Anger As A Disorder: Moving Beyond DSM-IV-TR

Raymond DiGiuseppe, Ph.D., D.Sc., ABPP
St. John's University
and
The Albert Ellis Institute

Seneca On Anger

We are here to encounter the most outrageous, brutal, dangerous, and intractable of all passions; the most loathsome and unmannerly; nay, the most ridiculous too; and the subduing of this monster will do a great deal toward the establishment of human peace (Seneca, On Anger, 40-50 AD)

Seneca On Anger

My purpose is to picture the cruelty of anger which not only vents its fury on a man here and there but renders in pieces whole nations.@ (Seneca, On Anger 40-50 AD).

Thanks to:

Collaborators:

AG Ahmed, MD - University of Ottawa.

Ryan Fuller, PhD – St. John's University

Wilson Mc Dermut, PhD – St. John's University

Ray Chip Tafrate, PhD Central Connecticut State U

Influences:

Emile Coccao, MD University of Chicago

Jerry Deffenbacher, PhD Colorado State University

Howard Kassinove, PhD Hofstra University

Anger and the DSM-IV-TR

No anger disorders in the DSM-IV or ICD-10.

ICD-10 has an Explosive Personality Disorder.

However, many depressive (mood) disorders and anxiety disorders exist.

Many disorders for substance abuse and emotional problems of anxiety and depression. It appears substance abusers have no anger problems?

How Clinicians Diagnosis Anger Clients

We asked Clinicians to diagnosis cases studies of anger and anxiety cases (Lochman, DiGiuseppe, & Fuller, in press).

For the anger cases, the most common Axis I diagnosis was Intermittent Explosive Disorder.

Next most common is organic brain syndrome.

Very low agreement across clinicians.

80% use an Axis II diagnosis.

Anger was seen as very pathological.

Clinicians see the diagnosis of an anger disorder as unrelated to the treatment plan.

Anger As A Disturbance

Anger was always considered a major part of human suffering when psychology was subsumed under philosophy.

Anger ceases to be mentioned as part of abnormal psychology at the beginning of the 20th Century when Emile Kraeplin and then Sigmund Freud make it part of depression.

Anger As A Disturbance

Were Kraeplin and Freud correct?

All theories of basic human emotions recognize anger.

Anger is opposite from depression in circumspect models of emotions.

How then can anger and depression be part of the same system?

Anger And Depression

Anger and Depression are part of the social dominance system (Stevens & Price, 1996). Evolutionary Psychiatry).

Anger is the expression of dominance

Depression is the expression of submission.

Thus, they are opposite ends of the dominance/submission social system.

They are not the same emotions nor is one secondary to the other.

Anger And Depression

Anger and Depression do correlate.

However, measures of Anger-In account for this, not Anger-Out

Many patients have anger problems and no depression problems.

For those that have both we suspect a sequential relationship. They get depressed about their anger episodes.

Opposition to Anger as a Disorder

- An anger disorder will hold people less culpable for antisocial/aggressive behavior. This objection comes frequently from feminists concerning domestic violence offenders.
- DSM has too many disorders already.
- Anger is covered by other diagnoses.
- Anger can be functional.

Does the Lack of an Anger Diagnosis Matter?

Some researchers have complained that NIMH will not fund studies on anger/ aggression problems because they do not have a disorder:

- Domestic violence perpetrators.
- Child abusers.
- Aggressive drivers.

Can Anger Be Dysfunctional?

Certain wise men have claimed that anger is temporary madness. For it is equally devoid of self-control, forgetful of decency, unmindful of ties, persistent and diligent in whatever it begins, closed to reason and counsel, excited by trifle causes, unfit to discern the right and true -the very counterpart of a ruin that is shattered in pieces where it overwhelms. But you have only to behold the aspect of those possessed by anger to know that they are insane. Seneca On Anger - 50 AD (Basore, 1958, p. 107).

Dysfunctional Anger - Brevis Furor

Whereof it is that anger is called *Brevis Furor*, a short madness, because it differs not from madness but in time. Saving that herein it is far worse, in that he who is possessed with madness is necessarily, willy, nilly, subject to that fury: but this passion is entered into wittingly and willingly. Madness is the evil of punishment, but anger is the evil of sin also; madness as it were thrusts reason from its imperial throne, but anger abuseth reason by forcing it with all violence to be a slave to passion. For Anger is a disease of the mind. From “A Treatise of Anger” by John Downame, 1608, cited in Hunter and Macalpine, 1963, p. 55).

Can Anger be Dysfunctional?

- As many clients seek mental health services for anger as do for depression and anxiety (Posternak & Zimmerman, 2002).
- Clinicians claim they see as many angry as anxious clients (Lochman, DiGiuseppe, & Fuller, 2004).
- Anger can be as dysfunctional as any emotional excess.
- Why have the mental health professions ignored anger?

How Much Anger is Dysfunctional?

Researchers have found that people in the top 25% of anger scores are dysfunctional on many variables. (Tafrate & Kassinove; Deffenbach)

The normal curve dominates the study of dysfunctional Anger.

Others have studied

- ***Top 10%***
- ***Top 5%***
- ***Top 2.5%***

Anger As a Disorder

Anger can be dysfunctional:

- **War - Aggressors more frequently lose.**
- **Terrorism – most often fails to reach political goals.**
- **Torture – most often fails to get information.**
- **Rape – often fails to gain satisfaction.**
- **Murder – almost always regretted by offender.**
- **Anger impedes sexual functioning.**
- **Anger interferes with judgment.**

Anger As a Disorder

Anger can be harmful:

- Road Rage. Anger causes unsafe and dangerous behaviors
- Anger and Illness. Anger is associated with many forms of illness.
- Anger destroys interpersonal relationships.
- Effects on marital relations.
- Negatively effects goal attainment.
- Anger leads to Medication Noncompliance.
- Anger is the main component of Expressed Emotion which leads to relapse of serious mental illness.
- Anger increases Involvement in the Criminal Justice System.

Anger and the DSM-IV-TR

IED is the closest disorder.

- It identifies impulsive aggression only.
- Neither anger nor any emotion is mentioned as an inclusionary or exclusionary criteria.
- Impulsivity is the primary feature.
- This model relies on the proposed distinction between affective/impulsive aggression versus instrumental (non emotional) aggression.

What Research is Needed?

- Identification of symptoms.
- Not subsumed other another disorder.
- Discrimination from other groups.
- Symptoms hold together – factor analytic support.
- Different subtypes – Cluster Analysis.
- Etiology
- Treatment utility

Method We Used to Study Anger Disorders

Anger symptoms in a large sample of Psychiatric patients (N=1774).

Development of the Structured Interview for Anger Disorders (SIAD). Used with those referred for anger (N=120) compared with control sample.

Development of the self report Anger Disorder Scale 8 Multihealth Systems. Standard sample over N=1100 nationwide and more than 990 clinical cases.

Anger In Psychiatric Outpatients

- Thanks to Mark Zimmerman, MD of Rhode Island Hospital Director of the MIDAS project.

  And Wilson McDermut, Ph.D. of St. John's University.
- Complete Structured Interviews to all Outpatients

  Axis I – SCID

  Axis II – SIDP-IV

  N=1774

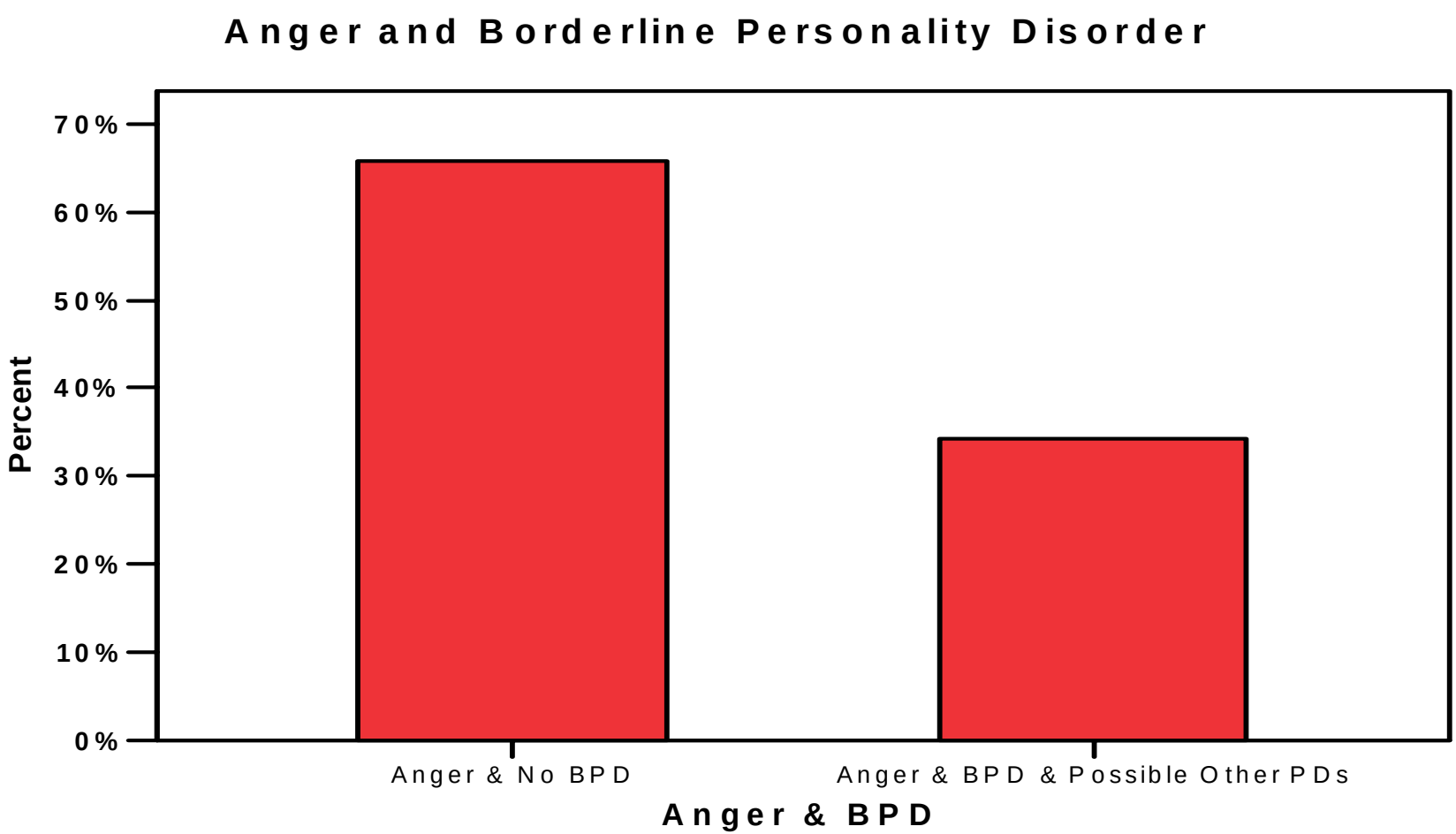
Identifying Angry Outpatients

- Best Item is Borderline Symptom 8. This has ten questions that ask:
  - Anger intensity, frequency, duration
  - Anger expression,
  - Type of triggers
  - Rated on scale of 0 to 3
  - Score of 2 or 3 indicated one has the symptom.

Anger In Borderline PD

- Since this symptom is part of the BPD module, does BPD account for anger in psychiatric outpatients?
- NO.

Figure 1



Anger and Personality Disorders

- Clinical Anger problems are often thought to be accounted for by Personality Disorders.
- Is this true for all DSM-IV-TR Axis II Disorders and for all PD s and those in Appendix B?
- NO.

Figure 2.

