Promoting Kinesthetic Empathy with Dance/Movement Therapy:
An Evidence-Informed Protocol to Support De-escalation

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Abstract

Promoting Kinesthetic Empathy with Dance/Movement Therapy: An Evidence-Informed Protocol to Support De-escalation
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The purpose of this capstone is to develop and implement an evidence-informed practice protocol that promotes kinesthetic empathy in de-escalation practice in inpatient psychiatric care. The protocol will be developed as a one-hour in-service and be implemented on an inpatient psychiatric unit in an urban university medical center. Foci within the in-service include kinesthetic empathy, self-awareness, non-verbal communication, somatic countertransference, and identification of early warning signs of aggression.

Relevant literature and research will be included to help inform the process and guide the protocol formation as well as reflections on participants’ experiences of the in-service following its implementation. The literature review includes research studies and theoretical articles examining de-escalation trainings, psychiatric nurses’ emotional experiences of patient violence, the effects of burnout on empathy, and dance/movement therapy skills including mirroring, attunement and clashing, and kinesthetic empathy. The protocol was developed to address identified limitations within psychiatric nursing literature, however is also beneficial to other mental health staff. It seeks to support and emphasize body-related aspects of de-escalation practice to bolster staff’s body awareness, empathy, and non-verbal cues of both themselves and others.

Sections detailing the experience of staff who attended and participated in the in-service experience will be included, highlighting their past experiences of de-escalation and their efforts to improve their process. The method will show how a dance/movement therapy informed supplemental de-escalation in-service can help mental health staff implement kinesthetic empathy into their de-escalation process.
CHAPTER I: INTRODUCTION

In 2007 the American Psychiatric Nurses Association (APNA) submitted an appeal for the evaluation of ethical violence prevention and de-escalation trainings and seclusion and restraint use (Bertram, Kichefski, Paradis, & Platon, 2012). What conspired was an alliance between mental health professionals, organizations, and associations including the American Psychiatric Association (APA). The APA and other organizations collaboratively evaluated student and practicing mental health professionals’ implementation of seclusion and restraint techniques in search of a resolution to the over implementation of seclusion and restraint (Bertram, Kichefski, Paradis, & Platon, 2012). The APNA suggested policy change towards seclusion and restraint practices and recommended further research studies. Additionally, the APNA task force promoted inter-professional advocacy to reduce the use of seclusion and restraint techniques, and in place, implement more effective de-escalation and violence prevention trainings and techniques (Bertram, Kichefski, Paradis & Platon, 2012). Within the literature to date, there remains suggestions for more effective de-escalation and violence prevention programs, specifically in inpatient psychiatry.

Knowledge gaps that continuously remain unaddressed in de-escalation trainings were reported as self-awareness, empathy, frustration tolerance/emotion regulation, self-efficacy, and ability to detect early warning signs of aggression (movement and observational skills) (Bowers, 2013; Hallet & Dickens, 2015; Lauge et al., 2013; Lauge et al., 2016). Due to the lack of clarity surrounding what constitutes violence in adult acute inpatient psychiatric settings, mental health staff continue to grapple with identifying early warning signs of violence and aggression, and appropriately, ethically, and effectively acting on these observations (Stevenson, Jack, O’Mara, and LeGris, 2015; Verhaege, et al., 2014). Further complicating this disparity, most organizations fail to define and identify the same characteristics surrounding violence in their de-
escalation and violence prevention trainings, thus preventing the development of a standardized de-escalation training. Due to knowledge gaps within trainings, mental health staff remain undertrained. As a result, psychiatric nurses are unaware of the use of their bodies, both consciously and unconsciously during instances of patient escalation. This is partially attributed to the lack of a concrete definition of de-escalation (Hallett & Dickens, 2015).

Extant research has shown staff trainings on violence prevention and verbal de-escalation techniques to be effective in decreasing the implementation of seclusion and restraint (Lundy & McGuffin, 2005). Consistency and clarity in trainings can also lessen the potential for using restraints. Research has shown the lack of consistency in de-escalation trainings can be held accountable for differing perceptions of aggression and violence amongst staff, leading to the overuse of restraint techniques (Delaney & Johnson, 2006).

The purpose of this capstone thesis was to develop an evidence-informed dance/movement therapy based supplemental de-escalation training. The training took the form of an in-service for psychiatric nurses and other mental health staff on an adult acute inpatient psychiatric unit at an urban university medical center. The aim for the in-service was to address gaps within de-escalation trainings identified in the literature. The training sought to support and emphasize body-related aspects of de-escalation, and aid staff in becoming more aware of the body language and non-verbal cues of both themselves and potentially escalating patients. The primary focus of the training was kinesthetic empathy, and additionally, perspective taking through embodiment and awareness of self and others. This training was complimentary to the hospital’s de-escalation training that was already in place and was created for psychiatric nurses and mental health staff.
Kinesthetic empathy is the practice of perceiving emotions through movement and the ability to convey to a client on a physical and non-verbal level that they are heard and understood (Rova, 2017). It is the “attempt to experience somebody else’s inner life and implies knowing what the other one feels, having information about the other’s situation and acting accordingly” (Fischman, 2009, p. 33-34). The training addressed the knowledge gaps found within psychiatric nursing literature by focusing upon kinesthetic empathy which is a culmination of empathy and awareness of self and other as non-verbally represented in the body (Bowers, 2013; Hallet & Dickens, 2015; Lauge et al., 2016; Rova, 2017).

Participants of the in-service engaged in collaborative movement experientials involving physical embodiment tasks and opportunities for discussion, while simultaneously learning and practicing kinesthetic empathy. The author’s intention was to provide a clearer lens through which mental health staff could understand their impact on patients non-verbally, by putting kinesthetic empathy into perspective and practice. Through the training, mental health staff gained insight as to how their kinesthetically empathic knowledge can inform and better their approaches to de-escalation.
CHAPTER II: LITERATURE REVIEW

The lack of clarity surrounding what constitutes violence and aggression in inpatient psychiatry directly affects psychiatric nurses and other mental health staff’s ability to accurately detect violence (Franza, Del Buono, & Pellegrino, 2015; Madathil et al., 2014; Stevenson, Jack, O’Mara, and LeGris, 2015; Verhaege, et al., 2014). Violence, as defined by the World Health Organization, is:

The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or mass deprivation. (World Health Organization, 2017, para. 2)

Research has shown mental health staffs’ misperceptions of violence are in part due to staff’s inability to successfully identify violence, as well as their biases towards previously violent patients (Franza et al., 2015; Madathil et al., 2014). Notwithstanding, not all organizations and facilities define the same characteristics surrounding violence, thus further complicating the development of a standardized de-escalation training. Patient facilitated violence in adult acute inpatient psychiatry against both staff and other patients has been a consistent problem within the field of mental health (Hallet & Dickens, 2015; Renwick et al., 2016; Stevenson et al., 2015). In Renwick et al.’s (2016) qualitative study (N=522) it was reported that approximately 40% of patients will display aggression of some form during their stay.

Renwick et al. (2016) reported patient-staff interaction contributed to 39% of violent and aggressive incidents. In their interpretive descriptive study, Stevenson et al. (2015) reported that nurses are at the highest risk for violence amongst other healthcare providers within acute psychiatric inpatient care due to their increased exposure to patients as compared to other mental
An estimate of 89% of psychiatric nurses will witness or experience an actual or potential assault in their career (Fuller, 2016). Due to the need and limited practice of self-awareness, self-efficacy, non-verbal communication skills, and empathy, it is suggested future research studies and de-escalation trainings consider focusing directly on the lacking skills (Bjorkdahl, 2013; Cowman et al., 2017; Guay et al., 2016; Hallet & Dickens, 2015; Laker et al., 2010; Stevenson et al., 2016; Verhaege et al., 2016).

### 2.1 Contributors to Aggression and Violence in Adult Inpatient Psychiatry

There remains conflicting evidence regarding the predictability of violence based on multiple patient factors. Although research provides substantial evidence supporting certain factors such as involuntary commitment, gender, and age (Fisher, 2016; George, Jacob, & Kumar, 2015; Renwick et al., 2016) other studies report strong evidence suggesting contradictory findings (Gerace et al., 2016; Iozzino, 2015). The following have been shown to recur throughout the literature as potential factors influencing violence/aggression in adult psychiatric inpatients: involuntary commitment, medication refusal, history of violence, substance use, gender, age, and the presence of psychosis, hallucinations, or delusional thought processes (Fisher, 2016; George et al., 2015; Gerace et al., 2016; Iozzino, 2015; Renwick et al., 2016).

#### 2.1.1 Involuntary commitment and substance use.

Research has shown involuntary commitment, or detainment, can be a contributor to inpatient aggression (George, Jacob, and Kumar, 2015). In their quantitative study (N= 272), George et al. (2015) reported both involuntary commitment and length of stay as predictive factors for violence, stating these variables often coincide as patients who had previously committed acts of violence were issued to stay longer, thus fueling their frustration. Renwick et al. (2016) also found involuntary
detention to be a leading factor in aggression, as did Fisher (2016), reporting “involuntarily admitted patients also possess a higher risk of violence than voluntarily admitted ones” (p. 569). Although involuntary commitment has been found to be a primary factor in the predisposition for aggression in research studies, the relationship between involuntary commitment and violence is complex (Fisher, 2016; George, Jacob, & Kumar, 2015; Renwick et al., 2016). Most notably, evidence a patient is a danger to self or others has been a global reason for admitting one into psychiatric care, often involuntarily. The process of involuntary commitment can increase one’s hostility, agitation, and potential aggression should they be unwilling to participate in their care (Iozzino, 2015).

Some researchers believe both a history of violence and illicit substance use to be the highest determinants of violence in psychiatric patients (Renwick et al., 2016). Comparably, a lifetime history of violence was found to be a primary predictor in Iozzino’s (2015) systematic review and meta-analysis. Fisher (2016) also reported past violent offenses best predicted future violent behavior among patients, while Baby et al. (2016) suggested the influence of drugs or alcohol as a leading cause for violent and aggressive behavior in psychiatric patients. Past or current substance use may equally influence a patient’s probability of becoming aggressive (Baby et al., 2016). This is in part due to the strong relationship between substance use disorders and impulsive behavior (Fisher, 2016).

The influence of, or previous history of alcohol use disorder was found to be associated with a major predisposition for violence in Iozzino’s (2015) study. Substance use was also a strong predictor for violence in Robbe et al.’s (2016) quantitative study (N=185). Substance withdrawal can affect one’s ability to cope, have impulse control, and frustration tolerance (Robbe et al., 2016). George et al. (2015) discussed the effects of alcohol and benzodiazepines
on patients’ ability to control agitation. Withdrawal may also increase disorientation, and in some cases cause hallucinations, which may lead to increased aggressive behaviors (George et al., 2015). Additionally, a history of parental substance use disorder was reported to influence a patient’s tendency towards violence and aggression (Fisher, 2016).

2.1.2. Gender and psychosis. There remains conflicting evidence regarding the predictability of violence based on a patient’s gender. George et al. (2015) examined pattern correlates of aggression in inpatient psychiatry in their quantitative study (N=272). They reported although male gender was found to be a risk factor for potential aggression or violence in research, their study was not able to support this claim. George et al. (2015) found the presence of a history of aggression was found to be the strongest predictor. Renwick et al. (2016) found in their study that although being of male gender was a strong factor, unit structure, staff variables, and environmental factors were equally impactful. These findings remained consistent even though other variables including diagnosis, age, and ethnicity were also present. Nonetheless, the influence of staff behavior and therapeutic relationships were discussed as too complex to not be considered and weighed (George et al., 2015).

