



## 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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<http://dx.doi.org/10.1016/j.apnu.2016.05.005>

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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

**Table 1**  
An Overview of Condensed Cases From Different Units.

Case	Situation	Participant data
<b>Psychiatric intensive care unit</b>		
1	A staff member followed an agitated patient to her room, paying attention to her experienced needs, such as listening to her anger. The staff member made it possible for her to go for a walk with her dog, which she missed a lot	Interview with: Patient (P1): female (aged 40–45), > 10 admissions Staff (S1): female (aged 30–35), 5–10 years' experience in speciality
2	Staff postponed taking action in a conflict situation in the living room. Unexpectedly, the patient said: 'I ought to go my room for a short while and then go for a walk in the garden'. The staff went along with the patient's suggestion, which helped him regain personal control	Interview with: Patient (P2): male (aged 60–65), > 10 admissions Staff (S2): female (aged 30–35), 5–10 years' experience in speciality Staff (S3): male (aged 50–55), 20–25 years' experience in speciality
3	A staff member and a patient were talking about a conflict situation earlier the same day. The patient told the staff member that he thought she acted in an authoritarian way, and she told him that she thought he acted defensively. Their reflections made both of them aware of the other's perspective and actions	Interview with: Patient (P3): male (aged 40–45), > 10 admissions (3 interviews alone) Staff (S4): female (aged 50–55), 15–20 years' experience in speciality
4	In a conflict situation, a staff member suggested to the patient to take a shower. This helped reframe the situation and distracted the patient. The patient agreed, and all parties involved were surprised that they avoided using mechanical restraints	1 joint interview Other material: 2 letters Interview with: Patient (P4): female (aged 35–40), > 10 admissions (2nd interview). Staff (S5): female (aged 30–35), 5–10 years' experience in speciality Staff (S6): male (aged 25–30), 0–5 years' experience in speciality Staff (S1): female (aged 30–35), 5–10 years' experience in speciality
5	A staff member understood why a patient was very upset and apologized that a colleague inadvertently had given her some wrong food, which calmed down the patient	Observation of: Patient (P1): female (aged 40–45), > 10 admissions Interview with: Staff (S1): female (aged 30–35), 5–10 years' experience in speciality
<b>Unit for mentally ill offenders</b>		
6	A staff member appeared authentic when she interacted with an angry patient who has started wrecking furniture. She was matching the patient's language, saying for example: 'I understand that you feel fucked up'. She was surprised at her own language use, but the patient calmed down	Observation of: Patient (P6): male (aged 20–25), 1–5 admissions. Interview with: Staff (S7): female (aged 30–45), 5–10 years' experience in speciality Fellow patient (P16), <5 admissions
7	The patient had positioned his furniture in a hazardous way, and the staff had discussed how to address the issue in a respectful manner that matched the patient's self-esteem. The ward manager went to the patient's room and asked him politely to reorganize the furniture. She reasoned with him by referring to hospital regulations. The patient followed her advice, as she was the manager of the unit, which he respected	Observation of: Patient (P7): male (aged 25–30), 1–5 admissions Interview with: Staff (S7): female (aged 30–45), 5–10 years' experience in speciality Staff (S8): female (aged 50–55), 10–15 years' experience in speciality
8	The patient was segregated from the general unit milieu. He was in the company of a helpful staff member. He had access to his own toilet, he felt safe and the area was calm. He felt appreciated and the staff member helped him draw pictures. He felt that it was his own decision to stay in the particular area	Interview with: Patient (P8): male (aged 40–45), > 10 admissions Staff (S9): female (aged 30–35), 0–5 years' experience in speciality
9	The patient felt violated and stigmatized. Staff paid attention to his needs, such as finding e-mail addresses of persons abroad who he hoped could help him. He wanted to spend time on his own, which was respected by staff members	Interview with: Patient (P9): male (aged 35–40), > 10 admissions Staff (S8): female (aged 50–55), 10–15 years' experience in speciality Fellow patient (P16), 1–5 admissions
10	The staff member realized that the patient was worried about being subjected to mechanical restraints. The patient had witnessed other patients being subjected to mechanical restraints. The staff member listened to the patient's fears and concerns and informed her about the legislation governing mechanical restraints and why some patients were subjected to such restraints	Interview with: Patient (P10): female (aged 40–45), 1–5 admissions, detained for mental assessment ordered by the court Staff (S18): female (aged 50–55), 10–15 years' experience in speciality
<b>Emergency department</b>		
11	A patient was upset after being compulsory detained. The staff members understood the patient's concerns and explained the reasons for this decision They listened to his point of view while staying calm themselves	Observation of: Patient (P11): male (aged 25–30), 1–5 admissions Interview with: Staff (P10): female (aged 45–45), 10–15 years' experience in speciality
12	A patient did not want to be transferred to another unit and was upset. A staff member tried to match the patient's state of mind and involved her in a little role-play, pretending that they were elegant, very polite and well-mannered ladies. They were both laughing when a group of staff members and a doctor prepared to escort her to the other unit. The other staff members talked appreciatively about the patient, saying for instance: 'She is such a lovely person'	Observation of: Patient (P12): female (aged 50–55), > 10 admissions Interview with: Staff (S11): female (aged 55–60), 25–30 years' experience in speciality Staff (S12): female (aged 25–30), 0–5 years' experience in speciality Staff (S13): male (aged 50–55), 20–25 years' experience in speciality

