Pediatric Dimensions

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Using de-escalation techniques to prevent violent behavior in pediatric psychiatric emergencies: It is possible

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Summary

The use of de-escalation techniques have been proposed to be effective and are recommended as first line treatments for the management of acutely agitated patients. Even though guidelines for management of agitation in children usually follow the adult guidelines, few have been published on de-escalation of pediatric patients, its practical application and results. We describe the successful management through de-escalation of agitated and potentially violent behavior in an 8 year- old African American male patient, who presented to the emergency department with aggressive behavior. With a strong rapport, patient and provider were able to negotiate together and complete tasks that were labeled improbable by nursing staff. Very little has been published in the scientific literature in this subject, but the emphasis in avoiding coercive methods is clear in adult guidelines. Our approach follows the domains of de-escalation, demonstrating that those domains, can apply to pediatric patients as well.

The use of de-escalation techniques (verbal and behavioral) have been proposed to be effective and highly recommended as first line treatments for the management of acutely agitated patients at risk for violent behavior [1]. Even though rapid tranquilization through pharmacological interventions might be quick and effective [2], medications can induce adverse effects and moreover, involuntary intramuscular medication should be avoided, since it has been experienced by patients as coercive [3].

However, daily practice in emergency settings many times presents challenging patients to health care providers, and intense emotions are elicited by an agitated/difficult patient, such as anger, but most importantly, fear. This is true for Pediatric Emergency settings as well. When attending staff are exposed to defying, aggressive children, it is a common reaction to avoid contact and try to prevent harm. Unfortunately, this practice can sometimes alienate patients, and therefore increase patient's feelings of loneliness and having no one to trust. It is not unusual the pediatric patient developing explanations for the restrictive or coercive measures they are receiving, reinforcing guilty and unworthy feelings [4].

Besides providing effective management for agitated patients, many times allowing avoiding coercive and more aggressive methods such as physical restraints and involuntary medication, de-escalation has been described as a mean of preserve or restore contact with the patient, a very important factor when providing any kind of medical treatment [5]. Scientific literature has provided guidelines for the use of de-escalation as first line treatment for agitation in adult patients. Even though the guidelines for management of agitation in children usually follow the adult guidelines, few have been published on de-escalation of pediatric patients, its practical application and outcomes.

Case report

We describe the successful management through de-escalation of agitated and potentially violent behavior in an 8 years old African American male patient, who was living with foster parents, and presented to the emergency department with potentially aggressive behavior.

Upon arrival at the Emergency Department, the patient was verbally frustrated, but not physically combative, and was escorted to a small, empty room with a closed garage door to hide the medical equipment.As part of the institutional protocol for potentially violent patients, a security guard was stationed outside of the room on a 24-hour watch in anticipation of an outburst.

After his one-hundredth hour in the room waiting for a psychiatric inpatient bed, one of the authors was assigned for his care as his Clinical Assistant (CA).His mattress was bare—without a stretcher or sheets—in the left corner of the room, indicating he recently had a bout of agitation. Other providers reporting about the preceding hours of the patient, highlighted multiple rage episodes each day, with several security guards physically restraining him, and, on occasion, intramuscular injections. The general way of describing the patient was unfavorable, with the providers adding subjective feelings to the clinical information.

Starting from now, the CA decided to sit down with the patient and introduced himself before asking him to complete tasks. The ultimate goal was to provide the boy the understanding of the staff as someone who could take care of him.

After introduction, it was noticeable that the patient desperately

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needed someone to believe in him.Although his behavior in the emergency room did not warrant autonomy or decision latitude, the impact of the staff's reactions was having on his behavior clearly contributed to an atmosphere of unrest, where he eventually exploded.

In the sequence of his management, the provider has chosen to sit next to him and have a conversation about meaningful subjects that could be of interest for the patient, after what he agreed in having a shower—the first one in four days. While in the bathroom, he said that he deserved "to be punished with needles" because he was a "bad boy."It was explained that the shots were given not as a punishment, but to keep him safe.

The CA was able to see him intermittently on that day, to sit and listen to him, and when he became agitated, he looked out of his door for the professional, who became sort of a reference, to whom he could express his frustration. He was encouraged to express his needs verbally, in a calm, respectful manner. With a strong rapport, patient and provider were able to negotiate together and complete tasks that were labeled improbable by nursing staff. The boy made his bed, brushed his teeth, and changed into clean clothes. Later that day, an inpatient bed was secured. For the first time in four days, he did not need to be restrained.

Discussion

This case illustrates how a verbal and behavioral approach can be effective in de-escalating a pediatric patient. Very little has been published in the scientific literature in this subject, but the emphasis in avoiding coercive methods is clear in adult guidelines [6]. Many authors have highlighted the impact of physical restraints and other coercive methods in the patient's recovery and how restrictive methods can be experienced as traumatic in a lifetime [4].

Moreover, strong evidence has been provided about physical restraints practice in pediatric patients as life threatening procedures, to be considered as last resource since the danger of harm and even death is increased in pediatric populations [7].

Even though it is known that pediatric patients experience more difficulty in verbal expression of their feelings, we showed in our approach that appropriate and careful posture from the health care provider can result in better rapport and therefore good verbal and attitudinal responses in children. Because pediatric patients that are seen as " angry children" can come from a troubled environment, many times their aggressive behavior being part of a context of neglect and abuse. It is more difficult for these patients to establish a trusting relationship with adults, what sometimes can lead to aggression as a self-protecting behavior, inducing counter transference in health staff [4]. Frequent bouts of aggression can separate empathy from a staff's clinical treatment, and group polarization intensifies the negative aura surrounding aggressive patients.

Our approach follows the domains of de-escalation proposed by Fishkind [8] and summarized by Richmond et al. [1]. Table 1 demonstrating that those domains, first described for adults, can apply to pediatric patients as well. Many facilities have been implementing intervention teams for the management of acute episodes of agitation [5,9].

Prospective, controlled studies evaluating outcomes of non-pharmacological de-escalation in pediatric populations are needed, in order to strengthen the evidence for a less restrictive practice in the management of psychomotor agitation in children.

Table 1. 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. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

Adapted from Fishkind (2002) [8] and Richmond et al. (2012) [1].

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