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ANGER, AGGRESSION AND VIOLENCE IN HEALTHCARE

-Material for Nursing Education

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Anger can be found everywhere in our societies – homes, schools, workplaces, roads, shops, media, airplanes, places of worship, hospitals, and the list could be endless. These days anger and its expression also represent a significant problem in health care settings. As the nursing workplace settings expand constantly to a wider area, the anger is encountered between many groups. It is commonly expressed from patients to nurses, nurses to other nurses, family members to nurses, physicians to nurses, etc. (Miracle 2013, 125.)

Tv programme Silminnäkijä implemented an online questioning about workplace violence in January 2014. This was done because every year 100 000 Finnish workers are experiencing workplace violence in forms of verbal violence, hitting, biting, spitting, tearing, kicking, strangling, stabbing etc. In less than two days 1153 people replied and the results were especially alarming in nursing point of view, because most of the comments were concerning nursing, especially young female nurses. (Valkeeniemi 2014 a,b.) In addition to changes needed to workplace policies, nurses should learn to recognize risks of anger, aggression and violence on patients and their families but also within other nurses and working colleagues. Nurses should be educated to deal with these situations. They should also learn to recognize their own anger emotions, and get advise how to cope and handle with these kind of feelings.

When the situation escalates to a level of violence, the studies point out the fact that education is valid, employees in the nursing field with proper training face it less. Though violence is common in nursing it is not spoken. For example a nurse working with intellectually disabled may have to face slapping and hitting, “mild violence”, so often that for them it is nothing to tell about mainly because they blame themselves for that “I should have remembered to protect myself better from that unpredictable patient”. (Tornberg 1997, 133.) Ellilä (2005) specifies that the threat of violence is real but it should not be tolerated, and every insult should be reported and proper after care provided (Ellilä 2005). As Shirey (2007) highlights, anger does not only present a public health risk and threaten societies, but it creates teaching-learning problems, also for nursing students (Shirey 2007, 568).

These are the background reasons why this educational material of anger, aggression and violence has been created. It is designed to give a wholesome knowledge for nursing students about this subject, and this material can also be used for post-graduates who are interested in the subject, or as independent study material. It can be used as one ensemble or as a partial teaching material depending on the teaching situation.

KEYWORDS:

anger, aggression, violence, healthcare, nursing, education

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VIHA, AGGRESSIO JA VÄKIVALTA TERVEYDENHUOLLOSSA - Oppimateriaali sairaanhoitajan koulutukseen

Viha on nähtävissä joka puolella yhteiskunnassamme; kotona, koulussa, työpaikoilla, maanteillä, kaupoissa, mediassa, lentokoneissa, kirkoissa, sairaaloissa ja lista voisi jatkua loputtomiin. Näinä päivinä viha ja sen ilmaiseminen esiintyvät myös merkittävänä ongelmana terveydenhuollon toimintayksiköissä. Eri hoitotyön työskentelymahdollisuuksien jatkuvasti lisääntyessä laajemmalle alueelle vihaa kohdataan monien eri ryhmien välillä. Yleisimmin sitä tavataan potilaiden ja sairaanhoitajien kesken, sairaanhoitajien keskuudessa, omaisten ja sairaanhoitajien kesken sekä mm. lääkärien ja sairaanhoitajien välillä (Miracle 2013, 125.)

Tv-ohjelma Silminnäkijä toteutti internet-kyselyn koskien väkivaltaa työpaikalla tammikuussa 2014. Kyselyn taustalla oli tieto siitä, että vuosittain 100 000 suomalaista työntekijää kokee jonkinlaista väkivallan muotoa; nimittelyä, lyömistä, puremista, sylkemistä, repimistä, potkimista, kuristamista, puukottamista jne. Vajaassa kahdessa päivässä kyselyyn vastasi 1153 ihmistä ja tulokset varsinkin hoitotyön näkökulmasta olivat hälyttäviä, erityisesti ottaen huomioon nuorten sairaanhoitajien kommentit (Valkeeniemi 2014 a,b.). Työpaikka käytäntöihin tehtyjen muutoksien lisäksi, sairaanhoitajien tulisi tunnistaa vihan, aggression ja väkivallan riskit ei vain potilaihin nähden, vaan myös heidän omaisiinsa sekä muihin sairaanhoitajiin ja kollegoihin nähden. Sairaanhoitajat tulisi kouluttaa näihin vaikeisiin tilanteisiin. Heidän tulisi myös oppia tunnistamaan omat vihan tunteensa sekä oppia selviytymään että käsittelemään niitä.

Kun tilanne kärjistyy väkivallan tasolle, tutkimukset osoittavat että koulutus on tärkeää, joten kunnollisen koulutuksen saaneet hoitoalan työskentelijät kohtaavat sitä vähemmän. Vaikka väkivalta on yleistä hoitoalalla, siitä ei puhuta. Esimerkiksi vammaisten parissa työskentelevä hoitaja saattaa joutua kohtaamaan läpsimistä ja lyömistä, ns. ”mietoa väkivaltaa”, niin usein että eivät ajattele sen olevan eteenpäin kertomisen arvoista syystä että he syyttävät itseään ajatellen ” minun olisi pitänyt muistaa suojella itseäni paremmin ennalta arvaamattoman potilaan kanssa.” (Tornberg 1997, 133.) Ellilä (2005) tarkentaa että väkivallan uhka on olemassa ja sitä ei tulisi sallia, ja että joka loukkaus tulisi raportoida ja oikeanlainen jälkihoito tulisi taata (Ellilä 2005). Kuten professori Shirey (2007) korostaa, viha ei ainoastaan esiinny kansanterveydellisenä riskinä ja uhkaa yhteiskuntaa, mutta se aiheuttaa myös opetus-oppimis vaikeuksia, myös sairaanhoitajien keskuudessa (Shirey 2007, 568). Nämä ovat taustasyinä miksi tämä opetusmateriaali vihasta, aggressiosta sekä väkivallasta on luotu. Tämä materiaali on suunniteltu antamaan kokonaiskuva tästä aiheesta ja sitä voivat käyttää sekä jo valmistuneet, asiasta kiinnostuneet, että itsenäisesti opiskelevat. Materiaali on tarkoitettu käytettäväksi kokonaisuutena tai osissa riippuen opetustilanteesta.

ASIASANAT:

Viha, Aggressio, Väkivalta, Terveydenhuolto, Sairaanhoito, Koulutus

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1 INTRODUCTION

Though some occupations are known to be more prone to violence than others, for example working as a police or a security guard, the brutal encounters in the fields of service-, education- and care industries are not yet so acknowledged. Research shows that the most flammable occasions are when a person is trying to interfere or change another individual's behavior, especially women working in care- and service industries suffer more and more violence during their normal working tasks. (Tornberg 1997, 132.) Nurses are expected to be working with holistic perspectives according to nursing code of ethics: to promote health, to prevent illness, to restore health and to alleviate suffering (ICN 2012). However, these codes of ethics are not always followed. This should raise a question mark. What is causing this 'ward rage', why is there anger and aggression in nursing, and what could be done to stop it? These are not the only questions the answers are needed to. The concerning issue is that there has been an increase in figures of anger and violence in health care in past recent years (Miracle 2013, 125). That cannot be accepted, because undoubtedly it will have negative effects in functioning of health care facilities.

In this thesis we refer to aggression as well as anger because there is a known connection between these two. Aggression kicks in when a person sees a need of change in a situation, so it is the force that pushes things forward whilst demanding the necessary actions to get the wanted result. (Cacciatore 2009, 28.) Even there is a known connection between anger and aggression, and that anger many times precedes violent behavior, it should be highlighted that anger is not always leading to violence. (Hollinworth et al. 2005, 42-43.)

We hypothesize there is a need of educating the nurse students and nurses about anger, aggression and violence in health care settings, firstly because these may negatively influence nurses' clinical performance, and secondly because these can purely have negative impact on nurses' wellbeing in many levels (e.g. psychological, social and emotional wellbeing).

This thesis consists of two main parts, a literature review and a ready to be used educational PowerPoint slideshow (Appendix 2). The literature review was written in interest to discuss about this complicated but important topic in many perspectives, and to bring the selected details visible to nursing education. The text contains biological, psychological, social, behavioral, educational, methodological, and occupational safety approaches, because our intension was to make the educational material suitable for many different educational groups. In the end (Appendix 1) we have attached some general anger and aggression management models and interventions that may be used for educational purposes or as an individual learning material. The PowerPoint slideshow is an output of the review that can be used in lectures or also as an individual interest.

2 THE TASK AND AIM OF THE PROJECT

The task of this project is to teach nurses a) how to learn to recognize risks of anger, aggression and violence on patients and their families but also within other nurses and work colleagues b) how to deal with situations when facing an angry or aggressive person and c) how to recognize own anger emotions, and to give advice how to cope and handle with these kind of feelings

The aim of this project is to make nursing students familiar with issues of anger, aggression, and violence and their prevalence in nursing by providing educational material.

3 EMPIRICAL IMPLEMENTATION

3.1 The Process of the Literature Review

The literature review was done with help of different literature search engines, such as EBSCOHost, Elsevier: Science Direct, ERIC – Education Resources Information Center, and Ovid Nursing Database searching different peer-reviewed and full-text research articles. Also some other types of publications were used from these search engines, such as previous reviews and research documents published in nursing magazines. Search words used were: ‘anger’, ‘anger and nursing’, ‘anger in healthcare’, ‘aggression in nursing’, ‘aggression in healthcare’, ‘horizontal violence in nursing’, and ‘violence in healthcare’. Further literature was obtained from TUAS and Salo city library and on the Internet.

3.2 Progression of the Project

Literature review was done between February – September 2014. After finishing the literature review and studying the basics of the didactic and pedagogical background we started to prepare our educational e-material. A part of the educational material was tested on 26th of November 2014 on 1st and 3rd year nursing students (n=29) in TUAS at Salo Campus. Participants were given a pre-reading material week before for the lesson which can be seen in Appendix 1 ‘General anger and aggression management, interventions and interaction with vulnerable people.’ Main purpose of the material was to provide answers to our interaction tasks which were held in the end of the lesson. The rest of the educational material was planned on the basis of feedback received after the test lesson and can be seen in the end of this thesis (Appendix 2).

Figure 1. Cover of Our Production.

4 DIDACTIC AND PEDAGOGICAL BACKGROUND

The Role of Empathy in Teaching

There is one quality that should be found in all fields of health care, whether it is on working field, learning or teaching; empathy and ability to show empathy. Without empathy there is no chance for successful communication and interaction between people. (Janhonen & Vanhanen-Nuutinen 2005, 105.) For example in tutorials, it will not be possible to have a successful session if there is no empathy in the group. Even there is a major need for theoretical approach in the information-seeking, the nurses are also required to show skills of conveying care. Therefore, tutorials are a really good chance concentrate how to express empathy that is always confronted in psycho-social aspects of care. The ability to show empathy walks hand in hand with equality and listening skills. If a nurse will not listen to a patient and show empathy, that itself can provoke aggression in the patient. (Janhonen & Vanhanen- Nuutinen 2005, 107.)

The Teaching-Learning Relationship

The process of teaching can be described with help of a didactic triangle (Figure 2), which means that the teaching process is interaction between a student, teacher and the study material. The relation between a student and the study material is called a didactic relation, and a pedagogical relation comprises the relation between a teacher and a student. (Repo-Kaarento 2007, 28.)

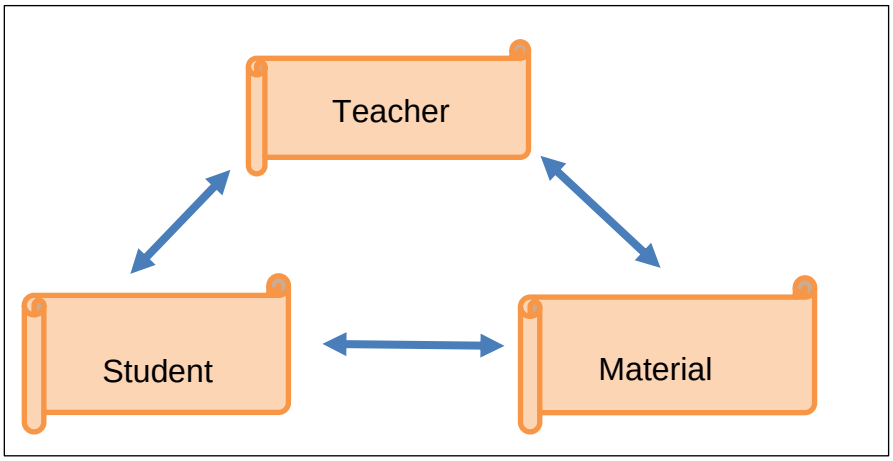


Figure 2. Didactic Triangle. (Repo-Kaarento 2007, 28)

It is a teacher's task to guide the didactic relation of a student with help of the pedagogical relation. The teachers should review own actions so that it promotes a student's learning process. Because the learning is a process itself, it consists of many phases. (Repo-Kaarento 2007, 29.)

Learning Process

One of the key concepts in successful learning is the motivation. Motivation is the inner power that guides, orientates and maintains the person's performance. For the learning motivation it is important that an individual is interested in contents of the studying material, and this requires that the individual feels the subject being important in his/her life. (Pruuki 2008, 21.)

The University of Jyväskylä (2014) uses the Complete Process of Learning-model (Täydellinen oppimisprosessi) created by Yrjö Engeström to describe the learning process. This model includes six phases: 1) Motivating, 2) Orientation, 3) Internalization, 4) Externalization, 5) Evaluation, and 6) Controlling (Jyväskylän yliopisto 2014).

The Problem-Based Learning

All the people that health care personnel meet come from different backgrounds. Whether they are angry/ aggressive/ violent or not, the every individual will have own beliefs, opinions and certain type of temper, therefore along with situational and environmental factors, it makes the meeting of a new patient different every time. That is why one skill the health care personnel need is the problem-solving skill. Therefore the problem-based learning (PBL) is very popular in studies related to health care. The PBL-method uses real working life situations or problems as a starting point of the learning process. (Vuokila-Oikkonen 2005, 145.) The method was taken into practice in 1950's in the USA to develop and renew the medical education. The goal of this type of learning method is to prepare a health care student to understand and conceptualize complex matters in the health care field by using the best possible methods. (Vuokila-Oikkonen 2005, 146.) Some studies have shown that the PBL-method may improve the ability to remember the learned skill or information later on in the life (Vuokila-Oikkonen 2005, 147). On this basis, it is recommended to use the PBL-method when teaching nursing students the anger/ aggression control methods. Functioning PBL requires a person to have devotion and the ability to learn independently and effectively which is a valuable skill to foster for the rest of one's life not only for studying but also in other life situations. People participating in PBL lessons narrate that the learning process is done to help their own understanding about the subject with the assistance of a wider range of sources and library. Students using PBL method tends are also to be less stressed, more contented and more supported in the environment when learning. (Hall et al. 2009, 6.)

Teaching Process

These days a teacher more supports and motivates a student's individual growth and organizes and guides the training and learning processes rather than just traditionally teaches. This requires good interaction skills and empathic

abilities, but also an ability to show real interest towards meeting new people with different developmental requirements and problems. A teacher must have an ability to guide a student to be a self-directed and active information seeker. (Helakorpi 2010, 119.) Both, students and teachers should recall that the expertise in certain subject is not self-evident feature, but it requires constant growth and development. Career expertise will increase with help of experiences, continuous information seeking and motivated learning. (Janhonen & Vanhanen-Nuutinen 2005, 17.)

For motivational reasons, in the beginning and during the lesson a teacher should clarify why the content is important, and where or how the knowledge can be used. It is important for a teacher to think about examples that are related closely to everyday situations and problems. (Pruuki 2008, 21.) For students, the meaningfulness of a lecture is connected to the factors, such as how many questions students can present to the teacher, and how much they are activated during the lecture. It is recommended for a teacher to present a couple of orientating questions or facts in the beginning of a lecture to get the students to think about the subject concerned. After this it is more useful to teach the new information and perspectives. At the end, for example group conversations make students to internalize and externalize the knowledge learned. (Pruuki 2008, 83.)

Furthermore, when teaching a group of students and learning the group dynamics, it is important to make use of both theoretic and experiential knowledge as well as the individual and whole group’s knowledge. The good group dynamics creates a balanced learning environment, which is described on Figure 3 (Repo-Kaarento 2007, 130.)

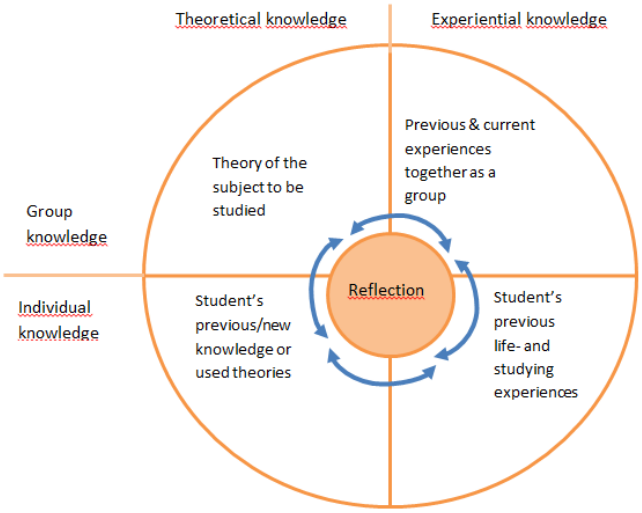


Figure 3. Balanced Learning Environment (Repo-Kaarento 2007, 131; with Nina Katajavuori).

Visualization

The situational story-telling is a teaching method based on same principles as the problem-based learning. The use of narrative approach by explaining the situation using story-telling methods has increased in Finland and also internationally. This narrative approach is common in the practical training in social- and healthcare environment. By creating and analyzing a narrative situational story with other people, makes it easier to understand the models and ideas that influence the human behavior. This approach has even opened an opportunity to find connections between people living in violent surrounding and their health issues. (Vuokila-Oikkonen & Janhonen 2005, 78.) The effective, appropriate and functional visualization should not be forgotten. It is important that the visual materials are carefully chosen for the lecture as they should not decrease the amount of active interaction, but vice versa. However, the visual material could include material such as pictures, drawings, short videos, audio clips and drama. (Pruuki 2008, 84.)

Many important things are better off explained with a picture. Different cognitive processes are activated in students with images than via text and therefore

things can also be explained with them. Pictures in a learning material can be used as guidance to the learner in order for him/her to read or interpret and observe them whilst promoting the learning. When the learning material has pictures, the students have the ability to draw their attention to them and by that learn to attach certain images to certain things learned. This manner acts as a memory rule or mnemonic. (Silander & Koli 2003, 73-74.)

The Use of e-Material Instead of Paper Version

Why should the studying material be available on the internet? Majuri & Helakorpi (2010) explain that already the changes on working culture require the skills to find and study new information online. On the aspects of learning, the internet can be seen for example as a source of information, context, tool for communication, and means to guide students or employees. For teaching and learning the internet offers a wide variety of possibilities. (Majuri & Helakorpi 2010, 134-135):

- Internet is a library and a place for information sourcing
- Internet offers possibilities for distance teaching and learning
- Internet functions as a tool for social learning
- Internet offers different students many possibilities to progress, also in different time schedules
- Internet is a flexible learning environment for example for those who work and study same time

5 ETHICAL CONSIDERATIONS

This thesis is a project that resulted in developing and producing educational material about anger, aggression and violence for nursing students based on the literature review written beforehand. Cultural sensitivity was considered by using by the authors from different countries, and the reference section includes the details of the authors of different data sources. The educational material was also tested on the population where the participants were from various different countries, maintaining their anonymity and confidentiality. The motive of the project arose from our own interest after this subject has been recently prominent on the media and because we both have had difficult interaction situations during our practical trainings. The review highlights the importance of the anger education for nursing students and health care personnel, but the objectivity has been maintained through the process by using literature by the experts in the field. The educational material includes moral problem-solving tasks where moral principles, ethical sensitivity with empathy and ethical decision-making skills are in priority. Therefore this project supports the development of stronger moral thinking skills and commitment which are important parts of the ethics of care (Juujärvi et al 2001 218-222).

6 EVALUATION OF THE PROJECT

6.1 Evaluation of the Teaching Process

The self- and peer evaluation are promoting the professional growth and developing the future teaching processes. The aim of this type of reflection is to make a teacher aware about own actions and how the action could be improved. There are three main types of reflection phases: (Pruuki 2008, 154.)

1) Reflection for action: This happens on the planning stage when different approaches and practices are examined and weighed.

2) Reflection in action: This takes place in the process of actual teaching when a teacher thinks what to do next and thinks about different options.

3) Reflection on action: After the teaching a teacher evaluates the process again. It is useful to write down straight away what worked really well and what were the problems. The factors leading to success and failure should be recorded.

(Pruuki 2008, 154.)

To have more than one teacher on the teaching process makes the peer evaluation possible that has a major developmental influence. The teachers should discuss about progression, strengths, weaknesses, opportunities, and threats (SWOT) of the teaching process. An open and critical self-evaluation and reflection with others is a prerequisite for learning new things. (Pruuki 2008, 155.)

For the evaluation of our lesson, we used Repo-Kaarento's (2007) self-reflection and evaluation table, which has slightly been modified to evaluate the teaching process.

Phases of the teaching process	What did I observe in myself, students, groups and other teacher/s?	What did I learn?	What made me learn and how?	SWOT (streghths, weaknesses, opportunities, threats)
In the beginning				
During the lecture				
At the end				

Figure 4. Self-Evaluation Form. (Repo-Kaarento 2007, 143; Pruuki 2008, 155)

The students were given the form below to fill in at the end of the lesson.

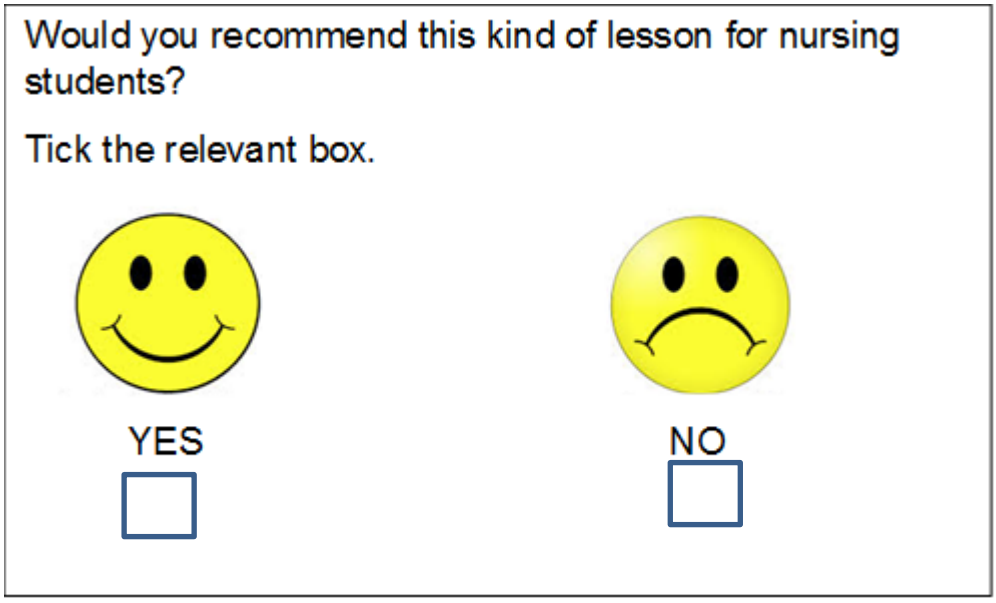


Figure 5. Evaluation Form for Students.

The response rate was 100%, with results 'YES' =27 (≈93%), and 'NO' =2 (≈7%).

6.2 Limitations, Validity and Reliability of the Project

The main limitations are that no detailed feedback was asked from the nursing students attending the test lesson, and not whole educational material was tested. Furthermore, in our point of view the educational material should have been checked and possible errors corrected by professionals of this field, which undermines the validity of the educational material.

Reliability is affected negatively by the material we used in our literature review because not all of them were research articles, not to be forgotten that some of the statistics are from abroad. Therefore the numbers cannot be compared directly with Finland's situation.

The literature review, which is the base for the educational material, consists of various sources from different academic search engines. The educational material was tested on two international nursing student groups where the students come from variety of ethnical backgrounds. Also, the repeatability of the use of the educational material can be considered after high positive response rate (93%) for our evaluation questionnaire. Moreover, there is an aspect of consistency of the educational material because the material can be used for nursing groups at different levels, and it will be available for access as e-material at least at Hoitonetti. These four perspectives strengthen the reliability of the use of the educational material. (Institute for Work & Health 2014.)

7 LITERATURE REVIEW

The educational material was planned and based on the literature review below:

8 PLEASANT AND UNPLEASANT FEELINGS

Some literature differentiates the feelings and emotions. For example, Dunderfelt (2007) has differentiated and defined felt sense, feelings and emotions separately. First a person experiences some kind of sensation, *felt sense*. It can be e.g. tingling in stomach, fingertips or feet, cool or a hot flush or just a change in breathing rhythm. These are felt many times per day, in a short period of time, and they often happen without the person even noticing them. *Feeling* on the other hand, is the result of the felt sense. Feelings can be divided roughly to two categories; pleasant and unpleasant feelings, as it was mentioned above, and can be seen from Figure 6. *Emotion* is usually referred to a person's experiences when the feeling is accompanied with a person's beliefs and interpretations. (Dunderfelt 2007, 22.) In this literature review, both feelings and emotions are used as one ensemble.

The origin of feelings is unknown, though there are many speculations from it; some people claim them to be just a part of brain chemistry, whilst others blame the causes of the brain's chemical reactions. Feelings are subjective, personal, and they are in charge of coloring individual's life. Because they are constantly changing and in move, it is hard to examine them, though every feeling causes a number of physiological changes in person. (Dunderfelt 2007, 19.)

Anger and aggression are part of the demanding feelings. It is important to learn to face, manage and channel these feelings, because that can help to prevent violence. However, the feelings are not the whole truth of a person's behavior or acts, because also at least the will, temperament, biological changes, and intellect are attached to the feelings, and model a person's behavior and functioning. (Cacciatore 2007, 22.)

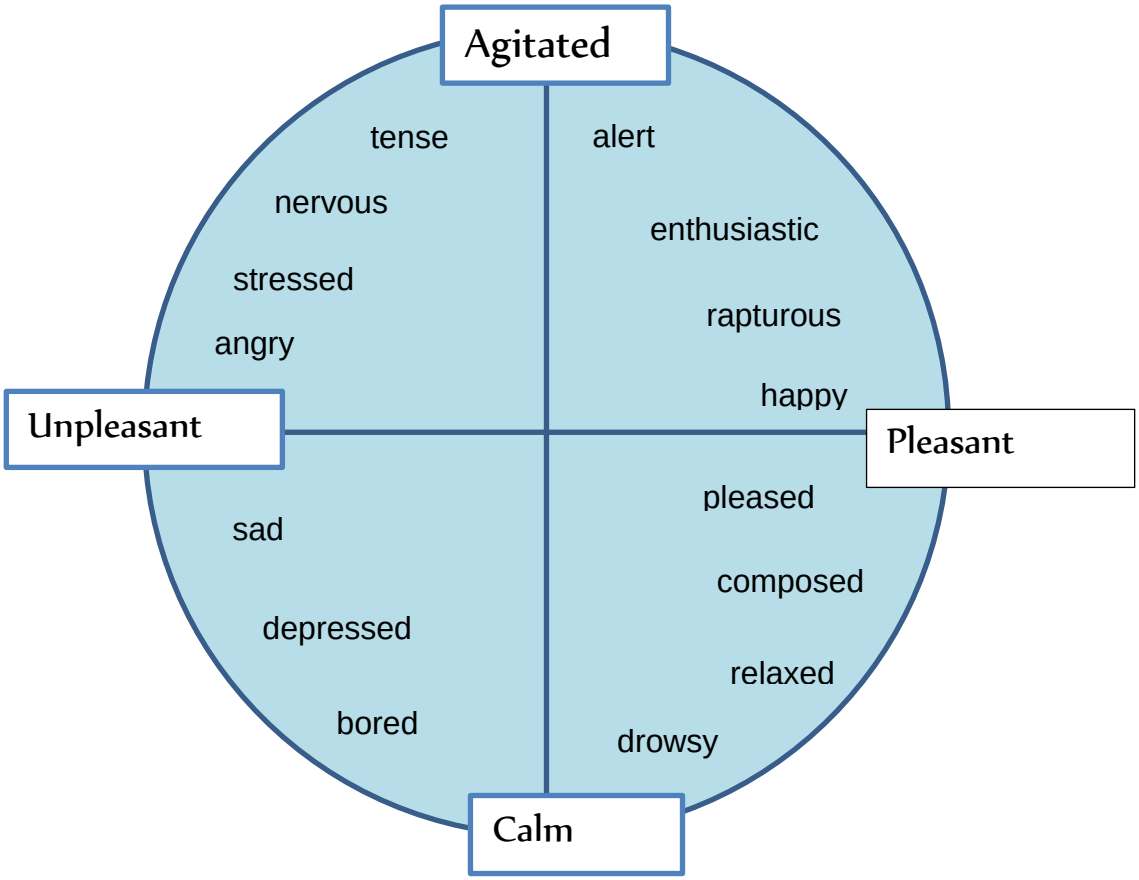


Figure 6. Circumflex of Four Valences Differentiating the Feelings (Sanström 2010, 143).

