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Psychological Theories of Aggression: Principles and Application to Practice

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ABSTRACT

Aggression and violence are studied in a variety of disciplines. However, it is difficult to study human aggression directly, because it occurs sporadically and people often have reasons for not acknowledging or reporting it. This methodological complexity is probably reflected in the fact that each scientific discipline has its own level of analysis and develops its own set of theories and methods to explain aggression. This chapter deals with theoretical issues related to psychological approaches to aggression. Three main groups of aggression theories are examined: Psychoanalytic, drive and learning theory. The reciprocal relationship between theory, definition of aggression and study method is addressed in this chapter. Another aim is to give a critical review of definitional, methodological and theoretical strengths and shortcomings pertaining to the three historically dominant theories of aggression presented here. A final scope is to discuss the current clinical relevance of the individual theory concerning the treatment of violent mentally ill patients.

1 INTRODUCTION

Aggression, violence, and related behaviors have been studied in a wide range of disciplines including anthropology, biology, economy, political science, communication research, history, and sociology. In the present chapter, however, the primary focus
is on psychological theories of human aggression. Elements from other disciplines, e.g., biology, sociology, etc., are only addressed provided they constitute naturally integrated parts of the actual psychological theory of aggression. Important issues such as the mutual relationship between genetics and psychosocial factors, gender and age differences, and measurement issues are not dealt with unless such topics are emphasized in the individual theory.

It is well known that human aggression is not an easy field to study. In this respect, the heterogeneous nature of the term “aggression” constitutes a major complicating factor. Bandura (1973) claimed that conducting research in this field was like entering a semantic jungle of ideas that span an ample range of phenomena and activities. A study in a Dutch psychiatric hospital illustrates the clinical relevance of Bandura’s point very well (Finnema, Dassen, & Halfens, 1994). Finnema and co-workers interviewed nurses working in a psychiatric hospital to find out more of how they perceived and characterized patient aggression. Most of the nurses acknowledged positive as well as negative aspects of aggressive behavior. However, the descriptions of aggression varied considerably and the authors concluded that “it was not possible to formulate a general definition of aggression on the basis of the results of the study” (Finnema et al., p. 1088). One may question how the nurses managed to plan and coordinate treatment interventions in relation to aggressive incidents when they apparently were unable to share a common definition of the phenomenon. It is claimed here that the definitional issue described above illustrates a situation representative of state of the art in a majority of clinical practice settings, and that this is closely related to the low status of theories of aggression in clinical practice. In sharp contrast to this, it is generally acknowledged that a sound theoretical grounding is at the core of efficient clinical practice. Taken together, these assumptions contribute to justify the focus on theories of aggression in this chapter.

The primary aims of this chapter are:

1. To give a brief introduction to three basic psychological theories of aggression;
2. To address their relevance to clinical psychiatric practice.

Contributions from the following main theories of aggression are presented:

- Psychoanalytic theory
- Drive theory
- Social learning theory

Naturally, limitations of space allow neither for detailed presentations and analysis nor for an outline of more than one theory from each theoretical perspective. The selection of perspectives is based on a search in the literature that yielded 140 works on theories of aggression (Bjørkly, 2001). At least one of the following criteria had to be met to be included here:

- Early theories of historical significance and/or of relevance to recent theories of aggression
Current theories of aggression that are distinguishable from other theories
Theories based on empirical research, including clinical research.

The presentation of the individual theory is arranged in the following way (1) theoretical main points, (2) definition and study design, (3) limitations and shortcomings, and (4) relevance to current clinical treatment of violent mentally ill patients.

2 PSYCHOANALYTIC THEORY

In approaching the topic of aggression from the perspective of psychoanalysis it is important to recognize that contemporary psychoanalysis is not a unified theory. As the original theory has been modified and expanded, it has gradually developed into several distinctive approaches. A basic disagreement exists between structural theorists, who tend to see aggression as an innate drive or instinct, and self-psychologists, who tend to view aggression as secondary to narcissistic injury. For a more detailed discussion of the various psychoanalytic views, the reader is referred to other literature, e.g., Buss (1961) and Pedder (1992). This chapter is confined to a brief review of Sigmund Freud’s theory of aggression as an instinctual drive.

