

Disruptive Behavior in the Respiratory Therapy Workplace

Amanda L. Roby, MHHS, RRT, RPSGT

Salvatore A. Sanders, PhD, RRT

John M. Hazy, PhD

Teresa A. Volsko, MHHS, RRT, FAARC

Abstract

BACKGROUND: The purpose of this study was to explore the prevalence, setting, sources, and types of disruptive behavior respiratory therapists experience. Three hypotheses were tested: (1) respiratory therapists experience disruptive behavior in the workplace; (2) verbal disruptive behavior is the most common form reported by respiratory therapists, (3) the incidence of disruptive behavior is higher among bedside caregivers than managers or educators. The greatest source of disruptive behavior is described. **METHODS:** A 23-question survey gleaned data to evaluate disruptive behavior respiratory therapists may witness or experience at their place of employment. This research was approved by the institutional review board and informed consent was obtained prior to participation. The survey was distributed electronically to respiratory therapists who were members of the American Association for Respiratory Care's adult acute care, management and education specialty sections. **RESULTS:** A total of 119 of a possible 3,941 participants (3%) completed the survey. Ninety-six percent of individuals surveyed experienced a form of disruptive behavior. Both hypotheses two and three were not supported. Similarly 96% witnessed a co-worker experiencing a disruptive event. No difference in the type of disruptive behavior was experienced by job category. Bedside caregivers did not experience disruptive behavior more often than department technical directors, educators, or supervisors. Disruptive behavior was deemed unacceptable. "Zero tolerance" initiatives were identified by some participants as a means to control disruptive behavior. **CONCLUSIONS:** Respiratory therapists in all job categories experience disruptive behavior. Those affected by disruptive behavior were willing to explore effective ways to control disruptive behavior.

Key Words: disruptive behavior; verbal abuse; physical abuse; sexual abuse; psychological abuse; disruptive work environment

Amanda L. Roby, MHHS, RRT, RPSGT
Cuyahoga Community College
Westlake, OH

Salvatore A. Sanders, PhD, RRT
Department of Health Professions
Youngstown State University
Youngstown, OH

John M. Hazy, PhD
Department of Criminal Justice
Youngstown State University
Youngstown, OH

Teresa A. Volsko, MHHS, RRT, FAARC
Department of Respiratory Care and Transport
Akron Children's Hospital
Akron, OH

Correspondence and Request for Reprints
Amanda L. Roby, MHHS, RRT, RPSGT
Cuyahoga Community College
31001 Clemens Road
Westlake, OH 44145
Amanda.Roby@tri-c.edu

Introduction

There is a need for research as workplace disruptive behavior in health care organizations gains increasing recognition as a growing concern. Violence in health care settings is a pervasive problem and an epidemic that constitutes an occupational hazard.¹ The literature reports disruptive behavior and threats of violence are major stressors for health care professionals of all disciplines.² Although this problem has been recognized by leading national organizations such as the National Crime Victimization Surveys, The Joint Commission (TJC), and the American Medical Association (AMA), there is a lack of agreement on the definition of disruptive behavior. Furthermore, there is no uniform testing instrument to measure disruptive behavior.

TJC acknowledges the negative effects intimidating and disruptive behaviors such as verbal outbursts, uncooperative attitudes, and impatience with questions create for a health care organization.³ This organization describes disruptive behavior as "...behavior or behaviors that undermine a culture of safety."⁴ The AMA describes disruptive behavior as, "Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively."⁵ Disruptive behaviors compound the stress health care workers experience, which is inherent to the physical and psychological demands of the workplace. The additional stress contributes to hypertension, ulcers, mental exhaustion, and other disease processes, as well as adverse stress-triggered health behaviors such as smoking, overeating, and substance abuse.¹