Recent studies have reported that patients who are younger in age tend to engage in aggressive and violent acts more often than older patients (Bader, Jacob, & Kumar, 2015; Renwick et al., 2016). This is in part because one’s ability to tolerate frustration and practice effective impulse control improves with age (Bader, Jacob, & Kumar, 2015; Renwick et al., 2016). Renwick et al. (2016) found age-related themes that coincided with younger patients’ aggression, such as younger patients striving for freedom and independence. In these instances, their personal needs and desires while in the hospital clashed with their current position: being in a psychiatric institution (Renwick et al., 2016). In their quantitative study of (N=185) psychiatric
inpatients Robbe et al. (2016) reported young age to be one of the primary statistics within the group of patients who perpetrated violence.

Although there is conflicting research regarding specific diagnoses’ predisposition for violence, there is extant research regarding the comorbidity of aggressive behavior and psychotic symptoms (Bader, Evans, and Welsh, 2014; Fisher, 2016). Fisher (2016) outlined psychotic symptoms as a leading psychiatric etiology accounting for violence in inpatient psychiatric settings. She reported the presence of psychotic symptoms could potentially increase the likelihood of a patient acting violently (Fisher, 2016). Bader, Evans, and Welsh (2014) revealed in their study patients who were most often identified as perpetrators of violence or aggression had a primary diagnosis of a psychotic disorder. Reportedly, 67.76% of patients had either schizophrenia or schizoaffective disorder (Bader, Evans, and Welsh, 2014). Iozzino (2015) however, revealed the proportion of patients with diagnoses of schizophrenia did not appear to be directly associated with an increased predisposition for violence. Although psychotic disorders may be considered general risk factors for violence, the presence of substance use increases the risk for violence regardless of the presence of a psychiatric diagnosis (Iozzino, 2015).

2.2 Contributors to and Effects of Limited Staff Threshold

Although there is research regarding the effects of burnout on psychiatric nurses’ emotional well-being, there remains limited research regarding the effects on patients who reside in the care of nurses who are emotionally drained and experience burnout. Verhaege et al. (2014) reported in their cross-sectional study (N=63) emotionally depleted staff displayed more intolerant and negative attitudes toward patient aggression. They found burnout, secondary traumatic distress, and compassion satisfaction (pleasure derived from providing care for others)

Within the field of psychiatric nursing, direct patient contact has been shown to increase stress levels, as well as the risk for burnout (Madathil et al., 2014). Fatigue, as well as apathy towards work have been shown as signs of burnout due to overwork and stress. Although research is sparse regarding contributors to burnout in psychiatric nursing in the United States, studies have shown several consistent causes relating to burnout, turnover, and job outcomes amongst psychiatric nurses across the globe (Madathil et al., 2014). Causes of burnout include: quality of nurse-physician relationship, leadership style of nurse supervisor/manager, communication amongst staff, level of work experience, and emotional exhaustion (Iozzino et al., 2015; Madathil et al., 2014; Van Bogaert et al., 2013).

For their survey, Madathil et al. (2014) examined the role of leadership styles and depressive symptoms in relation to burnout of psychiatric nurses (N=89). Psychological symptoms of burnout were found to overlap with depressive symptoms. Van Bogaert et al. (2013) also found the psychiatric nurse-physician relationship to be a crucial determinant of burnout in their cross-sectional study, suggesting the fragility of multidisciplinary staff relationships. Improving the atmosphere of the workplace as well as strengthening relationships between all staff members including psychiatric nurses, their supervisors, nurse managers, and physicians were suggested to decrease burnout and improve the system in which psychiatric nurses work (Madathil et al., 2014; Van Bogaert et al., 2013).
Van Bogaert et al. (2013) discussed the correlation between inter-staff relationships, depersonalization, and self-perceived quality of care. It was found nurses who reported more positive staff relationships and lower levels of depersonalization scored higher in self-perceived quality of care (Van Bogaert et al., 2013). Findings also reported lower levels of burnout when nurses reported higher levels of organizational support (Van Bogaert et al., 2013). Although higher levels of management and administration can play a role in inter-staff relationships, true job satisfaction and higher levels of self-reported quality of care were more positively correlated on the unit level (Van Bogaert et al., 2013). Experiencing aggressive incidents and verbal threats have also been found to increase symptoms of anxiety, post-traumatic stress disorder, and burnout (Verhaege et al., 2014).

Additionally, compassion fatigue, like burnout, can negatively impact psychiatric nurses’ quality of life, job satisfaction and ability to have empathy for their patients (Fisher, 2016; Franza et al., 2015; Iozzino et al., 2015; Wentzel et al., 2014). The psychological effects of compassion fatigue are like burnout and include sadness, guilt, depressive symptoms, lower frustration tolerance, fatigue, and other behavioral problems (Franza et al., 2015). The core difference between burnout and compassion fatigue is exposure to trauma and suffering. Any professional can experience burnout; however, mental health staff pose greater risk to experiencing compassion fatigue (Franza et al., 2015).

### 2.2.1 Staff’s lack of confidence and self-efficacy

Perceived self-efficacy directly influences a psychiatric nurse’s behavior and reaction towards an aggressive patient (Verhaege et al., 2014). In their cross-sectional study (N=219), Verhaege et al. (2014) studied psychiatric nurses’ perceived levels of self-efficacy, as well as their professional quality of life in relation to each other. It was found that the largest determining factors of one’s perceived self-efficacy
included the nurse’s gender, level of burnout, presence of secondary traumatic stress, and compassion satisfaction with their job (Verhaege et al., 2014). Those with lower levels of burnout and secondary traumatic stress, often had higher levels of compassion satisfaction, as well as higher levels of perceived self-efficacy (Verhaege et al., 2014). Male nurses were found to overall, have higher levels of perceived self-efficacy than their female counterparts (Verhaege et al., 2014).

2.2.2 Countertransference and somatic countertransference. Staff’s clinical behavior, as well as patient outcomes can be attributed to staff’s negative outlook on patients, which may be attributed to negative countertransference (Hallet & Dickens, 2015). This issue primarily relates to weak nurse-patient therapeutic alliance, stigmatized attitudes toward those with mental illness, or misconceptions about the patient’s need/intention (Jorgensen Haugvalstad, & Lossius Husum, 2016). Dosamantes-Beaudry (2007) described countertransference (CT) as the emotional reactions a therapist may have toward their client during treatment (as cited in Drapeau, 2014). Although there is limited literature regarding CT’s effects on patients during the nurse-patient relationship, it is a significant factor in nurse’s perceptions of patients (Hallett & Dickens, 2015). In their qualitative study (N=8), Monetti, Ezomo, and Nwanonyiri (2016) expressed the need for more research on nurses’ understanding of CT. Nurses may benefit from a better understanding of how CT acts as a therapeutic or non-therapeutic factor within their care of patients (Monetti et al., 2016).

Somatic countertransference (SCT) can be used as a clinical tool to gain better somatic understanding of a client’s/patient’s inner emotional state and experience unconscious messages (Monetti et al., 2016). Somatic countertransference is defined as physical reactions within the body that occur during an experience of countertransference (Pallaro, 2007). It can also be
described as “The therapist’s awareness of their own body, of sensations, images, impulses, feelings and fantasies that offer a link to the client’s process and the intersubjective field” (McGarry & Russo, 2011, p. 181). Monetti et al. (2016) suggested future research on SCT to examine somatic responses within relationships; using both CT and SCT as clinical tools, to gain more authentic body knowledge, while attuning nonverbally (Monetti et al., 2016). Reportedly, Monetti et al.’s (2016) findings aligned with this viewpoint stating, “the client’s and the therapist’s wisdom is revealed through sensory awareness” (p. 35).

2.2.3 Misconceptions of patient violence and aggression. The misidentification of violence and thus improper proceeding actions are in part due to the lack of clarity surrounding the definition of violence. Further complicating this, psychiatric nurses across the globe view aggression in different ways based on a variety of beliefs and circumstances (Verhaege et al., 2014). Stevenson et al. (2015) found psychiatric nurses in their study had difficulty defining specific types of violence they had experienced. Nurses described 25 incidents of physical violence directed toward them by patients, however, none of the nurses had identical definitions of violence. Relating to this, there is no clear definition of de-escalation within the field of psychiatry, causing further confusion and lack of clarity in practice (Hallett & Dickens, 2015).

Staff’s ability to accurately perceive instances of aggression can be altered if the staff member previously witnessed or experienced violence themselves (Stevenson et al., 2015). Staff in Stevenson et al.’s (2015) study who experienced violence reported reacting more quickly to perceived violence. Participants stated they were more likely to implement the use of medications to control a patient as well as other coercive measures (Stevenson et al., 2015). Additionally, they reported being more cautious around patients, while also depersonalizing violent situations (Stevenson et al., 2015).
Gerace et al. (2016) reported that conflict could be either avoided or amplified based on the nurse’s level of self-awareness, as well as their values, biases, and reactions to the patients. They reported although they could not always be fully aware of their transference and countertransference related reactions, remaining non-judgmental was crucial to diffusing conflicts (Gerace et al., 2016). Baby et al.’s (2016) study (N=141) examined nurse manager’s perceptions of patient aggression and violence prevention strategies. Participants reported experience and expertise were helpful skills for identifying early warning signs of aggression. These skills were needed to successfully prevent episodes of violence (Baby et al., 2016).

Iozzino et al. (2015) reported temporary staff (who replaced long-term staff due to high turnover) displayed lower standards of care. Additionally, Hsiao et al. (2015) found psychiatric nurses and other mental health staff who had less experience or held junior positions expressed less favorable attitudes towards psychiatric patients. Verhaege et al. (2014) found similar results, reporting more experienced nurses were less likely to blame patients for their behavior and less frequently held them responsible. They embraced a perspective in which it is more accepted that patients become violent when they feel vulnerable, helpless or afraid (Verhaege et al., 2014).

The role of stigma towards mental illness and substance use is a large factor in psychiatric nurses’ attitudes and reactions to violence. Hsiao et al. (2015) reported the need for further education addressing prejudice and discrimination against individuals with mental illness. Psychiatric nursing staff, particularly those in Asian cultures and countries, could benefit from further training regarding their attitudes and how their cultural background may influence their practice and treatment of patients (Hsiao et al., 2015). Additionally, discriminatory attitudes towards patients were dependent on the specificities of the patient’s mental illness. For example,
patients who had comorbid substance use problems faced more discrimination versus those with diagnoses of schizophrenia or major depression (Hsiao et al., 2015).

Furthermore, Hsiao et al.’s (2015) findings were like work previously done in Western cultures, regarding stigmatizing attitudes towards those with a substance use history (Fisher, 2016; Renwick et al., 2016; Robbe, et al., 2016). Factors regarding culture need to be further explored to better explain specific causes for misconceptions of violence (Gerace et al., 2016). Hawamdeh and Fakhry’s (2014) interpretive phenomenological study (N =17) acknowledged the importance of looking at cultural influence’s role on mental health professionals’ attitudes regarding mental illness and stigma. They emphasized attitudes influenced by culture and practiced by mental health professionals as playing a central role in how the public views those with mental illness (Hawamdeh & Fakhry, 2014).

