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De-Escalation in Mental Health Care Settings

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1 Introduction

De-escalation is defined as

A collective term for a range of interwoven staff-delivered components comprising communication, self-regulation, assessment, actions, and safety maintenance, which aims to extinguish or reduce patient aggression/agitation irrespective of its cause, and improve staff-patient relationships while eliminating or minimizing coercion or restriction. (Hallett & Dickens, 2017)

For many decades, mental health staff used mainly physical techniques to manage aggressive and violent situations. Mechanical or physical restraint and/or seclusion were the interventions that staff were trained in. De-escalation emerged more implicitly through the intuition of selected nurses and doctors. The physical

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component of aggression management was reinforced by distinctive training programs for (more or less violent) self-defence (Gertz, 1980).

In recent years, we have seen a move towards the introduction of de-escalation techniques in aggression management training. De-escalation relies on mental health staff skilfully employing verbal and nonverbal communication to redirect the client towards a calmer personal space (Berring et al., 2016a, b). Internationally, de-escalation has been identified as the first-line intervention in the management of aggression in mental health settings by the World Health Organization (2017).

Despite its prominence in policy and practice, empirical evidence to support de-escalation as a technique is currently lacking. De-escalation training has evolved from staff anecdotal reports of what works, rather than empirical evidence (Gaynes et al., 2017). There is limited evidence that current training in de-escalation techniques is effective in improving staff's ability to de-escalate violent and aggressive behaviour (Johnston et al., 2022; Price et al., 2015) and practice varies significantly by ward even when patient populations remain similar (Renwick et al., 2016). When used, de-escalation is estimated to be effective in halting the escalation sequence in approximately two-thirds of cases, with early intervention associated with better outcomes (Lavelle et al., 2016).

Nurses, doctors and other mental health workers need adequate options for every stage of the escalation curve. In recent years, de-escalation practice has received increasing attention from a qualitative research perspective. These studies employ in-depth observations of practice alongside analysis of staff and client perspectives of aggression management intending to develop an empirical understanding of de-escalation. This research has advanced our understanding of these complex social interactions, highlighting a number of factors that support, or conversely hinder, effective de-escalation. For example, stressful working environments and/or the impact of client trauma (Beattie et al., 2018). The qualitative findings alongside the direct experience of staff have led to the emergence of de-escalation principles, approaches and interventions. Furthermore, de-escalation has been integrated into complex models of care including Safewards (Bowers, 2014; Bowers et al., 2015) trauma-informed care (Huang et al., 2014; Muskett, 2014) and recovery (Slade et al., 2014).

This chapter provides the reader with state-of-the-art information on conflict management and interpersonal de-escalation in mental health settings and an overview of the practical approaches to implementing it in practice.

2 Situational Dynamics and Conflict Escalation

Many aggression management approaches refer to an escalation curve that illustrates the increasing emotional arousal in the conflict situation. Although the notion of a curve simplifies the complexity of aggressive situations, the curve highlights the empirically well-known fact that most violent situations, inside and outside of psychiatry, grow out of a situational escalation. The empirically based Safewards model (Bowers et al., 2014; Bowers et al., 2015) describes domains that influence

the frequency of conflict on mental health wards including, but not limited to, patient characteristics, the staff team and the physical environment. The model illustrates how these domains naturally give rise to '*flashpoints*', which can trigger conflict and/or containment events and how patient and staff factors can influence and modify this link.

2.1 Patient Factors

The majority of research to date has focused on patient characteristics and behaviours; schizophrenia, young age, alcohol use, drug misuse, a history of violence and hostile-dominant interpersonal styles were found to be the predictors of patient violence (d'Ettoire & Pellicani, 2017). Although it is important to identify risk factors associated with patient behaviour, this is only one aspect. Recently, there has been an increased focus on how post-traumatic experiences can trigger a violent response (Beattie et al., 2018).

2.2 Ward Environment

Ward environment and design have been found to play a role in aggression and it can be perceived as a threat to physical and psychological safety for staff and patients (Beattie et al., 2018).

The customs and practices of staff on a ward including the clarity of, and adherence to, patient rules, the cleanliness and tidiness of the ward and the ward ideology have also been shown to influence rates of conflict on wards (Bowers et al., 2014; Bowers, 2009). Wards designed specifically to reduce environmental stress by reducing ward social density, reducing noise, improving access to nature and designing spaces to conduct unobtrusive observations have been beneficial in reducing the use of restrictive practice (Ulrich et al., 2018).

2.3 Staff–Patient Interactions

In mental health care, several studies have shown that violence is often preceded by staff–patient interactions and patient behavioural cues (Papadopoulos et al., 2012a, b). A meta-analysis revealed that patient–staff interactions accounted for 39% of the variance in patient violence (Bowers et al., 2011). Specifically three circumstances are frequently identified in literature as antecedents to escalation: staff denial of a patient request, staff suggesting that a patient act in a particular way and staff requesting that the patient desist from some action (limit setting) (Bowers et al., 2011). This can be experienced as psychological pressure (Potthoff et al., 2022), even though psychological pressure aims to improve treatment adherence it can be seen as informal coercion, this can escalate a situation as the patient's legal rights are violated.

Innovate research studies mapping incidents on wards reveal that most incidents occur in places where interactions between staff, patients and visitors take place (i.e. staff office, ward entrance and the day rooms), people get close to each other and conflicts arise out of 'normal' encounters (e.g. asking for medication) (Nijman et al., 1997; Papadopoulos et al., 2012a, b).

Another well-established fact is that the events and situations that lead to violence in psychiatric institutions are viewed quite differently by staff and patients (Duxbury & Whittington, 2005; Fletcher et al., 2021). Whereas staff attribute aggressive behaviour mainly to the mental illness itself, patients are more likely to see situational aspects and staff behaviour as precursors (Fletcher et al., 2021; Price et al., 2018). Taken together, this research suggests that staff behaviour may be as important as a precursor to violent incidents as patient behaviour.

Negative emotional reactions of staff towards patients may be another factor in triggering angry, hostile and potentially violent reactions (Haugvaldstad & Husum, 2016). Staff displaying a dominant style (i.e. dominance orientation) can become dangerous for two reasons. First, it may shape the ward milieu so that aggression and counter-aggression set the tone of the ward (Haugvaldstad & Husum, 2016; Nijman et al., 1999). Second, staff who are prone to dominance orientation are likely to react more aggressively and violently toward even minor hostile behaviour (Omer, 2021). This is in no way meant to blame staff for aggression and violence with which they are confronted, it just means that staff should be aware of their own reactions and behaviour.

As mental health workers who are trained in psychology and psychiatry, they can be biased toward an individualistic perspective that looks only to cognitions and emotions. However, communication interactionists who have specialised in the field of conflict management try to see the 'relational logic' (Donohue, 2003) that emerges from the interaction of the parties involved. Escalation, in this sense, means that hostile and aggressive behaviour tends to be mutually reinforcing so that each party's reactions lead to greater harm with each new round of actions. The escalation from interaction to violence might take several hours, but it also might only take seconds. This is the reason why an escalation curve is misleading when you try to apply it to real situations. The escalation curve suggests an ideal type of interaction with a steady increase of tension, which usually is not the case.

