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Review article

De-escalation Strategies for Managing Violence Risk in Psychiatric Settings: Clinical Communication Approaches and Practical Recommendations

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Abstract: Violence and aggressive behaviour in psychiatric settings represent a major challenge for healthcare professionals and may compromise patient safety, therapeutic relationships, and quality of care. In recent years, increasing attention has been directed toward non-coercive interventions capable of reducing agitation and preventing escalation in clinical environments. De-escalation strategies based on communication, empathy, and behavioural observation have emerged as valuable tools for improving the management of high-risk situations in psychiatric wards. This study presents a narrative review of the literature concerning verbal and nonverbal de-escalation strategies in psychiatric and healthcare settings. The discussion is complemented by professional reflections derived from psychiatric, forensic, and healthcare practice, used solely to contextualize the reviewed literature and illustrate practical applications of de-escalation principles. The literature consistently indicates that aggressive behaviour develops through identifiable stages characterised by increasing emotional and physiological activation. Early intervention during the trigger and escalation phases appears to improve the effectiveness of de-escalation strategies. Active listening, empathic communication, reduction of environmental stimuli, non-threatening body posture, and clear verbal interaction emerged as central elements in preventing escalation and promoting therapeutic engagement. De-escalation represents an essential clinical competence in psychiatric and rehabilitation settings. Communication-based interventions may reduce the use of coercive measures, improve therapeutic relationships, and contribute to safer healthcare environments for both patients and professionals. The implementation of specific training programs focused on active listening, empathic interaction, and early recognition of behavioural escalation is strongly recommended for healthcare personnel working in high-risk clinical settings.

Keywords: De-escalation; psychiatric wards; aggressive behaviour; crisis management; active listening; nonverbal communication; healthcare professionals

1. Introduction

Since its emergence in the 1960s, the study and interest in the application of de-escalation have established it as a multidimensional concept applicable to a variety of situations characterised by the need to manage real or potential conflict and stabilise a crisis situation [1]. Healthcare professionals working in psychiatric, emergency, and commu-

nity settings frequently encounter individuals experiencing agitation, emotional distress, or behavioral crises. These situations tend to become even more demanding when they involve individuals with mental health conditions or emotional disorders [2], as well as cognitive or developmental disabilities, physical limitations, language barriers, substance misuse, or behavioral crises [3]. Regarding the former, media attention has increased following incidents where the use of force by law enforcement officers was deemed disproportionate to the potential risk. These events have highlighted the importance of crisis management strategies and reinforced the relevance of de-escalation as a core approach to preventing escalation and reducing the use of coercive interventions [4]. In hospital settings, since the second half of the 1990s, there has been a rise in reports of both physical and verbal assaults against ward nurses [5].

This narrative review aims to examine the principal communication strategies and de-escalation techniques described in the literature. By integrating evidence from contemporary research with relevant communication concepts, the review seeks to provide practical recommendations to support the implementation of de-escalation practices in psychiatric and healthcare settings.

Although controversial, the view that certain severe psychiatric disorders—particularly manic disorders and schizophrenia—are primary determinants of aggressive behaviour remains widespread [6], as reflected in studies from the 1990s [7] and subsequent research. Figure 1 illustrates the progressive escalation continuum of aggressive behaviour, highlighting the transition from verbal hostility to severe physical violence and underscoring the importance of early de-escalation interventions.

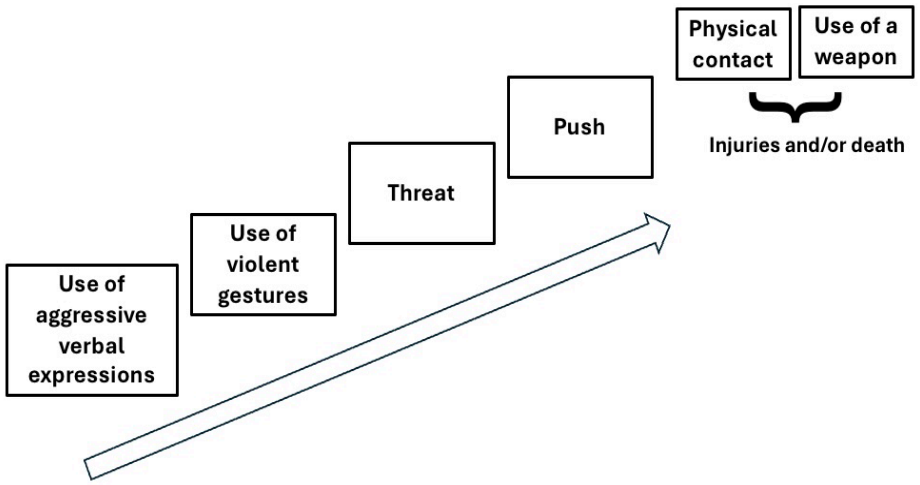

Figure 1.
Illustrative escalation continuum of aggressive behaviour (authors' elaboration based on the de-escalation and crisis intervention literature).

