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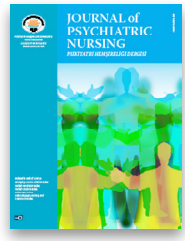

Review

De-escalation model in the simple form as aggression management in psychiatric services*

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Abstract

Aggression management in psychiatric wards has been a difficult but important issue. Classical methods that have been used in aggression management in the past have a repressive-compelling nature and can cause emotional / physical harm. This has led to the emergence of alternative methods that provide flexibility for the management of aggression. Alternative methods consider the patient's feelings and what is wanted to be expressed. It recommends working with the patient to solve the problem, and in this way aims to reduce the potential harm to patients and health workers. In this article, the de-escalation model in the simple form, developed by Len Bowers (2014) as one of the alternative de-escalation methods, is explained. This model is thought to be a guide for clinical psychiatric nurses in creating a therapeutic environment focused on preventing aggression in psychiatric wards due to its ease of application, low cost, and solution-oriented approach.

Keywords: Aggression; aggression management; aggressive patient; de-escalation methods.

What is known on this subject?

- Methods used for the containment of aggression and de-escalating aggressive patients in psychiatric services are categorized under two main titles as classic (repressive-compelling) and alternative methods, with the new trend prioritizing alternative methods.

What is the contribution of this paper?

- This study not only includes a detailed analysis of the concept of aggression and methods used for de-escalation, but also discusses how and why alternative methods should be used within the concept of responsibilities of nurses.

What is its contribution to the practice?

- This study aims to contribute to the practice by replacing the classic de-escalating methods, which are commonly used in Turkey, with alternative methods. Among these methods, a systematically structured and simplified de-escalation method was explained with examples.

Aggression in psychiatric services is a common case which the personnel have difficulty in managing, and which directly involves both the service personnel and the patient.[1] Inappropriate interventions intended to de-escalate patient's aggression can jeopardize the quality of patient care, the security of healthcare professionals, other patients, and the patients' relatives.[2] Providing the security of the patient and other people in the same environment should be the first and primary target when aggression occurs. Healthcare professionals are expected to be aware of their own emotions, and have accurate information for the appropriate intervention to prevent aggression concerning in-patients in psychiatric clinics and effectively manage the crisis. The perception of the healthcare professional toward aggression determines their response and approach to the patient. Knowledge, skill, attitude and behavior of the healthcare team toward aggression are described as the predictors of the aggression.[3] The healthcare professionals' familiarity with the reasons behind this aggression can prevent unwanted outcomes.[1] The healthcare team has important roles in identifying and controlling risks in the environment that can lead to aggression.[4] Inappropriate interventions carried out to de-escalate the patient's aggression can impact the quality of patient care and the security of health care providers, other patients and the patients' rel-

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atives.[2] Empathic and reassuring approaches of healthcare professionals toward the patients' aggressive behaviors have a great importance.[5] This review investigated aggression under these titles: "Theoretical definition of aggression and its reasons, Management of Aggression, Repressive-Compelling Methods Used in Aggression Management, Alternative Methods Used in Aggression Management, De-Escalation Model in The Simple Form Used as an Alternative Method in Aggression Management, Roles and Responsibilities of Psychiatric Nurses in Aggression Management."

Theoretical Definition of Aggression and its Reasons

Investigating the concept of aggression theoretically is important in terms of determining the nature of aggression, and how and why the aggression occurs.