Escalating behaviours can be triggered by diverging goals and intentions of the interacting parties. Whereas staff try to fulfil their therapeutic and safety roles, patients often have short-term goals that support their subjective quality of life and, most importantly, their subjective needs and identity. Some authors argue that striving for needs and identity are the main causes that trigger violence, regardless of the social context and institution. John Burton, a leading violence theorist stated, after reviewing the general literature on violence causation:

'The conclusion to which we are coming is that seemingly different and separate social problems, from street violence to industrial frictions, to ethnic and international conflicts, are symptoms of the same cause: institutional denial of needs of recognition and identity and the sense of security when they are satisfied, despite losses through violent conflict'. (Burton, 1997, p. 38)

This is also true for interpersonal conflicts in mental health care. When the incompatibility of staff and patient intentions becomes clearer to both sides, the escalation is fuelled by emotions (e.g. anger) and cognitions (e.g. prior experiences). In general, expectations shape our behaviour as well as the observation of the other party involved (Haugvaldstad & Husum, 2016). Therefore, the incompatibility of the two parties' expectations can be regarded as the key factor for conflict escalation. Mental Health workers can expect a patient to comply with orders, and a patient will expect a nurse to show caring (and not security) behaviour (Engström et al., 2020; Fletcher et al., 2021). When these or other expectations are violated, distrust can occur. Distrust is a key cognition that can lead to increased aggression. Both sides, staff and patient, experience being aversively stimulated by the other's behaviour (Haugvaldstad & Husum, 2016; Whittington & Richter, 2005; Whittington & Wykes, 1996).

The feeling of being provoked by the other party will, in many cases, lead to aggressive reactions which will stimulate the opponent in return (Haugvaldstad & Husum, 2016). Distrust and aversive stimulation can lead both parties into the above-mentioned relational logic of escalation, where inflammatory language is only the overt signal of underlying cognitions and emotions. Being trapped in this logic of escalation will, then, lead to more or less fixed expectations about the other party's behaviour: *This nurse wants to harm me and I have to defend myself*. Cognitive processes turn to narrowness and rigidity the more the interaction escalates (Omer, 2021).

Questioning participating staff and patients after a violent incident, Benson et al. (2003) found discourses of blame on both sides. In conflict theory, this expectation and its connected rigidity are regarded to be some of the most powerful cognitive frames that make resolving conflict so difficult. Breaking this logic and its expectation frame is, therefore, a key task for nonviolent conflict resolution.

At this point, it is important to stress the role of the patient's psychopathology. The symptoms of the actual mental disorder surely shape the patient's observational and appraisal abilities. Further, the control of impulsivity and conflict-solving skills are impaired by the disorder. Experimental psychological research has shown that subjects who score highly on trait hostility (persistent over time) will also express higher levels of state hostility (temporary condition, present for short periods of time) (Lindsay & Anderson, 2000). However, the basic conflict situation is still based on an interaction. Without a triggering event from the social environment of the patient, which has been regarded as an aversive stimulus, the escalation would not have begun. Thus so far, violence by psychiatric patients is not materially different from violence committed by healthy subjects. For a common-sense approach to research on interpersonal violence in general, risk factors can be divided into the following categories: predisposing factors and processes, situational elements and triggering events (Reiss & Roth, 1993). To prevent a violent escalation, staff have only minimal chances to affect the predisposing psychopathology in the short term. Even the situation of the often involuntary admission cannot be changed easily. What staff can do is to learn from previous situations, such as within a trauma-informed perspective, where the focus is on learning from the service providers. For

example, programmes exist where service providers educate healthcare professionals in how to create safety by reducing seclusion and restraints (US Department of Health and Human Services 2014).

3 Staff Stress and Emotion Regulation

Staff behaviour is one of the crucial points where the prevention of violence is initiated. If patients feel aversively stimulated by staff, this usually does not happen by the staff's intention, rather it will happen unintentionally.

Many mental health workers who work in psychiatric institutions have to face traumatic events, such as violence and the use of coercive measures, an overwhelming work-load and organisational pressure and, thus, feel highly distressed (Beattie et al., 2018; Johnson et al., 2017; Siegrist et al., 2003). Working conditions affect the encounters between staff and patients. Staff may not be able to react as calmly and therapeutically as they intend to. Current working conditions in mental health care, and the stressful situations associated with aggression itself, mean staff must be able to manage their own distress in order to behave in a way that reduces the risk of aggression and violence (Haugvaldstad & Husum, 2016). Therefore, stress management and emotion regulation are the basis for applying de-escalation skills effectively.

There is some indirect positive effect from dedicated training programs in relation to staff stress and emotional regulation especially when the training targets the whole organisation such as Trauma-Informed Care (TIC (see Chap. [Trauma Informed Care](#))). TIC aims to promote a safe environment for everybody and thereby minimise conflict by changing organisational cultures to respond appropriately to the effects of trauma at all levels (Fernández et al., 2023; Keesler, 2020).

Staff can, for example, be trained in mindfulness as this has the potential to reduce symptoms of burn-out and thereby increase safety as this may raise nurses' self-awareness (Wampole & Bressi, 2019). The key to managing emotions is self-awareness, being able to share stressful emotions with colleagues (Nay, 2004) and engaging in reflective practice or debriefing following stressful events (Asikainen et al., 2023; Scott et al., 2022). As mental health workers, we have to know the personal signs that indicate stress and arousal. These indicators might be physical (e.g. sweating, elevated heart frequency) or psychological (e.g. polarised thinking, labelling). Because such indicators are highly individualistic, anger therapists recommend setting up a personal anger scale that includes the whole range of reactions in connection with experienced anger (see Nay, 2004). However, we also need to know how to prevent violence.

4 Basic Rules of Conflict Management

De-escalation alone is not an option for all aggressive and potentially violent incidents. In some situations, physical techniques against aggressive patients are unavoidable. However, even in such circumstances, supportive and reassuring

communication is still required. Which option to choose depends on several contextual factors: the current situation on the ward, the patient's psychiatric symptoms, the patient's conflict-solving skills and impulsivity control, staff experience of conflict management, and, of course, the intensity of the conflict. The type of aggression or violence is also highly relevant. Instrumental violence (acts that are related to specific goals) has to be handled differently than emotional violence (behaviour that emerges from interpersonal tension) (Dutschmann, 2000, 2003). For instrumental violence, general cognitive behavioural interventions are more appropriate than specific body language or rhetoric skills, which are better applied to situations with high arousal.

Generally, verbal interventions are possible for patients who are not highly delusional or disorganised (e.g. patients with dementia) (Alpert & Spillmann, 1997). Quite common, but difficult to master, are triggered displaced aggressions. Patients sometimes feel more provoked by fellow patients, relatives or other mental health workers than the one who becomes the target of the aggression. Triggered displaced aggressions are a combination of two aversive stimulations by different people where a minor stimulus can lead to an excessive violent outburst (Miller et al., 2003).

The types of conflict and the contexts within which they happen are so diverse and specific, that it is generally recommended to first consider and learn several basic rules rather than to stick to highly ambitious skills or techniques which may only be appropriate in special situations. That is not to say that mastery of such skills may not be advantageous, and we provide details of specific skills below.

The following recommendations are mainly about general attitudes toward conflict, staff involvement in such conflicts, and the adequate timing of interventions. These recommendations are informed by the findings of a substantial thematic synthesis of key components of de-escalation techniques conducted by Price and Baker (2012) and previously published similar recommendations including Safewards (Paterson & Leadbetter, 1999; Stevenson, 1991).

Before going into details of conflict management and de-escalation, two important warnings must be given. First, the reader has to be aware that the following recommendations must not be used in a cookbook manner. It is possible that the same intervention applied to the same patient works successfully in one situation but not in another. Don't stick to the rules too tightly. A well-known example from experience for many psychiatric nurses is that the appearance of an authoritarian doctor can, in some situations, change an aggressive patient into a calm and compliant one. Sometimes it is possible to enforce a conflict resolution, namely when the force is associated with capability, legitimacy and credibility (Schellenberg, 1996).