Staff’s understanding of cultural influences on aggressive behavior can lead to more empathic attitudes and outcomes (Verhaege et al., 2014). Relatedly, research exploring how psychiatric nurses can actively empathize with patients during conflict and potentially violent situations is needed (Hawamdeh & Fakhry 2014; Hsiao et al., 2015; Stevenson et al., 2016; Verhaege et al., 2014). Research that has been conducted has only explored empathy in narrow terms, with differing and inconsistent definitions (Gerace et al., 2016). Although training has been suggested in many research studies regarding the importance of identifying early warning signs of aggression and appropriate reactive and preventative measures, psychiatric nurses must first gain a better, clearer understanding of the meaning of aggression. Training alone is not fully substantial (Baby et al., 2016; Hallett, Huber, & Dickens, 2014; Verhaege et al., 2014).

2.2.4 Psychiatric nurses’ attitudes towards aggression. The phenomenon of underreported violent incidents against staff by patients spans worldwide, particularly regarding
verbal aggression (Fuller, 2016; Stevenson et al., 2015; Verhaege et al., 2014). This in part can be directly attributed to psychiatric nurse’s views on violence as being part of the job (Fuller, 2016; Stevenson et al., 2015; Verhaege et al., 2014). In their descriptive interpretive study (N=12) Stevenson et al. (2015) found psychiatric nurses often refrained from reporting instances of verbal violence, even though they were required to report all instances of violence or aggression. Verhaege et al. (2014) described three perspectives regarding attitudes toward aggression in their cross-sectional study (N=219). The first type perceived aggression as dysfunctional, violent in nature, destructive, or harmful. The second perspective perceived aggression as functional or communicative, attempting to address a need. The third perspective interpreted aggression as protective or an acceptable reaction to anger. Although psychiatric nurses have been considered more tolerant of aggression than other mental health staff, only those with more open-minded attitudes towards the possible causation of aggression have better clinical skills when responding to aggression such as compassion and frustration tolerance (Verhaege et al., 2014; Stevenson et al., 2015).

2.2.5 Power struggles and interpersonal dynamics. Psychiatric nurses provide the most direct patient-contact care within inpatient mental health settings (McAllister, 2017). Nonetheless, defining the role of the psychiatric nurse has remained ambiguous (McAllister, 2017). Due to the amount of direct contact between patient and psychiatric nurse, power dynamics play a decisive role in the possibility of aggression. Registered psychiatric nurses view themselves as being accountable for “controlling patients and the environment” (Stevenson et al., 2015, p. 8). Nurses also reported their engagement in power struggles, as well as their inability to have control over patients directly contributed to patient violence (Stevenson et al.,
2015). Often, nurses had difficulty giving up their sense of power and control, due to fear of arising violence (Stevenson et al., 2015).

Gerace et al. (2016) reported psychiatric nurses identified conflict as a way for patients to exercise power. The system in which psychiatric nurses work also plays a role in the power dynamic between patients and staff (Gerace et al., 2016). The verbal and nonverbal interchange and relationship between nurses and psychiatric inpatients is essential to the patients’ care, well-being and emotional safety while in the hospital. Nonetheless, Radcliffe and Smith (2007) reported psychiatric patients were found to be socially disengaged for most of their day in inpatient settings (as cited in McAllister, 2017). Although not every encounter with a nurse involved participating in therapeutic activities, a majority of their work contributed to the emotionally safe containment, and therapeutic well-being of the patients (McCallister, 2017).

Psychiatric nurses provide direct psychosocial support to patients during their most mentally vulnerable states (McAlister, 2017). Patients may gain a sense of safety and social satisfaction through their therapeutic relationship with a psychiatric nurse (McAllister, 2017). Nonetheless the psychiatric system within hospitals does not often support such interactions or engagements (McAllister, 2017). This, in part, can be directly related to lower staffing levels, restrictive safety measures, and other administrative demands (McCallister, 2017). The core of the problem, in McAllister’s (2017) study was found to be the “discrepancy between care ideals and administrative efficiency” (p. 493).

2.2.6 Effects of burnout on empathy. The capacity to have empathy and develop and engage in therapeutic relationships with patients is a core competency in psychiatric nursing (Hawamdeh & Fakhry, 2014). Empathy, considered the foundation of therapeutic relationships, can be defined as the “capacity to understand and respond to the unique affective experiences of
Hawamdeh and Fakhry (2014) found that psychiatric patients in their interpretive phenomenological study expected empathy from their nurses. In their cross-sectional study Hsiao, Lu and Tsai (2015) also described empathy as being core to the therapeutic alliance. Hsiao et al. (2015) found that nurses who expressed greater empathy towards patients had more positive attitudes towards people with mental illness. Gerace et al. (2016) identified empathy as being a vital component to nurse-patient relationships, stating both nurses and patients reported empathy as a vital tool to achieve positive outcomes and relationships. It was found that empathy increased patient satisfaction when resolving conflict situations (Gerace et al., 2016).

Through all of this, unfortunately, due to the high demand within the field, nurses are more often not able or willing to provide the level of comfort and empathy patients often need (Hawamdeh & Fakhry, 2014). In Gerace et al.’s (2016) qualitative study, psychiatric nurses (N=13) reported that due to the demanding administrative requirements, patient contact, and therefore empathic interactions, were limited. Stevenson et al. (2015) also reported in their interpretive study, (N=12) psychiatric nurses reported their empathy towards patients to have been negatively affected after having witnessed or experienced violence. Interactions with patients became less client-focused, a self-preserving coping mechanism for the nurses when interacting with potentially aggressive patients (Stevenson et al. 2015). Due to the emotional impact of a violent incident, nurses often questioned their safety, felt vulnerable and, thus, made their work more task oriented (Stevenson et al., 2015). When nurses were unable to practice empathy in their nurse-patient interactions, patients felt depersonalized, and as though the nurses were unable to differentiate between the patient and their mental illness (Gerace et al., 2016).
The experience of patient aggression was reported to decrease empathy and lower staff’s levels of compassion satisfaction in Verhaege et al.’s (2014) study. Verhaege et al. (2014) reported, “emotionally depleted staff might find it difficult to have empathy with aggressive patient behavior” (p. 20). Baby et al. (2016) found the lack of empathy and compassion from staff was a direct trigger for patient violence. Gerace et al. (2016) too found nurse-patient conflict to be directly related to the nurse’s lack of empathy, reporting consistent expression of empathy to be key to successfully handling future nurse-patient conflict.

Recent research demonstrated mental health staff’s specific emotional changes during burnout, including difficulty with empathy, therapeutic alliance and engagement with patients (Baby et al., 2016; Franzia et al., 2015, Gerace et al., 2016; Verghaege et al., 2016). In their article exploring compassion fatigue’s emotional effects on the trauma nurse, Wentzel and Brysiewicz (2014) found results like Franzia et al. (2015). Psychiatric nurses who experienced compassion fatigue displayed issues relating to annoyance, lower levels of tolerance, depressive symptoms, disconnection, and lack of compassion and empathy for their patients (Wentzel & Brysiewicz, 2014). This psychological morbidity directly affected the nurses’ capacity to provide quality care to their patients (Wentzel & Brysiewicz, 2014). Wentzel and Brysiewicz (2014) suggested education surrounding the insidious effects of burnout and compassion fatigue be addressed early in a nurse’s career. Due to the frequent dismissal of symptoms and warning signs, nursing programs should prioritize early education on the subject (Wentzel & Brysiewicz, 2014). They suggested specifically promoting not only self-care practices such as yoga, meditation, and mindfulness, but also coping skills and empathy enhancement that can be practiced in the workplace (Wentzel & Brysiewicz, 2014).
Research regarding the psychological and emotional outcomes of psychiatric nurses who have witnessed, or experienced violence remains limited. However, the existing research reports psychiatric nurses who have been exposed to or have personally experienced violence of any form report negative effects to their psychological well-being, altering their perceptions of their own safety (Fuller, 2016; Stevenson et al., 2015). Participants in Stevenson et al.’s (2015) study reported exposure to either physical or verbal violence from patients directly affected their personal and professional lives.

The emotional impact of the violent incident affected their professional role including feelings of decreased job satisfaction, an increased desire to quit their job, a lower health-related quality of life, and in some cases, post-traumatic stress disorder (Fisher, 2016; Stevenson et al., 2015). Although nurses in Fuller’s (2016) study showed various ways in which they dealt with the psychological aftermath of a violent event, all reported the experience was an expected part of their job. Nonetheless, the psychological impact of the event had significant impacts on the nurses’ work to home life experience (Fuller, 2016).

2.3 Appraisal of Literature on De-escalation Trainings

Verbal de-escalation techniques are the primary intervention used to manage patients before they become physically violent (Hallett & Dickens, 2015). Currently, verbal de-escalation is the most ethically appropriate intervention, while restraint, seclusion, or the implementation of intramuscular medications are used as last resorts (Bowers, 2014; Hallett & Dickens; Lauge et al., 2016). Regrettably, clinical errors, staff misjudgment and misconceptions, and patient and staff injuries continue to result due to the lack of clarity surrounding appropriate de-escalation trainings and working definitions of violence.
Limited research exists surrounding what constitutes helpful and successful de-escalation (Bowers, 2014; Hallett, & Dickens, 2015; Lauge et al., 2016). Hallet and Dickens (2015) discussed in their cross-sectional mixed-methods questionnaire (N=72) the varying definitions of de-escalation across settings and the tumultuous effects of a lacking practice guideline. The lack of coherence regarding a clear definition “impedes the provision of best practice guidelines and is a potential barrier to effective research and education (Hallet, & Dickens, 2015, p. 325). Dilemmas faced by staff regarding proper implementation of de-escalation include not understanding when to intervene when a patient is escalating or becoming violent (Lauge et al., 2016). Other problems include staff’s negative emotions regarding previously offending patients (Lauge et al, 2016).

Within the literature across the globe, the most common themes regarding what makes mental health staff good at de-escalation included: self-awareness, empathy, self-control of emotions, strong therapeutic alliance or relationship with patients, continuous training/education, and self-efficacy/confidence (Bowers, 2014; Lauge et al., 2016; Renwick et al., 2016). The ability to see and detect early warning signs of aggression, and self-efficacy were also noted as contributors to successful de-escalation (Lauge et al., 2016; Renwick et al., 2016). Lauge et al. (2016) reported in their ethnographic multiple case study (n=41) that the most successful instances of de-escalation included the following elements in the following sequence: creation of a safe space by staff, establishment of mutual relations, empathic acts, and finally, foreseeable social interactions to promote human integrity. The emphasis in all the cases fell upon empathic interactions: the staff’s ability to empathize through imagining taking the place of the patient (Lauge et al., 2016).
Stevenson (1991) described four similar critical aspects to consider during de-escalation: knowing yourself, knowing the patient, knowing the situation, and knowing how to communicate (as cited in Lauge et al., 2016). Price and Baker (2012) also described similar suggestions, offering the importance of behaving in an empathic and respectful manner during de-escalation. Price and Baker (2012) emphasized staff’s responsibility to have emotional and physical control of themselves; including of self-awareness and both verbal and non-verbal communication skills. Similarly, Hallet and Dickens (2015) reported comparable suggestions, offering the importance of emotional regulation, empathy, respect, and other interpersonal skills on behalf of the de-escalator. The importance of providing self-aware and empathic attention to patients was suggested in additional studies (Renwick et al., 2016; Stevenson et al., 2016; Verhaege et al., 2016).