De-escalation: Current Research Status and Relevance Across Clinical Contexts.

Evidence supporting the effectiveness of de-escalation interventions has been reported in several psychiatric settings. For example, Celofiga et al. [8] conducted a study in acute psychiatric wards across six psychiatric hospitals in Slovenia. The study was conducted in two phases, the first over five consecutive months in 2018 and the second during the corresponding period in 2019. Hospitalised patients were randomly assigned to either an experimental or a control group. During the study period, the staff in the experimental group received

training in verbal and non-verbal de-escalation techniques, while the control group received standard treatment.

During the intervention period, the incidence rate of physical restraints due to aggression in the experimental group dropped to 30% of that in the control group. Over a period of approximately 100 days, the risk of patient aggression was 55% lower in the experimental group compared to the control group [8].

Research suggests that, with few exceptions, aggressive and violent incidents continue to be managed reactively using traditional methods (including restraint and medication) as the primary response to critical situations. In fact, de-escalation has been used as a non-violent containment strategy in only a quarter of reported incidents. At the same time, other authors [9] note that this may be due to a lack of training on the effective use of this approach or the absence of guidelines specifying its procedures and practices.

One of the key issues identified by Duxbury [22] is the difficulty in distinguishing physically violent behaviours from verbally aggressive behaviours, despite their different implications and outcomes. Duxbury's framework also provides a scale of escalating aggressive behaviours, illustrating the proportional increase in physical reactivity across different stages of escalation (Figure 1).

Authoritative sources, including the MacArthur Violence Assessment Study, have questioned the presumed association between mental illness and violence. Evidence suggests that the correlation between mental illness and violent behaviour is generally weak, that most individuals with psychiatric disorders are not violent, and that aggressive behaviour is more likely to occur during acute symptomatic phases. Furthermore, victims are more often family members or close acquaintances than strangers, while substance misuse represents a more significant risk factor for violent behaviour than the presence of a mental disorder alone [10, 11, 25].

Aggressive and deviant behaviour are generally understood as the result of a complex interaction between neurobiological predispositions and environmental influences rather than a single causal factor [26, 37].

Supporting these considerations, major studies conducted at Vita-Salute San Raffaele University in Milan and the Centre for Mood Disorders at IRCCS San Raffaele Milan [11] have helped reduce the social stigma linking psychiatric illness and violence. These studies found that the correlation between aggressive acts and the typical symptoms of manic phases—such as psychomotor agitation and irritability—occurred only in a minority of cases, contrary to common belief [11].

Individuals may experience behavioural crises in response to a wide range of circumstances, including acute psychiatric symptoms, substance intoxication, interpersonal conflict, traumatic events, suicidal crises, or experiences of physical or sexual violence [13, 25].

This review synthesises evidence from the international de-escalation literature into a structured framework applicable to psychiatric and healthcare settings, with particular attention to the contemporary Italian context. Rather than proposing a new theoretical model or generating original empirical evidence, the manuscript integrates existing knowledge and translates it into practical recommendations aimed at supporting healthcare professionals in the prevention and management of aggressive behaviour. Furthermore, the review emphasises practical implementation strategies for healthcare professionals operating in psychiatric and emergency settings, an aspect that remains relatively underrepresented in the literature.

The following sections outline the main elements of non-verbal communication and de-escalation techniques applicable across forensic, psychiatric, and substance-use-related clinical contexts.

2. Methods

This manuscript is a narrative review of the literature concerning de-escalation strategies in psychiatric and healthcare settings. The review is complemented by professional reflections derived from the authors' clinical, psychiatric, forensic, and healthcare experience. The objective is to discuss communication-based approaches to aggression prevention and crisis management and to provide practical recommendations for healthcare professionals working in high-risk settings.

The professional reflections included in the manuscript are presented solely as illustrative examples intended to contextualise the literature and do not constitute systematic data collection, observational research, or a formal case series.