2.1 Theory of Aggression

Freud initially sought to derive all manifestations of human behavior from one basic life instinct, designated as Eros. Conceived of as a force, this life instinct was referred to as libido which functioned to enhance, prolong, and reproduce life. Freud showed very little interest in aggression, as such, in his early writings. In 1920, however, he proposed a dual-instinct theory in which the life instinct was matched by a death instinct, termed Thanatos (Freud, 1920). This instinct was conceived of as a force urging the disintegration of the individual and human life at large. The relationship between the life and death instinct is polarized and any destructive or non-destructive activity can be construed as the specific interaction of the antagonistic forces. Freud also claimed that feelings of anger and hostility result in conflict and unconscious guilt in the same manner that sexual wishes do, and that these effects initiate defensive activity. Further, he observed that many impulses contain both sexual and aggressive components, and that many clinical manifestations, including sadism, masochism, and ambivalence, can be explained in terms of varying degrees of conflict between these drives or their fusion. In Freud’s view, the death instinct forces the individual to direct aggressive acts against the social and physical environment in order to save themselves from self-destruction. Displacement and sublimation were introduced as central dynamic agents in the conversion of the potential attack on the self into an outward redirection. This inner dynamic process was instrumental to very different behavioral outcomes, such as coping, creativity, self-destruction, and aggression toward inanimate objects and living beings. According
to the dual drive-theory, if the aggressive impulses are not combined with or ade-
quately “bound” or fused with love, then increased aggression and destructiveness
can be expected. Deprivation, object loss, or child abuse are all traumas that can
interfere with attachment and the normative fusion of love and aggression. In case
of such failures, destructive energy will accumulate and, in its primitive form, result
in destructive behavior. Freud entertained the notion of catharsis or tension reduction
in connection with destructive energy. Catharsis refers to a process in which the
affective, nondestructive display or hostile and aggressive inclinations can discharge
destructive energy and thereby reduce the strength of these inclinations.

2.2 Definition and Study Design

Aggression is defined as an intrapsychological phenomenon. The death instinct is
its basic source of energy, but this energy can also result in creativity, coping, or
self-injurious behavior. The definition of aggression is wide and different human
behavior and emotions such as sarcastic language, passive–aggressive responses,
and murder are understood to be expressions of one unifying concept. The definition
is process oriented and of an intuitive nature.

Because psychoanalysis is built on the foundation of the patient’s narrative,
psychoanalytic research differs from research in other areas of psychology. The
traditional study design is founded on therapy material (the patients’ contribution)
and therapy interventions (the therapists’ contribution). Psychoanalysis is also
the preferred method to detect the causes of individual aggression. Scientifically
valid analysis rests on psychoanalytic interpretations of psychological data and the
assumption that there exists one underlying order in the universe that the phenome-
on under study represents. Freud was the first to adopt the causality principle to the
study of personality (psychological determinism). One of the main aims in psycho-
analytic treatment of aggression is to help the patient gain insight into the intrapsy-
chological mechanisms behind the aggressive drive. A move from unconscious to
conscious motivation is basic to this process. In line with this, the emphasis on the
role of intrapsychic mechanisms in aggression is reflected in the wide psychoana-
lytical definition of aggression.

2.3 Limitations and Shortcomings

Freud’s death instinct is perhaps the most controversial element of psychoanalytic
theory. Some authors are very harsh in their criticism of Freud’s contribution to the
theoretical understanding of human aggression:

“The basic concepts of Freud’s theories are metaphorical and do not yield
testable hypotheses.” (Tedeschi & Felson, 1994, p. 39)

Other serious objections to Freud’s theory of aggression are (1) Is it really possible
to understand aggression, which is a highly complex phenomenon, by means of a
single explanatory factor, the death instinct? (e.g., Okey, 1992). (2) Freud’s stance
that aggression is of a primary (instinctual) nature, held up against strong empirical
evidence of its reactive (secondary) character (Pedder, 1992). (3) Lack of empirical
documentation of the biological origins of aggression as a drive (Brenner, 1971).
(4) According to Freud, the never-ceasing self-destructive impulses of the death
instinct have to be transformed continuously into outwardly directed hostility and
aggression to ward off the lasting threat of discontinuation of life. Aggression is thus
inevitable, and attempts to control and eliminate it can only be temporary (e.g.,
Bandura, 1973). (5) Finally, Freud’s reasoning on catharsis has been questioned: Is
the reduction of tension a matter of seconds, minutes, days, or months? Does it
happen quickly or very slowly? And, how is it possible to treat catharsis as an
unquestionable mechanism in spite of strong negative research evidence on this
point? (e.g., Zillman, 1979).

2.4 Relevance to Current Clinical Practice

The psychoanalytical model of aggression has undergone considerable changes over
time. According to Akhtar (1995) there are two extreme positions concerning the
nature and origins of aggression. Sigmund Freud is found at one extreme, one that
holds to the concept of death instinct and that aggression is a destructive outward
deflection of this instinct. The other extreme is represented by Suttie, Fairbairn,
Guntrip, and Kohut whose view holds that aggression is a reactive and interactional
phenomenon that definitely does not have an instinctual basis.

Apart from some articles on the role of countertransference reactions to violent
patients, e.g., Dubin (1989) and Lion and Pasternak (1973), there is a paucity of pub-
llications on specified treatment approaches based on Freud’s theory of aggression.
On the other hand, there are a growing number of publications that focus on the clin-
cal application of the Rorschach method for diagnostic purposes in the assessment
of violent psychiatric patients. The scope of this diagnostic procedure is to provide
information about implicit motives and underlying personality dimensions that the
patient may be unaware of, or does not want to reveal (e.g., Bornstein, 2001;
Gacono, Meloy, & Bridges, 2000). In particular, these studies have addressed the
option of differentiating between psychopathy and other antisocial disorders, and the
difference between violent and nonviolent offender groups.