Number of Personality Disorders for Angry Patients

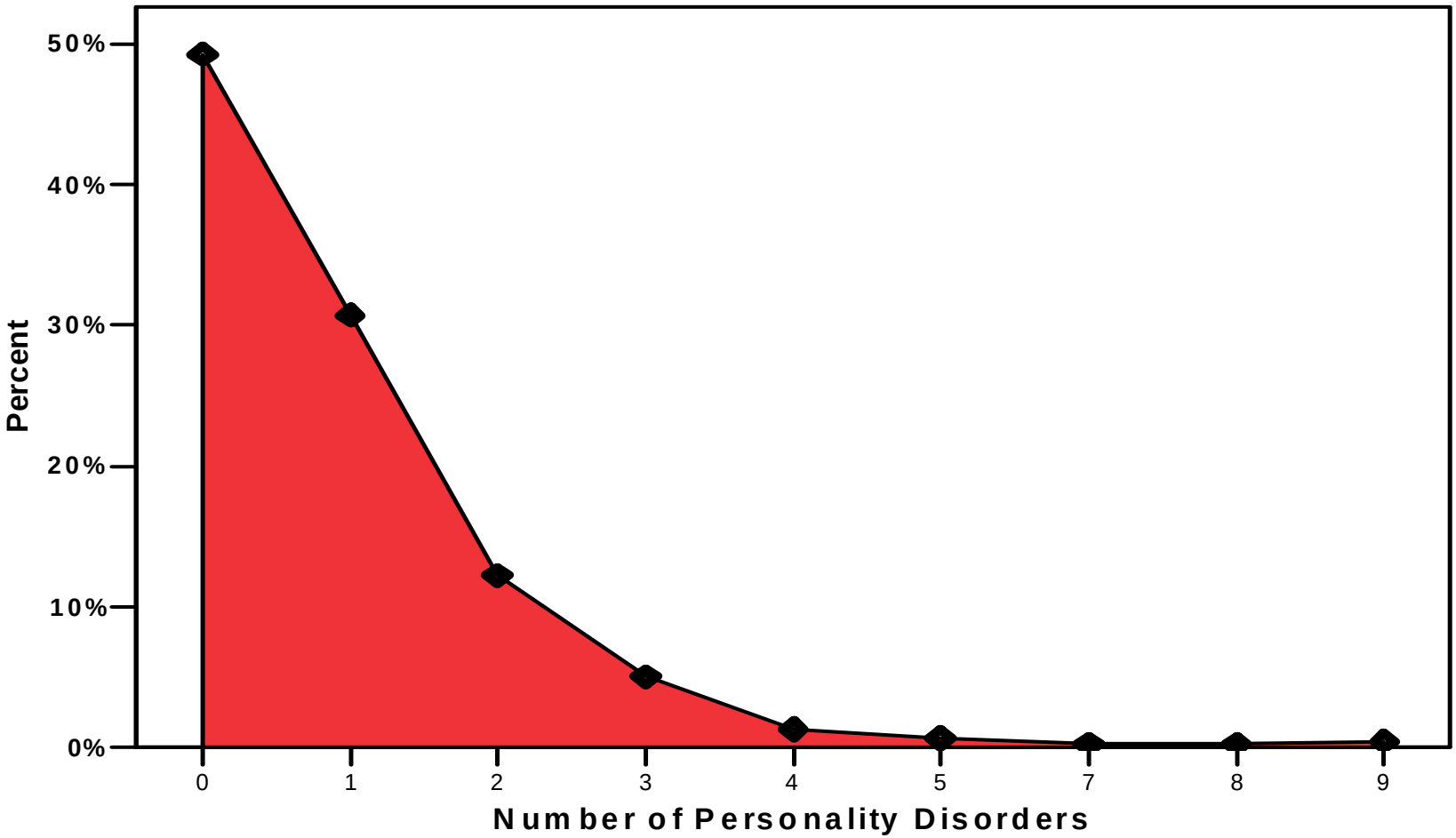
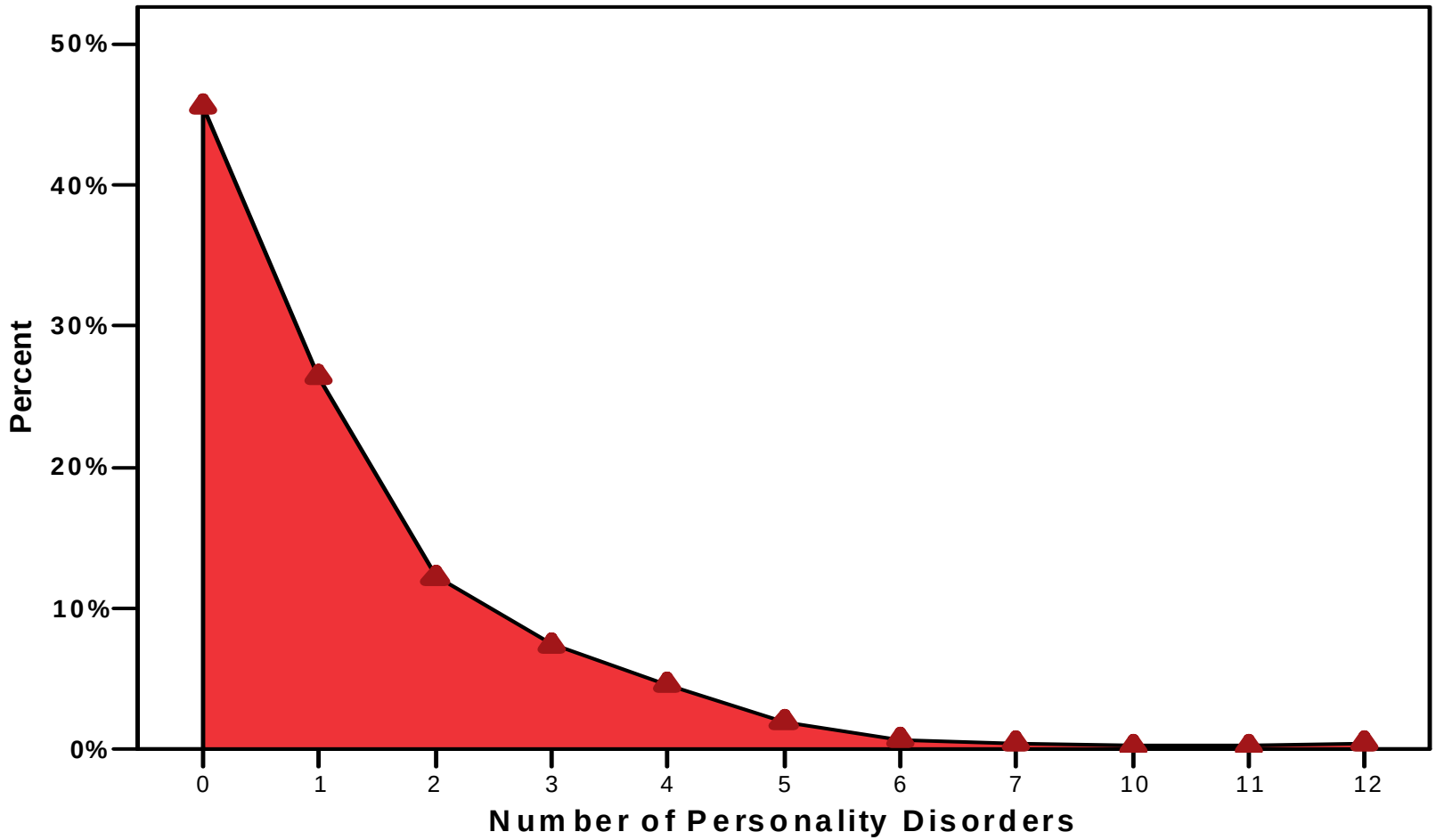


Figure 2A.

Number of Personality Disorders for Angry Patients (Including Appendix B Enteries)



Anger and Personality Disorders

- Beside BPD, Angry clients are diagnosed with:
  - Avoidant PD
  - Antisocial PD
  - Paranoid PD
  - Obsessive Compulsive PD
  - Negativistic (Passive Aggressive) PD

Axis II Disorders in 459 patients who have Anger Symptoms	**Number & Percent of Angry Clients who meet the Disorder**
Any Personality Disorder	233 / 50.8%
Paranoid Personality Disorder	**37 / 8.1%**
Schizoid Personality Disorder	9 / 2.0%
Schizotypal Personality Disorder	10 / 2.2%
Antisocial Personality Disorder	**37 / 8.1% I**
Borderline Personality disorder	**157 / 34.2%**
Histrionic Personality Disorder	7 / 1.5%
Narcissistic Personality Disorder	22 / 4.8%
Avoidant Personality Disorder	**68 / 14.8%**
Dependent Personality Disorder	11 / 2.4%
Obsessive Compulsive Personality Disorder	**36 / 7.8%**
Self Defeating Personality Disorder	21 / 4.6%
Negativistic Personality Disorder	**28 / 6.1%**

Anger and Impulse or Manic Disorders

- Anger is often considered to be an impulse disorder, like IED, or part of mania as proposed by Kraeplin and Freud.
- Do these disorder account for those with anger symptoms?
- No.

Figure 3A. Diagnosis of Impulse Disorders & Anger, Out of 1774 Patients

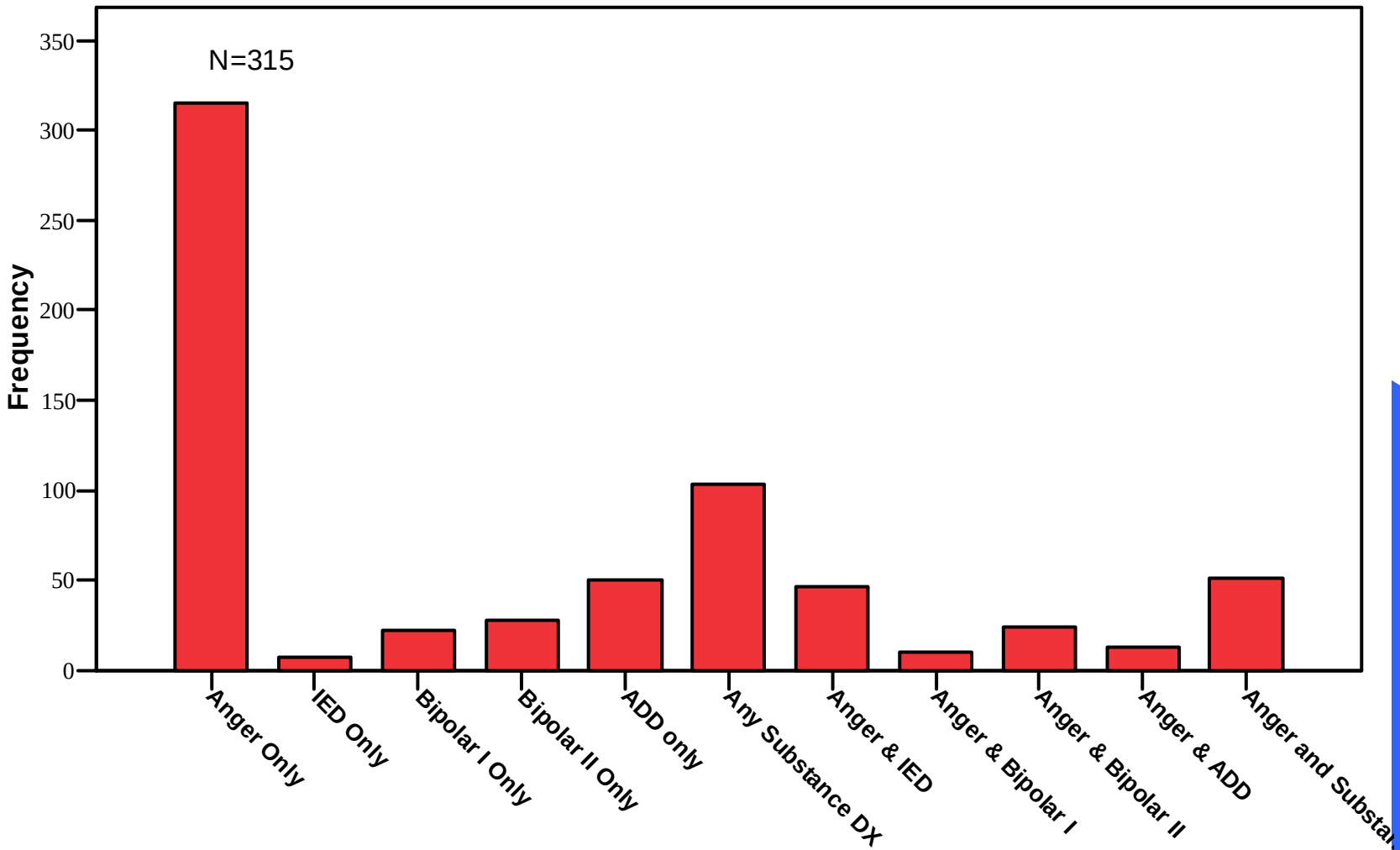
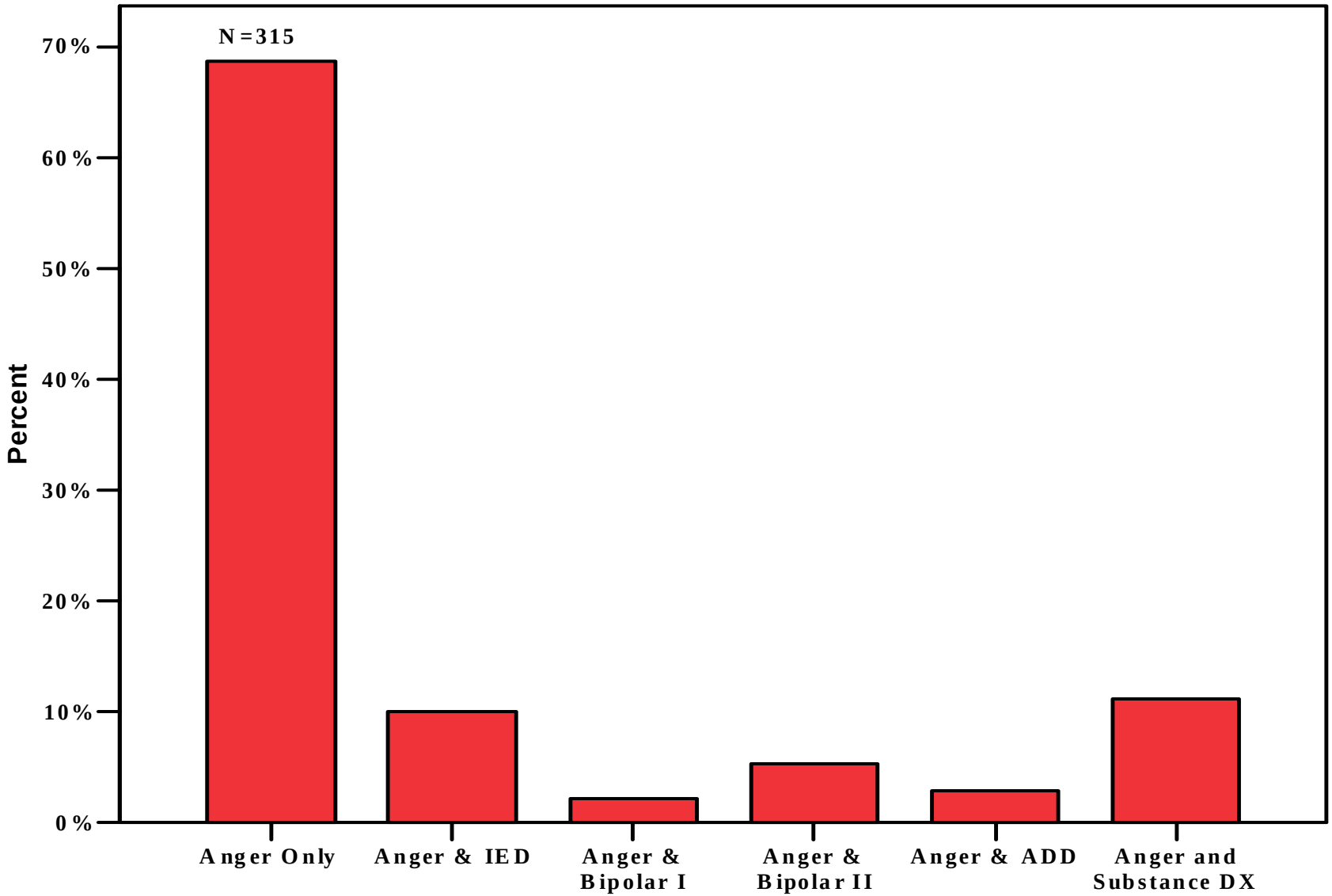


Figure 3. Anger Patients & Comorbid Impulse Disorders, N = 459.