The literature search for this narrative review was conducted between January and February 2026 using PubMed, Scopus, Web of Science, and Google Scholar. Search terms included combinations of the keywords "de-escalation", "violence prevention", "aggression management", "psychomotor agitation", "psychiatric settings", "communication strategies", "nonverbal communication", and "mental health care". Publications in English and Italian published between 2000 and 2025 were considered, including clinical guidelines, systematic reviews, narrative reviews, original research articles, and professional recommendations. Sources were selected according to their relevance to communication-based approaches for the prevention and management of aggressive behaviour in psychiatric and healthcare settings. The final selection of references was based on their methodological relevance, clinical applicability, and contribution to the objectives of this review. The literature selection process was based on the authors' expert judgement regarding methodological quality, clinical relevance, and consistency with the objectives of this narrative review. No formal systematic review protocol or quality appraisal tool was applied. The analysis aimed to identify recurring behavioural patterns associated with aggression escalation and to provide practical recommendations for healthcare professionals working in psychiatric and rehabilitation settings.

3. Non-Verbal Communication Elements for Observer Development

While recognising that the interpretation of non-verbal cues should be guided by emotional self-regulation and contextual awareness [14], this section focuses on the largely automatic behavioural and physiological responses associated with stress and agitation. It examines paraverbal and non-verbal manifestations that may emerge during high-pressure situations, when individuals often display spontaneous reactions. Understanding these responses may support the early identification and management of individuals in crisis.

Key dimensions of non-verbal communication include [15]:

- Facial expressions, gaze patterns (including changes in eye contact and pupil dilation), gestures, and other body movements.
- Spatial behaviour (proxemics), posture, physical contact, and paraverbal characteristics such as tone, volume, and speech rate.
- Clothing, personal appearance, and other contextual factors that may influence interpersonal communication.

Observable indicators should be considered indirect manifestations of physiological and emotional activation. Although no single sign is sufficient to predict aggressive behaviour, the presence of multiple indicators may suggest increased arousal and the need for closer monitoring and early de-escalation interventions [12, 15, 16].

Physiological signs of heightened arousal may include facial flushing, increased muscle tension, accelerated breathing, changes in eye contact and facial expression, altered

posture, and other autonomic stress responses. In situations of intense anger or agitation, individuals may also display a forward-leaning posture, clenched jaw, tightened lips, increased motor activity, or a fixed and threatening gaze.

These indicators should not be interpreted in isolation but rather within the broader clinical and situational context. Their relevance lies not in predicting inevitable violence, but in helping healthcare professionals recognise escalating distress and adapt communication strategies accordingly.

During episodes of intense anger or agitation [16], individuals may display additional behavioural indicators such as changes in posture, facial expression[17], muscle tension, and gaze patterns [18]. These signs should be interpreted cautiously and always within the broader clinical and situational context, as they do not necessarily predict violent behaviour.

Nonetheless, in order to achieve a non-violent de-escalation, the observation of such indicators provides crucial insights into the message being conveyed (or intended to be conveyed) and how it is likely to be perceived [34].

4. Communication Techniques Applicable in the Context of De-escalation

It can therefore be useful to first consider the nonviolent communication (NVC) approach [20], developed and codified by American psychologist Marshall Rosenberg. This approach focuses on observing others' behaviours, examining the emotions associated with them, formulating requests, and recognising whether needs are being met or unmet.

The application of nonviolent communication in critical situations is based on four fundamental skills: observing situations without judgement, recognising associated emotions, understanding how these emotions relate to met or unmet needs, and formulating clear, concrete, and non-demanding requests aimed at addressing the needs of all parties [21].

At the core of this perspective lies the assumption that developing empathic abilities is crucial for understanding the reasons behind aggressive behaviours. It is therefore important to move beyond the assumption that aggressive behaviour arises solely from internal factors unrelated to interpersonal interactions or environmental influences [22]. Empathy thus becomes a key element underlying the effectiveness of de-escalation techniques, preceding objective observation and the interpretation of paraverbal and nonverbal cues. It requires acting from the outset by assuming the other person's perspective, or more precisely, by placing oneself in their condition.

Treating individuals with dignity and respect during conflict situations is not always an immediate or intuitive response, particularly when the individual in crisis exhibits aggressive behaviours that may trigger reciprocal negative reactions. Responding in a conscious, empathic, and professional manner requires training, while empathy itself represents a learned skill that can be developed and refined through experience [23].

However, it is also important to clarify that empathy, as understood here, does not necessarily imply sympathy for the interlocutor. Rather, it is a professional approach aimed at conveying concern and gathering information while striving to adopt the other person's point of view [24]. Urgent unmet needs should not be underestimated [18]. Here, the healthcare professional's ability to demonstrate interest and empathy facilitates an unbiased assessment of the situation and reduces the likelihood that personal emotional reactions or trauma-related triggers will interfere with the de-escalation process. This approach promotes a receptive rather than reactive stance, ultimately enhancing the effectiveness of communication-based interventions [27].