Bowers (2014) suggested mental health staff not only gain control of their own emotions and personal reactions during patient escalation but offer an empathic and respectful attitude. Lauge et al. (2016) suggested more research regarding how mental health staff learn de-escalation techniques, to develop more effective trainings. Hallett and Dickens (2015) likewise, suggested clearer de-escalation interventions and more emphasis on how mental health staff most effectively learn their de-escalation trainings. De-escalation requires the learning and practice of interpersonal skills, however not all techniques are inherently instinctual: clinical, ethical and evidence-based skills often requiring teaching (Lavelle et al., 2016; Richmond et al., 2012).

Studies showed de-escalation trainings should also adopt a more client-centered approach, increasing the chance of understanding why the patient is escalating through strengthened patient-staff relationships (Guay et al., 2016; Lantta et al., 2016; Lauge et al., 2016; Lee et al., 2012; Magnavita, 2011). The mental health field should continue to promote verbal de-
escalation techniques as opposed to coercive measures such as seclusion and restraint (Hallet & Dickens, 2015; Richmond et al., 2012; Stewart et al., 2010). Additionally, future de-escalation trainings should implement a physical intervention/role-playing or training aspect (Stewart et al., 2010).

Research studies have been conducted attempting to address the present issues and limitations within de-escalation trainings. These gaps include, lack of empathy, self-awareness skills including non-verbal communication, the lack of a consistent working definition of de-escalation, and the overall lack of effective de-escalation and violence prevention trainings (Cowman et al., 2017; Hallett & Dickens, 2015; Kuivalainen et al., 2017; Lantta et al., 2016; Lee et al., 2012; Magnavita, 2011). There remains limited research regarding both staff and patient views on de-escalation practices, though research has reported limitations and offered suggestions for improvement (Lauge et al., 2016; Bowers, 2014).

Through all of this, the emphasis on improving self-awareness, self-efficacy, empathy, and ability to detect physical warning signs and precursors to violence have been identified as requiring further attention (Hallett & Dickens, 2015). Mental health staff, and psychiatric nurses can benefit from continuous training in relation to all these aspects, in turn gaining and maintaining stronger rapport and relationships with their patients. Continuing education and supplemental trainings may bolster staffs’ professional capabilities, emotional well-being, and sense of self (Hallet & Dickens, 2015; Lauge et al., 2016; Lavelle et al., 2016). De-escalation and violence prevention alone are reportedly not sustainable or substantial (Baby et al., 2016; Hallett et al., 2014; Verhaege et al., 2014).

2.4 Dance/Movement Therapy
Dance/Movement Therapy (DMT) as defined by the American Dance Therapy Association (2016) is “the psychotherapeutic use of movement to promote emotional, social, cognitive, and physical integration of the individual, for the purpose of improving health and well-being” (para 1). Dance/movement therapy is grounded in the idea that body and mind are connected, and engage in a reciprocal relationship, recognizing the two as part of an integrated system (Winters, 2008). Dance/movement therapy actively engages both the brain and the body through interventions that impact both physical and psychological functioning, while encapsulating the significant role of the body in the perceptual process (Berrol, 2006; Homann, 2010).

Although research has been conducted regarding DMT and inpatient psychiatry, and DMT and violence prevention, little research has combined DMT with violence prevention in the inpatient psychiatric setting. Despite this, numerous elements, tools, and practices within the field of DMT have been and can be utilized to aid in the de-escalation process and violence prevention (Koch et al., 2015). Dance/movement therapists utilize embodied empathy techniques such as mirroring, empathic attunement, and kinesthetic empathy to build therapeutic relationships, and aid patients with mental illness. Dance/movement therapy tools from the field can be beneficial to those working in acute psychiatric settings when facing potential violence (Koch et al., 2015).

2.4.1 Kinesthetic empathy and embodied empathy. Berrol (2006) described empathy as extending beyond understanding one’s emotional state and embodying the experience of that state. Kinesthetic empathy is defined as the “attempt to experience somebody else’s inner life and implies knowing what the other one feels, having information about the other’s situation and acting accordingly” (Fischman, 2009, p. 33-34). Gallese (2008) examined embodied empathy and the
human brain’s capacity for sharing emotional states through mirror neurons. He stated that neural mechanisms involved during mirroring related to empathic processing and embodied interaction, thus suggesting empathy can be experienced as both a deliberate action or state. Gallese (2008) also described the empathic body state between observer and observed as enabling direct understanding of the other’s emotional state.

Fraenkel (1983) conducted a pilot study investigating the relationship between empathy and movement through dance/movement therapist’s use of synchrony, echoing, and empathy. It was reported there was a link between empathy and the therapeutic movement relationship (Fraenkel, 1983). Young (2017) found similar results in her phenomenological study (N=8) and reported empathic connection occurred through movement and was necessary in building therapeutic relationships with clients. Overall, dance/movement therapists can provide useful information and teach vital skills to other mental health staff to help bolster their therapeutic relationships with clients and build rapport (Behrends, 2012).

2.4.2 Mirror neurons. Research has shed light on the relationship between the neurological underpinnings of mirror neurons and embodiment (Winters, 2008). Mirror neurons, found in the extrastriate body area within the lateral occipital cortex of the brain, become active when we view body parts of others in motion (Winters, 2008). Mirror neurons enable us to interpret others’ movements and actions without having to see their entire body, opening a gateway into understanding the intentions of others (Alford, 2016; Winters, 2008). The discovery of mirror neurons has provided concrete neurological explanations regarding how movement perception is linked to non-verbal communication (Alford, 2016).

The field of DMT has benefitted from scientific discoveries, providing more information regarding how kinesthetic empathy and empathy are processed (Winters, 2008). Such scientific
support has substantiated the practice of mirroring in DMT, as its purpose is to attune with the client and engage in an empathic connection (Winters, 2008). Physically and empathically attuning to clients can create a stronger therapeutic relationship, as the attunement activates the client’s mirror neurons during the process (Winters, 2008).

The discovery of mirror neurons and their functions has also fortified research and discoveries regarding where we process and how we practice empathy (Alford, 2016). Mirror neurons enable us to mutually feel what other’s feel (Alford, 2016). Our capacity for empathy can be attributed to the mirror neuron system (Homann, 2010). Mirror neurons’ ties to empathy and physical embodiment through movement aid in the process of developing and practicing kinesthetic empathy (Homann, 2010). Berrol (2006) stated that empathy must be taught and practiced since emotions may often hinder the process of empathy. Furthermore, through understanding the connection between body and mind, mirror neurons, empathy, non-verbal communication, and kinesthetic empathy, clinicians can provide safe containment for their patients through relationships based on empathy (Homann, 2010).

2.4.3 Mirroring. Embodiment of another’s movement can evoke non-verbal emotional understanding through muscle feedback to the brain (McGarry & Russo, 2011). Mirroring can be described as the embodiment or imitation of a client’s movement by the therapist to enhance emotional understanding and empathy (McGarry & Russo, 2011). Although there is limited research on the direct effects of mirroring on emotional understanding, some research suggests the practice of mirroring can strengthen empathy between therapist and client (McGarry & Russo, 2011). Mirroring does not necessitate the exact imitation of another’s movement but can rely on capturing the essence of the movement, including tone of voice, movement, posture, or a
combination of these components. Mirroring is often referred to as empathic attunement or empathic reflection due to their similar psychological processes (Alford, 2016).

2.4.4 Attunement and clashing. Attunement is often considered a precursor to empathy and begins with the mother and infant relationship, preverbally (Berrol, 2006). Attunement posits itself on being a framework for mutual meaning-making, while establishing our intersubjective states, unconscious and conscious decisions, and social cognition, while allowing us to build relationships (Berrol, 2016). Through attunement, individuals can experience another’s ability to see, and be seen and understood, thus allowing for mirroring to take place. Attunement can also be described as the responsive duplication of changes in muscle tension, which is based on mutual empathy (Kestenberg et al., 1999).

In human development, DMT, and psychological theories and practice, there resides numerous forms of attunement including rhythmic, somatic, empathic, and affect attunement (Homann, 2017; Kestenberg et al., 1999). Empathy is based on complete attunement between two individuals, whether that is mother and infant, or therapist and client (Kestenberg et al., 1999). Kestenberg et al. (1999) stated attuning can also be regarded as kinesthetic empathy. Sharing similar rhythms or attuning to mutual rhythms builds the foundation for empathy and non-verbal communication (Kestenberg et al., 1999). Both infants and adults can psychologically benefit from attuning to one another, as they can feel mutually joined and better understood. When interacting with one another through movement, humans can engage in social contact and feel both felt and seen (Kestenberg et al., 1999). Somatic attunement on behalf of the dance/movement therapist through embodied movement activates the mirror neuron system, allowing for empathy to form and grow (Homann, 2010). Dance/movement therapists use all
modes and forms of attunement to respond to their clients’ physical, psychological and psychosocial needs (Kestenberg et al., 1999).

Clashing, which can oppose, or compliment attunement refers to instances when two individuals’ movements are mismatched (Kestenberg et al., 1999). During clashing, the act may create feelings of conflict, or differentiation between individuals (Kestenberg et al., 1999). Although complete attunement is not always possible or appropriate, extreme levels of clashing can be detrimental to any human relationship, often causing dysfunction or miscommunication (Kestenberg et al., 1999). Within human relationships, the balance between attuning and clashing is essential for healthy functioning (Kestenberg et al., 1999). Lundy and McGuffin (2005) discussed both attuning and clashing behaviors in their mixed methods study with children in a psychiatric facility. Both attuning and clashing were reported as essential to promoting attunement between child and staff member, promoting effective communication (Lundy & McGuffin, 2005).

2.4.5 Therapeutic movement relationship. To date, the field of DMT has lacked a clear working definition for the therapeutic movement relationship, which can also be referred to synonymously as the therapeutic alliance (Young, 2017). Research in both DMT and psychiatry has proven the need for strong therapeutic relationships, therapeutic alliances, and the need for more self-awareness and self-control both bodily and verbally (Young, 2017). Chaiklin and Schmais (1993) noted the development of the therapeutic movement relationship with regards to DMT which was initially established by Marian Chace. Chace observed and mirrored clients’ movements as a way of kinesthetically attuning to them, offering an empathic movement response (as cited in Young, 2017).
Empathy is believed to be foundational to the therapeutic relationship across many professions including DMT and psychiatric nursing, as it is pivotal to improving therapeutic rapport and effectiveness of the relationship (Young, 2017). Young’s (2017) phenomenological study examining the therapeutic movement relationship in DMT examined (N=8) board-certified dance/movement therapists. Several themes were discussed in her findings, including the importance of a shared presence and connection through each other’s movement (Young, 2017). Similarly, the therapeutic relationship with patients is indisputably essential to that of the psychiatric nurse (Young, 2017). As psychotherapy is rooted in human encounters and engaging in relationships, much can be learned from dance/movement therapist’s perspectives on the therapeutic relationship (Young, 2017).