Inspired by Fairbairn, John Bowlby developed the attachment theory, located at
the other extreme of psychoanalytical theories of aggression. Within this perspec-
tive, humans are essentially social animals who need relationships for survival, and
whose first relationships with parental figures have unique characteristics (Bowlby,
1989). The child’s expression of distress normally elicits a helpful response from the
caregiver. A consequence of this is that the child will most likely develop and gen-
eralize a strategy of seeking proximity to the caregiver when distressed. Conversely,
when the child’s expression of distress results in further rejection or conflict, the
child’s most adaptive strategy is to control the distress by either attempting to inhibit
it, or by amplifying and exaggerating it. Attachment theory further assumes that
cognitive strategies (internal working models) developed early in life will come to
regulate how internal stimuli are attended to and interpreted, the nature of the emotional experiences triggered, and the memories that are retrieved in adulthood. There are numerous methods for assessing adult attachment. Mary Main’s Adult Attachment Interview (AAI) has been subject to the most rigorous evaluation, and its psychometric properties are well demonstrated (e.g., Bakermans-Kranenburg & van Ijzendoorn, 1993). The classification has four attachment categories: secure, avoidant, ambivalent, and disorganized. Although several studies indicate an increased risk of aggression stemming from avoidant attachment patterns, the strongest evidence of aggression risk pertains to the disorganized category. The term disorganized refers to the apparent lack, or collapse of, a consistent strategy for organizing responses to the need for comfort and security when under stress. Disorganized behavior increases under attachment-relevant family risk conditions such as maternal alcohol consumption, maternal depression, adolescent parenthood, or multiproblem family status.

The contributions of Paul G. Nestor and Peter Fonagy may illustrate the growing number of clinically relevant publications on relation-focused psychodynamic perspectives pertaining to mental disorder and violence. Nestor (2002) mapped clinical risk factors for violence onto four fundamental personality dimensions resulting from early attachment relationships and interaction with significant others. Two were related to regulatory functions of impulse control and affect regulation, and two to the personality surface traits of narcissism and paranoid cognitive personality style. Nestor also presented empirical evidence for, and recommendations of, measurement methods with very good psychometric properties. This kind of assessment may prove to be a highly relevant contribution to improve the quality of milieu treatment approaches. Fonagy (2003) delineated a developmental understanding of violence in the mentally ill. He emphasized that the key to the understanding of the development of violence and its treatment may be found in a thorough analysis of the individual’s attachment patterns. Attachment enables the mastery of aggression through the process of mentalization. According to Fonagy, mentalization refers to our capacity to understand others’ subjective experiences. Although he argues for early intervention, the main point of creating strong attachment relationships to enhance mentalization is highly relevant to clinical practice with adult psychiatric patients as well.

In sum, psychoanalytic understanding of aggression has moved from a medically and psychiatrically dominated strategy with a focus on the individual child and his or her pathology to include social interactionist perspectives on the etiology and treatment of aggression. A social, interactionist approach is critical to the view that aggression is “pushed out” or “compelled” by inner forces such as death instinct or aggressive energy. At present, attachment theory forms the dominant psychoanalytic contribution to clinical research on aggression. This represents a major change from an instinctually based understanding to an interactional understanding of the nature and origins of aggression. Methodologically, this has resulted in a change from Freud’s narrative research method to quantitative measurement by means of structured interviews and observation of social interactions. The current standing of
Sigmund Freud’s theory of aggression in clinical practice outside the classical analyst context seems to be of a historic nature.

3 DRIVE THEORY

As described above, Freud’s theory of aggression was heavily attacked by contemporary psychoanalysts and psychologists. In particular, the notion of spontaneity in aggression; that is, the endogenous build-up of aggressive energy, has been dismissed. Still, in the late 1930s the energy concept was re-labeled “the drive concept” by the Yale researchers Dollard, Doob, Miller, Mowrer, and Sears (1939) in their formulation of the frustration–aggression hypothesis. This was motivated by a wish to translate the Freudian instinct propositions into more objective behavioral terms which could be put to empirical test.

3.1 Theory of Aggression

The original hypothesis first posited that any interference with an individual’s goal-directed activities causes frustration. In the frustration–aggression hypothesis, not only those factors that will determine how frustrated an individual will become was specified, but also how and when aggression will be expressed. One may wonder why this approach to the understanding of aggression was termed a hypothesis. Obviously, it was more distinct and open to empirical testing than Freud’s original approach. Maybe this formulation was chosen because Dollard and collaborators meant that they were actually only expanding on Freud’s theory. Thus the premise of the frustration–aggression hypothesis is that when people become frustrated (thwarting of goals) they respond aggressively. This is clearly highlighted by Dollard and coworkers in their original work:

“The occurrence of aggressive behavior always presupposes the existence of frustration and, contrariwise, that the existence of frustration always leads to some form of aggression” (Dollard et al., 1939, p. 11).

