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Defusing the Difficult Patient

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DEFUSING THE DIFFICULT PATIENT

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Objectives

- Recognize potentially unsafe situations involving agitated patients
  - Defuse
- Describe appropriate de-escalation techniques for agitated patients
  - De-escalate
- Employ physical threat mitigation techniques when dealing with agitated patients
  - Depart

What is agitation?

- Excessive verbal and/or motor behavior[1]
  - Psychomotor activation – see indicators
  - Mood lability
  - Verbally abusive
  - Aggression
  - Potential to harm self, others, or property
- 7 million EM visits per year may involve agitated patients[2]
- Spectrum from restlessness to combativeness
  - Patient is not fully in control of themselves

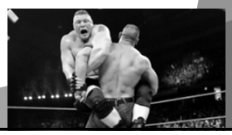
1. Citrome L. *Postgrad Med*. 2002 2. Sachs GS. *Journal Clinical Psych*. 2006

Indicators of Agitation

- Repetitive non-goal directed motor activity
  - Hand wringing, foot tapping, hair fiddling, pulling at clothing or other objects
- Repetitive thoughts are verbalized
  - "I've got to get out of here… I've got to get out of here… I've got to get out of here…"
- Irritability and heightened response to stimuli
- Continuum from high anxiety to agitation to aggression

Agitation is an Emergency

- Requires immediate intervention to prevent progression to aggression
- Old school
  - Tackle, restrain physically, restrain chemically
    - Problematic
      - Injury to staff and patient, expensive, coercive
- New school
  - Verbal engagement
  - Establish a therapeutic alliance/collaboration
  - Verbal de-escalation
    - Avoid coercion



But I like "Old School"

- Physical intervention reinforces the patient's idea that violence is necessary to resolve conflict
  - De-escalation demonstrates that non-aggression can help the patient succeed. FOSTERS TRUST
- Physical restraint prolongs length of stay and increases likelihood of injury to patient/staff
- Joint commission and CMS consider **low use of restraints** a key quality indicator

Verbal De-escalation

- Goal is to help the patient regain control of him/herself
- 4 main objectives
  - Ensure safety of everyone
  - Help patient manage his emotions and maintain control of his behavior
  - Avoid use of restraints
  - Avoid coercive interventions that escalate the patient

Setting the Stage

- Be ready for an agitated patient
- Environment
  - Space with movable furniture, adequate exits, potential weapons minimized
  - minimized sensory input
    - Dark, cool, quiet, private area as much as possible
- Clinician
  - IT IS NOT PERSONAL. Control counter-transference
  - Do not "act – in"
    - Do not respond to the pushed buttons – they are experts.
  - Good attitude, empathy. Two year old glasses.

Setting the Stage

- Clinician
  - YOU MUST BE CALM and UNAFRAID.
    - 90% of emotions and 50% of total information communicated is by body language and tone of voice.
  - Spot cognitive impairment and personality disorders
    - Still try, but less likely to have success
  - Verbal looping
    - Listen, find a way to agree or validate, then ask for the patient to do what is wanted
    - Have to repeat many times
      - Try for at least 5 minutes

Setting the Stage

- Non Verbal communications to patient
  - Adequate staff trained and in the wings
    - In sight of patient but far enough away not to be a threat
    - 4-6 people
  - Communicates that violence is not acceptable
- Use an objective scale
  - Behavioral Activity Rating Scale (BARS), others
  - Helps spot early signs of agitation

10 Commandments of De-escalation[1]

- Respect personal space
- Do not be provocative
- Establish verbal contact
- Be concise
- Identify wants and feelings
- Listen closely to what the patient is saying
- Agree, or agree to disagree
- Lay down the law and set clear limits
- Offer choices and optimism
- Debrief the patient and staff

1. Fishkind A. *Current Psychiatry*. 2002

Respect Personal Space

- 2x arms length from patient or more
  - Paranoid patients may need extra space
- Normal eye contact
- Offer a line of egress
  - Provider and patient should have a clear path to the exit
- Move immediately if told to do so