Second, the reader should be aware that they are not able to apply effective de-escalation techniques from reading this or other printed matter on the topic. De-escalation requires in-depth training. Experience from several training programs has further shown that it is beneficial to train personnel from one ward together so that every staff member receives the same knowledge and each one can rely on their colleagues. However, a very important way of learning is to receive feedback from the service users (Slade et al., 2019), this will give mental health care workers a concrete experience of what to do better the next time.

4.1 Respect, Empathy and Concern for Patients

The first basic rule stresses the general attitude towards the patient and his or her aggression. Effective de-escalators are open and sincere, and display empathy, concern, respect and fairness (Engström et al., 2020; Price & Baker, 2012). Staff have to be aware that, apart from patients with specific personality disorders, human beings and, therefore, patients, are usually not voluntarily aggressive or violent. In general, aggression and violence are triggered by the subjective notion that one has to defend oneself against another's intimidations, provocations or unjust behaviour (Anderson & Bushman, 2002; Haugvaldstad & Husum, 2016); however, justified these accusations might be from a different perspective.

Patients who violently try to abscond from the ward, understandably, see their quality of life severely reduced by the closed door. Thus, aggressive and potentially violent patients subjectively face a serious problem that they cannot cope with in any other way. The attitude of empathy and respect may in many cases help to find out which problem it is that triggers the patient's aggression and, at the same time, is the basis for interpersonal conflict resolution in so far as the patient can feel more accepted and understood by staff (Price & Baker, 2012).

4.2 Assess the Risks

The second rule of conflict management is to assess the risks, this may be achieved using tools such as the Brøset Violence Checklist (Woods & Almvik, 2002). This will enable staff members to be prepared and better able to initiate a de-escalation intervention (Hvidhjelm et al., 2023). It is important that expectations are realistic. Staff must ask themselves '*Can this situation be managed without physical intervention?*' Because of the situation's acuity and variability this question, in many cases, must be answered by intuition. If staff don't feel safe enough to manage this situation using nonphysical options alone, they should switch over to plan B, i.e. the preparation of physical interventions.

4.3 Control the Situation, Not the Patient

Third, the next basic rule is not to control the patient but to control the situation. Conflict management within an interaction has the goal of getting the best out of the situation for both parties, a win-win situation as it is commonly termed in game theory (Davidson & Wood, 2004). The goal of avoiding violence depends on both parties' reactions. However, it is impossible to predict the outcome of an interaction in advance. If the patient has the impression that staff are trying to control or even coerce him or her into specific behaviour, hostile reactions are very likely to emerge. The use of power usually contradicts a therapeutic relationship (Engström et al., 2020; Fletcher et al., 2021).

Staff appearing calm and in control of the situation are thought to facilitate patients' ability to manage their own feelings and emotions alongside showing a degree of trust in the patient (Duperouzel, 2008; Price & Baker, 2012). Techniques staff use to remain calm include focusing on the assessment of patients or acknowledging feelings of anxiety when they arise rather than denying them (Price & Baker, 2012).

4.4 Teamwork—Share Thinking, Decisions and Responsibilities with Colleagues

In cases where this is possible, risk assessment, decision-making, responsibilities and actions should be shared with colleagues and if possible, the patient. Several reasons make this rule obligatory. Conflict situations are associated with high emotional tension, and staff decisions might be biased by their own emotional involvement.

Although de-escalation works better within a one-to-one interaction, fellow staff can create safety for the person who is responsible for the one-to-one interaction, by scaffolding their interaction; ensuring other patients nearby are calm and that the environment is optimised. Furthermore, colleagues will be attuned to pivotal moments in the de-escalation interaction, where the patient begins to calm down or when crisis interventions need to be used (e.g. physical interventions) helping to save patients and staff from injuries.

4.5 Early Intervention

De-escalation works more successfully when it is done as an early intervention (Lavelle et al., 2016; Price & Baker, 2012). This is illustrated by the escalation curve. The more both parties' behaviour and tensions are similar to 'normal' dimensions, the better they are able to plan and respond to a nonviolent intervention. In other words, de-escalation may be less appropriate in situations that are accompanied by high risks and tensions.

4.6 Slow Things Down

One of the main subgoals in de-escalation is to gain time. Very often, aggressive interpersonal communication, e.g. accusations and shouting, proceeds quickly. Emotional arousal makes quick responses highly likely, and participants feel subjectively under pressure to respond so that the opponent will not get the impression that one has given in. Experimental psychological research has, however, shown that time pressure leads to less thorough information processing and, consequently, to inadequate decisions (De Dreu, 2003; Van Kleef et al., 2004). A gain in time may not only lead to better decisions, but it may reduce interpersonal tension.

4.7 Spatial Awareness

Spatial considerations are equally important. A balance must be struck between being close enough to the patient to develop rapport but not invading their personal space (Price & Baker, 2012). Although some patients may have a preference for touch and find it calming, it may lead to further escalation in others. As with most aspects of de-escalation, an understanding of the specific preferences and needs of the individual will inform the approach. However, keeping a distance between staff and patients will safeguard against immediate hits or blows.

4.8 Confidence and Certainty without Provocation

De-escalation interventions have to be applied with apparent self-confidence and certainty, without being provocative. Like several other principles and techniques in this regard, this rule asks for a balanced procedure. If staff show too much complacency, it may be regarded as arrogant and provocative. No, or too little, self-confidence may give the impression that staff are not able to codetermine the outcome of difficult situations. This problem is known from research on aggressive children, where parents who permanently give in are known to increase the demands and aggressive actions of their children. Omer (2001, 2021) uses the term ‘complementary escalation’ for this kind of escalation which stands in contrast to the well-known type of reciprocal escalation.

4.9 Avoid Power Plays

Power plays between staff and patients have to be avoided. Quite often, major conflicts grow out of minor disputes or misunderstandings. The question of whose perspective is right or wrong can lead to an argument. Conflicts are fuelled by each party’s notion that one cannot give in because this might show weakness. Apparently unimportant differences become issues of personal identity and honour.

For experienced and self-confident staff, this kind of conflict should not be necessary in many cases. Effective de-escalation should facilitate autonomy and empower the patient to feel they are choosing to de-escalate (Duperouzel, 2008; Price & Baker, 2012). Face-saving alternatives can be offered to patients to achieve this. Of course, staff cannot make promises or concessions that will lead to conflict in later situations.

4.10 Safety Awareness

Staff should be aware of general safety issues. Aggressive situations often occur in ward environments where there are several other people. The safety of fellow patients or inexperienced staff should always be kept in mind. As one does not know

the outcome of a de-escalation attempt from the start, the place of such an intervention should be carefully considered. Where possible, an open way to flee should be within reach and potentially dangerous objects should be removed.

5 De-Escalation Practical Principles and Interventions

Duperouzel (2008) described how good de-escalators explained their strategies and illustrated how they initially tried to discover the reasons for the patient's behaviour in order to help them solve their problems. Furthermore, good de-escalators invest a lot of time in developing relationships with patients. Studies employing grounded theory approaches (Delaney & Johnson, 2006; Johnson & Delaney, 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 emphasised 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 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, humour and calmness.

