Understanding Aggressive Behaviour

Role of a Nurse

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WE can recognise at least four individual aspects of mood, namely, depression, elation, anxiety, and aggressive arousal.

When the mood change is one primarily of *aggression*, this is liable to be turned outwards and impinge on society in a more direct way, since its members will be the sufferers or recipients of any aggressive outbursts directed against them. Aggressive behaviour of patients rapidly causes relatives' tolerance to wear thin. Aggression is an entity that has received little attention in most of the psychiatric textbooks, although it is a predominant part of many of the personality disorders and is widespread as a symptom of many conditions.

During the daily activities on a ward or unit the nurse will be continually forming relationships with patients. Patients may present many difficulties and problems with which the nurse will have to cope. Amongst these problems will be aggression.

Aggression can be defined as an act or gesture, verbal or physical, which suggests that an act of violence may occur. It is a forceful, goal-directed, physical or verbal action; the motor counterpart of the effect of anger, rage, or hostility. Aggression may be realistic and healthy in representing self-assertion; constructive when it is problem-solving, and appropriate as a defence against realistic attack. For example, through the defence mechanism of displaced aggression an individual eases his angry feelings by aggression at an object or person who is not the proper target of his hostility. It is pathological when unrealistic, self-destructive, non-problem solving, and the outcome of unresolved emotional conflict.

Social learning theory on aggression (Bandeva : 1977) rejects the notion of aggression as an instinct (as viewed by Freud) or frustration-produced drive (Doland *et al*, 1939) and proposes that aggression is no different from any other learned response.

Causes of Aggressive Behaviour

(a) Pathological aggressive behaviour can be seen as a result of brain damage, as part of an epileptic fit, or as a result of the influence of drugs.

(b) Aggressive behaviour may be seen as a symptom of hypomanic illness, of schizophrenia, or in psychopathic disorders.

(c) In childhood, separation and maternal deprivation engender frustration and rage as well as anxiety and the motor representation of this rage is aggression.

(d) Violent outbursts are often the reason for referral of an elderly patient.

(e) Aggression merges with erotic thought and action in sadism and masochism.

(f) The mentally handicapped with communication difficulties.

(g) Boredom and frustration are often precursors to violent behaviour.

(h) Physical environment—overcrowding, room temperature too high, restricted movement.

(i) The semi-conscious/confused patient unable to relate to his environment, which may be due to injury, illness, or drugs—disorientation.

(j) Unrelieved pain can also cause a patient to become aggressive. Similarly, simple conditions such as a full bladder may precipitate an aggressive outburst.

(k) Provocation from staff, other patients, or visitors.

(l) Other factors such as: fear of being hurt; lack of information and sense of neglect; insufficient attention; to attract attention.

Prevention of (or Ways of Minimising) Aggressive Behaviour

Prevention is the chief objective. Knowing the patient and becoming familiar with his ways is important; learning the things that calm him, and the things that provoke him. Always try to find out why the patient feels as he does. Restlessness, increased emotional instability, changes in normal habits, anxiety, depression, or bizarre behaviour may often be a precursor to aggressive outbursts. Sometimes the causative factor is simple to solve initially, whereas if left it can precipitate a major upset. Try if possible to find some outlet or diversion for the patient's aggression. Boredom and frustration are often the precursors to aggressive and violent behaviour. Work sharing should be encouraged; joint consultation in the day-to-day management of the ward by patients and staff can ease tensions by fostering mutual trust and confidence between them.

A good nurse-patient attitude will help a patient to relate to the nurse; a poor attitude will turn the patient away—and an attitude that the patient feels to be threatening may lead him to attack the nurse.

A relaxed, friendly atmosphere is very important; restrictive rules should be kept to a minimum and,

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where necessary, should be simple and supported by an explanation. Tact and a friendly objective approach by all grades of staff will do much to limit aggressive and violent behaviour. Whenthe staff attitudes to the patients are good, there is much less disturbed behaviour; if the nurse's attitude is usually right, the nurse's instinctive reaction at a moment of danger is likely to be right too.

It is important to listen to what the patients feel about their treatments. No attempt should be made to 'force' treatment upon a patient against his will as this may result in aggression being directed against staff.