Supporting this, the relationship between empathy and anger responses toward an agitated interlocutor has been the subject of various studies [28]. These studies demonstrate that the greater the ability to put oneself in another's shoes, the lower the tendency to react with anger to provocations [29].

Considering this, we can now examine the fundamental techniques for conflict management, which include *active listening*, the *universal greetings* technique, and *modelling calmness*.

Active Listening

Beyond empathy, active listening also involves comprehension and objectivity and aims to facilitate communication, encourage individuals in crisis to express their concerns, and identify relevant information to support collaborative problem-solving.

This technique includes several complementary elements designed to facilitate communication, promote understanding, and strengthen the therapeutic relationship [30]:

- Emotional recognition: acknowledging and reflecting the emotions expressed by the individual to demonstrate understanding and encourage further communication [31].
- Reflection and paraphrasing: restating key ideas or concerns expressed by the individual in order to confirm understanding and maintain engagement.
- Therapeutic silence: allowing appropriate pauses during the conversation to encourage expression and reflection.
- Minimal encouragement: using brief verbal responses to demonstrate attention and support continued communication.
- First-person statements: expressing concern, availability, and willingness to help in a manner that does not appear threatening or judgmental.
- Open-ended questions: encouraging the individual to provide information, describe concerns, and participate actively in the discussion.
- Summarising: periodically reviewing the main points of the conversation to ensure mutual understanding and clarify priorities.

Universal Greeting

Various studies highlight that power imbalances, prejudice, lack of respect, and reactions to feelings of fear often serve as the initial driving force behind conflicts and subsequent aggressive behaviour. Similar dynamics have been identified in the context of psychological violence and intra-family moral abuse, where dysfunctional communication patterns, emotional manipulation, and escalating interpersonal tensions frequently precede overt forms of aggression [19]. Consequently, the universal greeting technique [32] represents a valid approach when interacting with sensitive or highly emotional individuals, those who may be confused, or people in crisis—especially when speaking from a position of authority or power (e.g., healthcare professionals, social workers, or law enforcement officers).

This technique aims to prevent an interaction from starting on a negative note or escalating immediately. It consists of four key steps:

1. Appropriate greeting
2. Name and affiliation
3. Reason for contact or request
4. Pertinent and concise question

If these questions do not receive a prompt response, the other person may feel disrespected, leading to communication breakdown. In some cases, the interlocutor may misinterpret arbitrary or misleading responses as a veiled accusation, fail to recognise the authority figure, or simply assume that the interaction will

take much longer than necessary. Demonstrating genuine concern through simple acts of engagement and attentive care may help establish trust and reduce distress.

For example, a healthcare professional might say:

"Good morning. My name is [Name], and I am a member of the healthcare team.
I would like to speak with you because you seem distressed.
How can I help you?" [24].

If this is not the first interaction with the person, steps 3 and 4 remain applicable, integrating the individual's name. The same principle applies in psychiatric settings, where it is good practice to explain the reasons behind a request or intervention, as well as the procedures involved in a given action or therapy.

Modelling Calmness

Studies have shown that during difficult interactions, body language often reveals visible signs of negative reactions. However, by consciously choosing positive nonverbal communication and limiting the negative signals we may inadvertently transmit, it is possible to facilitate emotional convergence—essentially "modelling" a more appropriate emotional state in the agitated individual. For example, maintaining a relaxed facial expression and posture in response to moderate agitation, or using a slow, calm voice when the other person speaks in a hurried or shouting manner.

It is important to note that in critical situations, verbally instructing someone to "calm down" can come across as hostile and counterproductive. Instead, it is more effective to model the desired behaviour oneself [24].

The key elements of this technique include adapting one's communication style to promote emotional regulation and reduce perceived threat. This may involve maintaining a calm and measured speaking pace, using controlled breathing techniques, and conveying confidence and reassurance through verbal and non-verbal communication.

For effective modelling, it is also important to establish an empathic connection with the individual in crisis, thereby facilitating the adoption of calm, appropriate, and consistent behaviours through processes of behavioural mirroring (postural echo).

5. Results and Practical Considerations

The literature reviewed consistently indicates that aggressive behaviour develops through identifiable phases and that communication-based interventions are most effective when applied during the early stages of escalation. The practical considerations presented below integrate findings from the literature with illustrative professional reflections derived from psychiatric, forensic, and healthcare practice.

Aggressive behaviour may develop through five distinct phases: trigger, escalation, critical phase (acting out), recovery, and post-critical depression, as outlined in the framework below. Each phase is described in detail; however, communication-based de-escalation interventions are generally most effective during the pre-aggression stages, namely the trigger and escalation phases.

