UNIT 4 AGGRESSION AND VIOLENCE

Structure

4.0 INTRODUCTION

Human aggression is any behaviour directed toward another individual that is carried out with the proximate (immediate) intent to cause harm. In addition, the perpetrator must believe that the behaviour will harm the target, and that the target is motivated to avoid the behaviour (Bushman & Anderson 2001, Baron & Richardson 1994, Berkowitz 1993, Geen 2001).

Aggression is 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.

When we hear the word 'aggression' we probably tend first to think of physical force - a fist-fight, an assault with a weapon, a loud verbal retort or some other form of intense and punitive action enacted in the course of conflict between two people. Actually, according to the definition we have adopted, aggression may be carried out in any behaviour actuated by intent to harm another person against that person's wishes. Spreading vicious gossip about someone in hopes of ruining that person's reputation would be considered aggression.

In this unit we will be dealing with nature and type of aggression, and learn how to measure aggression. Following this we will learn about causes of aggression from various perspectives including biologic, neurophysiologic and social perspective. Whether aggressive behaviour is in any way related to parental rearing style and the influence of parental attitudes on children. Also there will be environmental stressorws and the unit will take up all the theories of aggression. Finally the unit will talk about the interventions to prevent aggression.

4.1 OBJECTIVES

After successful completion of this Unit, you will to be able to:

- Define aggression;
- Differentiate between various types of aggression;
- Analyse the various causes of aggression;

- Explain aggression in the light of different theories; and
- Explain effective techniques to reduce aggression.

4.2 NATURE AND TYPES OF AGGRESSION

Apart from physical violence against the body of other humans, there may also be verbal abuse and verbal assault etc., which all can be considered as aggression. In addition, damaging or destroying another's property can be a highly effective way of aggressing against another person. Even something as subtle and controlled as a social snub can be a powerful source of harm to the victim, a harm that is clearly intended by the person delivering it. Accidental harm is not aggressive because it is not intended. Harm that is an incidental by-product of helpful actions is also not aggressive, because the harm-doer believes that the target is not motivated to avoid the action (e.g., pain experienced during a dental procedure). Similarly, the pain administered in sexual masochism is not aggressive because the victim is not motivated to avoid it. Indeed, the pain is actively solicited in service of a higher goal (Baumeister 1989).

Aggressive behaviour during early childhood is considered a part of the normal developmental process (Greydanus, Pratt, Greydanus, & Hoffman, 1992). Acts of aggression change during a person's life span. When young children lack verbal skills, aggression is predominantly physical. When verbal skills develop, they could be used as peaceful communication, but also for aggressive purposes (Ferris & Grisso, 1996). Outbursts of anger usually peak around 18 to 24 months of age and gradually decrease by five years of age. Tremblay et al. (1999), found that most children have experienced their onset of physical aggression by the end of their 2nd year. Early aggressive behaviour consists of crying, screaming, temper tantrums, biting, kicking, throwing, and breaking objects (Achenbach, 1994; Raine, Reynolds, Venables, Mednick, & Farrington, 1998). At this stage, intention is instrumental.

Early childhood aggressive behaviour may be in response to parental authority and unrealistic expectations on the part of the parent toward their child. Later as social interactions increase, aggression may be directed towards peers (Greydanus et al., 1992). Later on, such behaviours as teasing, bullying, fighting, irritability, cruelty to animals, and fire-setting occur. During early adolescence, more serious violence develops, including gang fights and use of weapons.

In human research, a widely used definition of aggression is behaviour deliberately aimed at harming people and/or objects. In this definition harm has implicitly been defined as hurting someone physically, e. g. by kicking. However, other forms of harm, like psychological harm, e. g. humiliating, and relational harm such as malicious gossiping, are just as important. In addition to physical aggression, two other forms of aggression are currently recognised, namely psychological aggression and relational aggression.

Antisocial behaviour is defined as behaviour by which people are disadvantaged and basic norms and values are violated. Examples of such behaviours are lying, stealing and truancy. Aggressive behaviour then is a specific form of antisocial behaviour. Aggressive behaviour is an important component of several common mental health disorders in young people, including conduct disorder, oppositional-defiant disorder, attention deficit hyperactivity disorder, and intermittent explosive disorder.

Effective treatment of aggression is important not only because this behaviour is associated with negative developmental outcomes for perpetrators but also because it harms people in addition to the client

There are different types of aggression. Theoretical perspectives on aggression suggest that typographically and functionally distinct subtypes of aggression exist (Dodge & Schwartz, 1997). It is important to consider the multidimensional nature of aggression because different stimuli combine with different types of physiological and mental processes to create distinct forms of aggression. Although different classification systems for aggression have been proposed, as seen below, these typologies tend to overlap somewhat, with each system having a slightly different emphasis. The forms of types of aggression that are reviewed consist of the clinical classification, the stimulus-based classification, the instrumental versus hostile classification, and the positive versus negative classification.