In a thematic synthesis, based on 11 papers, Price and Baker (2012) extracted key characteristics of effective de-escalators and key components of de-escalation techniques. Some of these characteristics are presented in other sections of this chapter where relevant (see Sects. 4 and 6) but the overall findings are summarised here. Characteristics of effective de-escalators include an ability to empathise with the patient, communicate in an open, honest, supportive, coherent, non-judgemental, confident and genuine manner; effective de-escalators maintain control, appearing calm when met with aggression; effective de-escalators present with a calm, gentle and soft voice, use tactful language, sensitive use of humour and an awareness of their body language as a way of expressing concern and empathy for the patient and developing rapport. Early intervention was recommended, although acknowledged that this depends on the specific circumstances; a de-escalation strategy requires flexibility and creativity to try to understand the reasons for the patient's behaviour and intervene in a way that meets the specific needs of the patient while balancing safety with patient autonomy (Price & Baker, 2012).

5.1 De-Escalation Interventions

De-escalation is difficult to describe, anyhow, it has become an important part of complex violence and restraint reduction models such as Safewards (Bowers et al., 2014; Bowers et al., 2015), six core strategies (Huckshorn et al., 2006) and recovery (Slade et al., 2014). 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 et al., 2012). Definitions of de-escalation are most often based on theoretical descriptions; for example, Stevenson (1991, p. 6) defined de-escalation as ‘*a complex interactive process in which the patient is directed toward a calmer personal space*’. Stevenson’s account identifies four important aspects of de-escalation:

1. Knowing yourself.
2. Knowing the patient.
3. Knowing the situation.
4. Knowing how to communicate.

These four themes are generally recognised by other authors as being central to de-escalation (DelBel, 2003; Paterson & Leadbetter, 1999; Stubbs & Dickens, 2008).

The de-escalation component of the Safewards intervention is called ‘Talk Down’ (Bowers, 2014; Bowers et al., 2015). This is a three-step process, which draws on a range of previously developed techniques and details the three steps staff should take when interacting with a patient who is agitated, angry or upset. The steps are summarised in a poster:

1. Delimiting—establishing safety and getting started.
2. Clarifying—eliciting and hearing the patient, establishing the nature of the problem.
3. Resolving—addressing the issue via appeal negotiation, comprise or providing choices.

Staff qualities required for this process are also displayed including self-control, respect and empathy. Wards using the talk-down component of Safewards are required to display the talk-down poster in a prominent position on the ward and nominate a ‘talk-down champion’ who is a ward staff member already identified as someone who is skilled at de-escalation. As champions, they will explain the techniques to their fellow team members and facilitate the implementation of this method in practice (Bowers, 2014; Bowers et al., 2015).

The de-escalation component of the six core strategies includes a trauma-informed care (Huang et al., 2014; Muskett, 2014) approach and is related to the use of language, e.g. learning how to ask and debriefing (Riahi et al., 2016). Within this approach, violence and restraint are viewed as critical incidents that must be avoided in the future, using debriefing techniques such as formal post-incident review to support this goal.

An example of a de-escalation approach, which was underpinned by these principles and co-created with experts by experience, can be seen in Table 1 (Berring et al., 2016a). The de-escalation components were co-created based on real-life situations in acute mental health care settings. This de-escalation approach includes two phases: (i) an acute phase and (ii) a relationships phase. In the *acute phase*, a feeling of safety must be established; this is achieved when personal space is respected and only *one* staff member is engaging and communicating with the patient, while other

Table 1 De-escalation divided into seven components

<i>Acute phase</i>	
Respect personal space	To make a dialogue possible, it is important not to violate the patient's personal space. The space within which the patient feels safe, and to which she/he can withdraw to regain self-control. Personal space is established by the staff keeping their distance and signal plenty of time. This also demonstrates that the staff are willing to spend the time needed to help the patient.
Create focus	The patient must feel that there is one person present who wants to help him/her. This is achieved through focused attention from the caregiver, which means that the caregiver interacts with nobody but the patient. With the caregiver focusing only on helping the patient, it becomes possible to engage the patient in a dialogue.
Change context	Changing context means creating a new situation. This can be done by creating a diversion, but also by giving a new meaning to the situation. A change of context can take a patient by surprise and lead to a turning point.
<i>Relationship phase</i>	
Show empathy	Empathy is a pre-condition for a successful de-escalation. You show empathy by putting yourself in the patient's shoes. Empathy can take a variety of forms, but supporting autonomy must be included.
Understand the patient	Once the patient is in a state that allows dialogue, you must make a determined effort to understand the patient's perspective. In this interpretative process, the most important thing is to keep on listening to the patient's experience. In this process, you must be open and curious.
Align expectations	The goal of de-escalation is to support a common solution to the problem. Before the process is finalised, it is important to align expectations. The basis for an alignment of mutual expectations lies in involving the patient in shared decision-making.
Evaluate the process	Evaluation is the last and most important part of the de-escalation process. It is important to create an atmosphere in which staff and patients can reflect on what happened, thus turning it into a learning situation. Do not interpret the behaviour of others. Stay focused on your own actions while the patient is processing the experience.

staff members stand by in order to have an overview of the situation, thereby protecting both patients and staff, against physical and psychological injuries. Before the *relationship phase* can start, staff members must establish a trusting relationship in order to continue the de-escalation process. In the *relationship phase*, staff start to know the patient, listen to the patient's point of view, and understand the situation from the patient's perspective. This de-escalation approach requires teamwork to meet the patient's needs. This collaborative approach focuses attention on skills related to the whole community rather than individual mental health workers only. In both phases, staff must be aware of their own reactions and feelings. This collaborative de-escalation approach offers a potential turning point in violence management because the problem will be solved together with the patient (i.e. in aligning expectations). Immediate validation of the encounter is provided in the final step of the process where all parties give feedback in the final debriefing/evaluation step. This is where staff and patients process their experience and achieve learning (Berring et al., 2016b).

5.2 De-Escalation Training

Health and social care provider organisations should train staff who work in services, where restrictive interventions may be used, in psychosocial methods to avoid or minimise restrictive interventions. Many countries have guidelines to achieve this and have adopted the BILD/Restraint Reduction Network Training Standards recommendations (citation needed):

- De-escalation training should aim to facilitate culture change and improve the quality of life of those being restrained and those supporting them.
- Reduce reliance on restrictive practices by promoting a positive culture and practice that focuses on prevention, de-escalation and reflective practice.
- Increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs.
- Where required, the de-escalation training should focus on the safest and most dignified use of restrictive interventions, including physical restraint.

A training curriculum could include:

- A person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promote health underpin the therapeutic relationship.
- An understanding of the relationship between mental health problems, early childhood traumatic experiences and the risk of violence and aggression.
- Skills to assess why a behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors.
- Skills, methods and techniques to reduce or avert imminent violence and defuse aggression when it arises (for example, verbal de-escalation).
- Skills, methods and techniques to undertake restrictive interventions safely when these are required.
- Skills to undertake an immediate post-incident debrief.
- Skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service.

6 Communication Skills

The de-escalation interventions described in the previous section state the importance of verbal communication during de-escalation in understanding and clarifying the concern from the patients' perspective and negotiating a solution. However, verbal de-escalation techniques do not occur in isolation but are intrinsically linked with the gestural and physical (nonverbal) communication of the de-escalator.

The mastering of body language and related physical features is one of the most important and at the same time one of the most difficult tasks when learning conflict

management. Verbal communication is usually overemphasised in de-escalation training. This emphasis on verbal communication is in stark contrast to research findings which stem from the 1960s, but still hold true today, where nonverbal communication was found to be more important for sending social cues and emotional signals (De Gelder, 2009; Hall et al., 2019; Mehrabian & Ferris, 1967; Mehrabian & Wiener, 1967; Roter et al., 2006). Related to the overemphasis of words in interactions is the common notion that humans are rational beings who calculate their decisions and actions thoroughly in order to make the best out of each situation. During periods of high arousal, e.g. during an escalation phase, our attentional scope is narrowed (Gable et al., 2015). With diminished cognitive resources, greater reliance is placed on interpretation and communication via the nonverbal channel. The spoken word alone does not fully capture the complexity of the interaction (Turner, 2002).

