are willing to change to help resolve the issue	consider that only the other person has to change

## Assertive Communication

	DO	DON'T
Consequences	make the consequences explicit	be ashamed to talk about positive and negative consequences
	give a positive reward for change in the desired direction	give only punishment for lack of change
	select goals/objectives that are desirable for the other party	select something that only you might find rewarding
	select a meaningful positive consequence and provide sufficient support to maintain a behaviour change	offer a positive consequence you can't or won't deliver
	select consequences that you are willing to carry out	make exaggerated treats or use unrealistic/exaggerated threats of self-defeating punishment

Adapted from Bower 1976, Davis 2006, and McAffer *Effective and Value-Based Leadership Workshop* 2004.

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**Appendix E**  
Stages of Change Model

## Stages of Change Model

Also known as the Transtheoretical Model of Change, this model views behaviour change as a process that can be supported with stage-matched interventions. Embedded within the model are two key concepts: self-efficacy and decisional balance. Self-efficacy is a belief about one's ability to perform a particular behaviour at a certain level. Decisional balance, a component of decision-making theory, involves people weighting the importance of pros and cons and then adopting a behaviour based upon their evaluation of the cost benefit associated with the change. The model is applicable to health behaviours such as exercise, weight-reduction and smoking cessation. It is not clear if this model applies to populations with pain.

### PRECONTEMPLATION

**CHARACTERISTICS:** The client is not aware they have a problem, nor do they intend to take action in the foreseeable future usually defined as the following six months. Or, the client has tried to make changes a number of times and has become demoralized about their ability to change.

**MATCHED INTERVENTION:** Increase client awareness of the need for change, to personalize the information on risks and benefits, while promoting the benefits of changing.

**POTENTIAL FOR CONFLICT:** Clients are often characterized as being resistant or unmotivated to change.

### COMTEMPLATION

**CHARACTERISTICS:** The client is thinking about changing in the near future and intends to take action within the next six months. There is an awareness of the pros of changing but also the cons. The balance between the costs and benefits of changing is not great. Simply put, the cons outweigh the pros.

**MATCHED INTERVENTION:** Motivate the client, encourage specific plans and decrease the person's cons of changing.

**POTENTIAL FOR CONFLICT:** Ambivalence about the behaviour change keeps one in this stage for a prolonged period. Clients may be perceived as chronic contemplators or procrastinators.

### PREPARATION AND COMMITMENT

**CHARACTERISTICS:** The client is making plans to change, intends to take action within the next 30 days. Some significant behavioural steps in the desired direction have occurred.

**MATCHED INTERVENTION:** Assist the client in developing their action plan and setting goals.

**POTENTIAL FOR CONFLICT:** At this point decisional balance is paramount. The pros and benefits must be perceived as outweighing the cons such as costs and risks behaviour.

## Stages of Change Model

### **ACTION**

**CHARACTERISTICS:** The client has implemented an action plan and has changed their behaviour for less than six months. For the adoption of healthy behaviours such as exercise, the pros outweigh the cons.

**MATCHED INTERVENTION:** Provide feedback, support, reinforcements to help with the problem solving.

**POTENTIAL FOR CONFLICT:** There is usually a criterion level of behavioural change required for a positive change in health and reduction of risk.

### **MAINTENANCE**

**CHARACTERISTICS:** The client has changed their overt behaviour for more than six months.

**MATCHED INTERVENTION:** Help clients prepare for, avoid or handle relapse; help with coping, reminders, finding alternatives when faced with challenges and continue matching interventions.

**POTENTIAL FOR CONFLICT:** Generally, clients ability to maintain the change of behaviour is high. The client can be motivated and challenged.

### **TERMINATION**

**CHARACTERISTICS:** The client has adopted the new behaviour and can hardly remember having done the old behaviour.

**MATCHED INTERVENTION:** Continue providing maintenance-matched interventions as necessary,

### **REGRESSION AND RELAPSE**

**CHARACTERISTICS:** Can occur anywhere in the continuum.

**MATCHED INTERVENTION:** Clients rarely regress to precontemplation but often regress to the contemplation or preparation stage.