There are many types of disruptive behaviors. Verbal disruptive behavior is manifested in the words, tones, and non-verbal mannerisms an individual uses. This form of workplace violence leaves no visible scars, but can be emotionally devastating.⁶ Power over another can be also be used with the intent to dominate. Bullying, horizontal or lateral violence, and mobbing are examples of this type of disruptive behavior. Bullying is currently widespread and refers to situations of repetitive harassment that occur between persons of the same level of authority or in differing hierarchical levels (i.e. manager to a subordinate).⁷ Horizontal or lateral violence is associated with displays of aggression towards someone on the same hierarchical level (i.e. staff respiratory therapist).⁸ Mobbing occurs when disruptive behaviors stem from a group and impact one individual.⁹ This type of behavior dismantles cohesive teams, threatens the victim's well-being, and contributes to serious safety events.⁴

Disruptive behavior may affect the victim and health care organizations differently. Hamlin and colleagues reported that victims of disruptive behavior experienced physical and psychological ailments such as nausea, stomachaches, headaches, weight change, blood pressure changes, fatigue, and insomnia, which influenced their willingness or decision to leave

the organization.¹⁰ A disruptive work environment compromises the function of the health care institution through litigation, job performance issues, employee dissatisfaction, decreased work effectiveness, decreased productivity, high absenteeism, low staff morale, and high staff turnover.¹⁰ A dearth of literature exists to describe the prevalence or types of disruptive workplace behavior respiratory therapists experience. Most of the research in this area is nursing focused. The purpose of this research is to determine whether respiratory therapists experience disruptive behavior, where disruptive behavior is most prevalent with regard to work environments, and if disruptive behavior is different among job classes. Three hypotheses were tested: (1) respiratory therapists experience disruptive behavior in the workplace, (2) verbal disruptive behavior is the most common form reported by respiratory therapists in the health care environment, (3) the incidence of disruptive behavior is higher among bedside caregivers compared to managers and educators. Finally, the greatest source of disruptive behavior is described.

Methods

Research Design

A survey was used to ascertain the prevalence, type, and past and current experience with and impact of disruptive behavior on respiratory therapists. This study was approved by the institutional review board and conducted in a non-experimental approach.

Instrument

The testing instrument, Appendix A, was an electronically distributed 23-question survey. Since a published validated survey was not readily available, a survey instrument was constructed. Validation of this instrument was conducted on a small sample of respiratory care practitioners 12 months prior to the initiation of this study. Six questions addressed participant demographics such as age, gender, and longevity in the field. Workplace data, including organizational type, bed capacity, and geographic location, were also collected. The remainder of the questions elicited responses on the occurrence, setting, and details of the disruptive behavior experienced or witnessed by the participant, as well as precipitators of the disruptive behavior. One open-ended question collected ideas for ways to minimize and/or eliminate disruptive behavior in the workplace.

Validation of the Instrument

Prior to the initiation of this research project, validation of the survey instrument was performed to test for construct and content validity. The respiratory care staff at a large academic medical center in Youngstown, OH, was recruited. A hard copy of the testing instrument was distributed to credentialed and licensed respiratory therapists at the 500-bed

academic medical center. The survey was anonymous and confidential. It was administered and proctored by the co-investigator after informed consent was obtained. Bedside caregivers, educators, supervisors, and managers were eligible to participate. Thirty-two participants were recruited and a 100% survey return rate realized. The process allowed participants to address concerns and ask or clarify questions prior to the completion of the instrument. Participant comments regarding question clarity were recorded and used to refine questions for the final survey instrument.

Selection of Subjects

The sample consisted of practicing credentialed respiratory therapists who were also members of the American Association for Respiratory Care (AARC) and subscribed to one or more of three specialty sections. Specifically, AARC members of the adult acute care, management, and/or education specialty sections were recruited. This sub-section was selected to make efficient use of the research time and financial resources. The listing of AARC members recruited for the study was accessed through the association's member services and provided the potential for a convenience sample of 3,961 participants. Subscribers to more than one specialty section were only listed once. Prior to the distribution of the survey the AARC president and executive committee reviewed the instrument and study procedures and approved distribution to the sample population.