Adequate staff support, so that the patient receives adequate attention and, should an aggressive episode occur, other patients can be supervised. Regular ward meetings and discussions are extremely useful.

An effective hand-over between staff is most important. Change in the environment may be the solution in the case of some elderly patients. Drugs such as chloro-diazepoxide or diazepam or other tranquilizers have some place in calming down the pathologically aggressive behaviour. An agreed Medical and Nursing Policy for dealing with potentially aggressive and violent patients must be communicated to all staff.

To sum up, the patient must be respected as an individual. The emphasis must be placed upon understonding aggressive behaviour and how to anticipate and prevent violent outbursts. Aggression often occurs in people who are unable to communicate in more appropriate ways. Reject the aggressive behaviour but *do not reject the patient.*

References :

Garland, M., 1983 : *The Other Side of Psychiatric Care.* London. The Macmillan Press Ltd.

Haslam, M.T., 1982 : *Psychiatry Made Simple.* London, Heinemann.

Koshy, K.T., 1982: Revision Notes on Psychiatry, 2nd Edn., London, Hodder and Stoughton.

Ocular Emergencies

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It is the duty of the trained doctors and nurses to educate the people working in factories (Iron) dealing with the welding work. Parents should not encourage children to play with bow and arrow and *Gulli Danda*. Even minor ailments of the eye should not be ignored. In the hospitals there should be posters in the Out-Patient Departments. Ophthalmic Nurse can educate the people, patients and their relatives. In the schools, teachers can teach the students regarding the care of the eye.

In factories workers can protect their eyes with protective glasses. During Diwali and Dussehra, children start playing with bow and arrow and *Gulli Danda*. They are dangerous games and the major causes of losses of eyes. Secondly, children should not be allowed to play with crackers and grown-up people should also play with care. These Ocular Emergencies are preventable. Other emergencies like R.D. and Glaucoma can be taken care of in the nearby hospital if the patients are aware of the dangers of the disease.

Important Decisions of the Council and House of Delegates

(Continued from Last Month)

Negotiating Status: The following measures may be taken to attain negotiating status for the TNAI with Government.

The State Nursing Superintendent/State Nursing Officer of each State may be taken as member of the TNAI Council. Necessary changes in the Rules & Regulations, and Byelaws be brought about.

A representative of the local Nurses' Association may be coopted as ex-officio member of the Branch Executive Committee provided he/she is a member of the TNAI.

To make membership of TNAI mandatory necessary changes in the State Nurses' Registration Council Act be initiated.

The TNAI policy on strikes be reviewed.

The ILO recommendations be taken up with the Government once again.

The Nursing Journal of India: The Advertisement Rates have been revised.

It was clarified that the State Branches which are not able to procure one advertisement in a year for the *Journal* may now be charged Rs. 750, equivalent to ½ page advertisement charge.

Revised Advertisement Rates

	Cover Pages	
	Contract	*Casual*
Inner Title and Back Cover each (single colour)	Rs. 2,000	Rs. 2,500

	Ordinary Position	
	Contract	*Casual*
Full Page	Rs. 1,200	Rs. 1,500
Half Page	Rs. 750	Rs. 900
Quarter Page	Rs. 450	Rs. 500
Job Position	Rs. 60 per centimetre per column with a minimum of Rs. 160 (Flat Rate)	

Policy on Strikes: The TNAI Policy on Strikes should be reviewed as the nurses are compelled to join the Unions because of lack of support from the TNAI in this respect.

SNA Decisions: The Council considered the measures to raise funds for SNA. It was decided to raise SNA Subcription fee from Rs. 3 to Rs. 5 per member per annum.

Status quo be maintained in respect of the number of Scholarships.

SNA Units be established in Multipurpose Health Workers' Training Schools also.

Vice-Presidents : Elections: The election for the offices of the Vice Presidents were held on October 8, 1985. The following were declared elected as Vice Presidents of TNAI: **1. Mrs. R.K. Sood, New Delhi; 2. Sister Francisca, Quilon, Kerala; 3. Mr. H.B. Joshi, Chandigarh.**