9 DEFINITIONS

9.1 Anger

Anger is sometimes wrongly used synonymously with aggression. However, there are differences between these concepts. Anger can be defined as a strong, uncomfortable emotional response to an incitement that is unwanted and incoherent with a person's values, beliefs, or rights (Miracle 2013, 125). It can also be categorized as rational (positive) or irrational (negative). Anger is described as rational and legitimate when a person gets angry about situations that are incongruent with his/her rights. Whereas irrational beliefs can evoke irrational anger, and that may be manifested in a way of negative outcome, such as violence or rage. (Shirey 2007, 569.)

A person can get angry with himself or to some other people around. Whatever the target is, the ultimate goal stays the same; modification of someone's behavior. A person might have put on some weight and get angry for that, the target then being him/herself. As well as a slow cashier can irritate and again a person gets angry; this time the target is the cashier. Both times a behavior change is needed; if a person gains weight, it needs to be lost; when a cashier is slow she needs to be rushed to move quicker. Therefore anger is said not only to be the greatest force of a person wanting to change his/her own behavior but also a attempt to get another person to do what is wanted. (Shrand & Devine 2013, 20.)

Nurmi (2013) describes anger as a necessary, energetic, healthy and protective feeling. Anger is thought to be one of the four main feelings human have, along with happiness, sadness and fear. She clarifies that without anger people are without protection and prone to injustice and abuse by other people. (Nurmi 2013, 20.)

Anger feeling could be described as a TV screen, which is channeling all the reasons and background feelings out for others to see as facial expressions, vocal expressions and acts. There are usually many different kind of feelings

behind visible anger that angry person cannot or does not dare to express. Anger is learned and allowed way to express negative state of mind. Many times the reasons behind the anger can be distress, fear, feeling unsafe, shame and feeling of being on dead-end road. (Cacciatore 2007, 30.)

9.2 Aggression

Nurmi (2013) points out that aggressive behavior is a different concept than aggression as a feeling. Officially the feeling is not a violent or any other type of act. It is powerful flow of energy. As a positive resource it gives an individual strength and courage to respect, defense, express and believe in oneself. (Nurmi 2013, 22.)

There are several types of aggression, and it is mainly seen as being physical, verbal, or relational; overt or covert; or proactive (using aggression to meet a goal) or reactive (reacting negatively to an actual or perceived threat) (Lochman et al. 2006, 115). Sometimes terms such as ‘instrumental aggression’, ‘offensive aggression’ and ‘cold-blooded aggression’ are used to describe the proactive aggression, as it often involves some efforts to obtain power or goods from other people. Synonyms for reactive aggression are ‘defensive aggression’, ‘angry aggression’ and ‘emotional aggression’. Aggression can also be direct or indirect (social aggression) which can both be manifested as physical or verbal, and offensive or threatening behavior. (Sandström 2010, 196-198.) (See figure 7).

Direct aggression		
	Physical aggression	Verbal aggression
- offensive - threatening	- fighting - preparing for the fight	- swearing, criticizing - threatening to cause a fight
Indirect aggression		
	Physical aggression	Verbal aggression
- offensive - threatening	- destroying ones property - threatening close ones	- gossiping - blackmailing

Figure 7. Types of Aggression (Sandström 2010, 197).

Moreover, Viljamaa (2012) points out that direct aggression is often focused directly to another person by shouting, whilst indirect aggression kind of via bypass by sabotaging, using facial expressions and manipulation (Viljamaa 2012,11).

Physical aggression can exist already in one year old children, and it increases whilst a child is two year old, finally reaching its peak when a child is four years old. After this physical aggression is decreasing gradually from pre-school age all the way to the old age, but the indirect, social aggression increases slightly whilst aging. Approximately 3 % of people maintain the tendency for physical aggression. (Sandström 2010, 197.)

9.3 Connection between Anger and Aggression

. This is better understood, when defining anger as an instant emotional arousal, hostility as longer lasting negative attitude, and aggression as prospective or actual harming of other people. According to some research

results only 10 per cents of anger leads to overt aggression. In health care, many angry outbreaks could be refrained if the nurses would concentrate on having a patient-centered approach that values individual requirements. However, nurses easily respond to anger in defensive manner, which can enhance anger and aggressive behavior. (Hollinworth et al. 2005, 42-43.)

Viljamaa (2012) highlights the reasons behind anger and aggression could be inability to show empathy and insufficient or unlearnt social skills (Viljamaa 2012, 165). The nurses and other healthcare staff should understand that the anger does not show up by itself, so it cannot be denied or demanded to fade away without any outlet channel. Anger can be de-escalated by resolving the reasons and conflicts behind it. (Cacciatore 2007, 30.)

10 POSITIVE SIDES OF ANGER AND AGGRESSION

10.1 Effective and Protective Anger

For most of the people anger can be a healthy emotional response to feeling hurt or frustrated. It can be so called justified reaction to an iniquity and a way of emotionally ‘standing up’ for person’s ego when abused. (Fauteux 2010, 196.) Anger, outbursts of anger, feeling of aggression and rage are all reactions or responses that provide strength in situations when some action is urgently required (Cacciatore 2007, 17). However, studies have shown that people do not have so many strategies for controlling anger that they have for some other emotional states, such as fear, anxiety, and sadness (Thomas 2003, 103). This raises a question what is actually the good healthy amount of anger. It definitely does not go so that ‘the more the better’. Davies (2009) describes the effectiveness of the anger with help of the graph below (Figure 8). It shows that the anger is effective only in small amounts. If the anger increases, so does the effectiveness. If the person gets very angry, then the effectiveness is turning negative, which means that the person is functioning away from the target and behaving counter-productively. (Davies 2009, 77.)

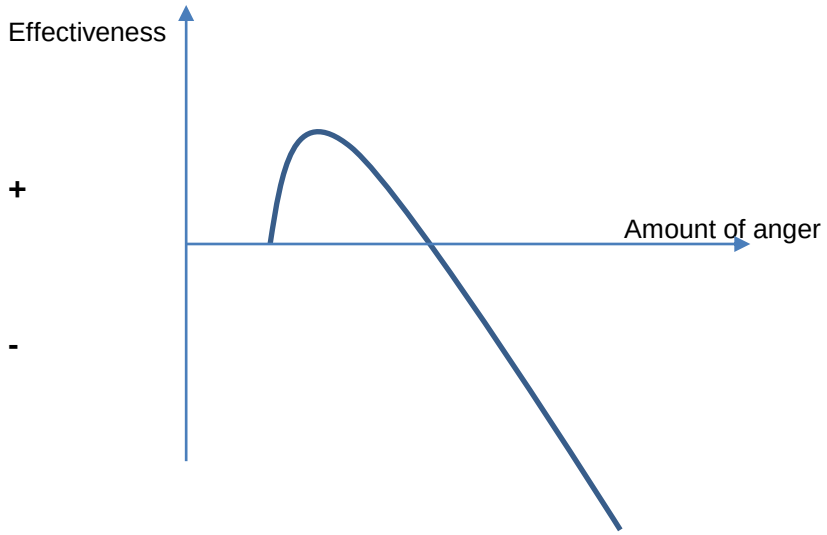


Figure 8. Effectivenes of Anger

It is important to know that many conflicts and arguments involving anger also promote the training of social skills, self-control, channeling of feelings. This is the case especially amongst youngsters and adolescents. (Cacciatore 2007, 17.) The anxiety and anger are not bad or scary things, even the factors causing those feelings may be. A person should not be scared or ashamed of his/her own feelings or neither to escape them. (Cacciatore 2007, 25.) Anger is also a protector; it emerges when a person is feeling injustice. When the feeling of anger is ignored, pushed down, the consequences can be devastating, not only for the angry persons themselves but also for people around them. (Dunderfelt 2007, 114-115.)

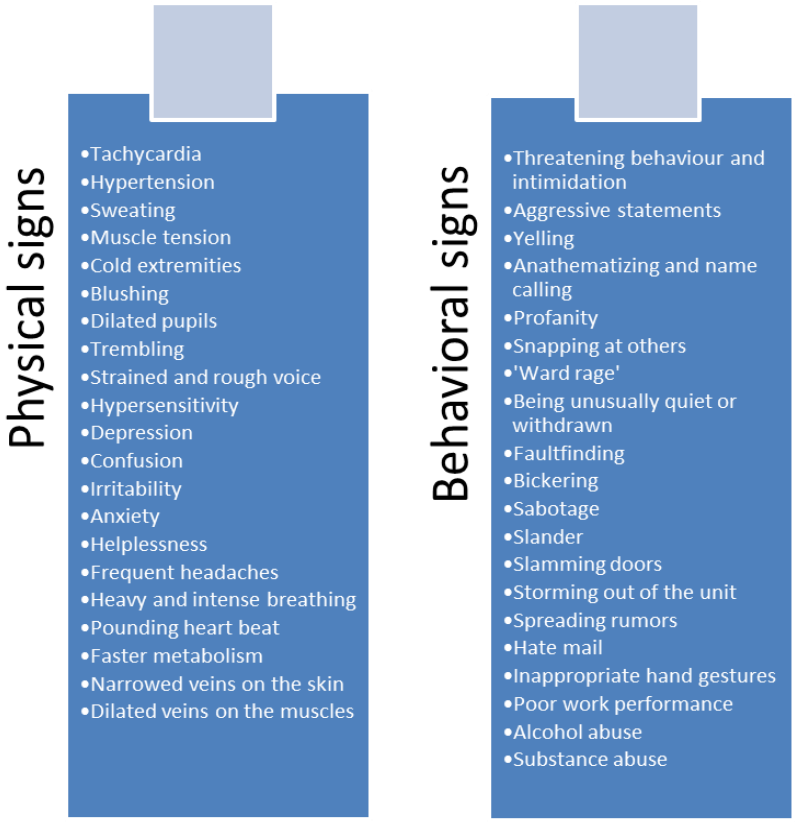
10.2 Aggression as a Positive Resource

Aggression is also wrongly thought automatically as a negative feeling. When a person learns to use aggression as a positive resource he appears as a confident individual who is not afraid of letting his opinions to come out and is also standing behind them with a strong faith. Unfaltering self-expression and self-esteem, as well as balanced way of living, are also related to the feeling of aggression. (Cacciatore 2009, 28.) Therefore, aggression is seen as resource that helps a person to fight for his/her and others' rights, and against oppression, domination and manipulation. Constructive aggression is also useful in setting the healthy limits at work. It prevents burn-out and excessive covering of other employees' work duties. In limits, aggression is also known to be a power for the creativity (Reenkola 2008, 30-32.) The ability to control emotions and the utilization of aggression are key concepts in the strengthening of a person's self-esteem. Thus, aggression can be a motor of normal functioning against the low confidence and helplessness, whereas motivation and will are the fuel. (Viljamaa 2012, 12-14.) '*Moving forward and getting closer*' is the real translation for the Latin word *aggredi*, and a word "aggression" has been taken and transformed from it (Tornberg 1997, 7), and not to be forgotten, Sigmund Freud described the expression of aggression non-negatively as 'searching energy' (Viljamaa 2012, 10).

11 SIGNS OF ANGER

There are many signs of anger, psychical and physical, which can differ from a person to person. When an individual gets angry, his/her feelings, intellect and physical functions work hand in hand. Very fast decisions are usually made based on our brain's automatic assumption what would be the best way to function. The person may want to surrender, escape, rage or stay calm. The will to stay calm is usually leading to thoughts, which deescalate anger and maintain the person's rational functioning and behavior. The feelings can also vary a lot. For example, a person may be afraid, feel panic or confused, and he/she may get feelings of injustice, shame or frustration. (Cacciatore 2007, cd.) The most common physical and behavioral signs are mentioned in the table below.

Table 1. Physical and Behavioral Signs of Anger and Aggression (Cacciatore 2007, cd; Miracle 2013, 126; Tornberg 1997, 9-10).



12 BIOLOGICAL FACTORS INFLUENCING ANGER

12.1 Brain Structure Involvement

When an individual faces a feeling, there are changes happening also in the brain, and that was already explored in 1848. Phineas Gage who was working as a supervisor in a building site for railways famously inserted a dynamite into ground by using an iron bar. Accidentally the dynamite ignited and the iron bar perforated his brain. After the miraculous healing, the previously well-behaving and nice Gage ended up being aggressive and unreliable. Years later, when the skull of Gage was examined, it was concluded that the iron bar had caused wide damages especially in left side of the prefrontal cortex, which has later been proved to be one part of the brain that has a role in regulation of feelings. (Sandström 2010, 151.)

Although there may not be brain structures, which are **only** processing feelings, the structures of the brain that have roles in the perception of emotional stimuli, production of emotional reactions and regulation of feelings, can still be pointed out. (Sandstöm 2010, 155.) For example, when a person sees an angry facial expression, it activates the orbito-frontal cortex and anterior girdle of cingulum in the brains (Sandström 2010, 163).

The structures of the brain that produce aggressive behavior are often called the brain's 'aggression centres'. These are amygdala, the center of hypothalamus and PAG (periaqueductal grey). The structures of the brain that regulate the aggressive behavior are the dorsal, ventral orbital and medial parts of the prefrontal cortex, lateral area of septum, insular cortex, thalamus and hippocampus (See Figure 9 and 10). Impulsive reactive and proactive aggression is transmitted by different structures of the brain and possibly by different neurotransmitters. (Sandström 2010, 210.)

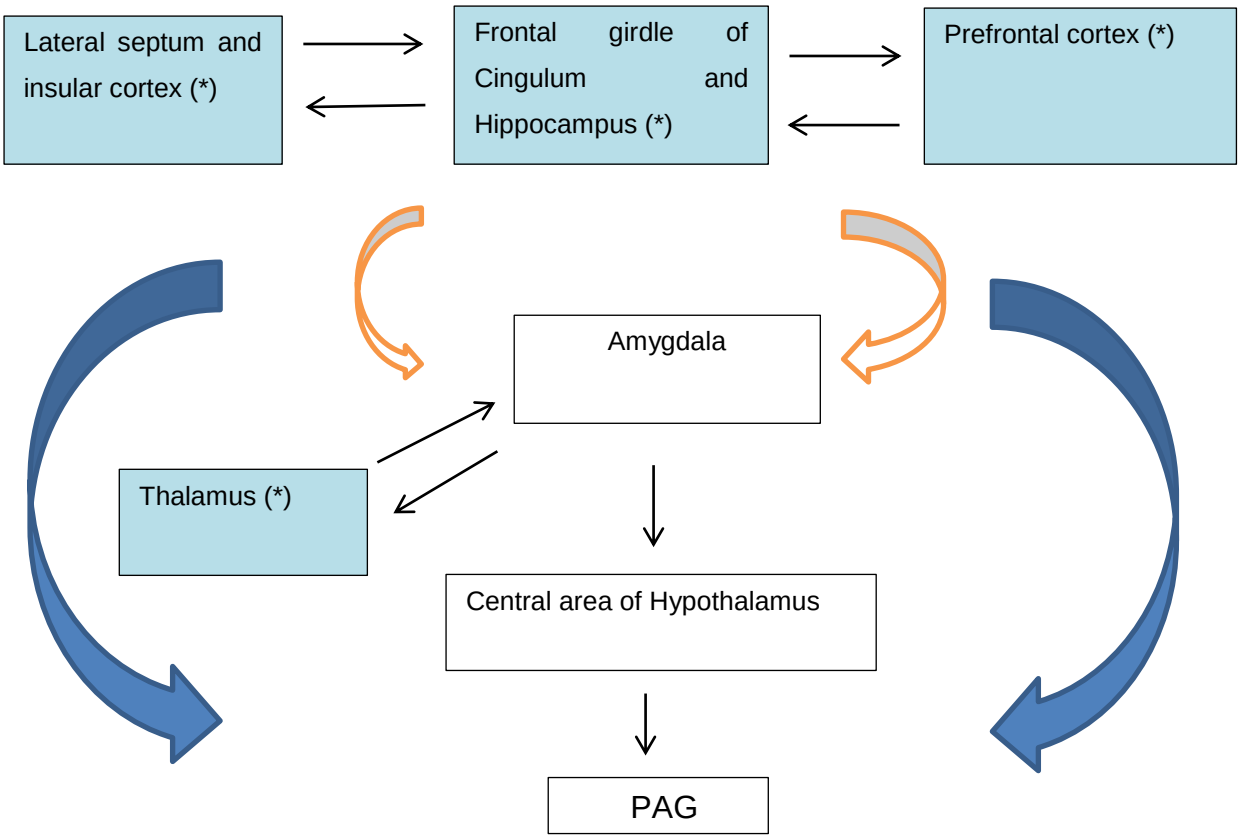


Figure 9. The Brain Structures Producing and Regulating Aggressive Behavior. (The symbol (*) is marked in those areas involved in regulating aggressive behavior.) (Sandström 2010, 210).

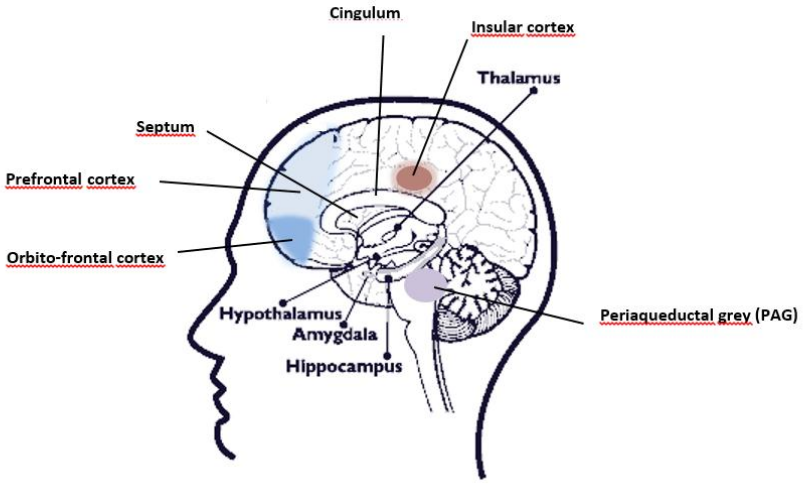


Figure 10. Major Regions of the Brain Involved in Producing and Regulating Aggressive Behavior. (National Institutes of Health 2014).

12.2 Hormones and Genes Involving in Aggression

Although the genes themselves influence only a little how any type of aggression is developing, the changes they cause in the anatomy of the brain and metabolism of neurotransmitters engage clearly with an individual's way of reacting to social stimuli (Sandström 2010, 213). Table 2 below explains the hormones and genes involving with aggression.

Table 2. Hormones and Genes Involving with Aggression (Sandström 2010, 213-216; Tornberg 1997, 9-10).

HORMONES AND GENES INVOLVING WITH AGGRESSION
low serotonin levels
high testosterone levels
varying progesterone & estrogen levels
low oxytocin levels
low cortisol levels
high adrenalin & noradrenalin levels
high levels of arginine-vasopressin hormone
active form of MAOA-gene (known as violence-related gene) in those men consuming high amounts of alcohol

It should be highlighted that even the genes are inherited, the environmental factors mold the behavior. (Sandström 2010, 214.) Therefore, it is important to rely partly on social psychological aspects when studying factors relating to anger or aggression: an individual with certain genes reacts to stimulus in a certain way in a certain environment (Viljamaa 2012, 17).

13 ENCOUNTERING FEELING OF ANGER

13.1 The Stages of Anger

According to Fauteux (2010) there are seven main stages of anger which usually follow each other, unless the anger is de-escalated at some point. These are:

1. Frustration
2. Defensive anger
3. Being difficult (difficult, angry people)
4. Hostility
5. Rage
6. Threats
7. Violence

(Fauteux 2010, 197.)

Frustration:

When a person is frustrated, he/she can sometimes become angry. In this stage the person usually yells or curses, which is a part of showing how the person expresses what angers him/her. The person who yells in order to be heard will no longer yell when he/she is heard.

Defensive anger:

Anger creates an emotional wall that protects the individual against hurt feelings, and against the person / thing which is causing that hurt. A person may say “I would rather be mad than sad!”

Being difficult:

In this stage a person is more than defensive. He/she is chronically argumentative, uncooperative, opinionated, and stubborn. This person may not yell, but his/her anger is seen beneath his/her criticism, sarcasm,

combativeness, and reluctance. The person is trying to keep others at an emotional distance.

Hostility:

Hostility is a verbal attack, which no longer is a healthy expression of anger. It is about control. The person tries to get control by bullying or intimidating someone. Things should be done by his/her way. The person can be very antagonistic in ways to keep the control.

Rage:

A person in this stage has an impaired impulse control. He/she has a problem to feel the anger without having to scream out that anger. The person breaks up in 'fits of rage' or temper tantrums. Anger is uncontrollable. The previously used control mechanism may no longer work and the person may not have 'the option two'.

Threats:

In this stage the aggressive efforts may be multiplied. A person is pushing others around psychologically. He/she is directly scaring others with threats, for example by saying "…and if it takes hurting someone that is what I'll do!"

Violence:

This is the stage where anger and aggression accelerate into assault. The angry individual's violence often has a goal: to get something the person wants through physical force, and sometimes without a warning. Violence can be as a punishment to others who have prevented the person to get what he/she wants. (Fauteux 2010, 198-210.)

13.2 How Feelings Occur

A person is provoked to actions by recognized and unrecognized feelings. Facing a feeling of anger (or any other) is a multistage process (Figure 11) and

instead of facing it, it can also be rejected. (Nurmi 2013, 24.) Feeling of anger lasts usually 15-30 seconds, and sometimes it leads to rage if the anger is not deescalated on time (Dunderfelt 2007, 114). A person's own behavior can become hardly understood even to person him/herself if the feeling is unfamiliar, because the lack of discussion of feelings. Person might also develop difficulties in confronting or accepting own feelings if they are not discussed, for example in early childhood with parents. Writing is also a useful method for expressing what happens inside of individual's head. After reading about feelings a person can receive insight about the reactions which trigger the feelings. (Nurmi 2013, 24.)

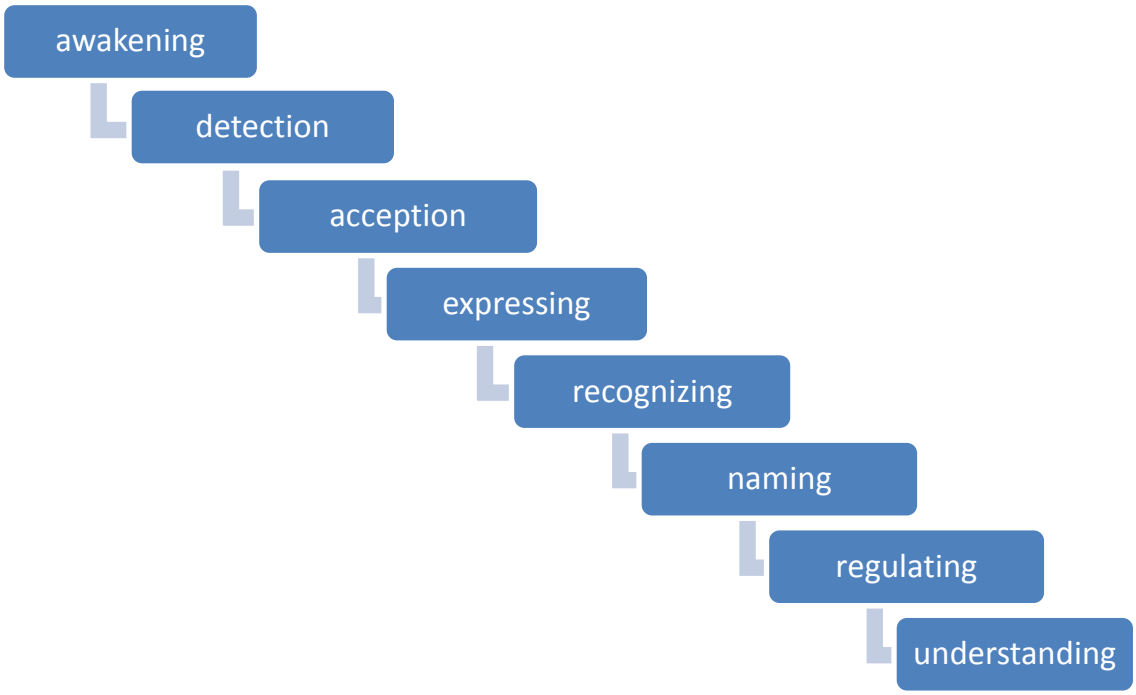


Figure 11. The Process of Facing a Feeling (Nurmi 2013, 24).

Both, individual differences and situational factors can increase the probability of aggression with help of three separate but co-operating mechanisms. These three mechanisms are: feelings related to anger, aggressive thoughts, and a real or experienced physiological agitated state of mind. According to general aggression provoking model, the activation of one or more of these mechanisms leads to a fast and automatic evaluation of the situation. If an

individual does not have time cognitively to deal with the situation, the instant situational assessment leads to an impulsive action, which can be aggressive or non-aggressive. If an individual has time to think and process the information he/she obtains by the instant assessment of the situation, the person may also think about the possible consequences of his/her actions. The probability of a person facing aggression depends on how much the reassessing the situation increases the concept of usefulness of aggression. (Sandström 2010, 204.)

14 ANGER RESPONSE MODEL BY DAVIES

14.1 Inhibitions, Triggers and Appraisal/ Judgement

Davies (2009) explains that people control their feelings with internal and external inhibitions that form one type of self-control mechanism putting breaks on anger. The moral guidelines and thoughts that people have for themselves are known as internal inhibitions. External inhibitions are the awareness of the outcomes that may take place if an individual responds disproportionately to a stimulant of anger. (Davies 2009, 24.) However, inhibitions are not forming the only mechanism breaking on anger. An appraisal and judgment are factors that will determine whether a person will become angry and to what degree, and it may even totally preclude the trigger that tries to produce anger. (Davies 2009, 43.) “In other words, it is not so much the trigger in itself that produces the anger; it is what goes through the person’s mind when prompted by the trigger” (Davies 2009, 42).

14.2 Roles of Beliefs and Moods in Anger Response

However, why does everyone appraise and judge a situation in different way? Davies (2009) explains that is because all the people have developed own basic beliefs throughout the life. These beliefs influence people’s judgment and appraisal of the trigger, but they also influence the inhibitions, feeling of anger and the response to the situation (Davies 2009, 47-48). With regards to measuring individuals’ beliefs about their emotions, previous studies have also examined how people tempt to rely on the implications of any relevant mental constructs that are accessible at the time of judgment (Lambert et al. 2014, 92).

Moreover, because all the people are different, so is the variation of their irritability. Some people have clearly notable ‘mood swings’ making them really irritable some days and almost not irritable at all in other days. (Davies 2009, 62.) There are also some factors and habits that influence on people’s moods,

such as illnesses (mental/ physical), circadian rhythm, amount of exercise, diet, amount and quality of sleep, stress, medication and recreational drugs and social factors (e.g. arguments and loneliness) (Davies 2009, 66).

Davies' description of anger response process is summarized on Figure 12 below.

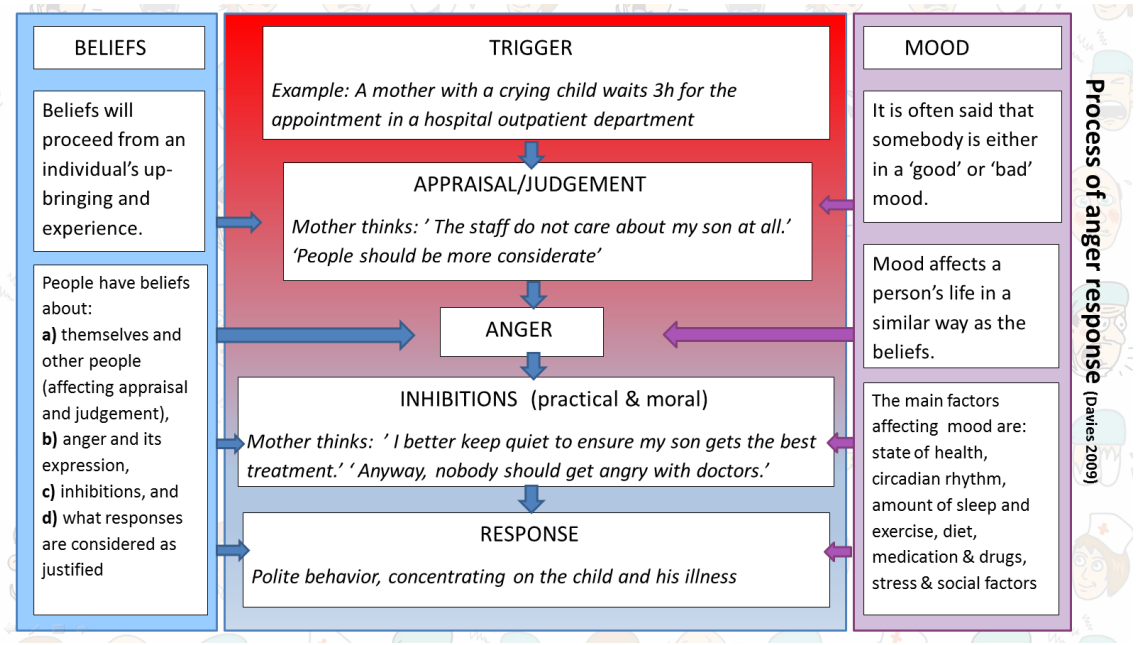


Figure 12. Process of Anger Response (Davies 2009).