(continued on next page)

Table 1 (continued)

Case	Situation	Participant data
<b>Medium-security unit</b>		
13	A staff member followed the patient into the garden. She listened to him for more than 30 minutes, while he spoke angrily about feeling violated. Knowing the patient's usual behavior made the nurse remain calm and engaged, even though the patient was upset and appeared threatening	Interview with: Patient (P13): male (aged 25–30), 1–5 admissions Staff (S14): female (aged 60–65), 10–15 years' experience in speciality Staff (S15): female (aged 40–45), 0–5 years' experience in speciality Staff, student (S16): female (aged 20–25), 0–5 years' experience in speciality
14	A staff member collaborated with the patient and his relatives. She listened to the parents' concerns about their son not being treated respectfully, and to the patient's worries and experiences of not being treated fairly	Interview with: Patient (P14): male (aged 20–25), 1–5 admissions Staff (S17): female (aged 40–45), 0–5 years' experience in speciality
15	The patient argued with another patient and wanted some p.r.n. medication. While assisting the patient, the nurse asked him about what had upset him. The patient recalled this as helpful and explained how the nurse had reminded him that getting upset was not only his responsibility, but a shared responsibility. The patient also appreciated that the nurse had watched a film with him	Interview with: Patient (P15): male (aged 20–25), 1–5 admissions Staff (S18): female (aged 40–45), 15–20 years' experience in speciality
16	The patient was to be given medication against his will. The staff member listened to the patient's anger without correcting him. She wanted to assist him in managing the feeling of abuse and helped him regain control by creating an opportunity to exercise, which the patient recalled as very helpful	Interview with: Patient (P16): male (aged 25–30), 1–5 admissions Staff (S17): female (aged 40–45), 0–5 years' experience in speciality
<b>Forensic medium-security unit</b>		
17	The patient received a notice that he was going to be given compulsory medication in 3 days. He found it helpful to talk about his thoughts about the coercion, and he was able to reflect upon the way in which staff members had prepared him. This made him aware that he preferred to be involved, that he wanted the medication as tablets and not as injections	Interview with: Patient (P17): male (aged 30–35), 5–10 admissions
18	A staff member made herself available for interaction with patients by sitting in the living room. The patient told her that he thought that nobody ever listened and that he was provoked by the staff's right to define the truth. Having the opportunity to talk freely was experienced as helpful because he had started obsessing about it	Interview with: Patient (P18): male (aged 30–35), 1–5 admissions
19	The patient explained that she sometimes threw herself on the floor and banged her head. She found it helpful that staff members avoided the use of mechanical restraints and sat close by and made sure she did not hurt herself. Staff suggested that she should write down her thoughts on the specific moment, in order to learn how to manage a crisis differently	Interview with: Patient (P19): female (aged 35–40), >10 admissions. Detained under court order Staff (S18): female (aged 30–35), 10–15 years' experience in speciality
20	The patient was confrontational towards other patients and staff. She found it helpful when staff did nice things with her, such as going for a walk or going to the fitness room. She had a special care plan that included these activities. Staff helped her regain personal control by asking: 'What's next on your schedule?', instead of saying: 'You have to do....'	Interview with: Patient (P20): female (aged 40–45), >10 admissions. Detained under court order Staff (S19): female (aged 55–60), 20–25 years' experience in speciality Staff (S20): male (aged 50–55), 1–5 years' experience in speciality
21	The patient felt cheated because staff members forgot to take time 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 mechanical restraints and was surprised when a staff member instead helped him gain control by stating that she understood his frustration and helped him do his fitness in the evening	Observation of: Patient (P21): male (aged 25–30), 1–5 admissions. Detained under court order Interview with: Staff (S20): female (aged 45–50), 10–15 years' experience in speciality

