Skills to Calm and De-escalate Emotionally Dysregulated Patients

AN ATTACHMENT/OBJECT RELATIONS THEORY PERSPECTIVE

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Identify developmental and environmental influences that shape behavior.

Review emotional self-regulation and how to use this to co-regulate an upset person.

Consider designing scripting and other staff developed interventions to manage particular difficult people.

Understand that to be an adult means to be in charge of your emotions.

INTRODUCTION

Workplace Violence in Outpatient Physician Clinics: A Systematic Review Pompeii et al 2020

Workplace violence (WPV) has been extensively studied in hospitals, yet little is known about WPV in outpatient physician clinics.

From 2000–2019 thirteen quantitative and five qualitative manuscripts were included which all focused on patient/family-perpetrated violence in outpatient physician clinics.

Workplace Violence in Outpatient Physician Clinics: A Systematic Review Pompeii et al 2020

The overall prevalence of violence ranged from 9.5% to 74.6%, with the **most common** form being **verbal abuse** (42.1–94.3%), followed by **threat of assault** (14.0–57.4%), **bullying** (2.5–5.7%), **physical assault**, (0.5–15.9%) and **sexual harassment/assault** (0.2–9.3%).

Most workers did not receive training on how to manage a violent patient.

All experience the trauma of normal development, some experience worse.

We live in a world with people in crisis.

There is a general failure to effectively communicate.

Dealing with people in crisis adds a whole new level of emotional complexity to any situation.

PEOPLE IN CRISIS

Human Aggression may be defined s a sequence of behavior in which one or more individuals inflict, threaten to inflict, of attempt to inflict harm on another.

Among humans, culture and biology are so tightly wedded that the task of identifying and isolating the most salient aggression-eliciting factors is formidable, if possible at all.

Human aggression can be turned either on or off volitionally, abetted or inhibited, sanctified or vilified, mostly in accordance with the prevailing sociocultural milieu.

HUMAN (PRIMATE) AGGRESSION

Much human aggression is either currently adaptive or derived from adaptive strategies - ***Aggression is not a single behavioral category***

We learn from:

Parents

Peers most important after leaving home

In groups and out groups - pseudo kinship

COOPERATION AND AGGRESSION

Previous (epi)genetic and social history (500 plus years etc…)

Childhood experience when the brain was assembled (epigenetic/environmental)

Socialization throughout life

Pain (physical or emotional) and Frustration (increases aggression)

Displacing aggression makes one feel better if the organism is predisposed to aggression

Environmental triggers and **Other – what happened today, yesterday, the day before….**

INFLUENCES ON PROMPTING AGGRESSION

Dominance – the individual regularly wins rather than loses aggressive encounters with particular others. This dominant person finds his place in a dominance hierarchy.

Dominance subtypes: Sociable or Aggressive

A contested resource or goal is often determined by the nature of the item being competed for and how badly the person needs to win

This interaction must be analyzed in a resource-specific context

1. Identify the context

2. Identify the resource or goal

DOMINANCE AND AGGRESSION

CATEGORIES OF AGGRESSIVE BEHAVIORS

	Reactive	Proactive (Foraging/Predatory)
Trigger	Fear or Contest	Desire
Arousal	High	Low
Initiation	Sudden	Planned
Function	Reduce Threat	Achieve Goal
Targets	Easily Switched	Single
Facial Features	Wide eyed, red faced (pale, if very afraid	Impassive, staring, smiling, or smirking
Actions	Disorganized, Impulsive	Deliberate, Methodical
Tone of Voice	Angry, Loud, Shrill	Firm, Calm, Menacing
Emotions	Highly Aroused	Apparently Controlled

The distinction between **PROACTIVE** and **REACTIVE AGGRESSION** is centered upon the aims of aggression.

Reactive aggression is a response to a threat or frustrating event.

The **goal** is to remove the provoking stimulus.

It is always associated with anger, as well a sudden increase in sympathetic failure of cortical regulation, and easy **switching among targets**.

Sometimes proactive and reactive aggression can express in the same act, such as when a premeditated act is met with an effective defense and the initiator is forced into a reactive fight.

TWO CATEGORIES OF AGGRESSIVE BEHAVIORS

Proactive aggression involves a purposeful planned attack with an external or internal reward as a **goal**.

Characterized by attention to a **single target**, often without emotional arousal.

Aggressors normally initiate action only when they perceive that they are likely to achieve their goals.

TWO CATEGORIES OF AGGRESSIVE BEHAVIORS

When reminded of their mortality, people become particularly hostile to other individuals who do not share their beliefs about the nature of reality.

Increasing of the distance between the observer and the one who “looks different”.

If given an opportunity to “harm someone” who has a different belief system or who looks different, people may be internally predisposed some form of violence.

This causes an anticipated increase in irrational and hostile behaviors.

