Ten Domains of De-escalation

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patient is saying
7. Agree or agree to disagree
8. Set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

Domain I: Respect Personal Space

Key Recommendation: Respect the Patient's and Your Personal Space

When approaching the agitated patient, maintain at least 2 arm's lengths of distance between you and the patient. This not only gives the patient the space he needs, but also gives the clinician the space needed to move out of the way if the patient were to kick or otherwise strike out. The clinician may want to give himself more distance in order to feel safe; and, if a patient tells you to get out of the way, do so immediately. Both the patient and the clinician should be able to exit the room without feeling that the other is blocking his way.

A high percentage of patients have a past history of trauma, and the emergency experience has the potential for repeating the traumatic experience when specific aspects of personal space are ignored. A person who lives on the street may be very sensitive about protecting his belongings. Those who have been sexually abused may be apprehensive about being unclothed, which can increase their sense of vulnerability and cause humiliation.

Domain II: Do Not Be Provocative

Key Recommendation: Avoid Iatrogenic Escalation

The clinician must demonstrate by body language that he will not harm the patient, that he wants to listen, and that he wants everyone to be safe. Hands should be visible and not clenched. Avoid concealed hands, which imply a concealed weapon.[20] Knees should be slightly bent. The clinician should avoid directly facing the agitated patient and should stand at an angle to the patient so as not to appear confrontational. A calm demeanor and facial expression are important. Excessive, direct eye contact, especially staring, can be interpreted as an aggressive act. Closed body language, such as arm folding or turning away, can communicate lack of interest. It is most important that the clinician's body language be congruent with what he is saying. If not, the patient will sense that the clinician is insincere or even “faking it” and may become more agitated and angry. It is also important to monitor closely that other patients or individuals do not provoke the patient further.

According to Lazare and Levy,[28] humiliation is an aggressive act where a person has threatened another person's integrity and very self. In some cases, humiliation itself can be traumatic. Therefore, do not challenge the patient, insult him, or do anything else that can be perceived as humiliating.

Domain III: Establish Verbal Contact

Key Recommendation: Only 1 Person Verbally Interacts with the Patient

The first person to make contact with the patient should be the person designated to de-escalate the patient. If that person is not trained or is otherwise unable to take on this role, another person should be designated immediately.

Multiple people verbally interacting can confuse the patient and result in further escalation. While the designated person is working with the patient, another team member should alert staff to the encounter, while removing innocent bystanders.

Key Recommendation: Introduce Yourself to the Patient and Provide Orientation and Reassurance

A good strategy is to be polite. Tell the patient your title and name. Rapidly diminish the patient's concerns about your role by explaining that you are there to keep him safe and make sure no harm comes to him or anyone else in the emergency setting. If the patient is very agitated, he may need

additional reassurance that the clinician wants to help him regain control. Orient the patient as to where he is and what to expect. If the patient's name is unknown, ask for his name. Judgment is required in deciding whether to call the person by his first or last name. Although some prefer calling all patients by their last names, this formality, in some situations, can add to a patient's suspicion and appear patronizing. When in doubt, it is best to ask the patient how he prefers to be addressed; this act communicates that he is important and, from the very beginning of the interaction, that he has some control over the situation.

Domain IV: Be Concise

Key Recommendation: Be Concise and Keep It Simple

Since agitated patients may be impaired in their ability to process verbal information, use short sentences and a simple vocabulary. More complex verbalizations can increase confusion and can lead to escalation. Give the patient time to process what has been said to him and to respond before providing additional information.

Key Recommendation: Repetition Is Essential to Successful De-escalation

This involves persistently repeating your message to the patient until it is heard. Since the agitated patient is often limited in his ability to process information, repetition is essential whenever you make requests of the patient, set limits, offer choices, or propose alternatives. This repetition is combined with other assertiveness skills that involve listening to the patient and agreeing with his position whenever possible.[19]

Domain V: Identify Wants and Feelings

Examples of wants include succorance, the wish to ventilate to an empathic listener, a request for medication, some administrative intervention, such as a letter to an employer, or intervening with a difficult spouse or parent. Whether or not the request can be granted, all patients need to be asked what their request is.[1] A statement like, “I really need to know what you expected when you came here,” is essential, as is the caveat “Even if I can't provide it, I would like to know so we can work on it.”

Key Recommendation: Use Free Information to Identify Wants and Feelings

“Free information” comes from trivial things the patient says, his body language, or even past encounters one has had with the patient.[19] Free information can help the examiner identify the patient's wants and needs. This rapid connection based on free information allows the clinician to respond empathically and express a desire to help the patient get what he wants, facilitating rapid de-escalation of agitation.

