Key components of de-escalation techniques: A thematic synthesis

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ABSTRACT: De-escalation techniques are a highly recommended set of therapeutic interventions that are frequently used to prevent violence and aggression within mental health services. A thematic synthesis literature review identified 11 international papers. Seven themes emerged from the data synthesis. The first three related broadly to staff skills, including: characteristics of effective de-escalators, maintaining personal control, and verbal and non-verbal skills. The last four relate to the process of intervening and include: engaging with the patient, when to intervene, ensuring safe conditions for de-escalation, and strategies for de-escalation (including two sub-themes, autonomy confirming interventions, and limit-setting and authoritative interventions). De-escalation techniques are an example of a complex intervention, which has been overlooked by rigorous research, and it is often assumed that staff are able to perform these techniques in clinical practice.

KEY WORDS: de-escalation techniques, literature review, nursing interventions, violence and aggression management.

INTRODUCTION

De-escalation techniques consist of a variety of psychosocial techniques aimed at reducing violent and/or disruptive behaviour (NICE 2005). They are intended to reduce/eliminate the risk of violence during the escalation phase, through the use of verbal and non-verbal communication skills (CRAG 1996). Following several high profile deaths involving restraint (Blofeld 2003; Evans et al. 2003), the use of de-escalation techniques has become central to policy related to the management of violence and aggression (Royal College of Psychiatrists 1998; NICE 2005; NIMHE 2004). Despite the focus on de-escalation techniques, and evidence that they are used regularly by nurses and health-care workers in clinical practice (Epps et al. 1999; Lee et al. 2001), there is evidence that patients and staff regard these skills as inadequate (Duxbury & Whittington 2005). Furthermore, research continues to identify staff–patient interactions as a frequent antecedent to assaults on psychiatric wards (Duxbury 2002; Duxbury & Whittington 2005; Whittington & Wykes 1994), which suggests that developing these techniques will be critical to reducing violent and aggressive behaviours. Improving the ability of staff to de-escalate potentially violent situations clearly requires further examination.

Training in de-escalation techniques is often a key feature of restraint/seclusion reduction and aggression management programmes (Farrell & Cubit 2005; Richter et al. 2007; Zarola & Leather 2006). A systematic review evaluating the impact of these programmes (Richter et al. 2007) concluded that there was a stronger relationship between the programmes and increases in staff knowledge and confidence than there was between the programmes and reductions in violent and/or aggressive incidents. Furthermore, they report significant heterogeneity in the content and duration of training courses that have been evaluated (Richter et al. 2007). This variation would suggest both that there is a lack of consensus
regarding what is understood by the term de-escalation techniques, and raises questions around to what extent interventions/training programmes to date have been based on best available evidence. The suggestion of a lack of consensus is supported elsewhere in the published literature (Cowin et al. 2003; Duxbury 2002; Johnson 2001). A further limitation of the existing research is the lack of any randomized controlled trials (Muralidharan & Fenton 2006).

The limitations of research identified by previous reviews (Muralidharan & Fenton 2006; Richter et al. 2007) suggest that further trials are necessary to determine the effectiveness of training in de-escalation techniques. To inform the modelling of future interventions based on best available evidence, this review will extract and synthesize data from qualitative studies that elucidate best practices in the use of de-escalation techniques. The synthesis of data will also contribute to addressing the lack of consensus in this area.

METHODS

Search strategy

Searches of Medline, Psychinfo, EMBASE, AMED, BNI, Cochrane library (CENTRAL, CDSR + DARE), CINAHL, Sociological Abstracts, ASSIA, and the National Research Register databases were conducted. The search terms ‘de-escalation’, ‘violence prevention’, ‘verbal de-escalation’, ‘conflict resolution’, ‘defusion’, ‘talk down’, ‘assault cycle’, ‘verbal skills’, and ‘non-verbal’, were combined using OR and then AND with the term ‘nurs*’ using wildcard features. The wildcard feature is not available for the National Research Register so the terms were searched individually. There were no limits in terms of date of publication. Hand searching of the reference lists of previous reviews was also conducted (NICE 2005; Richter et al. 2007). Relevant papers were then retrieved and 94 were initially identified. The criteria for inclusion for more detailed analysis were: (i) published in English; (ii) not opinion or discussion articles; (iii) included qualitative data that could contribute to a description of the process of de-escalating violence and aggression; and (iv) not related to management of aggression in patients with dementia. Of the 94 articles retrieved, 78 were excluded because of their design (opinion and discussion articles, literature reviews, and quantitative studies) and six were excluded that related to the management of aggression in people with dementia. This left a total of 11 papers for more detailed analysis (Fig. 1).