DEATH ANXIETY (TERROR MANAGEMENT THEORY) BECKER; SOLOMON ET AL

AVOIDING THE ABYSS

People engage in a frantic attempt to counter the threat of emotional and physical abandonment in an attempt to avoid the dread of death and nothingness.

Helping people realize they are a valued person

in a meaningful world will reduce the reactivity.

Clear threats of violence

Previous history of violence and conflict

Drug induced disinhibition/psychosis – intoxication/withdrawal, excited delirium, steroid psychosis, etc

Unrelenting depression with notable anger, high agitation or mood swings

Paranoia, homicidal/suicidal thoughts

Substance abuse, past and/or present

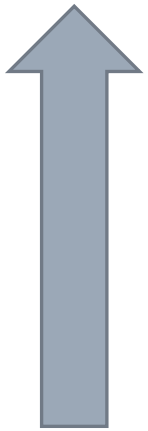
Obsession and strong feelings of anger, humiliation or injustice

Weapons training, formal or informal

SOME RISK FACTORS FOR VIOLENCE

Establishing a Hierarchy of Danger

MOST



LEAST

* Brandishing an object or weapon in a menacing way. Go to safety!
* Approaching or standing too close with menacing intent.
* Kicking objects, punching walls, or throwing objects.
* Pacing, stomping, and inflating the body in an aggressive manner (posturing).
* Shouting
* Language that is intended to violate, demean, or degrade.

Avoid the threat.

Drive the threat away.

Destroy the threat.

Anger and rage often masks anxiety, fear, terror.

PRIMAL THREAT RESPONSES

Attachment quality depends upon a ***good enough*** initial attachment relationship with one's primary caregiver.

Initial caregiver infant/child attachment tends to replicate throughout the life span with all relationships.

Degree of success with others in later life often depends upon initial attachment, plus the degree of "self work" and social distance.

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MODERN ATTACHMENT THEORY

THE INFANT (human) NEEDS TO BE SEEN TO SURVIVE

Being ***Seen, Heard, Understood …Validated*** leads to a sense of **Safety.**

We must self-regulate emotionally to co-regulate!

Connection is paramount (implicit message: "I will not shun or abandon you").

EMOTIONAL REGULATION

Present at birth

No sense of recollection present when memories recalled

Incudes behavioral, emotional, perceptual, and possibly bodily memory

Includes **Mental Models**

IMPLICIT MEMORY

Develops during second year of life and beyond

Sense of recollection present when recalled

If autobiographical, as sense of time and self are present

Includes semantic (factual) and episodic (autobiographical) memory

EXPLICIT MEMORY

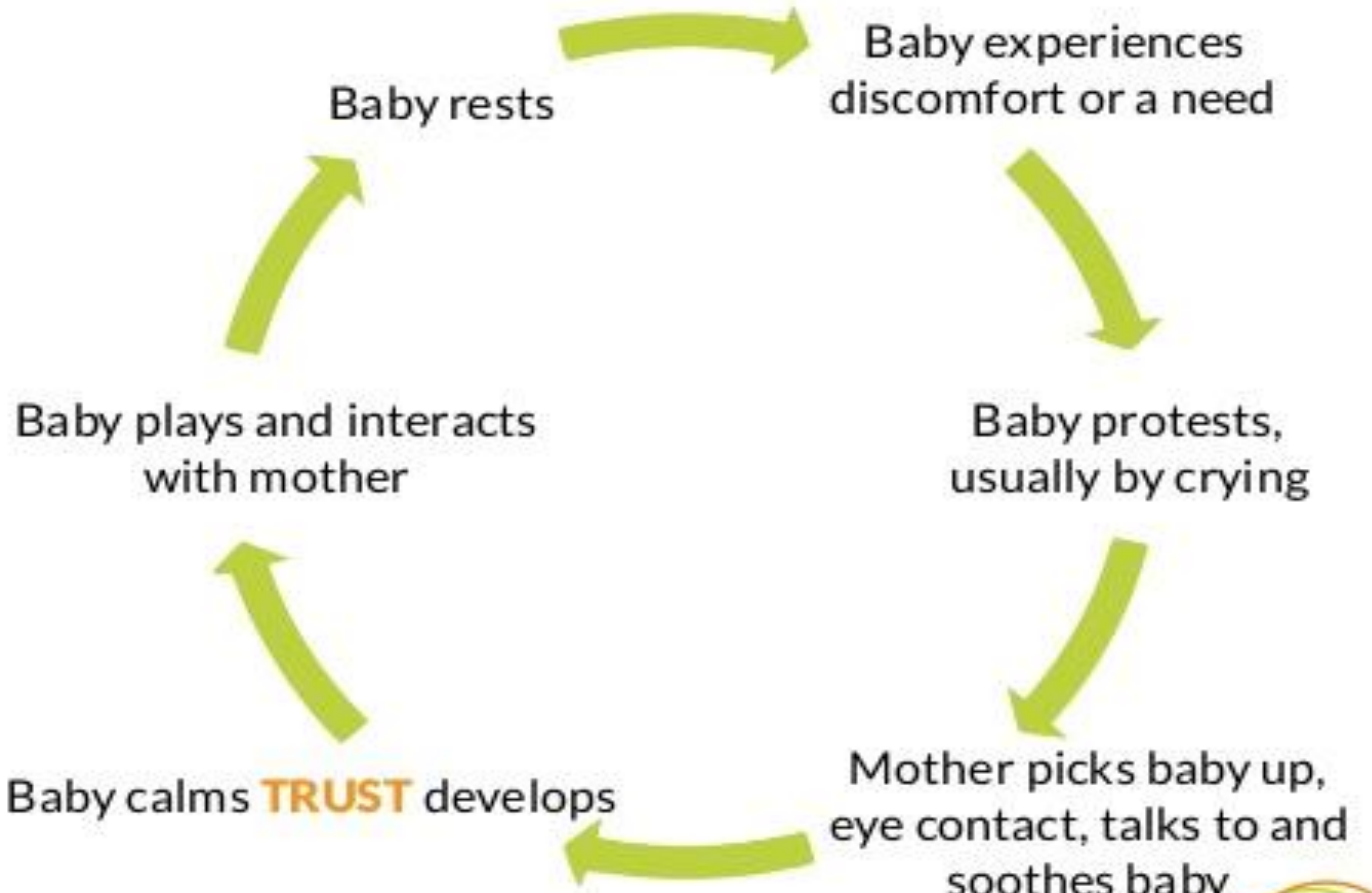
Initial caregiver attachment
(good enough vs neglect/abuse)

