Calming agitation with

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With a little practice, you can improve your skills at verbal de-escalation of the acutely agitated patient, learn how to avoid unnecessary emergency medications, and prevent assaults and injuries to you and your staff.

Are you at risk of being assaulted?

Most psychiatrists do not arm themselves with the bare essentials of self-protection. Consider these questions:

- Have you attended one of the available training institutes, such as the Crisis Prevention Institute (CPI)[1] or Management of Aggressive Behavior (MOAB)[2], or a state-sponsored program such as Prevention and Management of Aggressive Behavior (PMAB), offered by the Texas Department of Mental Health and Mental Retardation?[3]
- Have you developed a safety plan, especially in your practice? Examples of such plans include placement of furniture for easy exit if attacked, panic buttons that call or alert security services, and even video surveillance.
- Have you reported "minor" assaults by patients? Acts of violence in psychiatric settings are rarely discussed and dramatically underreported. Psychiatrists often go into denial when assaulted, rather than being motivated to get the appropriate training to manage future patient aggression episodes.
- Do you focus on pharmacotherapy as the first line of aggressive behavior management instead of methods of protection and de-escalation?

All too often, psychiatric residency training simply pays "lip service" to de-escalation of the violent patient, instead overemphasizing the pharmacology of behavioral emergencies. This has left many psychiatrists unprepared in an era where mental health advocacy groups, ethicists, and attorneys are applying pressure on us to find new ways to avoid

words, not drugs

10 commandments for safety

seclusion, restraint, and intramuscular medication for psychiatric emergencies.

Let's look at how to assess a patient's potential for violence, as well as nonpharmacologic interventions you can use to keep you and your staff safe and prevent aggressive behaviors from escalating.

Three strategies for assessing violence

You can start to protect yourself against violent attacks by using a 3-part strategy that involves knowing the DSM-IV diagnoses associated with violence, using a checklist to gauge a patient's potential for violence, and developing an observational awareness to quickly recognize the warning signs of an imminent violent act.

How quickly can you recognize the DSM-IV diagnoses associated with aggression and violence (*Table 1*)? Here are some clues to fast action:

1. Rule out a medical or substance-induced etiology for the presenting symptoms. Intoxication with alcohol, amphetamines, cocaine, phencyclidine, and sedative-hypnotics is associated with violence. Withdrawal from benzodiazepines or alcohol may also lead to aggression.
2. Rule out delirium.
3. Among the many organic causes of violence and aggression, pay careful attention to the usual intracranial suspects including infection, stroke, trauma, autoimmune syndromes, neoplasm, and encephalopathy.
4. Rule out metabolic abnormalities, including thyrotoxi-

Table 1

DSM-IV DIAGNOSES ASSOCIATED WITH VIOLENCE OR AGGRESSION

- Attention-deficit/hyperactivity disorder
- Bipolar I disorder, manic
- Conduct disorder
- Delirium
- Dementia
- Intermittent explosive disorder
- Mental retardation
- Mood disorder due to a general medical condition
- Personality change due to a general medical condition
- Personality disorder
  - Paranoid
  - Antisocial
  - Borderline
  - Narcissistic
- Posttraumatic stress disorder
- Premenstrual dysphoric disorder
- Schizophrenia
- Sexual sadism
- Substance abuse and withdrawal
- Substance-induced mood disorder

cosis, hypoxemia, and endocrinopathy.

5. Violence in temporal lobe epilepsy may occur in the ictal, interictal, or postictal periods.

The second tool in violence assessment is a checklist (*Table 3*) that covers a range of risk factors including symptoms, demographics, and predisposing historical factors. I recommend that all clinicians preparing for work in emergency rooms or inpatient psychiatric units memorize such a checklist and remain prepared to use it. In assessing the potential for violence, there is no time to look up the risk factors in a textbook—or even in a personal digital assistant.

The third tool is to develop observational awareness, mostly using a watchful eye for behaviors that signal impending violence. Patients signal violence initially through psychomotor agitation (pacing, repeatedly asking to see the doctor, slamming doors), followed typically by verbal threats (cursing, insulting staff), and then outright acts of aggression. Many authors have detailed the phases of escalation and the pre-violence behaviors that psychiatric staff should observe and document.[4-6]

Table 2
THE 10 COMMANDMENTS OF DE-ESCALATION

I	You shall respect personal space
II	You shall not be provocative
III	You shall establish verbal contact
IV	You shall be concise and *repeat yourself*
V	You shall identify wants and feelings
VI	You shall listen
VII	You shall agree or agree to disagree
VIII	You shall lay down the law
IX	You shall offer choices
X	You shall debrief the patient and staff

Do you obey the '10 commandments?'

The psychiatric literature describes many methods of preventing and managing aggressive behavior. I find that each time I am involved with a potentially aggressive patient, the script changes. Each encounter with violent patients is idiosyncratic. So instead of using a flowchart, I have developed what I call the "10 commandments" of preventing and managing aggressive behaviors (*Table 2*). These rules can be used whenever needed, and mixed and matched as necessary, to de-escalate agitated patients.