Five-phase framework of aggression and de-escalation (adapted from Hillard R., Zitek B., 2005, p. 60):

1. **Trigger phase:** The cycle begins with an initial deviation from the individual's baseline psycho-emotional state.
2. **Escalation phase:** Progressive intensification of emotional distress and threatening behaviour, characterised by increasingly hostile verbal expressions and a growing need for communication-based interventions (talk-down approach).
3. **Critical phase (acting out):** The peak of arousal, during which aggressive behaviour may occur. Interventions should prioritise safety and the management of the acute crisis.

4. **Recovery phase:** Gradual return to the baseline psycho-emotional state. During this phase, the individual may remain sensitive to additional triggers.
5. **Post-critical depression phase:** Emergence of emotions such as guilt, remorse, shame, or emotional exhaustion following the crisis episode.

Phase 1: ***Trigger***

In this phase, it is essential to recognise and remove the triggering factor, relocating the person to a neutral environment with reduced and less intense stimuli [30]. Particular attention should be paid to behaviours that may inadvertently contribute to escalation.

Interaction-related triggers associated with healthcare professionals:

- Use of derogatory terms (e.g., disparaging comments)
- Sarcastic tone (e.g., contemptuous behaviour)
- Rolling eyes, smiling, or laughing inappropriately
- Intimidating postures (e.g., pointing a finger)
- Perception of a lack of alternatives [33]

When interacting with an individual in crisis, it is important to recognise that they may be more sensitive to negative stimuli. Therefore, from the initial approach and throughout the trigger phase, healthcare professionals should adopt an appropriate and supportive mindset. The use of appropriate language and tone of voice is important, as nonverbal communication cues often play a primary role in determining the outcome. Nonverbal expressions that convey a lack of confidence (e.g., avoiding eye contact, slouching, appearing anxious) or threat (e.g., staring, standing on tiptoes) cannot be counteracted with calm and confident words or tone of voice. [24, 34]

Healthcare professionals should adopt a focused, non-judgemental, and person-centred approach that prioritises the individual's needs while minimising the influence of personal biases and emotional responses.

Controlled breathing techniques, including autogenic breathing, may help regulate stress responses and mitigate the physiological effects of the fight-or-flight response during high-pressure situations [35].

To detect the early signs of aggression, healthcare professionals should be attentive to verbal and nonverbal indicators of escalating distress [12]. Early signs of agitation may include changes in facial expression, gaze patterns, muscle tension, posture, vocal intensity, breathing patterns, and motor activity [14, 30, 33]. Verbal threats, increased vocal intensity, pacing, abrupt movements, and other manifestations of psychomotor activation may indicate an increased risk of escalation.

Pre-aggression interventions for individuals exhibiting early signs of aggression and psychomotor agitation:

Meeting Unmet Urgent Needs

- Addressing unmet physical, emotional, or practical needs may help reduce distress and support de-escalation. Examples include providing food, water, privacy, comfort measures, or assistance with communication.

Reducing Stimuli

- Reduce or eliminate external sources of noise (e.g., TV, radio, alarms, music).
- Dim bright or flashing lights and ensure no sudden loud noises cause distractions – as long as this does not pose a physical safety risk.
- Disperse any crowd, if present.

Nonverbal Communication Strategies

- Be aware of your facial expression and maintain an appropriate demeanour.
- Relax facial muscles to appear calm, focused, and confident—even if you do not feel that way—since anxiety can make the person feel anxious and insecure, increasing aggression.
- Adopt an assertive but non-threatening posture.

Mirroring Techniques

Nonverbal communication strategies that promote rapport and reduce perceived threat may facilitate de-escalation. Healthcare professionals should respect personal space, seek permission before approaching when appropriate, maintain communication at eye level, and adopt a non-threatening posture. Positioning oneself at a slight angle rather than directly face-to-face and avoiding unnecessary physical contact or potentially confrontational gestures may help reduce distress and support effective communication [36].

Verbal Communication Strategies

• Whenever possible, communication should be coordinated through a single healthcare professional to reduce confusion and promote clarity [23].