15 EXPRESSIONING ANGER

15.1 Ways of Expressing Anger

Everybody reacts spontaneously in ways they express anger, because humans' feelings motivate their actions. In the most cases the consequences of the anger expression are only thought afterwards. (Nurmi 2013, 23.) There are three ways of expressing anger: 1) anger-in, which means that the person remains calm, does not show his/her emotion, 2) whereas anger-out resembles to cursing, hitting objects, yelling, confronting and criticizing. 3) Anger control is a feature that allows the person to behave in a calm, understanding, and patient way all the time having the control over his/her anger and remaining calm. (Arslan 2010, 26.) Anger can also be categorized in two sections; "trait" anger and "state" anger. A person who has "trait" anger is more easily irritated and therefore gets and stays angry easier. Fortunately, "state" anger is more common among people whereas the anger is only temporary and quickly passing state. (Shrand & Devine 2013, 43-44.) Accepting and facing the feelings of anger might be difficult, but a person's body or mind can be taught to learn to recognize them slowly. Once the feelings are detected they should not be avoided, because the existing feeling does not mean that a person will verbally hurt someone or thing. (Nurmi 2013, 23.)

15.2 Factors Influencing on the Expression

Temperament and already learned ways of dealing with anger are the aspects that effect on individual's anger expression styles (Nurmi 2013, 24). Everyone has an individual behavior feature and that is referred to temperament, the ensemble of it and the environment creates a personality. Temperament is permanent and the individual differences can be seen in early phases of living; some have the tendency to express emotions loud whilst others do it out by themselves, quietly. Temperament features are born within a person before the

environment has the opportunity to effect on them and the way of showing them varies according to the person's age. If a person is easily irritated the trait will not disappear, that is because of the biological roots of temperament, which are making it also a genetic feature. (Nurmi 2013, 25.)

In other words, it is not always possible to tell whether a person is angry or not just by looking at him/her. Usually temper, aggression and violence are connected. Those with a flamboyant temperament can really easily get angry and throw tantrums. Also the age, alertness and past experiences affect how many feelings people have and how constructively they can express their unpleasant feelings. Sometimes the actual act can be nasty and evil without that kind of feelings. The feeling of anger and aggression must be differentiated from aggressive behavior or any kind of behavior. The cruelest violence can exist without almost any feelings of aggression. This kind of behavior can be seen by a person who is treacherous, self-interest-seeking and using violence as a power tool. In turn, another person can show the most ferocious aggression without any violence, such as a person screaming into a pillow whilst kicking around. It should be pointed out that it is impossible to control things that are not understood, or if there is inability to talk about those things. (Cacciatore 2007, 17-23.)

Furthermore, the research results have indicated that perceiving violence activates both emotion- and memory networks, where the earlier perceptions of violence connect with new practices. For example, it has been detected In Finland that if youngsters spend approximately 21 hours a week playing violent video games, they will show signs of restlessness and aggressive behavior. (Sandström 2010, 205-206.) These results may lead to gruesome consequences in the future if no action is taken.

15.3 Aggression Behavior Models by Perkka-Jortikka

Aggressive person may not be hostile, as well as angry person can stay quiet. Perkka-Jortikka (2007) describes in her book "Hankalan ihmisen kohtaaminen"

the three most common types of hostile and aggressive persons 1) the ones who are acting ruthless, caring only for the final result, not the ways of getting it, 2) the ones who are stabbing others in their back, 3) and finally the ones who are known to emotionally explode, not having any control of their feelings.

The following section reveals more about the common characteristics and behavior models which are related to them. (Perkka-Jortikka 2007, 46.)

Ruthless and indifferent persons

These kinds of people charge straight towards their victims and they can also be violent. Their behavior is arrogant, rude, self-serving and obnoxious and though they do not get physical, their gestures and body language may seem like they will attack. When they evaluate on somebody's doings, they immediately start to criticize the person who has done the task, not the task itself. They lack the ability to give positive feedback, blame others for their mistakes and their speaking is normally loud, almost shouting. (Perkka-Jortikka 2007, 47-49.) They also like to humiliate others around and act as "better than everyone else". Some of them are also very skillful on wearing others down by their adamant justifications and therefore getting what they want and the powering feeling along with it. Their main goal is to cause confusion, helpless frustration or make someone cry, and after that their victims become irrational and nervous, then they will act. They seem to be lacking faith in others and the capability to care. Values that are close to them are confidence and aggressiveness and they are prone to get irritated when spoken with a friendly voice or spoken too much. (Perkka-Jortikka 2007, 47-49.)

Backstabbing persons

These people do not ever attack their victims visibly. They behave in a backstabbing way and their vicious comments towards their victims may be very hurtful and malicious. The insults are usually said in a way that the victim has no choice but to pretend that their behavior or comments would be ok, or pretend that he/she did not hear them. Backstabbing persons usually uses a lot of nonverbal mockeries, such as sarcastic smiles and laughs, or yawning and

rolling their eyes and they have learned to act so insidiously that the victim himself does not get these insults. All and all, they spread negativity and undermine the victim. Usually the angry backstabbers have suffered some kind of unfairness and the behavior will not end until the victim defends him/herself by stopping being a victim. (Perkka-Jortikka 2007, 59-61.) These types of angry persons are the saboteurs, who are skillfully hiding in the crowd and unfortunately are protected by many guards from which most of them being unaware about being guardians to anyone (Perkka-Jortikka 2007, 63).

Persons who are not in control of their feelings

The third type of aggressive-hostile persons is sometimes referred as having adult-temper tantrums because of their similar behavior. The whole scenario can begin with a friendly conversation, with no aggressiveness at sight and within a minute these persons literally explode, shouting to others and also insulting everyone, throwing items around and all objections are fuel to the fire, increasing their wrath. These persons usually feel like they are threatened and defeated and when they become frustrated, they explode. (Perkka-Jortikka 2007, 69.) Threat and defeat equal an explosion, so in order the situation to remain calm, threat should be excluded from their minds. The words that they commonly hear as a threat are usually subtle, and are not intended to cause menace, and therefore when they get suspicious and angry, the opponent gets frightened and surprised by it. These persons let their feelings and emotions come out without control and they do not have a planned agenda, which makes them different than the previously mentioned ruthless and backstabbing persons. Those two types are referred as rude, obnoxious people, whereas the persons who have the tendency to explode are described as overly sensitive and irritable. As a child the temper tantrum has been a useful method to get the person’s own way, and same kind of behavior is still continuing in the adulthood. (Perkka-Jortikka 2007, 71-72.)

16 AWARENESS OF OWN ANGER

16.1 Elimination of Anger Awareness

When it is said that an individual is denying the anger, it actually means that he/she is eliminating the awareness of the anger. However, the anger will not disappear by blocking the awareness of it, instead it will increase. (Simula 2013, 160.) According to an American research in 1990's one fifth of the population never gets angry, because they are already chronically angry. Aggressiveness was constantly at issue in the thoughts of the study population. (Simula 2013, 165.) The chronically aggressive person often remains in a stand-by state with his/her aggression and anger, and snaps very easily. The time is easily spent in aggressive thoughts, backstabbing, developing conspiracy theories, and harping on about injustice. The person starts to feed the anger and aggression, and forms a shield around him/herself. (Viljamaa 2012, 27.)

16.2 Defense Mechanisms

Aggressive people often use defense mechanisms that make them feel more secure and safe whilst still expressing their anger or aggression, however, maybe more discretely. One of these defense mechanisms is to be passive-aggressive. A passive-aggressive person puts the breaks on, pretends to be helpless, postpones tasks, and resents people who are initiative and outgoing. The person acting passive-aggressively thinks that he/she is always right and creates conspiracy theories. The faults are found from coworkers or different systems. The passive-aggressive person thinks that one of the main meanings of the life is to be prepared for future disappointments, but there is no need for the person him/herself to change. (Viljamaa 2012, 30.)

Other two defense mechanisms used by aggressive people are projections and introjections. Those people who use projections as defense mechanism blame others for their miseries. The person would not like to hit, but may do so,

because ‘others are annoying him/her’. The person would not like to get drunk, but does anyway, because ‘others are stressing him/her’. Own weaknesses are not seen or admitted. Using projections is almost narcissistic behavior. Those aggressive people relying on introjections use additionally unwanted features along with all the strengths of the role model as a building material of the personality. For example, a little boy who is punching other children on the playground wants to be as big and scary as his dad, because his dad is violent towards him at home. (Viljamaa 2012, 30-31.)

17 PROBLEMS IN ASSESSING ANGER

17.1 Gender Differences

There are some gender differences when looking at the anger, aggression and violence experiences between men and women, and that can cause some uncertainty and have effects on the nurses' ability to interact with angry patients in healthcare settings (Thomas 2003, 105).

Some of the major findings of these differences are listed below:

- Women generally use the word 'hurt' and have problems separating the anger from feelings of 'hurt' - only few men use that word
- Women commonly cry while being angry – men do not
- Women's anger mainly consist of internal agitation – men's anger erupts with force
- Women's anger generally provokes within close relationships – men's anger is usually provoked by strangers, and broken mechanical objects
- Women get angry easier if they feel that staff is uncaring and unable to listen – for men the anger is more caused by loss of control, and inefficiency and unprofessionalism of the staff

(Thomas 2003, 105.)

Especially women throughout times have been forbidden to show anger and it is still nowadays considered a sign of weakness if the temper is lost. The situation is not any better among men, though they are known not to have the capability for suffocating their anger and it usually just bursts out and is almost immediately forgetten. (Dunderfelt 2007, 115.)

Reenkola (2008) also describes that men are more likely to express rational aggression, but women express aggression more manipulatively. That means if a man is angry at someone, he is more likely to criticize things such as a person's abilities to do something. Women who express aggression manipulatively are more likely to criticize a person him/herself, the looks or private life. (Reenkola 2008, 47.)

Sometimes indirect aggression can be difficult to notice until it causes further signs, such as depression or physical symptoms. The indirect aggression can be hidden behind a feeling of forceful thoughts or a force to do something constantly in a certain way. It is the most developed form of aggression, because it involves discreet social skills, which often leads to a situation that a person him/herself does not notice it happening. Several studies in different cultures have concluded that girls use more indirect aggression than boys at school. Indirect aggression is already seen when young girls' are playing: Often the third person is too much and is left outside of the play and games. In adult women, the indirect aggression is often mixed with jealousy. (Reenkola 2008, 47-49.)

17.2 Age Related Differences

It is good to remember that the angry person's age effects on the reaction of anger and therefore causes difficulties when assessing it. The development in the brain during puberty, especially in the areas responsible for the regulation of feelings, is very strong and therefore a person is not capable of making rational decisions and is in need for new approaches towards different situations (Cacciatore 2009, 11). The ability to control and regulate the feelings is also called 'emotional intelligence', which widely described means perceiving and understanding own and other people's feelings. In addition to that, it covers the skills to evaluate, express and analyze own feelings. (Sandström 2010, 149.) Because children's emotional intelligence is not yet well developed, they may also copy aggressive behavior very easily (Sandström 2010, 201-202).

Therefore, it is normal for children of any age to have temper tantrums. However it is good to remember that temper tantrums can also be a sign for something more severe, for example a symptom of an illness, though the primary reason is usually hunger, fatigue or frustration, and therefore the assessment should be done accurately. (Daniels et al. 2011, 570.)

18 IMPACTS OF MISMANAGED FEELINGS

18.1 Costs of Hidden Anger

Anger has been described as a physically and socially expensive emotion (Sell 2011, 384). That is true when thinking about the financial costs that can evolve from treatments and experts required for people showing mental health problems or psychological symptoms such as depression, self-harm, anti-social behavior, crime, learning problems, and psychosomatic symptoms that all can be related to outcomes of not expressing anger or repressed anger. (Cacciatore 2007, 66; Blake & Hamrin 2007, 209; Shirey 2007, 569.) Ignored or repressed anger can also cause unwanted emotional costs. Especially, if anger (especially associated with irrational beliefs) is projected towards the others, it can cause even the endangerment. (Shirey 2007, 569.)

These type of situations have been distressingly common these days. One of these alarming examples is the incident in 2002 at the University of Arizona College of Nursing, where the anger and rage by a troubled nursing student lead to three brutal deaths of faculty members. (Shirey 2007, 568.) Furthermore, an American research done in 1990's came up with the worrying results that a person who is often dissatisfied, sceptic, or angry is five times more likely to die before the 50th birthday than those who have positive attitude for their life (Simula 2013, 165). That is why the results could be devastating if the anger is hidden, mismanaged, and follows the youth to the adulthood. (Thomas 2003, 103).

Along with financial and emotional costs, ignored anger can cause huge medical costs due to various illnesses, such as hypertension and coronary heart disease, it has been linked to (Thomas 2003, 103). For example, according to Mostofsky et al. (2014, 1404-1408) anger, rage and other emotional outbursts increase the risk of cardiovascular events. Based on several previously published research results Mostofsky et al. concluded that there is an increased risk of myocardial infarction, acute coronary syndrome, arrhythmia, and

ischaemic or haemorrhagic stroke in the two hours after outbursts of anger. In group of people having one anger outburst per month causes estimated one to four excess cases of coronary heart disease per 10 000 persons per year, and the risk is bigger if the frequency of anger outbursts is increasing (up to 657 excess cases per 10 000 persons per year if a person has five anger outbursts per day). Please see figure 13. (Mostofsky et al. 2014, 1404-1408.)

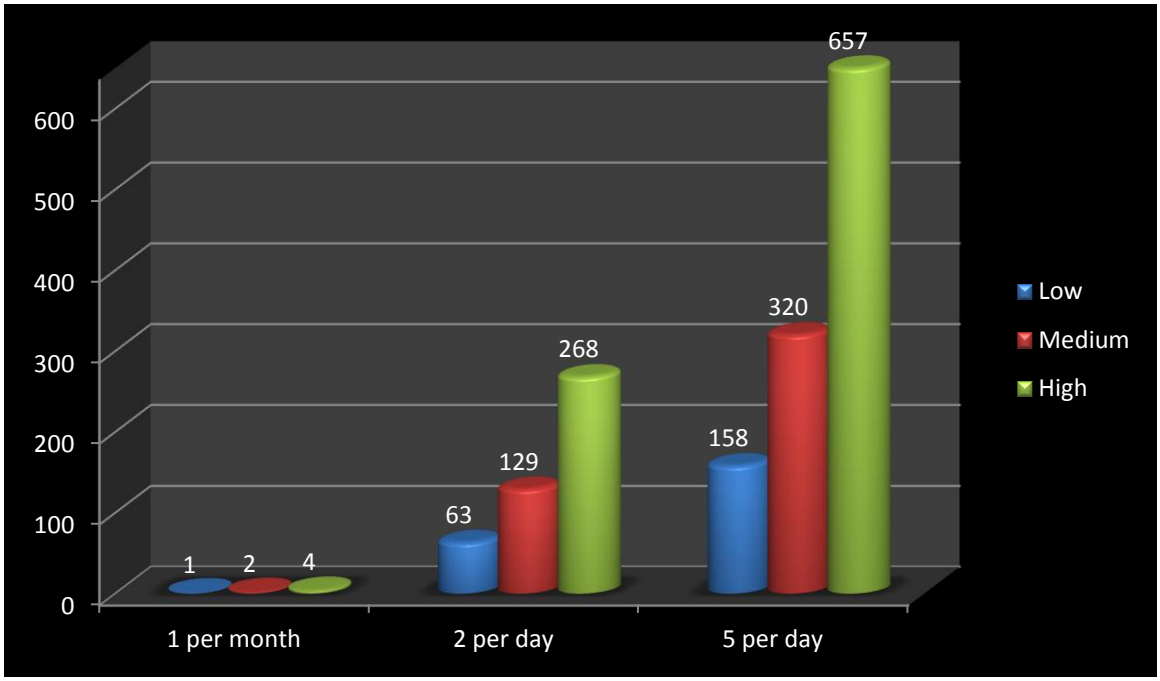


Figure 13. Relation between Anger and Coronary Heart Disease (Mostofsky et al 2014, 1408).

18.2 'Remote Controlling' Anger is Harmful

The feeling of anger and other negative feelings should not be seen as totally bad things that break down the harmony and well-being. Everybody should have a right to show the emotions without getting stigmatized. Sometimes feelings are also 'remote controlled'. For example, the feelings of the children may be manipulated by the parents. A mother may say to a child: "If you are not doing what I ask, mum will get sad and angry." This is unfair against a child, because the child will not understand this type of 'remote-controlling of the feelings', and in long-term it teaches the child dishonesty. Taking responsibility

should not be constant making insistences, because this kind of behavior can easily limit the ability of a person to show the emotions. (Simula 2013, 168-172.)

18.3 Benefits of Losing Control Every Now Again

In adults' working environment certain tools should be used to recognize the feelings and emotions of the employees. When the happiness, enthusiasm and gratitude are recognized in front of everyone, the awareness of them strengthens. Furthermore, if dissatisfaction, alienation and anger can also be expressed, the negativity of those feelings will more likely disappear, making the problem-solving much easier. (Simula 2013, 168-173.)

Dunderfelt (2007) also highlights that it is not always a good thing for a person to repress his/her anger. Although the things slipping out of one's mouth during argument might be bad, a person should be allowed to "flip" once in a while. If all the resentment, bitterness and anger stay bottled up it will cause nightmares, headaches, or make the angry person to seek for scapegoats and criticize others. (Dunderfelt 2007, 114.)

19 BENEFITS OF ANGER EDUCATION

19.1 Beneficial Investment in Early Education

Although educational programmes on anger, aggression and violence management exist, they are mainly offered only to post-graduate staff (Nau et al. 2008, 198). Nonetheless Nau et al. (2008) tested a three day course in aggression management for a group of students, and they came up with results that there is a positive correlation between the development of a good confidence and the training course in aggression. Nau et al. (2008) highlights that this finding should be considered as a significant ethical issue. Therefore, integrating this kind of three-day training programme within a full-time pre-registration diploma course should be a beneficial investment. These kinds of trainings should make it easier for beginners to learn to cope with practical demands, and they would provide a solid basis for advanced trainings. Although, according to the study results future research should be focused on finding out the impact of such training courses on the actual performance in healthcare. (Nau et al. 2008, 205-206.)

19.2 Lack of Education Increases Risk of Assaults

According to Thomas (2003), previous study results suggest that there are long-term consequences for the job performance of nurses who have been assaulted by the patients. They felt being blamed by the management, and found themselves labeled as ‘the nurse who has been hit’. So the question arises if the training course would have prevented these consequences, or at least minimized them. However, Thomas (2003) concludes that all nurses should receive training in assessing angry patients, and also in violence prevention techniques. (Thomas 2003, 106.)

The campaign by Tehy (2011) – ‘Älä riko hoitajaasi’ (Don’t break your caregiver) – got some attention in media due to the publication quoting that one in four

nurses in Finland experiences some sort of violence by patients or by patients' families. This figure should be minimized. One of these de-escalating steps would be teaching anger and aggression management skills for nursing students. (Tehy 2011.)

19.3 The Training Programmes Should be Evaluated

Lack of training is not the only negative issue. Nau et al. (2008) also explain that there is an ongoing problem of evaluating training programmes (Nau et al. 2008, 198). The problem was highlighted when the authors of the National Institute for Health and Care Excellence (NICE) -guideline on the short-term management of disturbed/violent behavior stated that "at present, very few of the training programmes are based on evidence of either the effectiveness of training or the benefits perceived by staff and/or service users" (NICE 2005, 23).

20 ANGER IN HEALTHCARE

20.1 Anger Within Nurses

Recognizing anger in nursing is extremely important. It is too common for nurses to swallow the feelings of anger and to just go along with the others as a mass, which is already described as an ‘occupational illness’. (Reenkola 2008, 32.) Nurses are meant to work with holistic perspectives, and the anger can diminish that from happening. Anger can eat out a nurse’s energy and make him / her feel vulnerable. Keeping control and being non-judgmental in a tensed up situation is of course desirable but can be hard to achieve. The way a nurse has learnt to cope with anger provoking situations is usually adopted in a family, social group, or it can be partly a culture related thing. Those nurses who are lacking in self-awareness may deal with angry outbreaks in a way that generates more anger. Rather than mirroring the angry behavior, nurses need to think critically what type of relationship they develop with other individuals. (Hollinworth et al. 2005, 44-47.)

In nursing students five common causes of anger include:

1. The perception of faculty unfairness, rigidity, and discriminations based on ethnicity, race, or gender
2. Complaints about excessive expectations of the faculty
3. Very critical teachers
4. Reactions to unforeseen changes
5. Problematic personal or family issues

(Shirey 2007, 569)

20.2 Anger Within Patients

Patients can get angry because of several reasons. Patients' anxiety and fear may evoke to anger, which they use as a defense against the stressful situations. Also, being ill can itself irritate people. Patients who are not satisfied about their health or the healthcare system, who try to cope with strange hospital routines, who have gone through complicated surgeries, and who receive bad news about their future, may feel emotionally distressed, vulnerable, and powerless, which can further develop to anger. Therefore nurses and other healthcare staff should understand that anxiety often increases when individual's perception of personal control decreases. (Hollinworth et al. 2005, 43.)

However, it is still important to accept and acknowledge the anger of a patient. If a patient feels that his/her aggressiveness caused by the despair, fear and distress is taken seriously and respected, he/she is more likely to respect also him/herself and the nurse on call. This is because the patient gets a feeling of being a worth of something whilst being listened to and cared of as an individual, which de-escalates the feelings of aggressiveness. (Simula 2013, 178.)

Moreover, it is normal to show anger also in the case of death of a close family member. This anger is due to emotional pain and sorrow. A close family member may blame the dead for leaving him/her alone, or there may be some other selfish concerns. Health care personnel should remember that anger is a part of grief and they should show understanding and tolerance also in these kinds of situations. (National Institutes of Health 2006, 8.)

20.3 Understanding the Causes

The nurses should critically assess the situations and be aware of changing behavior or attitude of the patients. The anger can be triggered by many different things, and some of the people get angry much easier and quicker than others. (Miracle 2013, 125-126.)

Thomas (2003) states that lack of nurses, their time pressures, and failure of nurses to recognize the patients' uniqueness may influence patients' anger to be vented to their nurses. Nurses do not always realize that it can be patients' fears of abandonment that cause anger. Furthermore, it is due to nurses' extended periods of direct contact with patients and their families that make the nurses especially vulnerable for patients' anger. There is also a risk that a patient's or family member's anger could escalate to aggression and violence. The studies show that younger, less-experienced nurses and student nurses are more likely to be at risk for patients' anger, aggression and violence. (Thomas 2003, 105-106.) Unfortunately nurses in all kind of clinical settings also face high amounts of verbal aggression and swearing, and this can be very distressing for the nurses. Especially nurses working in mental settings are continuously reported to experience verbal abuse. One of the definitions of the verbal aggression is known as 'a behavior which attacks a person's self-concept in order to deliver psychological pain', and swearing is often a part of this type of aggression. (Stone et al. 2010, 528-529.) According to research by Stone et al. (2010) only 12% of the nurses questioned reported hearing no swearing within their unit during the previous week of working, and 1/3 of the nurses explained ignoring the usage of bad language by others, even it had evoked distress in them (Stone et al. 2010, 531-532).

There are many causes of anger in healthcare working environment, and the figure 14 below consists of the most common sources. However, it is not all-inclusive. (Miracle 2013, 126.)

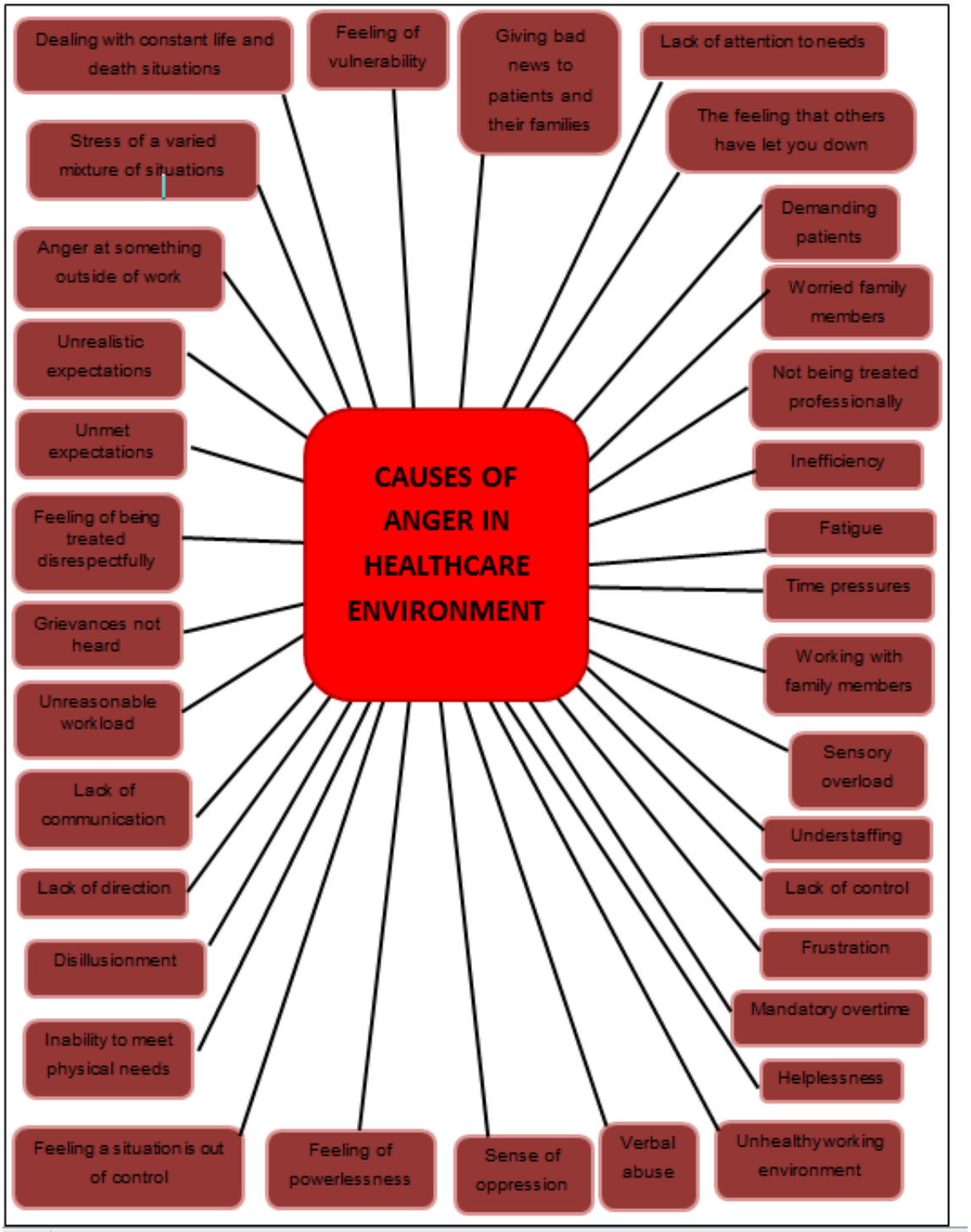


Figure 14. Main Causes of Anger in Healthcare Environment (Miracle 2013).

21 STRESS BEHIND ANGER IN HEALTHCARE

21.1 Nature of Stress

On the current period of nursing shortages and lack of nursing faculties, the presence of unresolved anger and its combination with stress is counterproductive for the whole nursing profession (Shirey 2007, 569). However, stress and anxiety are common in nursing settings, and unfortunately often these emotions build up to anger and aggression. Research results have clarified that it is often stress that underlines the anger. (Hollinworth et al. 2005, 45.)

A human being always needs a little bit of stress to stay alert and motivated. There are two main types of stress: eustress and distress. Eustress is the good stress that keeps up the motivation, makes person enthusiastic and makes concentration possible. Distress is so called bad stress that makes the person anxious, causes panic and tiredness, which can lead to mood changes. (Viljamaa 2012, 84.)

When a task is too demanding or difficult, body starts to defend towards it by causing a person to feel stressed. A small amount of stress can help an individual to achieve a deadline in time or achieve better on a work assignment, but that does not mean that it helps every individual. (Lehestö et al. 2004, 195.) Everybody acts differently in stressful situations and react differently to stress, but still nurses are expected to be able to identify circumstances that can bring about anger. Ideally this kind of ability to foresee all those circumstances would give a possibility to enhance patient satisfaction, and provide professional status for nurses. (Hollinworth et al. 2005, 42-46.) Stressful situation often occurs suddenly; e.g a person might be attacked, might have a near death experience, severe accident or even witness someone else getting attacked. This kind of incident leads to acute stress reaction and the reaction varies among people. No matter how the person appears to be after the sudden

stress, defusing and debriefing should always be done after it (Lehestö et al. 2004, 197.)

21.2 Coping with Stress and Anger

Simula (2013) points out that the anger is a healthy feeling, but when a person faces a combination of stress, fear and anger, it causes a physiologic stress reaction producing stress hormones, which however makes the person stronger. This defense mechanism is healthy when the fear and anger correspond to the needs of the threat. If the fear and anger are under- or overestimated, a person's behavior and thoughts often reflect some neurotic attitude, jealousy, and the fight against awareness of the situation begins. (Simula 2013, 177.)

Arslan (2010) explored the relationship between coping with stress and interpersonal problem-solving skills, and anger and its expression. As the main result of this study, it was discovered that avoidance in coping with stress explains the anger-out behavior. It was also discovered that anger expressing styles as well as trait anger are noted with interpersonal problem-solving and coping with stress. (Arslan 2010, 25.) Avoidance includes emotion-focused coping; it is guided to change an individual's own emotional reaction towards the stressor (Arslan 2010, 37). Another important aspect was the positive relationship found was between avoidance and anger-out, and anger control and avoidance. This indicates that in coping with stress, once the avoidance behavior increases, anger control increases and on the other hand, anger-out decreases. (Arslan 2010, 25.)