NOTE. Helpful situations are illustrated and participant data are listed.

others what was helpful, what would you highlight?'. In this way we captured different perspectives. During the interview, the researcher would ask the participants: 'Who would you recommend I also talk to? Who might be able to tell me more about this particular situation?' in order to explore how different actions influenced the definition of the situation. We sought to include different age groups and both genders in the sample. However, the mental health workers were mainly women ( $n = 19$ ), and most of the patients were men ( $n = 15$ ).

### Analysis

The analysis was a constant comparative process (Miles, Huberman, & Saldaña, 2014) guided by the symbolic interactionist theoretical framework. The process consisted of several steps: first, the total dataset (21 cases) was studied across the different units to obtain a sense of the entirety and all audio-records were listened to repeatedly. Texts from the interviews and the observation notes were coded manually line-by-line to explore how people ascribed meaning to de-escalating situations, and how they defined helpful solutions. In full accordance with our symbolic interactionist framework, text sequences describing the

stream of actions, de-escalation definitions, and descriptions of links between actions and thought were coded, and a list of temporary codes was made. Second, all data were read again and the cases were compared, using the temporary codes from the first reading, which were reduced to identify more abstract categories. This led to the creation of an initial framework of sub-themes. These sub-themes became the emergent themes, as they summarized important aspects of how helpful de-escalation was defined across the cases. Third, the material was examined again in order to test whether the themes captured the substance of the dataset. This included a theoretical explanation of the themes as well as selected quotations to represent the themes (Table 2 shows an example of the coding-process). Fourth, we combined the themes in a model representing the main concerns of the participants and how they influenced each other in a multi-perspective definition of helpful de-escalation interactions.

The first author of this article analyzed the data. Throughout the analysis, memos were written to prompt analysis and creative thoughts (analytical memoing (Miles et al., 2014, p. 95), and to capture feelings at all stages. During the process, preliminary interpretations were discussed with research peers ( $n = 6$ ) and service users ( $n = 5$ ) for

**Table 2**  
Example of the Coding Process Exemplified by the Theme: Safety and Creativity and the Underlying Sub-Themes, Codes, and Quotes.

Final theme	Defining helpful solution is influenced by safety and creativity				
Sub themes (defining successful de-escalation)	Creating a safe space	Establishing relations	Taking the role of other	Foreseeable social interactions	Creativeness
Codes (strategies)	Distance, observing the other, testing, protecting, taking control	Positive facial and bodily expressions, time, focused, mutual, collaborative	Empathic, helpful, human integrity, different perspectives, follow patient's own ideas	Foreseeable, mutual, inclusive, caring, appreciative, listening, recognizable actions, sharing responsibility	Bending rules, changing context, surprising solutions, thinking out loud, reframing
Examples of supporting quotes (links between actions and thoughts)	'...they shouldn't be too close, that's unpleasant' (field note Feb. 2013)	'When body language was connected to what people said' (patient case 3) We waited a bit longer (staff case 3)	'They're also afraid that I'll hit them' (patient case 19)	'Staff case 18 talked to me yesterday, she said: 'You have to do something about it, but it's not only your responsibility"' (patient case 15)	'...I thought they would put me in a belt, but S.no.1 offered me a shower...' (patient case 4).