Replication of attachment
throughout lifespan

HUMAN ATTACHMENT

"NORMAL" CHILD DEVELOPMENT

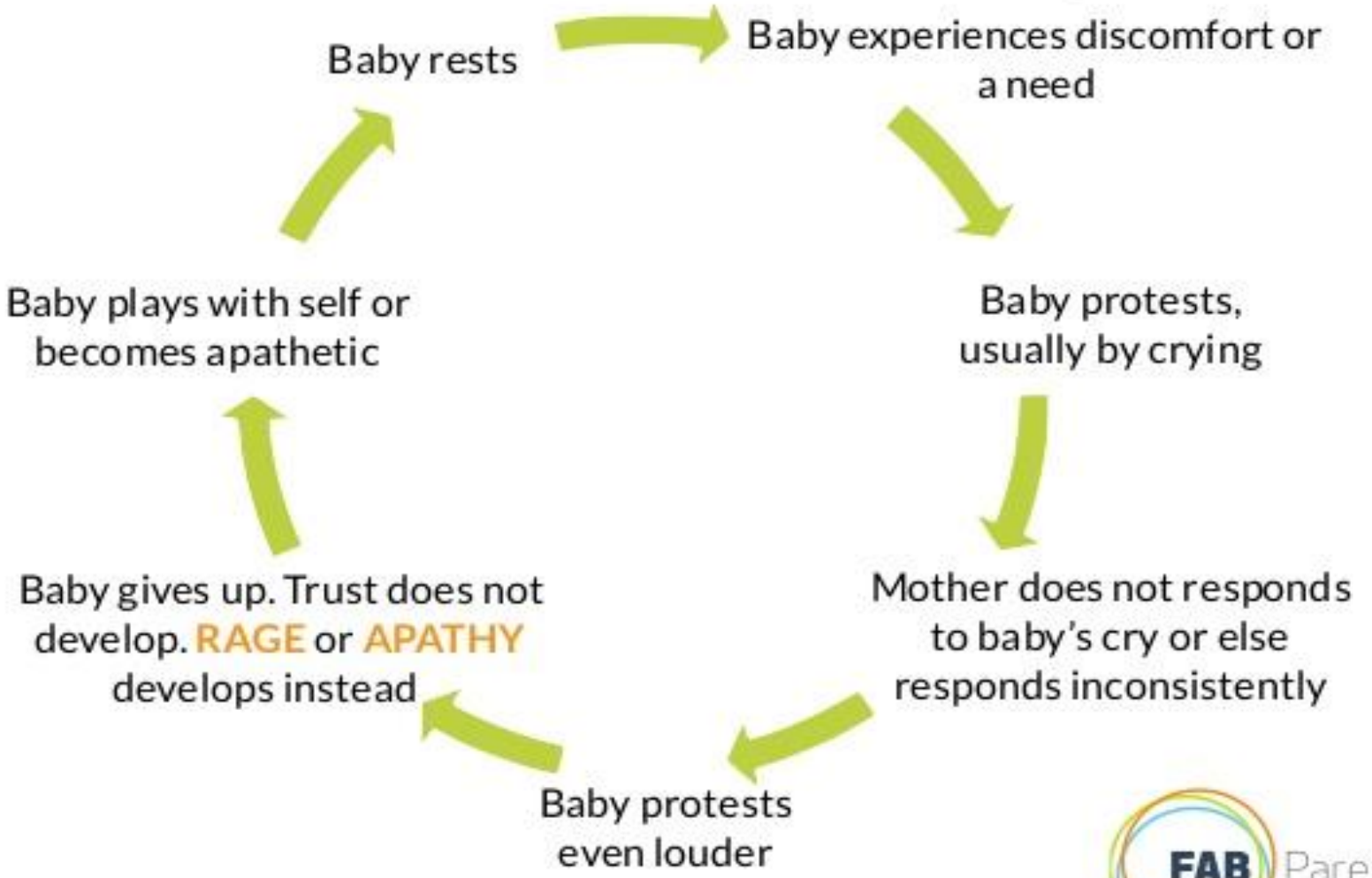
Secure Attached Cycle



FAB Parents

"DISTORTED" CHILD DEVELOPMENT

Disturbed Attachment Cycle



FAB Parents

Deficits with regulatory / emotional, intrapersonal (self), interpersonal (social) and cognitive development

LEAD TO

Difficulties with regulating physiological, emotional, behavioral and cognitive experiences.

UNDERSTANDING DIFFICULT BEHAVIORS

EFFECTS OF PHYSICAL, SEXUAL, EMOTIONAL AND NEGLECT TRAUMAS

Dysregulated and manipulative behaviors **that were once adaptive** in childhood to get needs met in difficult circumstances become **counterproductive in adulthood**.

Developmental environment has a predictive effect for violence potential.

Stressors and Behaviors experience over the past three days are predictive also!

UNDERSTANDING DIFFICULT BEHAVIORS

Many have not learned the appropriate social contexts for aggressive behaviors.

Often there is a subconscious assumption of danger……

“all caregivers (aka authority figures) are dangerous”.

UNDERSTANDING DIFFICULT BEHAVIORS

The Limbic System Gives us Pleasure and Pain:

Approach positive stimuli. (Need fulfillment - pleasure)

Patient avoids noxious stimuli. (Safety seeking – avoid pain)

PRIMAL DRIVES

Extreme Need Fulfillment Behaviors

Emotional relational needs:
emotionally demanding whiny, interrupting, dramatic,
acting up, poor emotional interpersonal boundaries
Lying and other manipulations.

Physical nurturance needs: too much physical contact,
inappropriately sexualized behaviors, poor physical boundaries
Hoarding/stealing food, clothing, objects; drug use.

Extreme Safety Seeking Behaviors

Externally directed physiological arousal: aggression, irritability, anger, hyperactivity.

Withdrawal and escape: social isolation, avoidance.

Stilling and hypervigilance: constricted emotions, vigilance to environment.