Psychoanalytic Theory: According to Sigmund Freud (1914),[6] the founder of the Psychoanalytic Theory, humans have two basic instincts: one of them is the life instinct (Libido) the other one is the death instinct (Thanatos). While libido represents the instinct to live, thanatos is associated with aggression.[4,7,8] According to the theory, the individual struggles to balance their life and death instincts. When the instinct of death gets stronger, the individual transforms this instinct into a desire for nothingness, and expresses these feelings through aggressive behavior. The intensity of this instinct increases the aggression towards people and objects.[7–12]

Karen Horney (1939)[13] rejected the death and aggression instincts, and gave a different explanation for the occurrence of aggression. According to Horney, the main reason behind aggression is anxiety. The individual is surrounded with dangers, and is helpless and alone in the face of these dangers.[13] From the birth of an individual, their relationship or interaction with the external environment, which includes whether their needs are met, approved, and appreciated; the attitudes of parents, number of siblings; the responsibilities that can cause the individual to form certain feelings, develop coping methods for these emotions, and use defense mechanisms. All these interactions essentially lead to anxiety which the individual tries to overcome. While the individual tries to preserve their self-integrity, they perceive all kinds of stimulus that disturb their self and cause anxiety as threats; as a result, they may show aggressive behaviors.[8,9]

Ethological Theory: Ethological theory, which is another instinct theory, states that species show aggressive behaviors to survive, and that aggression is a part of the evolution.[7] However, Konrad Lorenz (1963),[14] one of the analysts that describes aggression as an instinctive situation, suggested that this energy exists regardless of external stimulus, and that this is independent of the target attacked. According to Lorenz, the individual does not kill someone because they are in a war; they start the war because they possess the aggression instinct.[14,15] Even though it is considered to be true to a limited extent, the theory receives criticism when it is evaluated in terms of the lack of concepts such as learning, cultural, and moral development.[16]

Ethological studies have found that aggressive behaviors of other creatures are triggered by an external stimuli or threat.[4] The instinctive structure which was developed for survival and passed down through generations, causes a fight or flight response through hormonal changes in the face of danger.[17] Physiologically, an increased blood circulation in extremities, increased secretion of adrenalin hormone, and stimulation of sympathetic nervous system can be considered as the reasons for aggressive behaviors in the organism. Considering the biological aspect, imaging studies have determined that the temporal lobe and cortex are activated during aggressive behaviors.[15–19]

As studies and observations in the ethological field increased, the strict separation of heredity, instinct, environmental factor/s, and stimulus from one another decreased, and a mentality is adopted that defends the fact that correlating these concepts is more accurate.[18]

Impulse Theory [Frustration-Aggression]: According to this theory, aggression is explained as a harmful and destructive form of behavior.[9] Preventing the individual from reaching their goal or their efforts to reach their goal results in instinctive aggression.[9,10] Instinctive behaviors towards the frustration or the factor causing frustration include harmful and destructive actions. If frustration is related to external factors, aggressive behaviors can be directed to those external factors. If frustration is related to internal factors, the individual can direct the aggression to themselves. With this theory, the relationship between aggression and provocation concepts have been established. Frustrated movement causes reactiveness by provoking the individual. The frequency, intensity, duration, and density of provocation affects the power of the behavior.[4,7–12]

Criticism towards the theory suggested that behaviors other than aggression also occur when the individual encounters frustration. The counterargument claimed that individual differences, personality characteristics, experiences, and habits cause changes in reactions against frustration.[4] In line with these criticisms, Leonard Berkowitz (1969),[20] a theoretician, tried to describe the types of frustrations that cause aggressive behaviors. At first, it was suggested that the power of aggressive behavior and the action of escape is determined by the power of the instinct and how strictly this instinct is frustrated; however, emotional reactions were later also included in the theory.[20] As emotional components have been included in the theory, it has been found that frustration does not always cause aggression, it is not always the reason behind aggression and aggression cannot be linked to only one reason and one outcome.[10] The individual can experience different emotions towards frustration regarding their individual characteristics, perception of powerlessness against frustrations, and whether the outcomes are acceptable.[8,10,11] These emotions affect the individual's reaction against frustration. If

the individual experiences fear in the face of frustration, they may show an escapist behavior, and if they feel anger, they may express an aggressive behavior.[12]