You shall respect personal space When approaching an aggressive patient, I usually use the 2-times-arm-length rule, that is, twice your arm length or the sum of your arm length and your estimate of the patient's arm length. That's the distance I keep between me and the patient, which is generally accepted as non-threatening. If the patient is paranoid, you may want to increase your distance.

Similarly, maintaining your usual social eye contact is more tolerable to the agitated patient than consistently staring or averting your eye. A direct gaze may be interpreted as aggressive behavior, while averting your eyes signals fear; either state may prompt the patient to become aggressive.

Always maintain an "escape route" for you and the patient. Do not make the patient feel he or she is trapped with no egress. If the patient feels you are too close and tells you to "get out of the way," do so immediately.

You shall not be provocative A calm demeanor and facial expression are important. Be soft-spoken and do not allow an angry tone to slip into your voice. Imagine yourself with a patient you enjoy working with, and use that level of empathy and concern with the agitated patient. Use a relaxed stance with your knees bent, arms uncrossed, and your palms upward. As you may be tense or anxious, try to prevent yourself from balling your hands into fists. A fist, made even as your hands hang down at your sides, will be noticed by the patient.

Never threaten the patient. The sure way to lose control of the situation—and destroy your therapeutic alliance—is to use any form of coercion. Your initial therapeutic alliance with the patient is a critical factor in an effective de-escalation. The agitated patient should be involved in a fair, collaborative, and meaningful process that allows the patient self-expression.

You shall establish verbal contact Members of your clinical staff should resist the temptation to intervene individually. The first person to make contact should be the designated clinician to de-escalate the patient. If for any reason you do

Table 3

CHECKLIST FOR ASSESSING VIOLENT TENDENCIES

	Questions	Yes	No
1.	Is the patient abusing alcohol or other substances?	○	○
2.	Is the patient demonstrating alcohol or other substance intoxication?	○	○
3.	Is the patient making threats to harm others?	○	○
4.	Has the patient ever committed violent acts with subsequent arrests or in conjunction with criminal activity?	○	○
5.	Was the patient physically abused as a child?	○	○
6.	Has the patient demonstrated recent acts of violence (including damage to property)?	○	○
7.	Has the patient recently brandished weapons, including objects that may be used as weapons (e.g., forks, rocks)?	○	○
8.	Does the patient have thoughts or fears of harming others?	○	○
	…with intent?	○	○
	…with current plan?	○	○
	…with means?	○	○
9.	Does the patient have command auditory hallucinations?	○	○
	…with specific instructions?	○	○
	…with response<1 month?	○	○
	…with familiar voice?	○	○
10.	Is the patient clinically depressed with severe psychomotor agitation, suicidal ideation, panic attacks, or suicidal plan with urge to take family with him/her?	○	○
11.	Is the patient experiencing a paranoid delusion?	○	○
	…with planned violence toward the person as persecuting the patient?	○	○
	…with a hallucination-related delusion?	○	○
	…with history of acting on such a delusion?	○	○
	…which is systematized?	○	○
	…with accompanying intense anger or fear?	○	○
12.	Is the patient experiencing threat control override symptoms?	○	○
	…thought insertion?	○	○
	…delusion of being followed?	○	○
	…made feelings?	○	○
	…sensation of mind control by external force?	○	○
13.	Does the patient have a personality disorder with rage, violence, or impulse dyscontrol?	◎	◎
14.	Does the patient have one of the following risk factors: male, age 15-24, low socioeconomic status, few social supports, brain disease, frontal lobe syndrome?	○	○
15.	Does the patient display catatonic or manic excitement?	○	○
16.	Does the patient have more than one major Axis I diagnosis?	○	○

not feel capable of performing this duty, quickly identify which staff member will verbally engage the patient.

Learn the patient's name and address him or her using the last name. Using the patient's first name may be perceived as too personal or not genuine. Tell the patient who you are, and establish that your job is to keep the patient safe and to allow no harm to befall him or her.

The agitated patient should be involved in a fair, collaborative process that allows him or her self-expression

If the patient is yelling and screaming, or perhaps has already broken a chair or hit the wall, offer additional reassurance that you want to help him or her regain control.

IV You shall be concise

When making verbal contact, remember the adage that less is more. Use short phrases or sentences and a simple vocabulary. Wordiness will cause confusion.

Here is a common scenario: You can see outside the nursing station that a patient's temper is rising. The patient is pacing and slamming his or her fists on a tabletop. You ask the psychiatry resident to go help the patient. Barely 30 seconds later, the resident informs you that the patient just "ignored" him or her.