Anger and IED

Most people experience state anger when they behave aggressively.

Some people have moderate trait anger but explode and express anger aggressively when they get angry.

For these few with IED this may be an adequate category.

But most of those who meet criteria for IED are angry.

Anger and IED

IED is inadequate for most people with anger symptoms.

Most IED and aggressive clients have high trait anger when they aggress. Thus, they are not adequately described by IED.

Anger and Emotional Disorders

- What about other disorders of excess affect such as anxiety and mood or depressive disorders?
- Do these disorders account for anger symptoms?
- NO.

Figure 4. Frequency of Emotional Disorders and Anger Symptoms & Comorbide Cases. N = 1774.

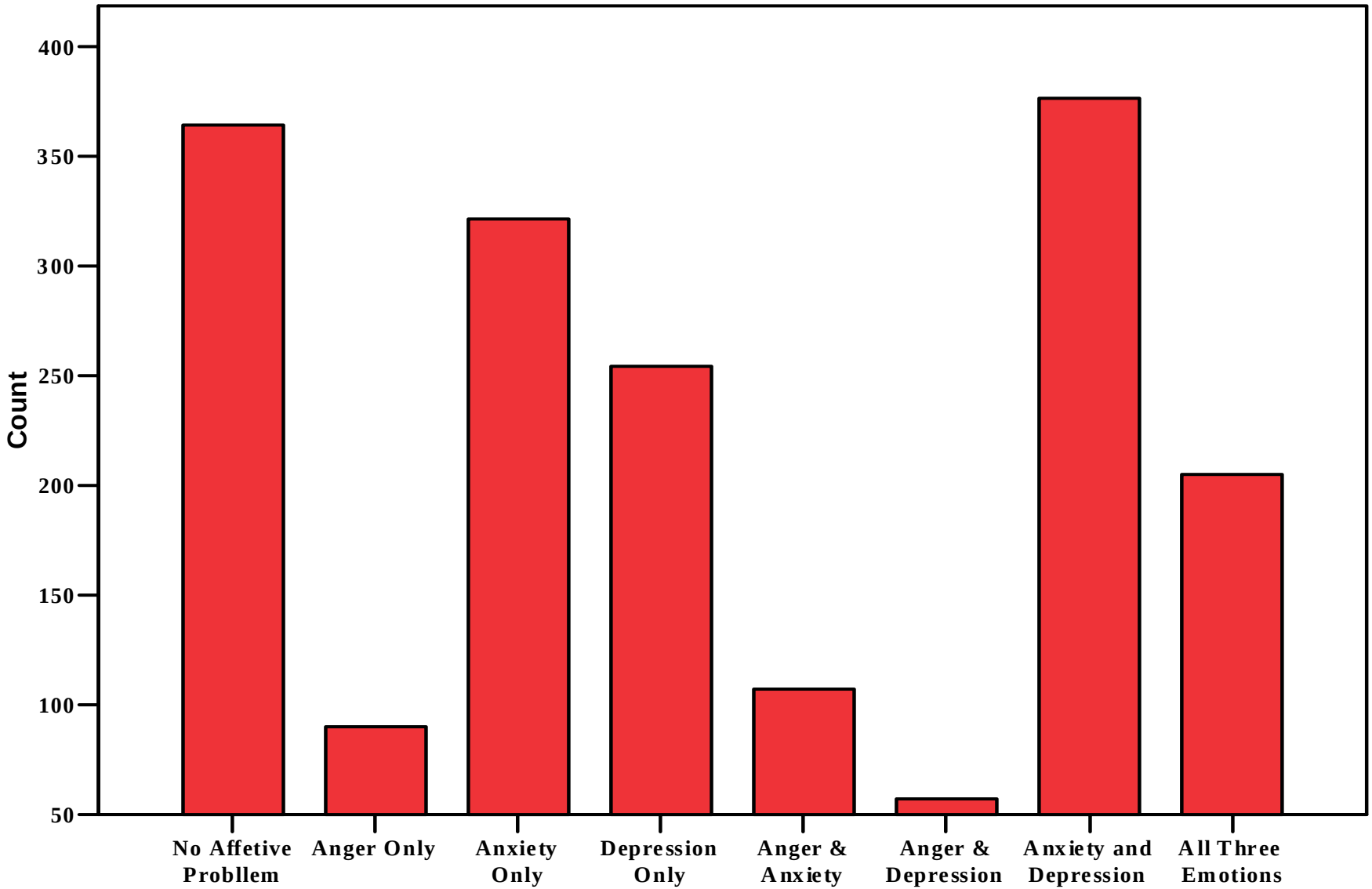


Figure 4A. Percent of Patietns with Emotional Disorders, Anger Problems & Comorbidity. N = 1774.

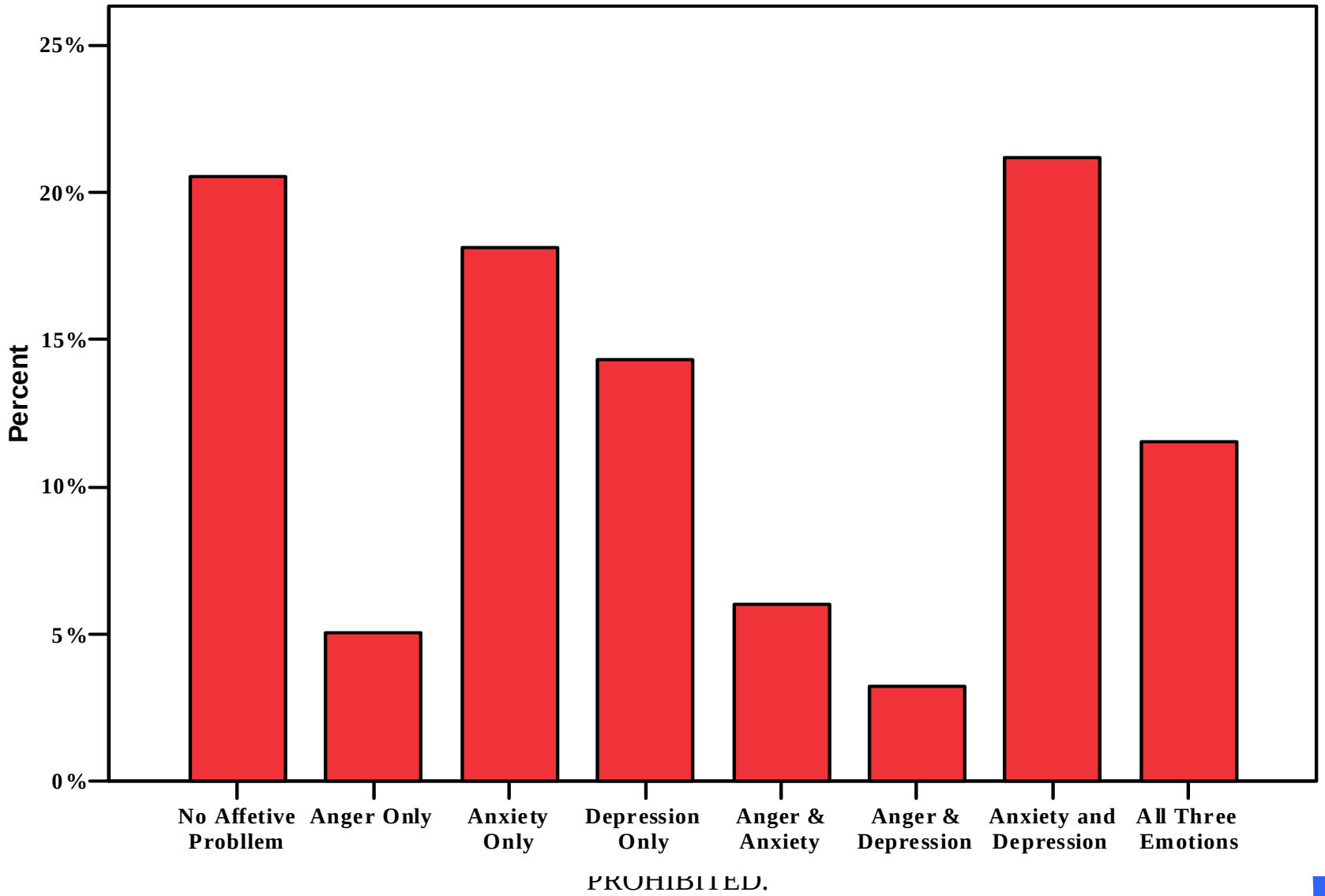
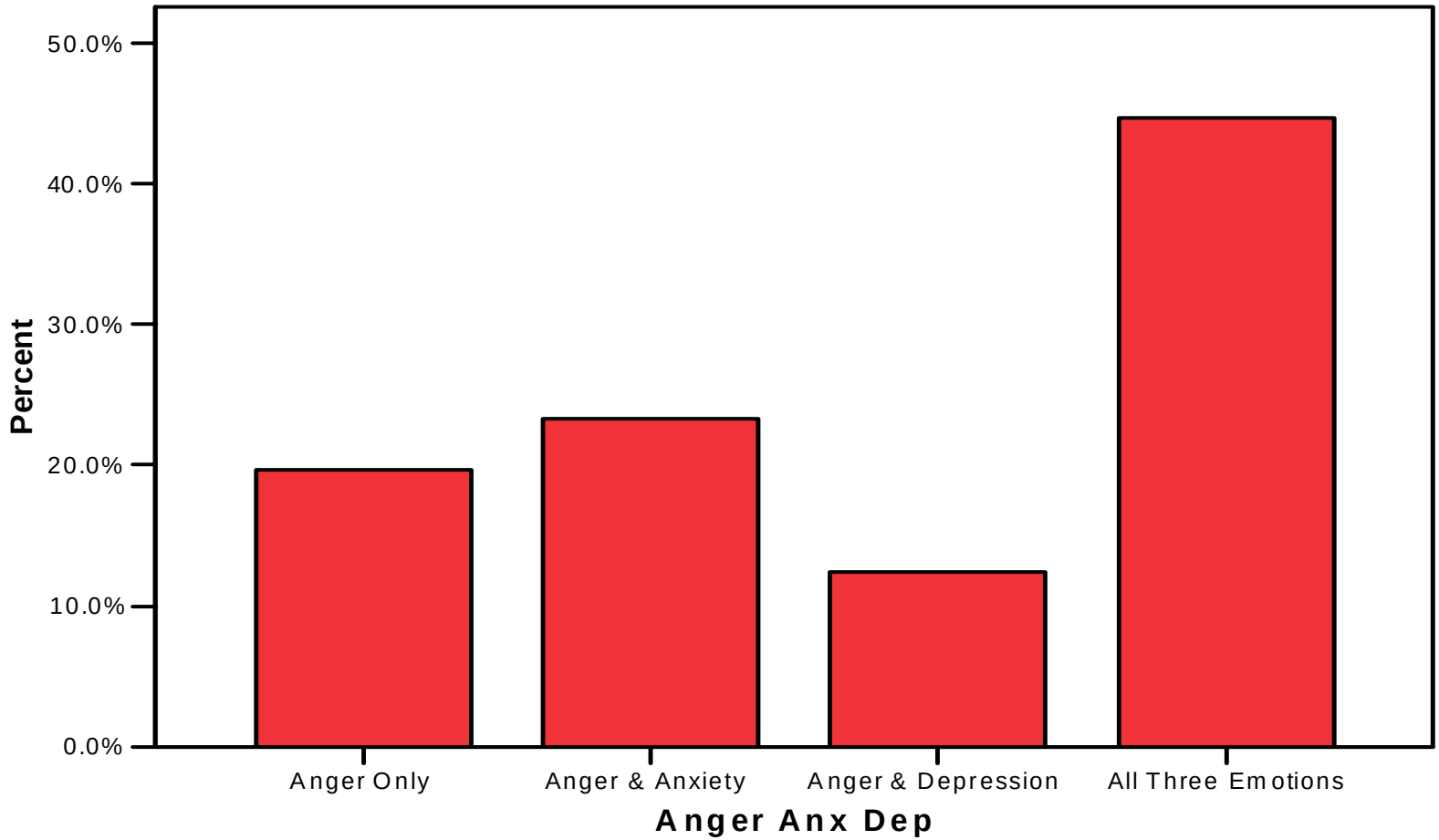


Figure 4B. Clients with Anger Symptoms

with and without Other Emotional Disorders, N = 459.