4.2.1 Clinical Classification

The clinical literature research, heavily influenced by the work of Feshbach (1970) has frequently referred to two forms of aggression the first form being "affective," "reactive," "defensive," "impulsive," or "hot-blooded" aggression. This type of aggression is defined as a violent response to physical or verbal aggression initiated by others that is relatively uncontrolled and emotionally charged. In contrast, the second form of aggression is referred to as "predatory," "instrumental," "proactive," or "cold-blooded" aggression. This type of aggression is characterised as controlled, purposeful aggression lacking in emotion that is used to achieve a desired goal, including the domination and control of others.

4.2.2 Instrumental versus Hostile Aggression

Feshbach (1970) originally developed this typology, and it has been elaborated upon more recently by Atkins et al. (1993). This influential model separates aggression into instrumental and hostile functions. Instrumental aggression produces some positive reward or advantage (impact) on the aggressor unrelated to the victim's discomfort. The purpose of hostile aggression is to induce injury or pain (negative impact) upon the victim. In this case, there is little or no advantage to the aggressor. This model has been widely studied in community samples of children and adults with varying results (Atkins et al., 1993). One problem with this classification is that the constructs require careful delineation because many aggressive episodes will have components of both instrumental and hostile aggression.

4.2.3 Proactive and Reactive Aggression

A number of recent studies of aggression draw a distinction between reactive and proactive aggression. The first of these terms refers to aggressive behaviour that is enacted in response to provocation, such as an attack or an insult, and it is manifested in both self-defensive and angry actions. The latter term refers to aggression that is initiated without apparent provocation, such as we see in bullying behaviour. Such behaviour is not evoked by anger, hostility or the need to defend oneself, but by other motives that relate to obtaining goods, asserting power, assuring the approval of reference groups and other such goals. Reactive and proactive aggression are the equivalent of what earlier theorists called affective and instrumental aggression.

4.2.4 Positive versus Negative Aggression

Generally speaking, aggression is considered to have a negative function that not only elicits disapproval from others, but also is evaluated as destructive and damaging in its consequences. However, Blustein (1996) argues that the term "aggressive" behaviour is ambiguous, denoting both positive and negative behaviours. Ellis (1976) considered positive aggression to be healthy, productive behaviour if it promoted the basic values of survival, protection, happiness, social acceptance, preservation, and intimate relations. In the context of positive aggression, a certain amount of aggression is thought to be necessary and adaptive throughout childhood and adolescence because it helps build autonomy and identity (Gupta, 1983; Romi & Itskowitz, 1990).

Furthermore, a certain degree of aggression or dominance helps to facilitate engagement in cooperative and competitive activities with one's peers. Channeled in the proper direction, human aggression is the force that enables a person to be healthfully self-assertive, dominant, and independent and to achieve mastery of both the environment and the self. Therefore, it is believed that positive aggression takes many forms, including self-protection, standing up in the face of negation, pushing for new possibilities, and defending against harm.

With respect to negative aggression, this behaviour has been defined as acts that result in personal injury or destruction of property (Bandura, 1973). Alternatively, it also has been defined as attacking behaviour that harms another of the same species (Atkins et al., 1993). Negative aggression also is defined as forceful action that is directed towards the goal of harming or injuring another living being (Moyer, 1968).

Encroaching on the home or territory of a resident and causing others financial, physical, and emotional damage also is included in negative aggression (Moyer, 1968). Negative aggression is considered unhealthy because it induces heightened emotions that can in the long-term be damaging to the individual.

4.3 THE MEASUREMENT OF AGGRESSION

Aggression has been measured in a number of different ways. Perhaps the most popular technique has been to use rating scales that are completed by either the mother of the child or the schoolteacher. One well-used example of such a rating scale is the Child Behaviour Checklist (Achenbach, 1994). A second frequently used measure of aggression consists of self-report measures where the individual fills out a questionnaire to assess different aggressive attitudes and behaviours. Perhaps the most popular is the Buss-Durkee Hostility Inventory (Buss & Durkee, 1957).

Aggression also can be measured by observers. For example, the Overt Aggression Scale (Yudofsky, 1986) measures four different types of ward behaviour in psychiatric patients by nurse raters. Furthermore, aggression can be measured using a subtype scale that can classify different types of aggression. Proactive and reactive aggression can be reliably and validly assessed by a brief self-report measure (the Reactive-Proactive Aggression Questionnaire) with a reading age of eight years.

In addition, aggression and aggressive-related measures can be assessed in the justice system by using

1) official files of the police, court, and correctional agencies

2) self-report measures, for example Self-Reported Delinquency

3) Psychopathy Checklist Revised (PCL-R), a rating scale designed to measure traits of psychopathic personality disorder (Hare, 1991).

PCL-R is the most popular clinical instrument for assessing psychopathic behaviour Finally, aggression may be assessed using clinical projective tests such as the Thematic Apperception Test (Murray, 1957; Wodrich & Thull, 1997).

Self Assessment Questions

1) Discuss nature and types of aggression with suitable examples.

.....

.....

.....

.....

2) What are the clinical classification of aggression?

.....

.....

.....

.....

3) Differentiate between proactive and reactive aggression.

.....

.....

.....

.....

4) Define instrumental aggression and differentiate it from hostile aggression.

.....

.....

.....

.....

5) Explain proactive and reactive aggression.

.....

.....

.....

.....

6) What are the characteristic features of positive and negative aggression.

.....

