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Orphan's Aggression and Understanding Aggressive Behavior: A Systematic Review

Satish[1], Subodh Saurabh Singh[2], Anita Chauhan[3]

[1] Research Scholar, School of Ancient Indian Wisdom and Yogic Studies, Shoolini University, Solan, Himachal Pradesh- 173229, India. ranny3737@gmail.com
[2]Associate Professor, School of Ancient Indian Wisdom and Yogic Studies, Shoolini University, Solan, Himachal Pradesh- 173229, India. subodhmdniy@gmail.com,
[3]Assistant Professor- Psychologist, Faculty of Basic Sciences, Shoolini University, Solan, Himachal Pradesh- 173229, India

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Abstract:

Children without parents are some of the most at-risk individuals affected by worldwide emergencies and disputes. Kids who have lost their parents encounter a diverse array of challenges, spanning psychological, physiological, social, and quality-of-life aspects, along with additional health-linked worries. Orphaned children are unable to achieve their goals, they feel incompetent. When confronted with failure, they act violently. They exhibit aggressive behavior as a result of both internal and external forces. It was also found in the study that orphan children exhibit more aggressive behavior than no orphan children. This study offers a concise examination of the various factors, including biological, social, and environmental, that are believed to contribute to the emergence of aggressive behavior. Furthermore, this research underscores the unique risk factors associated with aggressive behavior during different life stages, encompassing childhood, adolescence, adulthood, and later life. Gaining insight into these risk factors and their specific relevance to age-related expressions of aggression can empower nurses to devise and implement prevention and intervention strategies with greater efficacy.

Keyword: Orphan, Aggression, Consequences, Prevention.

INTRODUCTION

A child who has been permanently separated from or abandoned by his or her parents is referred to as an orphan (from the Greek word "Orfanos"). Only a child who has lost both parents is typically referred to as an orphan. According to Case et al. (2003),[1] an orphan is a boy or girl under the age of 18 who has lost both of their parents, either their mother or father (total orphan). One of three justifications is used to bring children to the orphanage home: First off, their parents have left them. Second, the parents' parental rights have been terminated by the state because they are behind bars, are drug addicts, or have harmed the child, and third, the parents of the child have passed away.[2]

Because they lack care and assistance, an orphan's life is particularly vulnerable. As a result, many other types of stressful situations affect orphans, including lack of family support, violence, physical and mental stress, and more. It may have an impact on their outlook on life, making them grumpy and depressed. Because of their lack of awareness, tension, and resentment, orphans occasionally leave the mainstream, endangering their growth and self-worth. These orphans may engage in antisocial behavior or drug abuse, which is not acceptable in our culture. The majority of research in this field has been conducted in Western societies. The results of the current study will now be useful in understanding the amount of violence in orphans. The study would provide new theoretical knowledge about the level of violence in orphans as well as some practical benefits. As a result, it will assist us in offering such information that is very important for mental health workers (psychologists, sociologists, counselors, and clinical psychologists) and policymakers to offer intervention programs and take effective action to encourage their development.

In its broadest sense, aggression refers to strong, hostile, or offensive behavior or disposition. The majority of theories of human behavior center on aggressive conduct. According to Baron (1977), [3] aggressiveness is any action taken with the intent to hurt or harm another living being who is trying to avoid receiving such treatment.

This definition captures the social and interpersonal nature of the organism. Three aspects have been highlighted. These are: (1) aggression is goal-directed behavior; (2) there is an intent to harm another person; and (3) it involves a victim who is motivated to resist the aggressor's treatment.

When compared to children who were never institutionalized, infants who were raised in orphanages display abnormal neuronal function in limbic areas, including the hippocampus, according to research by Chugani et al. (2001).[4] This was demonstrated by functional (Magnetic Resonance Imaging) MRI studies.

According to a study by Johnson et al. (2006)[5] on young children in institutional care who were at risk of damage, the lack of one-on-one interaction with a primary caregiver is the main factor contributing to the children's delayed social and emotional development.

In Iraqi Kurdistan's conventional foster care and orphanages, Ahmad et al. (2005)[6] monitored the competence, socio-emotional issues, and post-traumatic stress symptoms of the children. They discovered that orphans had much greater levels of sentiments of hopelessness and suicidal thoughts and were more likely to be nervous, depressed, and angry.