Thematic synthesis

Thematic synthesis (Thomas & Harden 2008) is an approach to qualitative data synthesis that evolved from a need to review evidence for interventions that extended...
beyond only effectiveness, and revealed factors such as acceptability and intervention need (Barnett-Page & Thomas 2009). Although the approach facilitates the inclusion of rich, contextualized descriptive data from a range of methodologies, there remains a commitment to the key principles of systematic reviews, such as transparency of search methods and screening processes (Moher et al. 2009). Thematic synthesis uses a similar approach to analysis as grounded theory, which is based on inductive reasoning and where themes are developed using a constant comparative approach (Thomas & Harden 2008). All included studies were uploaded to Microsoft Word 2007. The material was then read and re-read and emerging themes noted. The themes were then discussed and agreed between the authors of the research, before the data were coded in detail, and extracted and categorized into appropriate themes. Finally, the data was condensed and synthesized into a coherent text and is presented by theme.

RESULTS

Table 1 provides key methodological features of the 11 included studies. The studies were conducted largely in the USA (Delaney & Johnson 2006; Gertz 1980; Johnson & Delaney 2007; Johnson & Hauser 2001; Lane 1986) and the UK (Duperouzel 2008; Lowe 1992; Mackay et al. 2005; Ryan & Bowers 2005), but there were also studies conducted in Sweden (Carlsson et al. 2000) and Finland (Virkki 2008). Table 2 provides a summary of the major findings of each study.

Seven themes emerged from the data synthesis. The first three related broadly to staff skills, including: characteristics of effective de-escalators, maintaining personal control, and verbal and non-verbal skills. The last four relate to the process of intervening and include: engaging with the patient, when to intervene, ensuring safe conditions for de-escalation, and strategies for de-escalation (including two sub-themes, autonomy confirming interventions, and limit-setting and authoritative interventions).

Staff skills

Theme 1: Characteristics of effective de-escalators

Effective de-escalators are open, honest, supportive, self-aware, coherent, non-judgemental, and confident, without appearing arrogant (Carlsson et al. 2000; Delaney & Johnson 2006; Duperouzel 2008; Gertz 1980; Johnson & Hauser 2001; Lane 1986; Lowe 1992). They express genuine concern for the patient, appear non-threatening and have a permissive, non-authoritarian manner (Carlsson et al. 2000; Duperouzel 2008; Gertz 1980; Johnson & Hauser 2001; Lowe 1996; Virkki 2008). These qualities help to gain the patient’s trust, making appeals for self-control more likely to be accepted (Duperouzel 2008; Lowe 1992). The ability to empathize is also vital, because it makes the patient feel understood, validates their experiences, and reduces the need for aggressive behaviour (Carlsson et al. 2000; Duperouzel 2008; Johnson & Hauser 2001; Lowe 1986; Virkki 2008).

Theme 2: Maintaining personal control

The importance of appearing calm when faced with aggression is emphasized throughout the reviewed studies (Carlsson et al. 2000; Delaney & Johnson 2006; Duperouzel 2008; Gertz 1980; Johnson & Delaney 2007; Johnson & Hauser 2001; Lowe 1992; Ryan & Bowers 2005; Virkki 2008). Effective de-escalators are able to create an appearance of calm, even when anxiety is being experienced internally (Duperouzel 2008; Lowe 1992). The sense of calm conveyed by the staff is believed to help the patient to manage feelings of anger and aggression, and communicates to the patient that, despite their anger, they are trusted not to be violent (Duperouzel 2008; Lowe 1992). Calmness conveys that the member of staff is in control of the situation, whereas fear can increase anxiety, make the patient feel unsafe, insecure, or even that they have gained the ‘upper hand’ (Virkki 2008 p81; Duperouzel 2008; Gertz 1980). Remaining calm also enables staff to make the most therapeutic decisions (Johnson & Hauser 2001). Strategies for controlling anxiety include focusing attention on assessment of the patient, rather than own feelings or, conversely, acknowledging feelings of fear, rather than attempting to deny them (Carlsson et al. 2000; Lowe 1992). Feelings of anger or offence should be suppressed and it is crucial that personal feelings toward the patient are avoided (Duperouzel 2008; Lowe 1992; Virkki 2008). Perceiving the behaviour as out of the patient’s control can be useful in achieving this (Duperouzel 2008; Lowe 1992).