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## Appendix F

Dealing with Anger and Hostility

## Dealing with **Anger** and **Hostility**

Hostile and angry persons exhibit predictable patterns of behaviour that involve a cycle of escalating anger/rage for short periods then slowing down, escalating anger/rage and slowing down.<sup>3</sup> During the rage phase it is important to remain calm, and demonstrate active listening skills and not attempt to intervene. It is during the slowing down phase of the cycle that interventions and reasoning are effective. Gently redirect the person to a more private environment. Use supportive phrases that convey kindness and reassurance, such as “I know this must be difficult for you”, “If that happened to me, I would be angry too”, to show that you are hearing the patient. Being supportive does not mean you agree with the patient, it is a technique to defuse the escalating emotional response.<sup>9</sup> When the patient has finished the outburst, try to reach a solution and conclude the meeting with a plan for action. Finally, record all relevant information in the patient record.<sup>16</sup>

Try using the Five A’s when dealing with patients who are angry:<sup>14</sup>

**ACKNOWLEDGE** the problem

**ALLOW** the patient to vent uninterrupted in a private place

**AGREE** on what the problem is

**AFFIRM** what can be done

**ASSURE** follow through

**Example** Breaking news about funding. Gerald is referred following failed back surgery for treatment of low back and right lower extremity pain. He sustained the injury in a work-related accident and epidural steroid injections, non-opioid and opioid medications have all been unsuccessful in resolving his pain. Physical therapy treatment has had limited success, with pain scores remaining 7/10. No significant increases in function have been identified using outcome measures. Gerald has a history of substance abuse and family conflicts.

Your clinic has just received notification that Gerald’s visits will no longer be funded by the insurer. The information did not arrive in time for you to contact him before today’s scheduled appointment.

## Dealing with **Anger** and **Hostility**

When Gerald presents to the reception area and is told that his visit today will not be paid by the insurer and the clinic would like to establish who would be paying for his treatments, he reacts belligerently, shouting and verbally abusing the receptionist stating she could have contacted him earlier. Gerald demands to see the clinic manager.

He is provided with the appropriate outcome scales to monitor his status. Following that, he agrees to return for a reassessment if there are any changes in his status.

Adapted from the American Hospital Association 1983, Davis 2006, Potter 2003, Princeton Insurance, and Wasan 2005.

**Discussion** The receptionist pages the clinic owner, Tanya, who comes to the reception desk. She moves to the patient area of the waiting room, ensures that her body language and eye contact demonstrate she understands Gerald's dilemma. When it appears that his outburst is subsiding, Tanya asks Gerald to move from the reception area to her office. What follows is a reasoned discussion about the value Gerald places on the continuation of physical therapy services. He shares his perspective on the outcomes he felt were met and the implications of being able to afford the costs of future treatments. They agree upon a plan in which Gerald will take two weeks off to assess any changes in pain intensity or function levels.

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**Appendix G**  
Dealing with a Suicidal Patient

## Dealing with a **Suicidal Patient**

Over the lifespan of a career, physical therapists will encounter patients who are experiencing severe, unrelenting pain and other significant losses of physical health or mobility. Some of these patients may express suicidal intent. While it is not the role of the physical therapist to treat the underlying root of the suicide intent, it is ethically appropriate to address suicidality. The ethical conflict that arises from appropriately addressing suicidality is the conflict between “duty to warn” and maintaining “confidentiality of the patient’s health information”. A health care professional’s “duty to warn” arises when there is reason to believe a patient may cause serious harm or death to an identifiable person or group.

In Alberta, there is no legislation that imposes a positive “duty to warn” on health care professionals. Privacy legislation establishes the circumstances in which personal information can be disclosed without a patient’s consent, where the disclosure is necessary to prevent harm to a person.

A physical therapist should not hesitate to follow-up on patients who express suicidal thoughts and express intent. Such questioning will not increase the chances of self-harm. Instead, it demonstrates to the patient that the physical therapist is concerned about his or her life and well-being and that in itself can be a mitigating factor in decreasing the chances of attempted suicide. Suicidal intent should be taken seriously, despite any suspicion that an individual is engaged in attention seeking behaviour. Suicide attempts when disclosed should be discussed openly. Coordination with the attending physician or licensed mental health practitioner is essential. For crisis situations, patients must be informed of any limits of confidentiality and the necessity of active consultation with other parties trained to deal with patients in crisis.