Hermenau et al. (2011)[7] conducted an experimental investigation to evaluate childhood adversity, mental illness, and aggressive behavior in an African orphan. Two-time points were used to evaluate the samples of 38 kids. The findings of the first study indicate a correlation between the aggressive behavior of the youngsters at the time and the violence faced by the orphans. The adoption of a new instructional system and psychotherapy treatment for trauma-related disease were assessed in the second study with the aid of the pre-post-study assessment. According to the findings, an orphan's exposure to violence also has a significant impact on how violent they become. According to the study, a new educational system and psychotherapy care might be implemented in an orphan to promote mental health.

Hodges and Tizard (1989)[8] studied how a group of about 40 orphans developed socially, behaviorally, and emotionally from preschool through adolescence. These kids were discovered to be too friendly toward adults, argumentative and unpopular with their friends, anxious, afraid, and aggressive before they reached puberty. They observed this group until they were 16 years old and discovered that they lacked close friends, had trouble with peers, were more adult-oriented than peer-oriented, were indiscriminate in their friend selection, and had problems with peers. It was discovered that several of these characteristics were 10 times more prevalent in ex-institutionalized youngsters than in control kids. The authors concluded that long-term impacts continue in all of the ex-institutional group members, even though they are more subtle in children adopted into rich homes than in groups that either return to their underprivileged biological families or stay in institutions.

Tizard and Rees (1975)[9] conducted research on the impact of early institutional raising on fourth-year-old children's behavioral issues and functional connections. They found that children's emotional and behavioral conditions deteriorated in orphanage homes, and even in well-run institutions, kids showed hostility and unrestrained adoration for adults. Age and gender are independent predictors of the likelihood of various forms of hostility and violent behaviors, regardless of a particular time or particular nation.

Aggression and antisocial behavior were studied by Coie and Dodge in 1997.[10] They demonstrated that men are more violent than women. There is scientific evidence that males react more quickly to hostility when it comes to the influence of gender on violent conduct. The same type of sex effect is frequently shown in laboratory experiments, although provocation significantly diminishes sex differences in physical aggression, and different provocations have varying effects on male and female aggression.

The development of excessive and impulsive violence is strongly influenced by early life stress, according to persuasive data from numerous research.[11] In this study, the relationship between orphans' stress and violence and their gender and place of living was examined. This study's primary goal was to determine whether orphans' levels of stress differ depending on their gender and place of residence. According to the mean score, male orphans scored lower on stress ($M = 19.98$, $SD = 2.72$) than female orphans ($M = 21.35$, $SD = 3.59$). Due to the socialization differences between the sexes, girls are expected to be subservient, well-behaved, docile, and repressed whereas boys are expected to be assertive and autonomous. Because of this, girls struggle with mental issues including stress, depression, and anxiety, which is similar to what Roberts et al. found (2005).[12] According to him, stress and depression were more common in girls than in boys and were caused by repressed emotions.

On the other hand, the mean score shows that the urban orphan's stress score was greater than the rural orphan's stress score (M=21.97, SD=3.03 vs. M=19.37, SD=2.93). This discovery is confirmed by (Atkins and Krantz 1993).[13]

The second goal of this study was to determine whether orphans' levels of violence differ according to their gender and place of residence. According to the mean scores, male orphans scored more aggressively than female orphans (M = 77.07, SD = 7.06) than female orphans (M = 70.47, SD = 5.88). Cox et al. (2000)[14] According to a large body of evidence, men tend to be more physically aggressive than women while women tend to be more verbally aggressive than men.