Universal Greeting Approach

- Address the individual directly, applying active listening techniques, frequently repeating their name to create an emotional connection and keep them engaged in the conversation.
- Give only one instruction or ask one question at a time.
- Make a safety statement, such as: "You are safe with me; let me help you."
- Use a calm, low-pitched, and slow-paced voice—the natural tendency is to have a high-pitched and tense voice when scared or under tension.
- Do not get defensive or judgmental—even if comments or insults are directed at you, they are not about you. Do not defend yourself or others from insults, profanity, or misconceptions about your role.
- Offer choices, giving the individual a sense of "power," but express the consequences of inappropriate behaviour in an assertive yet calm manner—without making threats.
- Respond selectively by addressing informational questions, even when they are expressed in a frustrated or confrontational manner, while avoiding engagement with insulting, provocative, or non-constructive remarks. Communication may be more effective when healthcare professionals wait for a natural pause in the individual's speech before responding.

Verbal and Nonverbal Communication Strategies with Psychiatric Patients in Psychomotor Agitation [44]:

• Whenever possible, care should be delivered by healthcare professionals familiar with the individual's needs, preferences, and established care plans.

• Immediate concerns expressed by the individual should be addressed promptly, recognising that psychomotor agitation may be associated with sleep–wake cycle disturbances, unmet physical needs, discomfort, or environmental stressors.

• Potential contributors to agitation and sleep disturbances may include pain, coughing, nocturia, dyspnoea, hunger, thirst, the need for personal care, the presence or removal of medical devices, and unfavourable environmental conditions such as excessive noise, inadequate temperatures, or unsuitable bedding.

• Maintaining familiar routines, providing advance information regarding planned activities or staff changes, and explaining procedures clearly may help reduce anxiety and enhance cooperation.

• Communication should occur at eye level and be characterised by empathy, reassurance, and respect, particularly during personal or intimate care procedures. Reprimanding or overly directive language should be avoided.

• Psychosocial interventions may include strengthening social support networks, encouraging patient–staff interaction, promoting relaxation techniques, and providing reality orientation.

Phase 2: *Escalation*

It is important to remember that crisis escalation can involve *violent acting-out* behaviours, both outwardly *aggressive and self-harming*. Therefore, it is crucial to be aware of the nonverbal cues exhibited by the person in crisis, especially indicators of depressive disorders. This awareness allows for a proper response that avoids reacting with further aggression, which could unintentionally trigger severe self-harming behaviours (e.g., suicide). The goal of intervention at this stage is to reduce emotional arousal sufficiently to enable effective communication and negotiation while progressively decreasing threatening behaviours.

During escalation, it is essential to consider that the individual may have urgent medical needs. Healthcare professionals should assess whether underlying medical conditions, such as hypoglycaemia, infection, intoxication, or other acute medical emergencies, may be contributing to the individual's presentation [39]. Additionally, a practical and pre-established response plan should be in place for situations in which conflict may arise or the individual's condition deteriorates. This plan should include communication strategies, escape routes, procedures for requesting assistance, and institutional safety protocols [39].

De-escalation must be continuous throughout the process, involving talking, reassuring, negotiating, and striving to reach a compromise [36].

The effectiveness of de-escalation strategies should be continuously reassessed throughout the interaction. If these interventions appear ineffective or the level of risk increases, additional assistance should be requested in accordance with institutional procedures [40].

Observable indicators during escalation may include increasing verbal hostility, repetitive or louder speech, changes in facial expression, heightened muscle tension, autonomic activation (e.g., sweating or facial flushing), and intensified motor activity [30]. Behaviours such as pacing, forceful gestures, foot stomping, striking nearby objects, or other signs of psychomotor agitation may indicate an elevated risk of aggressive behaviour.

A potential progression may follow this pattern: antisocial actions → veiled threats → overt threats → violence.

This stage may benefit from the use of the talk-down approach, a negotiation-based strategy that relies on verbal and nonverbal communication:

- *Direct communication*—address the person by name.
- *Specific communication*—use short phrases and simple terms focused on concrete demands.
- *Positive communication*—maintain a non-judgmental and non-confrontational attitude, showing a willingness to cooperate in solving problems by acknowledging concerns. Adapt verbal communication—voice modulation and paralinguistic cues are critical tools for de-escalation.
- Healthcare professionals should consider potential language barriers and adapt communication accordingly.
- Provide support by calling qualified professionals and interpreters.
- Slow down the interaction and use short, clear sentences with a warm and reassuring tone. Use the person’s name, avoiding diminutives and nicknames.