Considering the importance of the interaction, it cannot be overstated that the outcome of the situation does not depend solely on patient behaviour. As discussed previously, staff are very likely to attribute aggression and violence to the mental disorder and to underestimate contextual and personal factors that may contribute to the outcome (Fletcher et al., 2021). Related to this problem are two further common misunderstandings. Many interpersonal conflicts are based on different notions about what has been said or done. Current sociological and communication research stresses the point that communication is not just a message from A to B. Communicative messages are co-constructed by both sender and receiver (Clark & Brennan, 1991; Hall et al., 2019; Kessler, 2013). This means that a communicative '*message*' is encoded by A and has to be decoded by B. This includes verbal speech alongside nonverbal cues such as body language, facial expression, gestures, vocal pitch, and tone. Equal to, or even more important than the sender's intentions, is the receiver's perception and interpretation of the sender and their message. Therefore, the verbal and nonverbal presentation of staff to the patient is highly important.

It must be cautioned at this stage that both staff and patients may fall into the trap of self-fulfilling prophecies. When I, as a mental health worker, have had experience with specific patients who are not able to comply with nonviolent interventions, I might be reluctant to apply them next time. The opposite is also true: when I, as a patient, have had only bad or even victimising experiences during my previous admissions, I will expect that the next nurse I encounter will also behave like that, regardless of how they actually behave. Friendly or therapeutically positive signals viewed through this lens may be interpreted by the patient as a '*trick*'.

As mental health workers who try to de-escalate interpersonal tensions, we have, therefore, to be aware that our bodies are communicating our emotions and feelings, regardless of what we are trying to express verbally. Facial expressions, gestures and other aspects of body language that can be observed by others make it impossible not to communicate (Watzlawick et al., 2017). Therefore, the most important task in this regard is to know what we look like when we are heightened emotionally due to interpersonal conflict. As we normally do not walk in front of a mirror during a dispute with our partner, most of us do not know what kind of body language we present to others.

Role plays recorded on video may give the first impression of what our body reveals to others. Some mental health hospitals are now using body-worn cameras to record de-escalation to support staff reflection and learning (Wilson et al., 2022). While trying to master our body language, the next task is to avoid incongruent impressions towards the other party in the conflict (Stevenson, 1991). Our body language should give the same message as our verbal communication. If verbal and nonverbal channels contradict, an observer will most likely regard the nonverbal expression as ‘true’ and the verbal signals as faked. Furthermore, incongruent messaging has been shown to increase distress in other healthcare contexts (Gorawara-Bhat et al., 2017). Nevertheless, although nonverbal cues arise naturally and automatically, it is possible to suppress or alter their expression (Ekman, 1997).

The goal of nonverbal communication displayed during de-escalation is to give the distressed interacting partner a feeling of comfort and safety. Details of nonverbal communication depend on the (multi-)cultural settings and the ethnic origins of all the people involved. Staff have to be aware that some aspects of nonverbal communication are culture-bound. Nonverbal behaviour is likely to lead to misunderstandings on both sides. Thus, the following recommendations, which are thought to be effective on the European continent in general, have to be considered carefully when translated into local mental health settings. These recommendations are largely based on research exploring patient and staff perceptions of what communication is effective rather than analysis of what works in practice.

In line with our verbal communication, body language should minimise threats and give a clear signal of openness about the patient’s concerns. The calm, gentle and soft tone of voice alongside tactful and sensitive language should be used (Price & Baker, 2012). Hand and arm gestures are a powerful vehicle to provide signals of threat. Lowered, uncrossed arms with open hands show that we are not aggressive (Troisi, 1999). A relaxed appearance is also presented through body posture, of the head and the gaze of the eyes (Bannerman et al., 2009; Troisi, 1999). An upright position of the head, combined with subtle tilts to the left and right may induce the observation that one is interested in the other person and actively listening (Price & Baker, 2012). Active or empathic listening is further supported by head nodding and maintaining eye contact without staring. All gestures should be slow and gentle. Sudden movements toward another person may be regarded as an attack (Troisi, 1999) and should be avoided. Sufficient spatial distance should also be provided (see Sect. 4).

Although nonverbal communication plays an important role in the management of interpersonal conflict in mental health care, mastering these features is not trivial. Having an awareness of your communicative signals and an understanding of how they might be perceived by others is a great first step but may not necessarily lead to an adequate use of techniques in practice. Artificial manipulations of nonverbal signals (e.g. facial expressions) may end up sending mixed messages because basic emotions and associated expressions are difficult to

mask. Professional stage actors can surely talk about this problem. However, studies beyond mental health settings have shown body language may be one factor in preventing assaults, as it affects perceptions of vulnerability and submissiveness (Blaskovits & Bennell, 2019). More successful than just manipulating one's expression is changing the thinking about conflicts and their solutions. Thus, technique alone doesn't make for successful conflict management; stress management and basic conflict management rules (see Sect. 4) are equally important.

7 Situation-Intervention-Rationale: A Clinical Example of De-Escalation Practice

The purpose of this final section is to assimilate the key themes presented in this chapter and apply them to a clinical example. Here a description of each stage in the de-escalation process is provided detailing three important aspects of information at each stage:

- **The situation:** the scenario context and the behaviour of the patient and staff.
- **The intervention:** the actions employed by the staff to actively de-escalate the patient.
- **The rationale:** the beliefs and assumptions that underpin the actions taken by staff.

The clinical example used here is adapted from Berring et al. (2016b, p. 501). To summarise the scenario, the patient felt cheated because staff members forgot to take him to the fitness room. The patient responded by entering the dining room, pulling down his trousers and 'mooning' at the other patients. He expected to be subjected to physical interventions and was surprised when a staff member instead helped him gain control by stating that she understood his frustration and worked with him to achieve his goal through a compromised approach.

7.1 Situation Part 1

Tristan was irritable and upset because staff members forgot to take him to the fitness room, as they usually would. It was a busy shift and the staff simply forgot. When staff saw Tristan at lunchtime, he appeared tense and irritable.

Staff called Tristan and the other patients to dinner. When they were entering the dining area, Tristan entered and responded by pulling down his trousers and 'mooning' at the other patients. Some of the patients told Tristan to stop, asking the staff to intervene. Tristan stated, 'If my will doesn't count for anything I don't care, even if they put me in mechanical restraints...'.

Principles of Intervention

Respect personal space and pay attention to the patient's needs. Observation and early intervention.

Attention to angry and aggressive behaviour manifested by the patient.

Focus on preventive measures instead of behaviour management measures intervening as early as possible, (prevention in early stages, always).

Rationale

Minimisation of angry behaviours and ineffective limit setting are the most frequent factors contributing to the escalation of behaviour and violence.

Respecting personal space is key to assessing and implementing de-escalation measures.

7.2 Situation Part 2

The nurse who was in the dining area, approached Tristan and asked him, 'Could I invite you to come with me to somewhere more private so we can have a chat and try to understand why you are upset?'

Tristan hesitated for a moment but then followed the nurse to a space known as a 'comfort room'.

Principles of Intervention

Assess the therapeutic milieu.

Ensure safe conditions for de-escalation.

Suggest the patient accompanies a professional to a space that guarantees privacy.

