Agressive behaviour is a part of basic human nature. It is an adaptive behaviour having its origin in genetically coded neural mechanisms that are acted upon by hormonal and psychosocial factors. It has multiple determinants whose manifestations and effects vary with age, sex and culture. Aggressive behaviour promotes the survival of the individual as well as the social groups. However, in the context of rapid social and cultural changes, the survival value of aggression becomes suspect. The new roles and norms required by social change create uncertainties. These are reflected in the form of various interpersonal and social problems. Aggression becomes one of the ways of expressing these. As is generally believed, appropriate aggression may not be harmful, and attempts to extinguish all forms of its may prove maladaptive. As such, violence is aggression gone astray and is a short term coping mechanism which in the long run tends to prove maladaptive to the individual and to society.

Violence denotes action

Violence has been defined as "overtly threatened or overtly accomplished of force which results in injury or destruction of person or property or reputation or the illegal appropriation of property" (Mulvihill and Tumin, 1969). Megargee (1976) has defined violence as an "act characterised by the application or overt threat of force which is likely to result in injury to people". The semantic distinction between violence and dangerousness has been a matter of debate. At first glance, the difference between 'violent' and 'dangerous' behaviour appears to be simple. For instance, being shot, stabbed or punched could be labelled as violent. The meaning of a sign reading "dangerous" placed behind a gasoline truck or near a patch of thin ice is likewise clear. Yet as soon as one goes beyond these obvious examples, problems arise. While Sarbin (1967) cogently distinguishes between violence and dangerousness - "violence denotes action, dangerous denotes relationship" - virtually all other workers hold the terms as synonymous. Some define violence to include only injury or death to person (e.g. Mulvihill and Tumin, 1969). Violent thoughts are also considered dangerous by some "because patients with fear and fantasies of violence sometimes act them out" (Ervin and Lion, 1969)

Prediction of violent behaviour

Behaviour is learnt. It does not exist in germ plasm but varies with past experiences and the type and intensity of situation. It is difficult even under the best of circumstances to predict behaviour of any kind, especially behaviour like violence which is relatively infrequent. For exam-
pie, one might suppose that by knowing the pattern of one monozygotic twin, the other might be expected to behave in the same manner under similar circumstances. However, such is not the case. It has been observed that persons with identical inherited mental deficiency or similar organic brain disorders do not behave in a predictably similar fashion. Stone (1975) postulates that, even if a hypothetical instrument could be produced which would be 95 per cent effective in predicting dangerousness, out of every 100,000 people who were tested, several thousand could be termed potentially dangerous and would become so-called false positives, i.e. predicted as likely to be dangerous but not displaying such behaviour. Even though the tendency to over-predict dangerousness has been discussed at length within the professional community, it is still widely practiced as a precautionary procedure. But there may be many mistakes that a psychologist or psychiatrist can make in predicting violent behaviour. They can mis-score, forget to ascertain a relevant fact or simply be unaware of research findings in the area. The four most common blind spots with clinical prediction of violent behaviour appear to be: (i) ignoring statistical base rate, (ii) lack of speciality in defining the criteria, (iii) relying on elusive correlations, and (iv) failing to incorporate situational or environmental information.

In spite of these limitations, the prediction of violent behaviour has played an important role throughout legal history. It is currently used to assist in making a wide variety of legal decisions from civil commitment to the imposition of the death penalty. Megargee (1976) has presented a model of clinical process for the prediction of violent behaviours, as have many others (Mischel, 1968, 1973).

Dynamics of violent behaviour

Mischel (1973) has categorised relevant predictor variables as: (a) personality factors, (b) situational factors; and (c) interaction between these two factors. According to Megargee (1973), three kinds of personality factors need to be assessed, viz., motivation, internal inhibition and habit strength.

Motivation. A distinction has been made between "angry aggression" and "instrumental aggression" in the assessment of motivation. Angry aggression is motivated by a desire to harm someone and is reinforced by the victim's point; instrumental aggression is a means to some other end and has other reinforcements (e.g. shooting a guard to get at money in bank). Of course both types of motivation may coexist, as in an angry parent who spanks a child partly to help socialize that child and partly to vent his or her own feelings.

Inhibition. Internal inhibitions are personal taboos against engaging in violent behaviour. When inhibition exceeds motivations, violence does not occur. Inhibition may vary by the type of the target (e.g. one may be more inhibited from punching one's friend than from punching a stranger), and by the type of the act. Inhibition can be lowered by alcohol or other drugs. Megargee also notes that some extremely violent people are characterised by excessive inhibition. In such individuals, the suppressed instigation to aggression apparently gets summated to the point where massive inhibitions are overwhelmed and erupt into violence.

Habit. Habit strength in this context is simply the extent to which violent behaviour has been reinforced in the past. When violence becomes instrumental in obtaining money, peer group approval or sex, it reinforces the strength of violent habits.
Violent behaviour among criminals

It is suggested that violence is higher in groups where social interaction is characterised by isolation, anonymity and impersonalization. Influence of the family also plays an important role. Further, the relationship of alcohol and violence is also intricate, and answers remain elusive and controversial. Violent aggression by homicides, riots is a form of attempted coping behaviour despite its maladaptive and destructive results.

