Academic Psychiatry (2024) 48:1–4
https://doi.org/10.1007/s40596-023-01919-x

EDITORIAL

Beyond Psychopharmacology: the Interpersonal Dynamics of Agitation Management

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Published online: 7 December 2023

The management of agitation has long been a component of the practice of medicine and remains a common and critical clinical emergency in psychiatry. Agitation and physical aggression pose risks to the patients themselves, to other patients in the vicinity, and to health care professionals. Historically, due to the nature of their work, psychiatric trainees may experience higher rates of assault than trainees of other specialties [1–3]. One of the most stressful adversities of training in psychiatry is assault by a patient, as it can induce a myriad of conflicting emotions and posttraumatic stress symptoms [4]. Violence in health care has been on the rise, and all the more so during the COVID pandemic [5–8].

There are several reviews summarizing etiologies, medical work-up, and medications available in rapid-acting intramuscular formulations to manage agitation [9, 10]. Becoming knowledgeable about the differential diagnosis of agitation (including delirium, substance intoxication and withdrawal, and decompensated psychiatric illness) and medication options is an important component of training. Despite substantial education in the above topics, managing agitation remains an intimidating scenario for many trainees, and it is a stressful adversity in psychiatric training [11]. In these complex scenarios, trainees are pressed to make quick decisions (including decisions about more coercive measures, such as restraints and medication over objection) that benefit both the individual patient, but also alleviate suffering for other patients and staff. Perhaps the most challenging aspect is managing one's own internal thought processes and reactions to make appropriate judgments in the moment and processing the potential trauma that may be involved for both the patient and treatment team.

In this editorial, we discuss the challenging dynamics that agitation scenarios bring up between the psychiatry resident and the patient, the resident and other treatment team members, and the resident and the larger community of the residency training program. We assume that psychiatry residents will be informed about evidence-based medical evaluation and pharmacological management strategies, which is a topic out of scope for this editorial. Here, we focus on psychiatry residents and their possible emotional responses and interpersonal dynamics in treating agitated patients and the implications of these dynamics for education and training. Taking these dynamics into account will assist in the provision of safe, compassionate, and ethically justified treatment decisions.

Dynamics Between Resident and Patient

During an acute behavioral emergency, many complex dynamics are at play between the patient and the physician. The American Psychiatric Association (APA) Task Force Report on Clinical Aspects of the Violent Individual [12] delineates an array of considerations when assessing an agitated patient, including evaluating etiologies of agitation, sociocultural factors, and patient personality structures. For patients, anger and agitation can mask underlying feelings of helplessness, desperation, and fear. Emotional factors also can impact decision-making for all health care workers; agitation from a patient can generate feelings of fear, helplessness, anger, and hate in health care staff. As there are limited tools for

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standardized prediction of violence, a physician's internal dynamics (especially if unconscious) can influence the way the physician assesses whether the level of agitation meets a threshold for intervention and what kind of intervention. Vestal [13] described how, as a trainee, the first experience of directly managing an agitated patient was very startling and unsettling. The acute stress in the moment can cause trainees to employ cognitive shortcuts and activate implicit biases in making decisions that profoundly impact patient care.

First, a trainee's own background is critical. For example, residents' history of trauma may influence their thresholds for action, for example, whether to have a lower threshold to intervene for fear of the consequences of a patient's actions or a higher threshold when residents aim to avoid an acutely agitated patient. In one survey [14], avoidance of certain types of patients was reported as a residual effect of prior experiences with threats and violent assaults by patients. Residents' perception of vulnerability to harm for themselves on the basis of physical characteristics, such as residents' height and weight, can also influence thresholds for action.

Second, qualities of the patient and the therapeutic or working alliance, including how well the patient is liked or identified with, can influence the threshold for intervention. For example, if the resident overidentifies with the patient (e.g., the patient is at a similar life stage as the resident, invokes a beloved family member, or shares a similar diagnosis), the physician may be more hesitant to intervene with measures like restraints. On the other hand, a negative countertransference toward a patient (especially if the trainee is not consciously aware of it) can cause the patient to be perceived as more dangerous than justified by objective evidence [12, 15]. Intense feelings, whether positive or negative, in the treatment alliance can influence future behaviors and interfere with clinical judgment by leading to overreaction or avoidance.

The race of the patient can also play an important role when managing agitated patients. It has been demonstrated that Black patients receive a disproportionately higher rate of physical and chemical restraints in emergency room settings [16–18]. For example, Agboola et al. [17] describe a harrowing experience of a Black man, with no history of active medical or psychiatric illness, being brought involuntarily to the emergency room. The man was reportedly terrified, and his distress was inaccurately perceived as a threat, leading to an inappropriate application of physical restraints.

Dynamics Between the Resident and Treatment Team

While trainees are navigating their interactions with patients, they are also navigating the dynamics within the treatment team. In behavioral emergencies, a trainee, who is often a junior resident on an inpatient rotation, leads the treatment team's response. In this leadership role, residents must be able to balance the input from multiple team members, deescalate the patient, make decisions about restraints, communicate clearly, and debrief and support the team. These can be daunting tasks, and residents may lack confidence in their delivery, have difficulty advocating for their own view on the management of a patient, or be intimidated by challenging the views of other team members. They can thus feel "caught in the middle" between different factions ([19], p. 87).

Nurses, mental health technicians, and other team members are also weighing multiple factors, including their role in preventing harm to the patient while maintaining everyone's safety, the stress of understaffing, their own psychological responses, and the possibility of being repeatedly threatened [19]. Nurses and mental health technicians are often the team members who spend the most face-to-face time with the patient, and residents have an important role in supporting them. Additionally, health care team members have reported feelings of stress and disgruntlement from a constant rotation of physicians, who all may have different personalities, leadership styles, and approaches [19]. There may also be implicit biases or interpersonal factors that detract from the alliance between a trainee and staff members. The quality of this alliance can impact how clinical scenarios are communicated and the level of collaboration in resolving these scenarios. Scenarios of severe agitation can easily split the treatment team if the above dynamics are not managed properly.