However, the mean score shows that the urban orphan's aggression score was greater than the rural orphan's aggression score (M=72.02, SD=6.91; M=75.52, SD=7.25). Rahman backed up these findings (2003).[15] These results demonstrated that aggression is moderated by both gender and residential origin. Male adolescents displayed higher hostility than female adolescents, and urban versus rural household backgrounds differed in the expression of aggression. Numerous characteristics of inner city life include violence, physical aggression, substandard housing, drug use that might compromise safety, and the psychological growth of orphans who are exposed to these characteristics regularly. The study's ultimate goal was to determine whether orphans' violence and stress were related in any way. With an alpha level of p.01, a positive correlation between stress and aggressiveness of rural and urban orphans was discovered (r = 0.38). It demonstrates a marginally significant link between orphans' stress and violence. Measurable social, emotional, and language development delays were seen in orphans raised in foster care facilities (Zhao et al. 2010).[16] Lack of parental engagement and direction, academic pressure, difficulty selecting best mates, lack of warmth or affection, and lack of close supervision all contribute to stress in orphans.[17] Their physical and emotional health may suffer substantial short- and long-term effects from how they handle this stress, such as persistent fear and anxiety, strained interpersonal relationships, violence, and other social disorders. This reminds me of Masten et al (1990).[18] They discovered that teenagers exhibit more disruptive or aggressive behaviors while under stress.

Adolescents who reside in orphanage homes represent a distinct population with a special setting, so they require special care. The current study may have crucial recommendations. Therefore, community health professionals are more likely to recognise those who require special attention to prevent developmental and psychological issues; The results are also valuable for educators and overseers of orphanages to recognize the difficulties confronted by these grieving teenagers. This enables them to provide necessary counseling and guidance services to aid the adolescents in managing their issues effectively. Future research should develop and establish official says the necessity to create a National Orphan Policy and ensure that the government, through the Ministry of Health and Child Welfare, protects the most vulnerable children and offers vital services was cited because psychosocial management is a crucial part of psychiatric therapy.

Understanding aggressive behavior

It's essential to differentiate between the concepts of aggression, aggressive behavior, and violence, despite their resemblances. Aggression is characterized as any deliberate action aimed at causing harm, discomfort, or injury to another individual. Aggressive behavior, on the other hand, is the visible display or expression of aggression.[19] It's crucial to remember that while aggressive behavior and violence are frequently equated, they are not. Violence is a type of physical assault, but aggressive behavior is a more general term that refers to harm inflicted through verbal, physical, psychological, and other means; violence is merely one example of aggressive behavior. As a result, aggressive behavior may not always involve physical contact. This distinction holds significant importance because, while recognizing aggressive behavior as a linked or predictive factor for violence is informative, it's equally important to investigate aggressive behavior that doesn't escalate to violence, as it can still have detrimental consequences. Given the broad spectrum of potential adverse public health outcomes, such as youth violence, heightened utilization of healthcare resources (including emergency departments, psychiatric care, and critical care), increased financial burdens, and greater involvement in the criminal justice system, the examination of aggressive behavior is indispensable for the healthcare sector. According to a World Health Organization study conducted in 2002, approximately 4,400 individuals lose their

lives each year due to acts of violence,[20] highlighting the need to understand and prevent aggressive behavior for public health.

Manifestations of aggressive behavior across the lifespan

Toddlers & pre-schoolers

It is commonly held that aggressive behavior in childhood is a normal part of the developmental process.[21] Physical aggression in youngsters shows up before verbal aggression does. Later on, linguistic abilities can be utilized to be aggressive, but they can also be used to control aggressive behavior by communicating requirements that cannot be physically conveyed. Toddlers act aggressively by wailing, biting, kicking, throwing, and smashing things.[22] Typically, anger outbursts peak between 18 and 24 months of age and gradually decline until age 5. It was discovered that most kids started acting aggressively about 17 months of age, or before they became 2 years old.[23] Additionally, a higher proportion of aggressive behavior and other externalizing behavior issues was discovered in kids with developmental delays.[24]

School-age children

A significant portion of the violent actions displayed by children during their preschool years may endure as they grow older and commence their schooling journey. These behaviors include actions like crying, shouting, biting, kicking, throwing objects, and breaking things. Nevertheless, as these school-age children become more involved in social interactions and form additional relationships, their aggressive behavior towards peers may start to become more apparent. Furthermore, behaviors such as ridicule, lack of patience, intimidation, conflicts, and even acts of harming animals or initiating fires could be noted. Nonetheless, reports from mothers regarding instances of physical aggression among children aged 2 to 11 suggest that aggressive behavior might decrease as they grow older. The identical study revealed a rise in accounts of mildly antagonistic behavior in the age range of 4 to 11. This shift could be attributed to children employing their linguistic skills more frequently and participating in a greater number of social relationships and exchanges during this period. Multiple studies have revealed no indication of the development of physical violence in children after the age of six, even though school-age children may exhibit violent behavior.[25] This indicates that the violent behavior observed in school-age children during this developmental phase is a continuation from earlier stages rather than beginning anew at this point.