reflection and elaboration. Moreover, the analysis, data findings and discussions were shared with two supervisors (the second and third authors) through all stages for comments and feedback. These peer-debriefings were a way to establish trustworthiness within a naturalistic study, such as this multiple case study (Guba, 1981).

*Ethics*

The project was carried out in accordance with the Declaration of Helsinki II Principles. There were no risks, disadvantages or discomfort associated with the project for the participants involved. Informed consent was obtained from the participants. Participants were informed orally and in writing about the purpose, methods, anticipated benefits and potential risks of the study, and that they could drop out of the study at any time without any consequences. All empirical material was handled in confidentiality and published data are written anonymously. The project was submitted to the local Research Ethics Committee, who had no objections to the study.

**RESULTS**

The analysis indicated, across different units and different parts of the trust, that both staff and patients aspired toward achieving non-confrontational and social relationships building when they interacted in violent and threatening situations. We named the first theme: 'memories and hope'. This showed how memories of similar situations created expectations for the current moment and had an impact on how they defined the present (index) situation. The second theme: 'safety and creativity' included all social interactions occurring in the present situation and consisted of a stream of actions, executed in phases. In the first

phase, participants sought to create a safe place and in the second phase, a stream of inclusive actions followed, which helped the patient to calm down. The third theme: 'reflective moments' took place immediately after the incident in which the parties understood the consequences of their actions, achieved learning and created expectations for similar situations in the future.

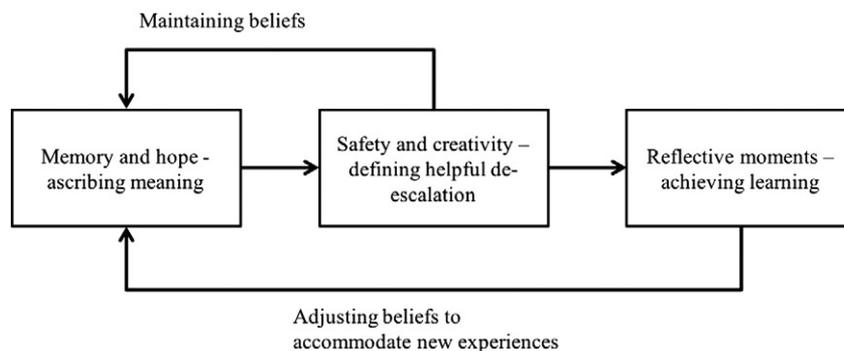
The relationships between each theme were gathered in a mental model of de-escalation (Fig. 1).

The model illustrates how participants defined their environment in stage one. Based on that definition they ascribed meaning to the stream of actions (de-escalation practices) in stage 2 and in stage 3 they understood the consequences of their actions and they achieved learning. This model illustrates how de-escalation solutions can be defined in two different ways: either they ascribed meaning to de-escalation based on existing beliefs (steps 1 and 2) or they changed their beliefs, because they reflected upon what had brought them to the particular situation and they achieved learning (steps 1, 2 and 3).

*Memories and Hope*

The data revealed that both patients and staff were influenced by past experiences when defining de-escalation. Memories formed the participants' understanding of reality, influenced their expectations of the present moment and induced distrust. Experiences could be rooted in fearful recollections such as flashbacks of traumatizing restraints experiences. Such flashbacks influenced the expectations and interaction at the specific moment.