Participants were not selected on the basis of job function, but were stratified by job function for sub-analysis and comparison of the incidence and type of disruptive behavior encountered.

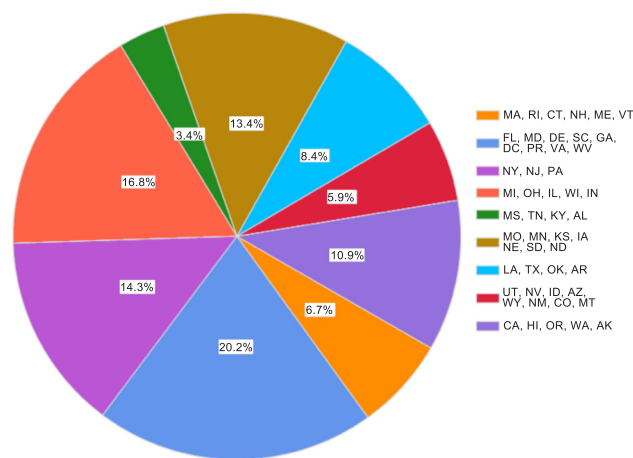
The survey was created in Survey Monkey under a Pro plan (www.surveymonkey.com), which allowed participants to log out and return to complete the survey at a later time. The survey was constructed to prevent subjects from responding to the survey more than one time. Informed consent was implied and obtained by virtue of the participant electing to respond to or complete the survey instrument.

A reminder email was built into the survey design to improve the response rate. The reminder was sent electronically approximately 1.5 weeks after the initial recruitment email. A sample size of 100 was targeted, with more being acceptable and any less than 50 considered insufficient. The survey did not allow participants to address any concerns or ask or clarify any questions. However contact numbers for the research team were provided in the recruitment letter to facilitate two-way communication and address concerns or provide clarification to those consenting to study participation.

Data Collection and Analysis

The introductory remarks and link to the survey tool were sent to the AARC's director of education and management

Figure 1
Regional Distribution of Participants (n = 119)



services, who in turn informed the AARC specialty section chairs of the study purpose and survey dissemination process. The invitation to participate was distributed electronically through AARConnect to members of the adult acute care, education, and management specialty sections by the respective section chairs. Participants had three weeks to access and complete the survey.

Completed surveys were collected electronically through Survey Monkey Data and entered into SPSS Version 15 for Windows (SPSS Incorporated, Chicago, IL) for analysis. Descriptive statistics were used to report incidence and type of disruptive behavior as well as the main source of the disruptive behavior. The proportion of subjects experiencing disruptive behavior by job classification was compared using Chi-Square. An ANOVA was used to detect differences in the incidence of disruptive behavior among bedside caregivers, managers, and educators. Statistical significance was established at $p < 0.05$.

Results

Demographic Profile of the Sample Population

A total of 119 from a possible 3,961 participants (3%) consented to participate in this study. Regional distributions of study participants are listed in Figure 1. There were no incomplete surveys. Subjects were predominately female, $n = 71$ (59.7%). Longevity in the field varied, with a majority of participants, 47.1%, having more than 30 years of experience in the field of respiratory care, Figure 2. The most responses were from department or technical directors of respiratory care departments (47.9%), Figure 3.

Nearly three quarters of participants (76%) worked in the acute care hospital. Educators represented 22% of the study population and worked either as a clinical educator within a

Figure 2
Longevity in the Field (n = 119)

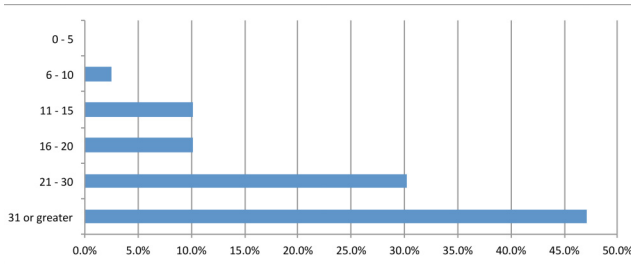


Figure 3
Percent of respondents stratified by their defined primary job function (n = 119). Staff respiratory therapists were defined as certified or registered respiratory therapists who function as primary bedside practitioners. The job category for supervisor or team leader also included responses from front line leadership roles such as quality specialist, manager, and clinical coordinator. The job category defined as “other” included charge or lead therapists who had a blended leadership and staff role.