A sad person wants something he has given up hope of having. A patient who is fearful wants to avoid being hurt. In a later discussion of aggression, it will be apparent that the aggressive patient has specific wants also, and identifying these wants is important for the management of the patient.

Domain VI: Listen Closely to What the Patient Is Saying

Key Recommendation: Use Active Listening

The clinician must convey through verbal acknowledgment, conversation, and body language that he is really paying attention to the patient and what he is saying and feeling. As the listener, you should be able to repeat back to the patient what he has said to his satisfaction. Such clarifying statements as

“Tell me if I have this right…” is a useful technique. Again, this does not mean necessarily that you agree with the patient but, rather, that you understand what he is saying.

Key Recommendation: Use Miller's Law

Miller's law states, “To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of.”[25] If you follow this law, you will be trying to understand. If you are truly trying to imagine how it could be true, you will be less judgmental, and the patient will sense that you are interested in what he is saying and this will significantly improve your relationship with the patient. For example, if the patient's agitation is driven by the delusion that someone is following him and intends to cause him harm, you can imagine how this is true from the patient's standpoint and engage the patient in conversation as to why this is happening to him and who would want to harm him. This will convey your interest and will result in the patient engaging in conversation about that which is driving his agitation. By engaging in conversation, the patient will begin to see that you care, which in turn, fosters de-escalation.

Domain VII: Agree or Agree to Disagree

Fogging is an empathic behavior in which one finds something about the patient's position with which he can agree.[19] It can be very effective in developing one's relationship with the patient. There are 3 ways to agree with a patient. The first is agreeing with the truth. If the patient is agitated after 3 attempts to draw his blood, one might say, “Yes, she has stuck you 3 times. Do you mind if I try?” The second is agreeing in principle. For the agitated patient who is complaining that he has been disrespected by the police, you don't have to agree that he is correct but you can agree with him in principle by saying, “I believe everyone should be treated respectfully.” The third is to agree with the odds. If the patient is agitated because of the wait to see the doctor and states that anyone would be upset, an appropriate response would be, “There probably are other patients who would be upset also.” Using these techniques, it is usually easy to find a way of agreeing, and one should agree with the patient as much as possible. Clinicians may find themselves in a position where they are being asked to agree with an obvious delusion or something else the clinician can obviously have no knowledge of. In this situation, acknowledge that you have never experienced what the patient is experiencing but that you believe that he is having that experience. However, if there is no way to honestly agree with the patient, agree to disagree.

Domain VIII: Lay Down the Law and Set Clear Limits

Key Recommendation: Establish Basic Working Conditions.

It is critical that the patient be clearly informed about acceptable behaviors. Tell the patient that injury to him or others is unacceptable. If necessary, tell the patient that he may be arrested and prosecuted if he assaults anyone. This should be communicated in a matter-of-fact way and not as a threat.

Key Recommendation: Limit Setting Must Be Reasonable and Done in a Respectful Manner

Set limits demonstrating your intent and desire to be of help but not to be abused by the patient. If the patient is causing the clinician to feel uncomfortable, this must be acknowledged. Often telling the patient that his behavior is frightening or provocative is helpful if it is matched with an empathic statement that the desire to help can be interrupted or even derailed if the clinician feels angry, fearful, etc.

The bottom line is that good “working conditions” require that both patient and clinician treat each other with respect. Being treated with respect and dignity must go both ways. Violation of a limit must result in a consequence, which (1) is clearly related to the specific behavior; (2) is reasonable; and (3) is presented in a respectful manner.

Some behaviors, eg, punching a wall or even breaking a chair, may not automatically indicate the need for seclusion or restraint, and the patient can continue to be de-escalated with some increase in limit setting and consequences. Reassure the patient that you want to help him regain control and establish acceptable behavior.

Key Recommendation: Coach the Patient in How to Stay in Control

Once you have established a relationship with the patient and determined that he has the capability to stay in control, teach him how to stay in control. Use gentle confrontation with instruction: “I really want you to sit down; when you pace, I feel frightened, and I can't pay full attention to what you are saying. I bet you could help me understand if you were to calmly tell me your concerns.”

Domain IX: Offer Choices and Optimism

Key Recommendation: Offer Choices

For the patient who has nothing left but to fight or take flight, offering a choice can be a powerful tool. Choice is the only source of empowerment for a patient who believes physical violence is a necessary response. In order to stop a spiraling aggression from turning into an assault, be assertive and quickly propose alternatives to violence. While offering choices, also offer things that will be perceived as acts of kindness, such as blankets, magazines, and access to a phone. Food and something to drink may be a choice the patient is willing to accept that will stall aggressive behaviors. Be mindful that these choices must be realistic. Never deceive a patient by promising something that cannot be provided for him. For example, a patient should not be promised a chance to smoke when the hospital has a no-smoking policy.

