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Incipient aggression in psychiatric or forensic settings: threat behaviour escalation and prediction

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Abstract

Aggression toward staff by individuals in psychiatric and forensic populations remains a persistent risk, often preceded by observable behavioural cues that are overlooked in formal risk frameworks. While structured assessment tools typically rely on historical or diagnostic factors, they lack sensitivity to the short-term, escalating behaviours that can signal imminent assault. Drawing from ethology, clinical observation, and forensic psychology, this paper synthesises evidence on non-verbal indicators of incipient aggression—such as gaze fixation, postural changes, and spatial intrusion. Particular attention is given to the 'square-up' posture as an illustrative example of a high-salience, visually recognisable signal. We argue for the development of a behavioural risk hierarchy that captures the sequential nature of increasing threat, offering a more dynamic and context-sensitive approach to risk assessment. Integrating findings from comparative aggression studies, observational research, and clinical practice, this paper outlines a conceptual framework for interpreting early threat behaviours and highlights opportunities for earlier interventions.

Keywords: *aggression, risk assessment, behavioural cues, threat escalation, violence prevention*

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1. Introduction

1.1. Assault in clinical settings and the case for observational risk

Aggression directed at healthcare personnel is a persistent and widely recognised occupational hazard, with implications for staff well-being, patient care, and institutional stability. Across emergency departments, inpatient psychiatric units, and forensic settings, staff frequently face verbal threats, intimidation, and physical assault [1–4]. Despite increased awareness and investment in formal risk assessment tools, frontline incidents continue to occur with alarming frequency.

Structured assessment instruments, while useful for long-term planning, often rely on static indicators such as diagnoses or historical risk factors. These tools lack sensitivity to the dynamic, short-term behavioural fluctuations that often precede an aggressive incident. A growing body of observational research suggests that aggression often unfolds along a sequence of escalating behaviours—pacing, personal space violations, clenched fists, fixed gaze—all of which may serve as early warning cues [5–7]. However, these are not consistently embedded in theoretical models or operational protocols, leaving staff to rely on intuition in the absence of structured guidance.

Comparable escalation patterns have long been observed in animal behaviour. Ethological studies based on direct observation have documented behavioural transitions in stage-wise conflict sequences. Animals assess their own level of aggressive motivation and their opponent's apparent strength, deciding at each stage whether to withdraw, continue or escalate [8, 9]. For example, red deer stags may roar first (the frequency of roaring is a measure of strength), engage in parallel walking (providing an opportunity to compare sizes), and maybe only then escalate to physical clash [10]. These graded threat behaviours may serve as high-risk bluffs—signals that aim to assert dominance or elicit submission without the costs of physical confrontation [8].

Recent work has highlighted strong functional parallels between human and animal aggression, particularly in the sequencing of observable behaviours and their underlying motivational and neurobiological substrates [11, 12]. Such continuity supports the idea that certain non-verbal acts—such as squared stance, intense gaze, or proximity encroachment—may be evolutionarily derived signals that serve as reliable behavioural risk markers [13, 14]. Indeed, rather than just being affectively expressive, threat behaviours by psychiatric patients and incarcerated persons may be unconscious or even deliberate attempts at intimidation and coercion.

This paper explores the gap between observable cues of incipient aggression and their incorporation into clinical risk frameworks. It is argued that many violent incidents follow recognisable escalation trajectories, and that early behavioural cues—if properly recognised and contextualised—may provide opportunities for proactive intervention. While staff training often emphasises behavioural management, less attention is placed on the nuanced interpretation of non-verbal threat signals with predictive value. A range of non-verbal behaviours—such as fixed staring, postural

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shifts, and spatial invasion—may function as visual signals of rising anger or dominance-related aggressive motivation. The present paper draws attention to such high-salience threat cues, using the "square-up" posture as one illustrative example of a visually recognisable behaviour that may indicate imminent risk. By synthesising literature from clinical, forensic, and behavioural science domains, the aim is to clarify how early-stage aggression may be identified and operationalised in psychiatric and forensic care settings.