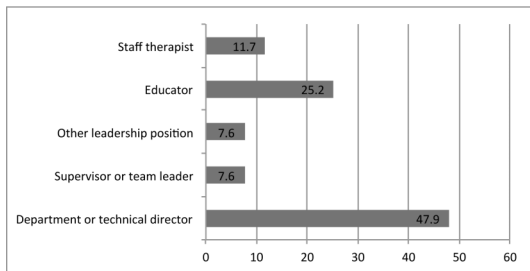
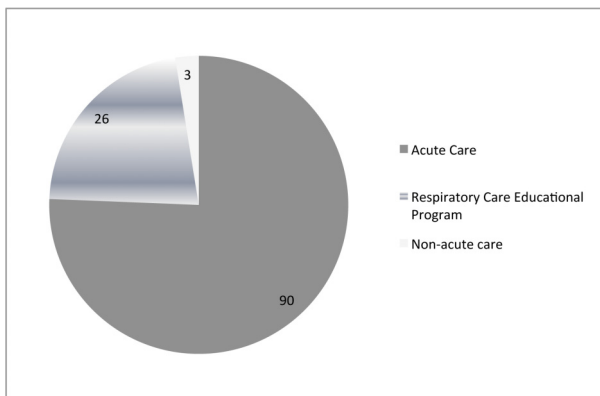


Figure 4
Primary Work Environment Reported by Study Participants (n = 119)



respiratory care department or faculty for a respiratory care program at a post-secondary institution. A minority of participants (3%) reported working in an area outside of acute care. Two reported working in the long term care setting (sub-acute care or skilled nursing facility) and one in a physician’s office, Figure 4.

Prevalence of Disruptive Behavior

Ninety-six percent of individuals surveyed experienced a form of disruptive behavior. An equivalent percentage of individuals, 96%, witnessed a co-worker experiencing a disruptive event. The disruptive behavior manifested itself in multiple forms. More than one half (55.5%) experienced verbal disruptive behavior. A few (4.2%) experienced sexual harassment and physical imposition. No difference was found in the disruptive behavior manifestation by job classification, $p = 0.29$, Table 1.

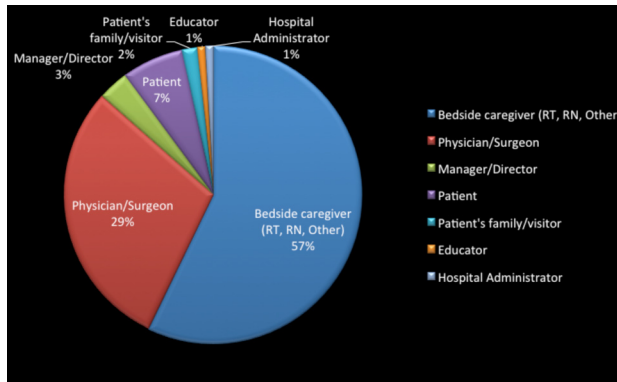
Bedside caregiver (57%), physician/surgeon (29%), and patient (7%) were identified as offenders, Figure 5. Males exhibited disruptive behavior (55.5%) more frequently than females (44.5%). Participants ranked peers (44.7%) as the most common offenders of disruptive behavior within the workplace, followed by a physician/surgeon (36%). Managers and supervisors were reported as the least common offenders (2%), Figure 6. Bedside caregivers did not experience disruptive behavior more often than department technical directors, supervisors, or educators, $p = 0.78$.