Appeasing and accommodating to others: denial of needs, pleasing behaviors, denial of affect or reaction.

UNDERSTANDING DIFFICULT BEHAVIORS

Anger – deliberate display of anger to intimidate and manipulate.

Guilt – manipulating conscientious person through their sense of responsibility.

Shame – contempt/sarcasm meant to play on a sense of inadequacy (shame) of the recipient.

Vilifying the victim – verbally attacking the actual victim (you).

Covert intimidation – threatening to keep the recipient anxious, apprehensive. Throws the recipient on the defensive – veiled threats.

TACTICS OF MANIPULATION AND CONTROL OMH

Playing the victim role – portraying oneself as the victim.

Seduction – using charm, praise, flattery or overtly supporting others for manipulative gain.

Blame shifting – projecting the blame on innocent others.

Minimization - denial coupled with rationalization.

Lying - outright lying, lying by omission, lying by distortion.

Confablulation - a falsification of memory by a person who, believes he or she is genuinely communicating truthful memories.

Denial - not the psychological defense mechanism definition…more akin to a lie.

TACTICS OF MANIPULATION AND CONTROL OMH

Evasion – using rambling, irrelevant responses to a question.

Feigning innocence – attempt to convince you that any harm inflicted was unintentional.

Feigning ignorance or confusion – aggressor acts like they have no idea what you are talking about.

Selective (in)attention – aggressors ignore warnings, and whatever distracts them from pursuing their agenda.

Rationalization – an excuse for an inappropriate behavior.

Diversion/distraction – keeps the focus off the inappropriate behavior.

TACTICS OF MANIPULATION AND CONTROL OMH

Interventions

Emotional
Self Regulation

TAKE A MINUTE!

Self Regulation – identifying, understanding and using your own body sensations and emotions to remain calm.