Theme 3: Verbal and non-verbal skills

Using a calm, gentle and soft tone of voice is central to the technique (Johnson & Hauser 2001; Ryan & Bowers 2005; Virkki 2008). Tactful language and the sensitive use of humour are also evident, although care is required that this is not perceived by the patient as belittling (Duperouzel 2008; Lowe 1992). Tactful language and the sensitive use of humour are also evident, although care is required that this is not perceived by the patient as belittling (Duperouzel 2008; Lowe 1992). Staff must be aware of their body language in terms of posture, intention movements, eye contact, proximity, touch, and facial cues (Lowe 1992). More generally, body language should express concern for the patient (Carlsson et al. 2000; Johnson & Hauser 2001, Virkki 2008). Active listening should be used to let...
TABLE 1: Methodological features

<table>
<thead>
<tr>
<th>Citation</th>
<th>Aim</th>
<th>Method</th>
<th>Sample characteristics</th>
<th>Data collection method</th>
<th>Method of data analysis</th>
<th>How was trustworthiness ensured?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlson et al. (2000)</td>
<td>To explore the phenomenon of positive nursing encounters with patients who display aggression and violence patients</td>
<td>Phenomenology</td>
<td>Self-selecting sample of two nurses + three nursing assistants</td>
<td>Unstructured interviews</td>
<td>Thematic content analysis</td>
<td>Open approach to data collection and analysis/multiple analysis sessions</td>
</tr>
<tr>
<td>Delaney and Johnson (2006)</td>
<td>To describe the de-escalation skills of mental health nurses</td>
<td>Grounded Theory</td>
<td>Purposive sample of 16 staff + 12 patients</td>
<td>Observations and unstructured interviews</td>
<td>Thematic content analysis</td>
<td>Prolonged engagement in the setting/triangulation of data sources and collection methods/peer debriefing/use of audit trail</td>
</tr>
<tr>
<td>Duperouzel (2008)</td>
<td>To identify effective interventions in the management of imminent aggression</td>
<td>Grounded Theory</td>
<td>A purposive sample of six nurses</td>
<td>Semi-structured interviews</td>
<td>Thematic content analysis</td>
<td>Critical examination of author’s influence on findings/member checking</td>
</tr>
<tr>
<td>Gertz (1980)</td>
<td>Qualitative investigation of interventions that reduce violence and aggression</td>
<td>Undefined qualitative</td>
<td>Purposive sample of 15 nursing staff</td>
<td>Focus group</td>
<td>Not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Johnson and (Delaney) 2007</td>
<td>Identification of conditions that influence how nursing staff manage patients whose behaviour is escalating</td>
<td>Grounded Theory</td>
<td>Purposive sample of 16 staff + 12 patients</td>
<td>Observations and interviews</td>
<td>Thematic content analysis</td>
<td>Not reported</td>
</tr>
<tr>
<td>Johnson and Hauser (2001)</td>
<td>The stories of psychiatric nurses who are skilled in the practices of de-escalating an escalating patient</td>
<td>Phenomenology</td>
<td>A purposive sample of 20 registered nurses</td>
<td>Unstructured interviews</td>
<td>Thematic content analysis</td>
<td>Peer debriefing/concurrent analysis of data by both authors/member checking</td>
</tr>
<tr>
<td>Lane (1986)</td>
<td>Exploration of the concept of empathy and its therapeutic impact with violent patients</td>
<td>Case study</td>
<td>NA</td>
<td>Four case studies</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Lowe (1992)</td>
<td>To investigate the interventions used by mental health nurses when faced with challenging behaviour</td>
<td>Undefined qualitative</td>
<td>A stratified sample of 33 psychiatric nurses</td>
<td>Observations and interviews</td>
<td>Matrix method of multi-dimensional scaling</td>
<td>Not reported</td>
</tr>
<tr>
<td>Mackay et al. (2005)</td>
<td>Perceptions of registered mental health nurses of the use of observation for those at risk of violence</td>
<td>Undefined qualitative</td>
<td>Purposive sample of six registered nurses</td>
<td>Unstructured interviews</td>
<td>Thematic content analysis</td>
<td>Member checking</td>
</tr>
<tr>
<td>Ryan and Bowers (2005)</td>
<td>Description and categorization of coercive manoeuvres used by nurses</td>
<td>Observation study</td>
<td>NA</td>
<td>Non-participant observations</td>
<td>Literal indexing</td>
<td>Peer debriefing</td>
</tr>
</tbody>
</table>
| Virkki (2008)         | To investigate the ‘feminine’ emotional skills that are supposed to prevent violence | Undefined qualitative   | Purposive sample of 20 social workers + 15 nurses.                                         | Interviews and narrative accounts | Thematic content analysis | Not reported                                                                                   