Furthermore, it may be useful for nurses to acknowledge that anger serves a function in coping with stress. When a person is feeling stressed, rather than to act apathetically and anxiously, it may be considered better option to take a role as a slightly angry and agitated person who is still able to function and gets the work done. (Hollinworth et al. 2005, 42-46.)

21.3 Stress amongst Nurses

Nurses can feel powerless. Not being heard is said to be the most common reason for nurses to feel anger. Jobs with low decision authority and high demand increase the nurses' emotional exhaustion and stress (Thomas 2004, 20-23.) Lack of confidence on tasks given to employee is also mentioned to be one of the first influencers to cause of negative stress (Olofsson et al. 2003, 352).

Thomas (2004) interviewed with her research team thousands of nurses to discover what were really the ultimate stressors that lead to frustration and eventually anger. It was seen that among the nurses there are some major problems that should be considered in order to relieve their daily stress. As one of the interviewed nurses stated there is always "100 and one things on your mind, working days are so hasty that there is no time for a lunch break, not to mention a bathroom break, you are giving everything you got, and still people around you are not satisfied". (Thomas 2004, 3.)

Breaks and meals are skipped and the care is not always the best they could offer because there is always a next task to do. Age and race discrimination, and sexual harassment, are also factors affecting nurses. (Thomas 2004, 13-15.) Also the lack of social support, e.g. problems to trust coworkers and feeling excluded from others is mentioned one of the aspects causing negative stress among nurses (Olofsson et al 2003, 352). Because nurses are considered to be messengers between e.g. laboratory and physician, and still they are the ones first facing the patients, they are often treated as scapegoats. Just like one of the interviewees quoted "Physicians are regarding us as a stupid bunch of nurses, and we are mainly treated like a garbage bin, everyone blames us." (Thomas 2004, 20.)

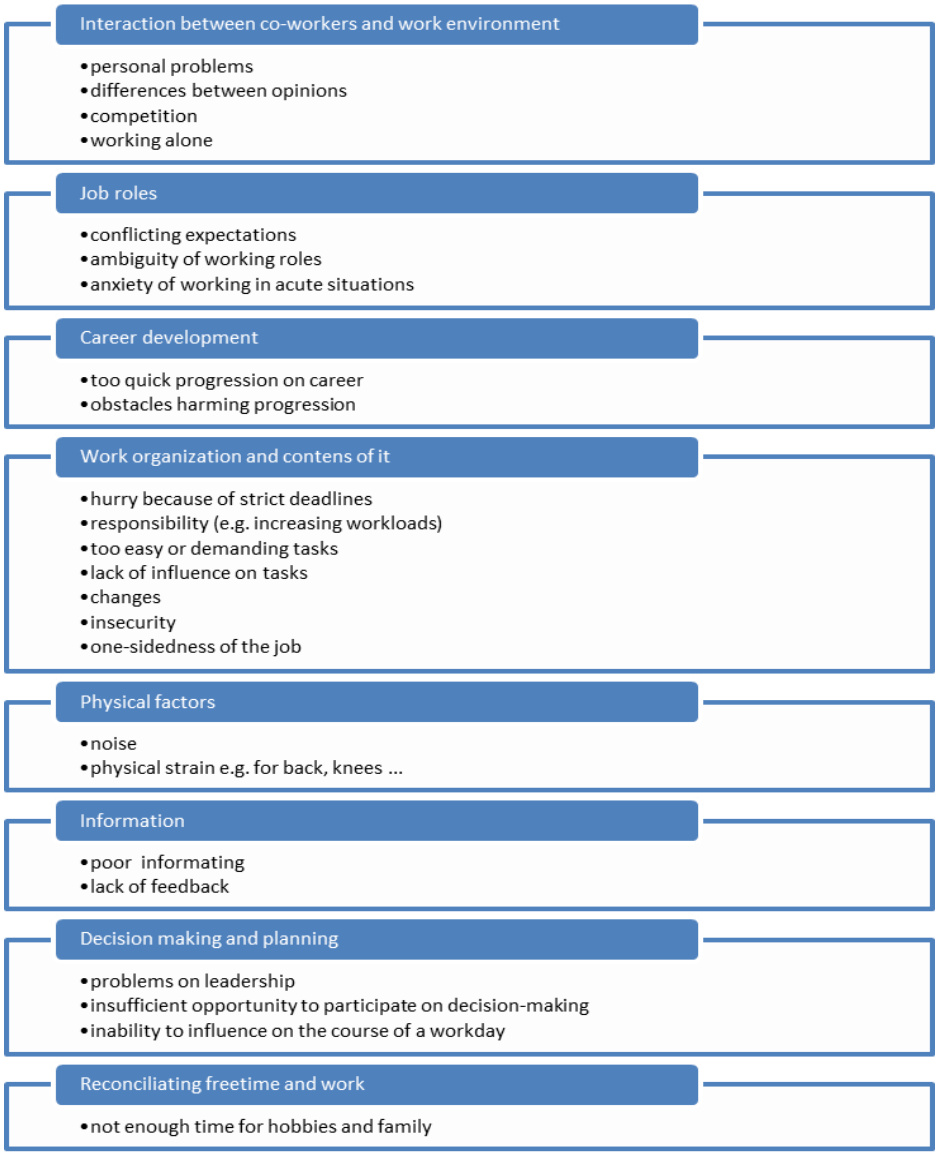
Immediate feedback on tasks done wrong and the lack of support were also said to be stress increasing factors. Instead of correcting mistakes right on the scene, the nurses explain they have been called idiots and yelled at later on. For example, one nurse asked for assistive hands to delivery and labor ward

during a night shift, and was answered by the manager “Well, where do you think I’m going to get these nurses, from cutout paper dolls?” (Thomas 2004, 26.) Generally, lack of feedback, whether it is good or bad, has also an influence to stress. A person feels undervalued when no feedback for a task is given. (Olofsson et al. 2003, 356.)

Symptoms of a stress can be seen in a working environment e.g. by avoiding challenges, having poor relationships, and acting bitter. Long-term stress may lead to burnout and therefore it is important to notice and intervene it on time. (Lehestö et al. 2004, 195.)

Below is a table showing the most common stressors in nursing in Finland.

Table 3. Stressors in Nursing. (Lehestö et al. 2004, 195-196; Hollinworth et al. 2005, 44-46; Olofsson et al. 2003, 351-352).



After all, currently it seems that anger and aggression will always be parts of the stressful healthcare environment. However, there is always a possibility to improve also the management methods, and new innovative ideas should always be welcome by employees. (Thomas 2003, 109.)

22 HORIZONTAL VIOLENCE IN NURSING

22.1 Horizontal Violence

Horizontal violence between nurses is known as an act of aggression that is performed by one colleague toward another. Horizontal violence is normally verbal or emotional abuse, but it can also include physical abuse, and it can also be diplomatic and overt by nature. Repeated acts of horizontal violence against other person are many times referred to bullying. (Longo & Sherman 2007, 35.) Therefore, the horizontal violence is a form of bullying, but there is not only one single definition for bullying. However, it is universally agreed that there are many types and all of them are mainly characterized as systematic, reoccurring and usually long-term. Horizontal violence can involve bullying a coworker about issues that affect his/her personality, reputation and work status. (Sandström 2010, 208.) That is why, indications could also include damaging gossip, nonverbal signals, and grim silence (Thomas 2003, 106).

Horizontal violence is not a new matter in nursing. McKenna et al. (2003) studied about horizontal violence experiences of registered nurses in their first year of practice and the results showed that of 551 first year graduates, 34 % had experienced statements by other nurses that were abrupt, abusive, humiliating or contained unfair criticism, and 3 % had experienced verbal threats (McKenna et al. 2003, 93). Moreover, the Working Life Barometer 2010 pointed out that horizontal violence, humiliation and workplace violence are more common in public than in the private sector (Viljamaa 2012, 16). Unfortunately, there have not been found any permanent methods for removing horizontal violence or any other type of bullying from workplaces, but for example in Finland, Sweden and Norway many laws and regulations have been made to protect employees (Sandström 2010, 209).

22.2 Reasons behind Horizontal Violence

Background of horizontal violence is usually sourcing from feeling of low self-esteem and lack of respect from other people. The influence of low self-esteem and the feeling of powerlessness due to lack of respect from others may give rise to frustration and oppression, which is sometimes manifested as conflicts between nurses, as so called horizontal violence from nurse to nurse. (Longo & Sherman 2007, 35.)

Lack of respect among nurses is also increasingly common nowadays. Physicians, peers and even supervisors mock and discipline nurses and even embarrass them in front of patients. Verbal abuse is also more and more common between nurses. Rowe and Sherlock (2003) studied the different ways and frequency of nurses' verbal abuse against each other. The most common group of insulting individuals were the nurses who were on the verge of burnout, and because of their behavior increasing amount of nurses stayed at home and pretended to be sick so they did not have to listen the abusive language which made them stressed and more willing to change their occupation. (Rowe & Sherlock 2003, 242.)

The studies have pointed out that individuals' aggressive behavior is connected with the coworkers' aggressive behaviour. Therefore, the perceived violence climate is connected to violence, verbal aggression, perceived danger and injuries, which are further linked to physical and psychological strain. (Spector et al. 2007, 123.)

The theory created of oppression has helped to clarify that many times the behaviors of horizontal violence are actually a response to the unpleasant situation in which the nurse finds herself. However, the fear of punishment and sanction from the management prevents the nurse from physically responding to the oppression, so the oppression may be expressed more silently, venting it out on a colleague when the management is not present. This is how a colleague starts to feel vulnerable and hurt, so the cycle of horizontal violence may be continued. This can be extremely damaging when a student nurse or

any new nurse gets a job in the unit where this kind of behavior is ongoing. The new employee will not necessarily realize the reasons behind it and may adopt these behaviors as normal behavior in the unit. (Longo & Sherman 2007, 35-36.) Interpersonal conflicts play a major part in work satisfaction which is a big section of a coping at work and not becoming stressed. Unfortunately the threat of becoming alienated and wanting to resign is huge with a nurse who is bullied every day. (Rowe & Sherlock 2003, 242.) Thomas (2003) explains that the previous studies have shown nurses with the highest burnout scores having the greatest amount of conflicts with other nurse colleagues. However, the more nurses get support from colleagues, the less there will be burnouts amongst nurses. (Thomas 2003, 107.)

22.3 Outcomes of Horizontal Violence

Horizontal violence between nurses can lead to devastating outcomes, because the communication barriers and frustration between colleagues can even increase the possibility of medical errors. Other negative effects could be job dissatisfaction and lack of enthusiasm, psychological and physical stress, depression, and excessive usage of staff sick leave. Therefore, horizontal violence can have bad influence also on recruitment, and more importantly on patient care. Because newly graduated nurses have often experienced horizontal violence during their first year of practice, there should be changes made to nursing management and work culture. The working environment values should include staff empowerment, effective communication and collaboration, promoting lifelong learning, celebration of staff achievements, and valuing different skills every nurse brings to the unit. (Longo & Sherman 2007, 37-50.) Thomas (2003) adds that there must be healing of the emotional pain that has been caused by all the backbiting and twitting (Thomas 2003, 107).

23 VIOLENCE AGAINST NURSES

23.1 Prevalence of Occupational Violence

The threat of violence in healthcare is real; nurses should be encouraged to learn to face difficult patients even from the early studies and they should be taught self-defense skills (Ellilä 2005). The violence, verbal as well as physical, against all medical staff has been increasing in the past 25 years, but still the nurses are in the most danger. There have been even deaths on duty. In the USA from 1993 to 1996 there were over 429 100 reported incidents of violence against nurses in their work places. (Thomas 2004, 3.) In the USA Spector et al. (2007) studied the workplace violence including 13 occupations that required caring for others, practicing physical control over others, or having contact with people on medication. It was found out that after the police officers' occupation, the greatest risk exposure and greatest violence incidence rates affected nurses. For example, it was 15 times more likely nurses to be physically assaulted than secretaries. The results showed that more than a quarter of the nurse participants were experiencing violence each year, and over half of the nurses experienced verbal aggression. The most of the violence was performed by patients or their families. (Spector et al. 2007, 119.)

When looking statistics in Finland, social- and health care professionals are at 1st place when it comes to facing work violence, though the incidents have decreased from the numbers of the study done in 1999. The amount of the employees who had been assaulted was 111 000 in 1999, which is 5 % of all the laborers. In 2007 the number was 100 000 (4 % of all), from those, over 40 000 were social- or health care professionals. Occupational violence does not necessary happen at work, it can occur also during commuting or even on a way to have lunch. (Tilastokeskus 2009.)

23.2 The Reasons Behind

Some persons are more sensitive to violence. It does not mean that they should be treated different way than other people; the nurse should only pay extra attention on preventing violent acts. Usually the people who may be unpredictably violent belong to one of the following categories; severely intellectually disabled, dementia patients, patients with brain-derived illness or psychosis (or other shock reaction) or the patient is under the influence of narcotics, alcohol or narcotic withdrawal. (Tornberg 1997, 135.) Cacciatore (2007) highlights that especially amongst Finnish population violence is usually combined with heavy use of alcohol. Other factors combined with high incidences of violence are flamboyant temperament, tiredness, usage of therapeutic drugs in addition to illegal drugs, and previous experiences of violence. The research results have shown that even 80% of those committing to violent acts have themselves experienced violence as a child. (Cacciatore 2007, 48-51.)

When looking at why nurses encounter violence there is nothing specific coming up. Some reasons could be from differences with income to mental health problems. Usually when people are feeling down they tend to erupt it to someone or something. One of the reasons could be in our hectic lifestyle; everyone is always on a rush, also in wards due to lack of employees and the intensified pace of work. (Ellilä 2005.)

Previous studies have also indicated that some workplace norms in healthcare settings will have an effect on aggressive and violent behavior. Some of the staff members' behaviour (e.g. unintentional/ intentional provocative behavior) may arise a signal that brings out feelings of anger and even violence by patients. (Spector et al. 2007, 123.)

24 PREVENTION OF VIOLENCE

24.1 'Perceived Violence Climate'

Spector et al. (2007) highlights that the management should at first focus on achieving a favourable and positive 'perceived violence climate' that is a measure to direct extension of the idea of a safety climate. This is started by instituting policies and procedures dealing with violence (possibly also establishing new ones), training the staff on avoiding and managing violence, and using models how to achieve and conduct good interpersonal interactions. Furthermore, nurses are encouraged to check the following questions with the employer (Spector et al. 2007, 120.):

- Does the employer provide assault/ violence prevention training?
- Does the employer provide assault/violence prevention policies and procedures?
- Are the procedures in place in the facility for reporting violence?
- Does the management encourage staff to report physical and verbal violence?
- Is it regarded as a normal part of the job if a patient/resident assaults staff?
- Are reports of workplace violence taken seriously by the management? Is there a follow-up?
  (Spector et al. 2007, 120)

24.2 Organizational Suggestions

There are fewer occasions reported about threatening encounters and violent assaults among permanent, well trained and more experienced nurses. When

the staff is not changing continuously, long-term patients and their families are experiencing safety, though it needs to be taken into consideration that there may not be suitable substitutes available all the time. Another important safety related issue is the number of the staff, as well as their qualifications towards the job especially in high-risk workplaces. Routines and rules create safety; therefore when doing a task what differs from “the normal”, extra staff may be needed or good to have as a backup (e.g. transferring a difficult and confused patient). Uncertainty and ambiguity of things increase anxiety both in healthy and sick people. No nurse should work alone, particularly those in high-risk workplaces and all the nurses should embrace a zero-tolerance against violence as well as healthy self-protection instinct. (Lehestö et al. 2004, 134-137.)

Mutual strategies are also important in cases of violence, because when there is a difficult situation the nurses know when to call for help or backup from security. Every nurse should also learn to detect and de-escalate possible threats during their shifts as well as to intervene quickly to disturbing behavior. Reporting the possible threat and violent cases/ patients is every nurse’s right and obligation without getting understated or laughed by fellow staff members. (Lehestö et al. 2004, 137-138.) When the incidents or threats are also registered for the co-workers and head nurses to see, it is easier to organize the necessary amount of nurses for the particular shifts where the incidents are usually occurred. Being cautious, yet without being paranoid or too scared against violent incidents, makes the staff prepared before the situation escalates. (Lehestö et al. 2004, 139.)

24.3 Health and Safety Suggestions

Prevention of violence is also promoted by keeping the corridors and patient rooms empty from possible objects to cause injuries (e.g. drinking glasses, unused infusion stands or vases) and organizing safety related meetings regularly, where the already happened incidents are talked through and the

possible new strategies are planned. (Lehestö et al.2004, 141-142.) Some of the preventive factors against violent occasions can be done as early as on the construction phase. Spaces need to be private and cozy but under surveillance, and the positioning of the furniture can provide shelter for violence or in worst case scenario, they can be used as a weapon. With technical surveillance equipment, cameras, door phones and access control, the contact with threatening persons are evaded. (Lehestö et al. 2004, 141.)

Every unit has to have an occupational safety and health action plan. It is done with a risk analysis, which contains the assessments and definitions of possible threats and risks of the particular unit. It is obligated by the Act of Occupational Safety. Co-operation with security businesses and police helps the nurses to feel more secure; phone numbers for both should be placed in the offices to a visible place. By comparing with other units and departments nurses can change strategies and give tips to others, and that way improving safety. (Lehestö et al. 2004, 141-142.)

After all, preventing violence in healthcare, as well as in any other surroundings, requires different resources and methods. These requirements differ also when dealing with different types of violent people, such as reactively or proactively violent people. (Nurmi 2013, 75-76.)

25 POST-ASSAULT CARE

25.1 Importance of Support

The person who has been angry, aggressive or violent is eventually calming down, and in many cases he/she may just forget what has been done. However, it is not necessary over for the assaulted person, neither when it is concerning verbal abuse, nor physical abuse. Many victims can have post-traumatic stress responses. They may feel anger at being mistreated, and also feel vulnerable and unsecure. Victimized people can get depressed and get feelings of helplessness. (Fauteux 2010, 212.) It is not unusual also for the victim to show signs of violence. He/she may seek consolation from illegal substances, behave impulsively, has inability to concentrate, experience extreme tiredness, and have suicidal thoughts. (Viljamaa 2012, 7.) Furthermore, traumatized person can deny what has happened, get symptoms of personality disorders, and even identify with the abuser (Nurmi 2013, 169).

After being verbally or physically assaulted, the best way to understand the feelings evoked, and to get back the feeling of control, is to discuss with someone as soon as possible to avoid any mixed feelings bothering the normal course of daily living. (Fauteux 2010, 212.) Stone at al. (2010) specify that support and debriefing should be available and offered for nurses who have gone through distressing levels of verbal or physical aggression. It is easier to eliminate the negative effects of workplace aggression, if there is a supportive work environment. (Stone et al. 2012, 533.)

25.2 Post-Assault Defusing and Debriefing

For the prevention of post-traumatic stress response it is crucial to act quickly after a sudden stressful situation. Defusing and debriefing are planned for the victims to start the recovery efficiently and soon after incident. (Lehestö et al. 2004, 197.)

Defusing:

This conversation should be kept almost immediately after the incident. In work place it means that it should take place on the same day. It is important for the victim and others involved participating because it can help them diminish their feelings of guilt and reduce the nonsensical pondering by themselves. Defusing conversation also gives the victim and the others involved readiness to act in the next sudden stress situation. (Lehestö et al. 2004, 197-198.)

Debriefing:

This, professionally guided discussion, is done 1-3 days after incident. In that time the shock reaction is passed and the incident can start to be processed and if needed, there can be more than one debriefing. The purpose of conversation is to increase the participants' understanding towards each other's emotional reactions of the incident, analyze the situation and help everyone to start grieving. (Lehestö et al. 2004, 198.)

A person who has been attacked may seem normal and calm. This does not mean that he/she should be left alone, especially during the first 24 hours, because the feelings can be paralyzed, hidden under the exterior and once they get let out the person might act really confusingly and. Thereforeit might be appropriate even to send the person home accompanied by a support person. (Lehestö et al. 2004, 198.)

26 PREFACE FOR ANGER MANAGEMENT

26.1 Basics of Anger Management

As Aristotle (384 BC- 322 BC) has famously quoted ‘Anyone can become angry – that is easy, but to be angry at the right person, with the right intensity, at the right time, for the right reason, and in the right way that is not easy’ (Smith 2014).

Anger is normal state of mind, but whilst being angry people usually do things that they would rarely normally do. Everyone may contribute to the way how they act whilst being angry. The ideal method would be to prevent anger, but it is good to know that the amount of anger can be de-escalated, and that it is a part of the anger management. The person is in charge of his/her own acts even when they are angry, and should learn to find the ways how to avoid any unpleasant consequences. Anger management does not mean that a person cannot get angry. The anger should not control a person, but a person should control the anger. (Cacciatore 2007, cd.)

There are people who can release the tension caused by anger just by using humor, but the situation should be carefully considered as anger and shame are fulfilling each other. Sometimes further interventions are needed for managing the feelings of anger and aggression. (Cacciatore 2007, 60-62.) It should also be recalled that demands, criticism, prohibitions and logic explanations are not helpful when dealing with emotions. Usually they just cause opposite outcome. The emotions should let to exist to make the dealing with them possible. (Simula 2013, 176.) An ability to calm anyone else down requires elaborate social and interaction skills. It requires that a person can feel guiltiness when hurting others, intentionally or not. It also requires increased ability of caring, empathy, and sympathy. (Reenkola 2008, 65.)

26.2 Anger Control amongst Nurses

To think about even helping to deescalate anybody else's anger, a nurse should be able to manage his/her own anger. It requires some practice to be able to face an angry patient. Therefore it is recommended to have an action plan ready and make sure that an employer is also prepared for difficult situations with valid guidelines and policies. (Leiper 2005, 45.) There are three main basic rules for nurses that will help to alleviate anger, and all the nurses should bear them in mind: 1)expect some changes and learn to cope with them (part of the job), 2) expectations should be communicated (nobody is a mind reader), and 3) learn to let go some expectations (everything cannot be controlled or changed) (Lyon 2000, 60-61). Nevertheless, forgiveness is also an important quality to have. It does not mean that an individual tolerates the wrongful actions of another, but it means relief from carrying burdensome load of old anger, bitterness, and sadness. (Thomas 2003, 109.)

The best way to control anger in nursing environments is to prevent it even from arising. By using some simple steps, an employer can play already a big part in creating an anger-free work environment. Anger management courses should be arranged for all the employees to teach how to identify the causes of anger, and how to control and de-escalate anger. Genuine concern should be shown to employees, and all the employees should be offered a chance to have one-to-one conversations with management in regular intervals. Nursing management should never take the anger personally or get agitated when dealing with angry employee or patient. (Miracle 2013, 127.)

26.3 Anger Management, Anger Education, or Anger Therapy

It is important to get the knowledge of the individuals' needs in aggression education, so the roots of anger can be weeded before they spread uncontrollably (Cacciatore 2007, 91).

With regards to children and adolescents, the anger management is not always the most appropriate term to be used, as their anger is often related to the developmental stages, and therefore ‘aggression education’ is usually the best description for the anger and aggression control methods for these age groups. The aim of the aggression education is that the trust, safety and permanent interaction between youngsters and adults make it possible to desist from any options leading to violence, and guide the youngster towards the use of more constructive interaction and communication methods in life. (Cacciatore 2007, 89-90.)

Anger management is not therapy, it is a psychoeducational intervention. Its main goal is to teach to a person specific tools and strategies for him/her to learn to change one’s behavior by providing a new perspective and increasing knowledge when the anger arises. The teacher of the intervention also has the role of a coach, not a therapist. Because anger is an interpersonal emotion, anger management is best done as a group intervention. (Thomas 2001, 42.) Anger management intervention is known to be effective even though a person is not participating in it voluntarily but has to participate in one, for example due to a court order (Thomas 2001, 45).

27 ALTERNATIVES FOR ANGER MANAGEMENT

Officially anger and aggression could also be managed with help of medication. However medications are not the preferable option, because they can also cause many side- and adverse effects. One simple method, massage, has turned out to be one very effective natural method to decrease angry or aggressive behavior. The therapeutic effects of massaging are based on the increased secretion of serotonin hormone, and oxytocin hormone that has a tendency to decrease aggressiveness. Oxytocin inhibits also the functioning of the sympathetic nervous system and activates vagus nerve that produces feelings of relaxation. The several studies have shown that both adults and children combatting with proactive aggression have benefitted of the 20 minutes lasting massage of back, arms, face and neck that took place in 5 weeks duration. Both adults' and children's dopamine levels of plasma and urine decreased and serotonin levels increased in during this period. Also breast cancer patients suffering from feelings of anger have benefitted of the similar massaging therapy. (Sandström 2010, 216.)

In medical point of view, recent study by Mostofsky et al. (2014, 1409) highlighted the connection between outbursts of anger and acute cardiovascular events. According to the study there are medications available which may narrow the connection between anger episodes and cardiovascular events by decreasing the interval of anger outbursts, or by minimizing the risk from each anger outburst. For example, beta-blockers are known to break the connection between the anger outbursts and cardiovascular events. In addition, paroxetine along with other serotonin-specific reuptake inhibitors may lower the frequency of anger episodes and enhance impulse control. (Mostofsky et al. 2014, 1409.)

28 DISCUSSION

The goal of this project was to highlight the importance of educating nurse students and nurses about the phenomenon of anger, aggression and violence in healthcare surroundings. This subject was chosen after noticing there is a lack of educational material by TUAS on this area, and our three and half year nursing curriculum did not contain any lectures on anger, aggression and violence. Still the subject has been often handled by media. We decided to study the latest research results and gather our findings on this literature review, which is the basis for the educational material we created for TUAS.

The very concerning find is that health care workers form the highest number of employees who have faced work violence and bullying (Tilastokeskus 2009; Hakojärvi et al. 2014, 138). Unfortunately it is not only the staff but also health care students who are affected by violence and bullying (Hakojärvi et al. 2014, 138). To be able to cope in such situations the nurse students require more awareness of this issue and its effects for themselves, people around and the profession. Therefore the education of anger, aggression and violence would be beneficial, especially because the likelihood that work-related aggression can be totally diminished from health care surroundings is minimal. (Deans 2004, 36; Nau et al, 205-206.)

It has been said that especially female health care workers suffer from more violence during their working hours (Tornberg 1997, 132), and it has been considered as a weakness if a woman's temper is lost (Dunderfelt 2007,115). However it has also been argued that men and women may be victimized in same levels, but women usually just more easily report their unpleasant experiences (Sakellaropoulos et al. 2011,56).

Some previous studies have benefitted of use of different questionnaires (Hakojärvi et al. 2014, 140; Sakellaropoulos et al. 2011,52) and interview methods (Hutchinson et al. 2008, 62; Deans 2004, 33) when researching the effects of aggression and especially bullying in health care field. The way how

the nursing students have responded to questions of Finnish study related to aggression and horizontal violence at their clinical practice placements is not impressive: “My willingness to continue the training and learn more diminished considerably”, “I started to feel like I never want to work in this profession”, “I got a negative impression of the entire ward and hospital”, “Bullying has totally eroded the credibility of the profession in my eyes”…(Hakojärvi et al. 2014, 141.) The outcomes and adverse effects of these kinds of thoughts by future nurses are not promising for nursing profession. We have summed up a list of the negative effects of different forms of aggression and violence in healthcare, which have been mentioned in the research results we studied for this project. This list supports our hypothesis why unmanaged anger should be taken care of, and why the anger-, aggression-, and violence education would be important part of the nursing curriculum.

- compromised patient safety
- reduced well-being and health status of workers
- increasing levels of anxiety, depression and irritability
- high job turnover
- negative work environment with strained working relationships
- increasing job stress
- low morale of workers
- increasing job dissatisfaction
- reduced concentration, motivation, productivity and clinical performance
- decreased professional engagement
- learning problems
- self-harm

(Sakellaropoulos et al. 2011, 51;Deans 2004, 32; Hutchinson et al. 2008, 68; Hakojärvi et al. 2014, 138; Cacciatore 2007, 66; Shirey 2007, 569; Blake & Hamrin 2007, 209)

It is already stressful of being a student nurse on the field, and extra stress caused by workplace aggression and violence is just burdensome for new

nurses to be. As discussed earlier, stress and anxiety are common in nursing settings, and unfortunately often these emotions build up to anger and aggression (Hollinworth et al. 2005, 45). The nurses' high demand tasks increase their emotional exhaustion and stress (Thomas 2004, 20-23), not forgetting new nurses' lack of confidence that is also building up the negative stress (Olofsson et al. 2003, 352). When taking into account also the current nursing shortages, the whole circle of stress, anger, aggression and violence is not at all counterproductive for the nursing profession (Shirey 2007, 569). We could deduce that the stress levels of nurses and nurse students should also be monitored so that the same circle would not repeat itself:

Nurses' High Demand and Lack of Nurses ➡ Stress, Anxiety and Tiredness ➡
Anger / Aggression ➡ Violence

To make it possible to start achieving some improvements all incidents should be reported and handled. We agree with Deans (2004) that management's expectations about staff's coping regardless of circumstances can be devastating. The management should not expect the nurses to carry on in a difficult situation by relying only on the fact that other nurses have previously done so in similar situations. (Deans 2004, 35.) However, according to Hakojärvi et al. (2014) students tend to report especially bullying experiences only to their friends, family and student colleagues, rather than to their teachers and clinical instructors (Hakojärvi et al. 2014, 142).

