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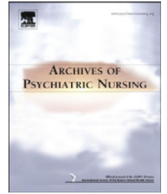

Coping with Violence in Mental Health Care Settings: Patient and Staff Member Perspectives on De-escalation Practices

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ABSTRACT

This multiple case study explored de-escalation processes in threatening and violent situations based on patients and staff members perspectives. Our post hoc analysis indicated that de-escalation included responsive interactions influenced by the perspectives of both patients and staff members. We assembled their perspectives in a mental model consisting of three interdependent stages: (1) memories and hope, (2) safety and creativity and (3) reflective moments. The data indicated that both patients and staff strived for peaceful solutions and that a dynamic and sociological understanding of de-escalation can foster shared problem solving in violent and threatening situations.

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Coping with and understanding violent and threatening behavior in mental health care settings are a challenging, but integral part of a caregiver's job (Breakwell, 1997). If not handled well, such situations can result in staff and patient injuries (Anderson & Clarke, 1996; Bowers, Nijman, Simpson, & Jones, 2011), and they can lead to stereotype representations of patients as divergent, unpredictable and dangerous (Berring, Pedersen, & Buus, 2015). Moreover, violence is harmful and can advance a culture of non-cooperation in which harm or destruction of others becomes a primary goal (Charon, 2010), and results in a high level of containment and coercive measures (Bowers, Alexander, Simpson, Ryan, & Carr-Walker, 2004; Paterson, McIntosh, Wilkinson, McComish, & Smith, 2013) and lack of staff engagement (Secker et al., 2004). To avoid imminent harm caused by anger, rage, hostility or violence, NICE (National collaboration Centre for Mental Health & National Institute for Health and Care Excellence, 2015) recommends using de-escalation. De-escalation is a collective term for a range of psychosocial interventions aimed at redirecting patients toward a calmer personal space. However, only a few empirical studies have explored the phenomenon in real life or how patients and staff members experience de-escalation practices.

A literature search using de-escalation, violence and psychiatry as search terms, identified several references describing de-escalation practices based on literature reviews, expert accounts and consensus statements (DelBel, 2003; Fauteux, 2010; Richmond, Berlin, Fishkind, et al., 2012).

The findings indicated that definitions of de-escalation are most often based on theoretical descriptions, such as Stevenson's (1991), which defined de-escalation as 'a complex interactive process in which the patient is directed toward a calmer personal space' (p. 6). Stevenson's account identifies four important aspects of de-escalating: knowing yourself, knowing the patient, knowing the situation, and knowing how to communicate. These themes are generally recognized by other authors as being central to de-escalation (DelBel, 2003; Paterson, Leadbetter, & McComish, 1997; Stubbs & Dickens, 2008).

Only a little empirical evidence about this topic exists. However, Cowin et al. (2003) developed a de-escalation kit consisting of a poster describing the de-escalation process and a learning session based on collaborative research methods. Duperouzel (2008) described how good de-escalators explained their strategies and illustrated how they initially tried to discover the reasons for the patients' behavior in order to help them solve their problems. Furthermore, good de-escalators invested a lot of time in developing relationships with patients. A grounded theory study (Delaney & Johnson, 2006; Johnson & Delaney, 2006, 2007) investigated different dimensions of de-escalation in two psychiatric units and described escalation and de-escalation as unpredictable as non-linear processes. The authors emphasized the dilemmas staff faced when deciding how and when to intervene: too early and too dramatic intervention might be perceived by patients as over-controlling, and too late intervention might

The study was designed by all of the authors.

The first author (Lene Lauge Berring) performed the study as a part of a Ph.D. education. She was responsible for the data collection, the analysis and the interpretation. The co- authors supervised the process and were assisting her while writing this article.

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endanger the safety of staff and patients (Johnson & Delaney, 2007, p. 50). Hallett and Dickens' (2015) survey showed a consensus on the nature of de-escalation among clinical staff in a low- and medium-security mental health setting, including expressing empathy, care, humor and calmness.

In a thematic synthesis literature review based on 11 papers, Price and Baker (2012) extracted key components of de-escalation techniques. Besides behaving empathically and respectfully, they also identified seven themes related to de-escalation. These themes included staff skills (characteristics of de-escalators, maintaining personal control, and verbal and nonverbal skills) and intervention processes (engaging with the patient, when to intervene, ensuring safe conditions for de-escalation, and strategies for de-escalation).

Despite the increase in research on de-escalation in recent years, only a little empirical evidence exists about that topic and there is still a lack of knowledge about what constitutes helpful de-escalation based on real life experiences in violent and threatening situations.