Agitated patients, especially those with psychosis, should not be expected to hear you the first time. After all, how often do your own spouse, children, or close friends hear you the first time? I often find that I may have to repeat a simple phrase to a patient as many as a dozen times until I am understood. Repetition is essential whenever you set limits, offer choices, or propose alternatives.

V You shall identify wants and feelings

You've gotten the patient's attention. Now it's time to empathize and solidify the therapeutic alliance. Recognizing the patient's wants and feelings becomes crucial at this point (*Table 4*).

Thus, if I find a patient banging his or her fists on the table and the walls, I approach the patient saying, "You seem angry ... is there something you want that you're not getting ... and do you still really want it? Perhaps I can get it for you." If a patient is crouched in the corner, looking as if he is going to strike out and run, I say, "You seem afraid ... do you feel something terrible is going to happen to you? Can I help keep you safe?"

Once again, repeat these simple statements until the patient appears to relax, an indication that he or she thinks you understand what is wrong.

VI You shall listen

Try to understand what the patient is saying—not what you think he or she is saying. I find it helpful to make sure that I have correctly understood by commenting, "Let me see if I understand you correctly." This tells the patient you are listening accurately, and conveys further empathy.

Whatever you do, don't argue with the patient. And if the patient insults you, don't up the ante with a verbal retaliation.

VII You shall agree or agree to disagree

Some believe that the most important part of de-escalation is the act of agreeing with the patient.

Agreeing with the patient without furthering a delusion or lying, however, is very difficult. For example, if an agitated patient asks if you believe aliens are torturing him or her, many of us would simply say, "no." I would agree by telling the patient, "While I have not seen the aliens or seen you tortured, I believe that you are being tortured." By so doing, I can diffuse the patient's anger.

Agree for as long as you can with the patient's experience. If you cannot go any further, you can always say, "We can agree to disagree."

Table 4

Identifying thoughts and feelings for making empathic statements

Thought	Feeling
I **want** something I didn't get it I still want it	Angry
I **want** something I didn't get it I'll never get it	Sad
I want to avoid something bad happening	Fearful

Adapted from: Bedell JR, Lennox SS. *Handbook for Communication and Problem-Solving Skills Training: A Cognitive-Behavioral Approach*. 2nd ed. New York: John Wiley & Sons, 1996.

VIII You shall lay down the law Clarity in describing to the patient what is acceptable behavior is critical.

Be honest. It is OK to tell the patient that he is scaring you, other patients, or the staff. Tell the patient that injury to himself or herself, or to others, is unacceptable. Be prepared to be challenged repeatedly as you set firm limits. You may find it necessary to tell the patient that arrest and prosecution are possible if he or she assaults anyone.

Early in the de-escalation process, emphasize that there are consequences to the patient's behavior. State both the positive and negative consequence of a behavior, then ensure that this statement is not perceived as a threat by asking the patient to make a choice.

IX You shall offer choices Choice is a powerful tool. For the patient who believes there is nothing left but fight or flight, being offered a choice, such as taking a time-out or a medication to decrease the anger, can be a welcome relief.

When an assault is imminent, do not expect the patient to engage in problem solving. Do not ask if they can name a behavior other than assaulting the staff that promises a better outcome. Be assertive. Quickly propose the possible alternatives to violence.

X You shall debrief the patient Despite your best efforts, some patients will still end up in seclusion or restraints after their emotions escalate. Some may require emergency intramuscular medications. I recommend that the psychiatrist who wrote the order for seclusion, restraint, or emergency medications take the time to debrief the patient after the episode is over and the patient is calm. The benefits of debriefing include restoring a therapeutic relationship, diminishing the traumatic nature of such events as emergency intramuscular injections, and decreasing the risk of additional violent events.

> Don't ever argue with the patient. If the patient insults you, don't up the ante with a verbal retaliation

Find a quiet location and begin by explaining why the intervention was necessary. Let the patient explain the events from his or her perspective. Then it is time for some problem solving in which you and the patient explore alternatives should he or she get angry again. Teach the patient how to request quiet time and how to recognize the early warning signs of impending violence. Let the patient know it is safe to approach the staff early and express anger while making a request for what he or she wants. You can also explain the role of medications in preventing violent acts.

Don't forget to debrief the staff as well. Takedowns, restraints, and seclusion can be traumatic for staff members, especially if there is an assault with injuries.

Just as internists learn advanced cardiac life support and run cardiac codes, psychiatrists can be responsible for directing behavioral codes when episodes of agitation and aggressive behavior occur, using verbal interventions to de-escalate patients. You will soon find yourself ordering fewer restraints, seclusions, and intramuscular medications.

Bottom Line

Every psychiatrist runs the risk of being assaulted by a patient. An injection may calm an aggressive patient, but verbal de-escalation may be the best method of prevention. Start by quickly recognizing impending violence. Then follow the 10 commandments of interaction to defuse the patient's aggression.

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DISCLOSURE

The author reports no financial relationship with any company whose products are mentioned in this article.