2.4.6 Dance/movement therapy trainings. Dance/movement therapy skills can be utilized to aid in the prevention and management of aggression in various contexts. Lundy and McGuffin (2005) explored the use of DMT techniques in a mixed methods study (N=20) to improve the effectiveness of therapeutic holding in a psychiatric facility for children. Therapeutic holding is a violence management technique in which one or more adult staff physically hold children to contain their violent or aggressive behaviors (Lundy & McGuffin, 2005). The method was introduced to provide a more ethical and humane alternative to seclusion/restraint (Lundy & McGuffin, 2005). Although therapeutic holding has been argued to be untherapeutic, staff continue to lack alternative methods for violence prevention and management (Lundy & McGuffin, 2005).

Lundy and McGuffin (2005) implemented a staff training, utilizing DMT tools and techniques to aid in the process of, or decrease the need for, therapeutic holds. Dance/movement therapy skills utilized in the training included kinesthetic empathy, mirroring, and Kestenberg’s
concepts of attunement and clashing (Kestenberg, 1999). Lundy and McGuffin (2005) reported a significant decrease in the number of holds implemented by staff, as well as a clearer focus on staff’s ability to experience perspective taking from the child patient’s point of view. Lundy and McGuffin (2005) reported a 125% increase in confidence in their techniques, suggesting the DMT techniques were useful and accessible. Additionally, the study found that the DMT techniques reduced stress and injuries amongst the adult staff and increased awareness and sensitivity surrounding staff’s and children’s’ emotions.

Dance/movement therapy was shown to offer complimentary tools to psychiatric nurses in Biondo’s (2017) program evaluation of a de-escalation program using DMT techniques (N=73). Dance/movement therapy tools discussed and included in the training included observation skills, kinesthetic empathy, mirroring, and attunement (Biondo, 2017). Movement observation skills within DMT were identified as an essential skill in supporting the early identification of warning signs for violence (Biondo, 2017). The observation of changes in muscle tension, as well as understanding rhythmic changes and patterns were discussed as a crucial element for movement observation (Biondo, 2017). Kinesthetic empathy was practiced through a mirroring task, which explored the empathic connection between individuals through movement (Biondo, 2017). Nurses showed an increase of knowledge relating to non-verbal communication and more empathic approaches to de-escalation (Biondo, 2017). Finally, the training supported DMT techniques by positively supplementing pre-existing violence prevention and de-escalation trainings already in place within the nurses’ inpatient psychiatric facilities (Biondo, 2017).

2.4.7 Critique of the literature. A critique and appraisal of relevant de-escalation literature was conducted, concluding the implementation and practice of kinesthetic empathy
could positively affect psychiatric nurses’ de-escalation skills and practice. Within the appraised literature which included research studies, participants who experienced de-escalation trainings that focused on aspects of empathy (Hallet & Dickens, 2015; Price & Baker, 2012), non-verbal communication skills (Bjorkdahl et al., 2013; Hallet & Dickens, 2015; Lauge et al., 2016; Nau et al., 2010; Stewart et al., 2010), and awareness of self and others (Lantta et al., 2016; Lee, Gray, & Gourney, 2012; Magnavita, 2011; Price & Baker, 2012) were more effective in their de-escalation skills. Additionally, understanding the impact of compassion fatigue/burnout (Guay et al., 2016; Lantta et al., 2016; Verhaegge et al., 2016), detecting early warning signs of aggression (Bjorkdahl et al., 2013; Cowman et al., 2017; Lantta et al., 2016; Lauge et al., 2016), and fostering therapeutic relationships with patients built on trust (Bjorkdahl et al., 2013; Lantta et al., 2016; Lauge et al., 2016; Lee, Gray, & Gourney, 2012; Magnavita, 2011; Price & Baker, 2012; Stewart et al., 2010) were suggested skills to learn and practice to improve de-escalation.

The literature suggested a strong emphasis on practicing empathy as well as non-verbal communication and body-based knowledge and skills during de-escalation, while also indicating a strong need for continuing education and in-service trainings. This need for further developed skills suggests the teaching and practice of kinesthetic empathy may address the verbal and non-verbal communication aspects of de-escalation, helping to support mental health staff. The evidence informed protocol (found in Chapter 3 and Appendix A) was developed based on the information and suggestions found within the literature; the detailed literature appraisal can be found in Appendix B.

2.5 Kinesthetic Empathy in Practice

As the demand for more empathy and self-awareness on behalf of psychiatric nurses
continues to rise, kinesthetic empathy may prove to be a successful intervention for practice (Hallet & Dickens, 2015; Stevenson et al., 2016; Young, 2017). Both empathy and kinesthetic empathy are interactive processes which allow individuals to embody each other’s experiences (Young, 2017). Dance/movement therapy particularly uses the process of kinesthetic empathy as movement is generated through a responsive dialogue between therapist and client (Young, 2017). Dance/movement therapists develop kinesthetic empathy through attuning with the client, allowing their bodies to physically resonate with and move in response to one another (Young, 2017). Both empathy and kinesthetic empathy develop from attunement, through affective changes, as well as reciprocal movement behavior, thus resulting in awareness of each other (Young, 2017).

Although there are limited theoretical articles and research studies regarding kinesthetic empathy, there have been suggestions for continued practice and research to bolster its efficacy (Federman, 2011; Fischman, 2009; Reynolds & Reason, 2012). Described by Meekums (2012), kinesthetic empathy is an essential element for positive therapeutic change (as cited in Reynolds & Reason, 2012). Kinesthetic empathy was linked to the perception of movement metaphors, providing a strong therapeutic relationship between therapist and client (Lundy & McGuffin, 2005; Reynolds & Reason, 2012). Fischman (2009) stated that empathy and kinesthetic empathy allow the dance/movement therapist to become aware of their own inner sensations, while promoting a therapeutic relationship with a client.

Kinesthetic empathy provides psychological and physical knowledge data to those in practice, allowing for ways of communicating non-verbally (Federman, 2011; Fischman, 2009). It can be practiced through mirroring, attunement, or shifts in body posture or tone of voice (Fischman, 2009). Therapeutic movement interactions involving kinesthetic empathy allow the
therapist or other mental health professional to experience and feel what their client is feeling, while allowing for intimacy, safety and closeness in human relationships and interactions (Federman, 2011; Fischman, 2009).

Federman (2011) stated the term kinesthetic empathy can be interchangeably referred to as body empathy and body countertransference. Federman’s (2011) quasi-experimental study (N=62) found that kinesthetic empathy can be practiced in psychotherapy and may benefit those undergoing psychotherapeutic training. This is due to the practice of empathy depending on the emotional understanding between client and therapist. The results determined empathy is a skill that can be learned practiced through training and education (Federman, 2011).

Kinesthetic empathy, as opposed to empathy was demonstrated as effective due to the importance of conveying expressive and genuine body language as communication between client and therapist (Federman, 2011). Federman’s (2011) study suggested empathy as a skill can be learned and developed through training and constant practice. Furthermore, the process of practicing empathy through movement during the therapeutic process may be a useful clinical tool when working with clients (Federman, 2011). Behrends, Muller, and Dziobek (2012) discussed the applicability of kinesthetic empathy practice within the field of mental health. Behrends et al. (2012) suggested a clear and transferable working definition for kinesthetic empathy to promote transparency, credibility, and best practice. Furthermore, kinesthetic empathy may help bolster psychiatric nurses’ de-escalation skills, in providing a direct way to empathize and be aware of a patient non-verbally.

2.6 Conclusion

Definitively, research has shown the negative physical and psychological effects burnout and compassion fatigue have on staff’s ability to detect early warning signs of aggression,
perform effective de-escalation, and practice empathy (Gerace et al., 2016; Hawamdeh & Fakhry, 2014; McAllister, 2017; Verhaegge et al., 2014; Stevenson et al., 2015). Additionally, staff’s lack of training, education, and practice of effective, ethical, and best-practice-based de-escalation techniques highlights the need for improved trainings and continuing education. Through the identification of needed skills and suggestions from the literature, it can be implied that a body-based supplemental in-service training focusing on the identified skills (self-awareness, empathy, non-verbal communication, etc.) would benefit psychiatric nurses and mental health staff.
CHAPTER III: EVIDENCE-INFORMED PROTOCOL

3.1 Supplemental De-Escalation Training on Kinesthetic Empathy Practice for Psychiatric Nurses and Other Mental Health Staff

The specific purpose of this protocol is to provide a supplemental dance/movement therapy-based de-escalation training, which will focus on the teaching and practice of kinesthetic empathy for psychiatric nurses and mental health staff in an adult acute inpatient psychiatric facility. The training will incorporate dance/movement therapy-based techniques and experientials aimed to increase the knowledge and practice of kinesthetic empathy. Through tasks that practice embodiment, observation skills, and self-awareness, staff will improve knowledge and skills surrounding kinesthetic empathy to bolster and support their de-escalation skills.

In 2007 the American Psychiatric Nurses Association (APNA) proposed a request to evaluate the ethical implications of seclusion and restraint use (Bertram, Kichefski, Paradis & Platon, 2012). It was reported that nursing programs, psychiatric nursing and mental health organizations, and the American Psychiatric Association (APA) form an alliance to evaluate student and mental health professionals’ implementation of seclusion and restraints. Advocacy towards policy change was encouraged to reduce the instances of seclusion and restraint. Additionally, suggestions for the effectuation of further research studies, the continuation of an APNA task force to promote papers and standards on seclusion and restraint, and advocacy within mental health care settings promoting the reduction of seclusion and restraint culture (Bertram, Kichefski, Paradis & Platon, 2012).

Research and literature within the field of psychiatric nursing and mental health has directly addressed numerous issues surrounding the implementation of seclusion and restraint,
de-escalation trainings, and violence prevention. Psychiatric nursing literature suggested and supported the need for clearer de-escalation trainings, reporting the following specific skills to be addressed: empathy, self-awareness, frustration tolerance/emotional regulation, ability to detect early warning signs of aggression (movement/behavioral observation skills), and self-efficacy (Bowers, 2013; Hallet & Dickens, 2015; Lauge et al., 2013; Lauge et al., 2016).

The location in which the in-service was held was a 22-bed inpatient acute dual-diagnosis unit of an urban medical center. Mental health staff from both the inpatient acute dual diagnosis and inpatient rehabilitation units were invited to attend. Five mental health staff participated in the in-service, including one psychiatric nurse, an art therapist, a mental health technician, and two social workers/case managers. The psychiatric nurse had the most inpatient psychiatric and de-escalation experience. Aside from the psychiatric nurse’s twenty-plus years of experience, other staff had varying levels of experience surrounding inpatient psychiatric work and de-escalation; the four remaining staff had experience ranging between 2-8 years of work within the related field. All staff reported feeling confident in their ability to detect early warning signs of aggression and de-escalate, however were open to further education and training. Although staff were confident in their de-escalation skills, and were also familiar with dance/movement therapy, most staff were uncomfortable or lacked confidence regarding the use of their body when de-escalating. Initially, staff reported focusing on their thought processes, versus their bodily felt reactions when de-escalating a patient; staff were intrigued and excited to learn how self-awareness could bolster their aggression detection and de-escalation skills.

3.1.1 Definitions of key terms. De-escalation: “A complex range of skills designed to abort the assault cycle during the escalation phase, and these include both verbal and non-verbal communication skills. De-escalation involves the use of verbal and physical expressions of
empathy, alliance and non-confrontational limit setting that is based on respect” (Hallet & Dickens, 2015, p. 324).