- Communication should be concise, clear, adapted to the individual's level of distress and cognitive capacity, and delivered at a pace that allows sufficient time for processing and response.
- Do not respond to a raised voice by raising your own voice.
- Do not use derogatory or threatening language.
- Instead of repeatedly saying "Calm down," try using more welcoming language (e.g., "Can you help me understand what's happening?") and model calmness [41].
- Acknowledge the person's expressed feelings with empathy, but not their behaviour (e.g., "I understand that you have every right to feel angry, but it's not okay to treat me or others this way"), while also clearly stating your expectations.
- Explain limits and rules with an authoritative, firm, yet always respectful tone.
- While in the trigger phase, it is important to encourage openness in a potentially aggressive person by using open-ended responses. However, at this stage, the person may not be able to articulate a complex explanation. Therefore, closed-ended questions should be preferred—questions that can be answered with a "yes" or "no" or brief, concrete responses [31].
- These can help the professional gain commitment and obtain specific information (e.g., the question should start with "Are you…", "Do you…", or "Would you…". Examples of closed-ended questions include: "Are you thinking about hurting yourself?" and "Would you allow me to help you seek assistance?").

Maintain appropriate physical distance.

Healthcare professionals should maintain appropriate interpersonal distance that facilitates communication while allowing safe withdrawal if necessary. Personal space requirements should be adapted to the individual's level of agitation, the clinical context, and institutional protocols. Professionals should remain aware of their surroundings, preserve access to available escape routes, and adopt a non-threatening position, such as standing at a slight angle rather than directly face-to-face, to reduce perceived confrontation and support safe communication. Physical contact should be avoided unless it is necessary to prevent immediate harm and is consistent with local regulations, institutional protocols, and professional training requirements.

Nonverbal Communication and Body Language

Healthcare professionals should adopt non-threatening nonverbal behaviours that promote trust and reduce perceived hostility. This includes maintaining visible and relaxed body language, communicating at eye level when appropriate, avoiding prolonged direct eye contact, refraining from pointing or making abrupt gestures, and ensuring that facial expressions remain neutral and congruent with the individual's emotional state. Communication should focus on understanding the individual's perspective rather than analysing or challenging their emotions.

Providing Alternative Options

Offering appropriate choices may help promote collaboration, preserve the individual's sense of autonomy, and redirect attention away from escalating behaviours. Whenever possible, healthcare professionals should identify acceptable alternatives and allow sufficient time for the individual to process information and respond.

Phase 3: *Acting-out*

Acting-out is the peak of the cycle, the actual aggression, consisting of the violent act and its immediate physical and psychological repercussions on the victim. Some examples of acting-out include breaking and throwing objects, substance

abuse, suicidal acts (attempted or completed), physical attacks on someone or something, self-harm, and engaging in disordered eating behaviours [42].

The primary objectives during this phase are to ensure safety and minimise harm. Interventions during this phase should prioritise immediate safety and rely on simple, clearly defined responses focused on containment, withdrawal, and self-protection.

Potential indicators associated with imminent aggression may include [43]:

- A frontal stance with the dominant leg positioned behind.
- Paralinguistic signs (e.g., growling).
- Provocative physical contact (e.g., pushing).
- Exaggerated arm movements.
- Reddened eyes, decreased blinking rate (Harris et al., 1966 in Argyle M. 1988).
- Facial pallor.
- Clenched jaw, aggressive grin, showing teeth.

Communication Strategies

- Continue applying the vocal and postural techniques indicated in Phase 2, keeping in mind that, at this critical stage, the person may not be able to think clearly or pay attention.
- Assess the level of risk (e.g., the presence of weapons) and be mindful of threat indicators—signs suggesting that your safety may be at risk because the situation remains unresolved [24].

Non-Verbal Behavioural Strategies and Best Practices [44, 45, 46]

- Healthcare professionals should remain aware of their surroundings, familiarise themselves with available escape routes, and follow institutional safety and containment procedures.
- Adopting a position at a slight angle rather than directly face-to-face with the individual in crisis may help reduce perceived confrontation, convey openness, and facilitate safe withdrawal if necessary.
- Maintain an appropriate interpersonal distance that supports both communication and personal safety. The distance should be adapted according to the individual's level of agitation, the clinical context, and institutional protocols.
- Maintaining open hands in a visible position, accompanied by a clear and respectful verbal message, such as “Please keep your distance” or “Please step back”, may help reinforce personal boundaries if the individual continues to approach in a manner perceived as threatening.

Disclaimer: The safety indicators and responses outlined in this section represent emergency situational safety measures only. These recommendations are intended to support immediate personal safety and facilitate escape when necessary. They do not replace institutional protocols, formal training, or established clinical intervention procedures.

In situations where de-escalation efforts fail and an imminent physical assault cannot be avoided, healthcare professionals should prioritise personal safety, activate institutional emergency procedures, seek assistance, maintain awareness of escape routes, and apply only those self-protection measures for which they have received formal training. Any physical intervention should be limited to emergency situations, implemented in accordance with local regulations and organisational policies, and aimed exclusively at ensuring safety and facilitating escape rather than confrontation.