The model of Sentencing Act generally defines two types of dangerous offenders: (i) the offender who has committed a serious crime against a person and shows a behaviour pattern of persistent assaultiveness based on serious mental disturbance; and (ii) the offender deeply involved in organised criminal behaviour. In one of the studies on 'Alcoholism and criminal behaviour in Goa' (Sharma 1983) in the convicts of the Central Jail in Aguada Fort; it was found that 37.9 per cent of the criminals were in the habit of drinking, only 24.2 per cent of the criminals were drunk at the time of crime and out of this one-third took alcohol intentionally before the crime.

Various other studies on the relationship between the use of alcohol and commission of violent crimes have shown that in case of homicide and other assaultive offences alcohol was used by at least half of the offenders directly prior to the crime. Some studies also suggest that in alcohol related violent crimes, violence is most often directed at relatives and friends who were drinking together. Some researchers have also suggested that a criminal is more prone to excessive drinking in order to increase courage in preparation for the crime.

In our study it was found that most of the criminals came from those families where the children were not brought up by both the parents and there was absence of either mother or father in the family. In certain parts of Goa, especially from Bardez, there is a high degree of migration among male members of the family who are either working on a ship or remain away from home for long time, or have jobs in Middle East countries or some African countries. It was also clear that violence rate was higher among migrants, both who moved from rural to urban areas and from one State to another.

Mental Illness and Violent Behaviour

Mental illness and violent behaviour have been linked for many centuries. Traditionally, the roots of civil commitment of mentally ill in England have been traced to “the old Roman law” which provided that guards or keepers be appointed for madmen not only to see that they do no mischief to themselves, but also that they are not destructive to others. Though this belief is age-old, it is only in recent times that a growing and converging body of empirical research has emerged on the relationship between violence and mental illness. It addresses primarily two questions: (i) What is the prevalence of psychiatric disorders among prison population?, and (ii) What is the violent crime rate among hospital inmates or those released from mental hospitals?

Psychiatric disorders in prison population

Bolton (1976) has reported the results of psychiatric epidemiological survey of inmates of adult jails and juvenile detention facilities in 5 California counties. He reported that 6.7% of adults and 7.9% of juveniles were diagnosed as psychotic. 9.3% of adults and 20.6% of juveniles were found to have non-psychotic mental disorders. Personality disorders were
reported for 21.4% of adults and 25.2% of juveniles. Overall studies can be summarised as follows: psychosis, schizophrenia, primary affective disorders and various neurotic disorders are seen only in a minority of identified criminals. There is no complete agreement as to whether any one of these conditions are more common in criminals than in general population, but it is clear that these disorders carry only a slightly increased risk of criminality, if any at all.

Guze (1962) in his study found sociopathy, alcoholism and drug dependence are psychiatric disorders characteristically associated with serious crime. With the exception of higher prevalence of disorders of alcoholism and drug dependence, prisoners do not appear to have higher rate of diagnosed mental illness than their class matched peers in the community.

**Violent behaviour among former mental patients.**

An interesting pattern exists in the data on violent crime rates of former mental patients. Almost without exception, studies performed in 1950's and earlier found that released patients had lower rate of arrest for violent behaviour than the general population (Ashley 1922, Pollock 1938, Cohen and Freeman 1945, and Brill and Malzberg 1954). The studies performed in 1960's and 1970's have consistently found a higher rate of violent behaviour among former patients than among non-patient population (Rappaport and Lassen, 1965; Giovannoni and Gurel 1976; Sosowsky 1978).

A striking pattern of results emerged from study by Cocozza et al. (1978). It was observed that while the former patients as a group do have substantial higher arrest record for all types of crime than the general population, patients without an arrest record prior to going to hospital had a lower arrest rate than the general population. Patients with one arrest prior to going to hospital had a slightly higher than average rate for violent crime once they were out of hospital. Patients with 2 or more prior arrests had a drastically higher violent crime rate than the general population.

**Violent behaviour among hospital inmates.**

Violence in mental hospitals is not an uncommon phenomenon. A study was carried out at the Central Institute of Psychiatry in Ranchi to know the violent behaviour among in-patients in the hospital (Sharma, 1985). It was found that violence was more common among males than females, and among the male group, it was more in the age group of 20-40 years. It was also noted that patients were more aggressive during morning hours between 6-8 a.m. and in the evening between 3-6 p.m. An interesting finding in this study was that violence was more common during the period when there was minimal medical and nursing staff in the wards, and also it increased when there was more than one excited patient in the same ward. It was also observed that in patients who were not able to articulate their problems or did not have a reasonable solution of the matter tended to become more violent. The duration of institutionalisation was found to be inversely related to the tendency to be aggressive.

Some workers have reported that patients with serious psychiatric disorders are more likely to be withdrawn and apathetic. Some mentally ill people may be violent, but the image of the mentally ill person as essentially a violent person is erroneous and often unfounded.
Conclusion

In the context of the above observations, violence as a part of human behaviour repertoire needs to be studied, both intensively and extensively. Factors contributing to violent behaviour are many and varied, necessitating a multi-disciplinary approach to understand this phenomenon. It is particularly important in the light of observations made contemporary thinkers that man has not changed in this regard in his journey from the Stone age to the Nuclear Age. We not confront a comparatively greater problem because of the availability of highly potent weapons. These may threaten the very survival of the human race itself.

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