All participants expected mechanical restraints to be the solution. Mechanical restraints represented an intervention that both patients and staff saw as the 'worst case'. This was exemplified by an episode



**Fig. 1.** Illustrates a mental model of how participants defined their environment in stage one. Based on that definition they ascribed meaning to the stream of actions (de-escalation practices) in stage two and in stage three they understood the consequences of their actions and they achieved learning. This model illustrates how de-escalation solutions can be defined in two different ways: Either they ascribed meaning to de-escalation based on existing beliefs (step 1 and 2) or they changed their beliefs, because they reflected upon what had brought them to the particular situation and they achieved learning (step 1, 2 and 3).

where the researcher was sitting in a unit, and Andrew (case 9, interview with patient) had an experience he wanted to share. Andrew was a peaceful man who was sitting by himself in a corner. He related how he found it difficult to identify staff as helpful. He explained how he was convinced he would be subjected to mechanical restraints, if he did not follow the staff's rules. He voiced the fact in the following quote: 'Then I'll probably be restrained with a belt or something, you know, 4–5 people rushing in and there I am, fixated for the next 24–48 hours'. Even though we encouraged participants to describe moments of success, they recalled old fearful experiences.

The same fear was present in a team discussion (staff members) about a patient that the staff perceived as very dangerous. They said about the patient: 'He has to be in mechanical restraints until we can move him to another unit' (researcher's field notes, October 2013). This showed how it was difficult to provide care for patients, whom they perceived as potentially dangerous. They knew mechanical restraints were not a helpful solution, but they believed that they had no other choices. The quote indicated how staff, when things turned out to be very difficult, hoped for another future, such as transfer of the patient to another unit.

Andrew described similarly how he organized his own actions in order to achieve a personal goal, such as sitting in a chair all by himself, not talking to anybody. His goal was: 'To get away, as far away from those people as I possibly can, that's my dream and the only thing that keeps me going'.

These examples show powerlessness, and it comprises negative emotions that undermine societal order. Moreover, it also illustrates how people acted according to their definitions, recalled through past experiences (mind action) and in hope for another future. Thereby, participants were not responding to physical reality directly, but to the meaning they attributed to things at that specific moment. The material also indicated that staff hoped for a better environment, improved violence management training or another job; whereas both patients and staff hoped for better staffing.

#### *Safety and Creativity—Defining Helpful De-Escalation*

Participants acted according to the meaning they attribute to something, as illustrated above. However, the meaning they give is not permanent. It is influenced by social interactions with different people, which are illustrated in this second theme.

Helpful de-escalation consisted of a stream of actions, executed in phases. First, participants created a safe place. Second, mutual relations were established. During this phase, empathic acts were performed, followed by foreseeable social interactions, which promoted human integrity. Third, it was possible to de-escalate anger by engaging in creative and surprising social interactions.

In *creating a safe place* everybody, both patients and staff, acted according to their interpretation of the situation. This included various strategies, such as keeping a certain distance, testing "the others" reactions or scanning surroundings for dangers. Distance created a safety zone, which afforded both patients and staff protection. The following quote was a typical way of ascribing meaning to safety, voiced by both patients and staff: '...they shouldn't be too close, it's unpleasant ...' (researcher's field notes, February 2013). The feeling of safety was a personal experience influenced by both physiological and psychological conditions. A certain physical distance created a personal space for both parties to stop up and to rethink the next step. Moreover, the feeling of safety was influenced by the presence of trustworthy persons. 'Testing the other' was a strategy whereby participants challenged each other in order to interpret other people's reactions and the level of safety in the unit. A staff member explained in case 3 how she tested a patient's state of mind: 'We prod him a little, to make sure he gets some medication'. This example showed how some participants induced the next step. The strategy was also described by patients, for instance Peter, who said that he had been 'in the system his whole life'. Being a very experienced patient, he described how he tested safety by identifying weaknesses in the unit: 'I would put matches in the lock, to

check if safety was OK here' (case 8, interview with patient). He knew that keys were important (symbols) to staff members as a means of taking control, and he wanted to test the staff's reactions. Like all the patients in the study, he was concerned about safety, remembering how co-patients had managed to commit suicide. Both patients and staff observed each other from a distance, watching through windows or through different objects, such as a mirror placed in a corner of the unit. Keeping a certain distance and having strategies to control safety were important means of creating the basis for establishing relations.