.....

.....

.....

7) Describe the methods by which aggression can be measured.

.....

.....

.....

.....

4.4 CAUSES OF AGGRESSIVE BEHAVIOUR

4.4.1 Neurophysiologic Perspectives

Neurophysiologic perspectives argue that aggression is a biological response that is under the control of the brain. There are several important principles, It emphasises the role of the brain, hormones and neurotransmitters in aggressive behaviour; It stresses that our behaviour is largely governed by biological forces rather than environmental ones; It states that aggression is innate not learned.

4.4.2 Biological Causes

Research is beginning to indicate that biological processes (internal stimuli) may serve a role in predisposing to aggression. Five specific processes are selected for brief description: (1) brain dysfunction, (2) testosterone, (3) serotonin, (4) birth complications, and (5) nutrition deficiency.

4.4.2.1 Brain Dysfunction

Aggressive criminals have been found to have poor brain functioning. One source of evidence comes from neuropsychological tests, which have indicated poor functioning of the frontal and temporal regions of the brain in violent offenders. In addition, EEG studies have shown that aggressive prisoners are more likely to show EEG abnormalities.

Aggressive psychopaths are more likely to show excessive slow EEG wave. A third source of evidence comes from brain imaging studies. Aggressive prisoners have been shown to have reduced glucose metabolism in the prefrontal region of the brain, while individuals with antisocial personality disorder show an 11% reduction in the volume of prefrontal gray matter compared to normal and psychiatric control groups. The reason why brain dysfunction predisposes to aggression may be because the prefrontal region of the brain normally acts to control and regulate the emotional reactions generated by deeper, limbic brain structures like the amygdala. If the prefrontal region of the brain is functioning poorly, it will be less able to keep these aggressive impulses in check, resulting in an increased likelihood of impulsive, aggressive acts.

4.4.2.2 Testosterone

Sex hormones appear to play a role in shaping aggressive behaviour. Aggressive, violent offenders have been found to have significantly higher levels of testosterone than controls. Female criminals also have been found to be much more likely to commit crimes around the menstrual phase of their cycle when progesterone is low, while aggression is reduced around the time of ovulation when estrogen and progesterone levels are high (Carlson, 1998). Weight-lifters who take anabolic steroids become more aggressive and hostile, and normal men who are given testosterone become more irritable and hostile.

4.4.2.3 Serotonin

There has been a recent increase in research on neurotransmitters and their relationship to aggression in animals and humans. Although there is emerging data implicating the role of a variety of neurotransmitters in mediating impulsive aggressive behaviour in humans, most data have suggested a particularly strong role for serotonin. Both animal and human research has shown that aggressors have lower levels of the neurotransmitter serotonin. Nevertheless, the links between brain chemistry and aggression in humans are complex, because the environment plays a key role in regulating neurochemistry.

Social dominance influences serotonin levels in monkeys, and alcohol consumption also plays a significant role (Carlson, 1998). Birth complications have been repeatedly found to be associated with later increased aggressive behaviour in childhood and criminal activity in adults . Interestingly, birth complications alone have rarely been found to have a direct link with aggression and violence. Instead, aggressive behaviour is especially likely to develop when birth complications combine with psychosocial risk factors such as disadvantaged family environment, and poor parenting (Arsenault, Tremblay, Boulerice, & Saucier, 2002). Specific birth complications e.g., forceps delivery etc. are believed to result in central nervous system damage, which in turn impairs brain function, which then predisposes aggression (Liu, 2004a).

4.4.2.4 Nutrition Deficiency

Research on nutrition deficiency and aggressive behaviour is beginning to get attention. Factors include food additives, hypoglycemia, cholesterol, and deficiencies in protein, iron, and zinc. In humans, the male offspring of pregnant women starved during the German blockade of food to Holland at the end of World War II had 2.5 times the rates of antisocial personality disorder in adulthood compared to controls. In addition, several studies reported that iron deficiency is directly associated with aggressive behaviour and conduct disorder. Similarly, zinc deficiency has been found to be linked with aggressive behaviour in both animals and humans. It is believed that early malnutrition negatively impacts brain growth and development, and that brain impairments predispose individuals to antisocial and violent behaviour by impacting cognitive functions (Liu, Raine, Venables, & Mednick, 2004).

4.4.3 Environment and Genes

Twin and adoption studies suggest a large shared (family) environmental effect, a moderate non-shared (unique) environmental effect, and a modest genetic effect. Typical twin concordance rates for adolescent delinquency are 87% for

monozygotic twins and 72% for dizygotic twins. Adoption studies suggest that genetically vulnerable children—that is, children whose birth parents were antisocial—may be especially susceptible to unfavourable family conditions. The genetic element seems to be stronger for adult criminality than childhood conduct disorder and delinquency.

4.4.4 Parental Rearing Style

Five aspects of how parents bring up their children have been shown repeatedly to be strongly associated with long term antisocial behaviour problems, namely (a) poor supervision, (b) erratic, harsh discipline, (c) parental disharmony, (d) rejection of the child, and (e) low involvement in the child's activities. One study showed that among antisocial boys aged 10, differences in parenting styles predicted over 30 % of the variance in aggression two years later.