2. Behavioural precursors and predictive risk cues

2.1. What precedes an attack? Observational indicators of escalating risk

A growing body of observational research has documented a consistent set of behaviours that frequently occur in the minutes or moments before an act of aggression. These include increased pacing, clenched fists, direct and prolonged eye contact, verbal hostility, erratic movements, and the invasion of personal space [6, 7]. In both emergency room and inpatient settings, such actions are often interpreted as agitation or restlessness, but when viewed in sequence or in combination, they may signal the transition from emotional dysregulation to behavioural escalation. Presumably more rarely, such escalation might be deliberate, as would be expected for psychopathic individuals.

However, the predictive reliability of these cues varies considerably depending on the context, individual baseline behaviour, and the observer's interpretive skill. For instance, pacing may be normative for certain patients or situations, while for others it may signal rising internal tension. Similarly, verbal hostility may be a routine communication style for one patient, but may indicate imminent loss of behavioural control in another. This context sensitivity complicates efforts to standardise behavioural risk indicators, especially in environments where staff lack consistent tools for interpreting behavioural escalation [15]. Empirical studies further suggest that while frontline personnel often 'sense' escalating tension prior to an assault, such intuitive impressions rarely translate into timely intervention due to the absence of formalised observational guidance [16].

Among the earliest and most common indicators of potential aggression is mutual staring, a behaviour observed across species and developmental stages, often preceding physical confrontation [13]. Ethological and developmental research suggests that sustained, direct eye contact frequently functions as a challenge or dominance display. In cross-cultural studies, Eibl-Eibesfeldt [17] documented instances of mutual staring duels between children in diverse cultures, noting that these interactions typically resolved only when one individual averted their gaze. More recent work in preschool settings has identified similar patterns of embodied dominance in which children use prolonged gaze and body positioning as part of social negotiation [18]. Contemporary neurobiological research supports the relevance of these early findings, showing that gaze cues can act as potent triggers of reactive aggression by amplifying perceived social threat and arousal [19].

This continuity across species and developmental stages suggests that the visual threat signal of mutual staring may be deeply rooted in the evolution of human aggression hierarchies [13, 17]. However, not all forms of staring denote hostility. The meaning of a stare is often dependent on relational context, emotional state, and situational norms. In clinical settings, where patient intentions are frequently ambiguous, recognising when a stare shifts from disengaged observation to active confrontation remains a critical interpretive task.

Importantly, most existing checklists and staff training protocols do not differentiate between ambiguous behaviours and high-probability indicators of violence. Nor are they typically grounded in a structured theoretical model of aggression escalation. Hence, early-stage behavioural cues—such as changes in gaze or posture—are often underutilised, inconsistently acted upon, or entirely missed, even when staff report sensing the rising tension prior to incidents [20]. A more structured approach to interpreting visual and postural signals could support earlier recognition of imminent threat. The following section examines how more complex, full-body cues, such as the square-up posture, may build upon these earlier visual signals.

2.2. Postural and spatial cues in escalating threat

Non-verbal indicators of impending aggression are not limited to facial expressions or gaze. Full body cues—particularly shifts in posture and spatial positioning—can provide early warning of escalating threat, often before verbal hostility or physical contact occurs. These behaviours include sudden changes in stance, increased physical proximity, body rigidity, and the blocking of exits or personal space [6, 21]. Despite being highly visible, such cues are frequently overlooked in clinical practice or dismissed as incidental, in part because they are not integrated into standard violence risk frameworks.

One prominent example is the 'square-up' posture, characterised by squared shoulders, frontal torso alignment, prolonged eye contact and very close proximity. This stance is commonly interpreted as a challenge posture or pre-fight signal, and parallels have been drawn with ethological threat displays in primates and other social animals [9]. In a study of dyadic physical aggression in street fight videos posted onto the internet, Potegal, Li, and Kim [22] identified the square-up posture as a recurring 'pre-fight pose' across multiple contexts. Square-ups were repeatedly observed by field researchers taking notes on confrontations and fights in bars in Australia, England, Scotland, and the US [23–26]. There were various triggers for these square-ups, the most deliberately aggressive of which was a direct, prolonged hostile stare intended to intimidate. Importantly, square-ups were so distinctive that they could be visually identified by observers in establishments so noisy that the spoken words cannot be heard. This is strong evidence that square-up behaviours are a signal.