Thus, although aggressive behavior emanates from an aggressive drive, this drive is not of an instinctive nature. The drive is only initiated due to perceptions of frustrating external stimuli. Accordingly, this represents a breach with Freud’s instinctual understanding by the fact that aggression is understood as a reactive phenomenon. The blocking of an ongoing goal response leads to a build-up of aggressive energy within the organism. This energy is noxious and must be released by the organism in the form of aggressive behavior. Any response that releases this aggressive energy is an instance of aggression. The strength of the instigation to aggression (e.g., the aggressive drive) varies according to three factors:

1. The amount of frustration.
2. The degree of interference with a goal-seeking response.
3. The number of frustrated responses experienced by the individual.
Aggressive responses are considered self-reinforcing within the hydraulic model adopted by frustration-aggression theorists. Thus, the association between frustration and a particular aggressive response is strengthened by reinforcement associated with drive reduction. Still, the performance of the same behavior again requires a new build-up of drive for activation. Dominant aggressive responses may be weakened through punishment. This type of learned inhibition results, in effect, in the lowering of a dominant response in the hierarchy of aggressive responses. One possible consequence of this is that the organism will subsequently exhibit a different aggressive response. The aggressive drive has found a new outlet by means of displacement. However, Dollard et al. (1939) did not propose that frustration always leads immediately or directly to aggression. Learned inhibitions may dam up the drive until some later frustrating event occurs.

Although the potential for an aggressive drive is claimed to be inborn, frustrating stimuli must also be present to initiate its development. Both biological and social factors appear equally important in the development of aggressive behavior and, as a result, the frustration-aggression hypothesis implies no clear primacy of either genetics or environment in the etiology of individual aggressive behavior.

### 3.2 Definition and Study Design

Aggression is defined as the “sequence of behavior, the goal-response to which is the injury of the person toward whom it is directed” (Dollard et al., 1939, p. 9). The connection between frustration and the build-up of aggressive energy or drive was postulated to be innate. Aggressive drive serves to energize available aggressive responses. This is basically a process-oriented and intuitive definition, but the theory’s focus on frustration is also consistent with trigger-mechanism definitions.

Social psychological laboratory design represents the dominant study setting. While many different methods for investigating aggression in laboratory settings have been devised, most seem to fall into one of four major categories, involving (1) verbal assaults against others; (2) attacks against inanimate objects; (3) “safe” noninjurious assaults against live victims; and (4) ostensibly harmful attacks against such persons. The low threshold for behavior to be defined as aggression in drive theory is probably influenced by two factors: (1) the inheritance from the psychoanalytic founding of drive theory and (2) ethical limitations pertaining to the study of human aggression within the laboratory context.

### 3.3 Limitations and Shortcomings

Perhaps one of the strongest assets of the frustration-aggression hypothesis was the specifications of those factors which determine not only how frustrated an individual may become, but also how and when aggression will be expressed. The focus on these causative variables gave researchers the opportunity to test specific premises of the hypothesis empirically, resulting in intensive scientific scrutiny of the building blocks of the hypothesis. As a consequence, several specific predictions that
were made from this hypothesis were validated (for reviews, see Bandura, 1973; Feshbach, 1970; Parke & Slaby, 1983). In particular, the formulation that frustration was a necessary precipitant of aggression was questioned by a substantial number of researchers (e.g., Buss, 1963; Pastore, 1952). Bandura criticized the drive (and instinct) theory because the internal determinants were inferred from the behavior they caused. He pinpointed this by applying the term pseudoexplanations on this process of circularity and clarified his position by stating that:

“It should be emphasized here that it is not the existence of motivated behavior that is being questioned, but rather whether such behavior is at all explained by ascribing it to the action of drives or other inner forces.” (Bandura, 1973, p. 40).

In sum, without an independent ability to observe and measure the presence, accumulation, and release of aggressive energy, it is not possible to identify responses as aggression (Tedeschi, 1983). The assumption that an organism is programmed so that frustration always creates an instigation to aggress, and that this remains until it is discharged by aggressive behavior has been contradicted by two lines of evidence. Firstly, efforts to provide empirical support have failed to do so and, more fundamentally, biologists have found that an organism is simply not capable of storing energy or of cumulating energy over time.

In a midway point on the continuum of critics, Leonard Berkowitz (e.g., Berkowitz, 1993) emerged as a proponent of both support to, and criticism of, the original formulation. He reformulated the hypothesis by lending increased emphasis to the impact of social context and social judgment. By this he more or less discarded the original linear stimulus-drive conceptualization. One of his theoretical building blocks was to comprehend frustration to be an aversive event that generates aggression only to the extent that it produces negative affect.

The attractiveness of the actual goal, the character of associated cognitions and situational cues have an important influence on the strength of the instigation to aggression and the reader is referred, for example, to Tedeschi and Felson (1994) for a critical review of Berkowitz’s theory of aggression. In sum, the frustration-aggression theory was sufficiently accurate to allow for experimental disconfirmations as well as support for the theory. Thus, as is the case with all good scientific theories, it produced evidence of its own limitations.