If you cannot identify and manage your own emotions, you will be triggered, react instead of act, and potentially escalate social situations.

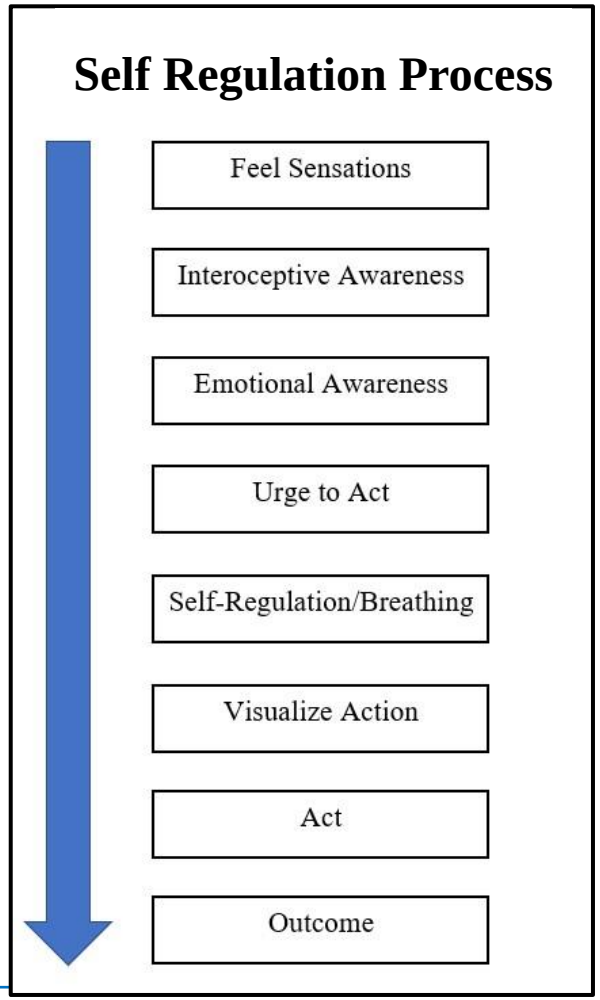
EMOTIONAL SELF REGULATION

We must understand, manage, and cope with our own emotional/physical reactions to better able to support the emotionally upset “other person”. This will create better and safer outcomes for all.

EMOTIONAL SELF REGULATION

SELF REGULATION PROCESS

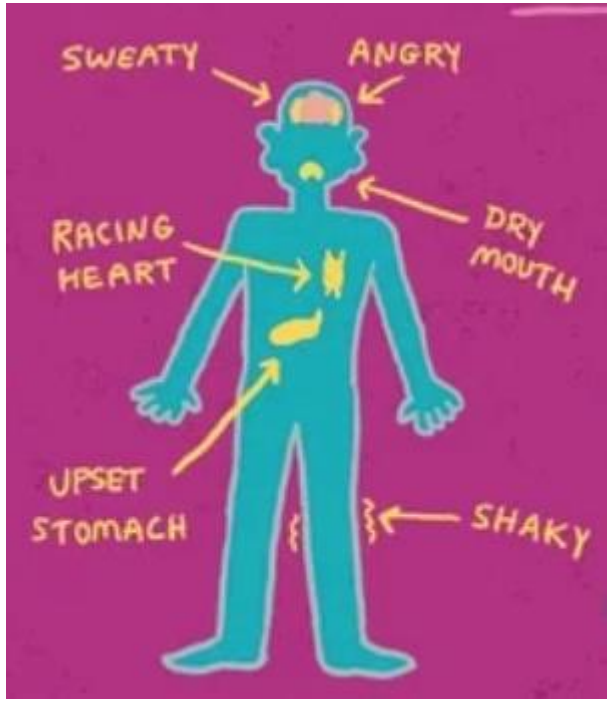
This is the process we go through when a situation affects us emotionally and requires us to act.
We either choose to notice the different steps (feel our sensations, visualize outcomes, choose to act), or we simply react spontaneously (without full awareness).



Interoceptive Awareness:
The ability to identify, access, understand, and respond appropriately to the patterns of internal sensations and signals. This skill provides a distinct advantage when engaging in life challenges and ongoing social adjustments.

INTEROCEPTIVE AWARENESS

Reading Interoception



Learn to recognize the specific signals your body gives you. Use interoception to help you assess new situations.

Independent Body Scan – Sample

Adapt this form to include specific descriptions the individual uses.