Rationale

Pay attention to the therapeutic milieu or service environment:

- Choose a quiet place or a comfort room, but one that is visible to staff. When going to this space, always let others know that you are there with the patient, leaving the door open.
- Have other staff members nearby.
- Ensure you, and the patient, can exit quickly if necessary.
- The angrier the patient, the more space needed to feel comfortable (pay attention to the communication being displayed and the physical distance between you and the patient).
- Ask how you can help the patient.
- Never turn your back on an angry patient.
- Leave immediately if there are signs that behaviour is escalating beyond what is manageable

7.3 Situation Part 3

The nurse, adopted a comforting and quiet posture and, engaging with Tristan, asked him, ‘*Do you want to sit down and speak about what has happened?*’

Tristan hesitated for a moment and said, ‘I think that I prefer to stay on my feet’.

Nurse: ‘Okay Tristan, but I’m going to sit down. It is more comfortable if you sit...’.

Tristan agreed and sat down.

Nurse: ‘I felt that you were tense and irritable... Is something bothering or concerning you at the moment?’

Principles of Intervention

Focus on your own emotions (self-awareness): Appear calm and in control.

Position in the room: If the patient agrees, both nurse and patient should sit at a 45-degree angle.

Attention to non-verbal communication: Do not tower over or stare at the patient.

Use clarification with the patient: When he begins to talk, listen actively.

Manage silences in the interaction and let the patient talk without interrupting.

Rationale

The perception that someone is in control of the situation can be comforting and calming to an individual who is beginning to lose control of managing their emotions/behaviours.

Sitting at a 45-degree angle puts you both on the same level but allows for frequent breaks in eye contact. Towering over or staring can be interpreted as threatening or controlling by paranoid individuals.

Clarification and active listening allow patients to feel heard and understood. It helps build rapport, and energy can be channelled productively.

7.4 Situation Part 4

Tristan said, ‘The only thing that I ask every day is to go to the fitness room for a bit and today no one remembers it.’

The nurse calmly said, ‘You are right, I am sorry we didn’t tell you about this earlier, but today we were very busy. I know this is not a reason. Can I help you see how we can get you to the fitness room some other way’.

Principles of Intervention

Understand the patient's perspective and respect the interaction: Listen to the patient even if they are yelling.

Use a non-provocative and non-judgmental approach with the patient.

Rationale

Behaviour generates behaviour:

- Loudly arguing with the patient will only escalate anger and violence.
- When the tone of voice is low and calm and the words are spoken slowly, anxiety levels in others may decrease.

7.5 Situation Part 5

Nurse: 'What do you think would help now since it was not possible to take you to go to the fitness room?'

Principles of Intervention

Displaying empathy and genuineness is a way of being present and engaged in the intervention (e.g. 'I'm here for you'):

Do not treat the individual in a humiliating manner.

Give back control (e.g. 'what will help now?')

Rationale

Even patients with more severe psychopathology may respond to non-provocative interpersonal contact and genuine expressions of concern and caring.

7.6 Situation Part 6

Tristan said, 'I don't know because the only thing that I wanted to do was go to the fitness room...'

Nurse: 'I understand your frustration, your anger, but it's not ok to moon the other patients, do you agree... If you need help controlling those feelings we could help at any time'.

Principles of Intervention

Align expectations: clear, consistent, and enforceable expectations about behaviour (e.g. empathise with feelings and emotions and not with behaviours: ‘It’s okay to be angry, but it is not okay to threaten him’.)

Offer help and availability to the patient: ‘if you are having trouble controlling your anger we will help you’.

Rationale

Gives the patient a better understanding of the expectations and consequences of not adhering to those limits on behaviour (i.e. empathise with emotions and not behaviours).

7.7 Situation Part 6

Nurse: ‘Next time, do you think that it would be possible for you to approach us and ask us to remember that you want to go to the fitness room? If it’s not possible could we negotiate another time of the day to go to the fitness room? For instance, how do you feel about going to the fitness room in the evening? Another important aspect is to do that without ‘mooning’ other patients... Do you think that is also possible? If not, try to imagine yourself in the other patients’ place, and imagine yourself being mooned when they don’t have something that they want...’.

Tristan thinks about the nurse’s suggestions and agrees.

Tristan: ‘Okay, since the staff cannot go with me to the fitness room now, the evening seems fine’.

Both parties apologise for what has happened and Tristan returns to dinner.

Principles of Intervention

Acknowledge the patient’s needs

Listen to a patient’s expressed needs, regardless of whether they are rational or irrational.

Give choices: Suggest other options and work with the patient to identify one that suits both.

Rationale

This contributes to the individual’s perception that the nurse is trying to understand, and tries to understand the reason at the core of their behaviour. Determine how some of the patient’s needs can be met productively.

Evaluating the incidents helps staff and patients to learn what caused the situation and learn how to prevent this in the future.

8 Conclusions

De-escalation is often an individual technique, scaffolded by team efforts aiming to meet patients' needs while protecting both patients and staff against physical and psychological injuries. Although de-escalation remains an under-researched area, there have been positive steps forward and de-escalation is now a central feature of many current complex models of care (e.g. Safewards). De-escalation is an important tool for mental health workers who stand between two dangers: using too much force or doing nothing when faced with violent behaviour. Good de-escalation skills help staff to cope actively with difficult situations without using physical force.

References

- Alpert, J. E., & Spillmann, M. K. (1997). Psychotherapeutic approaches to aggressive and violent patients. *Psychiatric Clinics of North America*, *20*(2), 453–472.
- Anderson, C. A., & Bushman, B. J. (2002). Human aggression. *Annual Review of Psychology*, *53*(1), 27–51.
- Asikainen, J., Vehviläinen-Julkunen, K., Repo-Tiihonen, E., & Louheranta, O. (2023). Use of debriefing following restrictive practices in forensic psychiatric care. *The Journal of Forensic Practice*, *25*(1), 46–56.
- Bannerman, R. L., Milders, M., De Gelder, B., & Sahraie, A. (2009). Orienting to threat: Faster localization of fearful facial expressions and body postures revealed by saccadic eye movements. *Proceedings of the Royal Society B: Biological Sciences*, *276*(1662), 1635–1641.
- Beattie, J., Innes, K., Griffiths, D., & Morphet, J. (2018). Healthcare providers' neurobiological response to workplace violence perpetrated by consumers: Informing directions for staff Well-being. *Applied Nursing Research*, *43*, 42–48.
- Benson, A., Secker, J., Balfe, E., Lipsedge, M., Robinson, S., & Walker, J. (2003). Discourses of blame: Accounting for aggression and violence on an acute mental health inpatient unit. *Social Science & Medicine*, *57*(5), 917–926.
- Berring, L. L., Hummelvoll, J. K., Pedersen, L., & Buus, N. (2016a). A co-operative inquiry into generating, describing, and transforming knowledge about de-escalation practices in mental health settings. *Issues in Mental Health Nursing*, *37*(7), 451–463.
- Berring, L. L., Pedersen, L., & Buus, N. (2016b). Coping with violence in mental health care settings: Patient and staff member perspectives on de-escalation practices. *Archives of Psychiatric Nursing*, *30*(5), 499–507.
- Blaskovits, B., & Bennell, C. (2019). Are we revealing hidden aspects of our personality when we walk? *Journal of Nonverbal Behavior*, *43*, 329–356.
- Bowers L. (2009). Association between staff factors and levels of conflict and containment on acute psychiatric wards in England. *Psychiatric services*. *60*(2), 231–239.
- Bowers, L. (2014). A model of de-escalation. *Mental Health Practice*, *17*(9), 36–37.
- Bowers, L., Alexander, J., Bilgin, H., Botha, M., Dack, C., James, K., et al. (2014). Safewards: The empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing*, *21*(4), 354–364.
- Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*, *52*(9), 1412–1422. <https://doi.org/10.1016/j.ijnurstu.2015.05.001>
- Bowers, L., Stewart, D., Papadopoulos, C., Dack, C., Ross, J., Khanom, H., et al. (2011). *Inpatient violence and aggression: A literature* (Report from the Conflict and Containment Reduction Research Programme, Kings College, London).