3.4 Relevance to Current Clinical Practice

Because drive theory of aggression attributes such behavior to the presence of specific environmental conditions, i.e., frustrating events, and not only to innate tendencies toward violence, it is somewhat more optimistic with respect to prevention, control, and treatment than Freud’s instinct theory. That is, it seems to suggest that the removal of all external sources of frustration from the environment would go a long way toward eliminating human aggression. Unfortunately, though, frustration is probably such a frequent and commonplace occurrence for most individuals that its total elimination seems quite unfeasible.
The impact of frustration as a precursor to intramural aggressive behavior in psychiatric patients clearly demonstrates this point. Clinical studies on the exact nature of patient–staff interactions that may increase the risk of violence in psychiatric wards are steadily growing in number (e.g., Nijman, Merkelbach, Allert, & a Campo, 1997). A strong relationship between problems of communication in staff–patient interactions and the increased risk of violence is documented in several studies (Owen, Tarantello, Jones, & Tenant, 1998; Whittington & Wykes, 1996). Shah, Fineberg, and James (1991) argued that authoritarian staff attitudes and lack of communication between staff and patient may elicit violence. Earlier studies have reached similar conclusions (e.g., Katz & Kirkland, 1990; Rice, Harris, Varney, & Quincey, 1989). In their studies, Blair (1991) and Flannery, Hanson, Penk, and Flannery (1996) found that inflexible attitudes among staff members and lack of consistency in setting limits may induce violence. Still another study concluded that experienced staff were significantly more competent in helping patients control their anxiety, more ready to ask for help and less reluctant to admit that they were anxious in certain limit-setting interactions (Perregaard & Bartels, 1992). The authors hypothesize that such characteristics explain the disproportionately low number of violent encounters experienced nurses were involved in, compared to those with less experience.

It is quite well documented that limit-setting situations are frequent precipitants of violence in psychiatric wards. Efforts to reduce the number of limit-setting interactions may be one evident consequence of these findings. However, limit setting is an integrated part of a structured treatment approach that has been demonstrated to be superior to an unstructured approach in the treatment of potentially violent, psychiatric patients (e.g., Aquilina, 1991; Flannery et al., 1996; Friis & Helldin, 1994; Katz & Kirkland, 1990). It is argued here that efforts to better nurses’ ability to identify escalating situations, together with measures taken to improve the quality of staff communication in limit-setting interactions, may reduce both rates of violence and the number of limit-setting episodes. Empirical evidence for the efficacy of staff training programs is steadily growing. Using a therapeutic management protocol, Kalogjera and associates obtained a 64% reduction in seclusions and restraints on three wards (Kalogjera, Bedi, Watson, & Meyer, 1989). Their protocol gives detailed suggestions about how staff members should react to patients’ disruptive behavior at an early stage. To reduce the individual patient’s level of frustration is basic to this procedure. To my knowledge, a study by Nijman and coworkers (1997) is one of the first studies of staff training programs that include control conditions. This study failed to find a strong effect of staff training on rates of aggression, mainly because there was a marked reduction in frequencies of aggressive behavior in both experimental (about 60%) and control wards (about 40%). Nijman and coworkers conclude that standardized reporting, by staff, of aggressive episodes may, in itself, reduce rates of aggression. Similar findings have been reported in other studies (e.g., Nilson, Palmstierna, & Wistedt, 1988). There are reasons to believe that one positive effect of accurate recording of aggressive incidents is to obtain an improved overview of frustrating factors and interactions for the individual patient.
Apparently, there is a need for further research to improve the content and clinical implementation of such standardized staff training programs. Such programs should primarily focus warning signs and situational antecedents of violence, in addition to communication styles aimed at conflict resolution and calming down in limit-setting interactions to minimize frustration.

Since violence rarely erupts without warning, staff guidelines for optimal timing of, and preplanned criteria for, when to set limits for patients are important factors in an optimal staff intervention procedure. Monitoring of early warning signs in the individual patient may allow for early interventions while the level of frustration is still low in both patient and staff (Tardiff, 1989). There appears to be good empirical evidence for the fact that recidivist patients generally show warning signs prior to violent acts in psychiatric wards (Linaker & Busch-Iversen, 1995; Powell, Caan, & Crowe, 1994).

Very few procedures and forms developed to measure violence in psychiatric patients give prominence to situational factors in their structures (Bjørkly, 1996). Referring to findings from studies within the drive theory tradition, it is claimed here that effective treatment and prevention of violence on psychiatric wards may profit from a more comprehensive and accurate monitoring of frustrating situational precipitants of violence (Bjørkly, 1999).

4 SOCIAL LEARNING THEORY

Learning theory was the dominant scientific approach to psychology in the first half of the twentieth century. The development and application of these theories to aggressive behavior has been led by Arnold Buss and Albert Bandura. In sharp contrast to the instinct or drive views of aggression, which suggest that aggression stems from one or a limited number of crucial factors, the social learning framework holds that it may actually be elicited and established by a large and varied range of conditions. Buss’s theory represented a transition by its emphasis on personality and social factors as variables affecting aggressive behavior. Still, Bandura’s theory is the most influential learning theory of aggression, and a natural first choice for presentation here.