4.4.5 Parent-child Interaction Pattern

Direct observation in the home shows that much aggressive behaviour in children is influenced by the way parents behave towards them. In many families with antisocial children the parents do little to encourage polite or considerate behaviour by the child. Such behaviour is often ignored and rendered ineffective. Yet frequently when the child yells or has a tantrum he or she gets attention, often the parent gives in, so the child wins and soon learns to adapt accordingly. The coexistent unresponsiveness to the child's communications and emotional needs contributes further to the child's disturbance.

4.4.6 Parental Influence on Children's Emotions and Attitudes

Difficulties can often be traced back to infancy. A high proportion of toddlers who go on to develop conduct problems show disorganised attachment patterns, experiencing fear, anger, and distress on reunion with their parent after a brief separation. This behaviour is likely to be a response to frightening, unavailable, and inconsistent parenting. The security of infant attachment can be predicted with substantial certainty before the child is even born, from the emotionally distorted, confused style in which the mother talks about relationships with her own parents.

By middle childhood, aggressive children are quick to construe neutral overtures by others as hostile and have difficulty judging other people's feelings. They are poor at generating constructive solutions to conflicts, believing instead that aggression will be effective. This quickness to take offence at the slightest opportunity is reflected on the street in sensitivity to disrespect, which can lead to swift retribution. This indicates the fragile self esteem and confrontational view of the world that these young people have come to develop after experiencing years of frustration and failure. Some find that being violent makes them feel good about themselves and give them control.

4.4.7 Difficulties with Friends and at School

In the school playground these children lack the skills to participate and take turns without upsetting others and becoming aggressive. Peer rejection typically ensues quickly, and the children then associate with the other antisocial children, who share their set of values. Those with difficulty reading typically fail to get any qualifications by the time they leave school, and they become unemployed. This may contribute to persisting aggressive behaviour.

4.4.8 Predisposing Child Characteristics

Hyperactivity, also known as attention deficit Hyperactivity disorder is predominantly genetically determined. Children who show this restless, impulsive pattern of behaviour do not necessarily start off aggressive, but over time a proportion become so. They have difficulty waiting their turns in social encounters and games and so easily provoke retaliation and get into fights. Where hyperactivity and conduct disorder coexist from an early age the long term outlook is especially poor.

Delinquents have repeatedly been shown to have an IQ that is 8-10 points lower than law abiding peers—and this is before the onset of aggressive behaviour. Other traits predisposing to conduct problems include irritability and explosiveness, lack of social awareness and social anxiety, and reward seeking behaviour.

The interplay between a child's characteristics and the environment is complex. As children grow older, their environment is increasingly determined by their own behaviour and choices. There may be turning points when certain decisions set the scene for years to come.Thus it is not simply a young person's level of antisocial behaviour per se that determines later outcome but also how the behaviour shapes the social world inhabited later on. This has important implications for intervention.

4.4.9 Environmental Stressors

4.4.9.1 Temperature

When the temperature rises people tend to feel more disposed to aggressive behaviour. A researcher looked at incidents of violence across the USA and the corresponding weather reports. He found that when it was moderately hot (84°F) there was the most violence, but after the weather showed higher temperature, the violence decreased. This was backed up by a lab study by Baron and Bell who put participants in rooms of different temperatures then increased the heat in each of the rooms. The participants were asked to give electric shocks. They found that as the temperature rose, the participants gave more electric shocks, but then once the temperatures got to extreme levels, the shocks decreased. However, another researcher called Anderson looked at cases of violent acts including rape, murder and assault. He found that there was a steady increase as the temperature rose but that there was no indication of decline in extreme heat. One problem with this theory is that it would probably not be true to say that people in hotter countries are more aggressive.

4.4.9.2 Crowding

A higher density of people leads to higher levels of aggression. This theory links to de-individuation. It is also unpleasant when your personal space is invaded. For example, there is the most aggression along the most heavily-congested roads. There are more prison riots when the population density in the prison is higher. A study shows there was more aggression in a day nursery as the nursery got more crowded.

However, this pattern is not found in families, as people expect others to be in close proximity. This suggests that it is not just a high density, but overcrowding that is the problem. There are also limitations to this, as some people do not find encroachment of their personal space to be a problem. Furthermore, there are

also cultural differences e.g. Arabs tend to stand very close together. Also, if you can confront people about it, aggression can be reduced. Both crowding and heat lead to physiological arousal which leads to aggression. However, this may depend on your interpretation of the arousal; for example, crowds can be uplifting, fun and exciting.

4.4.9.3 Noise

Noise is an unwanted sound that causes a negative effect. It can cause aggression when it is too loud or unpredictable. Glass and Singer conducted an experiment where participant were asked to complete a maths task and were then asked to complete a proof-reading task. During the maths task, some of participants were subjected to noise, but all of them had quietness and no noise during the proof-reading task. It was found that the people who had the noise in the first task made more mistakes in the second task. They made the most mistakes when the noise was very loud, was random and when they had no control over it.

Self Assessment Questions

1) Discuss the various causes of aggressive behaviour.

.....

.....

.....

.....

2) What are the neurophysiologic factors that contribute to aggressive behaviour.

.....