Anger and Emotional Disorders

Anger is comorbid more frequently with anxiety than depression, despite the focus on depression.

Anger symptoms occur more frequently with anxiety & depression.

Perhaps we need a disorder of excessive affect.

Anger without other disturbed affect occurs less frequently than anxiety and depression do alone, but still frequent enough to be a disorder in its own right.

The most common comorbid Anxiety Disorder is not GAD or PTSD.

It is Social Phobia.

Anger and Depression

- Most People Still think That Anger is part of depression,
- Our research on several hundred psychiatric outpatients indicates that the comorbidity here is complex. What is secondary?
- We find equal numbers of people with
  - Only anger problems
  - Only depression problems
  - Anger and depression mixed

Figure 10.1

Depression as Anger Turned Inwards

Loss of significant other

↓

Anger (& sadness)

↓

Fear of negative sanctions for expression of anger

↓

Depression

Interventions for depression focus on unexpressed anger. In cases of clinical depression, the anger is unconscious.

Figure 10.2

Anger as a Defense Against Depression

Parental loss or separation

(Later theorized to be lack of parental care)

↓

Depression

↓

***A*nger**

(Anger is a defense against depression)

Interventions for anger focus on the underlying depression. Defenses may fail in individuals with severe disturbance. Thus anger and depression may be experienced together.

Figure 10.3

Depression as Inhibited Anger Expression

Current or unresolved social conflict

↓

Anger

↓

Fear of negative sanctions for expression of anger

↓

Depression

(Later theorized to be hurt)

Interventions for depression focus on the unexpressed anger or on the issue that elicited the anger.

Figure 10.4

Anger-Effort-Failure-Hopelessness

Anger

↓

Sense of efficacy and motivation & attempts to cope

↓

Repeated failure to produce desired outcomes

↓

Hopelessness

↓

Depression

Figure 10.5

A. T. Beck=s (1976) Unique Alternating Cognitions Theory

Individuals experience depression and anger serially, not simultaneously, as a result of distinct cognitive processes. Treat each process separately.

Anger Disorder Scale

Revised seven times

Multi-dimensional nature: 5 Domains and 18 Subscales.

Each factor or sub-scale has implications for treatment and represents an aspect of anger observed in clients.

The number of sub-scales reflects our beliefs concerning what a clinician should know to plan effective treatment.

Anger Disorder Scale

Behavior Domain
- < Verbal aggression
- < Physical aggression
- < Passive aggression
- < Indirect aggression
- < Relational aggression
- < Anger in

Arousal Domain
- < Duration of Axis I Problem
- < Episode Length
- < Physiological reactivity

Anger Disorder Scale

Cognitive Domain

- < Rumination
- < Impulsivity
- < Suspiciousness
- < Resentment

Provocations

- < Hurt / Social Rejection
- < Scope of anger

Anger Disorder Scale

Motives Domain

- Coercion
- Revenge
- Tension Reduction

Higher Order Factor Score

- Verbal Expression
- Anger In
- Vengeance

Anger Disorder Scale

- This scale clearly distinguishes Angry clients and forensic samples from:
  - Normal controls
  - General Psychotherapy Outpatients

Nature of Disturbed Anger

- Several things that are thought to be true about anger were not supported by our data.
- Is anger an impulsive emotion?
- Are Anger In and Anger Out orthogonal constructs?
- Does the distinction between instrumental and affective aggression still hold.
- Are men more angry?

Types of Anger Disorders

More than 950 people who scored in the top 10% on the Anger Disorder Scale total or factor scores. They came from:

- High scorers from the standardization sample.
- Study of Angry Drivers.
- Prison Inmates: Men, Women, Sex Offenders.
- Referred for Forensic Evaluations.
- General psychotherapy outpatients (AEI)
- Patients referred for anger

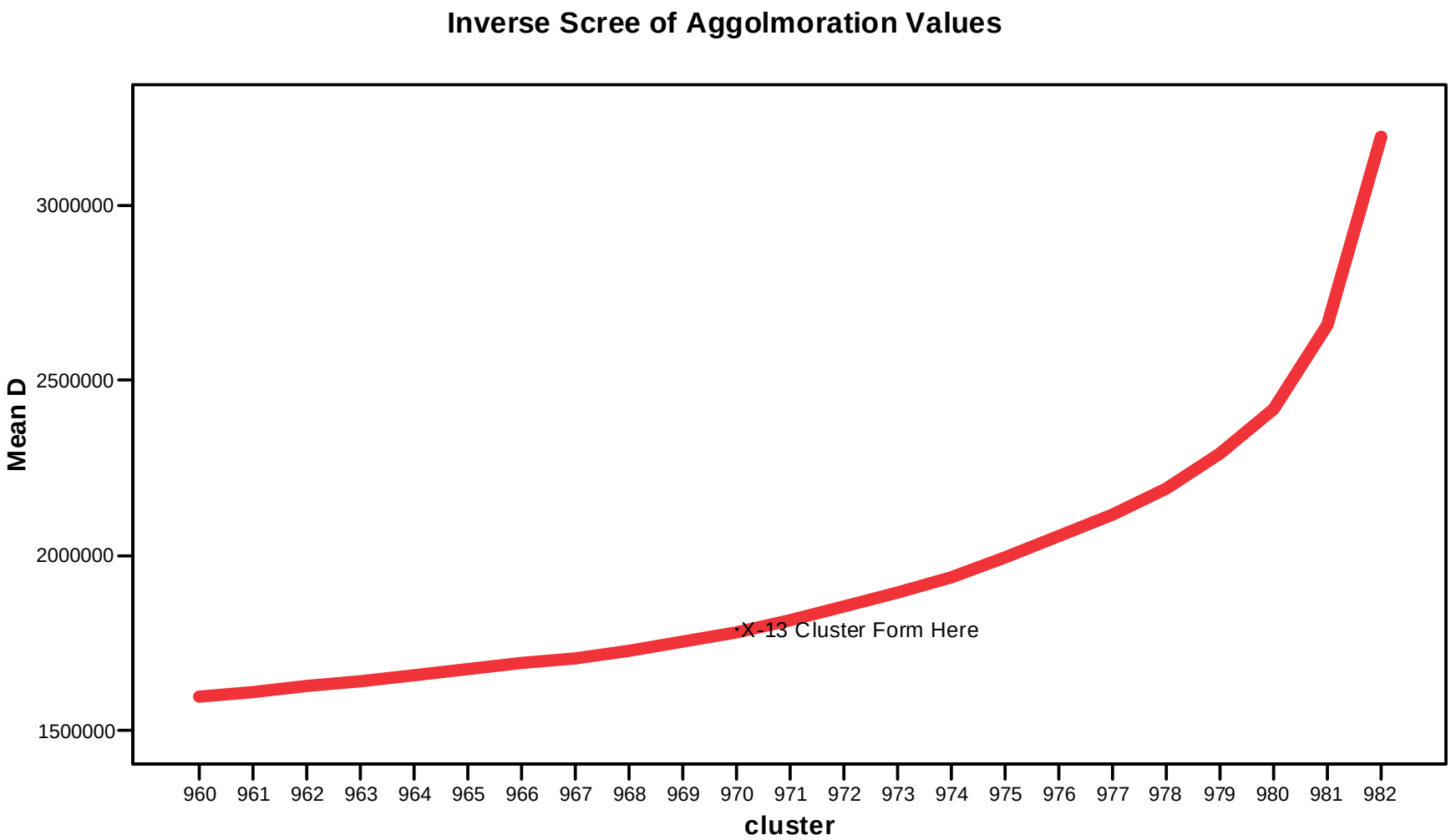
Cluster Analysis

- Ward's Method
- Squared Euclidian Distances
- An Inverse Scree test of the Agglomeration values created the Clustering Analysis.
- 13 clusters were identified as the best fit.
- We analyzed 12,14 & 15 cluster solutions.
- We then used Discriminate Function Analysis to confirm the results (Percent of accurate classification).

Cluster Analysis

- This uses the subscales to predict cluster membership. Also, Kappa coefficients were used to see which solution produced the most reliable categories.
- More clusters produced different levels of the same patterns.
- Fewer clusters missed some important groups.

Table 2

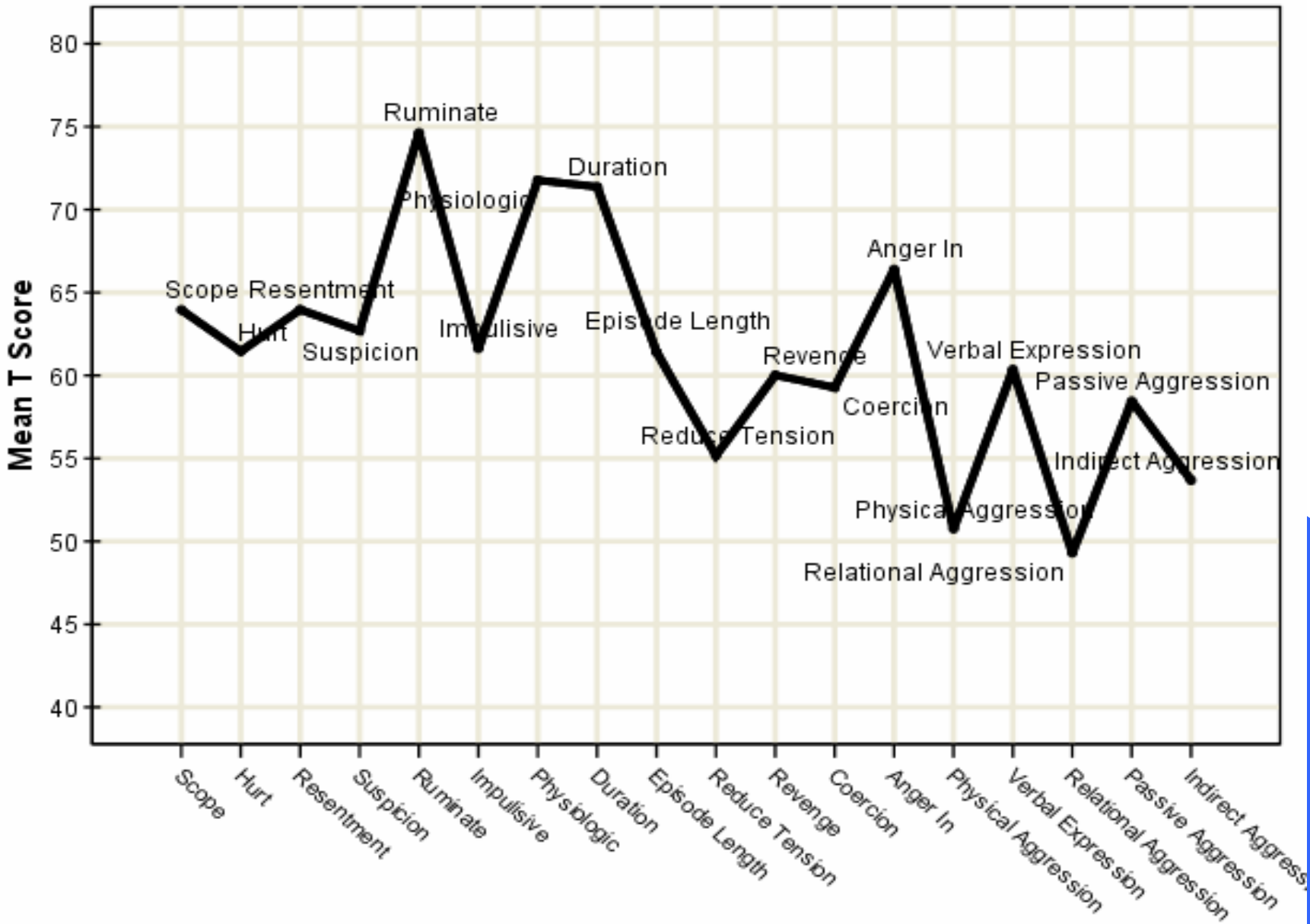


PROHIBITED.

Anger In Clusters

- Several clusters characterized by Anger In.
- They had some elevations on Passive Aggression.
- Anger-In is characterized by Suspiciousness and resentment.
- Triggered by social rejection.