*Mutual relations* were influenced by the participants' ability to 'take the role of the other'. This act was an empathic act, creating an image of what 'someone else thinks and sees'. Several patients described how they linked actions and thoughts, when describing gestures and expressions, for example an authoritative look or a look of arrogance or friendliness (cf. case 1, case 3, case 8 and case 10). They exemplified how they were able to define the staff by their body language, for instance: 'You can tell as soon as they enter the room, is it *do as you're told* or is it a merciful angel' (case 10, interview with fellow patient). In this quote, the patient highlighted how staff members acted differently. Staff members were aware of how they appeared, as this was part of their job. This was illustrated by a group of mental health workers when exploring a stream of actions in a de-escalation event. The patient involved had been held involuntarily in the unit for about 3 months. When the staff rejected his requests or when fellow patient talked negatively about his family, he felt violated and acted in a violent and threatening way. The staff explained: 'We had to work very hard to like him' (researcher's field note, December 2013). They further explained that taking his perspective and knowing his plans and reactions promoted helpful interaction and helped them adjust and customize their actions to the specific situation. In this way the meaning given to the specific situation was not permanent it was changeable.

*Foreseeable social interactions* included human social inclusive acts, such as sharing responsibility and being attentive. This was recalled by a patient in an interview (case 18): 'She talked to me yesterday, saying 'you have to be aware of how you affect other people, but it's not only your responsibility'. Sharing responsibility created trust and new memories. The patient added: 'Later that night, we watched a strange film together and spoke about it afterwards'.

A common experience was that patients accepted whatever the staff did, as long as it showed that they cared and that they acted in a foreseeable way. A patient was told to go to her room because she was yelling, threatening and running in the corridor. Afterwards, when she reflected on the event she thought this restriction was in fact helpful. Being in her room, together with a nurse who was attentive and a good listener compensated for being segregated from her fellow patients.

*Creativeness* was the ability to follow the patient's own ideas, bend the rules a bit and change the context. A patient (interview, case 4) described an incident the same morning. She was in the dining room and she was very upset. Staff told her to go to her room, and she was escorted to her room by a group of staff members: '...I thought they were going to put me in a belt, but instead Lonny offered me a shower...'. The patient was very surprised, but she found that this unexpected solution was helpful. Creativeness reframed the conflict situation and included an act of taking the role of a significant other. The same happened in another situation. Here, the nurse agreed to take part in a little play, based on the patient's experience of reality. The nurse explained the episode: '...she usually addresses me in a certain way ('Mrs. Olga'). And she says I speak in a beautiful language, with a beautiful voice, and then she bows and I curtsy and thank her. Then she laughs and walks into her room...' (staff interview, case 12). Through this playing, the patient was assisted toward a calmer personal space.

#### *Reflective Moments—Achieving Learning*

Reflective moments completed de-escalation, and the people involved understood the consequences of their actions, although only a

few cases included this stage. An example was when a staff member one morning offered to help a patient sort out some problems with an email, as he had asked earlier that morning. The patient responded by shouting: 'Show me some respect, don't talk to me that way' (researcher's field note, case 3). This quote illustrated how he did not respond to the interaction directly, but through the social understanding, as explained in the sub-theme 'memory and hope'. His reflections afterward, when the nurse and the patient talked about the episode, were: 'Maybe I misunderstood the situation, I was annoyed with you, you have that authoritarian body language when you talk' (patient interview, case 3). Moreover, he said that he was afraid the nurse would sound the alarm and call for help, and that he would then be subjected to mechanical restraints. The dialogue made him reflect on the situation, and he realized how his assumptions had influenced the stream of action.

The nurse was also reflecting, thinking aloud: 'After our talk, I can imagine why he is afraid I'll sound the alarm. It makes sense. He acts defensively all the time. That's also what you see here. He's just like a little child'. The case illustrated that the nurse understood the perspective of the patient, comparing his reaction to that of a small child. This act made it possible to define the patient's intentions, and it made her consider how she could act in the future to help the patient gain a sense of control.