.....

.....

.....

3) Put forward the biological causes of aggression.

.....

.....

.....

.....

4) Discuss the interaction between environment and genes in contributing to aggressive behaviour.

.....

.....

.....

.....

.....

5) In what ways parental rearing style and parental interaction cause aggression.

.....

.....

.....

.....

6) Discuss the parental influence on children's emotions and attitudes and the influence that the difficulties the child has with friends in then school.

.....

.....

.....

.....

7) Enumerate the various predisposing child characteristic factors in causing aggression

.....

.....

.....

.....

8) What are the various environmental stressors that cause aggression.

.....

.....

.....

.....

4.5 THEORIES OF AGGRESSION

4.5.1 Psychodynamic Theory

Freud argued that all human beings possess two important instincts, the life instinct (Eros) and the death instinct (Thanatos). The conflict between life and death instincts results in self-destructive tendencies which lead to aggressive behaviour. The struggle between life and death instincts creates a build up of tension in our unconscious mind. This tension needs to be released, either through suitable outlets such as sport (sublimation) or onto others (displacement). Failure to relieve these aggressive impulses may result in an outburst of uncontrollable aggression. Freud's theory is also known as the hydraulic model of aggression.

4.5.2 Frustration-Aggression Theory

It is essentially a behaviourist approach that suggests aggression is a learned response to frustration. Frustration occurs when an individual is exposed to external situations (stimulus) that cause discomfort or anger e.g. prolonged queuing,

overcrowding, failure to achieve a goal, etc. Frustration is cumulative – it builds up in an individual until it is discharged via an aggressive act (response). The frustration-aggression hypothesis is sometimes known as drive-reduction theory. Dollard et al claim that Frustration always causes aggression, and Aggression is always caused by frustration.

4.5.3 Cognitive Neo-association Theory

Berkowitz (1993) has proposed that aversive events such as frustrations, provocations, loud noises, uncomfortable temperatures, and odors produce negative affect. Negative affect produced by unpleasant experiences automatically stimulates various thoughts, memories, expressive motor reactions, and physiological responses associated with both fight and flight tendencies. In cognitive neo-association theory, aggressive thoughts, emotions, and behavioural tendencies are linked together in memory (Collins & Loftus 1975).

Concepts with similar meanings e.g., hurt, harm and, concepts that frequently are activated simultaneously e.g., shoot, gun, develop strong associations. When a concept is primed or activated, this activation spreads to related concepts and increases their activation as well. Cognitive neo-association theory not only subsumes the earlier frustration-aggression hypothesis (Dollard et al. 1939), but it also provides a causal mechanism for explaining why aversive events increase aggressive inclinations, i.e., via negative affect (Berkowitz 1993). This model is particularly suited to explain hostile aggression, but the same priming and spreading activation processes are also relevant to other types of aggression.

4.5.4 Social Learning Theory

According to social learning theories (Bandura, 2001; Mischel 1999), people acquire aggressive responses the same way they acquire other complex forms of social behaviour—either by direct experience or by observing others. Social learning theory explains the acquisition of aggressive behaviours, via observational learning processes, and provides a useful set of concepts for understanding and describing the beliefs and expectations that guide social behaviour. Patterson's work on family interactions and the development of antisocial behaviour patterns relies heavily on this approach.

4.5.5 Script Theory

Huesmann (1998) proposed that when children observe violence in the mass media, they learn aggressive scripts. Scripts define situations and guide behaviour. The person first selects a script to represent the situation and then assumes a role in the script. Once a script has been learned, it may be retrieved at some later time and used as a guide for behaviour. This approach can be seen as a more specific and detailed account of social learning processes. Scripts are sets of particularly well-rehearsed, highly associated concepts in memory, often involving causal links, goals, and action plans. When items are so strongly linked that they form a script, they become a unitary concept in semantic memory. Furthermore, even a few script rehearsals can change a person's expectations and intentions involving important social behaviours.

4.5.6 Excitation Transfer Theory

Excitation transfer theory (Zillmann 1983) notes that physiological arousal dissipates

slowly. If two arousing events are separated by a short amount of time, arousal from the first event may be misattributed to the second event. If the second event is related to anger, then the additional arousal should make the person even angrier.

4.6.7 Social Interaction Theory

Social interaction theory (Tedeschi & Felson 1994) interprets aggressive behaviour as social influence behaviour, that is, an actor uses coercive actions to produce some change in the target's behaviour. Coercive actions can be used by an actor to obtain something of value e.g., information, money, goods, sex, services, safety , to exact retributive justice for perceived wrongs, or to bring about desired social and self identities e.g., toughness, competence. This theory provides an excellent way to understand recent findings that aggression is often the result of threats to high self-esteem, especially to unwarranted high self-esteem i.e., narcissism.

4.5.8 Social Information Processing Theories

Although there is not yet one common theory of SIP in aggressive individuals, Crick and Dodge (1994) have convincingly integrated various constructs from studies on child and adolescent aggression.

According to their model, individuals in social situations:

- perceive and encode the situational and social cues,
- form a mental representation and interpretation of the situation,
- select a goal or desired outcome for the interaction,
- recall or construct possible reactions to the situation,
- evaluate these reactions and finally,
- initiate what they expect to be an adequate action.