Figure 15.7
The Low-Intensity, Hostile Attitudes, Anger-In Cluster

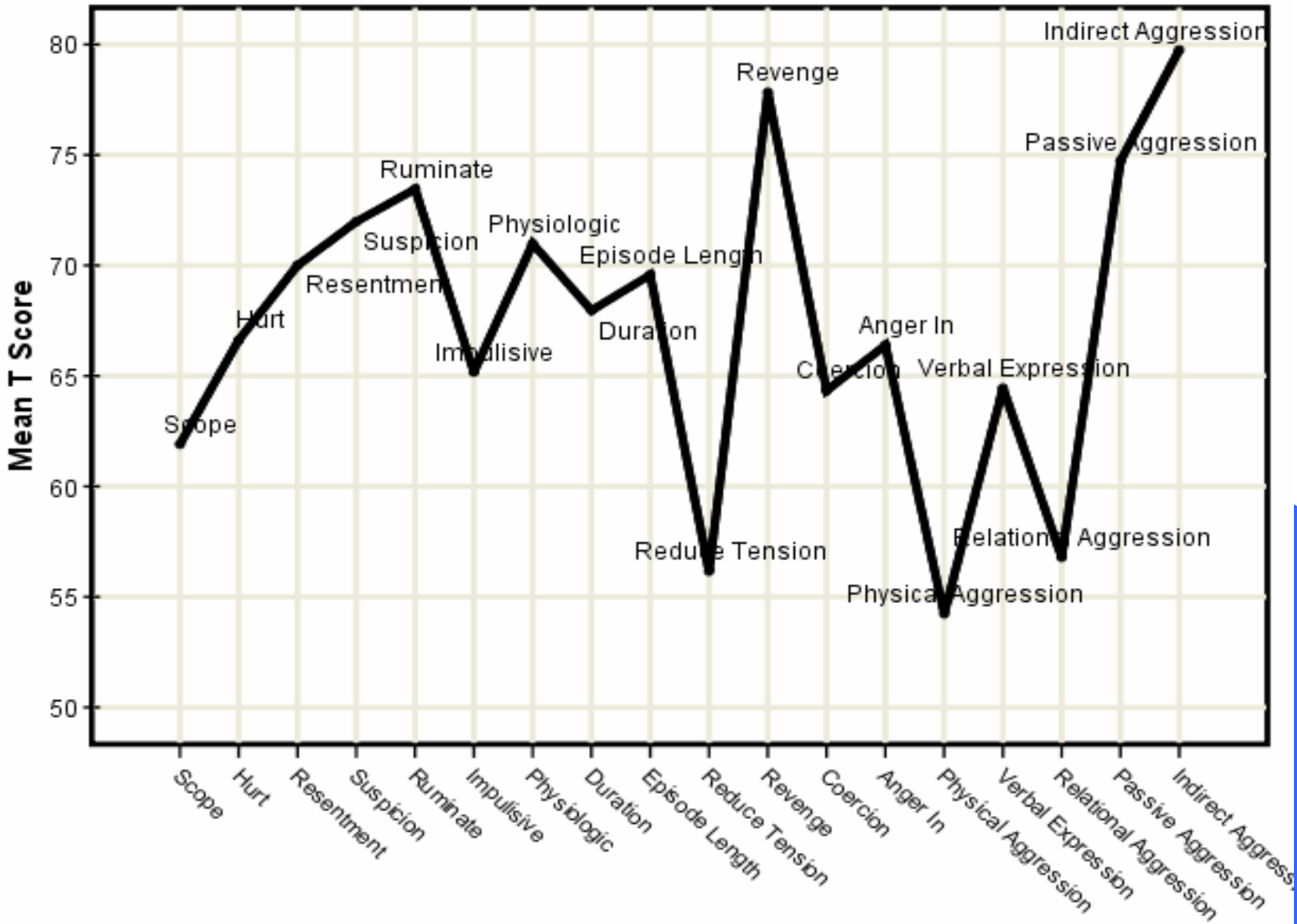


Anger - In

- Anger-In is supposed to be orthogonal to Anger-Out.
- We found that for each sample and for the ADS and the STAXI-2, Anger-In correlated significantly with Anger-Out (STAXI-2) and with the ADS Verbal and Physical Aggression.
- Perhaps the relation between anger and aggression is continuous.

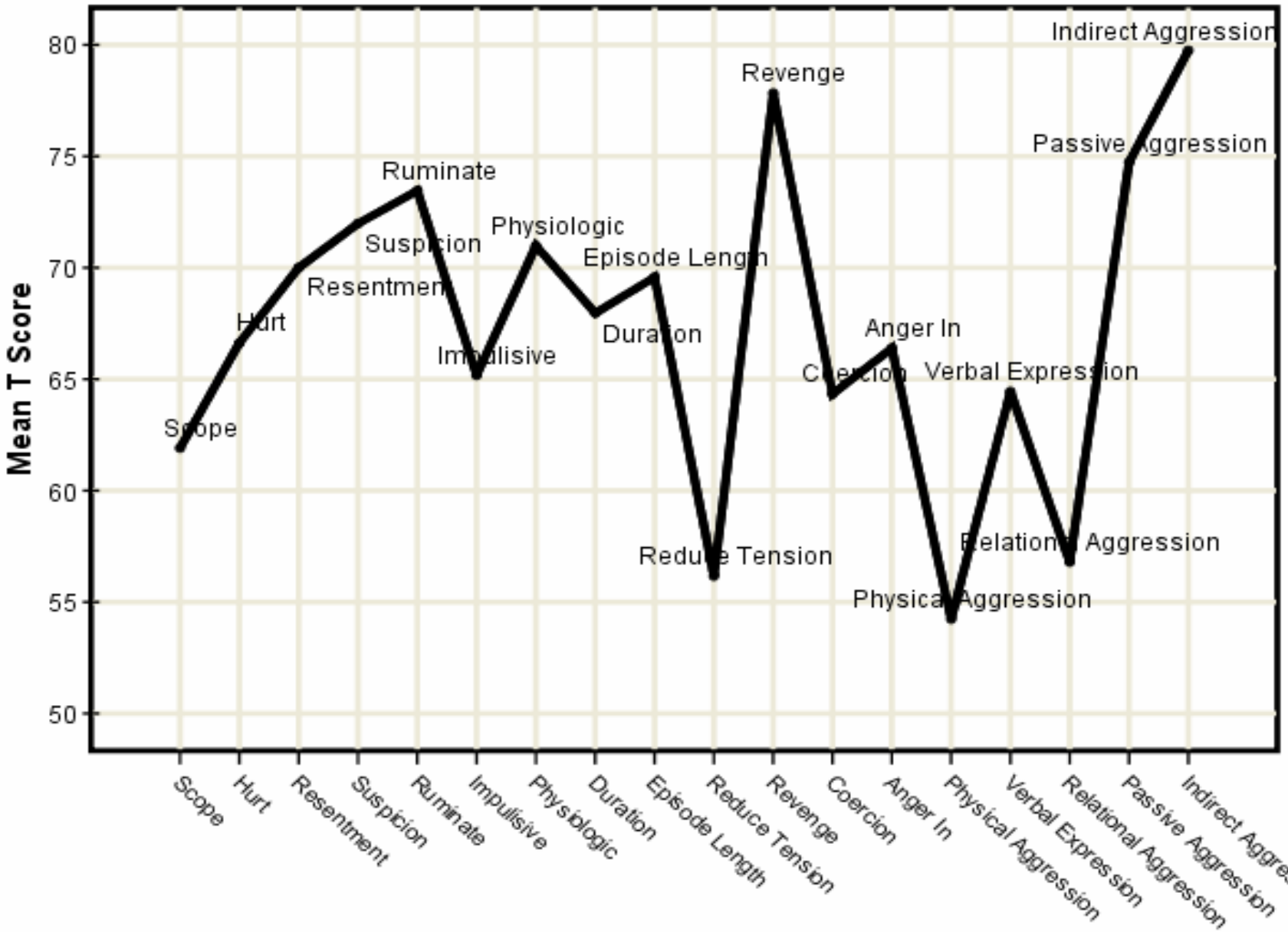
Non Confrontational Anger

- Not all aggression is impulsive, or confrontational.
- This cluster is vengeful, ruminative and non impulsive.
- The dominance of the Instrumental / Affective-Impulsive aggression distinction has blinded us to planned anger motivated aggression.



Revenge Motives

- Psychology does not study revenge. Go to the English or Classics Departments to learn about it.
- A rich source of stories since Sophocles' *Ajax*.
- Few references in Psychological abstracts on Revenge.
- Revenge on Managed Care is the main reference.
- If you want to know about revenge, watch the Opera *Rigoletto*, read the classic *The Iliad*, go see the musical *Sweeney Todd -The Demon Barber of Fleet Street*.