NA, not applicable.
et al. (2000). A degree of eye contact is necessary to maintain rapport, assessment, and the patient’s attention, although fixed eye contact was not recommended (Carlsson et al. 2000; Duperouzel 2008). There was some ambiguity regarding the use of touch, noting that it could be calming for some patients, yet threatening for others (Carlsson et al. 2000; Gertz 1980; Lowe 1992). Personal space should not be invaded, but the member of staff must be close enough to establish rapport (Carlsson et al. 2000).

Intervening

Theme 4: Engaging with the patient

Efforts to establish a bond with the patient displaying aggression should be made to foster a sense of mutual regard and remove the need for aggression (Carlsson et al. 2000; Delaney & Johnson 2006; Duperouzel 2008;
The focus should be on promoting the autonomy of the patient, through minimizing restriction as far as possible (Delaney & Johnson 2006; Duperouzel 2008; Lowe 1992). This demonstrates the staff’s trust in the patient, confirms their humanity, helps to create a sense of equality between the patient and staff members, and promotes positive emotions and self-control (Carlsson et al. 2000; Duperouzel 2008; Johnson & Delaney 2007; Lowe 1992; Virkki 2008). The staff must remain connected with the patient throughout the process, both in terms of maintaining rapport and assessing the patient for risk of violence (Carlsson et al. 2000; Duperouzel 2008; Johnson & Hauser 2001). The patient should be made to feel valued and respected (Carlsson et al. 2000; Delaney & Johnson 2006; Duperouzel 2008; Johnson & Hauser 2001; Lane 1996; Lowe 1992). Aggression is often a response to lost dignity, and feeling respected enables the patient to reclaim their sense of dignity and reduces the need for further aggression (Carlsson et al. 2000). Punitive approaches must be avoided (Lowe 1992).

Theme 5: When to intervene

There was widespread agreement that early intervention is vital in successful de-escalation, but there was also an acknowledgement that unnecessary interventions could exacerbate problems (Delaney & Johnson 2006; Johnson & Delaney 2007; Johnson & Hauser 2001; Lowe 1992; Mackay et al. 2005). Decisions regarding whether or not to intervene are based on: knowledge of the patient; meaning of behaviour; whether the patient’s behaviour deviates from their normal presentation; dangerousness of behaviour; impact on others; impact on the milieu; and staff resources (Delaney & Johnson 2006; Duperouzel 2008; Johnson & Delaney 2007; Johnson & Hauser 2001; Mackay et al. 2005). There was evidence that behaviour as a result of illness may be tolerated for longer (Delaney & Johnson 2006).

Theme 6: Ensuring safe conditions for de-escalation

An assessment should be made as to what level of staff support is necessary to safely de-escalate the patient, while bearing in mind that a ‘show of force’ can escalate rather than de-escalate patient aggression (Duperouzel 2008; Johnson & Hauser 2001). An assessment of the area should also be made, in terms of potential weapons and exits for staff to leave the area safely (Duperouzel 2008). If possible, the patient should be encouraged to move to a quiet area of the ward, separate from other patients and uninvolved staff (Duperouzel 2008; Gertz 1980; Johnson & Hauser 2001; Mackay et al. 2005). This should be done without obvious intention and only when moving the patient will not aggravate them further (Duperouzel 2008).