Melanie Klein (1946)[21] explained the aggression that occurs because of frustrations, with object relations theory. According to this theory, the individual experience inner conflict starting from their birth. The anxiety of getting hurt and desire to survive triggers aggression and destructive instincts as a primitive defense mechanism. The basic motivation for survival is oriented from aggression instinct. The desire to dominate others to survive with the aggression instinct has existed since the beginning of life. When the desire to dominate encounters frustrations, the individual gets more stressed and wants to remove the frustration.[22] According to Otto Kernberg (1975),[23] narcistic individuals experience anger and defeat against frustration, rather than feelings such as guilt and regret.[24] Heinz Kohut (1977) stated that fierce anger occurs with provocation. Frustration becomes a provocation element. Gregory Rochlin (1973)[25] stated that harmful anger is motivated by the injury of narcistic characteristics; such as low empathy, not caring about others' needs, egocentricity, and putting themselves and their needs above others. Narcissist structures that Rochlin foresaw can become intensified by spreading among society.[26,27] Rochlin says: "the cruelty of narcissism is a condition of humanity".[25]

Social Learning Theory: According to the social learning theory, the individual is in a constant interaction with their environment, and changes their behaviors or develops new ones according to these interactions.[9] This theory assesses the concept of aggression in terms of environmental conditions, and handles it within the context of stimuli.

Factors that cause aggression originate from the environment. and aggression as a response to this stimulus is learned from the environment. The difference between social learning theory and other theories is that the concept of "incentive" is as important as the "provocation" in activating instincts. The benefit expected from the action reinforces the behavior. Therefore, the theory assessed the reinforcers that lead the individual to aggressive behavior, and explained aggression through "instrumental learning" and "observational learning (modeling)" concepts.[7,8]

According to instrumental learning, reinforcing or rewarding behavior increases the repetition of that behavior. The aggressive behavior of the individual who received a reward for that behavior [who is confirmed, loved, cared for, who get what they want, or whose pleasure and satisfaction increase] is being reinforced. The individual whose aggressive behavior is reinforced tends to repeat that behavior in different environments and situations.[7,8,10]

According to Observational Learning (Modeling), aggression can be learned through observation or modeling other aggressive individuals besides reinforcers. This theory explains the fact that aggressive individuals can form their behavior by imitating the behaviors of children, their parents or caregivers, and by observing the reactions they give against events and situations.[10] Rewarding aggressive behaviors is another element that serves as an indirect reinforcing stimulus for the observer. As a result of this indirect reinforcing stimulus, these behaviors become easier to apply. When the behavior that the observer imitates is reinforced directly and repetitively, aggressive behavior becomes permanent and occurs frequently.[7–11]

Management of Aggression

It is important and necessary to explain the obstacles and restrictions that the patient may encounter, as well as the reasons behind them, both to the patient and their relatives during their admission to create and maintain a safe environment in psychiatric clinics.[28] Starting from the moment of admission, assessment of risk factors that play a role in the formation and occurrence of aggressive behaviors, informing team members about patients who have aggression risk and taking measures should be included among clinical procedures.[23] The next step after risk assessment and taking measures is the management of aggressive behavior. In the literature, these methods are analyzed under two groups: (i) repressive and compelling methods, and (ii) alternative methods.[30–32]

Repressive-Compelling Methods in Management of Aggression

Physical, chemical and mechanic restraint and seclusion used in management of aggression in psychiatric clinics are named as "repressive and compelling methods" and they have a physical and emotional negative impact on patients.[33] Moreover, these methods can increase aggression and agitation in patients, and cause negative effects on their behaviors after they leave the hospital.[34,35] Despite the repressive-compelling methods' negative effects on the patient, they are still commonly used in the prevention and control of aggressive behavior.[33]

In physical restraint, one of the repressive and compelling methods, healthcare professionals try to restrain the patient by using physical force because of the display of aggressive behavior, and try to prevent aggressive action in this way.[32,36] Physical restraint should be practiced by trained personnel who know how to use proper contact methods. During physical restraint, behaviors and practices that outrage, degrade the patient and ignore their privacy, personal needs, and differences are recommended to be avoided.[37,38]