Squaring up is a high threat stage of a male–male encounter, which can proceed to several relatively different outcomes, just as it does in other animals. It can, and sometimes does, lead to an immediate fight. However, in bars, it is often an occasion for a third-party intervention to de-escalate the conflict, a possibility of which the challenger is well aware. Alternatively, the challenge could be declined by a dismissive, face-saving remark, e.g., about how 'hard' the challenger thought he was with his friends around. In the latter case, the fact of having 'stood his ground' was a confirmation of masculinity, a source of satisfaction and even of post-encounter story-telling and boasting.

In clinical contexts, the Centres for Disease Control and Prevention [21] list squared shoulders, clenched fists, and intense eye contact among observable signs that may precede patient violence. In law enforcement contexts, Johnson [6] found that individuals who physically resisted apprehension often displayed body positioning consistent with a square-up stance, along with behaviours such as personal space invasion. Similarly, Jackson, Wilkes, and Luck [27] reported that fixed gaze, squared posture, and forward lunging frequently preceded violent episodes in hospital settings—even in the absence of verbal utterances. These findings suggest that physical positioning can serve as a high-salience signal, particularly when accompanied by other behavioural cues.

Emerging evidence from cognitive and physiological studies reinforces the importance of posture and space use in understanding early-stage aggression. Brugman et al. [28] found that attentional biases and implicit associations with aggression may contribute to observable behaviours such as posture changes or space invasion. These behaviours may be involuntary expressions of heightened arousal, frustration, or hostile attribution. Complementing this, a meta-analysis by De Looff et al. [29] reported that individuals with lower autonomic reactivity—such as reduced heart rate and skin conductance—are more likely to exhibit aggressive behaviours, particularly in forensic or clinical populations. While these physiological characteristics are not directly observable, they may help explain why some individuals externalise aggression without overt emotional or verbal escalation—making subtle behavioural cues, such as postural tension or spatial intrusion, especially important for early detection.

Improving staff awareness and interpretation of early non-verbal cues—particularly when considered in context and sequence, could allow for earlier, lower-intensity interventions. The following section explores how such behaviours, when understood as part of a broader escalation pathway, may help translate intuitive frontline recognition into structured clinical action.

2.3. From early cues to escalation: structuring a behavioural risk hierarchy

While individual behaviours such as pacing or clenched fists are often recognised as warning signs for violence, their predictive value increases substantially when they are interpreted within a structured progression—what can be conceptualised as a behavioural risk hierarchy. Clinical incidents of aggression rarely occur without warning; instead, they tend to unfold through a sequence of observable cues that escalate in intensity and immediacy [5, 22]. Based on a synthesis of observational studies, incipient aggression can be understood as a continuum—from subtle agitation to overt confrontation—marked by specific behavioural shifts. Early-stage cues may include glancing, foot-shifting stance, or mild verbal irritability; mid-stage behaviours may involve pacing, clenched fists, or glaring; and high-risk indicators often include space invasion, physical blocking, or square-up postures. While any of these behaviours may occur in isolation, their predictive weight increases when interpreted in sequence [15, 30].

Empirical support for this escalation pattern has been seen in clinical and forensic settings. In psychiatric environments, a study identified temporal sequences of agitation extending over hours or days, with assaults often preceded by intensified posturing and personal space invasion [31]. In emergency care settings, Sammut et al. [15] noted that staff tended to respond reactively rather than proactively—a shortcoming attributed to the lack of structured guidance in recognising early-stage aggression. In law enforcement contexts, Goormans and Vandeviver [32] reported that posture-based threat signals were commonly identified only in retrospect, despite their consistency across violent encounters.