Key Recommendation: Broach the Subject of Medications

The goal of medicating the agitated patient is not to sedate but to calm him. As Allen and colleagues[11] point out, a calm, conscious patient is one who can participate in his own care and work with the crisis clinician toward an appropriate treatment disposition, which is of benefit to the patient and also to the staff. It can decrease length of stay and make the emergency department experience a positive one.

When medications are indicated, offer choices to the patient. Timing is essential. Do not rush to give medication but, at the same time, do not delay medication when needed. Using increasing strategies of persuasion is a sound technique (Table 3). For example, the first step is not to mention medication at all but to ask the patient what he needs, what works. Try to get the request for medication to come from the patient himself, or perhaps the patient has a better idea.

Table 3.

Summary of strategies for broaching the topic of medication/escalating persuasion techniques.

What helps you at times like this?	STRATEGY: Invite the patient's ideas.
I think you would benefit from medication.	STRATEGY: Stating a fact.
I really think you need a little medicine.	STRATEGY: Persuading.
You're in a terrible crisis. Nothing's working. I'm going to get you some emergency medication. It works well and it's safe. If you have any serious concerns, let me know.	STRATEGY: Inducing.
I'm going to have to insist.	STRATEGY: Coercing. Great danger, last resort.

If the patient does not mention medication and the clinician believes it is indicated, then state clearly to the patient that you think he would benefit from medication. Ask the patient what medication has helped him in the past or state, “I see that you're quite uncomfortable. May I offer you some medication?”

Gentle confrontation may also be useful: “It's important for you to be calm in order for us to be able to talk. How can that be accomplished? Would you be willing to take some medication?”

Another step is one just short of involuntary medication. “Mr Smith, you're experiencing a psychiatric emergency. I'm going to order you some emergency medicine.” This strategy is authoritative, as in being knowledgeable and self-assured, possessing expertise, having the ability to explain one's thinking, and being persuasive. Giving the patient a choice in either oral or parenteral administration can help give the patient some control. He may willingly take medication if the means of administration is a choice, even if the administration of medication itself is not a choice. Appealing to the patient's desire to stay in control and the clinician's mandate to keep everyone safe, one might say to the patient: “I can't let any harm come to you or anyone else” or “I need to protect you from hurting someone, so I would like for you to take some medication to help you stay in control.” The clinician then says to the patient as many times as necessary, “Would you like to take medication by mouth or by a shot?” Emphasizing the protection aspect is very important and can be effective in empowering the patient to stay in control. “I feel medications can help, would you like a pill you can swallow, a pill that will melt in your mouth, or a liquid? If you agree to take a pill by mouth you can avoid taking a shot.” Even when there is no choice but to give an injection, the clinician can give a choice as to which drug is to be used, emphasizing that one has a more beneficial side-effect profile.

Finally, when verbal attempts to de-escalate fail, more coercive measures such as restraints or injectable medication may be necessary to ensure safety but always as a last resort.

Key Recommendation: Be Optimistic and Provide Hope

Be optimistic but in a genuine way. Let patients know that things are going to improve and that they will be safe and regain control. Give realistic time frames for solving a problem and agree to help the patient work on the problem. When the patient states, “I want to get out of here,” the clinician can respond, “I want that for you as well; I don't want you to have to stay here any longer than necessary; how can we work together to help you get out of here?”

Domain X: Debrief the Patient and Staff

Key Recommendation: Debrief the Patient

After any involuntary intervention with an agitated patient, it is the responsibility of the clinician who ordered these interventions to restore the therapeutic relationship to alleviate the traumatic nature of the coercive intervention and to decrease the risk of additional violence.

Start by explaining why the intervention was necessary. Let the patient explain events from his perspective. Explore alternatives for managing aggression if the patient were to get agitated again. Teach the patient how to request a time out and how to appropriately express his anger. Explain how medications can help prevent acts of violence and get the patient's feedback on whether his concerns have been addressed. Finally, debrief the patient's family who witnessed the incident.

Once the patient is calm, the clinician can acknowledge and work with the patient on a deeper level, help put the patient's concerns into perspective, and assist him in problem solving his initial precipitating situation. Since prevention of agitation is the best way to treat it, planning with the patient is best: “What works when you are very upset as you were today? What can we/you do in the future to help you stay in control?”

Key Recommendation: Debrief the Staff

If restraint or force needs to be used, it is important that the staff be debriefed on the actions after the event. Staff should feel free to suggest both what went well during the episode, and what did not, and recommend improvements for the next episode.

Reference:

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