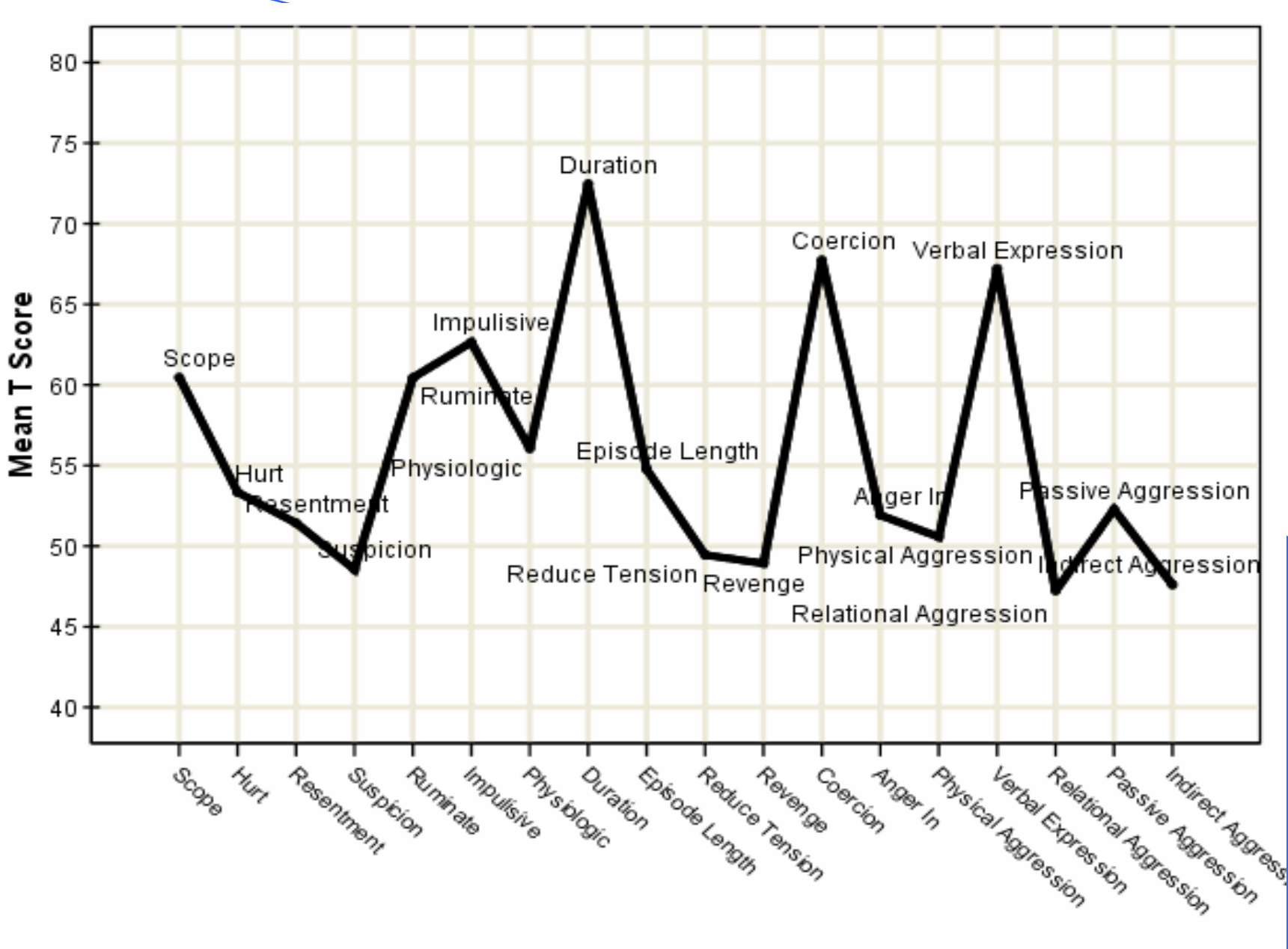


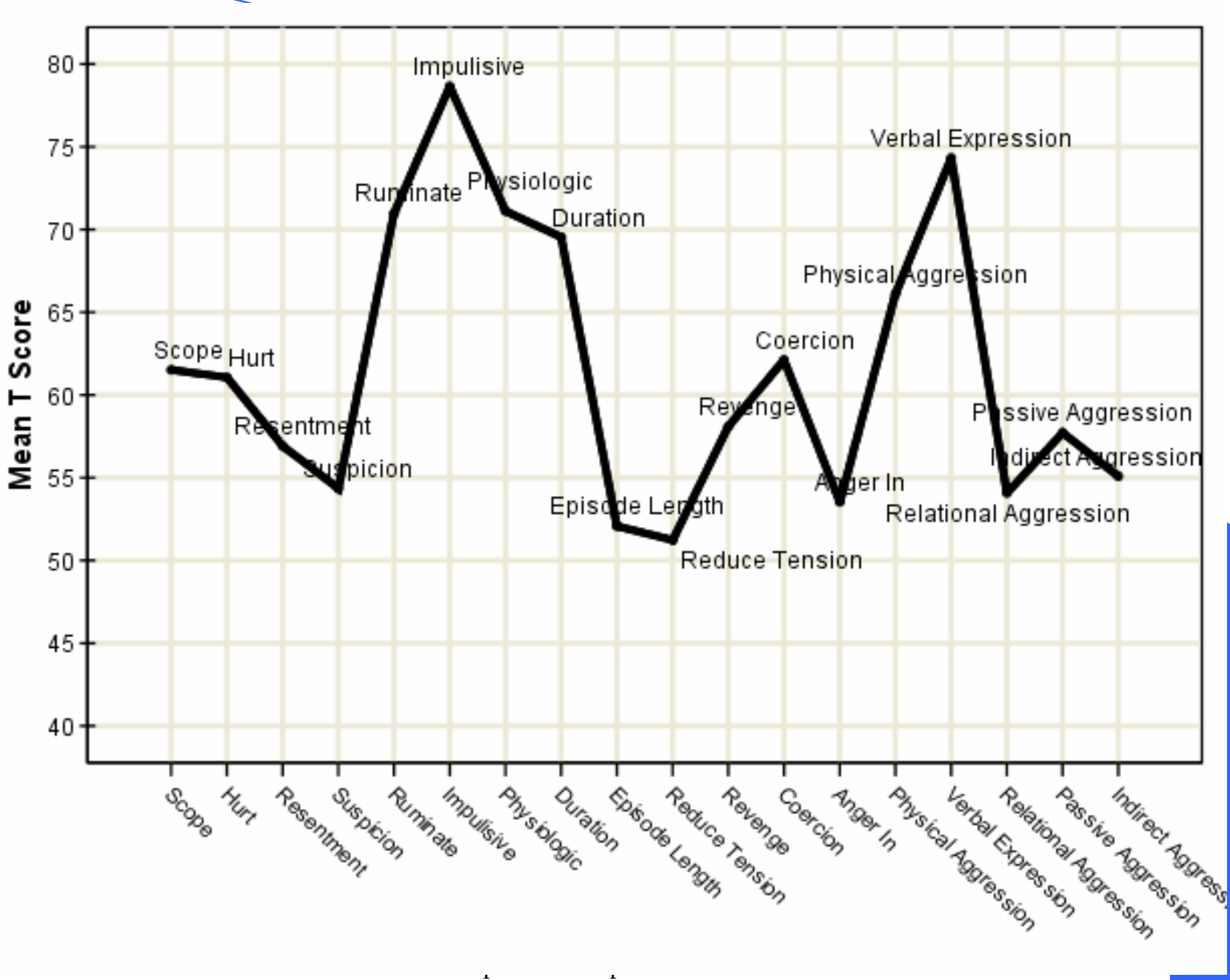
Coercion as a Motive

- The instrumental versus affective aggression distinction suggests these are independent or different types of aggression
- Bushman & Anderson (2001) have challenged this and we agree.
- Many angry clients scored high on our Coercion subscale.

Impulsivity

- Most theorists distinguish between affective and instrumental anger
- Affective anger is supposed to be impulsive.
- Our path analysis suggests rumination causes impulsivity.
- Most people ruminate before they transgress.
- Very few people are impulsive without ruminating.

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80
75
70
65
60
55
50
45
40
Impulisive
Verbal Expression
Ruminate
Physiologic
Duration
Physical Aggression
Coercion
Scope
Hurt
Revenge
Resentment
Suspicion
Anger In
Relational Aggression
Episode Length
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Suspicion
Ruminate
Impulisive
Physiologic
Duration
Episode Length
Reduce Tension
Revenge
Coercion
Anger In
Physical Aggression
Verbal Expression
Relational Aggression
Passive Aggression
Indirect Aggress

Impulsivity

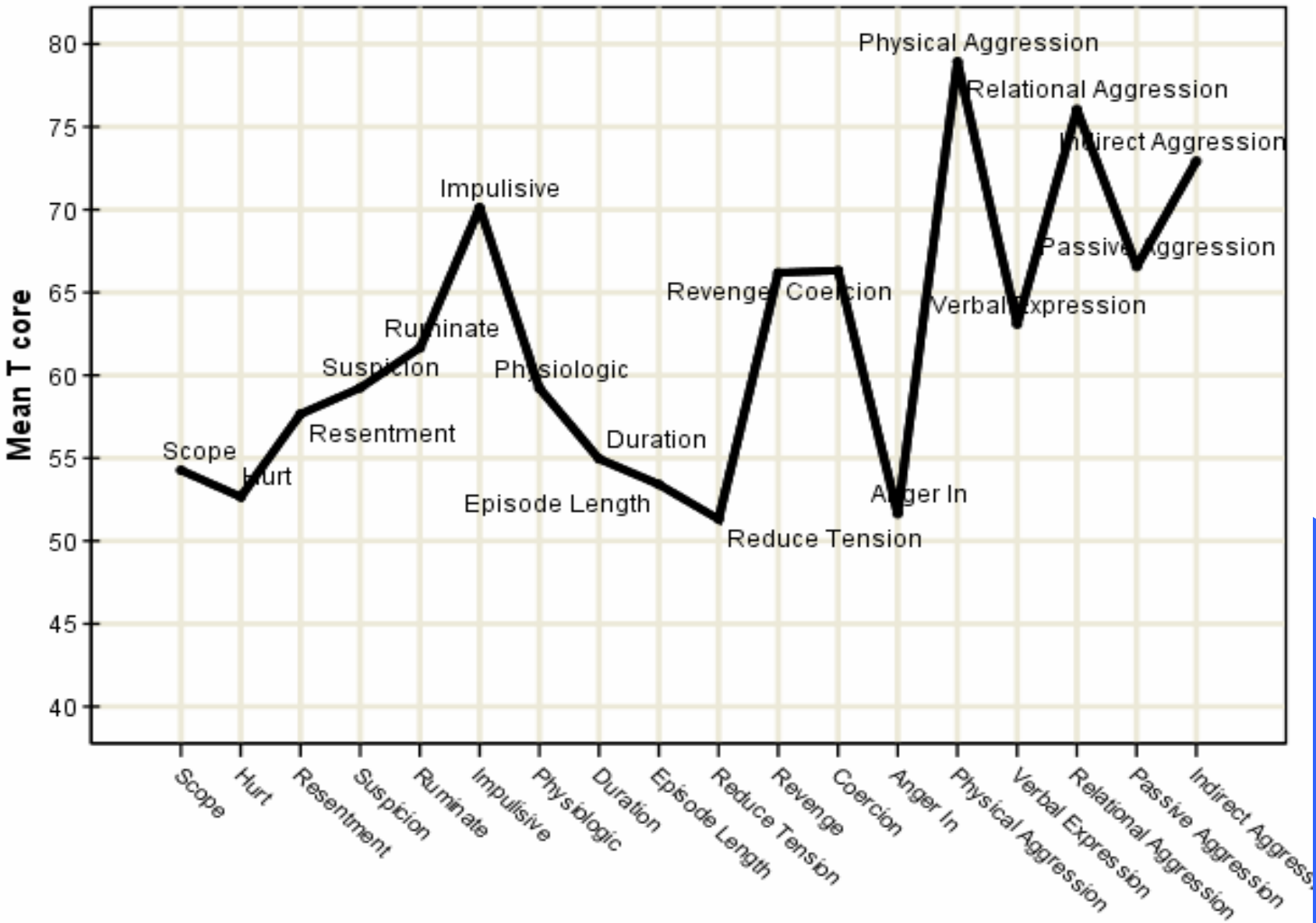
- Most angry clients have rumination and anger-in besides anger-out.
- Treating their impulsivity will not help totally
- Self control is like a muscle and it tires (Baumeister, 2003).
- Reducing rumination will lead to fewer aggressive incidences.

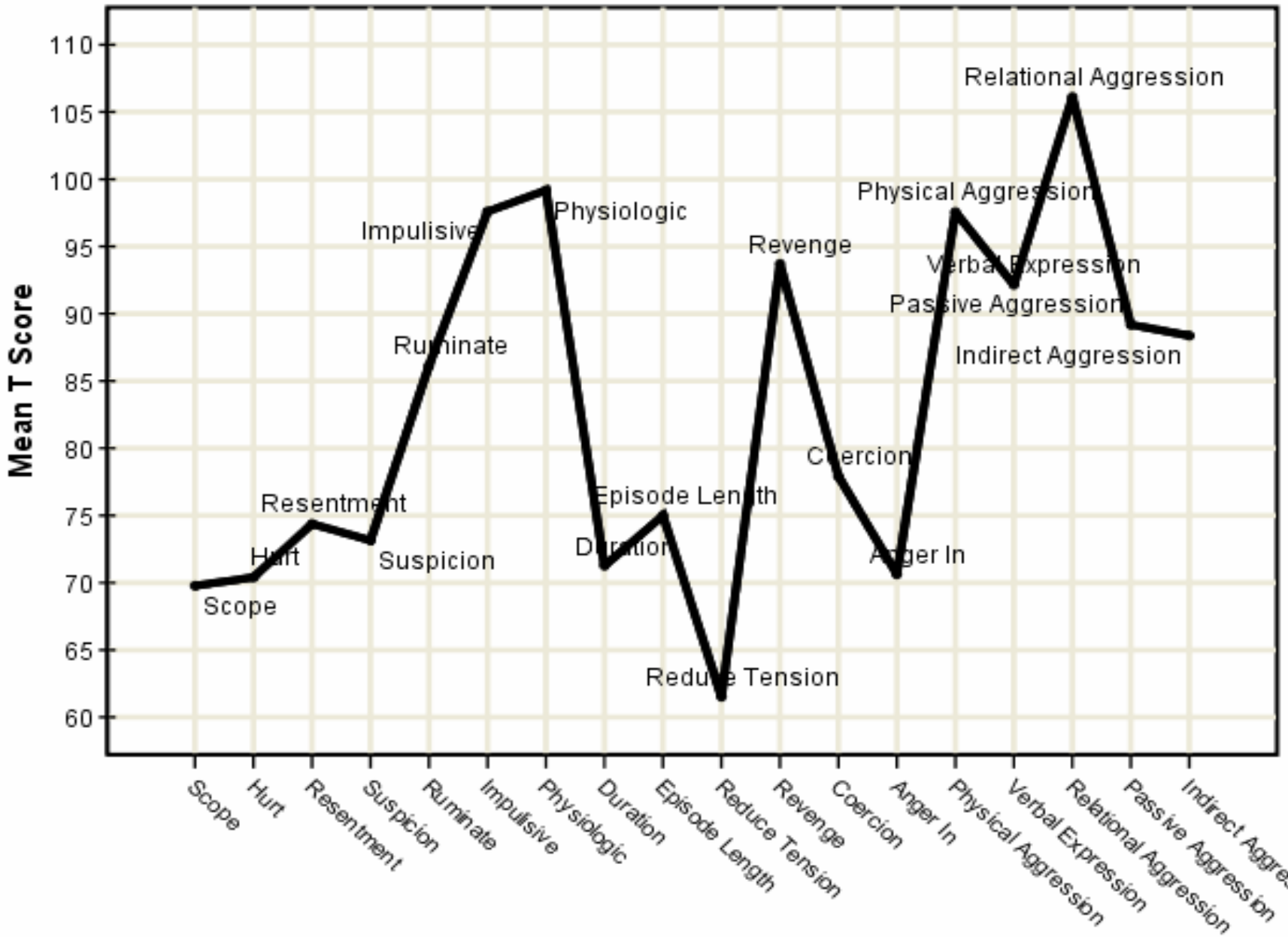
Impulsivity

- Affective anger is supposed to be impulsive.
- Impulsivity and Rumination are strongly correlated in adults.
- They cannot be separated as separate scales in adolescents.
- Most people ruminate before they aggress.
- Very few people are impulsive without ruminating.

Pure IED?

- We get a group that is impulsively aggressive without being angry.
- These people were high scorers in standardization sample, not from any clinical group.
- Most clusters have anger in and rumination in addition to impulsivity.





Structured Interview For Anger Disorders (SIAD)

Structured Interview assessment and closed ended questions may be more helpful and yield more information.

Presently we have been able to discriminate between those referred to anger clinics and normal community control.

Anger Regulation and Expression Disorder (ARED)

- Three subtypes

  Same as IED. Perhaps we have not found impulsively, moderately angry, non ruminative patients.

  High Anger confrontational aggression below the criteria set by IED Coccaro's new definition.

  High Anger with Anger-In only or non-confrontive aggression.

What is Needed?

- Studies comparing our measures with angry clients and clients with other known diagnoses.
- Etiological factors.
- Biological markers.
- Treatment utility

Clinical Implications

- Assessment
- Treatment

Anger Assessment

- 1) Total scale scores may be in the normal range yet the person may experience a clinical problem with some aspects of anger. Total anger scores may not be as informative.
- 2) Since people think anger is not a problem, they may not store all of the information together. Open-ended questions may not be as helpful as is usually the case as in other disorders.

Anger Assessment

- 1) Total scale scores may be in the normal range yet the person may experience a clinical problem with some aspects of anger. Total anger scores may not be as informative.
- 2) Since people think anger is not a problem, they may not store all of the information together. Open-ended questions may not be as helpful as is usually the case as in other disorders.

Research on Anger Treatments

- We completed a meta-analytic review of anger treatments
- DiGiuseppe, R., & Tafrate, R. (2003). Anger treatments for adults: A meta- analytic review. Clinical Psychology: Science and Practice, 10 (1) 70-84.
- Several conclusions emerge from these reviews that direct successful treatment of anger

Research on Anger Treatments

- First, optimism is justified.
- Successful treatments for anger exist with adults, adolescents, and children.
- Anger treatments appear to work Researchers have applied treatments to college students selected for high anger, volunteered angry men, outpatients, spouse abusers, prison inmates, special education populations, and people with medical problems, such as hypertension or medical risk factors like type A behavior.

Research on Anger Treatments

- Treatments are equally successful for all age groups and all populations.
- Anger treatments are equally effective for men and women.
- However, this enthusiasm is tempered by one limitation of the anger outcome research.
- Most studies used volunteers.

Research on Anger Treatments

- Many practitioners treat angry clients whom courts, employers or spouses have coerced into treatment ("You should get help or I am leveling you").
- The research participants used to date may not represent the clients who actually present for treatment. This may mean that actual clients have less of a desire for change than the volunteers. We will return to this point later.