4.1 Theory of Aggression

According to Bandura (1973), a comprehensive analysis of aggressive behavior requires careful attention to three issues (1) the ways such actions are acquired (“Origins of aggression”), (2) the factors that instigate their occurrence (“Instigators of aggression”), and (3) the conditions that maintain their performance (“Regulators of aggression”). In short, to understand aggressive behavior, we need exactly the same kind of analyses that would be required for any other kind of behavior. A wide variety of reinforcers appear to play a role (“Origins of aggression”) (1) acquisition of material incentives, (2) social approval or increased status, (3) the alleviation
of aversion treatment, and (4) pain and suffering on the part of the victim. Although people sometimes learn aggressive behavior by trial and error, most complex skills are learned vicariously by observing others. According to Bandura, learning by observation involves four interrelated processes. First, one must notice or pay attention to the cues, behavior, and outcomes of the modeled event. Then the observations must be encoded into some form of memory representation. Third, these cognitive processes are transformed into new imitative response patterns. Finally, given the appropriate incentives, the modeled behavior will be performed. The characteristics of the model are important in this process:

“People are most frequently rewarded for following the behavior of models who are intelligent, who possess certain social and technical competencies, command social power, and who, by their adroitness, occupy high positions in various status hierarchies.” (Bandura, 1986, p. 128).

Bandura claims that family members, individual subcultures, and mass media are the three principal sources of aggressive modeling.

Social learning theory distinguishes between two broad classes of motivators of behavior. Biologically based motivators include internal aversive stimulation arising from tissue deficits, and external sources of aversive stimulation that activate behavior through their painful effects. Cognitive representation of future outcomes aiding individuals to generate current motivators of aggression, form the other main group of motivators. Both classes of motivators are closely linked up to modeling of aggressive behavior. There are four processes by which modeling can instigate aggressive behavior (“Instigators of aggression”): A **directive function** of modeling serves to inform the observer about the causal means-ends relations in the situation. By extracting a general principle from observing the model’s experience, observers can generalize a causal understanding that, under the same conditions, they will receive the same outcome as the model if they imitate him/her. On the other side, a **disinhibitory function** of a model teaches observers that they can get away with aggressive behavior without being punished for it. Observations of others who engage in aggressive behavior cause **emotional arousal** in the observers. This may increase the likelihood of imitative aggression and even heighten the intensity of aggressive responses. Finally, observations of a model may have **stimulus-enhancing effects** by directing the observers’ attention to the aggressive expressions and methods being used. In addition to this, Bandura claims that **instructions** also serve as instigators of aggressive behavior, and that aggression can be triggered by bizarre internal beliefs such as delusions.

Once aggression has been acquired, a number of different factors operate to ensure that it will be maintained (“Regulators of aggression”). Not surprisingly, many of these are similar to the factors that facilitate their initial acquisition. (1) Successful aggression against others often continues to provide aggressors with tangible and social rewards. (2) It also has the potential of alleviating aversive or abusive treatment from others. (3) Self-reinforcement by self-administering praise and approval for the completion of aggressive behavior is yet another regulator of
aggression. It is worthwhile noting, however, that in social learning theory a self-system is not a psychic agent that controls aggressive behavior. Rather, it refers to cognitive structures that provide the referential standards against which aggressive and other behavior is judged.

4.2 Definition and Study Design

According to Bandura, aggression is defined as:

“Behavior that results in personal injury and physical destruction. The injury may be physical, or it may involve psychological impairment through disparagement and abusive exercise of coercive power.” (Bandura, 1983, p. 2).

The emphasis on the attribution of personal responsibility and injurious intent to the harm-doer places this definition within the trigger-mechanism group. The important role of various types of reinforcement and punishment as regulators of aggression confirms that this is also a consequence-oriented definition.

Assaults by individuals against inanimate objects are by far the most frequently used study method within the social learning paradigm. Typically, participants are first instigated to aggression through exposure to the actions of an aggressive model, and then provided with an opportunity to kick, punch, or otherwise attack some inanimate object. Aggression is then assessed in terms of the frequency with which they direct such actions against the target. The best-known application of such procedures is found in the “Bobo doll” studies first conducted by Bandura and his colleagues (Bandura, Ross, & Ross, 1963). These procedures have been criticized for only inflicting harm upon an inflatable doll and not upon another living being, as is explicitly included in Bandura’s definition of aggression. Bandura has responded to this criticism by calling attention to the distinction between the learning and the performance of aggressive responses. Still, one may question as to what extent Bandura’s strong emphasis on subjective judgments of intentions and causality in the definition of aggression is influenced by the preferred study design, and vice versa.