Although existing violence prevention protocols often acknowledge general signs of agitation, they often overlook the need to distinguish between low-risk and high-risk behaviours in a structured manner. This lack of differentiation between levels of behavioural risk may help explain why staff frequently report sensing a build-up to aggression, but lack the formal language or institutional mandate to intervene early [20]. Developing a well-thought-out behavioural hierarchy could offer a shared framework for recognising and responding to early warning signs more effectively. Implementation would require structured training, refined observational strategies, and empirical validation. Nonetheless, its potential benefits—including earlier intervention, reduced reliance on coercive measures, and enhanced staff safety—position this model as both a theoretical and practical priority.

3. Future directions

The present paper has argued that aggression in psychiatric and forensic settings often follows a structured behavioural trajectory, with early-stage visual and postural cues providing underrecognised opportunities for risk detection and prevention. Building upon this foundation, future work should aim to empirically validate the proposed behavioural risk hierarchy and explore its application across clinical, forensic, and contextual domains.

One priority is the development of behavioural databases documenting micro-sequences of escalating threat cues, particularly those that immediately precede physical assault, as observed in healthcare workplace settings [16]. These data could clarify not only the order and duration of specific behaviours (e.g., fixed gaze, space invasion), but also how sequences may vary by individual characteristics such as sex, psychiatric diagnosis, and aggression subtype. In cases of autism, e.g., escalation may be triggered by environmental overstimulation—such as exposure to bright lights or loud noise—and may follow a trajectory shaped more by sensory distress than by interpersonal provocation [33]. A patient with borderline personality disorder may escalate through reactive verbal and physical expressions linked to emotional dysregulation [34], whereas a person with psychopathy may exhibit calculated posturing with little overt arousal [35]. Their verbal utterances may at times take the form of 'cold threats'—deliberate, emotionally detached statements intended to manipulate or seriously intimidate such as "I won't kill you-I will kill your family" ([36], p. 29).

Individuals with traumatic brain injury (TBI) may exhibit distinct pre-violence patterns shaped by cognitive and affective disruptions, including increased hostility; factors recently identified as mediating the link between TBI and violent offending [37].

Incorporating physiological data may further enhance predictive accuracy. A growing body of research links autonomic underarousal to externalising behaviours and aggression [29], while recent work in biosensor-based detection suggests that real-time monitoring of physiological changes could flag high-risk states before aggression manifests [38]. Another important aspect is

the ability to distinguish threats that resolve without escalation. For example, a patient continuing with an assortment of threats for a prolonged period without attack may have reached a sub-threshold plateau. Survival analysis could help model these trajectories and identify durations past which intervention becomes unnecessary or potentially counterproductive.

Finally, future studies should attend to how staff behaviour contributes to conflict dynamics. Observational coding of staff–patient interactions may reveal how actions such as rapid approach, crowding, or boundary violations inadvertently trigger or accelerate aggression. This is consistent with Maier's [36] observation that staff proximity, tone, and communication style can influence whether a threatening interaction escalates or de-escalates. Staff should also accommodate other individuals with a beneficial influence on inmate behaviour, such as peer mentors, who may contribute to identity transformation by modelling prosocial behaviour and reducing conflict within correctional environments [39].

Such findings could inform staff training protocols, particularly in the interpretation of proximity and spatial tension. While this paper focuses on adult psychiatric and forensic settings, researchers interested in paediatric populations are referred to Saito et al. [40], whose review synthesises management and prevention strategies for aggression in child and adolescent inpatient care.

4. Conclusions

This paper has drawn attention to the observable behavioural cues that often precede aggression in psychiatric and forensic settings—cues that are frequently under-recognised, inconsistently interpreted, or omitted from formal risk frameworks. By examining patterns of escalation across clinical, ethological, and social contexts, we argue that behaviours such as fixed gaze, posture shifts, and spatial encroachment can serve as meaningful indicators of rising threat. Incorporating these cues into structured behavioural hierarchies—interpreted in sequence and context—may improve the timing and reliability of early intervention efforts. Moving beyond intuition toward theory-informed observational risk models represents not only a conceptual refinement, but also a practical step toward safer, more responsive care environments.

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Conflict of interest

The authors declare that they have no competing interests.

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