Research on Anger Treatments

- Second, the change is of a large magnitude.
- The upward range of effect sizes is less than the upward range of effect sizes reported in meta-analytic reviews of treatments for anxiety and depression.
- The upward range of effect sizes for Cohen's d statistic in anger treatments is 1.00.
- The upward range of the effect sizes in treatment studies of depression > than 3.00 and for anxiety, more than 2.00.

Research on Anger Treatments

- As Norcross & Kobayashi (1999) lamented, we cannot treat anger as successfully as we do other emotional problems. We still need new creative interventions.

Research on Anger Treatments

- Third, treatment effects appear to last.
- We analyzed the effect sizes of all the anger outcome studies that included follow up measurements (DiGiuseppe, & Tafrate, 2003).
- Most studies held the gains accomplished at post tests or and some even improved more at follow up.

Research on Anger Treatments

- Studies that maintained their effectiveness at follow up used interventions that incorporated multiple interventions. Arnold Lazarus' (1988) notion that multi-modal treatment produces the most long lasting change appears to apply to anger.

Research on Anger Treatments

- Fourth, anger outcome studies reveal change on different types of dependent measures, not only self reports of anger.
- Researchers have reported large magnitudes of change on physiological measures, self and other reports of positive and assertive behaviors, and with self and significant others' ratings of aggressive behavior.

Research on Anger Treatments

- This last finding may be the most important. Spouses and other family members see changes from our interventions.

Research on Anger Treatments

- Sukholdolsky & Kassinove's (1998) reported little change on measures completed by peers of children and adolescents.
- Two interpretations of these results are possible.

Research on Anger Treatments

- Perhaps peers represent the most valid measure of behavior, and people really do not change. This seems unlikely since parents, teachers, and unbiased observers all large report large changes in these studies.
- Perhaps peers stigmatize angry people, and peers retain their stereotype of angry people, despite changes made in therapy.

Research on Anger Treatments

- Fifth, symptom and treatment-modality matching has not been supported.
- Clinicians often try to match an intervention to the client's primary symptoms. This comes from the generally accepted notion that the treatment modalities will effect their corresponding outcome measures.

Research on Anger Treatments

- Sixth, 80% of all published and non published research studies employed group therapy.
- We would speculate that the majority practitioners treating anger problems work in correctional facilities, substance programs, hospitals, residential centers and schools regularly employ a group format.

Research on Anger Treatments

- Our meta analytic review indicated that the group therapy format had significantly lower effect sizes than individual therapy intervention on measures of aggression.
- Group and individual anger interventions are equally effective on measures of anger, assertion and physiology.

Group Therapy?

- Do not allow reinforcement of antisocial attitudes and behaviors.
- Be careful of personal feedback among members. It could lead to personal attacks.

Research on Anger Treatments

- Seventh, studies that use of treatment manuals and integrity checks to ensure that therapists follow the manual both produced higher effect sizes than ones who did not use manuals or integrity checks.
- This finding, again, occurred only for measures of aggression. If one want to reduce aggressive behavior use treatment manuals and monitoring of the therapists.

Research on Anger Treatments

- Finally, most of the empirical literature (forty-five for adults and forty for children and adolescents), tested either behavioral, cognitive, or cognitive behavioral therapies.
- Two studies evaluated mindful meditation, which could be considered a Buddhist intervention.
- One study included Yalom's process oriented or experiential group therapy.

Research on Anger Treatments

- The most widely supported anger treatments included :
- a) relaxation training.
- b) cognitive restructuring as proposed by Beck, Ellis, Nezu, and Seligman.
- c) exposure -learning new response to anger triggers.
- d) rehearsal of new positive behaviors to resolve conflict.

Research on Anger Treatments

- Adherents of other theoretical orientations have abstained from empirical corroboration of their effectiveness with anger.
- We found no psychodynamic, family systems, gestalt, or client-centered research studies upon which to draw.
- The absence of so many theoretical orientations from the outcome research literature

Characteristics of Anger

- Because anger has received so little attention in the scientific literature, reviewing some aspects of anger that differentiate it from other emotions may be helpful.
- This may provide some insights into aspect of anger that therapists could target in interventions that have not already been included in the existing anger outcome literature.

Motivation for Change

- People feel little desire to change or control their experience of anger. The only emotion that people are less likely to want to change is joy (Scherer & Wallbott, 1994).
- This feature of anger poses the greatest problem for therapists.
- Angry clients do not come for therapy; they come for supervision. They have tried to change their bosses, co-workers, or mates and failed.

Aspects of Anger That Block the Therapeutic Alliance

- Emotional responsibility and other blame.

- This refers to the failure to take responsibility for one's emotions and assign responsibility for emotions to external events. It is common to hear angry clients report, "He (She or It) made me angry." As long as the cause of anger lies outside of themselves they are unlikely to act to change it. Since someone else is responsible by behaving badly, that other person needs to change.

Aspects of Anger That Block the Therapeutic Alliance

- Other condemnation

- This refers to the fact that anger usually involves the cognition that the target of one's anger is a totally worthless human being. Since the target of their anger is such a worthless condemnable individual, it is his or her responsibility to change. The worthless individual is perceived as deserving of the anger outburst or at least of contempt.

Aspects of Anger That Block the Therapeutic Alliance

- Self-righteousness Anger is a Moral Emotion

- Angry patients usually report believing that they have been treated unfairly. The transgressor is portrayed as morally wrong while the patient sees him/her self as the aggrieved party. Self-righteousness leads one to believe that justice and God are on his or her side.

Aspects of Anger That Block the Therapeutic Alliance

- Cathartic expression

- Most angry clients maintain the belief that one must let out their anger. Our American culture seems to promote a hydraulic model of anger along with the notion that it must be dissipated or it will build up and explode. Clients believe that holding in their anger will eventually lead to greater anger outbursts and that anger expression is healthy and necessary.

Aspects of Anger That Block the Therapeutic Alliance

- Short term reinforcement

- Patients are often reinforced for their tantrums by the compliance of others with their requests. These rewards appear to be offset by the negative consequences of using coercive processes in a relationship. Significant others often comply, and they remain resentful, bitter and distant. Angry clients are unaware of the negative effect their anger on others. Attention to the short-term reinforcement of one's behavior and ignoring of the long-term consequences of the behavior is a common human foible and is referred to as a social trap.

Aspects of Anger That Block the Therapeutic Alliance

- Angry clients often have difficulty forming an alliance with therapists because therapist and client fail to agree on the goals of therapy.
- Therapists want to change their clients' anger, and clients want
- to change their instigators or
- get revenge.

Motivation for Change

- The most frequently used and researched interventions are designed to target those in the action stage of change.
- Perhaps this explains why anger treatments fail to attain the large effect sizes as treatments for anxiety and depression.
- Anger treatment can learn much from studies of addictions treatment - Miller and Rollnick's (1991) motivational interviewing.

Transgression to Retaliation Ratio Process

- The client reveals anger and a hostile response toward the instigator..
- The clients' retaliation is more offensive than the initiator's original transgression. Clients usually fail to perceive their retaliation as excessive and usually perceive themselves as justified.

Transgression to Retaliation Ratio Process

- Since the initiator transgressed against the client, and the retaliation was perceived as justified and the client demonstrates no desire to change his or her anger and feels no remorse for the vengeful act.
- This unnerves the therapist, who perceives the lack of motivation and remorse.
- Pointing out to the client that the revenge was out of proportion to the initiator's act, the therapist tries to give the client insight into the desirability of change.

Building the Alliance with Angry Clients

- Empathy. No one likes to hug a porcupine. People usually fail to elicit empathy form others when they experience anger (Palfai & Hart, 1997).
- This suggests that since psychotherapists are people, we may often fail to experience empathy for angry clients.

Building the Alliance with Angry Clients

- 1) Assess the client's goals. The therapist needs to clearly assess whether the clients have as their goal the reason for referral. Failure to closely attend to the issue of agreement on the therapeutic goals will clearly lead to an alliance rupture.
- 2) Agree on goal to explore. If the client does not wish to change the reason for referral the therapist believes that the referral issue is a problem the therapist may suggest to the client and seek an agreement that they spend some time reviewing the functionality and adaptiveness of the reason for referral.

Building the Alliance with Angry Clients

- 3) Explore the consequences on the emotion. The therapists can lead the clients through Socratic dialogue through an analysis of the consequences of their behavior. Clients are likely to focus on the immediate consequences of their behavior rather than the longer term social consequences.
- 4) Explore alternative scripts. Once the client agrees that it is in his/her best interest to change their EMOTION, they still can be thwarted because they may not know what to replace it with. They may have a limited scheme or scripts to apply to the situation or alternative scripts may be considered socially inappropriate to the individual's status in their group.

The Motivational Syllogism

- 1) The present script is dysfunctional.
- 2) There is an alternative script which is better.
- 3) There are therapeutic tasks which can help me change from the dysfunctional script to the new script.
- 4) Therefore, it is best to engage in the therapeutic tasks.
- Repeat the steps of the motivational syllogism each time the client presents a new anger episode or when you change to a new therapeutic task.

Focus on the Consequences

- This strategy is based on research on problem solving interventions of D'Zurilla & Nezu, specifically consequential thinking.
- It helps build the therapeutic alliance by strengthening agreement on the goals of therapy.

Anger Episode Record

- Have client complete the Anger Episode Record (AER).
- Either between sessions or in session for most recent or dramatic anger episode.
- Have them complete the AER out as often as possible or whenever they get angry.

Anger Episode Record

- Fill in box for activating event.
- Rate the degree of endorsement of various cognitions.
- Rate the degree of physiological responses.
- Rate behaviors in which they engaged.

Anger Episode Record

- Rate the consequences of the anger.
- This is done as a memory prompt.
- Write in the actual consequences in the four boxes.
- Short term negative consequences.
- Long term negative consequences.
- Short term positive consequences.
- Long term positive consequences.

Anger Episode Record

- No one ever puts anything in the long term positive box.
- Then ask clients to rate the helpfulness of their anger from 0-100.
- The answers are surprising.
- Ask why they assigned such a high value.
- This reveals selective abstraction or arbitrary inference errors.

Anger Episode Record

- Discuss the reasons the assign different weights to the outcomes .
- Discuss the cost of the consequences and their relation to their goal.
- Then ask the client to re-rate helpfulness of their anger on the 0-100 scales.

Impulsivity

- Most theorists distinguish between affective and instrumental anger
- Affective anger is supposed to be impulsive.
- Our path analysis suggests rumination causes impulsivity.
- Most people ruminate before they transgress.
- Very few people are impulsive without ruminating.

Impulsivity and Rumination

- Most angry clients have rumination and anger-in besides anger-out.
- Treating their impulsivity will not help totally
- Self control is like a muscle and it tires (Baumeister, 2003).
- Reducing rumination will lead to less aggressive incidences.

Managing Physiological Arousal

- Anger often causes immediate and high physiological arousal. Lowering the bodily tension before focusing on other aspects of the treatment will help the client to attend to the interventions.128

Managing Physiological Arousal

- Include in every case
- Relaxation training
- Mediation
- Yoga

Learning New Responses

- Assertion versus aggressive response
- Angry clients often have long periods of unassertive behavior, with ruminative resentful thoughts followed by explosive, aggressive outburst.
- They need to learn to act assertively early in the sequences of events.

Cognitive Models of Anger

- Most cognitive behavioral theorists propose that the same cognitions that elicit anxiety and depression also elicit anger.