Mechanical restraint is restricting or completely halting a patient's movement by using restraint materials, such as belt or wrist straps. The compelling nature of the mechanical restraint practice can be perceived as an aggressive behavior by the patient, and it can be a negative model for ineffective problem solving to the patient.[35,38] Besides, there are studies showing that the requirement of restraint and seclusion during intervention for aggressive behavior and the frequency of this practice reduce the success of treatment.[34] In spite of general criticism, mechanical restraint is commonly chosen for

controlling patient's aggression. The reason behind this is that healthcare professionals feel the need to gain full control of the patient, and prevent them from hurting themselves and others around them as quickly as possible.[35,39,40]

Chemical restraint is sedating the patient by using drugs and ceasing the aggressive behavior and agitation by this way. Chemical restraint is a commonly used restraint method.[41] Studies have shown that the chemical restraint method is useful during aggression but ineffective for the prevention of aggression; moreover, the patient may repeat the aggression after sedation wears off.[42]

Seclusion is one of the repressive-compelling methods that is used to make the patient showing aggressive behaviors stay in a room that was previously structured for this intervention, until their aggression stops.[43] Seclusion prevents the patient from hurting themselves or others around them, reduces agitation, and de-escalates the patient; or is applied with these intentions.[44] The seclusion practice is a primitive method and does not fit in with the humanistic aspect of the nursing profession. Values that make humans superior than other animals can be degraded with the seclusion practice; locking someone up in a place [a room] can stigmatize that person regardless of the features and conditions of the place.[30,43,44] The seclusion which is defined by being locked up can be seen as a confiscation rather than a medical intervention. Moreover, the patient can define the seclusion as a freedom-restrictive practice, and perceive this situation as a disproportionate use of force and/or punishment.[32,45] This situation can cause the patient to feel anger toward the healthcare professional who performs this practice.[38]

Alternative Methods in Management of Aggression

Methods which do not include repressive-compelling methods and are based on therapeutic communication for reducing the patient's aggression, are discussed under the title of alternative methods. These methods emphasize the significance of early period assessments "during which aggression signs emerge, and interventions performed in this stage. Early period intervention includes cooperation with the patient and discussion of the reasons of aggression.[32,37] Alternative methods include interventions, such as clarifying the needs of patient through communication, calming the patient down, and restructuring the environment through some arrangements.[35,40,46–50] On analyzing studies on alternative methods, no other model other than Len Bower's 'De-Escalation Model in The Simple Form'[51] was found; it was determined that its numerous verbal de-escalation techniques were used in time. Previous studies have shown that verbal de-escalation methods are as effective as pharmacological methods in preventing agitation, that these methods prevent the aggression and violence that can emerge after agitation, and that they decrease repetitive clinical violence cases.[45,46,50] Cowin et al.[52] stated that approaches that make the patient feel they are important are effective in the patient's participation in the treatment, rather than classical methods.

In line with this information, Bowers[51] reviewed more than 1000 articles about de-escalation. Bowers assessed the methods in those articles and systematically gathered effective methods used in these studies. He developed a model called "De-Escalation Model in The Simple Form" as a result of this analysis and synthesis.

De-Escalation Model in the Simple Form Used as an Alternative Method in Aggression Management

De-Escalation Model in the Simple Form is a model based on creating a "safe service" concept. It is hard to define a standard safe service due to the fact that these service places are prone to issues, and they differ from each other in terms of their sizes, locations, and what kind of resources they have. According to the model, one of the most functional ways to define and create a safe service is by defining behaviors that are wanted to be reduced or are undesirable in all services.[53] Within the scope of the model, conflict is defined as one of the obstacles for the safe service environment and as a behavior that should be prevented, and involves all patient behaviors that cause harm. Behaviors such as violence, suicide, and harmful actions against patients or others around them, alcohol/substance abuse or escape can be given as an example for these patients' behaviors. Additionally, refusing to see the personnel, or violating basic rules such as smoking in areas that can cause dispute with the staff/other patients, are being discussed under the concept of "conflict".[51,53]