- Burton, J. W. (1997). *Violence explained: The sources of conflict, violence and crime and their prevention*. Manchester University Press.
- Clark, H. H., & Brennan, S. E. (1991). Grounding in communication. In *Perspectives on socially shared cognition* (pp. 127–149). American Psychological Association.
- d’Ettorre, G., & Pellicani, V. (2017). Workplace violence toward mental healthcare workers employed in psychiatric wards. *Safety and Health at Work, 8*(4), 337–342.
- Davidson, J., & Wood, C. (2004). A conflict resolution model. *Theory Into Practice, 43*(1), 6–13.
- De Dreu, C. K. (2003). Time pressure and closing of the mind in negotiation. *Organizational Behavior and Human Decision Processes, 91*(2), 280–295.
- De Gelder, B. (2009). Why bodies? Twelve reasons for including bodily expressions in affective neuroscience. *Philosophical Transactions of the Royal Society B: Biological Sciences, 364*(1535), 3475–3484.
- Delaney, K. R., & Johnson, M. E. (2006). Keeping the unit safe: Mapping psychiatric nursing skills. *Journal of the American Psychiatric Nurses Association, 12*(4), 198–207.
- DelBel, J. C. (2003). De-escalating workplace aggression. *Nursing Management, 34*(9), 30–34.
- Donohue, W. A. (2003). The promise of an interaction-based approach to negotiation. *International Journal of Conflict Management, 14*(3/4), 167–176.
- Duperouzel, H. (2008). It’s OK for people to feel angry’ the exemplary management of imminent aggression. *Journal of Intellectual Disabilities, 12*(4), 295–307.
- Dutschmann, A. (2000). *Verhaltenssteuerung bei aggressiven Kindern und Jugendlichen* (Manual zum Typ A des ABPro’). DGVT.
- Dutschmann, A. (2003). *Aggressionen und Konflikte unter emotionaler Erregung: Deeskalation und Problemlösung (Das Aggressions-Bewältigungs-Programm ABPro)*. DGVT-Verlag.
- Duxbury, J., & Whittington, R. (2005). Causes and management of patient aggression and violence: Staff and patient perspectives. *Journal of Advanced Nursing, 50*(5), 469–478.
- Ekman, P. (1997). Expression or communication about emotion. In *Uniting psychology and biology: Integrative perspectives on human development* (pp. 315–338). American Psychological Association.
- Engström, I., Engström, K., & Sellin, T. (2020). Adolescents’ experiences of the Staff’s different interaction styles in coercive youth Care in Sweden: A qualitative study. *Issues in Mental Health Nursing, 41*(11), 1027–1037. <https://doi.org/10.1080/01612840.2020.1757794>
- Fauteux, K. (2010). De-escalating angry and violent clients. *American Journal of Psychotherapy, 64*(2), 195–213.
- Fernández, V., Gausereide-Corral, M., Valiente, C., & Sánchez-Iglesias, I. (2023). Effectiveness of trauma-informed care interventions at the organizational level: A systematic review. *Psychological Services, 20*(4), 849–862.
- Fletcher, A., Crowe, M., Manuel, J., & Foulds, J. (2021). Comparison of patients’ and staff’s perspectives on the causes of violence and aggression in psychiatric inpatient settings: An integrative review. *Journal of Psychiatric and Mental Health Nursing, 28*(5), 924–939.
- Gable, P. A., Poole, B. D., & Harmon-Jones, E. (2015). Anger perceptually and conceptually narrows cognitive scope. *Journal of Personality and Social Psychology, 109*(1), 163.
- Gaynes, B. N., Brown, C. L., Lux, L. J., Brownley, K. A., Van Dorn, R. A., Edlund, M. J., et al. (2017). Preventing and de-escalating aggressive behavior among adult psychiatric patients: A systematic review of the evidence. *Psychiatric Services, 68*(8), 819–831.
- Gertz, B. (1980). Training for prevention of assaultive behavior in a psychiatric setting. *Psychiatric Services, 31*(9), 628–630.
- Goarwara-Bhat, R., Hafskjold, L., Gulbrandsen, P., & Eide, H. (2017). Exploring physicians’ verbal and nonverbal responses to cues/concerns: Learning from incongruent communication. *Patient Education and Counseling, 100*(11), 1979–1989.
- Hall, J. A., Horgan, T. G., & Murphy, N. A. (2019). Nonverbal communication. *Annual Review of Psychology, 70*, 271–294.
- Hallett, N., & Dickens, G. L. (2015). De-escalation: A survey of clinical staff in a secure mental health inpatient service. *International Journal of Mental Health Nursing, 24*(4), 324–333.

- Hallett, N., & Dickens, G. L. (2017). De-escalation of aggressive behaviour in healthcare settings: Concept analysis. *International Journal of Nursing Studies*, *75*, 10–20.
- Haugvaldstad, M. J., & Husum, T. L. (2016). Influence of staff's emotional reactions on the escalation of patient aggression in mental health care. *International Journal of Law and Psychiatry*, *49*, 130–137.
- Huang, L. N., Flatow, R., Biggs, T., Afayee, S., Smith, K., Clark, T., et al. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf
- Huckshorn, K. A., CAP, I., & Director, N. (2006). *Six core strategies for reducing seclusion and restraint use*. <https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf>
- Hvidhjelm, J., Berring, L. L., Whittington, R., Woods, P., Bak, J., & Almvik, R. (2023). Short-term risk assessment in the long term: A scoping review and meta-analysis of the Brøset Violence Checklist (BVC). *Journal of Psychiatric and Mental Health Nursing*, *30*(4), 637–648.
- Johnson, J., Panagioti, M., Bass, J., Ramsey, L., & Harrison, R. (2017). Resilience to emotional distress in response to failure, error or mistakes: A systematic review. *Clinical Psychology Review*, *52*, 19–42.
- Johnson, M. E., & Delaney, K. R. (2007). Keeping the unit safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association*, *13*(1), 42–52.
- Johnston, I., Price, O., McPherson, P., Armitage, C. J., Brooks, H., Bee, P., et al. (2022). De-escalation of conflict in forensic mental health inpatient settings: A Theoretical Domains Framework-informed qualitative investigation of staff and patient perspectives. *BMC Psychology*, *10*(1), 1–17.
- Keesler, J. M. (2020). Promoting satisfaction and reducing fatigue: Understanding the impact of trauma-informed organizational culture on psychological wellness among Direct Service Providers. *Journal of Applied Research in Intellectual Disabilities*, *33*(5), 939–949.
- Kessler, G. (2013). Collaborative language learning in co-constructed participatory culture. *CALICO Journal*, *30*(3), 307–322.
- Lavelle, M., Stewart, D., James, K., Richardson, M., Renwick, L., Brennan, G., et al. (2016). Predictors of effective de-escalation in acute inpatient psychiatric settings. *Journal of Clinical Nursing*, *25*(15–16), 2180–2188.
- Lindsay, J. J., & Anderson, C. A. (2000). From antecedent conditions to violent actions: A general affective aggression model. *Personality and Social Psychology Bulletin*, *26*(5), 533–547.
- Mehrabian, A., & Ferris, S. R. (1967). Inference of attitudes from nonverbal communication in two channels. *Journal of Consulting Psychology*, *31*(3), 248.
- Mehrabian, A., & Wiener, M. (1967). Decoding of inconsistent communications. *Journal of Personality and Social Psychology*, *6*(1), 109.
- Miller, N., Pedersen, W. C., Earleywine, M., & Pollock, V. E. (2003). A theoretical model of triggered displaced aggression. *Personality and Social Psychology Review*, *7*(1), 75–97.
- Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51–59.
- Nay, W. R. (2004). *Taking charge of anger: How to resolve conflict, sustain relationships, and express yourself without losing control*. Guilford Press.
- Nijman, H. L., Allertz, W. F., Merckelbach, H. L., & Ravelli, D. P. (1997). Aggressive behaviour on an acute psychiatric admissions ward. *The European Journal of Psychiatry*, *11*(2), 106–114.
- Nijman, H. L., Muris, P., Merckelbach, H. L., Palmstierna, T., Wistedt, B., Vos, A., et al. (1999). The staff observation aggression scale–revised (SOAS-R). *Aggressive Behavior*, *25*(3), 197–209.
- Omer, H. (2001). Helping parents deal with children's acute disciplinary problems without escalation: The principle of nonviolent resistance. *Family Process*, *40*(1), 53–66.
- Omer, H. (2021). *Non-violent resistance: A new approach to violent and self-destructive children*. Cambridge University Press.
- Papadopoulos, C., Bowers, L., Quirk, A., & Khanom, H. (2012a). Events preceding changes in conflict and containment rates on acute psychiatric wards. *Psychiatric Services*, *63*(1), 40–47.