The reflective moments completed the de-escalation process and illustrated how meaning attributed to something can change. Awareness of how the understanding of helpful de-escalation is based on the meaning they gave the social interactions in step one, makes the reflective moment important. Reflective moments create a shared experience of the event and make people aware of what (might) have caused (the stream of actions) the violent and threatening situation. Reflective moments offer an opportunity to review and understand the consequences of one's own actions, the different ways to view reality, and to understand the perspective of the other.

## DISCUSSION

Symbolic interactionism, which was used as this study's framework, offered an extended explanation about de-escalation. Based on real life experiences we gained knowledge about how different perspectives influenced social interactions and highlighted the importance of staff member's ability to "assume the role of the other". We suggest that imagining the patient perspective and past experiences may help staff to avoid power struggles and interact in ways that patients experience as helpful.

The data indicated that both patients and staff members, no matter which unit they came from, strived for peaceful solutions in violent and threatening situations. Moreover, the study also revealed how all parties used the same basic patterns when they defined violent situations and ascribed meaning to de-escalation. When staff realizes that all parties have the same hope for safety and peaceful solutions, staff might be able to cooperate better with patients in these challenging situations.

We assembled this stream of actions in a mental model consisting of three interdependent stages. Memories and hope in the first stage, which influenced the participants' definitions of the violent and threatening situation. These definitions guided the social interactions in both stage two (safety and creativity) and stage three (reflective moments). Hereby we revealed a multi-perspective description of de-escalation, which illustrated how helpful de-escalation is created and re-created through social interactions. These common basic patterns leading to our mental model are also elements to be found in social learning theory (Argyris, 2002). According to these theories people promote learning by reviewing their actions as modeled in double-loop learning processes (Argyris & Schön, 1978). By including the perspective of social learning theory, the de-escalation process can change status from solely "talk-down interactions" (Maier, 1996) and problem solving (Bowers, 2014) toward critical reflection, where people understood what

brought them to the escalated situation. In step 3 of the mental model, the reflective moment, all parties identified own behavior, as exemplified in case 3 (above). This approach is a major difference from other published research about de-escalation, which tends to pay attention to how staff members solve the problems (for example Duperouzel, 2008). Moreover, the reflective moment had the possibility to create new memories, which people could draw upon in similar situations in the future. On the other hand, neglecting the reflective moment, maintains a risk of repeating the actions within a given frame [single-loop learning (Argyris & Schön, 1978)], such as illustrated by Berring et al.'s (2015). They identified how patient and staff identities were (re) produced by an automatic response from the staff that was solely focused on the patient behavior (p. 1).

Previous research found that mental health workers react differently to violence, (Duxbury, 2002; Morrison, 1993). Some are able to relate to patients in ways that produce positive solutions (Carlsson et al., 2000; Duperouzel, 2008; Gunasekara et al., 2014), while others manage patients with coercive measures. The current study explains through the mental model, in which memories and hope in stage 1 governs the actions in stage 2, and thereby also differences.

Violence is by nature driven by negative emotions that create distrust and undermine societal order (Charon, 2010), which makes it difficult to cooperate in violent situations. This might explain the importance of creation of safety (stage 2 in the mental model). Patients and staff members strived for safety by means of personal strategies, such as testing the other and controlling the situation in various ways. Such strategies may, according to Nijman, aCampo, Ravelli, and Merckelbach (1999), Nijman (2002), escalate a situation and cause repeated inpatient aggression, leading to the use of coercive measures, and develop corrupted cultures where the needs of the service users become secondary to the needs of the staff (Paterson et al., 2013). However, the focus on positive interventions in this study forced the participants to reflect upon solutions and strengths within the system. This made them aware of how they were able to stop this vicious circle by utilizing creativeness and transfer control to the patient, as advocated by Chandler (2008).

Participants in our study paid attention to how bending rules and changing the context reframed conflict situations. This flexibility confirmed the outcome found by Johnson and Hauser (2001), who described the practice used by expert psychiatric nurses when accompanying patients to a calmer personal space. This includes for example connecting with the patient at the right time and matching the patient's needs.