Body Part	What I Feel (circle)
Brain	Focused, distracted, dizzy, light-headed, tense, fast, swirly, heavy, blank, stuck, scattered
Eyes	Heavy, blurry, watery, stingy, itchy, squinty, teary
Nose	Runny, stuffy, tickly, itchy, burning
Cheeks	Warm, neutral, red, hot, tight, loose
Mouth	Dry mouth, tight jaw, soft jaw, sore throat
Voice	Shut-off, loud, fast, slow, yelling, content
Ears	Focused, sensitive, bothered, shut-off, itchy, sore, distracted
Skin	Sweaty, itchy, goose bumps, bothered, tight, dry, content, OK
Breathing	Fast, slow, normal, tight, short, panting
Heart	Fast, slow, warm, swelling, full, pounding
Stomach	Content, hungry, full, fluttery, tingly, nauseous, heavy, gurgling
Muscles	Tense, tight, relaxed, normal, loose, heavy, sore, wiggly, antsy, bursting, hot, burning
Hands & fingers	Still, squeezing, moving, twisting, clenched, sweating, flapping, fidgeting
Feet & toes	Curling, wiggling, fidgeting, shaking, pacing, clenching, tapping, loose

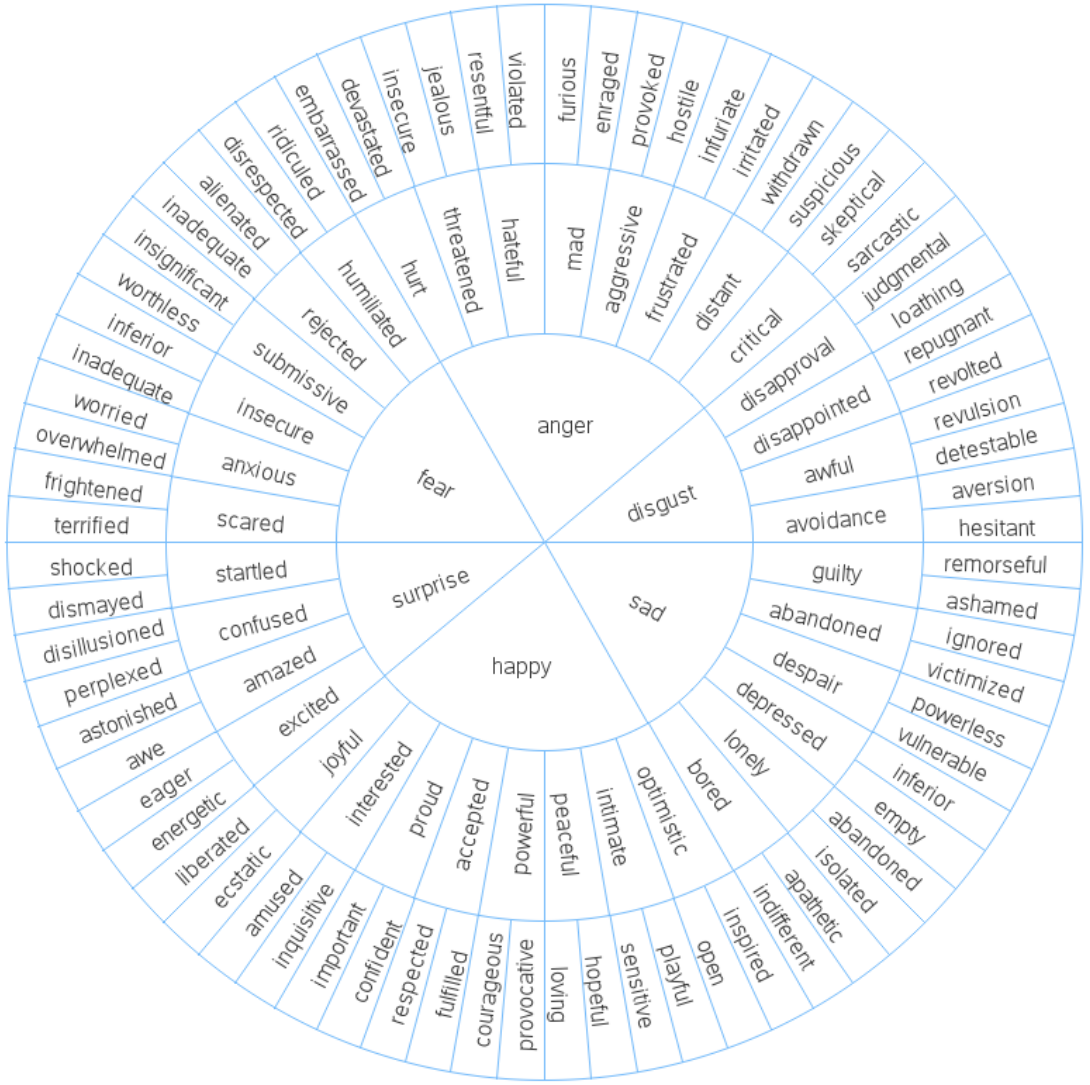
Emotional Awareness:
The ability to recognize and make sense of your own emotions and also the emotions of others.