Another obstacle for safe service environment is defined as the behaviors of the personnel.[54] Effective behavior of healthcare professionals, especially those who play an active role in the treatment and care of the patients and in the structuring of the therapeutic environment, are important in preventing and controlling aggressive behavior.[55] Nurses are in a key position for creating a safe service environment, as they are the ones who provide continuous basic healthcare, administer and direct the treatment in a health care team.[43] On the other hand, if nurses do not have sufficient awareness and effective communication skills, each contact with the patient may result in aggressive behaviors and intervention carried out by such nurses can be damaging. By adopting an appropriate behavior, it is possible to prevent aggression, and following the emergence of the aggressive behavior, to change into an effective and empowering emotion.[28,29,39]

The De-Escalation Model in the Simple Form suggests that the current service situation should be determined, and situations that endanger or prevent the safety of service should be identified.[51] In this context, there are two concepts called "flashpoints" and "originating factors." "Flashpoints" are defined as the factors/risks that cause "conflicts".[53] The flashpoint can be explained with the following example involving the locked

door in the psychiatric clinic: patient who wants to get out can have a flashpoint because of a statement made by a personnel or other patients against them or because of the patient's longing for their family that is reinforced upon seeing the visitor of another patient; the patient may want to get out of/escape from the service, and upon not accomplishing [control] they can hurt themselves or the people around [conflict].[54]

"Originating factors" are aspects related to service that cause potential flashpoints.[47] Originating factors are a part of the service life and an important component. Originating factors include factors regarding patient, environment and personnel. Opportunities provided by service to patients, the physical structure of the service, quality of the personnel and communication features, service rules, and diagnosis of the patient are assessed within the context of originating factor.[51,53]

In the context of the model concerned, Bowers named the behaviors exhibited to contain "conflict" situations that could arise between patient and team members as "containment behaviors." Such behaviors include situations such as the implementation of extra treatment [one-time dosages to de-escalate or control patients, chemical restraint], increasing patient monitoring, security measurements, restricting patients by transferring them to a different service or limiting patient movement. Personnel's "containment behaviors" and "patient's behaviors desired to be changed to prevent/resolve conflict" are connected to each other.[51,53,54] For example, while locking doors in psychiatric services reduces escape behavior, it can increase the risk of patients hurting themselves. The de-escalation model in the simple form involves understanding what being locked up means to the patient, and developing solution methods and precautions together with patients regarding this situation, rather than opening the doors.[54]

Figure 1 shows the aforementioned obstacles to the safe psychiatric service environment and correlations between those obstacles within the scope of De-Escalation Model in the simple form.

According to Bowers, personnel should focus on what they can do to prevent and effectively manage aggression for a safe service environment. The model suggests that the personnel can change the ambiance of the service by being aware of originating factors and preventing the formation of flashpoints. The stages of the intervention that can be used for the management of aggression have been developed after the assessments carried out based on the originating factors and flashpoints.[54]

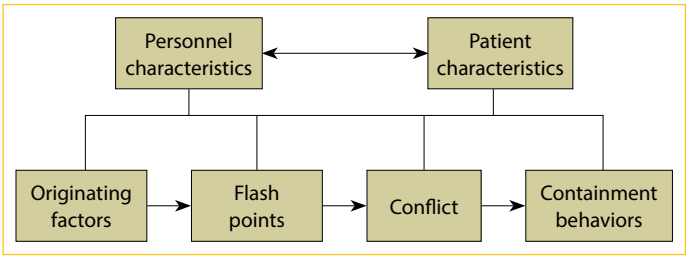

Figure 1. Obstacles to Create Safe Service in De-Escalation Model in the Simple Form.[48]

In the De-Escalation Model in The Simple Form, three stages to de-escalate patients on the verge of showing aggression are described as follows: (i) delimiting the situation, (ii) clarifying the patient's problem, and (iii) resolving the problem. During this process, the de-escalator is expected to control themselves and show respect and empathy to the patient.[51,53,54]