- Papadopoulos, C., Ross, J., Stewart, D., Dack, C., James, K., & Bowers, L. (2012b). The antecedents of violence and aggression within psychiatric in-patient settings. *Acta Psychiatrica Scandinavica*, 125(6), 425–439.
- Paterson, B., & Leadbetter, D. (1999). De-escalation in the management of aggression and violence: Towards evidence-based practice. In *Aggression and violence: Approaches to effective management* (pp. 95–123). Springer.
- Pothhoff, S., Gather, J., Hempeler, C., Gieselmann, A., & Scholten, M. (2022). “Voluntary in quotation marks”: a conceptual model of psychological pressure in mental healthcare based on a grounded theory analysis of interviews with service users. *BMC psychiatry*, 22(1), 186.
- Price, O., & Baker, J. (2012). Key components of de-escalation techniques: A thematic synthesis. *International Journal of Mental Health Nursing*, 21(4), 310–319.
- Price, O., Baker, J., Bee, P., Grundy, A., Scott, A., Butler, D., et al. (2018). Patient perspectives on barriers and enablers to the use and effectiveness of de-escalation techniques for the management of violence and aggression in mental health settings. *Journal of Advanced Nursing*, 74(3), 614–625.
- Price, O., Baker, J., Bee, P., & Lovell, K. (2015). Learning and performance outcomes of mental health staff training in de-escalation techniques for the management of violence and aggression. *The British Journal of Psychiatry*, 206(6), 447–455.
- Reiss, A., & Roth, J. (1993). *Understanding and preventing violence: Panel on the understanding and control of violent behavior*. National Academy Press.
- Renwick, L., Lavelle, M., Brennan, G., Stewart, D., James, K., Richardson, M., et al. (2016). Physical injury and workplace assault in UK mental health trusts: An analysis of formal reports. *International Journal of Mental Health Nursing*, 25(4), 355–366. <https://doi.org/10.1111/inm.12201>
- Riahi, S., Dawe, I. C., Stuckey, M. I., & Klassen, P. E. (2016). Implementation of the six core strategies for restraint minimization in a specialized mental health organization. *Journal of psychosocial nursing and mental health services*, 54(10), 32–39.
- Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Jr., Zeller, S. L., Wilson, M. P., et al. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *Western Journal of Emergency Medicine*, 13(1), 17.
- Roter, D. L., Frankel, R. M., Hall, J. A., & Sluyter, D. (2006). The expression of emotion through nonverbal behavior in medical visits: Mechanisms and outcomes. *Journal of General Internal Medicine*, 21, 28–34.
- Schellenberg, J. A. (1996). *Conflict resolution: Theory, research, and practice*. Suny Press.
- Scott, Z., O’Curry, S., & Mastroyannopoulou, K. (2022). The impact and experience of debriefing for clinical staff following traumatic events in clinical settings: A systematic review. *Journal of Traumatic Stress*, 35(1), 278–287.
- Siegrist, K., Rödel, A., & Siegrist, J. (2003). A theory-based study on psychosocial workload as an instrument of health promotion in a hospital. *Gesundheitswesen (Bundesverband der Ärzte des Öffentlichen Gesundheitsdienstes (Germany))*, 65(11), 612–619.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O’Hagan, M., Panther, G., et al. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12–20.
- Slade, M., Rennick-Egglestone, S., Blackie, L., Llewellyn-Beardsley, J., Franklin, D., Hui, A., et al. (2019). Post-traumatic growth in mental health recovery: qualitative study of narratives. *BMJ open*, 9(6), e029342.
- Stevenson, S. (1991). *Heading off violence with verbal de-escalation*. SLACK Incorporated.
- Stubbs, B., & Dickens, G. (2008). Prevention and management of aggression in mental health: An interdisciplinary discussion. *International Journal of Therapy and Rehabilitation*, 15(8), 351–357.
- Troisi, A. (1999). Ethological research in clinical psychiatry: The study of nonverbal behavior during interviews. *Neuroscience & Biobehavioral Reviews*, 23(7), 905–913.

- Turner, J. H. (2002). *Face to face: Toward a sociological theory of interpersonal behavior*. Stanford University Press.
- Ulrich, R. S., Bogren, L., Gardiner, S. K., & Lundin, S. (2018). Psychiatric ward design can reduce aggressive behavior. *Journal of Environmental Psychology, 57*, 53–66.
- US Department of Health and Human Services. (2014). SAMHSA's concept of trauma and guidance for a traumainformed approach.
- Van Kleef, G. A., De Dreu, C. K., & Manstead, A. S. (2004). The interpersonal effects of emotions in negotiations: A motivated information processing approach. *Journal of Personality and Social Psychology, 87*(4), 510.
- Wampole, D. M., & Bressi, S. K. (2019). Exploring strategies for promoting trauma-informed care and reducing burnout in acute care psychiatric nursing. *Journal of Nursing Education and Practice, 9*(5), 110.
- Watzlawick, P., Beavin, J., & Jackson, D. (2017). Some tentative axioms of communication. In *Communication theory* (pp. 74–80). Routledge.
- Whittington, R., & Richter, D. (2005). Interactional aspects of violent behaviour on acute psychiatric wards. *Psychology, Crime & Law, 11*(4), 377–388.
- Whittington, R., & Wykes, T. (1996). Aversive stimulation by staff and violence by psychiatric patients. *British Journal of Clinical Psychology, 35*(1), 11–20.
- Wilson, K., Eaton, J., Foye, U., Ellis, M., Thomas, E., & Simpson, A. (2022). What evidence supports the use of body worn cameras in mental health inpatient wards? A systematic review and narrative synthesis of the effects of body worn cameras in public sector services. *International Journal of Mental Health Nursing, 31*(2), 260–277.
- Woods, P., & Almvik, R. (2002). The Brøset violence checklist (BVC). *Acta Psychiatrica Scandinavica, 106*, 103–105.
- World Health Organization. (2017). *Strategies to end seclusion and restraint: WHO QualityRights specialized training*. <https://iris.who.int/bitstream/handle/10665/329605/9789241516754-eng.pdf?sequence=1>

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