Adolescents

Progressing, escalated aggressive conduct, encompassing more substantial aggression, often becomes evident in adolescence, resulting in a heightened occurrence of injuries or even fatalities. This is partially due to an increased likelihood of weapon utilization.[26] During the initial phases of violence, knives are commonly employed, while the utilization of firearms becomes more prevalent as adolescents mature. Adolescents may have a stronger predisposition to act aggressively against adults as a result of their increased physical strength and use of weapons.[27] Violent behavior among adolescents commonly occurs within groups, encompassing activities related to gangs, such as theft or truancy. Peer interactions play a substantial role in shaping adolescent aggression. By exhibiting authority or power, acting aggressively may be a strategy to become popular or achieve high social standing. Out of a fear of social rejection or loss of status, peer pressure may cause aggressive behavior to be displayed.[28] As cross-gender friendships become more significant, aggressive behavior between boys and girls also increases. When the dating phase begins, hostility between genders escalates, and it can even escalate into violent incidents like date rape and sexual assault. Furthermore, some teenagers may assume roles as partners and parents, elevating the potential for aggressive behaviors to manifest as domestic violence or child abuse. Adolescent aggression is a significant public health issue that numerous experts have noticed.[29] The World Health Organization conducted a comparison of violence rates in 35 countries using the Health Behavior in School-Aged Children (HBSC) survey. Among the 161,082 student participants, the engagement of boys in physical altercations varied from 37% to 69%, while girls' involvement ranged from 13–32%. Additionally, 2-5 percent of females and 10–21% of boys, respectively, reported carrying weapons.[30] Nonetheless, there exists a subgroup of aggressive conduct that emerges during adolescence and diminishes in early adulthood. This has been termed as "adolescence-limited antisocial behavior." Here, individuals who were previously in good health and exhibited typical behavior display delinquent actions during

their teenage years, which they subsequently abandon upon reaching adulthood. In such cases, the occurrence of adolescents showing limited-duration antisocial behavior is fairly widespread, temporary, and fundamentally usual.[31]

Adults

Aggressive conduct has the potential to escalate into progressively perilous and severe criminal acts as an individual grows older, encompassing acts like homicide, domestic violence, sexual assault, and child abuse. Among adults, an identifiable subset of intense aggression is road rage. While not explicitly mentioned in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, this phenomenon can be classified as intermittent explosive disorder. Road rage is the term used to characterize any angry driving behaviors, though these behaviors are also known as "angry or aggressive driving." Incidents of both violent and aggressive driving have increased. The majority of aggressive drivers are men between the ages of 18 and 26, making age the most significant factor in cases of aggressive driving.[32] Various factors, including situational and environmental elements like traffic and congestion, as well as personality traits and demographic characteristics, could potentially play a role in this.[33]

Factors that contribute to the likelihood of aggressive behavior throughout various stages of life

An individual's violent behavior can change significantly over their lives. Research suggests that aggressive behavior can manifest in two primary ways: either during childhood and continue into adolescence and adulthood, or emerge later in life, often as a consequence of physical or psychological trauma, substance misuse, illness, or brain injury.