The model suggests that some individuals develop specific characteristics of SIP that enhance their risk of aggressive behaviour. These processes are inferred from contents of the memory store, acquired rules, social schemata, and social knowledge.

Studies show that when aggressive youngsters encode situational cues, they focus more on aggression-relevant stimuli, they remember more aggression-relevant details of a situation, and they over perceive aggression in their partners. When interpreting the cues, aggressive children are less able to recognise the specific intentions and motivations of others, and they exhibit a tendency to attribute hostile intentions to others.

In the third phase, more egocentric and antisocial goals have been found in aggressive youngsters. They try more frequently to maximise their own utility even when this injures others, or they are more interested in dominating the interaction rather than maintaining a relationship. In the phase of response access or construction, aggressive children generate more aggressive and hostile alternatives (Zelli et al., 1999). This does not seem to be because of a generally smaller number of stored response schemata.

However, their repertoire of reactions lacks variety and is dominated by aggressive, impulsive, and sometimes fanciful reactions. In the phase of response evaluation and decision, antisocial individuals have a more short-term estimation of consequences. They also seem to expect more self-efficacy and relatively positive consequences of aggressive behaviour (Zelli et al., 1999).

These evaluations may be derived from enduring beliefs learned in the family and in peer groups. In the sixth phase, individuals initiate the reaction that seems to be most appropriate and in line with their goals.

Models of SIP assume that individuals go through these phases more or less automatically and with little if any reflection. Although the processes may depend partially on dispositions of neuropsychological functioning and temperament, the content of SIP is attributed mainly to learning in social contexts (e.g., Bandura, 1973).

For example, experiences of aggression, conflict, abuse, and inappropriate parenting in the family seem to have a basic influence. Aggression-prone schemata and beliefs may also be learned via media consumption, at school, and particularly in peer groups. The respective cognitions influence interactions in peer groups, and the resulting behaviour is again evaluated and reinforced cyclically by them (Crick & Dodge, 1994). Eventual changes in SIP may be because of new social experiences, differentiations of cognitive schemata, and acquired social skills during development.

4.5.9 General Aggression Model

In General Aggression Model (GAM), Anderson and Bushman (2002) tried to integrate existing mini-theories of aggression into a unified whole. The model is based on the concept of knowledge structures and how they operate to produce behaviour. Knowledge structures arise out of experience, influence perception, can become more or less automatic in some cases, and are linked to affective states, beliefs and behaviour. In essence, they are used to guide responses to the environment. Knowledge structures include perceptual schemata, person schemata, and behavioural scripts which define the kinds of behaviours that are appropriate in various situations. The model focuses on characteristics of person and the situation as they relate to a person's present internal state (affect, arousal and cognition), and ultimately appraisal and decision making processes. Appraisal and decision making processes lead to either impulsive or thoughtful actions, which in turn cycle back to the next social encounter.

Self Assessment Questions

1) Discuss the psychodynamic theory of aggression.

.....

.....

.....

.....

.....

2) In what ways frustration aggression theory explains aggression.

.....

.....

.....

.....

3) What is cognitive neo association theory? How does it explain aggression.

.....

.....

.....

.....

4) Delineate social learning theory from the point of view of learning aggressive behaviour.

.....

.....

.....

.....

5) What is script theory? How does it explain aggression?

.....

.....

.....

.....

6) Discuss excitation transfer theory and social information processing theories in terms of explaining aggression.

.....

.....

.....

.....

.....

7) Explain aggression from the point of view of social interaction theory.

.....

.....

.....

.....

.....

8) Put forward the general aggression model and explaina ggression in terms of the same.

.....

.....

.....

.....

4.6 INTERVENTION TO REDUCE AGGRESSION

Treatment needs to be targeted at major modifiable risk factors and its outcome measured objectively. It should preferably be at an early age as conduct disorder can be reliably detected early, has high continuity, is amenable to treatment at a young age, and is very hard to eradicate in older children..

4.6.1 Parent Training Programmes for Reducing Antisocial Behaviour in Children

Little published evidence exists that individual psychotherapy whether psychodynamic or cognitive behavioural, pharmacotherapy, general eclectic family work, or formal family therapy are effective in treating conduct disorder. Behaviourally based programmes to help parents, however, have consistently been shown to be effective. For example, the pioneering work of Patterson and colleagues showed that directly instructing parents while they interact with their children leads to significant and lasting reduction in behavioural problems. Many other studies have replicated this.

4.6.2 Developing a Programme

It is better to organise a training programme for the parents and teenage children and this can be done by two or three disciplines coming together. To get results the professionals need to be trained in the specific methods, and for this one needs a manual and a training centre with well qualified trainers. Most consistently effective programmes have at least 10 sessions, to increase the effects, a booster is desirable several months later. Also, intervention needs to be early, since teenage treatments have only small effects.

4.6.3 Training Using Videotapes

Although conventional one-to-one treatment is effective, a more cost effective approach is needed to treat larger numbers. One could have videos showing short vignettes of parents and children in common situations. They show the powerful effect of parents' behaviour on their child's activity, with examples of "right" and "wrong" ways to handle children. Ten to 14 parents attend a weekly two hour session for 12 weeks. Two therapists lead the group and promote discussion, so that all members grasp the principles; role play is used to practice the new techniques. Practical homework is set each week and carefully reviewed with a trouble shooting approach.

