Theories of aggression: an introduction

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In today’s world, mental illness and aggression are frequently inevitably linked, creating a stigma for patients and an uncomfortable environment for health care professionals. Hospitals, especially the psychiatric wards frequently face agitated or aggressive patients whom they have to manage. If not managed properly, these situations can quickly turn into a crisis, which results in nuisance and frustration for the staff members and a dangerous environment for other patients as well as the visitors. A well organized and professional handling of these situations is critical in maintaining a safe environment. Aggression is defined as the “ delivery of an aversive stimulus from one person to another, with intent to harm and with an expectation of causing such harm, when the other person is motivated to escape or avoid the stimulus”. (Geen, 2001). It can also be defined as the “ feelings of anger or antipathy resulting in hostile or violent behavior; readiness to attack or confront”. (Oxford dictionaries, 2011). The World Health Organization (WHO, 2002) categorized the forms of aggression in 2 categories namely physical and verbal aggression. Physical aggression can be described as the use of force against another person that results in physical, sexual or psychological harm. Whereas the verbal aggression, which is the most common form of aggression faced by the nurses, can be described as using abusive language, threats of physical harm or harming one family. (WHO 2002).

In socioeconomic context, Social and economic factors have an impact on the aggressive behavior. There are many factors which lead to the aggressive behavior. Among men and women under 45 years of age those who belong to a low socioeconomic class or have a low socioeconomic status are three times more likely to be aggressive than those in the highest. Rates

of aggression also increased with lower education levels, less social stability and unemployment. (Rueve & Welton et al., 2008).

During my clinical rotation at Nizari Old Age home, an 80 years old patient was my primary patient. He was very calm and cooperative in the beginning. But during the third week, his behavior suddenly changed. Whenever I tried to perform Mental Status Examination or bring him downstairs for doing group activity he showed anger. At first he started talking in a high pitched voice. After that when I tried to cool him down, he stood up, pushed his chair angrily, and walked away. And then he did not let anyone perform MSE.

After encountering this scenario, I couldn’t stop thinking about it. I wondered what has occurred to the patient suddenly. I kept on thinking that what is the reason behind his aggression and which factor suddenly exaggerated it.

In 1939, Dollard proposed the Frustration-Aggression theory. According to this theory occurrence of aggressive behavior is because of the existing frustration. The existence of frustration always leads to some form of aggression. The aggressive drive in the humans builds up slowly and gradually by minor frustrations. These minor frustrations add up and are maintained in the organisms until they reach a level where they cannot be maintained any longer. At that level the person shows the aggressive behavior. Frustration occurs when the goals of a person are not achieved and his attempts to achieve the goals are blocked by another party or the particular circumstances. (Dollard et al., 1939).

When a person gets older, he reflects back on the life he spent. He analyzes that whether he has accomplished his desired goals or he has failed to do so.

Every human being wishes that he earns good, he has a family with whom he can spend and enjoy the high’s and low’s of the his lifespan and when he gets old and cannot do everything on his own, his children are there to support him and take care of him. The patient I encountered did not have a family. He never got married. After his mother’s death, his siblings left him on his own. And now he is living alone in an old age home. From these facts I analyzed that these are the factors that have created and increased frustration in the patient.

Now, the question is that what should be done to manage an aggressive patient? Should he be restrained (physically or pharmacologically) or there is some other way to deal with them. Surely there is another way of controlling them, which is the verbal de-escalation. The measure other than de-escalation for e. g. Restraining, which can promote the aggression and escalate the patient because these measures restrict the freedom of a patient. (Richmond & Berlin et al., 2012). According to the literature, there are 10 domains of the verbal de-escalation. The first domain is respect personal space-When approaching the aggressive patient, the nurse should maintain 2 arms distance, so that the patient gets the space he need and the person approaching him can be safe if the patient tries to physically harm him. If a patient wants to leave, then he shouldn’t be forced to stay. The second domain is not to be provocative- The nurse should demonstrate by body language that he is there to listen. His hands should be visible not clenched, and he should have a calm facial expression. The third domain is establishing verbal contact-The nurse should politely introduce himself to the patient, orient him and provide reassurance. The fourth domain is to be

concise-The nurse should provide simple information using simple vocabulary. The patient should be given time to process the information given to him. The fifth domain is to identify wants and feeling-The nurse should try to identify what the patient wants. The nurse should ask questions to analyze the wants and feelings. The sixth domain is to listen closely to what the patient is saying-The nurse should show the patient by his body language that he is paying attention. If needed, repeat the information that the patient has given. The seventh domain is-Agree or agree to disagree. Agree with the patient as much as possible. However, if there is no way to agree, then agree to disagree. The eighth domain is to lay down the law and set clear limits-Inform the patient about the acceptable behaviors. But this should be communicated in a polite and proper way not as a threat. The ninth domain is offer choices and optimism-Giving choices to a patient can calm him down. Also give hope to the patient that they are going to improve. The last domain is debrief the patient-If any involuntary intervention is done, then the nurse should tell the patient and their family that why it was important to do that intervention. When the patient is calm, teach him how to manage his anger. (Richmond & Berlin et al., 2012).

In conclusion, Aggression is an emergency situation. The psychiatric patients suddenly and unexpectedly show an aggressive behavior towards the health care professionals. To deal with them de-escalation is one of the important techniques which can be used to calm down a patient rather than using the physical and pharmacological restraining methods. De-escalation also helps to build the therapeutic relationship between the patient and the health care professionals.