Kinesthetic Empathy: The practice of perceiving emotions through movement (Rova, 2017). The “attempt to experience somebody else’s inner life and implies knowing what the other one feels, having information about the other’s situation and acting accordingly” (Fischman, 2009, p. 33-34). Kinesthetic empathy can be practiced through mirroring and attuning with another.

Mirroring: The embodiment and emulation of a client’s movement by the therapist to enhance emotional understanding and empathy (McGarry & Russo, 2011).

Somatic Countertransference: “The therapist’s awareness of their own body, of sensations, images, impulses, feelings and fantasies that offer a link to the client’s process and the intersubjective field” (McGarry & Russo, 2011, p. 181). Physical reactions at the body level that occur during countertransference (Pallaro, 2007).

Violence: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (World Health Organization, 2017, para. 2).

3.2 Dance/Movement Therapy

Dance/movement therapy (DMT) as defined by the American Dance Therapy Association (ADTA) is “the psychotherapeutic use of movement to promote emotional, social,
cognitive and physical integration of the individual” (American Dance Therapy Association, 2016, para 1). Dance/movement therapy research and theoretical oriented articles have addressed various aspects surrounding de-escalation and violence prevention in adult psychiatry and other settings.

3.2.1 Brief review of pertinent dance/movement therapy literature. Lundy and McGuffin’s (2005) study \((N=20)\) investigated how DMT skills can be implemented to improve the effectiveness of therapeutic holding. Findings suggested DMT techniques increased staff self-awareness and sensitivity regarding their own feelings as well as the children’s self-awareness and sensitivity as well. Additionally, the reduction of stress and injuries amongst staff was reported. Koch et al. (2015) evaluated an arts-based emotional regulation training in a prison setting \((N=47)\). Role-play type experientials for those incarcerated promoted empathy as well as perspective taking. The importance of socialization and the building of peer relationships was emphasized. Although the study suggested positive findings, it lacked clear suggestions for transferability.

Biondo’s (2017) program evaluation of a dance/movement therapy-based de-escalation training for psychiatric nurses \((N=73)\) examined the program’s effectiveness. The program, *De-escalation with DMT*, aimed to improve empathy, self-efficacy, and observational skills to promote violence prevention and de-escalation. Findings showed an increase in observational skills, self-efficacy, empathy, and positive views towards the program, as described by the participants. Results suggested the program may improve and increase skills while promoting safe and effective de-escalation and violence prevention.

3.3 Protocol Procedure

The overall training will last between 45 minutes to an hour and include the following:

- Ten minutes introducing topic and going over key definitions.
• Ten minutes of psycho-education (plus an additional 5 minutes for any questions or commentary from participants) surrounding the topic of kinesthetic empathy, aggression/violence, perception of aggression, violence/escalation and warning signs and observation skills. During this time, the topics of transference, countertransference, and somatic countertransference will be discussed. Handouts will be provided to participants (and are provided in Appendix B).

• A five-minute brief movement warm-up lead by the facilitator, to focus on centering and grounding of the body in preparation for the movement experientials.

• Two movement-based experientials in pairs will last 20-25 minutes. The definition of kinesthetic empathy will be reiterated, then put into physical context through movement experientials. Each movement-based experiential will take approximately ten minutes leaving time for brief discussion in pairs.

The first movement experiential (10 minutes) will help participants practice kinesthetic empathy by focusing on observation skills, self-awareness, and embodiment of another’s movement. The second movement experiential (ten minutes) will practice building kinesthetic empathy through observation skills, memory recalling, and physical embodiment on behalf of one participant, while the second participant will practice kinesthetic empathy through observation skills and active listening. Role-playing will be implemented as part of the experiential task. Both participants will have the opportunity to embody both roles. The remaining 10-15 minutes will be a discussion with all participants.

3.3.1 Experiential 1: Mirroring exercise. Participants will be asked to split into pairs to engage in a mirroring experiential, in which they will practice observation skills and embodiment. Participants will begin by choosing which partner will be the leader and which will
be the follower. Participants will have the opportunity to embody both roles. Next, participants in the leader role will begin to move naturally, performing tasks, gestures, or creative movements of their choice. Participants in the follower role will face their partner at a distance they are most comfortable and embody their partners’ movements as exact as possible. Dyads will perform this experiential task in their respective roles for three minutes, then switch roles. Upon the completion of the experiential, participants will engage in an open discussion surrounding what thoughts and feelings were elicited during the task, and the different observations within each role (leader and follower).

Questions that may be asked by the protocol instructor include: What emotions were elicited in the leader/follower role? In the leader role, what, if anything, did the follower do to make you feel seen/heard/understood? What did you notice about yourself when following your leader/leading your follower? How did you feel you were able to express kinesthetic empathy?

3.3.2 Experiential 2: Embodiment of a past patient/story. Participants will split into pairs and designate roles (mover and observer). Proceeding the designation of roles, the participants in the mover role will have the choice of verbally recounting a time when they had to deal with a difficult patient. The mover will verbally share their story with the observer (from the perspective of the psychiatric nurse), then embody the role of the client/patient. Those embodying their patient may alter their location in the room or shift their position (sitting, standing). Participants in the mover role are encouraged to embody both physical and verbal elements of the patient. Individuals who are embodying their patient will do so for two to three minutes, then discuss with the observer their experience of embodying the client/patient. Witnesses may also share their experience of observing the mover. After discussion, the participants will switch roles and repeat the process. Upon completion of the task, all
participants will join in a dialogue to discuss common themes, observations and body-felt emotions and experiences.
CHAPTER IV: DISCUSSION AND REFLECTION

4.1 Discussion and Reflection of Protocol Implementation

Individuals who participated in the in-service reported similar experiences during the processing discussion. Participants in attendance included two social workers/case managers, a mental health technician, a psychiatric nurse, and an art therapist. During the introduction of the in-service, including the review of vocabulary and key concepts, the female social worker, art therapist, and psychiatric nurse requested personal examples of somatic countertransference, for further clarification. They were curious about how positive and negative somatic countertransference may affect one’s ability to notice signs of aggression, and one’s ability to effectively de-escalate. In addition, they inquired about how an overflow of negative somatic countertransference may lead to higher rates of burnout thus negatively affecting one’s ability to have empathy for patients.

During the movement experientials, participants were observed to be alert and focused on their bodies and the bodies of others. All participants were able to remain grounded, present and task-oriented, however often laughed nervously or took a moment to breathe deeply. All participants were able to participate in all movement experientials in both roles, however some preferred embodying the role of the client versus observing their partner embody a client. Instances in which participants preferred to embody their experiences or the role of the patient/client, the participant reported feeling as though the de-escalation at the time could have been improved. Unresolved emotions surrounding past self-doubt, embarrassment, or anxiety emerged for some participants. Additionally, during the discussion regarding the movement experientials, participants described the importance of being both physically and emotionally alert. They discussed the importance of being mentally and emotionally present and equated it to the importance of warming up the body before a workout. Participants believed this topic had
relevance due to the physical demand and often emotional toll working on a psychiatric unit has on the body.

Throughout the mirroring experiential, participants who had not been exposed to movement found the experiential to be overwhelming. The mental health technician worried he was not performing the right moves, and that his experiential partner, the social worker, would be confused. On the contrary, the psychiatric nurse and art therapist expressed excitement, connection and confidence in mirroring each other’s movements. They shared feeling “on the same level” and “seen” by one another. Participants discussed how mirroring could be viewed as mockery with some patients; but could also be helpful when acknowledging a patient’s presence non-verbally. They shared the lack of rapport in the staff-patient relationship could have adverse effects in the future.

All participants expressed a desire to further process and gain support post de-escalation experience. The mental health technician, upon embodying his experience of attempting to de-escalate a client in his previous job reported having feelings of anxiety, lack of self-efficacy, and limited support on behalf of his colleagues and the facility. He also reported needing closure and processing upon embodying the experience. Other participants including the social worker reported feeling like she had physically re-lived her experience of dealing with a difficult patient through her embodiment. Participants who embodied their experience with a patient, with whom other staff members were familiar started a discussion surrounding the importance of perspective taking. Additionally, being aware of both patient and staff behavior during escalation is important; noticing if other staff members need help when de-escalating.

During the embodiment experiential, the in-service facilitator observed a conversation between the psychiatric nurse and a social worker who were working together. The psychiatric
nurse was sharing (after having embodied her experience) her emotions and thoughts surrounding a recently aggressive patient. The nurse expressed her anxiety due to negative countertransference, but also confidence in her ability to de-escalate the patient. The social worker, surprised and intrigued by the nurse’s de-escalation techniques and experiences, then reflected on her experience de-escalating the patient. Both participants shared similar anxieties regarding de-escalating the patient, however each approached the de-escalation process differently based on the rapport they had with the patient, their bodily felt responses, and from where their anxiety was rooted. During the open-group discussion the facilitator asked the social worker and psychiatric nurse to share about their differing de-escalation experiences. Upon hearing of the two participants’ experiences, other mental health staff shared their personal experience de-escalating the patient based on rapport, countertransference, professional experience, and impulses. A discussion surrounding the versatility and flexibility of kinesthetic empathy within de-escalation emerged, highlighting the body as a therapeutic, resourceful, and informative tool during the process of de-escalation. The psychiatric nurses stated, “I did not know what I held in my body could affect the way I see others”.

4.1.1 Clinical impressions regarding use of evidence-informed practice protocol. In the opinion of this author, and creator of the protocol, staff who participated in the training found the psycho-education format at the beginning of the protocol to be helpful in setting the tone and clarifying the topic for discussion. The author observed it was beneficial and organizing to have an opening discussion overviewing the vocabulary before transitioning into the movement experientials. Participants found it helpful to take small personal breaks between experientials (which constituted walking around the room, stretching, or taking some deep breaths) to remain present during the in-service.
As a dance/movement therapist, the facilitator found allowing staff to take personal breaks as needed, as beneficial and necessary for their ability to stay focused and present during the movement experientials and discussion. As the topic of aggression, violence, and de-escalation can be overwhelming and often for some, re-traumatizing, future implementations of this in-service protocol should consider the multitude of variations of past de-escalation experiences of staff. Most participants were surprised, and at times overwhelmed by some of the emotions and physical sensations that emerged upon embodying the role of the client or even themselves during the final experiential.

Staff found debriefing about experientials and reflecting on their past experiences to be grounding and comforting. Although all staff in attendance were not familiar with the term kinesthetic empathy prior to the in-service, participants expressed positive reactions to its validity, applicability, and efficacy in their future practice.

4.1.2 Benefit of working within the evidence-informed practice protocol. In the opinion of this author, mental health staff, especially psychiatric nurses could benefit from the implementation of this evidence-informed practice protocol as an in-service. The Evidence-Informed Protocol was able to focus on one aspect of de-escalation that was deemed important and lacking within the literature, thus directly addressing limitations within research studies and de-escalation trainings. Specific benefits include providing further education on the topic of de-escalation, which was specifically lacking on the unit where the in-service was implemented (staff on the unit where the in-service was implemented had not undergone formal de-escalation and aggression management trainings in recent years).

4.2 Multicultural Considerations
Although this specific protocol did not explicitly address the practice of kinesthetic empathy with regards to ethnicities, races, cultures, or genders, literature across multiple nations and cultures expressed the need for practice such as empathy and body awareness (Federman, 2011; Hsiao et al., 2015; Renwick et al., 2016). Multicultural considerations, such as personal views on mental illness and substance use were considered due to the expansive cultural background of both patients and staff on the unit where the in-service was implemented. Additionally, most studies discussed in previous sections originated from countries outside of the United States, therefore, multicultural factors were inherently included (Hsiao et al., 2015; Verhaege et al., 2016).