Theme 7: Strategies for de-escalation

Deciding on a strategy for de-escalation is an instinctive, intuitive process, requiring flexibility and creativity and is based on the individual needs and characteristics of each patient displaying aggression (Carlsson et al. 2000; Delaney & Johnson 2006; Duperouzel 2008; Johnson & Delaney 2007; Johnson & Hauser 2001; Lane 1986; Lowe 1992; Mackay et al. 2005). Listening to the patient, use of empathy, and interpretation of non-verbal cues were considered useful in terms of accurate assessment of the individual’s emotional state and the formulation of appropriate interventions (Carlsson et al. 2000; Duperouzel 2008; Johnson & Hauser 2001; Lane 1986; Lowe 1992; Mackay et al. 2005; Virkki 2008). Effective interventions (i.e. those most likely to result in a positive outcome) are based on the need to balance support and control (Delaney & Johnson 2006; Lowe 1992). Several studies report a continuum of interventions, between those that are supportive and promote the patient’s autonomy, to those that are related to boundary and limit setting (Delaney & Johnson 2006; Lowe 1992; Mackay et al. 2005). It is crucial that staff interventions are proportionate to the risk posed by the patient (Mackay et al. 2005).

Autonomy confirming interventions

Shared problem solving

Attempts should be made to find out the reason for the patient’s aggression, as this will facilitate assessment of the patient and inform type of intervention, and means of resolving the problem (Duperouzel 2008; Johnson & Hauser 2001; Lane 1986). The patient should be asked what the problem is, what can be done to resolve it, and what normally helps the patient to feel calmer (Johnson & Delaney 2007; Johnson & Hauser 2001). Guidance should be given to the patient without appearing commanding or arguing with the patient, although it is not necessary to agree (Duperouzel 2008; Gertz 1980; Johnson & Hauser 2001). Staff should avoid threats of sanctions, delivering ultimatums, or entering into power struggles (Gertz 1980; Johnson & Hauser 2001). The focus should be on establishing rapport, answering questions, and finding agreements without making unreasonable concessions or appearing uncompromising (Johnson & Hauser 2001).

Facilitating expression

The patient should be encouraged to communicate openly with staff about his/her feelings and emotions, and identify and discuss feelings of anger and frustration (Duperouzel...
Opposing alternatives to aggression

Alternatives to aggression should be highlighted to the patient, either by offering alternative activities, teaching coping mechanisms, or suggesting new responses to frustrating situations (Duperouzel 2008; Gertz 1980; Johnson & Delaney 2007; Johnson & Hauser 2001; Lowe 1992). Depending on the degree of risk to the patient or others, giving the patient the choice of a ‘cooling off’ period might be an option (Lowe 1992). Several studies emphasize the importance of offering ‘face-saving’ alternatives, which involve negotiation of a mutually agreed alternative to aggression and enable patients to reduce their aggression without losing dignity (Duperouzel 2008; Gertz 1980; Lowe 1992). The aim is to empower the patient to feel they are choosing to de-escalate, rather than being forced by nursing staff (Duperouzel 2008). This should be combined with the use of positive reinforcement, which involves praising non-violent behaviour (Gertz 1980).

Limit-setting and authoritative interventions

The use of limit-setting is an aspect of the de-escalation process and involves knowing when to exert control and implement constraints on patients’ behaviour (Johnson & Hauser 2001; Lowe 1992). More authoritative approaches are associated with higher risk behaviour and should be used in proportion to the risk posed by the patient to themselves or others (Johnson & Hauser 2001). If a patient is presenting with threatening, intimidating, or violent behaviour, a firmer approach is taken. There is no longer a focus on discussing the patients’ feelings but instead the focus is on escorting the patient to a safer area to continue de-escalation, possibly in conjunction with medication (Johnson & Hauser 2001; Lowe 1992). Aggressive limit setting has been found to exacerbate aggressive behaviour and should not be considered in isolation from the autonomy confirming approaches described above.