## Dealing with a **Suicidal Patient**

When dealing with someone in crisis the following steps can be followed:

- evaluate the suicidal intent and lethality;
- establish the existence and feasibility of a suicide plan;
- identify evidence of self-destructive behaviour and past suicide attempts;
- attempt to establish an alliance with the patient;
- consider a contract for safety;
- refer to a mental health specialist with training in suicidal evaluation and treatment and/or escort or arrange an escort to a hospital emergency room for further evaluation; and
- document communication with the patient, treatment strategies and contacts with other health care providers.

More detailed information on suicide risk assessment can be accessed at [www.rmfm.harvard.edu](http://www.rmfm.harvard.edu).

Adapted from Montgomery Emergency Service Inc. and Wasan 2005.

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## Appendix H

Styles of Conflict Management

## Styles of Conflict Management

Individual responses to conflict management generally fall into one of five categories:

- competing
- accommodating
- avoiding
- compromising
- collaborating

The responses are based upon a model that views conflict management responses from the perspective of varying levels of assertiveness and cooperativeness (Figure 1).

While, it is suggested that a collaborative approach is the desired method for resolving conflict, the other four responses can also be used when circumstances warrant.<sup>16</sup>

It has been demonstrated that gender may impact one's response to conflict. Men and women differ in how they perceive and handle conflict. Men prefer using strategies involving social influence and persuasion whereas women prefer strategies involving negotiation and mediation.<sup>10</sup> Women often respond using avoidance and compromise and reject competition, whereas men often use a competing/dominating response.

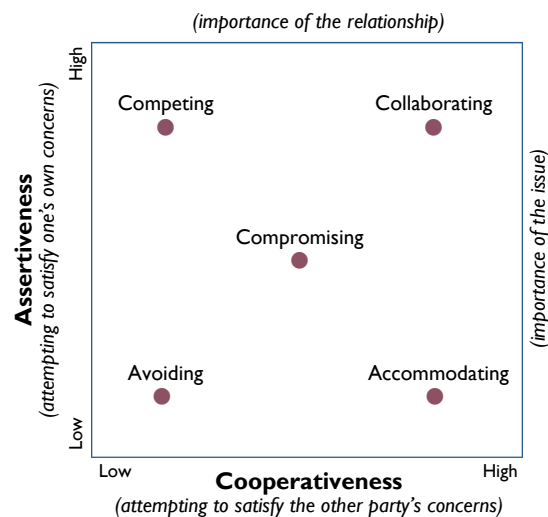


Figure 1: Two-Dimensional Model of Conflict Behaviour (Adopted from Ruble & Thomas 1976)

## Styles of **Conflict Management**

Front line nursing staff and nursing administrators typically respond using avoidance, accommodation or compromise as preferred conflict management styles.<sup>20</sup> Collaboration is rarely used. Competing strategies generally are rejected. Conflict management pattern nursing differs from male-dominated groups, and these differences are mainly attributed to the fact that the profession is female dominated.<sup>19</sup> It is thought that other factors inherent within the health care system, such as the power imbalance that exists between professional groups (i.e. physicians), influence the conflict management response of individual nurses.<sup>19</sup>

Physical therapists must be aware of their preferred conflict management style and understand that successful management of a challenging situation sometimes involves the adoption of different conflict management styles. When working in teams, physical therapists must be aware that a variety of factors not limited to one's own conflict response style, the healthcare team's gender composition and the mix of professionals on the team have the potential to impact the team's coherence in adequately addressing critical issues.

It is incumbent on physical therapists to use appropriate strategies to voice specific concerns about individual physical therapy programs and the overall contributions of physical therapy to care service delivery models.

### **Conflict Management Response**

**Competing** This power-oriented strategy involves meeting one's own needs, often at the expense of other individuals. The goal is to win, sometimes at all costs. This strategy often involves domination through formal use of authority, physical threats, manipulation ploys or ignoring the claims of another party.

The competing style is useful when a person has to take quick action, make unpopular decisions, handle vital issues or when one needs protection in a situation where noncompetitive behaviour can be exploited. To develop this style, one must develop the ability to argue and debate, use rank and position, assert opinions and feelings, learn to state his/her own opinion and stand his/her ground.