There are some suggestions that have been tested and proven to be useful in teaching nursing students how to conduct when meeting difficult people. One of these suggestions was the problem-based learning method (PBL), which was included into the tasks we planned for the trial lesson that was held to test the educational material we have provided for TUAS. Also Hakojärvi et al. (2014) had found research results, which state that PBL sessions enhance students' awareness on impertinence and add their confidence to face difficult people in nursing practice. Other research findings by Hakojärvi et al. pointed out that didactic lectures with interactive instructions and cueing cards have been useful

method in teaching nursing students how to handle difficult people. These methods should be taking into use already for the first year nursing students. (Hakojärvi et al. 2014, 143.)

Therefore we suggest that further research could consist of testing this type of educational material on the first year nursing students, with follow-up of their collaboration and interaction skills with aggressive people throughout their practical placements.

As this review points out, the phenomenon of anger, aggression and violence in healthcare surroundings create a broad topic, as these can be viewed from many perspectives. For example, work-place aggression such as horizontal violence consists of many categories itself (Sandström 2010, 208). Therefore all the categories are not reviewed so intensely that very reliable conclusions could be made, and that is why the scope of this study is one of its weaknesses.

29 CONCLUSION

We received feedback during the test lesson from participants that they are aware of the connection between good confidence and interaction skills with difficult people. Because of lack of the anger education for undergraduates in TUAS, students feel uncertain about their knowledge and ability to face angry, aggressive and violent people when entering their practical placements. These comments are relevant to the research results by Nau et al. (2008), after they tested a three day course in aggression management for a group of students. They pointed out the positive correlation between the development of a good confidence and the training course in aggression. We agree with Nau et al. (2008) that this finding should be considered as a significant ethical issue. (Nau et al. 2008, 205-206.)

Also Deans (2004) observed in his research that nurses are unprepared professionally and emotionally for aggression they may face with their patients and colleagues (Deans 2004, 36). We agree with Deans (2004) and Nau et al. (2008) that it would be a beneficial investment to include this type of educational material on self-awareness, assessment and diagnosis of aggressive or potentially aggressive people in the nursing students' curriculum (Deans 2004, 36; Nau et al. 2008, 205-206).

SOURCE MATERIALS

Amendola M. & Oliver R. 2013. Aggression Replacement Training and Childhood Trauma. Reclaiming Children and Youth. Vol 22, No 2, 56-60. Consulted 6.6.2014. http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=51a5739f-3ac7-4d41-9648-3c20fb2123c1%40sessionmgr115&vid=5&hid=125

Arslan, C. 2010. An investigation of anger and anger expression in terms of coping with stress and interpersonal problem-solving. Educational Sciences: Theory & Practice 10. Winter 2010. 25-43. Consulted 15.2.2014. http://files.eric.ed.gov/fulltext/EJ882723.pdf

Blake, C.S. & Hamrin, V. 2007. Current Approaches to the Assessment and Management of Anger and Aggression in Youth: A Review. Journal of Child and Adolescent Psychiatric Nursing, Vol 20, No 4, 209-221. Consulted 4.2.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/resultsadvanced?sid=625d189f-9e05-4e53-b2df 7954817a44a7%40sessionmgr114&vid=13&hid=127&bquery=Current+Approaches+%22to%22 +the+Assessment+AND+Management+%22of%22+Anger+AND+Aggression+%22in%22+Yout h&bdata=JmRiPWFmaCZkYj1jaW4yMCZkYj1seGgmZGI9OGdoJmRiPWFmdCZ0eXBlPTEmc2l 0ZT1laG9zdC1saXZl

Cacciatore, R. 2007. Aggression portaat - Opetusmateriaali kouluille. Opetushallitus. Vammalan Kirjapaino Oy.

Cacciatore, R. 2009. Kapinakirja – Aggressiokasvattajan käsikirja - koululaisesta aikuiseksi. Väestöliitto. Vammalan Kirjapaino Oy, Helsinki.

Daniels, E., Mandleco, B. & Luthy, K. 2011. Assessment, management, and prevention of childhood temper tantrums. Journal of the American Academy of Nurse Practitioners, Vol 24, 569–573. Consulted 24.7. 2014. http://web.a.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=7e085bab-4131-4f00-95f7-570d2736772f%40sessionmgr4002&vid=5&hid=4114

Davies, W. 2009. Overcoming Anger and Irritability: A self-help guide using Cognitive Behavioral Techniques. Constable & Robinson Ltd. London.

Deans, C. 2004. Who cares for nurses? The lived experience of workplace aggression. Collegian, Vol. 11, No 1, 32-36. Consulted 3.8.2015 http://ac.els-cdn.com.ezproxy.turkuamk.fi/S1322769608604539/1-s2.0-S1322769608604539-main.pdf?_tid=a995065c-3baf-11e5-a087-00000aab0f27&acdnat=1438806315_a42d4b2a85a7d937f063b3fc635b7d96.

Dunderfelt, T. 2007. Irti tunnekoukuista, 4th ed. Dialogia Oy, Helsinki.

Ellilä, H. 2005. Väkivaltaan ei saa tottua. Sairaanhoitaja-lehti. 6-7/2005. Consulted 20.2.2014. http://www.sairaanhoitajaliitto.fi/ammatilliset_urapalvelut/julkaisut/sairaanhoitaja-lehti/6-7_2005/paakirjoitus/vakivaltaan_ei_saa_tottua/

Fauteux, K. 2010. De-Escalating Angry and Violent Clients. American Journal of Psychotherapy, Vol. 64, No 2, 195-212. Consulted 13.2.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/resultsadvanced?sid=625d189f-9e05-4e53-b2df-7954817a44a7%40sessionmgr114&vid=12&hid=127&bquery=De-Escalating+Angry+AND+Violent+Clients&bdata=JmRiPWFmaCZkYj1jaW4yMCZkYj1seGgmZGI 9OGdoJmRiPWFmdCZ0eXBlPTEmc2l0ZT1laG9zdC1saXZl

Hakojärvi, H.R.; Salminen, L. & Suhonen, R. 2014. Health care students' personal experiences and coping with bullying in clinical training. Nurse Education Today, Vol. 34, 138-144. Consulted 3.8.2015 http://ac.els-cdn.com.ezproxy.turkuamk.fi/S0260691712002821/1-s2.0-S0260691712002821-main.pdf?_tid=ee363412-3bae-11e5-bde7-00000aab0f6c&acdnat=1438806001_7d7abb07647ce9bd5dba3ee522b6fae7.

Hall, K., Rushing, J. & Owens R.B. 2009. Anger In the Middle School: The Solving Problems Together Model. Journal of School Counseling, Vol. 7, No 39. Consulted 20.7.2014. http://files.eric.ed.gov/fulltext/EJ886155.pdf

Helakorpi, S., Aarnio, H. & Majuri, M. 2010. Ammattipedagogiikkaa uuteen oppimiskulttuuriin. Hämeen ammattikorkeakoulu: Ammatillinen opettajakorkeakoulu. Hämeenlinna.

Hollinworth, H., Clark, C., Harland R., Johnson, L. & Partington, G. 2005. Understanding the arousal of anger: a patient-centred approach. Nursing Standard. Vol.19, No 37, 41-47. Consulted 30.1.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/results?sid=625d189f-9e05-4e53-b2df-7954817a44a7%40sessionmgr114&vid=11&hid=127&bquery=Understanding+the+arousal+%22of%22+anger&bdata=JmRiPWFmaCZkYj1jaW4yMCZkYj1seGgmZGI9OGdoJmRiPWFmdCZ0eXBlPTEmc2l0ZT1laG9zdC1saXZl#ResultIndex_1

Hutchinson, M.; Jackson, D.; Wilkes, L. & Vickers, M. 2008. A New Model of Bullying in the Nursing Workplace: Organizational Characteristics As Critical Antecedents. Advances in Nursing Science, Vol. 31, No 2, 60-71. Consulted 3.8.2015 http://ovidsp.uk.ovid.com.ezproxy.turkuamk.fi/sp-3.16.0b/ovidweb.cgi.

ICN –International Council of Nurses 2012. The ICN Code of Ethics for Nurses. Consulted 18.2.2014 http://www.icn.ch/images/stories/documents/about/icncode_english.pdf

Institute for Work & Health 2014. What researchers mean by...validity and reliability. Consulted 27.11.2014 https://www.iwh.on.ca/wrmb/validity-and-reliability

Janhonen, S. & Vanhanen-Nuutinen, L. 2005. Kohti asiantuntijuutta: Oppiminen ja ammatillinen kasvu sosiaali- ja terveysalalla. Werner Söderström Osakeyhtiö. Helsinki.

Juujärvi, S.; Myyry, L. & Pesso, K. 2011. Eettinen herkkyys ammatillisessa toiminnassa. Kustannusosakeyhtiö Tammi. Helsinki.

Jyväskylän yliopisto 2014. Koppa. Täydellinen Oppimisprosessi. Consulted 2.9.2014 https://koppa.jyu.fi/avoimet/mit/tietotekniikan-opetuksen-perusteet/oppiminen/taeydellinen-oppimisprosessi

Lambert, A.J., Peak, S.A., Eadeh, F.R. & Schott, J.P. 2014. How do you feel now? On the perceptual distortion of extremely recent changes in anger. Journal of Experimental Social Psychology, Vol, 52, 82-95. Consulted 1.9.2014 http://ac.els-cdn.com/S0022103114000055/1-s2.0-S0022103114000055-main.pdf?_tid=44951d20-3357-11e4-8ca9-00000aab0f01&acdnat=1409741243_745d37fb642764c80b7039c5d984c04e

Lehestö, M., Koivunen, O. & Jaakkola, H. 2004. Hoitajan Turva. Edita Publishing Oy, Helsinki

Leiper, J. 2005. Nurse against nurse: How to stop horizontal violence. Nursing, Vol 35, No 3, 44-45. http://web.a.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?vid=4&sid=1f955570-596b-4e5c-aa43-b517bf4a5b81%40sessionmgr4001&hid=4107

Lochman, J.E.; Powell, N.R.; Clanton, N. & McElroy, H.K. 2006. Children's Needs III: Development, Prevention, and Intervention. Anger and Aggression. Consulted 18.2.2014 http://www.nasponline.org/publications/booksproducts/NAS-CBIII-05-1001-009-R02.pdf.

Longo, J. & Sherman, R.O. 2007. Levelling horizontal violence. Nursing Management. Vol. 38, Issue 3, p34-51. Consulted 17.2.2014 http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=5&sid=0213d1f1-0a27-40ed-a0b8-c3df2bc5ad07%40sessionmgr4004&hid=4209

Lyon, B. 2000. Don't go from mad to worse. Conquering chronic anger. Nursing, Vol 30, No 12, 50-61. http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=7&sid=e91daed6-7382-452a-ae27-1054effd36c6%40sessionmgr4003&hid=4114

McKenna B., Smith, N., Poole, S. & Coverdale , J. 2003. Horizontal violence: Experiences of registered nurses in their first year of practice. Journal of Advanced Nursing. Vol 42, Issue 1, 90-96. Consulted 12.3.2014 http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=903144a2-df43-4d25-ac34-5e79a27687fd%40sessionmgr198&vid=8&hid=125

Miracle, V. 2013. Suggestions for Handling Anger in the Workplace. Leadership Dimension. Vol. 32, No 3, 125-127. Consulted 11.2.2014 http://ovidsp.uk.ovid.com.ezproxy.turkuamk.fi/sp-3.11.0a/ovidweb.cgi?&S=FHMMPDKPHCHFIPMMFNMKLCAGLKGEAA00&Link+Set=S.sh.59%7c1%7csl_10

Mostofsky, E., Penner, E. & Mittleman, M. 2014. Outbursts of anger as a trigger of acute cardiovascular events: a systematic review and meta-analysis. European Heart Journal. Vol 35, 1404-1410. Consulted 20.8.2014 http://eurheartj.oxfordjournals.org/content/35/21/1404.1.full.pdf+html?sid=6fbe7f30-2fe4-486b-b26b-a89311151835

National Institutes of Health 2006. Talking to Children about Death. Patient Information Publications Clinical Center National Institutes of Health. Consulted 1.9.2014 http://www.cc.nih.gov/ccc/patient_education/pepubs/childeath.pdf

National Institutes of Health: National Institute on Drug Abuse; Teacher's Guide, 1997. The Brain: What's Going On in There? Consulted 20.10.2014 https://science.education.nih.gov/supplements/nih2/addiction/guide/lesson1-1.htm

Nau, J., Dasse, T., Needham, I. & Halfens R. 2008. The development and testing of a training course in aggression for nursing students: A pre- and post-test study. Nurse Education Today 2009, Vol 29, 196-207. Elsevier. Consulted 8.2.2014 http://ac.els-cdn.com.ezproxy.turkuamk.fi/S0260691708001160/1-s2.0-S0260691708001160-main.pdf?_tid=98e95482-96a3-11e3-8321-00000aacb35d&acdnat=1392511694_6204e8bee4261e53f311dc05737c7917

NICE – National Institute for Clinical Evidence 2005. Clinical Practice Guidelines Violence. The Short-term Management of Disturbed/Violent Behaviour in In-patient Psychiatric Settings and Emergency Departments. Consulted 13.2.2014 http://www.nice.org.uk/nicemedia/live/10964/29719/29719.pdf

Nurmi, P. 2013. Lapsen ja Nuoren viha. PS-Kustannus. Jyväskylä.

Olofsson, B., Bengtsson, C. & Brink, E. 2003. Absence of response: A study of nurses' experience of stress in the workplace. Journal of Nursing Management, 2003, 11, 351–358. Consulted 21.7.2014. http://web.a.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=5378f3f8-8687-43a5-82f4-58d4c5fcf0f8%40sessionmgr4005&vid=10&hid=4101

Perkka-Jortikka, K. 2007.Hankalan ihmisen kohtaaminen. Katriina Perkka-Jortikka ja Edita Publishing Oy. Helsinki.

Pruuki, L. 2008. Ilo opettaa: Tietoa, taitoa ja työkaluja. Edita Publishing Oy. Helsinki.

Reenkola, E. 2008. Nainen ja viha: Aggressio voimavaraksi. Elina Reenkola ja Minerva Kustannus Oy. Helsinki

Repo-Kaarento, S. 2007. Innostu ryhmästä: Miten ohjata oppivaa yhteisöä. Kansanvalistusseura. Dark Oy. Vantaa.

Rowe, M. & Sherlock, H. 2003. Stress and verbal abuse in nursing: do burned out nurses eat their young? Journal of Nursing Management, 2005, 13, 242–248. Consulted 11.2.2014. http://web.a.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=5378f3f8-8687-43a5-82f4-58d4c5fcf0f8%40sessionmgr4005&vid=5&hid=4101

Sakellaropoulos, A.;Pires, J.;Estes, D. & Jasinski, D. 2011. Workplace Aggression: Assessment of Prevalence in the Field of Nurse Anesthesia. AANA Journal, Vol. 79, No 4, 51-57. Special Research Edition. Consulted 3.8.2015. http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?vid=4&sid=91363ad3-a8d2-4ac8-87d4-2c53573dd836%40sessionmgr198&hid=101.

Sandström, M. 2010. Psyyke ja aivotoiminta: Neurofysiologinen näkökulma. Marita Sandström ja WSOYpro Oy. Helsinki.

Sell, A.N. 2011. The recalibrational theory and violent anger. Aggression and Violent Behavior, Vol 16, 381-389. Consulted 1.9.2014 http://ac.els-cdn.com/S1359178911000656/1-s2.0-S1359178911000656-main.pdf?_tid=8e01df40-333c-11e4-9003-00000aab0f27&acdnat=1409729770_c263845bfa5fa3b87c5353d1e3720be9

Shirey, M.R. 2007. An Evidence-Based Solution for Minimizing Stress and Anger in Nursing Students. Journal of Nursing Education. Vol.46, No 12, 568-571. Consulted 5.2.2014 http://ovidsp.uk.ovid.com.ezproxy.turkuamk.fi/sp-3.11.0a/ovidweb.cgi?&S=FHMMPDKPHCHFIPMMFNMKLCAGLKGEAA00&Link+Set=S.sh.23%7c1%7csl_10

Shrand, J. & Devine, L. 2013. Outsmarting anger: 7 strategies for defusing our most dangerous emotion. 1st ed. Jossey-Bass, A Wiley Imprint, San Franciso, USA.

Silander, P. & Koli, H. 2003. Verkko-opetuksen työkalupakki.Oy Finn Lectura Ab. Helsinki.

Simula, P. 2013. Käsikirja ihmiselle. Into Kustannus Oy. Helsinki

Smith, N.C. 2014. Anger Management At Work – Aristotle's Way. Corporate Wellness Magazine. Consulted 26.8.2014 http://www.corporatewellnessmagazine.com/issue-6/news-insights-issue-6/anger-management-at/

Spector, P.E., Coulter, M.L., Stockwell, H.G. & Matz M.W. 2007. Perceived violence climate: A new construct and its relationship to workplace physical violence and verbal aggression, and their potential consequences. Work & Stress, Vol 21, No2, 117-130. Consulted 1.9.2014 http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=49a49689-6a69-4381-a2ee-20a94f736600%40sessionmgr198&hid=127

Stone, T., McMillan, M. & Hazelton, M. 2010. Swearing: its prevalence in healthcare settings and impact on nursing practice. Journal of Psychiatric and Mental Health Nursing, Vol 17, No 6, 528-534. Consulted 21.1.2014 http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=4dc28fc2-0b45-495c-a1f3-9227133f5d95%40sessionmgr4005&hid=4206

Tehy 2011. Älä riko hoitajaasi. Consulted 15.2.2014 http://www.tehy.fi/medialle/esitteet-ja-kampanjat/ala-riko-hoitajaasi/

Thomas, S. 2003. Anger: The Mismanaged Emotion. Research for Practice. MedSug Nursing. Vol. 12, No2, 103-109. Consulted 30.1.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/detail?vid=15&sid=625d189f-9e05-4e53-b2df-7954817a44a7%40sessionmgr114&hid=127&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=cin20&AN=2003066335

Thomas, S. 2001. Teaching Healthy Anger Management. Perspectives in Psychiatric Care. Vol 37, No2, 41-48. Consulted 12.2.2014. http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=fd5576b0-541c-4152-b6ca-aabf177f9b39%40sessionmgr114&vid=1&hid=123

Thomas, S. 2004. Transforming nurses' stress and anger – Steps towards healing. 2nd ed. Springer publishing company. New York, USA.

Tilastokeskus. 2009. Työväkivalta on yleistä terveys- ja sosiaalialojen ammateissa. Consulted 20.2.2014 https://www.stat.fi/artikkelit/2009/art_2009-09-30_002.html?s=0

Tornberg H. 1997. Aggressio- vuorovaikutuksen suola. T:mi Malpana, Liminka.

Valkeeniemi, H. 2014 (a).YLE. Purtu, lyöty, potkittu. Consulted 13.3.2014 http://yle.fi/uutiset/pieni_palkka_raskas_tyo__bonuksena_musta_silma/7131474

Valkeeniemi, H. 2014 (b). YLE uutiset. Normipäivä - työkaverina pelko. Consulted 14.3.2014 http://yle.fi/uutiset/normipaiva_-_tyokaverina_pelko/7132194

Viljamaa, J. 2012. Käytä kiukkuasi – aggression hyötykäyttö. Janne Viljamaa ja Werner Söderström Osakeyhtiö. Helsinki

Vuokila-Oikkonen, P. & Janhonen, S. 2005. Kertomukset oppimisessa. Teoksessa Janhonen S & Vanhanen-Nuutinen L (toim.) 2005. Kohti asiantuntijuutta. Oppiminen ja ammatillinen kasvu sosiaali- ja terveysalalla. WSOY

General Anger and Aggression Management, Interventions and Interaction with Vulnerable People

The following section will introduce some typical interventions or models used in anger management:

OWN ANGER AND AGGRESSION MANAGEMENT

Everybody should acquaint oneself to get knowledge what makes them angry, why, and how they get angry and who they usually show anger. People have inner discussions with themselves constantly, but everybody should learn to control these thoughts. (Cacciatore 2007, cd.) The figure below (Figure 15) will show the ideal anger recognition process, which would more likely lead to a pleasant outcome. By accepting the awareness of the own anger, it is also easier to inhibit the impulsive will to hit or other unfavorable behavior (Simula 2013, 174). It is good to assess the situation in a large perspective: 'Will the situation really influence my life? Will I remember this after a few days?' If the answer is 'no', then it is pointless get bothered about the situation. Letting go or standing down is sometimes the best way of releasing the unnecessary pressure. (Simula 2013, 181.) Because the anger is so called additive, meaning it builds up, perhaps the best analogy for it is the 'leaky water bucket': If it is topped up too quickly, it can easily overflow, but if given some more time the anger will 'leak away' before it overflows. (Davies 2009, 168.)

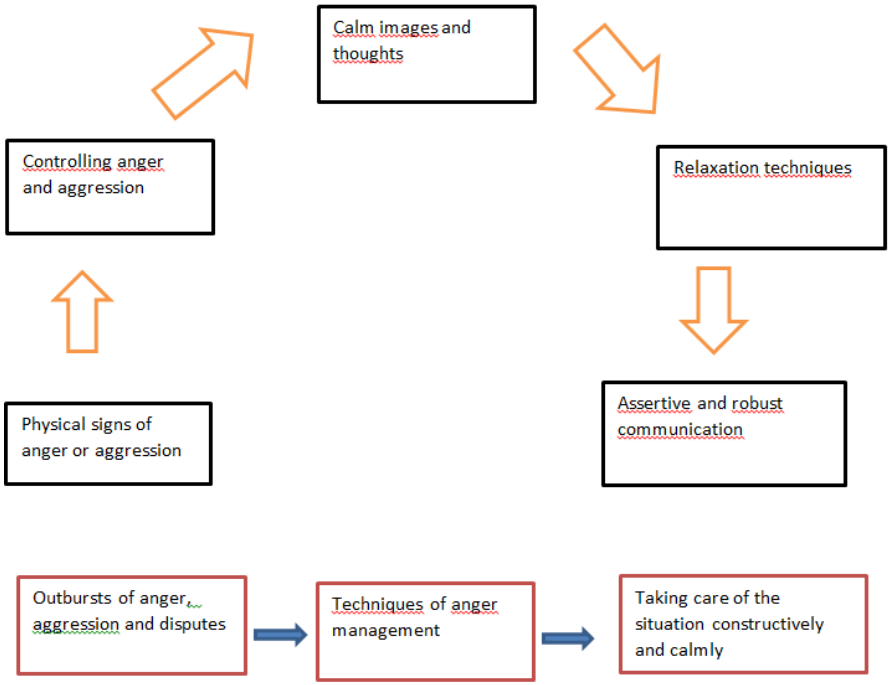


Figure 15. Management of Own Anger (Cacciatore 2007, CD).

Moreover, Viljamaa (2012) has gathered useful social skills as a guidance for everyday life how to maintain personal aggression in healthy levels. These are self-control, morality, taking responsibility, empathy, sharing, forgetting jealousy and revenge, helping others, and asking for a permission to do things when other people are involved. (Viljamaa 2012, 157.) Everybody should find 'smart' ways of using aggression. Paul Weller has famously quoted "Everyone gets fed up and angry every now and then. I rather defuse my aggression into playing guitar than into other people." This is normal for creative people, because creativity requires aggression. (Viljamaa 2012, 163).

One useful way of learning to recognize own emotions is to keep a diary. This is often recommended when an individual should get insight into what makes him/her irritable and angry, because by reviewing and analyzing the anger-filled cases helps to develop better alternative beliefs and to take action against triggers before those emotions escalate. (Davies 2009, 104 & 155.)

'SuTuHaKa'- MODEL

In Finland 'Sutuhaka-malli' (from Finnish words SUuuttunut, TUntua, HAluta, KAnnattava yhteistyö: meaning Angry, Feel, Want, Viable cooperation) is often used anger management model for constructive

expression of anger. It is a four-stage model suitable for adults and children, which helps an individual to express frustration or anger before the feelings escalate unbearable and lead to unnecessary conflict. Own feelings are not denied but they are expressed firmly without any insults by robust behavior, whilst also concentrating on posture, voice, gestures and facial expressions. It encourages individuals to tell how they are feeling, why they are angry, what they are after, and why cooperation would be favorable:

1) **The person should describe why he/she is angry** (without truckling, without humiliating). Words such as 'always' or 'never' should be avoided. Criticizing others should be avoided, and the person should focus on the issue that is currently bothering him/her.
2) **The person should tell how he/she is feeling** (without hesitation). Short and firm sentences should be used, for example starting with "I am angry because…".
3) **The person should specify what he/she wants from others to improve the situation** (politely, firmly).
4) **The person should tell why he/she thinks the cooperation would be the most favorable option** (supportively, without sarcasm). The positive outcomes of the cooperation should be pointed out.

(Cacciatore 2007, 62 & cd)

TRAFFIC LIGHT-MODEL

Ulpu Siponen has created a traffic light-model, which is based on practicing self-control. This model should be memorized and used in the situations when rage or fear is about to get the control of feelings.

- Red light: The person should stop and calm down. Anger and fear should be recognized, but any action should be avoided.
- Amber light: The person should still wait until he/she is also capable to listen to others. The person should gather the thoughts and find the most constructive way of functioning.
- Green light: The calmed down person can face the situation that is making him/her angry by using as constructive method as possible.

The traffic light method can be taught already for young children, because it is a more constructive anger

management/ aggression education method than just using constant prohibitions and parental demands for the child to be a good boy/girl. (Cacciatore 2007, 59.)

MINDFULNESS-BASED STRESS REDUCTION - TECHNIQUE (MBSR)

One evidence-based solution to help addressing anger is mindfulness-based stress reduction (MBSR) technique. Study results have shown that teaching MBSR strategies to nursing students has resulted in positive outcomes, developing better personal coping skills for them that are needed for creating healthy learning and practice environments. MBSR is a systematic approach using meditation as a basis of a program to help individuals cognitively delimit situations to make analyzing process easier, and to help avoiding irrational anger. Mindfulness-based strategies used in MBSR have shown to help individuals to practice self-reflection, acceptance, self-care and care for others. These strategies have also provided help to develop coping methods for addressing unpleasant emotions such as anger, and to manage stress. (Shirey 2007, 570.)

GROUP INTERVENTIONS

AGGRESSION REPLACEMENT TRAINING (ART)

Aggression replacement training (ART) is used among adolescents and children who are suffering from behavioral and emotional problems (Amendola & Oliver 2013, 56). Child or adolescent aggression does not happen without a reason, multiple causes are internal as well as external. The ART's main goal is to build competence in anger control, social skills and moral reasoning with the help of affective, cognitive and behavioral interventions. (Amendola & Oliver 2013, 56). Because adolescents tend to copy one another, interventions are most fertile when done in groups (Nurmi 2013, 212).

The three developmental challenges for adolescents and children are:

1) **Values.** Level of moral reasoning is more concrete, self-centered and egoistic among youth. In the moral reasoning training the youth are introduced to multiple moral problems and together they are ought to solve it. This helps them to gain prosocial features and learn empathy from each others.

2) **Skills.** Social cognitive, interpersonal and personal skills (foundation of prosocial behavior) are absent. The whole group is practicing one prosocial behavioral skill. These skills are trained with modeling behaviors that form the taught skill. The skill also needs to be rehearsed and practiced through role-playing and after this encouragement and feedback are important. Finally the skills will be taken to test somewhere else than in the training center. Important part of this process is self-talk; the trainees learn to control their deeds before they do them.

3) **Emotions**. Meeting the long term goals and daily needs with the use of aggression and repeated capricious behavior is insinuating about dysfunction in anger control. Anger control training is practiced in order the adolescent to remain calm. Its main focus is to teach the youth what should not be done when getting angry and how to cope with the feeling. It can be focused on internal and external triggers, anger reducers, bodily cues, thinking ahead, and the use of skill-streaming abilities. In the end self-evaluation is done. (Amendola & Oliver 2013, 57.)

THE SOLVING PROBLEMS TOGETHER- MODEL (SPT)

SPT is an effective problem-focused group intervention technique especially for adolescents. It is customized from

the teaching philosophy of problem-based learning and therefore problem-solving skills and critical thinking are grown at the same time when searching the favorable outcome for managing anger. The course of the intervention is similar than in PBL lessons, beginning with the presentation of a problem statement mirrored with their dilemma and forming open-ended questions about it, followed by independent research for the answer and discussing with the others about the answers and finally, practicing the skills which have been discovered during the research. Evaluation of the SPT's efficacy is done with a questionnaire, before and after (pretest/posttest instrument). As a result it has been seen that the participants are able not only to identify their anger triggers but also to implement their relaxation techniques in time of need. As a conclusion it can be said that for the managing anger, small group discussions are needed for the counselor to effectively provide information and different strategies for it. With SPT students can find their own anger management strategies and get excited about the joy of discovery of different resources. (Hall et al, 2009, 14.)

INTERACTION WITH VIOLENT, HOSTILE AND AGGRESSIVE PEOPLE

'KuKiPaSo'- MODEL

If an individual is really furious and enraged, it may be better to avoid any excuses and constructive negotiation. The person's rage should be deescalated to the status that violence will be avoided. In these kinds of situations 'Kukipaso-malli' (from Finnish words KUuntele, KIitä, PAhoitte, SOvi jotain: meaning Listen, Thank, Apologize, Agree something) should be used, which is a model also suitable for both adults and children. This model includes four main stages:

1) **Listening.** Aggressive person should be faced politely, calmly and with minimal facial expressions, because anything can be misinterpreted. The person should not be interrupted and positive nodding should be used, as it is important to give an

impression that the aggressive person's every word is listened to.