In the first stage called delimiting the situation, the nurse should ensure their security and that of the patient who shows aggressive behavior, and the people around.[51] In this context, the healthcare professionals should activate the alarm system if available, should request security support, should move other patients away from the area or take the patient to a quiet place, and eliminate the patients' potential to harm themselves and others. During the interaction with aggressive individuals, healthcare professionals should intervene by leaving an appropriate distance with the patients without risking themselves.[54,56] For example, when a patient starts to throw the things they grab and yell, healthcare professionals should inform security, and take the other patients and their relatives in that area to their rooms. Subsequently, they should remove the things the patient can reach. The patient should be treated after the environment is quietened down and the stimuli are reduced. During this process, the distribution of work should be made wisely, and the environment should be quickly secured and calmed down. Since making the distribution of work, deciding steps required, and applying those steps will be time-consuming during a crisis, the team should create a service protocol and determine the distribution of work beforehand.[39]

During the clarifying stage, healthcare professionals are expected to investigate the reason behind the patient's aggression. This can be achieved by asking the patient open-ended questions, such as "what happened" or "what bothers you". Healthcare professionals should remind who they are (for example: nurse), where they are (psychiatric service), the type of relationship between them (for example: patient-nurse relationship) in order to help the patients and ensure their orientation. While taking these steps, healthcare professionals should form sentences that the patient will be able to understand, and should check whether the patient has understood them. Another important issue at this stage is to check whether the healthcare professionals understand what the patient is saying.[49] Continuing with the example where the aggressive patient starts to throw things and yell; after the security of the environment is maintained and the healthcare professional is positioned with an appropriate distance from the patient, the de-escalator should primarily introduce themselves, and should assure them that they are not on opposite sides but on the same side during this treatment, and explain the behaviors of the patients to them. The de-escalators should ask the patient to explain the reason for their behavior, and should explain that if they knew the problem, they could help them, since the actual reason is not the aggressive behavior, but the reason that caused this

behavior. At this stage, it is important to use short and clear sentences. For example, when the patient yells "because you do not get food and beverage from outside, this is what you do!" The de-escalator should ask open-ended questions, such as "what is the reason you want to eat from outside?" to really understand the patient. There can be various reasons; the patient may have been unable to eat the food, or a visitor may have wanted to give a treat, or it can be a completely different reason. This can only be learned through the right communication with the patient. Throughout these stages, healthcare professionals should primarily control their own emotions and behaviors. They should not reveal the tension, fear, and panic to the patient, and talk to the patients with a calm and clear tone which can be considered neither high nor low. Otherwise, there is a risk that the control of the process will pass from the healthcare professional to the patient.[51,53,54]

In the resolving stage of the model - which is the last stage - healthcare professionals should try to reach an agreement with the patient, and attempt to resolve the complaints for the satisfaction of the patients. During this process, it is important to have a collaborative and positive attitude as opposed to strict and authoritative.[54] For example, rather than reminding the rules with an authoritative attitude, the healthcare professional should show a flexible attitude, make new readjustments suitable for the patient, and if necessary, can apologize to the patient. Making changes can be offered.[57] If it is not possible to be flexible, the healthcare professional can explain the reasons behind the rules as honestly as possible.[29] In cases where the two sides come to an agreement on the fact that the rules are difficult to comply with or not suitable for the patient, more reasonable and acceptable methods can be discussed with the patient for the patients' disobedience.[47] To do this, healthcare professionals should spare time for the patient, and it is also significant to carefully listen to what the patient is saying. If the patient is talking rather than continuing the aggressive behavior, it is accepted as an indicator of a successful solution.[29] Continuing with the same example; after reaching the behavior that was caused by the problem and the problem itself, it is possible that the patient can insist on getting food from outside the service, and can say that they miss the dishes of their aunt as a reason for this behavior when healthcare professionals are discussing possible solutions for the problem. In such cases, they should discuss how much the service rules can be stretched. If no flexibility is possible, then they should explain this to the patient.[57] To give an example of the ability and inability to execute the flexibility; the following can be offered: "you say that you miss your aunt's dishes very much. Would you like to offer your aunt's cookies for sharing day on Wednesday?" The following alternative can be offered: "the rule for not accepting food from outside cannot be changed because of the problems we experienced in the past. This situation is beyond me and I really want to help you. Do you want me to call your aunt, and ask her to come to visit you?" If the patient does not accept these options, healthcare professionals can ask one more recommendation from the patient considering their authority. The patient's recommendation can be reoffered to the patient by revising, adding or excluding certain aspects. The problem is not solved until an agreement is achieved with the patient through collaboration.