Most participants (58%) indicated the disruptive event did not occur during or immediately following a high stress situation. The primary cause was one in which there was an innate need for the offender to be in control of a particular situation or event. Survey participants (73.9%) described the

Table 1
Comparison of Disruptive Behavior by Job Classification

Type of Disruptive Behavior	Educator	Department or Technical Director	Staff Therapist	Other	Total	p Value
Psychological	11 (9)	30 (25)	3 (3)	4 (3)	48 (40)	0.29
Verbal	16 (13)	35 (29)	9 (8)	6 (5)	66 (55)	
Physical	2 (2)	0 (0)	1 (1)	0 (0)	3 (3)	
Sexual harassment	1 (1)	1 (1)	0 (0)	0 (0)	2 (2)	
n (%)					119 (100)	

Figure 5
Role of the Disruptive Behavior Offender (n = 119)



perpetrator as one who forced the respiratory therapist into a subordinate role.

Exposure to disruptive behavior elicited varied responses. Most participants felt angered (36.1%). The next most frequent response was embarrassment (21%), followed by powerlessness (10.1%), harassment (9.2%), fearfulness (5.9%), confusion (4.2%), and hostility (0.8%). The ability to report emotional responses was not displayed as a survey option. These data are reported in aggregate and categorized as "other." Approximately 12.6% of subjects added additional responses and reported feeling stressed, disappointed, anxious, annoyed, shocked, and frustrated.

Disruptive behavior reduced morale (100%) and productivity (93.8%); increased the propensity for medical error (87.6%); and reduced the quality of care delivered (75.6%). Respondents reported experiencing physical ailments such as depression, anxiety, and migraines (94.6%). A majority of participants (83.2%) disagreed with the statement, "Disruptive behavior occurs in health care. It is just something I must accept as a part of my job."

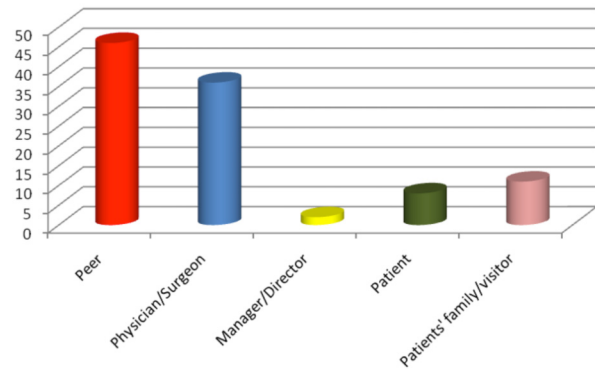
Most of those surveyed (87.4%) were aware of their institution's Workplace Violence or Corporate Code of Conduct policy. A few participants (4.2%) reported not having the aforementioned organizational policies, and 8.4% were unsure. Nearly 74% of participants reported the disruptive event to an organizational leader. Most participants (67.2%) agreed that a "Zero Tolerance" policy and structured discipline would eliminate or reduce disruptive behavior.

Discussion

Consistent with reports in the nursing literature, this survey confirmed that respiratory therapists experience disruptive behavior in the workplace. Verbal disruptive behavior was the most commonly experienced and was manifested as condescending, angry, accusatory, and/or vulgar comments.

Bedside caregivers were more likely to be offenders than

Figure 6
Frequency of Disruptive Behavior, Ranked by Frequency of Offense (n = 119)



individuals in a leadership role (supervisors, managers, educators). Respondents reported that this disruption compromised multidisciplinary teamwork, contributed to medical error, and reduced the delivery of safe and effective patient care. Our findings are consistent with reports in the literature describing how disruptive behavior undermines a collaborative work culture, especially when this behavior originates from the primary care team.¹¹ Hospitals with high teamwork ratings experience greater patient satisfaction, improved staff retention, and lower hospital costs.¹² Organizations in which disruptive behavior, aggression, and violence prevail accrue greater financial costs and lower quality of care ratings secondary to increased absences and turnover, as well as a reduction in employee morale, job satisfaction, and productivity.¹³