EMOTIONAL AWARENESS

Identify Your Emotions

Steps for using the Word Wheel:

- Pick out your emotions from the six choices at the center of the wheel. These are core emotions that all humans experience and recognize across cultures.
- When possible, fine-tune your choices by using the outer rings to further clarify what you are feeling.



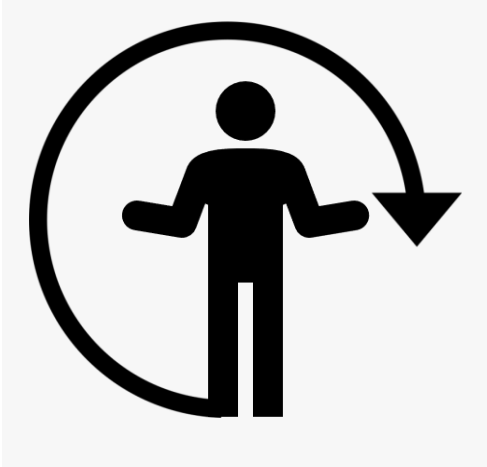
Kaitlin Robb

Unmasking Faces – Reading Emotions

Controlled Breathing

Controlled breathing is a proven technique that results in:

- ✓ A shift from sympathetic (stressed) to parasympathetic (rest) control of body functions
- ✓ Decreased heart rate & blood pressure
- ✓ Enhanced mood, attention & mental focus



Any slow patterned breathing gives results:

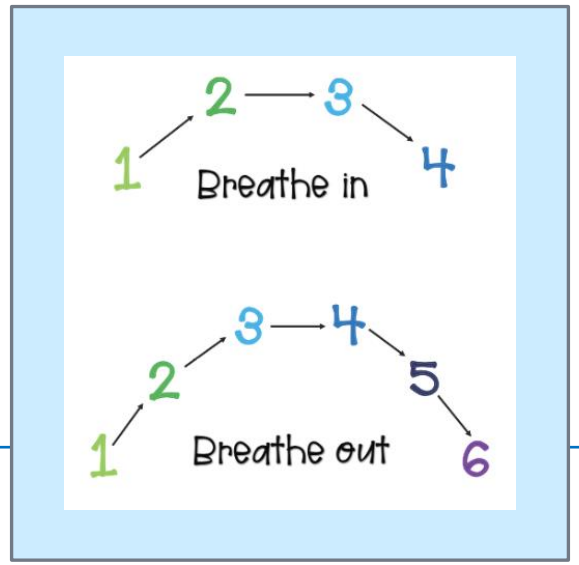
- ✓ **4 x 6 technique**

4×6 Breathing Technique:

1. Realize that you are feeling anxious!

2. Inhale deeply for a silent count of 4 and exhale for a silent count of 6. And repeat.

3. Do for a minimum of 1 minute to be effective in controlling anxiety/fear arousal, longer if needed.



Visualization

Visualize Action

"Imagine what you want to happen next"

1. Imagine yourself responding in the best manner, step by step, anticipating different problems and outcomes.
2. This will help you predict potential difficulties and choose the best response.
3. Develop alternate plans in your mind "Plan A…Plan B…."

Self Regulation Exercise

How would you feel if you were trying to help this coworker?

- Recognize when you are stressed/activated
- Remember the Self Regulation Process:
  - Do a body scan
  - Identify your sensations (interoceptive awareness)
  - Identify your emotions (emotional awareness)
  - Self-regulate
  - Visualize your responses
  - Take action

Emotional Logbook

- An emotional logbook is a tool for you to “remember” situations, sensations, emotions and triggers, and process them at a future date.

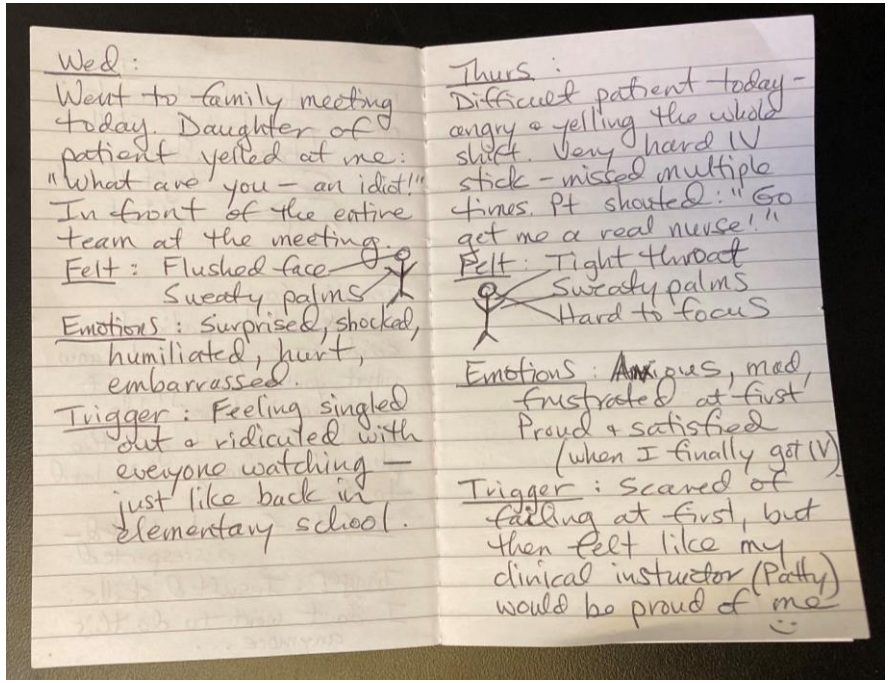
- As humans we tend to put difficult, painful and frightening situations, sensations and emotions out of our awareness. This eventually leads to stress related issues such as emotional and physical problems (burnout) as well as general feelings of unhappiness than can affect relationships and wellbeing.