Violence is a complex social interaction, which is characterized by an inability to cooperate, and it comprises negative emotions that undermine societal order (Charon, 2010). It includes 'nonverbal, verbal and physical behaviour that is threatening or harmful to others or property' (Morrison, 1992, p. 422). It is difficult to provide care for patients, who are perceived as being potentially dangerous (Fisher, 1995; Perron & Holmes, 2011; Schofield, Tolson, & Fleming, 2012), however expectations about dangerousness may also induce distrust and shape the way nurses handle these patients. This might explain why mental health workers react differently to violence (Duxbury, 2002; Morrison, 1993). Some are able to relate to patients in ways that produce positive resolution (Carlsson, Dahlberg, & Drew, 2000; Duperouzel, 2008; Gunasekara, Pentland, Rodgers, & Patterson, 2014), while others manage patients with coercive measures (Foster, Bowers, & Nijman, 2007). The latter are felt by patients to be dehumanizing (Newton-Howes & Mullen, 2011), and make patients recall bad memories such as a sense of powerlessness (Johnson, 1998). Although staff do not like to use such methods (Bigwood & Crowe, 2008), an observational study (Ryan & Bowers, 2005) found that nurses used a variety of restrictive methods, either physical or verbal, to shape patient behavior.

In order to investigate de-escalation practices, this article takes a "small-scale view perspective" on social interactions in violent and threatening situations in order to study what constitutes helpful de-escalation, as recounted by both patients and staff.

THEORETICAL FRAMEWORK

Symbolic interactionism, as interpreted by Charon (2010), was employed as the theoretical framework. Symbolic interactionism is founded on three premises: humans acts toward things depending on the meaning they have for them, different people have different meanings, and meanings can change (Blumer, 1969). Within this social psychological perspective, the basic assumptions are that all actions are generally meaningful for the individual, and that no activity occurs in a vacuum but in a situational context of the activities of others.

This perspective emphasizes that human beings define their environment rather than simply respond to it. People act according to their definitions. These definitions are created through a stream of actions; including interactions with others (social interactions) and interactions with one self (mind actions). The following stream of actions might occur: 1. Actors experience (problematic) social interaction and they draw on good or bad memories of similar situations. 2. This adds to creating the actors' definitions of the situation. 3. The definition influences actions in the situation, which can be mind actions (an internal thinking process) and social interaction (an external process). 4. The interactions create new memories, which will be drawn upon in similar situations in the future. By means of this process people ascribe meaning to certain phenomena.

Based on symbolic interactionist perspective we explored the stream of actions that influenced participants' definitions of successful violence management solutions, which we saw as the absence of coercive and restrictive methods. We wanted to discover how meaning was created and modified through the interpretative processes individuals used in dealing with violence.

AIM

The aim of this paper was to describe how patients and staff members defined violent and threatening situations and how they ascribed meaning to the stream of actions in successful de-escalation situations.

METHODS

We conducted an ethnographic multiple case study, which explored threatening and violent situations that were resolved without using coercive measures. This design provided a strong base for understanding and describing different perspectives on de-escalation, as the documentation of the phenomenon was based on varied empirical evidence (Hammersley & Atkinson, 2010; Thomas, 2011; Yin, 2009).

Study Context and Sampling

Data were collected September 2013 through March 2014. The study context consisted of five psychiatric mental health units attached to a psychiatric trust having Region Zealand as its catchment area (approximately 800,000 inhabitants). The units comprised: a psychiatric intensive care unit, an emergency department, a medium-security unit, and two forensic medium security unit. The units had mixed-sex occupancy and were staffed by a combination of registered nurses and healthcare assistants. All units regularly experienced threatening and violent situations. Considering importation of variation social context and culture and trying to avoid describing only a single culture, we decided to sample data from across different settings to generate diverse data.

All potential participants were introduced to the project at local patient and staff unit meetings and by means of written information (pamphlets and posters). The participants ($N = 41$) comprised patients as well as staff who had witnessed or been involved in the same situation. Three to four situations from each unit were included. At least one of the participants had to recognize a given situation as de-escalating.

Data Collection

Altogether 21 cases were explored (Table 1 details the cases). The empirical material consisted of semi-structured formal and informal interviews ($N = 41$; 21 patients and 20 mental health workers; 14 hours of interviewing, on average 24 minutes per case, range 5 to 45 minutes); participant observation at staff meetings, patient meetings and observations while waiting for participants in the unit (>200 hours), letters from patients ($n = 2$) and ethnographic field notes. Participants were encouraged to contact the researcher after experiencing a de-escalating situation. After a report of such a situation, the first author would conduct a series of interviews in order to investigate the case from several different perspectives.

A semi-structured interview guide was produced on the basis of the theoretical framework and on the basis of ideas and suggestions from service-users and staff-members. Questions were introduced gradually during interviews in order to foster participant reflection and to identify descriptions of streams of actions. First, we asked the participants to describe the situation as they remembered it. This was followed by prompts to describe details. Second, we asked if they remembered anything of importance about the surroundings. Third, we encouraged the participants to describe moments of success: 'What did you experience as helpful in the situation?', followed by: 'If you were to explain to

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