Within stage 2, empathic acts were performed, followed by foreseeable social interactions, which promoted human integrity. This is in full accordance within the general agreement and research about de-escalation (Bowers, 2014; Hallett & Dickens, 2015; Price & Baker, 2012). In addition, our study illustrated how basic characteristics of de-escalation were co-created and rooted in collaborative approaches, such as sharing responsibility and problem-solving processes.

Shared problem-solving processes are important within mental health care, as documented by Tee et al. (2007) co-operative inquiry. They stated that service-users do not want to be told what to do or have their actions judged, they want to be involved. Involving patients in avoiding violence and creating safe environments in mental health settings is an upcoming approach within violence management. Within this frame it is assumed that violence cannot be created without the active participation of the service users (Paterson, Leadbetter, Miller, & Bowie, 2010). This was echoed in our study as we identified how the stream of actions was creating helpful de-escalation in an interactional process between staff members and patients.

Secker et al. (2004) argued that three steps must follow an aggressive incident: emotional support, critical reflection and learning. These three steps were all contained in the mental model of de-escalation this study reported. Our analysis suggested that without critical reflection, the de-escalation process was incomplete. The reflective moments (stage 3) linked the past with the present and reminded people of what

(might) have caused the stream of actions. The reflective moment of stage 3 helped the participants adjust their mental models to accommodate new experience. It also enabled staff members to understand and empower their patients, which may help debunk the myth of psychiatric patients as deviant, unpredictable and dangerous (Berring et al., 2015; Perron & Holmes, 2011; Schofield et al., 2012).

This extended understanding of de-escalation can facilitate shared problem solving in violent situations and thereby create a safe environment together with the patients. Moreover, discourses of aggression, as identified by Berring et al. (2015), may also be altered by this understanding and replace the vicious circle with positive violence management in a collaboration between patients and staff.

This study's 21 cases included the experiences of the 41 participants from 5 different psychiatric units who were available and willing to participate. Although the participants articulated different definitions of helpful de-escalation, we believe that the three themes account for fundamental social processes across the cases. We focused on situations that successfully avoided the use of coercive measures, which excluded analysis of de-escalating actions that were not successful in avoiding violence and/or the use of coercive measures by the staff. However, we wanted to learn from what people experience as a type of 'best practice', as this could develop conceptual transferability to other settings. Furthermore, the study was based on post hoc reflections on past experiences and the participants' definitions of what was helpful in potentially aggressive and violent situations were always articulated in this 'successful' context. Therefore, the investigation of negative experiences was within the scope of this project. Data were constructed in interactions between participants and the researcher. The researcher made an active effort to meet the participants in a non-judgmental manner in order to promote open conversations. Furthermore, to ensure that the comparative analysis process captured different perspectives, data and the preliminary constructs were discussed with and interpreted by peers, such as service-users and mental health workers at different levels in the organization.

## CONCLUSION

We regard this study as an important contribution to the practice of de-escalation. It creates insight into organizational practices related to coping with and understanding violent and threatening behavior. This small-scale view of social interaction gave insight into how past experiences influenced present interactions. It highlights the importance for a change in violence management approaches such as including the service users in the active participation of creating safety.

The study exemplified how staff members can engage with patients in violent and threatening situations, however, more work needs to be done in order to investigate how people achieve learning about de-escalation practices. We suggest that the mental model of de-escalation can serve as a reflection tool, allowing participants involved in the same incident to investigate what brought them to the present moment. Helpful de-escalation requires insight into how assumptions developed from previous experiences can shape the choices participants make within the de-escalation process.

This study showed how an extended understanding of de-escalation may enable patients and staff to foster shared problem-solving in violent and threatening situations. It is to be hoped, this paper will raise awareness among managers, service-users and mental health workers of how symbolic interactionism and social learning theory can contribute toward forming a sense of community and a negotiating culture that may replace coercive measures with de-escalation strategies by means collaborative practices.

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