Do not be Provocative

- Calm demeanor and facial expression
  - Normal eye contact
    - Do not stare him down
- Soft spoken, kind tone
- Relaxed body posture
  - Hands visible and not clenched
  - Arms and legs uncrossed
  - Knees bent
  - Stand at an angle – do not directly face patient
- Do not challenge, insult, or do anything that could be perceived as humiliating to the patient
- Be empathetic – have genuine concern

Establish Verbal Contact

- One communicator
  - Be polite, ask name and how he would like to be addressed
- Tell him who you are
  - May need to orient the patient
- Establish that you are there to keep him safe
  - You will allow no harm to him
- You will help him regain control

Be Concise

- Use short phrases or sentences
- Use a simple vocabulary
- Give the patient time to process what was said, and to respond before giving more info
- Repeat yourself, repeat yourself

Identify Wants and Feelings

- Ask what they want
  - "I really want to know what you expected when coming here. Even if I can't provide it, I would like to know so I can work on it."
- Examples
  - To be heard/to vent. (Succorance)
  - Intervention
    - Employer, spouse, parent
- Observe
  - Fearful patient wants security, to know they will not be hurt
  - Sad patient wants something they have lost hope of having

Listen Closely to What the Patient is Saying

- Active listening
  - Body language, repeat back
  - "Tell me if I have this right…"
- Millers Law
  - Imagine what they are saying is true; see things from their point of view
  - Shows you are listening and care
  - Helps uncover the cause of the agitation

Agree or Agree to Disagree

- Fogging
  - Finding something about which you can agree
  - 3 ways to do it
    - Agree with the truth
      - You were tazed
    - Agree in principle
      - Everyone should be treated respectfully
    - Agree with the odds
      - There are probably others who feel they were disrespected
- If delusion, acknowledge you believe the patient believes the delusion even if you don't have that experience
- If unable to agree, agree to disagree

Lay down the Law and Set Clear Limits

- Set limits
  - Injury to patient or anyone else unacceptable
- Establish consequences
  - Related to specific behavior, reasonable, presented respectfully
  - TONE SHOULD BE MATTER OF FACT, not threatening.
- Offer choices, propose alternatives
- Use coaching to help patient stay in control
  - "I want you to sit down. When you pace, I feel threatened and 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. Can we sit?"

Offer Choices and Optimism

- Choice is a powerful tool because it is empowering, and not seeing a choice often leads to violence.
  - Propose alternatives to violence
    - Must be able to provide alternative
  - Include acts of kindness
    - Blankets, food, reading material etc
- Optimism
  - Be positive, provide hope. Things are going to get better. They are going to regain total control.

Medications

- Ask the patient what works for him
- May I offer you some medication?
  - Give options
- If mandating meds, explain emphasizing safety
  - Offer choice of route medication and/or route.
  - May have to repeat several times
- Tackle and shoot is a last resort.
  - Essentially failure

Debrief the Patient and Staff

- Patient
  - Explain why the forced intervention was necessary
  - Explore alternatives for next time agitated
    - Appropriate expression of anger
      - Time out
    - How medications help
  - Ask for feedback – concerns addressed
  - Debrief family if they witnessed
- Staff
  - How did it go? What was good and what should we do differently next time?

Medications for Agitation

- GOAL: Calm, not sedated
  - Reduce dangerous behavior, distress, anguish
  - Want to still be able to communicate
- Second Generation antipsychotics 1st line
  - Oral better choice
    - Risperidone 2mg
    - Olanzapine 5-10mg
  - IM
    - Olanzapine 10mg
    - Ziprasidone 10-20mg
- If ETOH or stimulants
  - Benzos

Types of Aggression

- Instrumental aggression
- Fear driven aggression
- Irritable aggression – two types
  - Violated boundaries
  - Chronic anger looking for a reason to explode

Instrumental Aggression

- Violent aggression or threats of the same, are used as a tool to get what the patient wants
- Not driven by emotion
- Can be handled by unspecified counter-offers
  - Pt: “I want to smoke or Im going to hurt someone”
  - PA: “I don’t think that is a good idea”
  - Pt: “What to you mean?”
  - PA: “Let’s not find out.”