Dynamics Between the Resident and Residency

Studies have shown that exposure to workplace violence increases the levels of posttraumatic symptoms in psychiatric workers [2, 20, 21], but the experience of agitation and aggression can also create ripple effects beyond those who were directly involved in the patient care. Wu [22] first used the term "second victim," referring to trauma experienced by physicians in the context of medical errors, and it expanded into the concept of vicarious trauma in health care. When a resident is the subject of or in proximity to violence, this news can quickly spread to the resident's classmates and the wider residency program and cause collateral damage. In addition, these impacts are compounded if they occur in the context of perceived lack of organizational support, including unresponsiveness from senior staff, prioritizing adherence to policies over caring for staff as human beings, and persistent short staffing [21]. Such perceptions of unresponsiveness can quickly increase the level of anxiety and hypervigilance in the residency group.

Strategies to Manage Agitation

Workplace violence increases stress and anxiety levels for health care professionals, and inappropriate use of chemical or physical restraints is traumatic for patients [5, 23]. There are clearly high stakes in managing these clinical scenarios for all those involved. So how can residency programs better equip trainees to be able to navigate the complex and wide-ranging web of dynamic and psychological factors?

First, training programs should encourage residents to acknowledge the strong feelings that emerge when managing aggressive or violent patients. This acknowledgement then allows efforts to prevent those same feelings from negatively influencing clinical outcomes [24]. To address physician–patient dynamics, every trainee must understand that their backgrounds and their patients' backgrounds can bias their threshold to intervene in agitation scenarios. To mitigate the influence of bias, residencies should include implicit bias training, process groups to explicitly discuss impacts of biases (both implicit and explicit) on clinical management, and exercises in cognitive empathy for patients' experiences. In addition, it is critical for residents to have opportunities to self-reflect on how their individual narrative influences their clinical decisions (whether through discussions with a supervisor or program support for individual psychotherapy). Moreover, processes of civil commitment and, by extension, the application of coercive treatments including the administration of chemical or physical restraints should be transparent and consistently free from bias as much as possible [25, 26]. These skills, which should be modeled and taught, include providing explanations to patients about how decisions were made, clarity in communication, listening with intent, and supporting open and constructive dialogues with patients [25, 26]. Use of standardized crisis prevention and intervention trainings (e.g., Crisis Prevention Institute [27] or Management of Aggressive Behavior trainings [28]) early on in residency may provide a foundation for trainees and ensure that early trainees have sufficient direct supervision (as opposed to remote supervision) in managing agitation which can help them hone their technique.

To address physician-team dynamics, it is imperative that trainees be able to mentalize interdisciplinary team member experiences and to develop strong leadership skills. Strengthening physician-team alliances can be facilitated by allowing time in clinical rotations for interdisciplinary team members to establish rapport, educating trainees about interdisciplinary roles, teaching effective communication and group management skills, designing more interdisciplinary sessions in routine didactics, and employing simulation to help teams practice. To address physician-residency dynamics, residencies must make space for debriefing as a group about acute behavioral emergencies. Debriefing should include discussion of residents' perception of the institutional and programmatic response to the emergency. Psychiatry residents will most likely experience these scenarios at some point or another during their training, and it is important to process the emotional impacts.

Beyond individual and programmatic interventions, attendings and trainees must also have humility and seek to create institutional systems that mitigate the risks of improperly managed agitation and the risks of inappropriate use of restraints [18]. The above processes are complex, and even the most cognizant and intentional clinician will not be free of errors. Training programs should also address residents' fears of violence, develop methods for addressing these fears, and teach violence risk assessment [29]. Several scales can be useful in measuring risk for agitation (e.g., BARS [30]), and these scales can be integrated into unit protocols and used as a common standard among team members. Specific behaviors can also be listed in as-needed emergent medication orders to indicate a clear threshold of when to proceed with oral versus intramuscular medications. Healthcare systems can also consider wider risk mitigation strategies, including designing clinical spaces that feel safe for patients, strategies in proactive consultation use of behavioral emergency response teams, ensuring adequate staffing ratios, continuing education for all staff members on implicit biases, and actively involving all interdisciplinary staff voices (including trainees) in quality improvement efforts to mitigate agitation.

Conclusion

The 1974 APA Taskforce [12] aptly wrote, "It is too often forgotten that dangerousness is an attribute not only of persons but of situations and environmental factors; more concretely, dangerousness should be regarded as an outcome of the interaction of these various factors and all must be attended to when considering the 'dangerousness' of an individual" (p. 25).

We have demonstrated that interpersonal dynamics and strong feelings when managing patients who are agitated or violent can undermine optimal clinical judgments, which may lead to an overzealous or unnecessary use of restraints or to avoidance and undertreatment that, in turn, increases the risk of adverse outcomes. These dynamics and strong feelings should be identified and acknowledged to prevent them from becoming unduly influential in treatment decisions and to support reasoned clinical judgments. Challenging patient events and their psychological consequences should be openly reviewed and discussed, and educational

processes that optimize residency-team dynamics and resident-residency dynamics should be enacted. Psychiatry residents will experience the adversity of an agitated patient, and training programs should prepare residents accordingly.

Acknowledgements Dr. Yau was an *Academic Psychiatry* Trainee Editorial Fellow, 2022–2023.

Declarations

Disclosures On behalf of all authors, the corresponding author states that there is no conflict of interest.

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