Aggressive conduct developing in early childhood

Many hypotheses regarding how aggressive behavior first appears throughout childhood have also been put forth to explain why aggressive behavior also appears in teens and adults. Aggressive behavior in youngsters as well as other age groups may be explained by the social learning theory, which holds that people pick up aggressive behavior by watching how others behave. An individual may utilize comparable behavior when faced with a similar challenge if they observe aggressive behavior and how it affects getting a potential reward (such as resolving a quarrel or getting what they want). Evidence shows that exposure to family violence is frequently linked to aggressive behavior among children in that family lends support to this in children.[34] Utilizing longitudinal data, concern that media impacts, such as violence in television or movies, may be connected to an increase in violent behavior in those who watch those programs, has found support in youngsters specifically.[35] According to a different idea called the social information processing theory, people start acting aggressively after being repeatedly exposed to certain social stimuli. For instance, proactive aggression may happen after aggressive behavior has resulted in a reward. Additionally, SIP suggests that those who act aggressively may be prone to misinterpreting social cues, behaviors, and motives, which can lead to reactive aggressiveness. Children with autism spectrum disorders scored higher on aggression in two trials.[36] This discovery might be partially explained by the social information processing theory. The debate over "nature versus nurture," which considers whether and to what extent genetic/biological elements vs. environmental variables contribute to the development of aggressive behavior in children, is more focused on this topic. According to some studies, violent conduct in children is strongly correlated with psychosocial contextual factors, like bad parental upbringing, while other studies contend that aggressive behavior may have a hereditary basis.[37] Still, other studies about the impact of genetics produce ambiguous findings. The emergence of aggressive behavior in youngsters is likely influenced by both heredity and environment. Greater aggressive behavior has been linked to increased prenatal exposure to toxins or air pollution.[38] Neurological tests, electroencephalographic exams, and brain imaging scans frequently reveal aberrant clinical findings in those who exhibit aggressive and/or violent behavior.[39] Additionally, impulsive behavior or attention-deficit hyperactivity disorder may co-occur with aggressive behavior. Additionally, neurotransmitters might be a problem because recent research has shown that increasing serotonin might reduce aggressive behavior.[40] Throughout the body, particularly the central nervous system, serotonin is a neurotransmitter that is thought to contribute to emotions of happiness and well-being [41]. The biological model of etiology may include sex hormones. The concept of "roid anger," which links the use of anabolic steroids to aggressive behavior, has drawn a lot of media attention. Men who received testosterone injections scored their manic symptoms more frequently, according to randomized controlled

research.[42] Health-related risk factors shouldn't be disregarded.[43] For instance, The appearance of violent tendencies in children is associated with complications during birth, such as oxygen deprivation and the use of forceps, along with additional risk factors like inadequate parenting and an unfavorable home environment.[44] Birth difficulties may cause harm to the central nervous system, limiting healthy brain function. Additionally, a lack of some nutrients may impede brain development, which could make malnourished youngsters more susceptible to behavioral problems.[45] Tremblay (2010) highlights the advantage of longitudinal research, which may help to elucidate the intricate relationship between genes and the environment. Without this information, strategies for treating or preventing violent behavior may emerge before the mechanisms are clearly understood.[46]