4.3 Limitations and Shortcomings

Bandura’s social learning theory has been criticized for not being a specific aggression theory per se (e.g., Pepitone, 1974). This concurs well with Bandura’s learning theory position claiming that even though deviant, e.g., aggressive, and constructive, e.g., pro-social, behavior are topographically different, they are established and maintained by the same basic learning principles. Tedeschi and Felson (1994) have focused on two main shortcomings in Bandura’s theory of aggression. Firstly, they question the evidence for the role of self-regulation as applied to aggressive behavior. Their main point is that the development of self-regulatory processes do not place all aggressive behavior under self-control:

“Cognitive reinterpretations can take the form of justifying the aggressive behavior, by minimizing, ignoring, or misconstruing the consequences, or by
dehumanizing or blaming the victim. Such justifications disinhibit behavior that otherwise would be considered reprehensible and would be inhibited by anticipations of self-punishment.” (Tedeschi & Felson, 1994, p. 108).

Secondly, they claim that social learning theory ignores the social context within which behavior is learned or performed. More specifically, this relates to limitations set by the laboratory design that has dominated social learning theory studies on aggression. The generalizability or external validity of laboratory findings is questioned by stating that, in spite of the name, the focus of social learning theory is on the individual, and the theory tends to underestimate the reciprocal behavior of people engaged in social interactions. Others have pointed at considerable ambiguity concerning the various mechanisms posited to explain the empirically demonstrated modeling effects in aggressive behavior (e.g., Zillmann, 1979). Exposure to models is a basic element for any kind of model learning. In his research Bandura has addressed important determining factors of this exposure (origins, instigators and regulators of aggression). Yet, basic questions remain unanswered concerning which of the mechanisms proposed is mainly responsible for the modeling effect: What type of model achieves what effect, on what kind of individuals, under what circumstances? The informative function, vicarious conditioning, and changes in the perception of salient features of the individuals involved are confounded: Is it possible to test their involvement or their respective contributions in the modeling process?

Whatever its shortcomings, Bandura’s theory is the most sophisticated theory of aggression from a learning perspective. Today, few psychologists question the importance of modeling in the study of human behavior or the view that anticipations of future consequences guide human behavior.

4.4 Relevance to Current Clinical Practice

Although originally not meant to be a model of clinical relevance, principles from social learning theory can be traced to current clinical psychology. In particular, cognitive behavior therapy (CBT) shares basic behavior analytical concepts and explanatory mechanisms with social learning theory. In addition to agreement on how behavior is regulated by external consequences, the understanding of self-regulatory mechanisms constitutes an important point of contact. According to Bandura, people can exercise some influence over their own behavior through self-generated inducements and self-produced consequences. In this self-regulatory process, people adopt through tuition and modeling certain standards of behavior, and respond to their own actions in self-rewarding or self-punishing ways. In social learning theory, a self-system refers to cognitive structures that provide the referential standards against which behavior is judged. Howells and collaborators have described nine types of basic CBT intervention methods for violent offenders (Howells, Watt, Hall, & Baldwin, 1997). Six of these reflect basic elements from Bandura’s social learning theory of aggression: identifying and modifying the immediate triggering events, identifying and modifying contextual stressors, changing
cognitive inferences and dysfunctional schemata, undermining dysfunctional inferences and schemata by tracing their developmental roots, broadening the repertoire of coping responses, and prevention of escalating social behavior. These interventions all relate to one or more of Bandura’s three main components of social learning analysis of aggression: origins, instigators and regulators of aggression.

Dialectical Behavior Therapy (DBT) is a comprehensive cognitive behavioral treatment originally developed for chronically parasuicidal women diagnosed with Borderline Personality Disorder (Linehan, 1993). Over the past decade it has been adapted for many other populations, including violent psychiatric patients (e.g., Berzins & Trestman, 2004). A central component of DBT involves targeting the following four behavioral skills modules (1) mindfulness skills, (2) distress tolerance skills, (3) emotion regulation skills, and (4) interpersonal effectiveness skills. Mindfulness targets lack of self-regulation and confusion by emphasizing self-awareness. Distress tolerance involves distraction and self-soothing techniques. Emotion regulation teaches people how to reduce their vulnerability to negative emotions and how to increase positive emotions. Interpersonal effectiveness teaches them assertiveness and how to deal with conflict situations. There is a striking resemblance between these skill modules and Bandura’s component processes in the self-regulation of behavior (1) self-observation (performance dimensions), (2) judgmental process (personal standards, referential performances, valuation of activity, and personal attribution), (3) self-response (self-evaluative reactions, tangible self-applied consequences, and no self-response).

Clinical assessment and interventions based on individual warning signs fit well into Bandura’s component processes in the self-regulation of behavior. Some patients isolate themselves, others become overactive, some become physically tense, others glower, some express psychotic symptoms, etc., as indicators of increased violence risk. Recognition and an awareness of these warning signs may help both patients and their environment to implement aggression preventive measures. In both CBT and DBT the recognition of recurrent warning signs as specific individual precursors of violence is emphasized to have an important role in successful treatment and relapse prevention. In spite of this, there appears to be a paucity of instruments available for accurate and clinically useful measurement of warning signs of violence.

Although the influence of principles from social learning theory, to my knowledge, is not outspoken in either the CBT or the DBT tradition, it appears to be present in the basic principles depicted above. No matter what came first of CBT and social learning theory, the clinical relevance of Bandura’s theory of aggression appears to be well demonstrated.