- An emotional logbook, reviewed weekly or more often, can help you understand yourself and help you process difficult situations.

Use any style or size notebook that works for you!

Logbook Process:

1) Using 3 sentences or less, write a summary of what happened.
2) Recall your body sensations and record them.
3) Recall the emotions you experienced at that time – you can use the Wheel of Emotions for the exact words – and record them.
4) If you can identify a trigger (for example: being screamed at, being ridiculed, etc.), record that also.
5) About once a week during a quiet time (or more often if you wish) review your entries and look for trends in your responses.



A sample logbook entry

“TAKE A MINUTE” – Make this your workplace culture!

- For best results, try to use the Self-Regulation process at least three times a day – whenever you are feeling anxious or activated.
- Self-regulation works best when you practice every day for 4–6 weeks. Consistent practice forms new connections in your brain.
- You will notice that you gradually feel better when you use these techniques.
- If you notice a coworker who is struggling, help that person step back and “Take a Minute.”

Non-verbal variables such as tone, tempo, rhythm, timbre, prosody, and amplitude of speech, as well as body language signals, are essential aspects of therapeutic communication technique.

Tone of voice

Ventilation

Distraction

Reassurance

One to One

Modifying the Expectations

Deflecting the Insult

Clarifying the Emotional Status

THE VERBAL TECHNIQUES: UNDERSTANDING/ACTIVE LISTENING OMH

Silence

Nods

Selective Focus

Eye Contact

Proximity

Touch

Limitation of Audience/Stimuli

Time Out

Body Language and Posture

Redirection

Modeling

NON-VERBAL TECHNIQUES OMH

Identify yourself by name first: My name is Charles and I am here to help understand what you need”

Choose emotions from the wheel [see handout] for the blanks below:

“I am sorry that makes you upset.”
“I can hear that you are angry, but please do not speak to me that way. I am here to help you.”
“I understand you feel that way. I hope we can find another solution.”
“I am hearing ____. Are you feeling _____ because of____?”
“If this happened to me, I would be feeling _____.”
“How can we prevent this kind of difficulty from happening in the future? Any ideas?”
“I feel ____, when you_____.”
“If I have said or done anything to cause you distress, I hope that you would tell me.”
“It sounds like when I said that, you started to feel _____.”
“I hope you understand I did not intend to upset you when I said/did that, yet it sounds like my statement/action did cause you distress/difficulty.”

BEHAVIORAL INTERVENTION SCRIPTING

1. Concretely explain ***which*** behavior is inappropriate.

2. Concretely explain ***why*** the behavior is inappropriate.

3. Give the person **reasonable choices**.

4. Allow an appropriate amount of **time** for the individual to make a choice.

5. **Enforce limits.**

1. “You cannot be yelling at me”.

2. “This is not helping understand what you need…””.

3. “Please speak in a lower voice tone or you can choose to talk another day.”

4. ‘I shall give you five minutes to make a good choice and decide what you want to tell me or we will have to end this conversation for today”.

5. After five minutes, request calmly to continue the conversation. If there is no compliance, end the interaction.

HARD LIMIT SET CLINICAL EXAMPLE CPI

1. ***What am I feeling now***?

2. ***What does this person feel, need or want***?

3. ***How is the environment affecting the person***?

4. ***What is the cognitive capacity of this person***? (If activated, cannot reason well)

5. ***What is the problem we are dealing with***?

6. ***What do we want to make happen***?

7. ***How do I best respond***?

THE LARGER PROCESS

Always self regulate to co-regulate!

It isn’t personal unless you make it so…so do not make the interaction personal!

If you can understand the why of behaviors, you can predict behavioral trajectories.

SUMMARY

If you can predict trajectories, you can shape (not control) behaviors!

Always be respectful, especially when limit setting!

Consider creating a communication plan for the specific individual or family.

SUMMARY

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