Aggressive behavior arising in adolescents, adults, and elderly individuals

Adolescents, adults, or older individuals might also display aggressive behavior as a new occurrence. Theoretical models akin to those used to explain childhood aggression, such as the social learning theory, can be applied to elucidate aggressive conduct that emerges for the first time beyond childhood. However, aggressive behavior that emerges later in life may also be linked to an increase in substance addiction. A person may act aggressively to get money to buy drugs or while under the influence of drugs. Illegal drug usage has been linked to rises in violence and injuries caused by violence.[47] Alcohol seems to be the most dangerous of the drugs associated with aggressive behavior. Violence, including violence against intimate partners, and alcohol are connected (Bye 2007).[48] For example, alcohol was a factor in 63 percent of partner violence incidents, 39 to 45 percent of homicides, 32 to 40 percent of sexual assaults, and 45 to 46 percent of physical assaults.[49] The degree of intoxication may also be a factor. People who engage in severe violent behavior may be more drunk than people who engage in less serious episodes.[50] However, it hasn't been proven beyond a reasonable doubt that alcohol leads to aggressive behavior. Self-control may be compromised by alcohol. Or possibly those who engage in aggressive behavior drink more frequently than those who do not. Recent research has looked at the relationship between traumatic brain injury (TBI) and the risk that violent behavior may emerge after childhood. For instance, TBI was frequently accompanied by aggressive behavior.[51] The frontal lobes in particular, which regulate aggression and impulse control, may be damaged by the first injury.[52] However, it is unknown whether TBI may have additional effects that cause violent behavior that brain scans would not pick up. Due to declines in intellectual ability, memory, and reasoning, the advent of dementia may have a role in the appearance of violent behavior in older persons. Additionally, patients with neurodegenerative disorders may experience hallucinations or delusions, which increases the likelihood that they would act aggressively when they mistakenly sense a threat.[53] In their analysis of the risk factors for aggressive behavior in people with dementia, Kunik et al. (2010)[54] discovered that these risks included physical pain, sadness, and strained interactions between the patient and caregiver. Bipolar disorder, depression, and post-traumatic stress disorder are other conditions linked to violent behavior.[55] These correlations hold for all adults, not just elderly people. Aggressive behavior can happen when a person has bipolar disorder, which is characterized by alternating episodes of mania and depression. Self-directed anger may appear in depressed people or bipolar disorder patients during a depressive episode. Psychological trauma is a common cause of post-traumatic stress disorder, which impairs a person's capacity to manage anxiety. It's possible to use violence towards other people as a coping mechanism for stress. If there is a causal connection, it is unclear. Aggressive behavior in older populations has been linked to pre-morbid personality dysfunction, the advancement of illnesses, verbal communication deficits, and incorrect behavior interpretations from caretakers (such as mistaking acts of personal hygiene, such as washing hands, for threats) (Shub et al. 2010).[56] In addition, even though the causes of homicide-suicide are frequently unknown, a variety of circumstances may be involved. For instance, it's more likely that the offender was the victim's carer. Similar to that, it was more likely that the offender had a history of domestic violence.[57] Conflict in the home and the family, impending divorce, and stressful life events are other variables. In some cases, caregivers are concerned about leaving their spouses alone since they are aware of their deteriorating health. For instance, increased dependency on the part of the care receiver and increased functional impairment on the part of the caregiver may result in higher strain and load, which is linked to increased depressive symptoms. Finally, due to the cumulative effects of physical and mental problems that are becoming more prevalent in later life, risk factors for suicide among older persons are thoroughly investigated and generally regarded as complicated. Significant physical sickness, perceived burdensomeness, lack of social support, and living alone all appear to

considerably enhance the risk of suicide in this demographic, as do psychiatric problems such as serious depression and psychotic illness.[58] Implementing preventative strategies could be challenging due to this intricacy.

Consequences of aggressive behavior

After it manifests, violent behavior can have serious health and psychosocial repercussions for the offender, the victim, and any onlookers. Children who have experienced family abuse may manifest troublesome behaviors more frequently. Infants who grow up in homes where aggression and violence are commonplace may exhibit irritability, sleep issues, emotional distress, and somatic symptoms. Compared to children who do not live in homes with firearms, children who live in homes with handguns are at a higher risk of injury or death. Additionally, when kids start school, exposure to violence may lead to biases in misattribution that lead them to infer negative intent from ambiguous or neutral social cues, which can make it difficult to build strong, useful relationships. As aggressive children grow into adolescence, they have an increased likelihood of participating in feelings of anxiety, and sadness, and even engaging in suicidal behavior.[59]

The economic cost of aggressive behavior is significant.[60] Projected figures indicate that violence incurs a yearly expense of $70 billion on the US economy, encompassing $64.4 billion in productivity losses and $5.6 billion allocated for medical care.[61] Both aggressors and victims of aggressive behavior can suffer unfavorable outcomes. Victims of aggressive behavior run the danger of psychological and emotional traumatic reactions as well as psychiatric problems such as panic attacks, phobias, and depression. This leads to an increased probability of encountering penalties and, at times, imprisonment. The inherently aggressive nature of the prison environment often reinforces the offender's violent conduct, giving rise to a cycle of negative reinforcement that can be difficult to break.