## Styles of **Conflict Management**

Overuse of this style leads to lack of feedback, reduced learning and low empowerment. People overusing this style often use inflammatory statements due to a lack of interpersonal skills training. While one's needs are met, the other party may feel defeated. Overuse results in errors in the implementation of a task.

Underuse of this style means concerns regarding patient care may not be expressed, heard or are overridden.

### Conflict Management Outcomes:

- win-lose
- assertive, uncooperative
- short-term resolution

**Avoiding** Avoidance neglects the interests of both parties by sidestepping the conflict or postponing a solution. One party does not pursue its own concerns or those of another party. The goal is to defer confrontation, escape responsibility or delay.

Avoidance may be appropriate for issues of low importance, as a cool down mechanism to reduce tension or buy time. It is also a useful response for those in a position of low power who have little control over a situation and/or when one wants others to deal with the conflict.

In some situations it is desirable to develop skills related to knowing when to withdraw and sidestep issues. Avoidance is best used when time is not a factor.

Repeated use of avoidance results in issues never being addressed from a strategic planning perspective. Issues are typically allowed to fester, remain unresolved and ultimately contribute to a breakdown in communication between team members. Decisions around crucial patient care issues tend to be made by default.

### Conflict Management Outcomes:

- lose-lose
- unassertive, uncooperative
- short-term resolution

**Compromising** In order to find common ground, both parties make sacrifices to arrive at a solution. Often the end result is partial satisfaction.

There is considerable practice application to a compromising response. Situations of moderate importance may be “quickly” resolved to the satisfaction of both parties with the sense that equality guided the decision-making process while relationships remain intact.

## Styles of **Conflict Management**

Compromising skills include the ability to maintain a dialogue about an issue and to assign value to all aspects of the issue.

In the long term, compromising does not address solutions for good patient care based on merit and has the potential to undermine long-term strategic goals. Overuse of compromising results in being perceived as having no firm values, who consistently concedes to another's desires without addressing the root of an issue.

**Accommodating** One party neglects their own concerns to satisfy concerns of others, seeks to maintain harmonious relationships by emphasizing similarities, minimizes differences and self-sacrifices. The goal is to yield. It is appropriate in situations where you want to show that you are reasonable, develop performance, create good will, keep the peace, retreat or for issues of low importance. Accommodating skills include the ability to sacrifice, the ability to be selfless, to obey orders and to yield.

The accommodating style is useful for routine issues, when one is wrong, when an issue is more important to the other party, when one is outmatched, to preserve harmony or to teach others.

Overuse results in ideas getting little attention, restricted influence, loss of contribution and anarchy. One of the main desires is to keep everything the same and may include self-sacrifice. Patient care or concerns around physical therapy service delivery may never be brought forth.

### **Conflict Management Outcomes:**

- lose – win
- unassertive, cooperative
- short-term resolution

**Collaborating** A collaborative response involves seeking to fully satisfy both parties' concerns with a goal of finding a win-win solution. This problem solving approach is used to find solutions to the issue without assigning blame or fault. Collaboration is considered the most efficacious conflict management strategy, appropriate for use in a team environment as it is good for dealing with critical issues and for long-term resolution of conflict where time is not a factor.

## Styles of **Conflict Management**

Promoting collaboration involves integrating solutions, learning, merging perspectives, gaining commitment and improving relationships. This style supports the open discussion of issues, task proficiency, equal distribution of work amongst team members, better brainstorming and creative problem solving. Collaboration skills include the ability to use active or effective listening, confront situations in a non-threatening way, analyze input and identify underlying concerns.

Overuse of collaborating can lead to focusing on trivial matters, diffusion of responsibility, being taken advantage of and becoming overloaded with work.

Underuse results in quick fix solutions, lack of team member commitment, disempowerment and lost of innovation.

### **Conflict Management Outcomes:**

- win – win
- fully assertive, highly cooperative
- long-term resolution

Adapted from Ruble and Thomas 1976, Whetten and Cameron 1995, Davis 2006, MIT Collaboration Toolbox 2001, Valentine 1998 and 2001.

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