For future practice, multicultural considerations should be at the forefront of practice as the interpretation of empathy as embodied may differ across cultures, religions, and spiritual beliefs. The appropriate and acceptable expression of empathy, whether verbally or embodied, may vary across cultures and instances of social interaction; therefore, the practice should be considered within the staff members’ and the patients’ social context and cultural background. Although staff were considered within the context of their own cultural background, staff often described being unsure about appropriate physical boundaries when a patient came from a dissimilar culture. Discussion surrounding differences in cultural beliefs and etiquette should be wholly noted, especially if also discussing mandatory pre-existing de-escalation practices that may not address cross-cultural competence.

4.3 Recommendations for Future Research and use of this Protocol

Due to the limited DMT literature and research covering the topic of de-escalation and violence prevention, it is suggested that future researchers look to develop other protocols and trainings to expand the knowledge base and assist mental health staff, specifically in inpatient
psychiatric settings where de-escalation efficacy is limited. Research studies suggested de-escalation trainings lack essential skills for successful violence prevention and aggression intervention and should focus on building the missing skills needed (Bjorkdahl et al., 2013; Cowman et al., 2017; Guay et al., 2016; Kuivalainen et al., 2017; Lantta et al., 2016; Lee et al., 2012; Magnavita, 2011). Skills that remain undertrained and under-addressed include the practice of empathy, self-awareness, non-coercive verbal and non-verbal communication skills, and self-control (Bjorkdahl et al., 2013; Cowman et al., 2017; Guay et al., 2016; Kuivalainen et al., 2017; Lantta et al., 2016).

Based upon advice and feedback from participants and professionals within the field of dance/movement therapy and counseling, the following suggestions were given in relation to the in-service. Participants from the in-service suggested designating more time to process and emotionally prepare for sharing their stories of a time with a difficult client. The mental health technician noted although he only shared and enacted an encounter with which he felt comfortable, he still felt he needed to talk about his experience and feel more grounded after the experiential. The social worker also reported feeling somewhat emotionally and physically “unresolved.”

Future implementations should add a section on how increased stress and witnessing violence can affect the body may be beneficial, as well as a grounding experiential to bring everyone back to the present. A mindfulness experiential focusing on somatic sensations while recalling the stress of the event may make participants more aware of their bodily felt reactions to violence as well as ground them. Foci during this section should include a heavier emphasis on countertransference’s effects on compassion fatigue, thus challenging one’s ability to express empathy, as well as post-incident staff support. Staff reported the need for debriefing and staff
or organization-led emotional support to process particularly stressful or traumatizing experiences of patient violence.

Additionally, future work should consider the timeframe for the in-service; although this in-service was limited to one-hour, future implementations could benefit from a longer timeframe. Facilitators should consider when their in-service will take place, as well as the differing shifts staff may be serving. Psychiatric nurses on the unit in which this in-service was implemented worked 12-hour shifts, while all other mental health staff only worked 8-hour shifts; thus, complicating when the in-service could most easily take place and benefit all staff. Ideally, future implementations should aim to have 2 hours with one 15-minute break, or one and a half hours.

Although original the purpose of this protocol was to focus on improving and bolstering psychiatric nurses’ de-escalation skills, this in-service benefited all mental health staff in attendance. Future implementations should consider inviting all mental health staff on the respective unit, but also emphasize the consulted research focused primarily on psychiatric nursing literature and training deficiencies. The multidisciplinary makeup of the participants reflected the interprofessional experience of working a psychiatric unit, thus potentially strengthening the psychiatric nurses’ experiences, rapport, relationships and respect for other mental health staff, and vice versa.

Furthermore, space and location should be considered when organizing the implementation of this, or a relating protocol. The space in which this protocol took place was the patient day room, which included tables and chairs that could be easily moved or rearranged. Future facilitators should make sure there is enough space for participants to comfortably move, but also take breaks from experientials if needed. Conclusively, this protocol should ideally be
held following each de-escalation training implemented by the respective site/organization. In the case of this unit, where de-escalation training refresher trainings were not required, all staff should be required to participate in one type of de-escalation training proceeding the implementation of this in-service. Ideally, all mental health staff should have the opportunity to learn effective and ethical de-escalation skills at the discretion of the facility. Staff should also be offered a refresher or supplemental training to bolster and support their skills, such as this training, after every hire cycle, or biannually.

4.4 Summary and Conclusion

There remains a clear need for culturally competent and empathically informed de-escalation trainings in inpatient psychiatric settings (Hsiao et al., 2015, Laker et al., 2010). Past research indicated de-escalation trainings continue to lack needed skills for efficacy (Bjorkdahl et al., 2013; Cowman et al., 2017; Guay et al., 2016; Kuivalainen et al., 2017; Lantta et al., 2016; Lee et al., 2012; Magnavita, 2011). Using dance/movement therapy as a tool for increasing de-escalation awareness and skills has previously shown to be effective (Biondo, 2017; Lundy & McGuffin, 2005). Moreover, future considerations and implementations of body-based, or DMT informed supplemental de-escalation trainings may be beneficial to the field of mental health, while also bolstering existing knowledge and best practice techniques (Bjorkdahl et al., 2013; Cowman et al., 2017; Federman 2011; Guay et al., 2016; Kuivalainen et al., 2017; Lee et al., 2012; Magnavita, 2011). Additional research and protocols surrounding the inclusion of kinesthetic empathy and related topics to increase and promote empathy, movement observation, and self-awareness may prove to be essential in decreasing the number of restraints and implementation of intramuscular medications as last resorts to escalating or aggressiong patients (Federman, 2011; Price & Baker, 2012). Furthermore, dance/movement therapy tools, such as
kinesthetic empathy can promote positive relationships between patients and staff, thus
decreasing the levels of compassion fatigue (Bjorkdahl et al., 2013; Cowman et al., 2017; Guay
et al., 2016; Kuivalainen et al., 2017; Lantta et al., 2016; Lee et al., 2012; Magnavita, 2011;
Verhaege et al., 2016).
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*Psychiatric Care, 52*, 12-24. doi:10.1111/ppc.12097


Stewart, D., Van der Merwe, M., Bowers, L., Simpson, A., & Jones, J. (2010). A review of interventions to reduce mechanical restraint and seclusion among adult psychiatric
inpatients. *Issues in Mental Health Nursing*, 21, 413-424.
doi:10.3109/01612840903484113


### Appendix A: Literature Appraisal Matrix

<table>
<thead>
<tr>
<th>Reference</th>
<th>Type</th>
<th>N</th>
<th>Results/Findings</th>
<th>Rationale/Relevant Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bjorkdahl, A., Hansebo, G., &amp; Palmstierna, T. (2013). The influence of staff training on the violence prevention and management climate in psychiatric inpatient units. <em>Journal of Psychiatric and Mental Health Nursing</em>, 20, 396-404. doi:10.1111/j.1365-2850.2012.01930.x</td>
<td>Prospective non-randomized intervention study with pre and posttest intervention comparisons. Impedent measures design, with a 13-item questionnaire.</td>
<td>n=854 staff before training</td>
<td>Findings suggested a focus on three levels of violence prevention could foster more positive warm climate, thus preventing violence.</td>
<td>Staff who attempted to understand the reasons for patients’ aggression had a better chance of solving the problem, as well as building more trust and rapport with the patient.</td>
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<tr>
<td></td>
<td></td>
<td>n=260 staff after training</td>
<td></td>
<td>The authors suggested staff take a more proactive approach to handling patient aggression versus reactive or passive, including waiting for warning signs of aggression to appear.</td>
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<tr>
<td></td>
<td></td>
<td>n=297 patients before training</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>n=156 patients after training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cowman, S., Bjorkdahl, A., Clarke, E., Gethin, G., Maguire, J., &amp; European Descriptive survey study</td>
<td></td>
<td>N =2,809</td>
<td>Low levels (19.5%) of de-escalation experience in participants (n=435).</td>
<td>Researchers suggested further education on de-escalation and violence prevention.</td>
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Program evaluation with pre and post-testing.  

*N* =89 | Perceived level of exposure to violence diminished, as well as confidence related to coping with patients’ aggression. There was marked improvement for all variables under study. The program led to exceptional improvement in both long-term and short-term scenarios. Positive effect on psychological distress on staff was found. Significant decrease in the amount of exposure to This article evaluated the impact of the Omega Education and Training Program. Promoted the resolution of conflict through a person-centered perspective, putting the experience of the individual at the center. The authors suggested future research should examine the impact of post violent incident debriefing’s effect on staff’s psychological wellbeing, as well as how to improve the effectiveness of this program, specifically assisting |
violent incidents can positively affect how staff perceive their job; the study reported staff who experience violence in the workplace are at a higher risk for commitment, motivation, and leaving.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallett, N., &amp; Dickens, G. (2015).</td>
<td>De-escalation: A survey of clinical staff in a secure mental health inpatient service. <em>International Journal of Mental Health Nursing</em>, 24, 324-333. doi:10.1111/inm.12136</td>
<td>Cross-sectional mixed-methods questionnaire.</td>
<td>N =72</td>
<td>Three themes were identified within the results: the objective/s of de-escalation, interventions or methods employed to achieve the objective/s (including verbal communication), and specific characteristics of the escalating patient or environment. Subthemes within the core themes included communication amongst staff and between patient and staff, interpersonal skills (empathy, use of humor, rapport), and the use of a calm tone of voice. Staff who displayed poor interpersonal skills were perceived as possible causes for aggression. Authors suggest steering away from coercive measures versus verbal forms of de-escalation.</td>
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</table>
Calm tone of voice was universally encouraged as an appropriate de-escalation method, and showing empathy, care, and calmness were perceived as highly important during the de-escalation process.

Overall, verbal/non-verbal communication between staff and the escalating patient was listed as the most used and witnessed intervention during de-escalation.

| Kuivalainen, S., Vehvilainen-Julkunen, K., Louheranta, O. Putkonen, A., Repo-Tiihonen, E., & Tiihonen, J. (2017). De-escalation techniques used, and reasons for seclusion and restraint, in a forensic psychiatric hospital. *International Journal of Mental Health Nursing*, 26, 513-524. doi:10.1111/inm.12389 | Cross-sectional retrospective descriptive study. | $N=175$ | All episodes of patient escalation resulted in seclusion/restraint. The most common de-escalation technique was verbal de-escalation, followed by medication. | It was suggested that staff be educated on an expansive range of de-escalation techniques. |

Descriptive, exploratory focus group study

<table>
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<tr>
<th>N = 22 registered nurses</th>
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Nurses who were overwhelmed by work overload or psychological distress became more cynical about their work, thus complicating their interactions with patients and impairing their judgement of aggressive behaviors.

Impaired judgement often caused nurses to be hypervigilant and overly anticipatory of violent events, causing further tensions between patient and nurse relationships.

Nurses who were undertrained or unskilled in interpreting early warning signs for violence were often unaware of their ability to negatively provoke patients.

Participants suggested more in-service or continuing education trainings with foci on observation skills and competent interactions between nursing staff and patients.

A gap within knowledge surrounding the identification of patient warning signs for aggression was also found.