2) **Thanking.** Angry person should be given some recognition by saying "Thanks for broaching this issue…" It is good to get the aggressive person's feelings out in words, even they may not make sense.
3) **Showing regret.** Own opinions and verbal defending should not be used, because enraged person cannot see the issues in other's point of view. Regret should be shown (e.g. by saying 'sorry'), even that may not be necessary. The aggressive person should not be made feeling unvalued.
4) **Agreeing to do something.** Issues should not be left unsolved or the conversation changed before something is agreed with the aggressive person. If the offered help by one person is not deescalating the situation, someone else should take over and carry on the discussion. It is always to better to seek further help rather than showing own fears. (Cacciatore 2007, 63-64.)

GUIDE BY PERKKA-JORTIKKA: HOW TO HANDLE DIFFICULT PEOPLE

In the chapter 15.3 Aggression behavior models by Perkka-Jortikka there was a description of three different types of aggressive and hostile people: 1) the ones who are acting ruthless, caring only for the final result, not the ways of getting it; 2) the ones who are stabbing others in their back; and 3) the ones who are known to explode emotionally, not having any control of their feelings. The following section provides a step-by-step guide for the interaction with them, and provides useful hints how to remain calm and also how to deescalate the other person's anger. (Perkka-Jortikka 2007, 46.)

Interaction with Ruthless and Indifferent Persons

1. Stand up and defend yourself! Self-defense is crucial because once submitted to ruthless behaviour of the angry person, he/she thinks the victim is worthless and does not deserve to speak. Therefore it is crucial to get a proper and genuine contact to angry person/(s) for making sure if he/she is in a fact only trying aggressively to achieve his/her goals or is the person becoming violent.

2. Keep calm, give time. An angry person will most likely start to abuse the victim verbally, saving no ugly words. The victim's main goal is to keep an eye contact, wait and let them shout. The victim should start to respond only when the angry person seems to have said it all.

3. Forget courtesy. The victim's chance to speak is when the ruthless person has stopped shouting and it may take a quite a long time. It may be even necessary to stop him/her by intervening their shouting in order to get a say. If the victim is again interrupted and over spoken, he/she must do the same to the angry person, possibly even several times, in order to get to say what is in his/her mind.

4. Distract! These ruthless persons will assume that everyone will react with the same condescended way and run away when shouting, so as a distraction calling them by their name and remaining calm is a good trick for it. The victim should not be belittled, and using Mr. or Mrs. may be convenient.

5. Ask to be seated. Some people are known to act more calmly while they are sitting. Therefore the victim can try to get them to sit down by sitting him/herself at first, but if that does not work he/she must stand up, so the angry person will not get a superior position.

6. Speak from own point of view. Some words can be interpreted as an assault or attack. The use of sentences and words that emphasize the speaker's own point of view without sounding offensive, such as "I disagree with you" or "I think that is a good idea" lets them know about the victim's own experiences without sounding like the victim is telling them what to do. Also, ruthless and indifferent people should never be pointed out as being right or wrong.

7. Avoid fighting. They ruthless and indifferent person will not give up in a fight; therefore it needs to be avoided. If the victim begins to show behavioral signs of willingness to battle, the angry person sees it as an invitation to start the 'war' that is unnecessary, because then the battle is already lost. Usually he/she has a many years of experience in winning fights, where the victim seems a rookie who has not had the chance to gather and store all the nasty and spiky arguments. These kind of angry and hostile people do not mind fighting, that is why even a thought of the victim to have revenge or strike back is useless.

8. Prepare to be friendly. Though it may seem odd, even the ruthless people can turn into nice persons when they are not given a chance to attack and rumble over the victim. It may be that they see then the victim as someone who they can have respect, because the victim did not run away from the fight, or did not try to steal his/her power position. They may also have so high wall around them that it truly takes a strong person to see through it. However, their appreciation is usually sincere, no matter what lies behind them and once turned friendly, they expect the same behavior from the opponent or otherwise the whole achievement is pointless. (Perkka-Jortikka 2007, 46-54.)

Interaction with Backstabbing Persons

The people, who do not reveal their true colors to the main victim, are the backstabbing persons. Whether their motives are the fear of getting in middle of the scene or overall the lack of loyalty to the victim, their participation to the bullying will come out once the hostile persons are confronted. Though these kind of angry persons usually act behind the victim's back, they may turn into ruthless persons if their victim tries to punish or get back at them, therefore it is important to behave in a controlled manner. (Perkka-Jortikka 2007, 63.)

1. Expose the attack. The victim must confront the hostile person; whether it is the obnoxious smile or the malicious, supposed-to-be-whisper, even when the hostile person tries to ignore the question by laughing. The main thing is the victim to look startled, smile and act polite, to do whatever it takes to catch the bullies. The question can be e.g. "What did you mean by laughing during my speech?" or "I am sorry, I did not

really hear what you were saying; do you really think like that? Because in my opinion it sounds inappropriate?"

2. Offer an alternative to fighting. When questioning the angry persons of their doings, battle can be avoided. They will most likely deny everything, and with that way avoid taking responsibility of their sayings, but still there will probably be less scheming in the future.

3. Search support among others. While searching support from the others who are not revealing the one/s that are speaking ill of the victim, it is important to figure out first do they all share the angry persons' opinions and thoughts. The hostile persons usually feel mistreated and the person confronting those needs to be prepared to talk about that. However the discussion should not be in front of everyone. An angry person may blurt out e.g. "That is the dumbest idea I have ever heard!" Allthough the victim would prefer questioning the comment by saying:" What would you do then?" This question should not be asked because that will lead to a wrong conclusion where the hostile person's opinion is heard and verified. Better way is to search answers from the others: Do they all agree with the angry person's comments. This way everyone gets to share their own opinions.

4. Conciliate and solve the problem. These angry persons are immediately ready to tell their problems, which may seem inappropriate. When starting to figure outthe problem, the dilemma should not be underestimated, but instead it should be inspected thoroughly and listen to all possible solutions and methods which are suggested. The most efficient prevention of the backstabbing behavior would be to organize regularly meetings only focusing on possible problems that are occurring to the staff during a normal working day.

5. Intervening as a third party. Witnessing the backstabbers' actions and bullying against the victim may cause irritation and it may even seem close to a case of slander charge. It might be best not to get involved in the case of bullying without proper and careful assessment of the situation. The situation may be on-going because of different kinds of reasons. One of them may be the fact that the angry persons may have some other respected features that are valued, and therefore the bullying is ignored. Another reason could

be that some people are just prone to choose difficult relationships, or some persons just get distorted pleasure from bullying. The most favorable time to intervene is when both parties want to reconcile. When acting as a peacemaker, the person is committed to keep up the conversation until both parties feel that it is over, and they should value the peacemaker's opinions. Acting as a peacemaker is voluntary and when intervening, it is done for the sake of the third party. The course of the intervention is best done as guided; exposing the attack, offering an alternative to fighting, and conciliating and solving the problems.

(Perkka-Jortikka 2007, 63-67.)

Interaction with Persons Who Are Not in Control of Their Feelings

1. Giving space for calming. Persons who are not in control of their emotions will not listen anything in the heat of the moment, which usually passes quickly. After the burst they usually realize what they have done and may begin to cry or just get quiet. On the opposite, if they keep on shouting, a simple phrase like: "Hey, stop, now!" can put an end to it. The main point is to draw their attention, and sitting down or vice versa, standing up, can do the trick.

2. Being serious. These, as well as the other types of angry and hostile people, do not like to be laughed at. The person interrupting should remain calm and let the angry persons to know that they will be heard but not when shouting.

3. Stopping the interaction. The pause will be needed for these kinds of people to calm down. The break will also offer the victim a chance to charge his/her batteries. An interruption during interaction will break it.

4. Solving the problems. After the "timeout", the upset persons will more likely co-operate and solving the problems will be possible and pleasant.

(Perkka-Jortikka 2007, 73-76.)

These three types of aggressive people mentioned above are examples of the worst case scenarios. By training how to face angry people will take time but 'the practice makes

perfect', and the interaction with difficult people will not be so stressful and unpleasant later on. Not letting the worst possible behavior to escalate is crucial. (Perkka-Jortikka 2007, 77.)

GENERAL ANGER-DEESCALATING TIPS

Interaction skills play a major part in preventing the violence in the field of nursing. Nurmi (2013) and Tornberg (1997) have listed some anger-deescalating tips that should help everyone to think before acting out in anger-provoking situations, and to deal with emotional conflicts so that anger will not escalate into violence.

1. Get contact. Make sure that the patient notices you even he/she may express dislike or other unpleasant feelings to you
2. Listen. Do not guess or try to mind-read. Ask if there are problems to understand something.
3. Look at into person's eyes when speaking or listening.
4. Be alert. Though nurses tend to work in pairs, do not forget to interact with the patient, it may prevent his/her violent outburst.
5. Never do anything whilst extremely outraged, or only because of emotions. Calm down first, and think logically.
6. Think before speaking out. Say what is meant, and mean what is said. Calmly. Remember that everyone is in charge what comes from their own mouth.
7. Do not raise voice unless a person really has a hearing problem. The tone of the voice also matters.
8. Concentrate on own expressions when talking to an agitated person to avoid further conflicts (such as facial expressions, sighing, rolling eyes, etc.)
9. Do not objectify the patient or treat without respect. Respect others but also yourself.
10. Violent-sensitive persons deserve the same treatment. Practice how the nursing intervention is a part of the ensemble of interaction. It is also important to explain the procedure to the patient though he/she is intellectually disabled.
11. Do not threaten or behave in a manipulative way. Everybody can have own opinions.
12. Beat your 'will' to be always right. There is no need to prove anything.
13. "You wouldn't hit a woman? Would you?" Traditionally in Finnish culture it is wrong to get physical with women. Especially when dealing with old men the nurse (in this case female nurse) should remember this.

14. Get someone (male) to back you up. As it was mentioned previously, woman's word may not be as powerful as man's.
15. Do not use any type of violent acts. Violence increases violence. Only in few cases it decreases it, persuasion gets more result than forcing.
16. The anger is in the person. Only that person can let it go.
17. Learn to say sorry, and learn to forgive.
18. Talk about the own feelings, and ask about others' feelings.
19. Bear in mind that not everyone has same kind of humor.

(Nurmi 2013, 159; Tornberg 1997, 136.)

Educational PowerPoint slide show

REASONS FOR EARLY ANGER EDUCATION

- Although educational programmes on anger, aggression and violence management exist, they are mainly offered only to post-graduate staff
- Study results suggest that there are long-term consequences for the job performance of nurses who have been assaulted by the patients
- One in four nurses in Finland experiences some sort of violence by patients or by patients' families
- Less-experienced nurses and student nurses are more likely to be at risk for patients' anger, aggression and violence

(Nau et al. 2008; Thomas 2003; Tehy 2011)

DEFINITIONS

ANGER ≠ AGGRESSION!!

- Anger's main goal is to modify someone's behavior
- Anger could be described as a TV screen, which is channeling all the reasons and background feelings out for others to see as facial expressions, vocal expressions and acts
- There are usually many different kind of feelings behind visible anger that angry person cannot or does not dare to express.
- Anger is learned and allowed way to express negative state of mind, the reasons behind the anger can be distress, fear, feeling unsafe, shame and feeling of being at dead-end road
- "Aggression" is translated from the Latin word *aggredi* which means '*moving forward and getting closer*'
- Sigmund Freud described the expression of aggression non-negatively as 'searching energy'

(Miracle 2013; Shrand & Devine 2013; Cacciatore 2007; Tornberg 1997; Viljamaa 2012)

AGGRESSION

- Aggressive behavior is a different concept than aggression as a feeling. Officially the feeling is not a violent act or any other type of act. It is powerful flow of energy
- There are many types of aggression. Often it is classified as direct or indirect:

Direct aggression		
	Physical aggression	Verbal aggression
- offensive - threatening	- fighting - preparing for the fight	- swearing, criticizing - threatening to cause a fight
Indirect aggression		
	Physical aggression	Verbal aggression
- offensive - threatening	- destroying ones property - threatening closed ones	- gossiping - blackmailing

(Nurmi 2013; Sandström 2010)

CONNECTION BETWEEN ANGER AND AGGRESSION

- Even there is a known connection between anger and aggression, and that anger many times precedes violent behavior, it should be highlighted that anger is not always leading to violence

- The nurses and other healthcare staff should understand that the anger does not show up by itself, so it cannot be denied or demanded to fade away without any outlet channel. Anger can be de-escalated by resolving the reasons and conflicts behind it

(Hollinworth et al. 2005; Cacciatore 2007)

BEHAVIORAL SIGNS OF AN ANGRY/AGGRESSIVE PERSON

- Threatening behaviour and intimidation
- Aggressive statements
- Yelling
- Anathematizing and name calling
- Profanity
- Snapping at others
- 'Ward rage'
- Being unusually quiet or withdrawn
- Faultfinding
- Bickering
- Sabotage
- Slander
- Slamming doors
- Storming out of the unit
- Spreading rumors
- Hate mail
- Inappropriate hand gestures
- Poor work performance
- Alcohol abuse
- Substance abuse
- Strained and rough voice

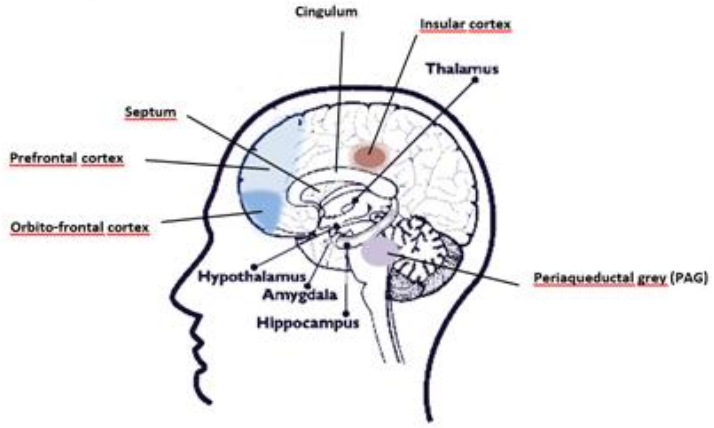
(Cacciatore 2007; Miracle 2013; Tornberg 1997)

PHYSICAL SIGNS OF AN ANGRY/AGRESSIVE PERSON

DEPRESSION
BLUSHING
HELPLESSNESS
TREMBLING
CONFUSION
FREQUENT HEADACHES
DILATED VEINS ON THE MUSCLES
HYPERSENSITIVITY
MUSCLE TENSION
NARROWED VEINS ON THE SKIN
HYPERTENSION
DILATED PUPILS
IRRITABILITY
SWEATING
TACHYCARDIA/ POUNDING HEART BEAT
FASTER METABOLISM
HEAVY AND INTENSE BREATHING
ANXIETY
COLD EXTREMITIES

(Cacciatore 2007; Miracle 2013; Tornberg 1997)

BRAIN PARTS INVOLVED IN AGGRESSIVE BEHAVIOUR



(National Institutes of Health: Teacher's Guide, 1997)

GENES AND HORMONES INVOLVING WITH THE FEELING OF AGGRESSION

- Genes have only a minor participation on the development of aggression

→ They effect on the individual's way of reacting to social stimuli with the changes they cause in the anatomy of the brain and metabolism of neurotransmitters

- Genes are inherited but it is the environmental factors which mold the behavior
- Individual's with certain genes have the tendency to react on stimulus in a certain way in a certain environment

HORMONES AND GENES INVOLVING WITH AGGRESSION:

- **low serotonin levels**
- **high testosterone levels**
- **varying progesterone & estrogen levels**
- **low oxytocin levels**
- **low cortisol levels**
- **high adrenalin & noradrenalin levels**
- **high levels of arginine-vasopressin hormone**
- **active form of MAOA-gene (known as violence-related gene)** in those men consuming high amounts of alcohol

(Sandström 2010; Tornberg 1997; Viljamaa 2012)

GENDER DIFFERENCES WITHIN ANGER AND AGGRESSION

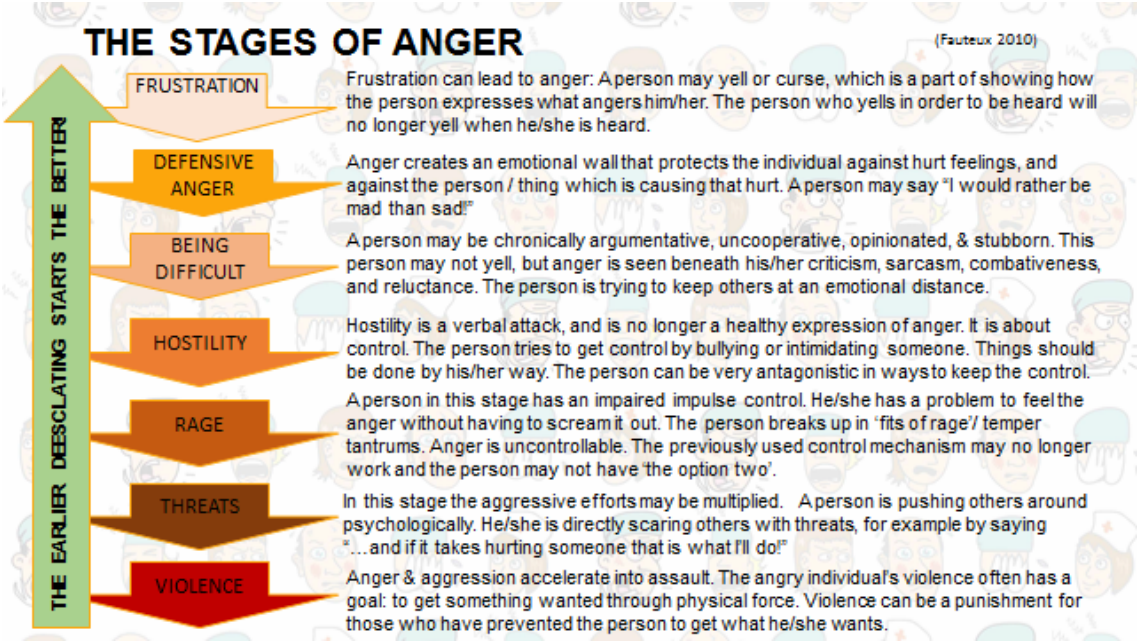
• Use the word "hurt" and have problems with separating the feelings "anger´" and "hurt"	• Only few men use the word "hurt"
• Are known to cry whilst being angry	• Do not cry
• Anger mainly consist of internal agitation	• Anger erupts with force
• Anger generally provokes within close relationships	• Anger is usually provoked by strangers, and broken mechanical objects
• Get angry easier if they feel that staff is uncaring and unable to listen	• Anger is more caused by loss of control, and inefficiency and unprofessionalism of the staff
• Are considered as "weak" if their temper is lost	• Are known to have outbursts of anger
• Express aggression more manipulatively → criticize a person him/herself or his/her private life or looks	• Use rational aggression → criticize a person's abilities to do something

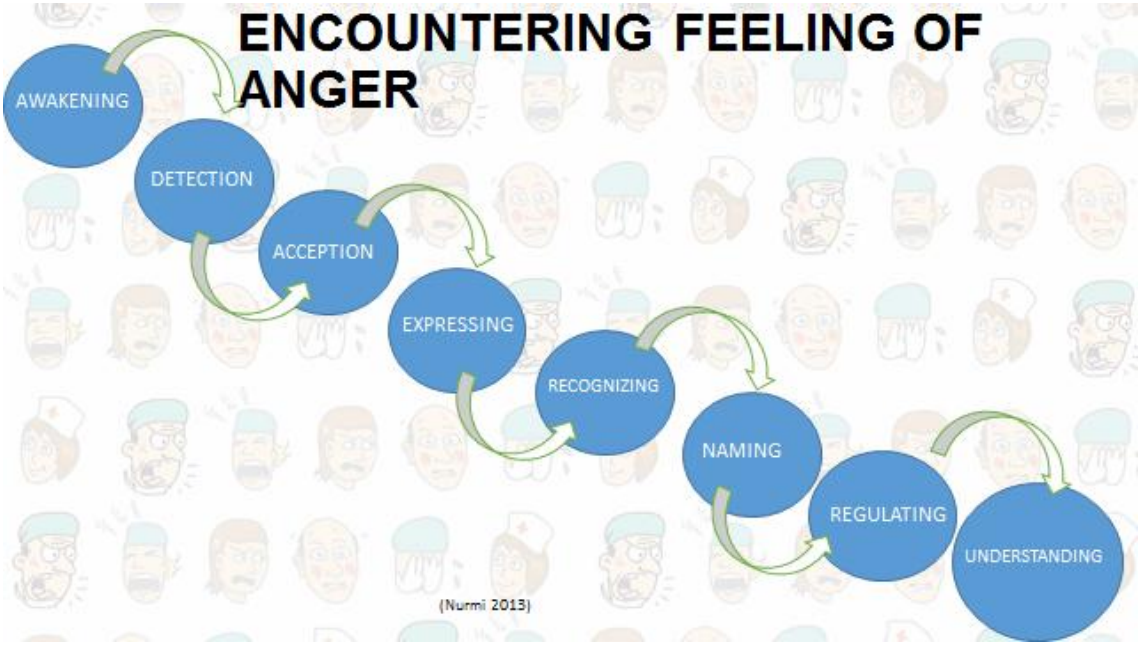
(Thomas 2003; Dunderfelt 2007; Reenkola 2008)

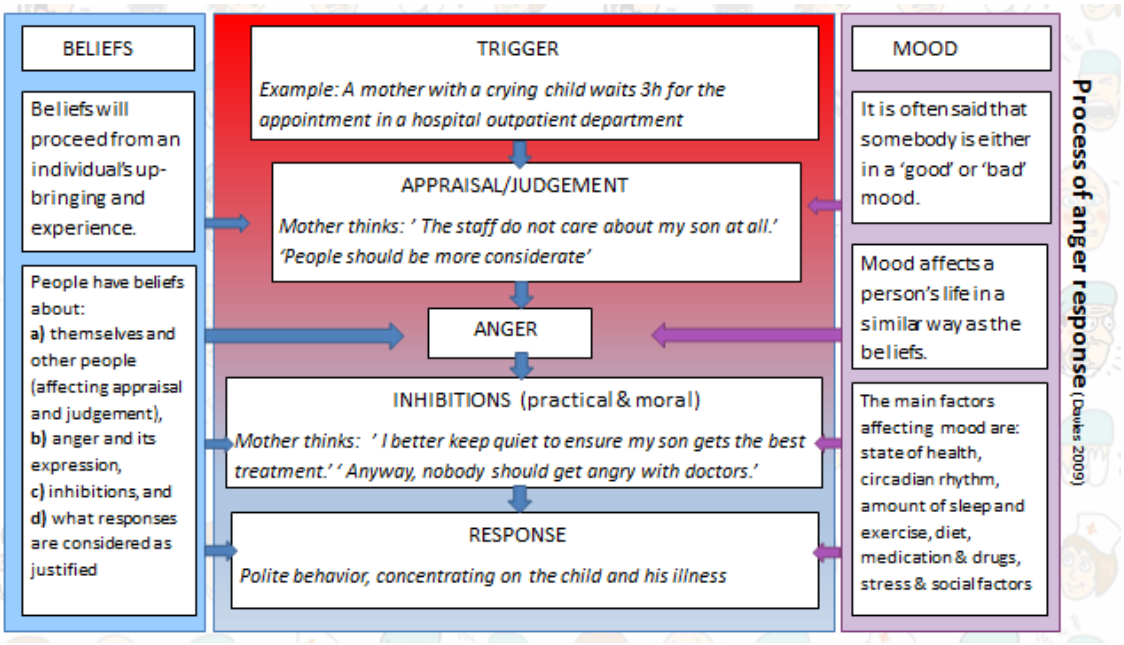
AGE RELATED DIFFERENCES IN ANGER EXPRESSION

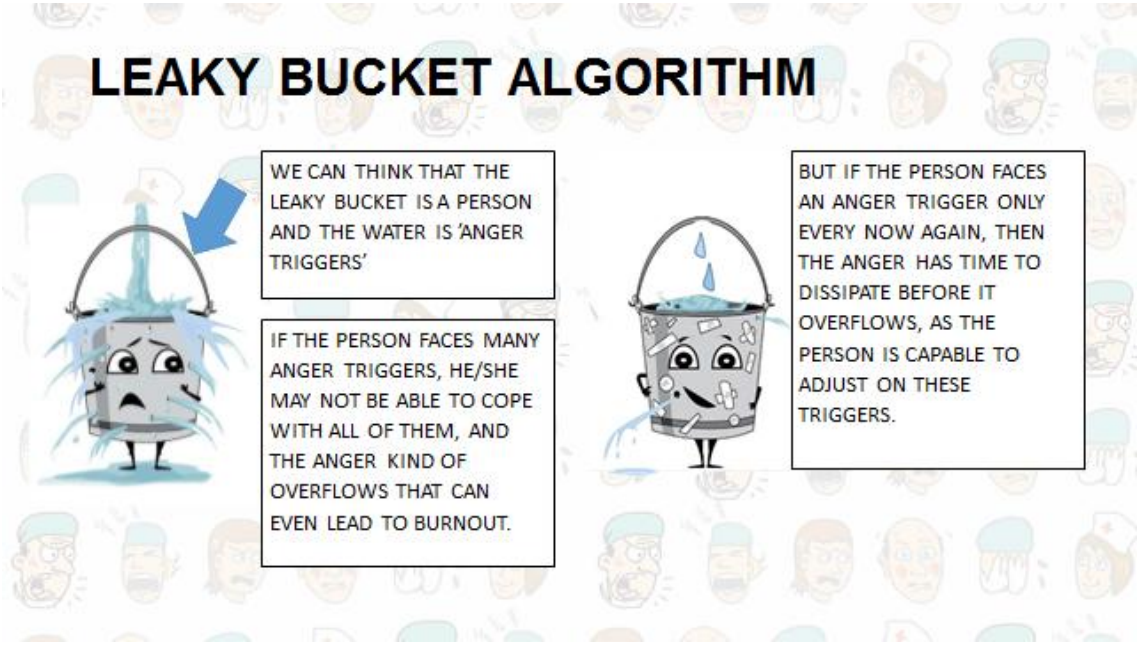
- Angry person's age has also an effect on the reaction of anger
- E.g. during puberty, the development in the brain, especially in the areas responsible for the regulation of feelings, is very strong and therefore a person might not be capable of making rational decisions
  → Adolescents are in need for new approaches towards different situations
- *Emotional intelligence* is the ability to control and regulate one's feelings
- This particular feature isn't developed among children, so they may copy aggressive behavior easily
- Because children's emotional intelligence is not yet well developed, they may copy aggressive behavior very easily

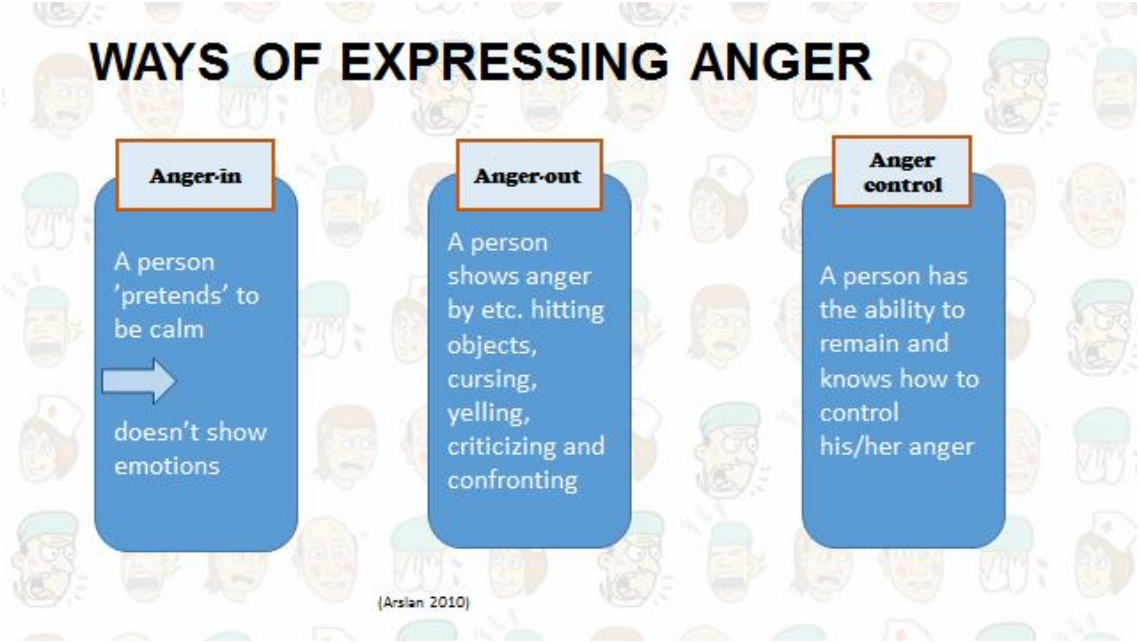
(Cacciatore 2009; Sandström 2010)

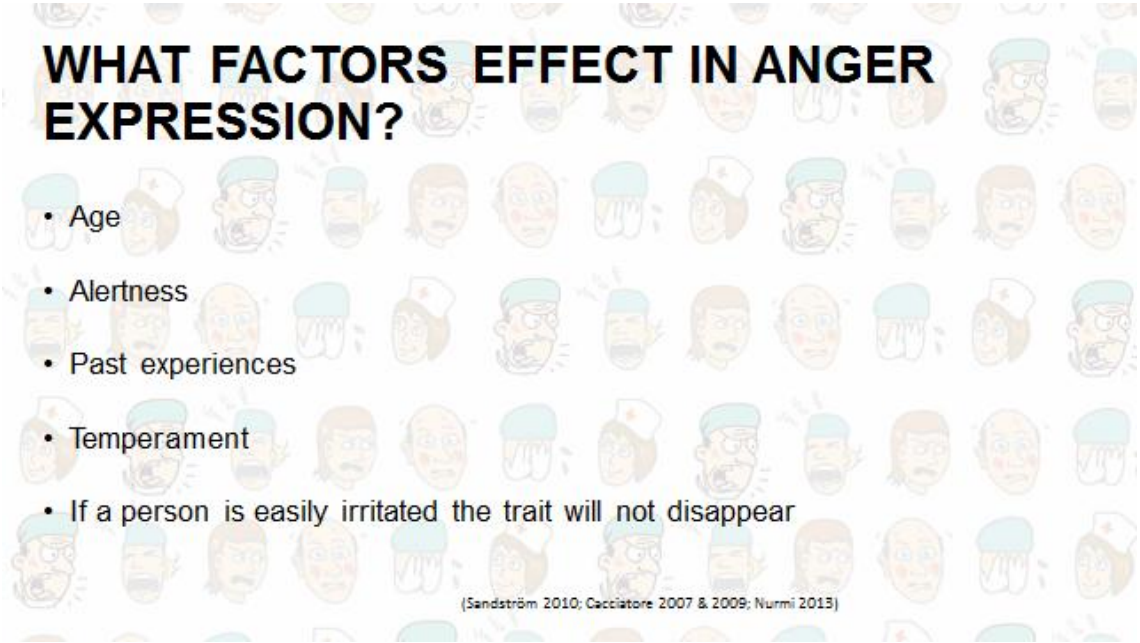

THE STAGES OF ANGER
(Fauteux 2010)
THE EARLIER DESCLATING STARTS THE BETTER
FRUSTRATION
Frustration can lead to anger: A person may yell or curse, which is a part of showing how the person expresses what angers him/her. The person who yells in order to be heard will no longer yell when he/she is heard.
DEFENSIVE ANGER
Anger creates an emotional wall that protects the individual against hurt feelings, and against the person / thing which is causing that hurt. A person may say "I would rather be mad than sad!"
BEING DIFFICULT
A person may be chronically argumentative, uncooperative, opinionated, & stubborn. This person may not yell, but anger is seen beneath his/her criticism, sarcasm, combativeness, and reluctance. The person is trying to keep others at an emotional distance.
HOSTILITY
Hostility is a verbal attack, and is no longer a healthy expression of anger. It is about control. The person tries to get control by bullying or intimidating someone. Things should be done by his/her way. The person can be very antagonistic in ways to keep the control.
RAGE
A person in this stage has an impaired impulse control. He/she has a problem to feel the anger without having to scream it out. The person breaks up in 'fits of rage'/ temper tantrums. Anger is uncontrollable. The previously used control mechanism may no longer work and the person may not have 'the option two'.
THREATS
In this stage the aggressive efforts may be multiplied. A person is pushing others around psychologically. He/she is directly scaring others with threats, for example by saying "...and if it takes hurting someone that is what I'll do!"
VIOLENCE
Anger & aggression accelerate into assault. The angry individual's violence often has a goal: to get something wanted through physical force. Violence can be a punishment for those who have prevented the person to get what he/she wants.