DISCUSSION

Implications for research

Staff–patient interactions have been found to be a major antecedent to assaults on psychiatric wards (Duxbury 2002; Duxbury & Whittington 2005; Whittington & Wykes 1994). This suggests that staff’s communication skills are critical to reducing assaults, and highlights the importance of ongoing R&D in this area. The need for additional evidence synthesis in relation to de-escalation techniques is highlighted by Richter et al. (2007), who reviewed the effectiveness of training programmes in de-escalation. The authors found that the programmes were limited in effectiveness and varied greatly in both content and duration. This would indicate that not all training programmes to date have been based on best available evidence. By systematically identifying all relevant qualitative studies, and extracting and synthesizing data, we have produced an evidence-based resource that can be used in a number of ways: first, as an aide for nurses in clinical practice; second, for researchers modelling future trials of effectiveness; and, third, to inform the content of the de-escalation techniques component of violence and aggression training programs. The synthesis may also go some way to addressing the acknowledged lack of coherence within the literature regarding what is meant by de-escalation techniques (Cowin et al. 2003; Duxbury 2002; Johnson 2001).

This review did not intend to evaluate the efficacy of the interventions described above because this has been the subject of previous reviews (Muralidharan & Fenton 2006; NICE 2005; Richter et al. 2007). How the techniques may differ according to age groups and psychopathologies has not been established, and this is recommended as a key area for future research. The only limiter in terms of psychopathology were studies relating to people with dementia, which were excluded following recognition that de-escalation of violence and aggression with these patients requires a significantly different skills set. The use of de-escalation with this patient group may be the subject of a future review. Studies included in the review used varying terminology in terms of the interventions and training programmes described. Although an aim of the review was to synthesize this data to move toward consensus, this might be regarded as a limitation.

Implications for clinical managers and policy-makers

Evidence would suggest that there is some way to go before the principles of de-escalation as described above are adequately translated into national training programmes. A national evaluation of violence and aggression programmes in the UK found that there was a relative lack of emphasis on verbal intervention strategies (Zarola & Leather 2006). This is certainly consistent with the two authors’ experiences of attending such programmes, where the teaching of de-escalation techniques is often restricted to 2 hours of a 5-day course. It is clear,
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from the complex processes and range of potential interventions identified by this review, that longer is required. It should be acknowledged, however, that there are limits to what can be covered in time-constrained training programmes.

Zarola and Leather (2006) also criticize de-escalation training programmes for lacking underpinning psychological models of aggression and human behaviour. This synthesis revealed that identifying the root causes of patient aggression and the use of empathy are key features of effective de-escalation. To promote the accuracy of nurses' empathy, it is essential that de-escalation training is rooted in psychological models of aggression, and considers: how patients' past experience can influence their current behaviour, person-specific triggers, the impact of threatened self-esteem, and displacement behaviours (i.e. the direction of aggression against non-instigating objects) (Baumeister et al. 1996; Berkowitz 1959).

It is possible that nurses' ability to effectively use de-escalation techniques is, to some degree, dependent on innate qualities of each individual nurse, such as personality type and emotional intelligence. Certainly, the extent to which de-escalation techniques can be taught effectively has not yet been clearly established (Muralidharan & Fenton 2006; Richter et al. 2007). In addition to the focus on teaching skills, it may be equally useful to establish what types of nurses are particularly effective de-escalators, and inform workforce planning accordingly (Baker et al. 2005; Delaney & Johnson 2006; Duperouzel 2008; Lowe et al. 2003).

The use of de-escalation as a first line intervention for the management of violence and aggression has been central to violence and aggression policy for over a decade (NICE 2005; NIMHE 2004; Royal College of Psychiatrists 1998). A criticism of the focus on de-escalation techniques is that they are reactive to, rather than pre-emptive of, patient violence (Duxbury 2002). Furthermore, Virkki (2008) cautions against the valorization of these skills because doing so implicitly accepts that violence is an intrinsic aspect of health and social care work, which absolves managers from their responsibility to address the root causes of patient aggression. De-escalation techniques, therefore, should not be considered in isolation from other important aspects of staff–patient interactions that help to maintain safety in psychiatric units. These include: monitoring and influencing the tone of the milieu; being present in the milieu to identify sources of agitation to patients and intervene before escalation occurs; offering activities; providing structure; meeting patient requests; being consistent; having adequate staffing levels and skill mix (Delaney & Johnson 2006; Duperouzel 2008; Johnson & Delaney 2006; 2007). The importance of maintaining effective therapeutic relationships beyond de-escalation techniques and staff maintaining self-awareness throughout all their interactions with patients cannot be underestimated (Duxbury 2002; Johnson & Hauser 2001; Whittington & Wykes 1994).