Phase 4: Recovery

In this phase, the individual gradually returns to their *baseline* psycho-emotional state [30]. It is a delicate phase, as the subject is receptive to potential new triggers;

untimely interventions (aimed at processing the episode) may trigger a reactivation of the crisis. During the recovery phase, interventions should focus on:

- Active but non-intrusive monitoring while minimising exposure to additional stimuli, which would be inappropriate.
- Providing a low-stimulation environment with appropriate observation and monitoring.

Phase 5: Post-Critical Depression

During this phase, individuals may experience negative emotions, including guilt, shame, remorse, or emotional distress following the crisis episode [30]. Psychological interventions should be initiated to help the person process the event. When appropriate and clinically indicated, facilitated post-incident discussions may support emotional processing and help preserve therapeutic relationships following episodes of other-directed aggression.

Structured post-incident discussion may provide reassurance, support emotional processing, and help prevent fear, mistrust, or retaliatory responses

6. Discussion

Although the present review primarily considered evidence derived from studies conducted outside Italy, the findings are highly relevant to the Italian healthcare context. Reports of workplace violence against healthcare professionals have increased in recent years, particularly in emergency and psychiatric settings [47]. Doctors and nurses frequently report concerns regarding their personal safety, and repeated exposure to aggression may negatively affect professional well-being, job satisfaction, and staff retention. A notable example is the case of a medical resident in Udine who, following an assault during an on-call shift in 2021, decided to leave her original specialty [48].

Growing public attention and media coverage have contributed to increased awareness of workplace violence in healthcare settings. In this context, Filippo Anelli, President of the National Federation of Medical and Dental Associations, emphasised the importance of effective communication and the need to foster healthcare environments in which individuals feel welcomed, informed, and supported [49]. These considerations highlight the importance of investing not only in infrastructure and security measures but also in staff training, communication skills, and organisational strategies aimed at preventing aggression.

Evidence suggests that aggressive incidents frequently occur in contexts characterised by high workloads, staff shortages, prolonged waiting times, limited communication, and insufficient training in de-escalation techniques. Addressing these factors requires a comprehensive approach that combines organisational interventions, adequate staffing, clear communication processes, and specialised training programmes for healthcare professionals.

While security measures may contribute to the management of acute situations, long-term prevention strategies should focus on understanding the underlying causes of distress and aggression. Studies consistently indicate that aggressive behaviour develops through identifiable stages and follows recurrent patterns of escalation [50]. Ensuring that healthcare professionals can recognise these stages and apply appropriate communication-based interventions may improve crisis management and reduce reliance on coercive measures.

7. Conclusion

This narrative review sought to integrate the existing literature on aggression prevention and de-escalation in psychiatric and healthcare settings. Its objectives were two-fold: first, to highlight the potential limitations and unintended consequences associated with coercive responses; and second, to synthesise evidence supporting communication-based approaches centred on recognition, understanding, empathy, and respect.

Future research should further explore the implementation and effectiveness of de-escalation interventions across different clinical contexts, with particular attention to the development, evaluation, and standardisation of training programmes for healthcare professionals. Such efforts should promote a shift from reactive approaches focused primarily on crisis containment towards preventive models that address the underlying needs and contextual factors associated with aggressive behaviour.

Professional experience in forensic, psychiatric, and addiction-related settings suggests that communication style, empathic engagement, and the early recognition of behavioural escalation are important elements in preventing crisis development. Although manifestations of agitation may vary across clinical contexts, the principles of active listening, respect, clear communication, and non-confrontational interaction appear consistently relevant for promoting de-escalation and maintaining therapeutic engagement.

Author Contributions

Conceptualization, V.M. and M.C.; methodology, V.M., M.C., and I.V.S.; validation, V.M., I.V.S., and P.R.; formal analysis, M.C. and I.V.S.; investigation, M.C., F.C., and M.D.N.; resources, V.M.; data curation, M.C. and I.V.S.; writing—original draft preparation, M.C., I.V.S., and V.M.; writing—review and editing, I.V.S., P.R., and M.D.N.; supervision, V.M.; project administration, V.M. All authors have read and agreed to the published version of the manuscript.

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Institutional Review Board Statement

Not applicable. This article is a narrative review of the literature supplemented by professional reflections. No human participants were recruited, no patient records were accessed, no identifiable personal data were collected, and no prospective or retrospective observational research was conducted.

Informed Consent Statement

Not applicable.

Data Availability Statement

No new data were created or analysed in this study. Data sharing is not applicable to this article.

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Conflicts of Interest

The authors declare no conflict of interest.

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