ENCOUNTERING FEELING OF ANGER
AWAKENING
DETECTION
ACCEPTION
EXPRESSING
RECOGNIZING
NAMING
REGULATING
UNDERSTANDING
(Nurmi 2013)


BELIEFS
Beliefs will proceed from an individual's up-bringing and experience.
People have beliefs about:
a) themselves and other people (affecting appraisal and judgement),
b) anger and its expression,
c) inhibitions, and
d) what responses are considered as justified
TRIGGER
Example: A mother with a crying child waits 3h for the appointment in a hospital outpatient department
APPRAISAL/JUDGEMENT
Mother thinks: ' The staff do not care about my son at all.' 'People should be more considerate'
ANGER
INHIBITIONS (practical & moral)
Mother thinks: ' I better keep quiet to ensure my son gets the best treatment.' ' Anyway, nobody should get angry with doctors.'
RESPONSE
Polite behavior, concentrating on the child and his illness
MOOD
It is often said that somebody is either in a 'good' or 'bad' mood.
Mood affects a person's life in a similar way as the beliefs.
The main factors affecting mood are: state of health, circadian rhythm, amount of sleep and exercise, diet, medication & drugs, stress & social factors
Process of anger response (Davies 2009)


LEAKY BUCKET ALGORITHM
WE CAN THINK THAT THE LEAKY BUCKET IS A PERSON AND THE WATER IS 'ANGER TRIGGERS'
IF THE PERSON FACES MANY ANGER TRIGGERS, HE/SHE MAY NOT BE ABLE TO COPE WITH ALL OF THEM, AND THE ANGER KIND OF OVERFLOWS THAT CAN EVEN LEAD TO BURNOUT.
BUT IF THE PERSON FACES AN ANGER TRIGGER ONLY EVERY NOW AGAIN, THEN THE ANGER HAS TIME TO DISSIPATE BEFORE IT OVERFLOWS, AS THE PERSON IS CAPABLE TO ADJUST ON THESE TRIGGERS.


WAYS OF EXPRESSING ANGER
Anger-in
A person 'pretends' to be calm
doesn't show emotions
Anger-out
A person shows anger by etc. hitting objects, cursing, yelling, criticizing and confronting
Anger control
A person has the ability to remain and knows how to control his/her anger
(Arslan 2010)


WHAT FACTORS EFFECT IN ANGER EXPRESSION?
• Age
• Alertness
• Past experiences
• Temperament
• If a person is easily irritated the trait will not disappear
(Sandström 2010; Cacciatore 2007 & 2009; Nurmi 2013)

PERSON'S AWARENESS OF OWN ANGER

- The chronically aggressive person often remains in a stand-by state with anger and snaps very easily
- The person may start to feed the anger without any purpose: The time is spent in aggressive thoughts, backstabbing, developing conspiracy theories, and harping on about injustice

DEFENSE MECHANISMS

Aggressive people often use defense mechanisms that make them feel more secure and safe whilst still expressing anger/ aggression

• PASSIVE-AGGRESSIVENESS:	Person pretends to be helpless, believes to be always right, does not have a reason to change own beheviour, faults are found on others
• USE OF PROJECTIONS:	Person blames others for their miseries, narcissistic behaviour
• RELYING ON INTROJECTIONS:	Person uses a role model as a building material of own personality, both strenghts and unwanted features are copied

(Viljamaa 2012)

COSTS OF HIDDEN ANGER

- *Financial costs* can evolve from treatments and experts required for people having mental health problems, psychological symptoms and psychosomatic symptoms that all can be related to outcomes of not expressing anger or repressed anger

- *Emotional costs*. E.g. The incident in 2002 at the University of Arizona College of Nursing, where the anger and rage by a troubled nursing student lead to three brutal deaths of faculty members

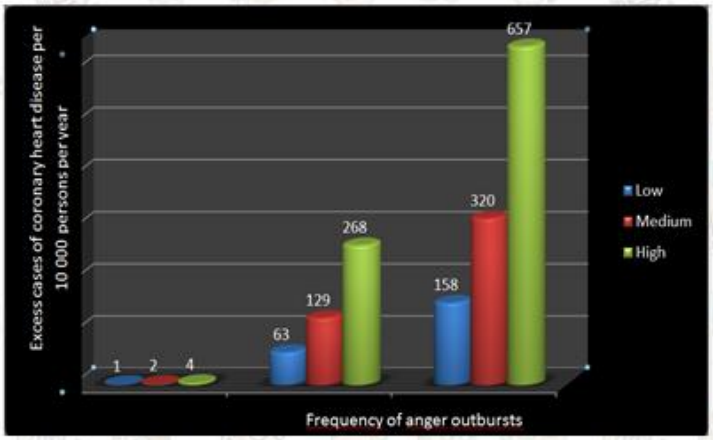
- *Medical costs.* Anger, rage and other emotional outbursts increase the risk of cardiovascular events.
  - Continuous anger has been linked to hypertension and coronary heart disease
  - There is an increased risk of myocardial infarction, acute coronary syndrome, arrhythmia, and ischaemic or haemorrhagic stroke in the two hours after outbursts of anger

(Cacciatore 2007, 66; Blake & Hamrin 2007; Shirey 2007; Thomas 2003; Mostofsky 2014)

RELATION BETWEEN ANGER & CORONARY HEART DISEASE

In group of people having one anger outburst per month causes estimated one to four excess cases of coronary heart disease per 10 000 persons per year.

The risk is bigger if the frequency of anger outbursts is increasing (up to 657 excess cases per 10 000 persons per year if a person has five anger outbursts per day).



(Mostofsky et al. 2014)

ANGER SHOULD NOT BE BOTTLED UP

A person should be allowed to "flip" once in a while. If all the resentment, bitterness and anger stay bottled up it will cause nightmares, headaches, or make the angry person to seek for scapegoats and criticize others.

(Daybreak Counseling Services and Anger Management Classes , 2015)

If dissatisfaction, alienation and anger can be expressed, the negativity of those feelings will more likely disappear, making the problem-solving much easier.

(Dunderfelt 2007; Simula 2013)

POSITIVE SIDES OF ANGER AND AGGRESSION

ANGER

- Can be a healthy emotional response to feeling hurt or frustrated. It can be so called justified reaction to an iniquity and a way of emotionally 'standing up' for person's ego when abused. So it is also a protector
- It definitely does not go so that 'the more the better'. It is effective only in small amounts

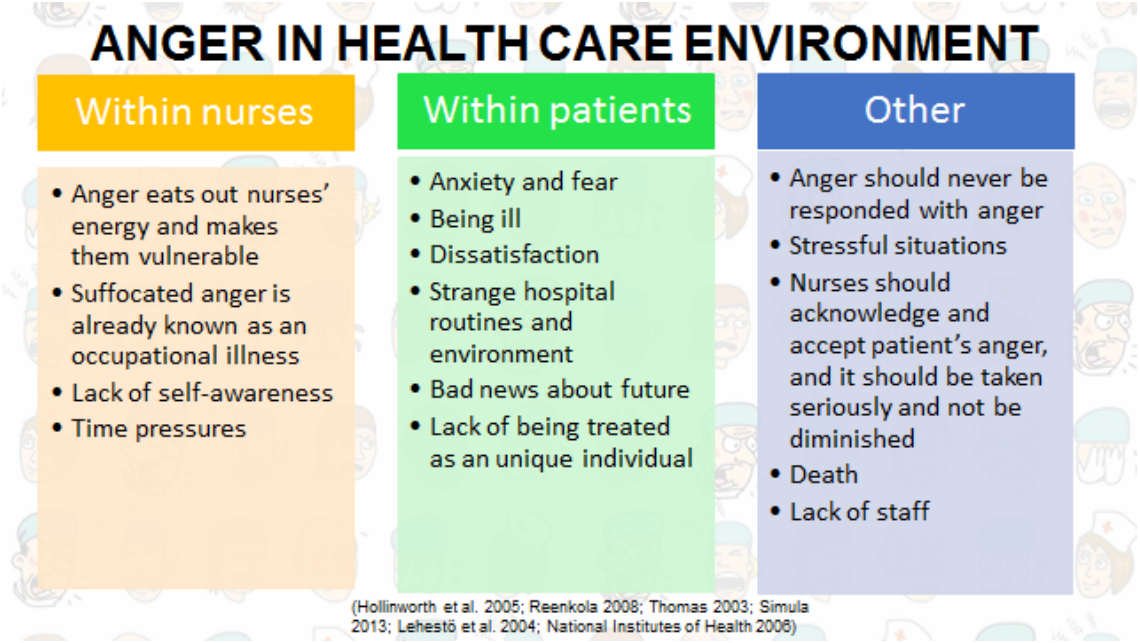
AGGRESSION

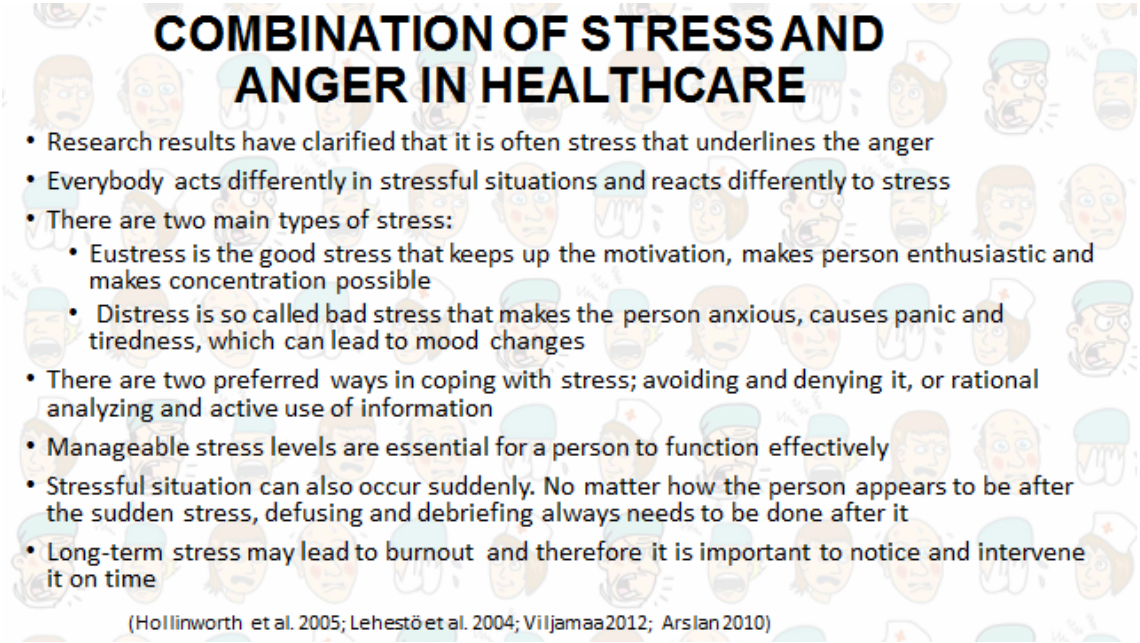
- When a person learns to use aggression as a positive resource he appears as a confident individual who is not afraid of letting his opinions to come out and has a strong faith for him/herself
- If used correctly in suitable limits it can prevent burn-out and excessive covering of other employees' work duties
- In limits, aggression is also known to be a power for the creativity

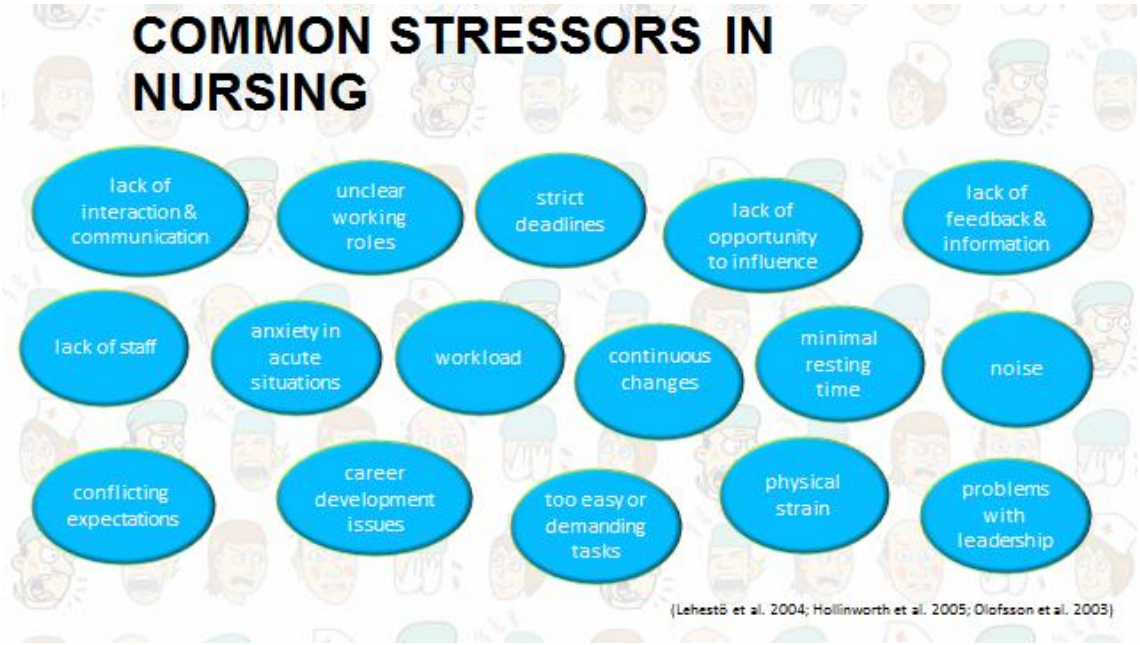
(Fauteux 2010; Dunderfelt 2007; Davies 2009; Cacciatore 2009; Reenkola 2008)

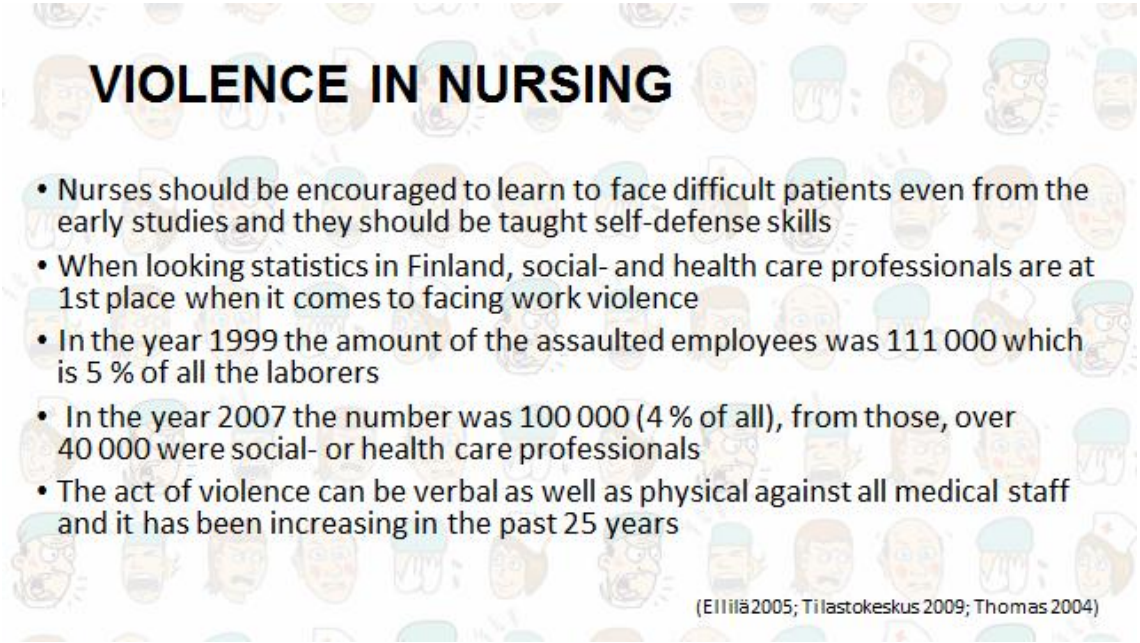
LET'S DISCUSS:

What factors could make you angry in the practice as a trainee nurse?


ANGER IN HEALTH CARE ENVIRONMENT
Within nurses
• Anger eats out nurses' energy and makes them vulnerable
• Suffocated anger is already known as an occupational illness
• Lack of self-awareness
• Time pressures
Within patients
• Anxiety and fear
• Being ill
• Dissatisfaction
• Strange hospital routines and environment
• Bad news about future
• Lack of being treated as an unique individual
Other
• Anger should never be responded with anger
• Stressful situations
• Nurses should acknowledge and accept patient's anger, and it should be taken seriously and not be diminished
• Death
• Lack of staff
(Hollinworth et al. 2005; Reenkola 2008; Thomas 2003; Simula 2013; Lehestö et al. 2004; National Institutes of Health 2006)


COMBINATION OF STRESS AND ANGER IN HEALTHCARE
• Research results have clarified that it is often stress that underlines the anger
• Everybody acts differently in stressful situations and reacts differently to stress
• There are two main types of stress:
• Eustress is the good stress that keeps up the motivation, makes person enthusiastic and makes concentration possible
• Distress is so called bad stress that makes the person anxious, causes panic and tiredness, which can lead to mood changes
• There are two preferred ways in coping with stress; avoiding and denying it, or rational analyzing and active use of information
• Manageable stress levels are essential for a person to function effectively
• Stressful situation can also occur suddenly. No matter how the person appears to be after the sudden stress, defusing and debriefing always needs to be done after it
• Long-term stress may lead to burnout and therefore it is important to notice and intervene it on time
(Hollinworth et al. 2005; Lehestö et al. 2004; Viljamaa 2012; Arslan 2010)


COMMON STRESSORS IN NURSING
lack of interaction & communication
unclear working roles
strict deadlines
lack of opportunity to influence
lack of feedback & information
lack of staff
anxiety in acute situations
workload
continuous changes
minimal resting time
noise
conflicting expectations
career development issues
too easy or demanding tasks
physical strain
problems with leadership
(Lehestö et al. 2004; Hollinworth et al. 2005; Olofsson et al. 2003)


VIOLENCE IN NURSING
• Nurses should be encouraged to learn to face difficult patients even from the early studies and they should be taught self-defense skills
• When looking statistics in Finland, social- and health care professionals are at 1st place when it comes to facing work violence
• In the year 1999 the amount of the assaulted employees was 111 000 which is 5 % of all the laborers
• In the year 2007 the number was 100 000 (4 % of all), from those, over 40 000 were social- or health care professionals
• The act of violence can be verbal as well as physical against all medical staff and it has been increasing in the past 25 years
(Ellilä 2005; Tilastokeskus 2009; Thomas 2004)

REASONS BEHIND VIOLENCE

- Severe intellectual disability
- Dementia
- Brain-derived illness
- Psychosis (or other shock reaction)
- The use of alcohol or narcotics
- Withdrawal from alcohol or narcotics
- Flamboyant temperament
- Tiredness
- Previous experiences of violence
- Income differences
- Hectic lifestyle, rush

(Tornberg 1997; Cacciatore 2007; Ellilä 2005)

HORIZONTAL VIOLENCE IN NURSING

- https://www.youtube.com/watch?v=ddeRWAXsWpY
- Horizontal violence between nurses is known as an act of aggression that is performed by one colleague toward another
- A form of bullying (e.g. about coworker's personality, reputation, etc.)
- Background of horizontal violence is usually sourcing from feeling of low self-esteem and lack of respect from other people
- Normally verbal or emotional abuse, but it can also include physical abuse, and it can be diplomatic and overt by nature
- Verbal abuse and lack of respect are more and more common between nurses
- Physicians, peers and even supervisors mock and discipline nurses and even embarrass them in front of patients
- The most common group of insulting individuals are the nurses on the verge of burnout

(Longo & Sherman 2007; Sandström 2010; Rowe & Sherlock 2003)

HORIZONTAL VIOLENCE IN NURSING
(CONT'D)

OUTCOMES:

- job dissatisfaction
- lack of enthusiasm
- psychological and physical stress
- depression
- excessive usage of staff sick leave
- increase in the possibility of medical errors

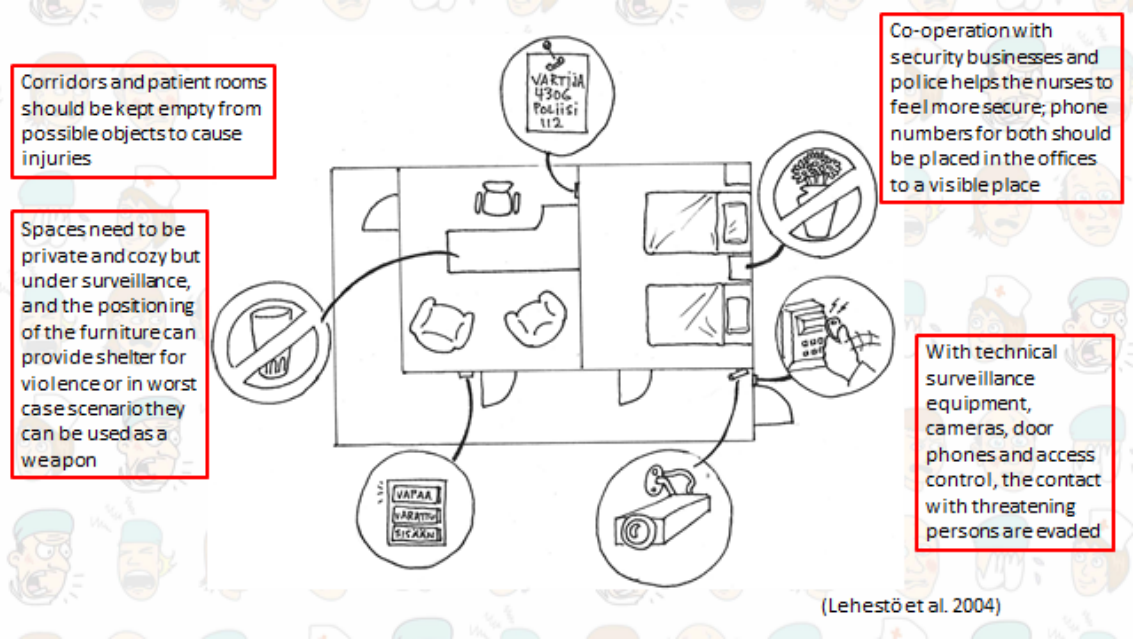
Because newly graduated nurses have often experienced horizontal violence during their first year of practice, there should be changes made to nursing management and work culture ...What could some of these factors be that are preventive against horizontal violence?