The authors suggest more opportunities for interaction between nurses and staff and a more routine process for sharing their experience and ideas for violence prevention.

Additionally, future trainings should emphasize teaching how to competently interact with patients, rather than resort to physical restraint in violent situations.
| Cooperative inquiry including ethnographic methods. |
| n=7 nurses  n= 1 nursing assistant |
| Staff turnover in the setting was high, and the specific unit studied was selected due to the high rate of patient violence; staff members were motivated to improve their aggression management and prevention skills. Results identified two significant themes: practical knowledge surrounding de-escalation and transforming knowledge about de-escalation. These themes included the sub-themes of critical attention (being curious when noticing actions of others) and changing practice (implementing learned de-escalation techniques rather than becoming emotionally affected by the situation). In the sub-theme of critical attention, it was found when colleagues listened to other’s stories, colleagues |
| The authors’ suggestions included focusing on the underlying causes of the patient’s aggression, establishing a therapeutic relationship (between nurse and patient), and balancing the need for behavioral control on the unit, and allowing for the patient’s autonomy. To further improve successful de-escalation practice, mental health professionals should continue to engage in de-escalation trainings/education to foster learning from experience. |
became more attentive to one-another.

One core problem was identified as not understanding how to interact with an aggressive/violent patient.

<table>
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<tbody>
<tr>
<td>Retrospective cohort study.</td>
<td>N=315 patients</td>
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<tr>
<td>This study examined the efficacy of the Strategies in Crisis Intervention and Prevention program (SCIP) as compared to control and restraint practices. The study found control and restraint were found to be more effective than the crisis intervention/violence prevention training (SCIP). Patients who were exposed to SCIP had longer stays in the hospital and faced a hazard ratio of 48% higher than those exposed to control and restraint</td>
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</table>

Communication amongst staff, and between patients and staff has been suggested as a growing edge. The authors suggested the inclusion of self-awareness within de-escalation trainings. The study favored the practice of control and restraint versus the SCIP program, arguing the implementation of the former is not necessarily unethical.
practices. Additionally, patients on the ward with SCIP practices had lower survival probabilities.

Instances of violence and aggression on behalf of patients included: assaults to staff or other patients, verbal abuse and threats of physical violence, and damage to the building/furniture, or equipment.

A possible explanation for the findings listed above is that staff who spent less time learning physical techniques resulted in lower skill levels (staff spent 80% of their control/restraint training learning physical techniques versus crisis intervention training).


<p>| Retrospective review of violent incident reports with pre and post-interventions. | Staff within the study reported 167 assaults from patients | The intervention reduced both the frequency and severity of the assaults. | Negative relationships between patients and staff, and lack of training/nursing experiences contribute to | Training programs and continuing education surrounding de-escalation and violence prevention is suggested, to specifically address the gaps in self-awareness, and patient-staff relationships. |</p>
<table>
<thead>
<tr>
<th>doi:0.1179/oeh.2011.17.4.36</th>
<th>during the study time period.</th>
<th>rising aggression amongst patients. Eighty percent of participants reported the training as significantly improving their skills.</th>
<th>Administrative and environmental changes regarding ethical policies surrounding de-escalation are also needed.</th>
</tr>
</thead>
</table>


Pretest-posttest within-and-between-group design, and cross-sectional longitudinal investigation. $N=104$ nursing students. This study examined the influence of the De-escalating Aggressive Behavior Scale (DABS) on nursing students’ de-escalation practice.

Participant performance levels rose significantly after participating in the training program (trained students performed more successfully than those who were untrained).

Students who were most in need of the trainings gained the most benefits.

Aggression management training building more skills improved nursing student’s ability to de-escalate

The authors noted efficacy in de-escalation relies on good communication and interpersonal skills.

Successful de-escalation and violence prevention trainings should focus on improved performance as well as acquired knowledge.

Training programs in aggression management can positively affect nurses’ attitudes and performance when de-escalating patients. Such training programs should be included as early as possible in nursing programs.

The authors stated improvement in practice cannot occur on its own accord; training and refresher courses on de-escalation provide
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Year</th>
<th>Methodology</th>
<th>K</th>
<th>Themes Resulted from Data</th>
<th>Important Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price, O., &amp; Baker, J.</td>
<td>2012</td>
<td>A thematic analysis</td>
<td>11</td>
<td>Seven themes resulted from the data, including: effective de-escalators, personal control, and verbal and non-verbal skills (relating to staff skills). Additionally, engaging with the patient, intervention timing, establishing safe conditions, and specific de-escalation strategies (relating to de-escalation intervention process).</td>
<td>The authors suggested successful de-escalators must have substantial body awareness, and non-verbal communication skills including awareness of the effects of their posture, intentional and unintentional movements, proximity, touch, and facial expressions. Body language should be empathic, and express concern for the patient. Staff de-escalating should aim to establish a bond with the patient, to convey a sense of mutual understanding and empathy. Overall, understanding non-verbal cues (awareness of the other), conveying empathy, and listening to the patient were considered most helpful and effective when de-escalating. Future trainings should seek to balance allowing the patient</td>
</tr>
<tr>
<td>Personal space was viewed as a controversial topic; reporting it should not be invaded, but staff should be close enough in proximity that rapport can be established.</td>
<td>autonomy, but also setting boundaries (the balance between support and control).</td>
<td>Communication skills are essential to reducing patient assaults.</td>
<td>De-escalation trainings are recommended as a first line of defense for interventions against violence.</td>
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<td><strong>Stewart, D., Van der Merwe, M., Bowers, L., Simpson, A., &amp; Jones, J. (2010). A review of interventions to reduce mechanical restraint and seclusion among adult psychiatric inpatients. <em>Issues in Mental Health Nursing, 21</em>, 413-424. doi:10.3109/01612840903484113</strong></td>
<td>Systematic review (of interventions)</td>
<td>$k=36$ empirical studies.</td>
<td>Most of the studies reported reduced levels of seclusion/restraint. Research was unable to state which interventions/program aspects were most successful. Most interventions had multiple components, including crisis intervention and non-violent interventions such as de-escalation techniques. Collaboration and communication between patients and staff was highly regarded in many interventions. Suggestions included more attention to nurses’ perspectives and how specific interventions are successful. The authors suggested the implementation of staff trainings/education to reduce the need for seclusion/restraint. Further research is needed to examine the effectiveness of restraint and seclusion reduction interventions, and how they are applied to practice.</td>
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Interventions which included a staff training component showed significant reductions in seclusion/restraint incidents.

| Verhaege, S., Duprez, V., Beeckman, D., Leys, J., Van Meijel, B., & Van Hecke, A. (2016). Mental health nurses’ attitudes and perceived self-efficacy toward inpatient aggression: A cross-sectional study of associations with nurse-related characteristics. *Perspectives in Psychiatric Care, 52*, 12-24. doi:10.1111/ppc.12097 | Cross-sectional study | N=219 | Burnout, secondary traumatic stress, and compassion satisfaction (pleasure deriving from providing care for others) accounted for 26.2% of nurses’ self-efficacy in their aggression management practice. Nurses without a degree in psychiatric nursing needed more training/skills to prevent/manage aggressive behavior. Staff confidence in managing aggression could be directly related to their compassion satisfaction. Nurses who had higher levels of compassion satisfaction exhibited more confidence and were more likely to believe in the importance of continued training. | The authors suggest more attention to nurses’ professional quality of life, self-efficacy in practice and positive attitudes toward managing patient aggression. Participants from the study reported a firm belief in continued trainings and education surrounding aggression management, specifically promoting self-efficacy and more empathic attitudes toward aggression. The authors suggested trainings should occur on the site of the workplace, in an open, non-threatening atmosphere. Interventions should take place in both individual and team settings encouraging multidisciplinary team discussions. Reflection of past events and training topics is encouraged, focusing on staff’s actions, |
aggression management trainings.

Burnout was linked to more negative attitudes towards patient aggression.

Emotionally depleted staff were more likely to have difficulty practicing empathy towards patients; they associated burnout with less tolerance toward patient behavior.

reactions, feelings, and thoughts towards aggression.
Appendix B: Evidence-Informed Protocol In-Service Handout

Dance/Movement Therapy Based De-Escalation In-Service

The purpose of the dance/movement therapy-based de-escalation in-service is to address the needs found within psychiatric nursing literature by providing a training focusing upon the following suggested knowledge gaps: body awareness (of self and other), self-efficacy, non-verbal bodily cues/behaviors, empathy, ability to detect early warning signs of aggression, and frustration tolerance/emotional regulation (Bowers, 2013; Hallet & Dickens, 2015; Lauge et al., 2013; Lauge et al., 2016). Through the in-service, participants will engage in collaborative movement experientials involving embodiment and discussion-based formats, to practice kinesthetic empathy skills that directly address the previously mentioned knowledge gaps.

What is dance movement therapy?

Dance/movement therapy (DMT) as defined by the American Dance Therapy Association (ADTA) is “the psychotherapeutic use of movement to promote emotional, social, cognitive and physical integration of the individual” (American Dance Therapy Association, 2016, para 1). Dance/movement therapy research and theoretical oriented articles have addressed various aspects surrounding de-escalation and violence prevention in adult psychiatry and other settings.

Key terms

De-escalation: “A complex range of skills designed to abort the assault cycle during the escalation phase, and these include both verbal and non-verbal communication skills. De-escalation involves the use of ‘verbal and physical expressions of empathy, alliance and non-confrontational limit setting that is based on respect’” (Hallet & Dickens, 2015, p. 324).
Kinesthetic Empathy: The “attempt to experience somebody else’s inner life and implies knowing what the other one feels, having information about the other’s situation and acting accordingly” (Fischman, 2009, p. 33-34). The practice of perceiving another’s emotions through movement (Rova, 2017).

Mirroring: The embodiment and imitation of a client’s movement by the therapist to enhance emotional understanding and empathy (McGarry & Russo, 2011).

Somatic Countertransference: “The therapist’s awareness of their own body, of sensations, images, impulses, feelings and fantasies that offer a link to the client’s process and the intersubjective field” (McGarry & Russo, 2011, p. 181). Physical reactions at the body level that occur during countertransference (Pallaro, 2007).

Violence: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.” (World Health Organization, 2017, para. 2).

**Relevance of Kinesthetic Empathy in Practice: Why Here and Why Now?**

Psychiatric nursing literature has identified the capacity to have and practice empathy as a core competency in psychiatric nursing, as well as being central to the therapeutic alliance (Hawamdeh & Fakhry, 2014; Hsiao, Lu, & Tsai, 2015). Empathy has been found to not only increase patient satisfaction and positive professional outcomes for nurses, but also resolve conflict situations (Gerace et al., 2016). Both empathy and increased body awareness have been
suggested as areas needing attention and improvement within de-escalation trainings, therefore
supporting the need for kinesthetic empathy within de-escalation practice (Lauge et al., 2016).

Kinesthetic empathy can also bolster one’s capacity for non-verbal communication
through understanding the client on a body level, while building rapport (Rova, 2017). Through
the reflection of past experiences with patients and directly practicing kinesthetic empathy,
psychiatric nurses and accompanying mental health staff may glean more information in
detecting early warning signs of aggression. Biondo (2017) identified movement observation
skills as essential to the accurate identification of early aggression warning signs. Additionally,
literature suggests the implementation of in-service trainings to make violence prevention more
effective (Lantta, Anttila, Kontio, Adams, & Valimaki, 2016).