Prevention and intervention: An approach with three key components

Due to the severe adverse consequences associated with aggressive behavior, it is crucial to implement preventive and therapeutic measures. The success of prevention and intervention hinges on grasping the risk factors tied to aggressive conduct. Many psychiatric treatments targeting aggressive behavior have been integrated into broader anger management therapies. Even though anger doesn't invariably lead to aggression, techniques for handling anger often encompass this as a primary objective. Effective methods encompass cognitive and skill-training aspects, like identifying and rectifying misinterpretations, reshaping negative thoughts into more balanced or positive ones, employing foresight and planned actions instead of impulsive reactions, enhancing problem-solving abilities, adopting perspective-taking to consider others' viewpoints, and self-monitoring to heighten emotional awareness and potential responses. Additionally, there are pharmacological treatments, which have demonstrated efficacy in both child and adult populations.[62] To address and mitigate aggressive and violent behavior through prevention and intervention, we advise a three-pronged strategy. In the first, programs for primary prevention are used, with an emphasis on the prenatal and postnatal stages of childbirth. Prenatal nurses and nurse midwives are qualified to offer quality prenatal care and conduct risk factor screenings. They can also instruct moms on good prenatal care, such as the value of nutrition and the need to abstain from dangerous habits like smoking and drinking. For instance, it has been demonstrated that supplementing with certain minerals or micronutrients (such as thiamine, lithium, and tryptophan) might reduce aggressive behavior. Parents can learn from postpartum nurses about good parenting practices and the value of nursing. However, there is conflicting information about the prevention of behavioral issues by breastfeeding.[63]

The second strategy might concentrate preventative efforts on vulnerable groups including teenagers who are pregnant and at-risk families. Once more, patient education regarding the harm caused by prenatal drinking or smoking may be helpful. School nurses can keep an eye on a child's development and growth. They can also collaborate with teachers to spot the precursors of violent behavior and provide emotion control methods. Additionally, school nurses can teach nurses various methods to lessen violent behavior in kids and teenagers who currently display it. For instance, massage therapy reduced the aggressiveness of preschoolers.[64] According to many case studies, music therapy, relaxation breathing techniques, and meditation may all help reduce violent behavior.[65] However, it was determined that using restraints in the classroom was ineffective because it merely made troublesome behaviors worse. Community health and public health nurses can assist at-risk families by enrolling them in ineffective family-strengthening programs or school- or community-based preventative

programs.[66] The Head Start program included an emotion-based prevention program that resulted in increases in emotion awareness and management as well as decreases in aggressive behavior, manifestations of negative emotions, and interactions between peers and adults.[67] The third strategy, which comes last, entails accepting persons who exhibit hostile behavior. Psychiatric nurses play a significant role in more conventional intervention techniques like psychotherapy and psychopharmacology. By guiding patients toward healthier actions and ways of thinking, cognitive behavioral therapy aims to address dysfunctional emotional, behavioral, and cognitive issues. Studies have demonstrated that cognitive behavioral therapy is beneficial in reducing aggressive and enraged behavior in children, adolescents, and adults.[68] Geriatric nurses must be familiar with the unique problems that arise when caring for older people. When caring for patients who have dementia, caution must be exercised because they may view the assistance as a threat. Dementia sufferers' aggressive behavior has been successfully reduced using a person-centered approach.[69] Atypical antipsychotic drug therapy is frequently used to treat behavioral issues, particularly violent behavior, in dementia patients. Equivalent nonpharmacological therapies can involve behavior modification strategies to teach patients nonaggressive communication techniques. It can also be crucial to watch out for early encounters between a risk person and others that turn aggressive later on. The efficacy of several non-pharmacological approaches was examined.[70] The elimination of stressful environments, scheduled activities, specialized cities, and specific staff training all had some success in lowering violent behavior. Although these programs might not always be successful, nurses can experiment with them to see which ones are most successful for certain patients. In general, when caring for older persons, nurses and caregivers must be honest with patients, patients' families, and each other to understand their requirements. Given their constant contact with patients and involvement in caregiving over the patient's day, nurses may be especially effective in the adoption of these behavioral methods. Nurses play a pivotal role in evaluating the likelihood of future aggression by examining past behaviors. When it comes to addressing aggressive behavior directly, medication proves to be a potent resource. Nurses are well-acquainted with a patient's specific triggers that lead to aggressive conduct, and their continuous engagement with patients provides ample occasions for imparting techniques to diminish such behavior through skill development. The strength of the nurse-patient interaction appears to be the most important factor in determining whether patients choose to take their prescriptions when they are hospitalized.[71] Hence, nurses play a pivotal role in vital responsibilities such as preventing, evaluating the risks associated with and treating aggressive behavior.

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