It is important to note that the survey participants did not feel that disruptive behavior was something that just happened and must be tolerated. A majority, 83.2%, acknowledged that disruptive behavior does occur in health care, but did not feel it is something the health care professional must merely accept as a part of the job. Respiratory therapists working in a disruptive environment show adaptive behaviors and possess significant coping skills. This is evidenced by the longevity in the field reported by the participants in this survey, with nearly one half (47%) documenting more than 30 years of work experience. Greater than 71% of participants reported they had never contemplated leaving their respective employment position after experiencing behavior that resulted in a disruptive event. Perhaps it is these individuals who face the challenge head on and try to redirect the aggressive behavior, thus deescalating the situation. Participants reported that it is important to encourage staff to document and report disruptive behavior immediately. Individuals need to know that they will be supported if they come forward with concerns about another's behavior.

There are respiratory therapists who, for reasons not assessed in this particular research endeavor, do not advocate for

themselves and succumb to the stress of the health care environment. This group of individuals may be among the nearly 29% who contemplated leaving health care. It is essential for those in leadership positions to develop a process to deal with disruptive behavior before it becomes an issue in the workplace. Educators play a significant role in improving the recognition and consequences of this type of behavior. Through education, policies, and administrative support, the incidence of disruptive behavior can be minimized.¹ Survey participants offered strategies to minimize and/or eliminate the occurrence of disruptive behavior similar to those reported in the literature. Increased awareness of the disruptive behaviors, developing a culture of respect, improved communication, and cooperation in the workplace were effective means of reducing disruptive behavior in the health care workplace.¹⁴

Limitations

The relatively small size of this convenience sample makes the results of this study difficult to generalize to the respiratory care profession. To illustrate this, our demographic profile did not match the demographic profile of respondents to the 2009 AARC Human Resource Study. Although members of the adult acute care section were recruited, the respondents to our survey were predominantly (63.1%) in leadership positions. Only 8% of those in leadership positions responded to the AARC Human Resource Survey. Recruiting from all AARC members, rather than those who also subscribe to a specialty section, may have improved our ability to generalize our results.

Our results may also have been impacted by the job classification of individuals who routinely utilize the section discussion lists. The Human Resource Study used postcards to recruit subjects, whereas our subjects were recruited by a posting on the respective section discussion lists. There were also disparities in the longevity in the profession. In our study population, 77.4% of participants had greater than or equal to 20 years of experience in respiratory care. Respondents to the AARC Human Resource Survey had on average less than 20 years in the field.

The increased awareness of organizational workplace disruption policies and/or Codes of Conduct may have been influenced by the fact that an overwhelming majority of participants were victims of or witnessed disruptive behavior in the workplace.

Conclusion

The causes of disruptive behavior are complex but can be identified within organizations that employ respiratory therapists. It was evident by the responses that disruptive behavior exists within the respiratory workplace and is experienced by those with different job classifications. An increased under-

standing of the causes and consequences of disruptive behavior will help members of the respiratory team effectively deal with disruptive events and high stress environments to help minimize displaced anger.

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APPENDIX A – Testing Instrument

Disruptive Behavior in the Respiratory Therapy Workplace

1. In what region do you work?
 - MA, RI, CT, NH, ME, VT
 - FL, MD, DE, SC, GA, DC, PR, VA, WV
 - NY, NJ, PA
 - MI, OH, IL, WI, IN
 - MS, TN, KY, AL
 - MO, MN, KS, IA, NE, SD, ND
 - LA, TX, OK, AR,
 - UT, NV, ID, AZ, WY, NM, CO, MT
 - CA, HI, OR, WA, AK

2. In what setting do you primarily work?
 - Acute care hospital
 - Home care
 - Subacute or long-term acute care
 - Skilled nursing facility
 - Respiratory care education program
 - Physician's office or clinic
 - Sleep Disorder Center

3. If you work in an acute care hospital, what is the bed capacity?
 - 1-100 beds
 - 101-200 beds
 - 201-400 beds
 - 401-or more beds