4.6.4 Other Training Programmes

Among more intensive programmes, the one developed by Puckering et al entails one day a week for 16 weeks. This programme has been shown to be effective in improving parenting in quite damaged families and enabling children to come off "at risk" child protection registers.

4.6.5 Failure of Parent Training

In many cases, aggression is caused by faulty parental behaviour, often because of parental psychiatric difficulties such as depression, drug and alcohol problems, and personality difficulties.

4.6.6 Management of Hyperactivity

Hyperactivity is distinct from conduct disorder, although they often coexist. Psychological treatment has to be rather different. Rewards have to be given more contingently and more frequently and have to be changed more often. Tasks have to be broken down into shorter components. Specific, clear rules have to be set for each different situation, as these children have difficulty generalising. School is often particularly difficult as the demands for concentration are great, the distractions from other children higher than at home, and the level of adult supervision lower. However, use of the principles outlined above can lead to useful improvements.

Management with drugs (usually methylphenidate or dexamphetamine) is reserved for children with severe symptoms in both home and school (hyperkinetic syndrome). This syndrome occurs in just over 1% of boys. The short term effects of drug treatment are large; less is known about long term benefits.

4.6.7 Interventions at Schools

Early preventive educational programmes can reduce later aggressive behaviour.

Self Assessment Questions

1) What kind of parent training programme will be useful in reducing aggression.

.....

.....

.....

.....

2) What are the various methods of developing a programme of intervention in Aggression?

.....

.....

.....

.....

3) Discuss the various other training programme for intervention in aggression and indicate if there is failure of parent training how would it affect the interventions?

.....

.....

.....

.....

4) How will you manage hyperactivity?

.....

.....

.....

.....

5) In what ways one could organise intervention programmes in schools for reducing aggression

.....

.....

.....

.....

4.7 LET US SUM UP

Aggression is 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. Accidental harm is not aggressive because it is not intended. Harm that is an incidental by-product of helpful actions is also not aggressive, because the harm-doer believes that the target is not motivated to avoid the action e.g., pain experienced during a dental procedure. There are different types of aggression. Theoretical perspectives on aggression suggest that typographically and functionally distinct subtypes of aggression exist. It is important to consider the multidimensional nature of aggression because different stimuli combine with different types of physiological and mental processes to create distinct forms of aggression. Treatment needs to be targeted at major modifiable risk factors and its outcome measured objectively. It should preferably be at an early age as aggression is amenable to treatment at a young age and is very hard to eradicate in adults

4.8 UNIT END QUESTIONS

1) Define the term aggression and discuss various types of aggression.

2) Describe the salient factors that contribute in the development of aggressive behaviour pattern.

3) Why do people behave aggressively as they do, critically evaluate?

4) Compare and contrast different theoretical models of aggression.

5) Design an intervention program to control aggression.

4.9 SUGGESTED READINGS AND REFERENCES

Bandura, A. (1973). *Aggression: A Social Learning Analysis*. Prentice-Hall; Oxford, England:

Baron R.A. & Richardson D.R. (1994). *Human Aggression*. 2nd ed. New York: Plenum.

Baumeister R.F. (1989). *Masochism and the Self*. Hillsdale, NJ. Erlbaum.

Berkowitz, L. (1993). *Aggression: Its Causes, Consequences, and Control*. New York: McGraw-Hill.

References

Achenbach, T.M. Child Behaviour Checklist and related instruments. In: Maruish, ME., editor. The use of psychological testing for treatment planning and outcome assessment. Lawrence Erlbaum Associates; Hillsdale, NJ: 1994. p. 517-549.

American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed.. Authors; Washington, DC: 1994.

Anderson, C. A., & Bushman, B. J. (2002). Human aggression. Annual Review of Psychology, 53, 27–51.

Arsenault L, Tremblay RE, Boulerice B, Saucier JF. Obstetrical complications and violent delinquency: Testing two developmental pathways. Child Development 2002;73:496–508. [PubMed: 11949905]

Atkins MS, Stoff DM, Osborne ML, Brown K. Distinguishing instrumental and hostile aggression: Does it make a difference? Journal of Abnormal Child Psychology 1993;21:355–365. [PubMed: 8408984]

Bandura A. (2001). Social cognitive theory: an agentic perspective. Annu. Rev. Psychol. 52:1–26

Blustein, J. Intervention with excessively aggressive children: Conceptual and ethical issues. In: Ferris, CF.; Grisso, T., editors. Understanding aggressive behaviour in children. New York Academy of Sciences; New York: 1996. p. 308-317.

Bushman B.J. & Anderson C.A. (2001). Is it time to pull the plug on the hostile versus instrumental aggression dichotomy? Psychological Review, 108, 273–79.

Buss, A. H., & Durkee, A. (1957). An inventory for assessing different kinds of hostility. Journal of Consulting Psychology, 21, 343–349.

Carlson, N. Physiology of behaviour. 6th ed.. Allyn and Bacon; Needham Heights, MA: 1998.