Characteristics of the De-Escalator

In the simplified de-escalation method, it is important that the de-escalator controls themselves. During this process; which includes delimiting the situation, clarifying the patient's problem, and resolving it; the de-escalator should not allow any feelings of anxiety or frustration in the communication with the patient.[51] The escalator is required to have therapeutics skills to be able to manage aggression.[53] The best situation is defined as the situation where the patient's perspective and conditions are understood; in other words, where the tension is eliminated, where healthcare professionals are content with their de-escalating skills, and where there is no anxiety or tension caused by the support team and restraint skills.[28,41,54] However, there can be cases where the de-escalator experience difficulties in managing all these variables; therefore, they can experience anxiety. In these cases, it is important to manage the anxiety and frustration and to not reveal them to the patient. By doing this, de-escalators can manage to calmly and safely take action. To accomplish this, the de-escalator can reduce their anxiety by deep breathing exercises, and thereby, remove the tension in their facial expression.[51,53,54] Additionally, softly talking with the patient through an attitude that is not defensive, and with clear body language, moving slowly and gently are behaviors that can positively contribute to the process. The de-escalator should avoid thinking about the situations they might be insufficient during the management of aggression, and should concentrate on the situation instead.[47,48,50]

Another important subject is that the de-escalator should absolutely not take this situation personally during the intervention. Situations in which the patient is angry or exhibits aggressive behavior are mostly not personally against the healthcare professionals; rather, they are against the hospital, psychiatry, institution, mental health laws, and other areas where the healthcare professionals are a symbol.[46,47] Therefore, the de-escalator should not be in a struggle for defending or justifying themselves, should not criticize the patient, should not be involved in an argument to convince the patient that they are wrong, and should not exhibit defensive attitudes. Healthcare professionals should certainly not give emotional answers in monotone, and use stereotyped expressions in response to the accusations that the patient made directly against them, as a result of aggression and anger.[54]

During the stages delimiting the situation, clarifying the patient's problem, and resolving the problem, healthcare professionals are also recommended to use respect and empathy to build an effective communication with the patient, besides controlling themselves by avoiding frustration and anxiety. The care, attention, and sincerity toward the patient should be expressed verbally and/or through action. To do this, it is

recommended to give the patient the opportunity to express themselves without a hurry, to investigate what the patient's emotions are, rather than saying what they should or should not feel, and to take time to understand the patient's perspective by empathizing. The de-escalator's voice, posture, eye contact, and facial expressions should also support the respect and empathy to be conveyed.[50,51,53,54]

Roles and Responsibilities of Psychiatric Nurses in Aggression Management

One of the primary functions of nurses in psychiatric services is to create a therapeutic environment, maintain it, and contribute to the improvement of it. Determining and defining the risks related to aggressive behaviors that directly affect the therapeutic environment, and taking the necessary measures are attempts to create and maintain the therapeutic environment.[58] Executing the appropriate intervention after the aggression is formed sustains the therapeutic environment. After aggressive behavior, notifying the necessary units, coming together with the team and reviewing the situation, taking new measures, or deciding on the rules that can be changed, and deciding on the rate of flexibility enables the therapeutics environment to improve.[29] The most important healthcare professionals in the prevention and management of aggression are nurses who non-stop work with the patients 24 hours a day in psychiatric services. Being the main coordinator who is present in the service, who executes interventions, and directs the team before, during and after in all of the stages of aggression, psychiatric nurse's attitude toward the aggressive patient determines the perspective of the service on this subject.[28]