Fear Driven Aggression

- Desire to avoid being hurt
  - Preventive attack
- Give plenty of space
- Remove show of force, reduce any perceived threats
- De-escalate by matching patient pace until he can focus on content of what is being said rather than fear. Gradually slow pace down.
  - Pt: “Dont hurt me. Don’t hurt me. Don’t hurt me.”
  - PA: “You’re safe here. You’re safe here. You’re safe here.”

Irritable Aggression

- Violated boundaries
  - Angry/aggressive because of a perceived wrong
    - Cheated, humiliated, otherwise emotionally wounded
  - Wants to be heard & have feelings validated
    - Trying to regain integrity/self-worth
- Identified by asking what has made him angry
- De-escalate by setting conditions
  - Regain control so can talk
  - Fogging, broken-record usually effective

Irritable Aggression

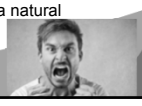
- Chronic anger just looking for a reason to explode
  - Want to release the pressure that results from their world view
    - Unrealistic and erratic demands used as an excuse to attack when not met
    - Give alternate choices to de-escalate
      - Broken record listing reasonable options
  - Enjoy creating fear and confusion
    - Feigned attacks common
  - Looking for emotional response/audience
    - Use emotionless responses, remove everyone (audience)
  - Most dangerous, least likely to de-escalate verbally
    - Tell him you will work with him when he is cooperative
    - Set firm limits, rapidly intervene if violates limits

Depart

- Keep distance and egress route open to you and the patient
- NEVER let the patient get between you and the door
- If patient stands, you stand
  - Decreased time to door, easier to defend yourself
- Listen to the little voice, hairs on your neck
  - Note the indicators of imminent attack
  - Leave room immediately and call for help

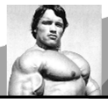
Indicators of Imminent Attack

- **Blading, sometimes called "pugilistic stance"**
  - The aggressor puts his strong foot slightly behind him so that his torso is facing around 45 degrees to the right or left of you.
  - It is an indication that he is settling his stance in preparation for an attack.
- **Fist Clenching or Pumping**
  - One of the side-effects of the fight-or-flight response is that blood is pulled from the extremities into the large muscle groups and major organs.
  - Due to vasoconstriction in the hands and fingers, a natural response is to pump or clench them.



Indicators of Imminent Attack

- **Avoiding Eye Contact**
  - When a person is trying to mentally process the situation in an agitated state, it is difficult to multitask
- **Posturing**
  - In most cases this is an involuntary act.
  - It is common among many animal species as well as us humans and indicates a display of dominance and threat of attack.
  - Examples are puffing up the chest to make one appear larger or lowering the head as if ready to charge.



Indicators of Imminent Attack

- **Bobbing and Rocking**
  - Similar to trembling and fist clenching.
  - The aggressor may display odd movements.
    - He may bounce up and down, rock back and forth, or start pacing
    - This provides a release of extra oxygen and indicates a subconscious preparation for action.
- **Hiding the Face**
  - An aggressor on the verge of attacking may attempt to conceal their stress and excitement by turning their head or hiding their faces.
  - This may also be seen when an aggressor wipes his face, slicks back his hair, scratches his nose, etc.

Indicators of Imminent Attack

- **Focused Attention on Target (You?)**
  - Often preceded by other indicators
  - They have essentially made a lock on their target
  - This also includes focused attention on a particular body part such as the chin or groin showing where they will probably strike.
- **Thousand Yard Stare**
  - This is the opposite of focused attention.
  - Here the aggressor isn't so much focusing on you but looking through you.
  - Mentally shutting down and is ready to go on aggressive autopilot.
  - May be combined with **scanning** (for targets)
    - Constantly looking around

Review

- Defuse
  - Recognize agitation as an emergency
  - Set the stage
    - Clinician: Calm, Verbal looping, Empathetic, Causes
    - Environment, team, objective scale
- De-escalate
  - 10 commandments
    - Respect space, non-provocative, make verbal contact, be concise, identify wants and feelings, listen closely, agree, lay down the law, offer choices (meds), debrief
    - Olanzapine 5 or 10mg
- Depart
  - Indicators of imminent attack
  - Egress route

Sources

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2. Zeller SL. Moving Beyond Haldol: Best Practices for Medication and Treatment Alternatives in Psychiatric Emergencies. Lecture, MSJ ED CME, July 2017.
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