Implications for clinicians

The findings of the review provide a set of guiding principles to clinicians and are not intended to be prescriptive. The causes of violence are multifactorial and unique to each individual situation and nursing interventions in response to aggression should reflect that. The need for creativity, flexibility, and interventions that are tailored to meet the specific needs of each patient is stressed within the literature. Furthermore, in situations that are highly stressful and anxiety-provoking for staff members, it might be more useful to be conscious of the need for more general self-awareness, rather than attempting to recall a set of rigid rules.

The need for creative, flexible, and tolerant approaches to patient aggression may be difficult for mental health workers because they are inherently associated with therapeutic risk-taking (Lowe 1992). Staff may feel vulnerable to criticism from their peers if they adopt a creative, autonomy-confirming approach that fails, whereas the negative consequences of adopting more restrictive measures might not be as immediately apparent (Lowe 1992). This may explain why senior nurses, generally more secure in their skills and less influenced by the perceptions of others, tend to use restrictive measures less often than junior nurses (Lowe et al. 2003).

The findings are also non-prescriptive in terms of when to intervene and what interventions to use, other than to say they should be proportionate to the risk of harm posed by the patient. Deciding when to intervene and what intervention to use is an intuitive process based on experience, knowledge of the patient, and the context of their behaviour (Johnson & Hauser 2001). Staff should attempt to achieve the right balance between support and control (Lowe 1992). The risk of the more tolerant approaches is that in the worst case scenario they may neglect a patient requiring intervention and increase the possibility of violence to others and/or self-harm (Duxbury 2002). In contrast, approaches that are too rigid, unnecessary, or excessively restrictive are known to increase the risk of violence (Duxbury 2002; Meehan et al. 2006). The ability to strike a balance between opposing and apparently contradictory variables, such as tolerance and control, appears to be a central aspect of de-escalation. This skill has been referred to as 'pliability' where the member of
staff is able to appear permissive yet in control, active yet inactive, and prepared both to act and wait to act (Carlsson et al. 2000). This ability to sensitively and intuitively match interpersonal actions with anticipated outcomes highlights what a highly skilled intervention de-escalation is, and this may explain the limited effectiveness of time-constrained training programmes to date (Richter et al. 2007).

CONCLUSION

The process of de-escalation is about establishing rapport to gain the patient’s trust, minimizing restriction to protect their self esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression. Through knowledge of the patient and clinical experience, the member of staff must be aware of the right time to intervene and the right time to apply constraints on patient behaviour and set limits. There is evidence that these principles have been incorporated inconsistently into training programmes to date (Richter et al. 2007; Zarola & Leather 2006), which might explain the limited evidence of the programmes’ effectiveness (Richter et al. 2007).

Previous research has demonstrated that assaults on nursing staff are often a result of nurse-patient interactions (Duxbury 2002; Duxbury & Whittington 2005; Whittington & Wykes 1994). This suggests that improving the way nurses communicate with patients may help to reduce assaults on nursing staff. De-escalation techniques will be an important but not sole factor in achieving this. Clinical managers should aim to provide safe, structured environments with adequate staffing levels and skill mix, and a focus on activity and positive interaction between staff and patients. In addition to the use of de-escalation techniques, nurses must aim to maintain self-awareness throughout all interactions, and focus on developing effective therapeutic relationships, to reduce the frequency of escalating incidents.

The lack of trials conducted under rigorous experimental conditions is a key area for development of de-escalation techniques (Muralidharan & Fenton 2006). It is hoped that the results of this synthesis may be used to model trials of effectiveness under adequately controlled conditions. De-escalation techniques are recommended as a first line intervention in policy governing the management of violence and aggression (NICE 2005; NIMHE 2004; Royal College of Psychiatrists 1998). Therefore, it is essential that clinical managers have at their disposal high quality evidence regarding both the effectiveness of training programmes, and what works for whom, when, and in what circumstances. Beyond training, it may also be useful for researchers, clinical managers, and policy-makers to consider what types of nurses, make effective de-escalators, considering factors such as age, clinical experience, attitudes, and personality characteristics. This information could then be used to inform workforce planning. There is considerable scope for practice and research development in this area.

REFERENCES