Professional knowledge and skills, experience in the field, perception toward the aggressive patient, and the aggressive behavior of the nurses have an impact on whether the nurses behave appropriately while fulfilling their responsibilities.[56,59] The nurse who spends more time with the patients and makes more observations should start to make a risk assessment starting with the admission of the patient to the clinic. During the risk assessment, they should collect data on the factors (related to the patients, environment, and personnel) that are reported to be effective in the formation and emerging of aggression.[24] The responsibility of the nurse is to take the necessary measures and/or ensure that these measures are taken based on the collected data. The possible measures include monitoring the patient who have a risk of aggression, executing a data flow related to this during shift changes, reducing stimuli, ensuring that the personnel that can cause the patient's agitation to increase remain in the background during the service, and keeping the patient way from the factors that can increase their agitation. The responsibility of the nurses before the aggressive behavior emerges is carrying out a risk analysis, taking measures, informing the team, and ensuring that the measures are followed.[60] After the aggressive behavior starts, the nurse should calm the patient down, and prevent someone else from being hurt. De-escalation and providing security for others can be performed with traditional or alternative methods.[51,53] Regardless of the method, the nurse has an active role and is the de-escalator in the de-escalation protocol. As the practitioner of traditional methods; they are the people who hold down the patient, apply their medication, and transfer them to a separate place. In alternative methods, they are the people who move the patient to a separate place, identify the issue, explain it to the patient, try to resolve the patient's problem by making an agreement cooperating with them and ensure the de-escalation of the patient by this way. Following the steps of identifying the risk and de-escalating the environment after the occurrence of aggressive behavior, the environment should be reassessed, and damages must be determined. After this step, a record of the situation should be created and a necessary unit should be informed.[47–51,53,54]

It was determined that the psychiatric services in Turkey do not have any procedures that adopt the alternative approaches regarding the perspective of the aggressive patients; and that they use particularly pharmacotherapeutic interventions that fall into the category of chemical restraints among the intervention steps described in the literature.[38,61] Intervention algorithms developed to contain aggression usually include classical methods. This situation presents an approach to the patient that the decision maker is the physician through order. However, alternative methods are team-focused and patient-centered approaches where nurses can perform their independent functions.[58,62,63]

When de-escalation methods are analyzed, the use of effective communication skills is the most frequently mentioned method for de-escalation. In a study that assesses the communication style of psychotic patients and nurses, Bowers observes that effective communication skills reduced clinical aggression.[64] Moreover, in the study of Price et al.,[35] it has been found that nurses who received de-escalation training and could use de-escalation methods feel significantly safer and have higher clinical control than nurses who do not use these methods. In the study of Cowin et al.,[52] it has been emphasized that use of the classical method does not meet healthcare professionals' safety needs, and these methods complicate the cooperation between the professionals and the patient.

Conclusion

It is important to be able to prevent the occurrence of aggression, which is a common condition in psychiatric services and threatens the safety of personnel and patients, and to effectively contain the aggression after it occurs, therefore preventing it from reoccurring. The De-Escalation Model in the Simple Form developed by Bowers offers a systematic perspective that can be useful in preventing and containing aggression. This model can be used for guiding psychiatric nurses on aggression management, and creating "safe services" until new systematic models are developed. In this model - which effectively prioritizes communication and task sharing within the team and cooperation with the patient - not only patients but also service

personnel feel valuable and safe. The model offers ease of implementation, is cost efficient, helps healthcare professionals understand the real problem, suggests finding the best solution in the current conditions for the problem in collaboration with the person that experiences this problem, and transforms problem-solving into a clinical doctrine. It should not be forgotten that this method, which is an effective, easy, and inexpensive method for making a difference, will be a guide for healthcare professionals in creating and maintaining a therapeutic environment. To implement this model for verbal de-escalation in Turkey, further studies in this field should be encouraged.

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