4. What is your primary job function?
 - Staff Respiratory Therapist
 - Pulmonary Function Technologist
 - Sleep Specialist
 - Neonatal or Pediatric Specialist
 - Supervisor or Team Leader
 - Department or Technical Director
 - Educator
 - Other _____

5. How many years have you been in healthcare? (Check one)
 - 0-5 years
 - 6-10 years
 - 11-15 years
 - 16-20 years
 - 21-30 years
 - 31 and over

6. Gender (check one)
 - Male Female

7. In your work experience in the hospital setting have you ever experienced a disruptive event? (Check one)
 - Yes No

8. In your work experience in the hospital setting have you ever witnessed a co-worker experiencing a disruptive event? (Check one)

- Yes No

9. Which type of disruptive behavior have you experienced or witnessed the most? (Check one)

- Verbal (examples: verbal outbursts, yelling, cursing)
- Physical (examples: hitting, pushing, shoving, striking, throwing objects)
- Sexual harassment (unwanted sexual advances, verbal or physical)
- Psychological (examples: uncooperative attitudes, impatience with questions)

10. What role was the disruptive behavior offender functioning in? (Check only one)

- Bedside Caregiver (RT, RN, Other)
- Physician/Surgeon
- Manager/Director
- Patient
- Patient's family/visitor
- Educator
- Hospital Administrator

11. What was the gender of the person(s) who most frequently performs these disruptive behaviors? (Check one)

- Male Female

12. Of the events you witnessed or experienced which of the following have been sources of disruptive behavior or un-professional conduct? (Rank on frequency of offense)
(1 = most common and 5=least or never)

Peer	1	2	3	4	5
Physician/Surgeon	1	2	3	4	5
Manager/Director	1	2	3	4	5
Patient	1	2	3	4	5
Patients' family/visitor	1	2	3	4	5

13. Which of the following best describes your feelings following a disruptive event? (Please check only one)

- Powerless
- Fearful
- Hostile
- Harassed
- Embarrassed
- Angry
- Confused
- Other: _____

14. Did the event occur during or immediately after a high stress situation (example: trauma teams, intensive care teams) for either you or the disruptive individual? (Check one)

- Yes No

15. Certain situations have been shown to trigger stress and possible disruptive behavior. Please indicate all that you feel would trigger these behaviors. (Check all that apply).

- Equipment needed for a procedure is malfunctioning.
- Equipment needed for a procedure is not immediately available.
- The disruptive individual feels the need to be in control so he/she forces the therapist into a subordinate role.
- The disruptive individual is angry at another department.
- The disruptive individual feels there is a time delay.
- The disruptive individuals order is questioned.
- A sudden change happens in the patient's status
- Other: _____

16. Have you ever contemplated leaving healthcare due to a disruptive event or behavior? (Check One)

- Yes
- No

17. Based on your experience with disruptive behavior, respond to the questions below based on what you believe to be true.

a. The incident can have a negative effect on morale? (Check one)

- Yes
- No

b. The incident can decrease the victim's level of productivity for a period of time? (Check one)

- Yes
- No

c. The incident could lead to an increase in medical errors? (Check one)

- Yes
- No

d. Repeated exposure will influence the caregivers or providers in a negative way? (Example: depression, anxiety, migraines)

- Yes
- No

18. Do you believe that quality patient care provided by the victim is affected by disruptive behavior?

- No

Yes, please explain: _____

19. Disruptive behavior occurs in healthcare. It is just something I must accept as a part of my job.

- agree with the statement
- disagree with the statement

20. Does your institution have a Workplace Violence Policy or Code of Conduct? (Check one)

- Yes
- No
- Unsure

21. Have you ever reported a disruptive incident? (Check one)

- Yes
- No

22. Do you feel that a policy of zero tolerance for disruptive behavior and a structured discipline process for offenders would help to reduce or eliminate the use of disruptiveness? (Check one)

- Yes
- No
- Uncertain

23. What do you feel would help to reduce or eliminate the disruptive behavior?