5 CONCLUDING REMARKS

By addressing the main theoretical points, this chapter deals with three classical theories of aggression and their definition of aggression, study design, limitations and
shortcomings, and relevance to clinical practice. In Table 1, the main theoretical foci of the three theories are depicted. It illustrates the psychoanalytic biological/instinctive position at one extreme, and the cognitive and social interactionist stance of social learning theory at the other.

Still, it is worthwhile to note that one of the hallmarks of modern psychoanalytic theories such as attachment theory is the emphasis put on cognitive functions and social interactions in the understanding of human aggression. In psychological terms, secure attachment relationships allow the developing individual to construct “internal working models,” of himself and others. These models are based on the interaction between the individual and the attachment figure, which becomes established as internal cognitive structures. The idea that disrupted social interactions with important others may predispose the individual to disrupted/aggressive cognitive schemata constitute a basic idea in Bandura’s theory of aggression. Thus, apparently the last decades have witnessed that psychoanalysis and social learning theory have approached each other concerning the view on the nature and origins of aggression.

Naturally, the main theoretical foci are reflected in the individual theory’s preferred definition of aggression as well. Psychoanalysis and drive theory share the process-oriented/intuitive type of definition (Table 2). Social learning theory stands alone as an adherer of a consequence-oriented definition, while it shares the trigger-mechanism element with drive theory.

The psychoanalytical definition does not include reactive aggression and social learning theory does not hold the view that self-injurious behavior is aggression (Table 3). Apart from that, the definitions are surprisingly similar when one takes into consideration that they represent different theoretical positions.

The inclusion of damage to property is controversial in terms of the discriminant validity of the definition of aggression. Discriminant validity involves documenting that a characteristic, e.g., aggression, does not relate to other characteristics, e.g.,

<table>
<thead>
<tr>
<th>Theory of Aggression</th>
<th>Biological Perspective</th>
<th>Instinct Perspective</th>
<th>Drive Perspective</th>
<th>Cognitive Functions</th>
<th>Social Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoanalysis</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drive theory</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social learning theory</td>
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<td>X</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Theory of Aggression</th>
<th>Process Oriented/Intuitive</th>
<th>Trigger Mechanism</th>
<th>Consequence Oriented</th>
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<tbody>
<tr>
<td>Psychoanalysis</td>
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</tr>
<tr>
<td>Drive theory</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Social learning theory</td>
<td>X</td>
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<td>X</td>
</tr>
</tbody>
</table>
anger, from which it should be independent. In short: What is the rationale behind categorizing damage to property as aggression instead of, let us say, anger? Freud’s theory has been criticized for lack of discriminant validity due to the wide array of very different social expressions he asserted to be governed by the death instinct. More precisely, it is not very easy to acknowledge that diametrically opposed behavior such as artistic creativity and homicide stem from the same instinct. Concerning the two other theories of aggression, one may question whether a wide definition of aggression has emerged due to the fact that the great majority of investigations of aggression have been performed within laboratory settings. Naturally, a research design involving damage to property is much more feasible and ethically acceptable than letting participants hurt each other physically. However, in addition to the definitional issue, laboratory research raises a number of potential problems. For example, participants know quite well that they are taking part in a psychological experiment, and once they do they may confirm, refute or ignore predictions of “what the experiment is all about.” Social learning theory is the most broadly based, and psychoanalysis the most limited, approach in terms of span of research methods (Table 4). One may question whether sticking to one single research method has deprived psychoanalysis of a more comprehensive external validation of the theory.

At the other end, the fact that social learning theory has been empirically validated within a range of multiple research designs may have strengthened its current position as the leading theory of aggression.

Table 3. Definitional Criteria

<table>
<thead>
<tr>
<th>Theory of</th>
<th>Physical Damage to</th>
<th>Type of Aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggression</td>
<td>Verbal</td>
<td>Indirect</td>
</tr>
</tbody>
</table>
| Psychoanalysis | X | X | X | X | X | (X)
| Drive theory | X | X | X | X | X | X |
| Social learning theory | X | X | X | X | X | X |

*aAs sufficient criterion in itself.
*bThe motive of the act may be unconscious but the act may still be intentional.

Table 4. Research Methods

<table>
<thead>
<tr>
<th>Theory of Aggression</th>
<th>Laboratory Trials</th>
<th>Indirect Methods*</th>
<th>Information from Victim/Aggressor</th>
<th>Direct Observation</th>
<th>Field Experiment</th>
<th>Therapy Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoanalysis</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Drive theory</td>
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<tr>
<td>Social learning theory</td>
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</tr>
</tbody>
</table>

*Criminal registers, information from collaterals, surveys, etc.
In this chapter, three classical theories of aggression and their relevance to clinical practice have been presented. The main motive for doing this has been to bring attention to the importance of a careful theoretical founding of research on aggression. It is claimed that this is of particular relevance to clinical research and practice pertaining to aggression in people with mental disorders, since atheoretical positions very easily lead into aimless clinical pragmatism. Still, one must always remember that theory is a useful servant, but a useless master.

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