Collins A.M., Loftus E.F. (1975). A spreading activation theory of semantic processing. Psychol. Rev. 82:407–28

Crick NR, Dodge KA. 1996. Social-information-processing mechanisms in reactive and proactive aggression. Child Dev 67:993–1002.

Crick, N. R., & Dodge, K. A. (1994). A review and reformulation of social information processing mechanisms in children's social adjustment. Psychological Bulletin, 115, 74-101.

Dodge, KA.; Schwartz, D. Social information processing mechanisms in aggressive behaviour. In: Breiling, JE., et al., editors. Handbook of antisocial behaviour. John Wiley; New York: 1997. p. 171-180.

Dollard J, Doob L, Miller N, Mowrer O, Sears R. (1939). Frustration and Aggression. New Haven, CT: Yale Univ. Press

Elliott, DS.; Ageton, S.; Huizinga, D.; Knowles, B.; Canter, R. The prevalence and incidence of delinquent behaviour: 1976–1980. Behaviour Research Institute; Boulder, Colorado: 1983. National Youth Survey. Report No. 26

Ellis A. Healthy and unhealthy aggression. Humanitas 1976;12:239–254.

Ferris, C.F. & Grisso, T. (1996). Understanding aggressive behaviour in children. Annals of the New York Academy of Sciences; New York, p. 426-794.

Feshbach, S. Aggression. In: Mussen, P., editor. Carmichael's manual of child psychology. Wiley; New York: 1970. p. 159-259.

Geen R.G. (2001). Human Aggression. Taylor & Francis. 2nd Ed.

Greydanus D.E., Pratt H.D., Greydanus S.E. & Hoffman A.D. (1992). Corporal punishment in schools: A position paper of the Society for Adolescent Medicine. Journal of Adolescent Health 13, 240–246.

Gupta P. Frustration in socially disadvantaged adolescents. Child Psychiatry Quarterly 1983;16:34–38.

Hare, RD. The Hare Psychopathy Checklist-Revised. Multi-Health Systems; Toronto, Ontario, Canada: 1991.

Huesmann LR. (1998). The role of social information processing and cognitive schema in the acquisition and maintenance of habitual aggressive behaviour. See Geen & Donnerstein 1998, pp. 73–109.

Klein, M. Watch out for that last variable. In: Medinick, SA.; Moffitt, TE.; Stack, SA., editors. The causes of crime: New biological approach. Cambridge University Press; Cambridge: 1987.

Liu JH, Raine A, Venables P, Dalais C, Mednick SA. Malnutrition at age 3 years predisposes to externalizing behaviour problems at ages 8, 11 and 17 years. American Journal of Psychiatry. 2004

Liu JH. Prenatal & perinatal complications as predispositions to externalizing behaviour. Journal of Prenatal & Perinatal Psychology & Health 2004a;18:301–311.

Meloy, JR. The psychopathic mind: Origins, dynamics, and treatment. Jason Aronson; Northvale, NJ: 1988.

Mischel W. (1999). Personality coherence and dispositions in a cognitive-affective personality (CAPS) approach. In D. Cervone & Y. Shoda (Eds.), The Coherence of Personality: Social-Cognitive Bases of Consistency, Variability, and Organization (pp. 37–60). New York: Guilford

Moyer KE. Kinds of aggression and their physiological basis. Communication in Behaviour Biology 1968;2:65–87.

Murray HA. Uses of the Thematic Apperception Test. American Journal of Psychiatry 1951;107:577– 581. [PubMed: 14819343]

Neugebauer R, Hoek HW, Susser E. Prenatal exposure to wartime famine and development of antisocial personality disorder in early adulthood. Journal of the American Medical Association 1999;4:479–481

Raine A, Reynolds C, Venables PH, Mednick SA, Farrington DP. Fearlessness, stimulation-seeking, and large body size at age 3 years as early predispositions to childhood aggression at age 11 years. Archives of General Psychiatry 1998; 55:745–751.

Romi S, Itskowitz R. The relationship between locus of control and type of aggression in middle-class and culturally deprived children. Personality & Individual Differences 1990;11:327–333.

Scarpa A, Raine A. Psychophysiology of anger and violent behaviour. Psychiatric Clinics of North America 1997;20:375–394. [PubMed: 9196920]

Tedeschi JT, Felson RB. 1994. Violence, Aggression, & Coercive Actions. Washington, DC: Am. Psychol. Assoc.

Wodrich DL, Thull LM. Childhood Tourette's syndrome and the Thematic Apperception Test: Is there a recognizable pattern? Perceptual & Motor Skills 1997;85:635–641. [PubMed: 9347553]

Yudofsky SC. The Overt Aggression Scale for the objective rating of verbal and physical aggression. American Journal of Psychiatry 1986;143:35–39. [PubMed: 3942284]

Zelli A, Dodge KA, Lochman JE, Laird RD, Conduct Problems Prevention Research Group. (1999). The distinction between beliefs legitimizing aggression and deviant processing of social cues: Testing measurement validity and the hypothesis that biased processing mediates the effects of beliefs on aggression. J Pers Soc Psychol 77:150–166.