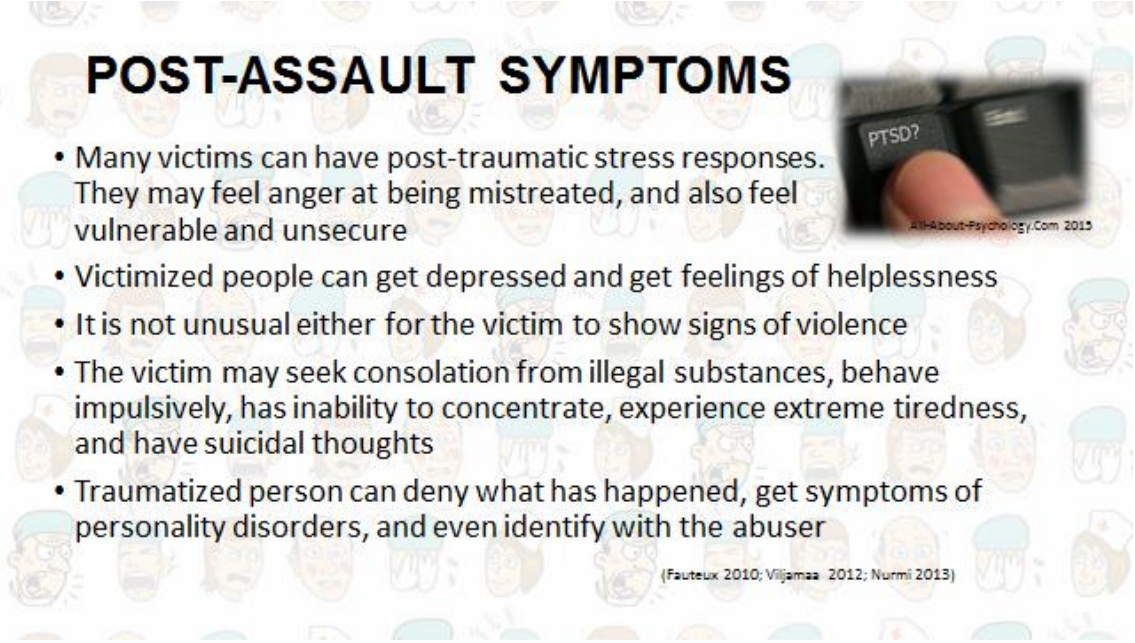
(Longo & Sherman 2007)

PREVENTION OF VIOLENCE

- Management should at first focus on achieving a positive 'perceived violence climate' that is a measure to direct extension of the idea of a safety climate
- Routines and rules create safety; therefore when doing a task what differs from "the normal", extra staff may be needed or good to have as a backup (e.g. transferring a difficult and confused patient)
- Another important safety related issue is the number of the staff, as well as their qualifications towards the job especially in high-risk workplaces
- Uncertainty and ambiguity of things increase anxiety both in healthy and sick people
- No nurse should work alone, particularly those in high-risk workplaces and all the nurses should embrace a zero-tolerance against violence as well as healthy self-preservation instinct
- Reporting the possible threat and violent cases/patients is every nurse's right without getting understated or laughed by fellow staff members

(Spector et al. 2007; Lehestö et al. 2004)


Corridors and patient rooms should be kept empty from possible objects to cause injuries
Spaces need to be private and cozy but under surveillance, and the positioning of the furniture can provide shelter for violence or in worst case scenario they can be used as a weapon
Co-operation with security businesses and police helps the nurses to feel more secure; phone numbers for both should be placed in the offices to a visible place
With technical surveillance equipment, cameras, door phones and access control, the contact with threatening persons are evaded
VARTIJA 4306 Poliisi 112
VAPAA
VARATTU
SICKAN
(Lehestö et al. 2004)


POST-ASSAULT SYMPTOMS
• Many victims can have post-traumatic stress responses. They may feel anger at being mistreated, and also feel vulnerable and unsecure
PTSD?
AllAbout-Psychology.Com 2015
• Victimized people can get depressed and get feelings of helplessness
• It is not unusual either for the victim to show signs of violence
• The victim may seek consolation from illegal substances, behave impulsively, has inability to concentrate, experience extreme tiredness, and have suicidal thoughts
• Traumatized person can deny what has happened, get symptoms of personality disorders, and even identify with the abuser
(Fauteux 2010; Viljamaa 2012; Nurmi 2013)

POST-ASSAULT CARE

- After being verbally or physically assaulted, the best way to understand the feelings evoked, and to get back the feeling of control, is to discuss with someone as soon as possible to avoid any mixed feelings bothering the normal course of daily living
- Support and debriefing should be available and offered for nurses who have gone through distressing levels of verbal or physical aggression
- It is easier to eliminate the negative effects of workplace aggression, if there is a supportive work environment

(Fauteux 2010; Stone et al. 2010)

POST-ASSAULT CARE (CONT'D)

DEFUSING

- This conversation should be kept almost immediately after the incident. In work place it means that it should take place on the same day, after the victim's shift ends
- It is important for the victim and others involved to participate because it can help them to diminish their feelings of guilt and reduce the nonsensical pondering by themselves
- Defusing conversation also gives the victim and the others involved readiness to act in the next sudden stress situation

(Lehestö et al. 2004)

POST-ASSAULT CARE (CONT'D)

DEBRIEFING

- This professionally guided discussion is done 1-3 days after incident
- In that time the shock reaction is disappearing and the incident can start to be processed and if needed, there can be more than one debriefing
- The purpose of conversation is to increase the participants' understanding towards each other's emotional reactions of the incident, analyze the situation and help everyone to start grieving

A person who has been attacked may seem normal and calm. This does not mean that he/she should be left alone, especially in the first 24 hours, because the feelings can be paralyzed and hidden, but once they come out the person might be really confused and agitated. Therefore it might be appropriate to send the person home accompanied by a support person

(Lehestö et al. 2004)

ANGER MANAGEMENT

- Anger management does not mean that a person cannot get angry
- The anger should not control a person, but a person should control the anger
- Nurses should be able to manage their own anger before trying to calm an angry person down
- Nurses should also make sure that an employer is also prepared for difficult situations with valid guidelines and policies
- Anger management isn't therapy, it is a psychoeducational intervention
- Anger management's main goal is to teach to a person specific tools and strategies for him/her to learn to change ones behavior by providing a new perspective and increasing knowledge when the anger arises
- The teacher of the intervention also has the role of a coach, not a therapist
- Because anger is an interpersonal emotion, anger management is best done as a group intervention

(Cacciatore 2007; Leiper 2005; Thomas 2001)

ADDITION TO ANGER MANAGEMENT

Pharmacological methods

- Beta-blockers
- Paroxetine along with other serotonin-specific reuptake inhibitors

Physical methods

- Exercise
- Massage
- Relaxation
- Enough sleep

(Sandström 2010; Mostofsky et al. 2014)

INTERVENTIONS – SuTuHaKa

'SuTuHaKa'- MODEL

- 'Sutuhaka-malli' (from Finnish words SUuuttunut, TUntua, HAluta, KAnnattava yhteistyö: meaning Angry, Feel, Want, Viable cooperation) is an often used anger management model for constructive expression of anger
- It is a four-stage model suitable for adults and children, which helps an individual to express frustration or anger before the feelings escalate unbearable and lead to unnecessary conflict
- Own feelings are not denied but they are expressed firmly without any insults by robust behavior, whilst also concentrating on posture, voice, gestures and facial expressions

(Cacciatore 2007)

INTERVENTIONS – SuTuHaKa (CONT'D)

It encourages individuals to tell why they are angry, how they are feeling, what they are after, and why cooperation would be favorable:

- **Person should describe why he/she is angry** (without truckling, without humiliating). Words such as 'always' or 'never' should be avoided. Criticizing others should be avoided, and the person should focus on the issue that is bothering him/her
- **Person should tell how he/she is feeling** (without hesitation). Short and firm sentences should be used, for example starting with "I am angry because..."
- **Person should specify what he/she wants from others to improve the situation** (politely, firmly)
- **The person should tell why he/she thinks the cooperation would be the most favorable option** (supportively, without sarcasm). The positive outcomes of the cooperation should be pointed out

(Cacciatore 2007)

INTERVENTIONS – Traffic Light

TRAFFIC LIGHT-MODEL

Ulpu Siponen has created a traffic light-model, which is based on practicing self-control. This model should be memorized and used in the situations when rage or fear is about to get the control of feelings

- **Red light:** Person should stop and calm down. Anger and fear should be recognized, but any action should be avoided
- **Amber light:** Person should still wait until he/she is also capable to listen to others. Person should gather the thoughts and find the most constructive way of functioning
- **Green light:** Calmed down person can face the situation that is making him/her angry by using as constructive method as possible

The traffic light method can be taught already for young children, because it is a more constructive anger management/ aggression education method than just using constant prohibitions and parental demands for the child to be a good boy/ girl

(Cacciatore 2007)

INTERVENTIONS – KuKiPaSo

'KuKiPaSo'- MODEL

- If an individual is really furious and enraged, it may be better to avoid any excuses and constructive negotiation. The person's rage should be deescalated to the status that violence will be avoided

- In these kinds of situations 'Kukipaso-malli' (from Finnish words KUuntele, KIitä, PAhoitte, SOvi jotain: meaning Listen, Thank, Apologise, Agree something) should be used, which is a model also suitable for both adults and children. This model includes four main stages: (next page)

(Cacciatore 2007)

INTERVENTIONS – KuKiPaSo (CONT'D)

- **Listening.** Aggressive person should be faced politely, calmly and with minimal facial expressions, because anything can be misinterpreted. The person should not be interrupted and positive nodding should be used, as it is important to give an impression that the aggressive person's every word is listened to

- **Thanking.** Angry person should be given some recognition by saying "Thanks for broaching this issue..." It is good to get the aggressive person's feelings out in words, even they may not make sense

- **Showing regret.** Own opinions and verbal defending should not be used, because enraged person cannot see the issues in other's point of view. Regret should be shown (e.g. by saying 'sorry'), even that may not be necessary. The aggressive person should not be made feeling unvalued

- **Agreeing to do something.** Issues should not be left unsolved or the conversation changed before something is agreed with the aggressive person. If the offered help by one person is not deescalating the situation, someone else should be taking over to carry on the discussion. It is always better to seek further help rather than showing own fears

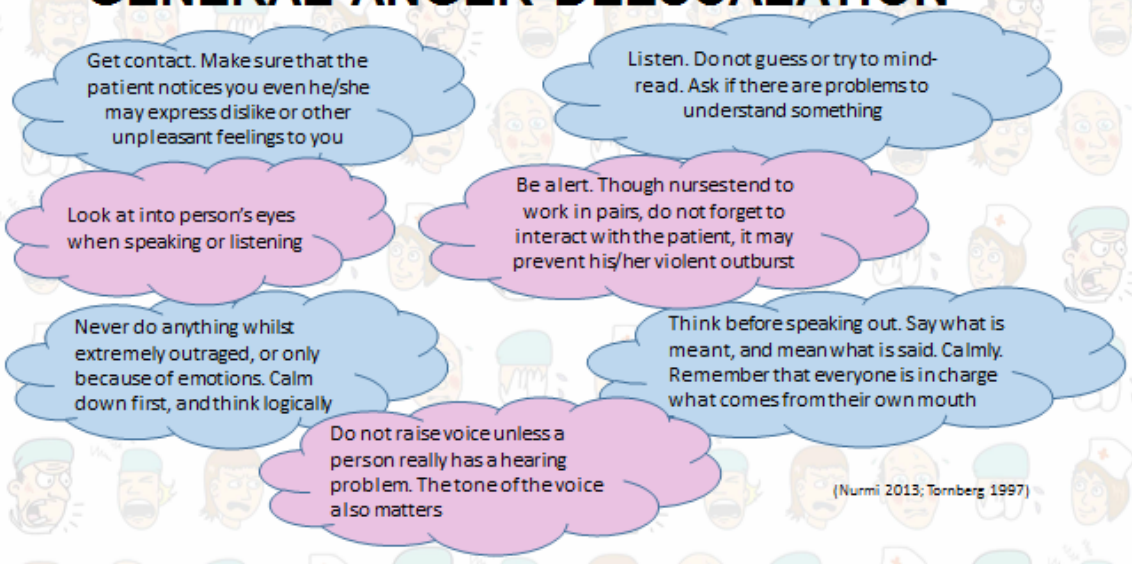
(Cacciatore 2007)

INTERVENTIONS – OTHER METHODS

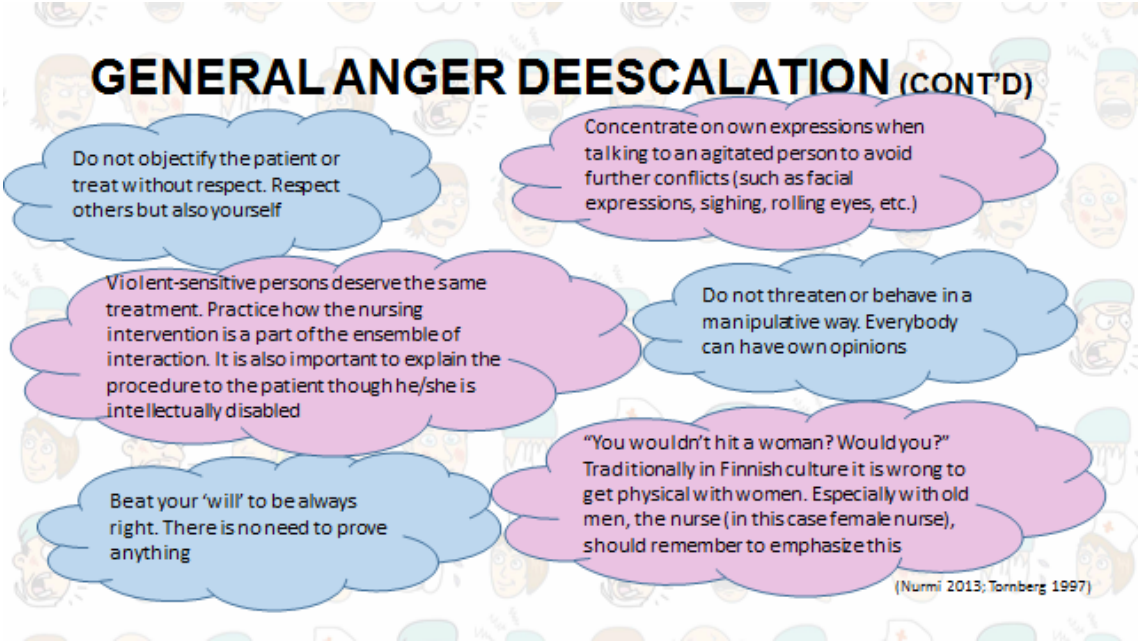
- **MINDFULNESS-BASED STRESS REDUCTION -TECHNIQUE (MBSR)**
  - Is a systematic approach using meditation as a basis of a program to help individuals cognitively delimit situations to make analyzing process easier, and to help avoiding irrational anger.
  - The strategies used in MBSR have shown to help individuals to practice self-reflection, acceptance, self-care and care for others.
  - These strategies have also provided help to develop coping methods for addressing unpleasant emotions such as anger, and to manage stress
- **AGGRESSION REPLACEMENT TRAINING (ART)**
  - Was developed in the USA in 1980 by Albert Goldstein who found out at that time there was no good method to handle the aggressive youth because the point of view against it was too narrow
  - It's main goal is to build competence in anger control, social skills and moral reasoning with the help of affective, cognitive and behavioral interventions
- **THE SOLVING PROBLEMS TOGETHER- MODEL (SPT)**
  - It is an effective problem-focused group intervention technique especially for adolescents
  - It is customized from the teaching philosophy of problem-based learning and therefore problem-solving skills and critical thinking are grown at the same time when searching the favorable outcome for managing anger

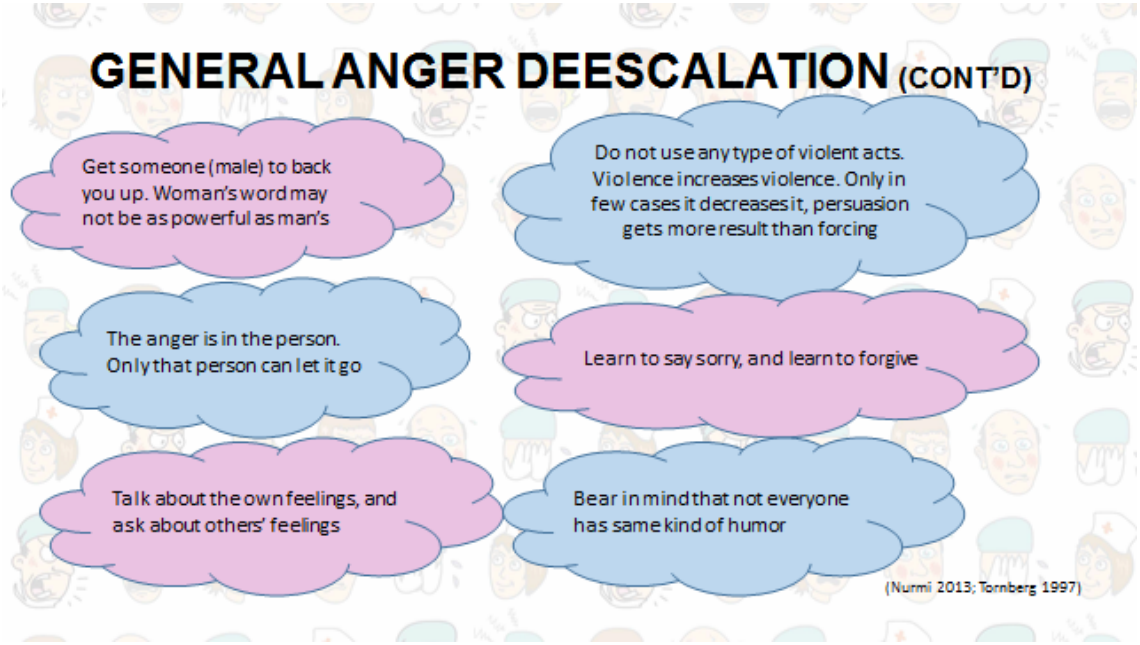
(Shirey 2007; Nurmi 2013; Amendola& Oliver 2013)

GENERAL ANGER DEESCALATION



(Nurmi 2013; Tornberg 1997)


GENERAL ANGER DEESCALATION (CONT'D)
Do not objectify the patient or treat without respect. Respect others but also yourself
Concentrate on own expressions when talking to an agitated person to avoid further conflicts (such as facial expressions, sighing, rolling eyes, etc.)
Violent-sensitive persons deserve the same treatment. Practice how the nursing intervention is a part of the ensemble of interaction. It is also important to explain the procedure to the patient though he/she is intellectually disabled
Do not threaten or behave in a manipulative way. Everybody can have own opinions
Beat your 'will' to be always right. There is no need to prove anything
"You wouldn't hit a woman? Would you?" Traditionally in Finnish culture it is wrong to get physical with women. Especially with old men, the nurse (in this case female nurse), should remember to emphasize this
(Nurmi 2013; Tornberg 1997)


GENERAL ANGER DEESCALATION (CONT'D)
Get someone (male) to back you up. Woman's word may not be as powerful as man's
Do not use any type of violent acts. Violence increases violence. Only in few cases it decreases it, persuasion gets more result than forcing
The anger is in the person. Only that person can let it go
Learn to say sorry, and learn to forgive
Talk about the own feelings, and ask about others' feelings
Bear in mind that not everyone has same kind of humor
(Nurmi 2013; Tornberg 1997)

CASE 1

I TOLD YOU TO SET THE MAYO TABLE CORRECTLY!!! IT LOOKS LIKE DONE BY AN UNDERGRADUATE!!! ARE YOU STUPID OR WHAT!!!?? DO IT AGAIN...NOW QUICKLY!

What would be your response as a nurse for this kind of comment ?

CASE 1= Suggestions for interaction

Interaction with ruthless and indifferent persons:

1. **Stand up and defend yourself!**
2. **Keep calm, give time**
3. **Forget courtesy**
4. **Distract!**
5. **Ask to be seated**
6. **Speak from own point of view**
7. **Avoid fighting**
8. **Prepare to be friendly**

(Perkka-Jortikka 2007)

CASE 2

How would you react to this situation:

A) if you were the blonde-hair girl?

B) if you were the person giving the report and heard what was said?

CASE 2= Suggestions for interaction

Interaction with backstabbing persons:

1. **Expose the attack**
2. **Offer an alternative to fighting**
3. **Search support among others**
4. **Conciliate and solve the problem**
5. **Intervening as a third party**
   - Both must be willing to reconcile
   - Keep up the conversation until both parties feel that it is over, make sure that your opinions are valued
   - The course of the intervention is best done as guided previously; exposing the attack, offering an alternative to fighting and conciliating and solving the problems

(Perkka-Jortikka 2007)

CASE 3

A) How could you prevent yourself from raging like this?
B) What would you do hearing some other nurse acting like this?

CASE 3= Suggestions for interaction

Interaction with persons who are not in control of their feelings

1. **Giving space for calming.**
2. **Being serious.**
3. **Stopping the interaction.**
4. **Solving the problems.**

(Perkka-Jortikka 2007)

CASE 4

- "Judy takes her small daughter to the health care centre and has to wait for two hours before they are seen by a doctor and a nurse. Whilst she is waiting she finds that all the patients there (at least 20 of them) have been given same 2p.m. appointment. She also notices that the doctor and two nurses are coming from the coffee break with no rush and chatting about personal issues. Judy loses her temper, marches in front of the doctor and nurses and shouts: "I have been f*cking waiting here for two hours with my sick child and you just have time to drink coffee....Plus all of us here have the same appointment!!!!! I want to be seen NOW!!"
- What would you do as the nurse?

MORE ABOUT THIS SUBJECT…

- **Haastavat asiakas tilanteet – väkivalta työssä** The book published by Talentum in 2015 is intended to support and prepare workers to face a demanding customer. The book describes how to prepare for a situation when risks are possible, what to observe, how to anticipate a customer's behavior and how to estimate dangerousness of a customer. It also describes how to function when the problematic situation has already occurred, what to learn about those situations and how to recover
- **Jussi-työ®** offers help for crises, therapeutic discussion, and guidance for men who want to prevent and stop violent behavior. The aim is to help men to use non-violent problem solving methods. Jussi-työ® is part of The Federation of Mother and Child Homes and Shelters
- **KAT ry (FINACAT)** is Finnish Association of Cognitive Analytic Therapists offers help for those who suffer from feelings, symptoms or experiences that prevent normal daily functioning. For example in the way how a person relates to him/herself or other people

(Talentum 2015; Ensi- ja turvakotien liitto Ry 2015; Kognitiivis-analyyttinen psykoterapiayhdistys 2015)

MORE ABOUT THIS SUBJECT…(CONT'D)

- **MAPA-Finland ry** offers training sessions how to learn to foresee and avoid challenging behaviour with methods of therapeutic interaction and functionality, before using physical methods
- **Mielenterveystalo** offers various types of psychotherapy services, such as psychodynamic psychotherapy. They have also a list of services available for service users willing to try different methods, such as art or music therapies
- **Rikosuhripäivystys** is a nationwide victim support network for anyone who is a victim of an offense, who thinks to be a victim of an offense, whose closed one has been a victim of an offense, who is a witness of an offense, or who wants to get advice or talk about an offence faced

(MAPA-Finland ry 2012; Mielenterveystalo 2015; Rikosuhripäivystys 2015)

SOURCES

- Arslan, C. 2010. An investigation of anger and anger expression in terms of coping with stress and interpersonal problem-solving. Educational Sciences: Theory & Practice 10. Winter 2010. 25-43. http://files.eric.ed.gov/fulltext/EJ882723.pdf
- Cacciatore, R. 2007. Aggression portaat - Opetusmateriaali kouluille. Opetushallitus. Vammalan Kirjapaino Oy.
- Cacciatore, R. 2009. Kapinakirja – Aggressiokasvattajan käsikirja - koululaisesta aikuiseksi. Väestöliitto. Vammalan Kirjapaino Oy, Helsinki.
- Davies, W. 2009. Overcoming Anger and Irritability: A self-help guide using Cognitive Behavioral Techniques. Constable & Robinson Ltd. London
- Dunderfelt, T. 2007. Irti tunnekoukuista, 4th ed. Dialogia Oy, Helsinki.
- Ellilä, H. 2005. Väkivaltaan ei saa tottua. Sairaanhoitaja-lehti. 6-7/2005. Consulted 20.2.2014. http://www.sairaanhoitajaliitto.fi/ammatilliset_urapalvelut/julkaisut/sairaanhoitaja-lehti/6-7_2005/paakirjoitus/vakivaltaan_ei_saa_tottua/
- Fauteux, K. 2010. De-Escalating Angry and Violent Clients. American Journal of Psychotherapy, Vol. 64, No 2, 195-212. Consulted 13.2.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/resultsadvanced?sid=625d189f-9e05-4e53-b2df-7954817a44a7%40sessionmgr114&vid=12&hid=127&bquery=De-Escalating+Angry+AND+Violent+Clients&bdata=JmRiPWFmaCZkYj1jaW4yMCZkYj1seGgmZGI9OGdoJmRiPWFmdCZ0eXBlPTEmc2l0ZT1laG9zdC1saXZl
- Hollinworth, H., Clark, C., Harland R., Johnson, L & Partington, G. 2005. Understanding the arousal of anger: a patient-centred approach. Nursing Standard. Vol.19, No 37, 41-47. Consulted 30.1.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/results?sid=625d189f-9e05-4e53-b2df-7954817a44a7%40sessionmgr114&vid=11&hid=127&bquery=Understanding+the+arousal+%22of%22+anger&bdata=JmRiPWFmaCZkYj1jaW4yMCZkYj1seGgmZGI9OGdoJmRiPWFmdCZ0eXBlPTEmc2l0ZT1laG9zdC1saXZl#ResultIndex_1
- Lehestö, M., Koivunen, O. & Jaakkola, H. 2004. Hoitajan Turva. Edita Publishing Oy, Helsinki
- Longo, J. & Sherman, R.O. 2007. Levelling horizontal violence. Nursing Management. Vol. 38, Issue 3, p34-51. Consulted 17.2.2014 http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=5&sid=0213d1f1-0a27-40ed-a0b8-c3df2bc5ad07%40sessionmgr4004&hid=4209

SOURCES (CONT'D)

- MAPA-Finland ry 2012. Koulutusta sosiaali- ja terveysalalle. Consulted 15.5.2015 http://www.mapafinland.fi/
- Miracle, V. 2013. Suggestions for Handling Anger in the Workplace. Leadership Dimension. Vol. 32, No 3, 125-127. Consulted 11.2.2014 http://ovidsp.uk.ovid.com.ezproxy.turkuamk.fi/sp-3.11.0a/ovidweb.cgi?&S=FHMMPDKPHCHFIPMMFNMKLCAGLKGEAA00&Link+Set=S.sh.59%7c1%7csl_10
- National Institutes of Health 2006. Talking to Children about Death. Patient Information Publications Clinical Center National Institutes of Health. Consulted 1.9.2014 http://www.cc.nih.gov/ccc/patient_education/pepubs/childeath.pdf
- Nau, J., Dasse, T., Needham, I. & Halfens R. 2008. The development and testing of a training course in aggression for nursing students: A pre- and post-test study. Nurse Education Today 2009, Vol 29, 196-207. Elsevier. Consulted 8.2.2014 http://ac.els-cdn.com.ezproxy.turkuamk.fi/S0260691708001160/1-s2.0-S0260691708001160-main.pdf?_tid=98e95482-96a3-11e3-8321-00000aacb35d&acdnat=1392511694_6204e8bee4261e53f311dc05737c7917
- Nurmi, P. 2013. Lapsen ja Nuoren viha. PS-Kustannus. Jyväskylä.
- Olofsson, B., Bengtsson, C. & Brink, E. 2003. Absence of response: A study of nurses' experience of stress in the workplace. Journal of Nursing Management, 2003, 11, 351–358 http://web.a.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=5378f3f8-8687-43a5-82f4-58d4c5fcf0f8%40sessionmgr4005&vid=10&hid=4101
- Perkka-Jortikka, K. 2007. Hankalan ihmisen kohtaaminen. Katriina Perkka-Jortikka ja Edita Publishing Oy. Helsinki.
- Reenkola, E. 2008. Nainen ja viha: Aggressio voimavaraksi. Elina Reenkola ja Minerva Kustannus Oy. Helsinki
- Rowe, M. & Sherlock, H. 2003. Stress and verbal abuse in nursing: do burned out nurses eat their young? Journal of Nursing Management, 2005, 13, 242–248 http://web.a.ebscohost.com.ezproxy.turkuamk.fi/ehost/pdfviewer/pdfviewer?sid=5378f3f8-8687-43a5-82f4-58d4c5fcf0f8%40sessionmgr4005&vid=5&hid=4101

SOURCES (CONT'D)

- Sandström, M. 2010. Psyyke ja aivotoiminta: Neurofysiologinen näkökulma. Marita Sandström ja WSOYpro Oy. Helsinki.
- Shrand, J. & Devine, L. 2013. Outsmarting anger: 7 strategies for defusing our most dangerous emotion. 1st ed. Jossey-Bass, A Wiley Imprint, San Franciso, USA.
- Shirey, M.R. 2007. An Evidence-Based Solution for Minimizing Stress and Anger in Nursing Students. Journal of Nursing Education. Vol.46, No 12, 568-571. Consulted 5.2.2014 http://ovidsp.uk.ovid.com.ezproxy.turkuamk.fi/sp-3.11.0a/ovidweb.cgi?&S=FHMMPDKPHCHFIPMMFNMKLCAGLKGEAA00&Link+Set=S.sh.23%7c1%7csl_10
- Simula, P. 2013. Käsikirja ihmiselle. Into Kustannus Oy. Helsinki
- Spector, P.E., Coulter, M.L., Stockwell, H.G. & Matz M.W. 2007. Perceived violence climate: A new construct and its relationship to workplace physical violence and verbal aggression, and their potential consequences. Work & Stress, Vol 21, No2, 117-130. Consulted 1.9.2014 http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=49a49689-6a69-4381-a2ee-20a94f736600%40sessionmgr198&hid=127
- Talentum Media Oy 2015. Haastavat asiakastilanteet – väkivalta työssä. Consulted 15.5.2015 http://www.talentumshop.fi/haastavat-asiakastilanteet-vakivalta-tyossa.html
- Thomas, S. 2003. Anger: The Mismanaged Emotion. Research for Practice. MedSug Nursing. Vol. 12, No2, 103-109. Consulted 30.1.2014 http://web.b.ebscohost.com.ezproxy.turkuamk.fi/ehost/detail?vid=15&sid=625d189f-9e05-4e53-b2df-7954817a44a7%40sessionmgr114&hid=127&bdata=JnNpdGU9ZWhvc3QtbGl2ZQ%3d%3d#db=cin20&AN=2003066335
- Thomas, S. 2004. Transforming nurses' stress and anger – Steps towards healing. 2nd ed. Springer publishing company. New York, USA.
- Tilastokeskus. 2009. Työväkivalta on yleistä terveys- ja sosiaalialojen ammateissa. Consulted 20.2.2014 https://www.stat.fi/artikkelit/2009/art_2009-09-30_002.html?s=0
- Tehy 2011. Älä riko hoitajaasi. Accessed 15.2.2014 http://www.tehy.fi/medialle/esitteet-ja-kampanjat/ala-riko-hoitajaasi/
- Tornberg H. 1997. Aggressio- vuorovaikutuksen suola. T:mi Malpana, Liminka.
- Valkeeniemi, H. 2014 (b). YLE uutiset. Normipäivä - työkaverina pelko. Consulted 14.3.2014 http://yle.fi/uutiset/normipaiva_-_tyokaverina_pelko/7132194
- Viljamaa, J. 2012. Käytä kiukkuasi – aggression hyötykäyttö. Janne Viljamaa ja Werner Söderström Osakeyhtiö. Helsinki

SOURCES (CONT'D)

PICTURES:

- All-About-Psychology.Com 2015. Post Traumatic Stress Disorder. Consulted 14.5.2015 http://www.all-about-psychology.com/post-traumatic-stress-disorder.html
- Daybreak Counseling Services and Anger Management Classes 2015. The Dangers of Internalizing Anger. Consulted 4.5.2015 http://daybreakservices.com/the-dangers-of-internalizing-anger/
- ShiftWise Inc. 2014. Mighty Nurse. Consulted 21.11.2014 http://www.mightynurse.com/adventures-of-mighty-nurse-vol-10/
- Tumblr.com 2015. Active Inspiration. Consulted 14.5.2015 http://activeinspiration.tumblr.com/

Other pictures by Seppo Råman

THANK YOU!!!