Empathy, Normalization and De-escalation

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Editors

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Management of the Agitated Patient in Emergency and Critical Situations

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Preface

Introduction: Meaning of the END Methods

Understanding social relations and the complexity of human behaviors in interpersonal relationships is really challenging. In this book we aimed to provide a full presentation of the main techniques and the practical skills to manage an agitated person in clinical and nonclinical settings. Working for several years in a psychiatric intensive care unit (PICU) as well as in an Emergency Department of one of the largest hospital in Italy, in the downtown of Rome, we have experienced everyday clinical situations of managing aggressive and potentially violent people. Later we introduced an easy and practical course for medical and paramedical staff for more than 10 years now. We also have learned that specific skills such as be calm, empathic, and de-escalate agitated persons are in some ways innate for somebody, while they are not innate for others. On the other hand clinicians found out very useful and innovative ways to learn communication techniques in hard situations. Talking to a scared or aggressive person is difficult, but this ability could be learnt.

It is constituted by two distinctive parts: the knowledge component, which regards theory and the primary nonverbal and verbal communication skills, and the practical component, which is to do with the ability to choose the right words at the right time with the right tone with the pivotal respect of listening to what the person is talking about without judgment. When a healthcare professional assists an aggressive patient the main rules are: to be calm and to work safety. Only successively the several techniques of de-escalation and normalization could be applied.

When we ask ourselves if we are emphatic in general or if we are more empathic in certain situation different sets of answers are possible. Apart from personal attitudes, many factors influence this feeling: the sense of belonging to a proper contest, the sense of place, and more ethnical, political, or professional identity. Even if nonverbal communication represents the most important issue in this kind of situations, language is pivotal. In our experience it is more simple to de-escalate a person when we share with her/him the same slang. This is because we reciprocally recognize our origins. At the opposite even if you are well experienced in managing agitated person it doesn't come so natural to think ourselves doing the same in a culturally diverse country. Nonverbal posturing and linguistic barriers may alter our skills. While some de-escalating and normalization procedures can be considered universally recognized. The END method consists in three main components:

Empathy, Normalization, and De-escalation. It is a sequence and every component has a theoretical background and practical norms to act.

The rationale is based on the ability to manage feelings, thoughts, and manifested behaviors in order to prevent aggression and violence, but also to build up a therapeutic alliance in several settings, and to reduce the forced hospitalizations. Our thinking as authors derived from our experience as psychiatrist but also from the experience of teaching these concepts to hundreds of colleagues. As editors we have retained the virtue of keeping these abilities simple. This is due to the decision to report what happens in clinical settings.

We start with a chapter focused on the definition of psychomotor agitation and aggression. Aggressiveness can be expressed verbally or behaviorally, and different levels of intention and consciousness may characterize specific conditions and behaviors. During the first END course it was astonishing to find out how many colleagues were familiar with these definitions. The nature of these conditions will be fully discussed.

Whereas in Chap. 3 readers find a very thorough review of the neurobiology of aggression and violence, the ability to modulate our own empathy in certain conditions is stated in Chap. 4.

It is not so obvious to psychologists and psychiatrists when, why, and with which person we have to be less or more empathetic. Many colleagues have served this incompetence. In everyday clinical activities unconsciously we normalize certain situations, besides a comprehensive description of the former technique is explored in Chap. 5.

The core issue of how to de-escalate an agitated person is fully presented in Chap. 6. Here readers will find out a set of techniques and guidelines in order to improve prevention and reduce damage risk for patients, healthcare operators, and family members who can often be victims of violence. De-escalation is conceived as part of the process of managing aggression and it is considered both as a preventive measure and the most reliable technique to avoid violent outbreaks deterioration. In Chap. 7 the safer and widely used protocol of pharmacological interventions for the agitated person is fully illustrated. Thus, an effective communication is central in patient's comprehension of treatment benefits and risks and increases compliance. A risk of impaired capacity to consent to treatment has often been associated with specific clinical characteristics, among these are excitement and positive symptoms together with psychiatric symptoms' severity, cognitive dysfunction, and impaired executive functioning. For these reasons in Chap. 8 authors describe how a good and supportive doctor–patient communication and a valid informed consent acquisition are often hindered by several issues, among which the clinician's fear of hurting the patient by communicating a bad diagnosis or not knowing how to manage the patient's emotional reactions. Finally, the relevance of a post-aggression debrief will be discussed for its role as a way to give significance to aggressive events in terms of possible shared meaning between the patient and

the staff. In other words, debriefing will be presented as a chance to comprehend the patient's psychopathological world, to restore a narrative coherence beyond the traumatic and violent event, and to keep a safe and trustable therapeutic environment.

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