Figure 8.1

Pathways to Perception of Threat: Narcissistic Entitlement, Resentment and Suspicion

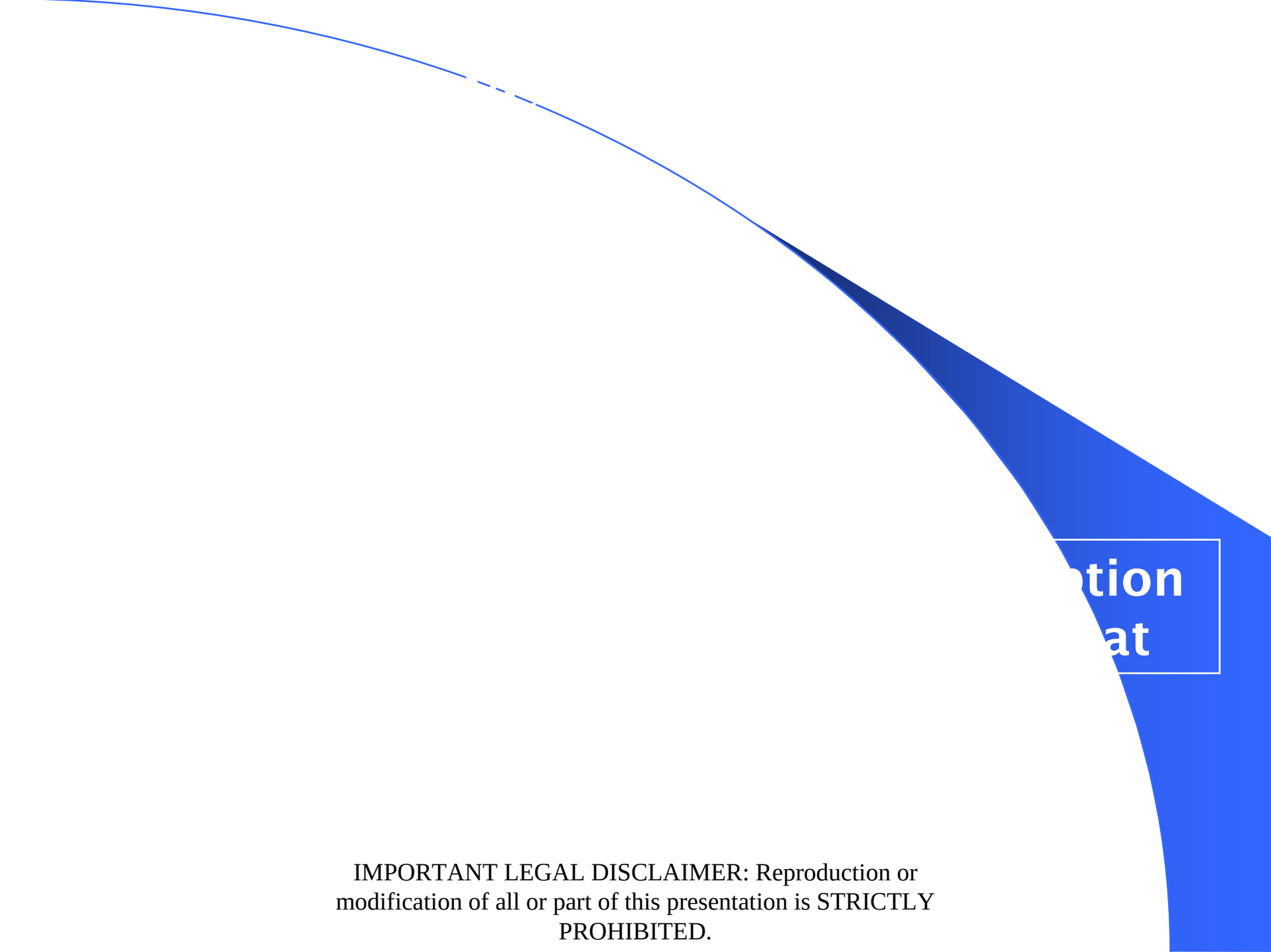


Figure 8.2

Pathways to Perception of Threat: Threat to Self-Image

A Cognitive Model of Anger

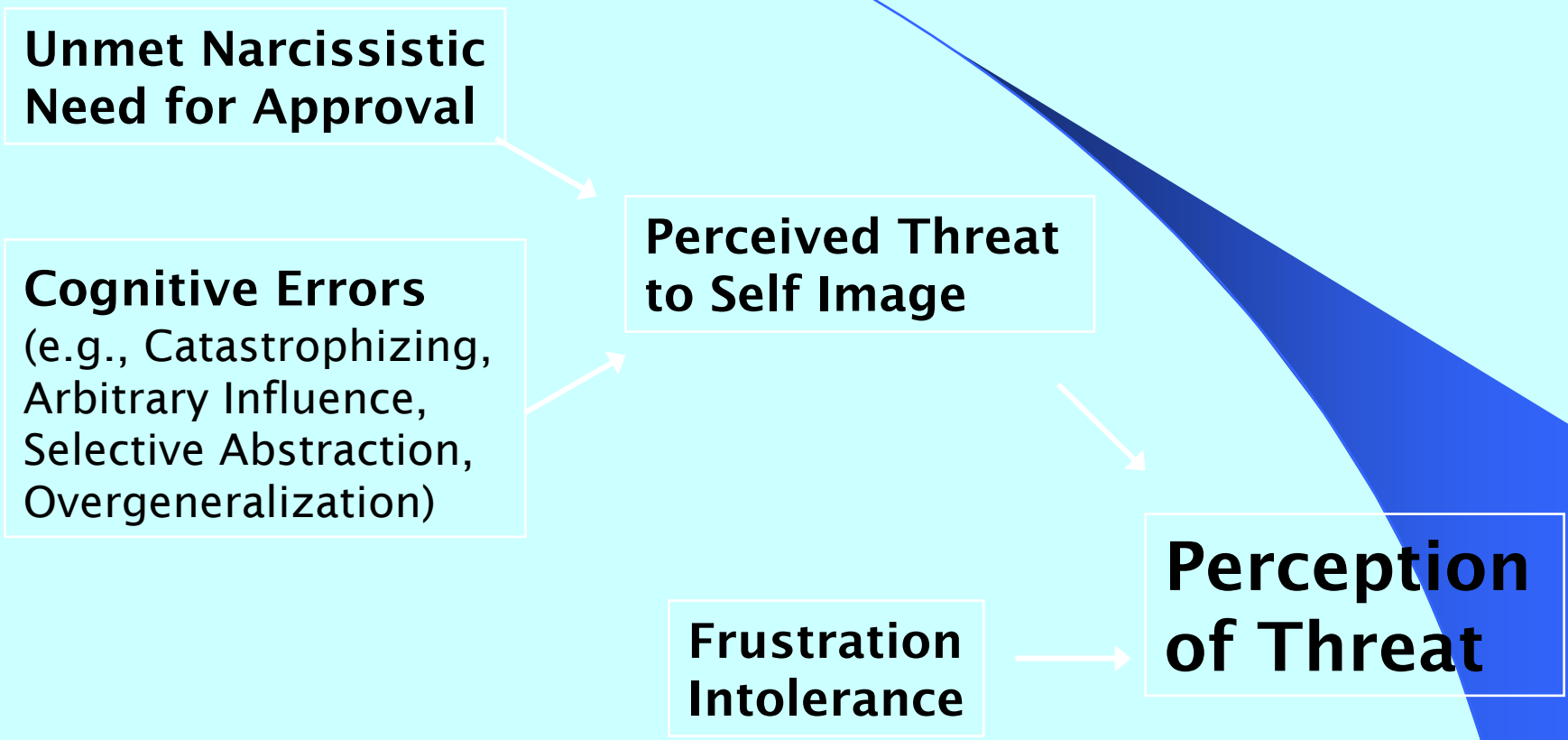


Figure 8.3

Internal Attributions for Blame Triggers Anger, Anxiety, or Depression.

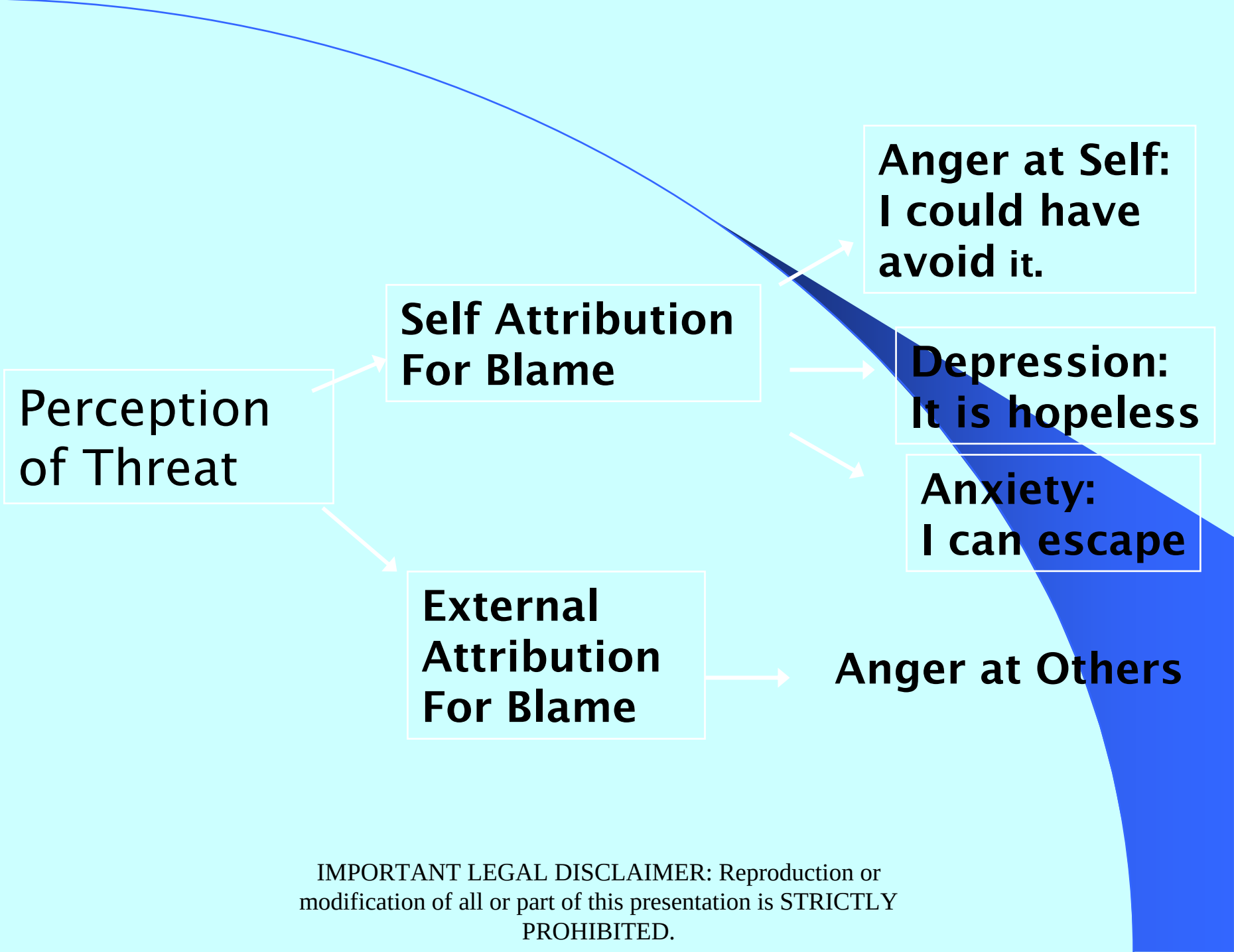
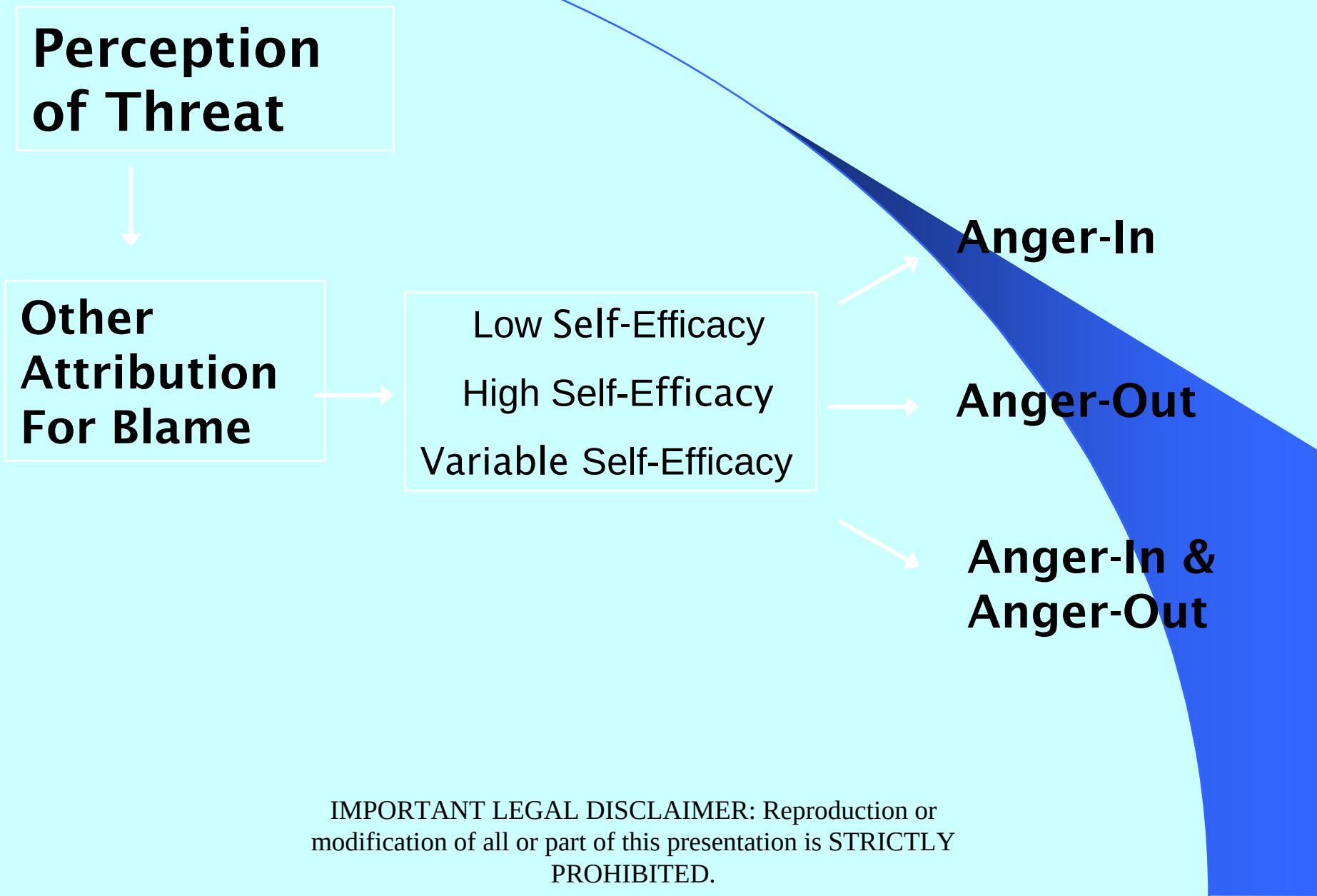
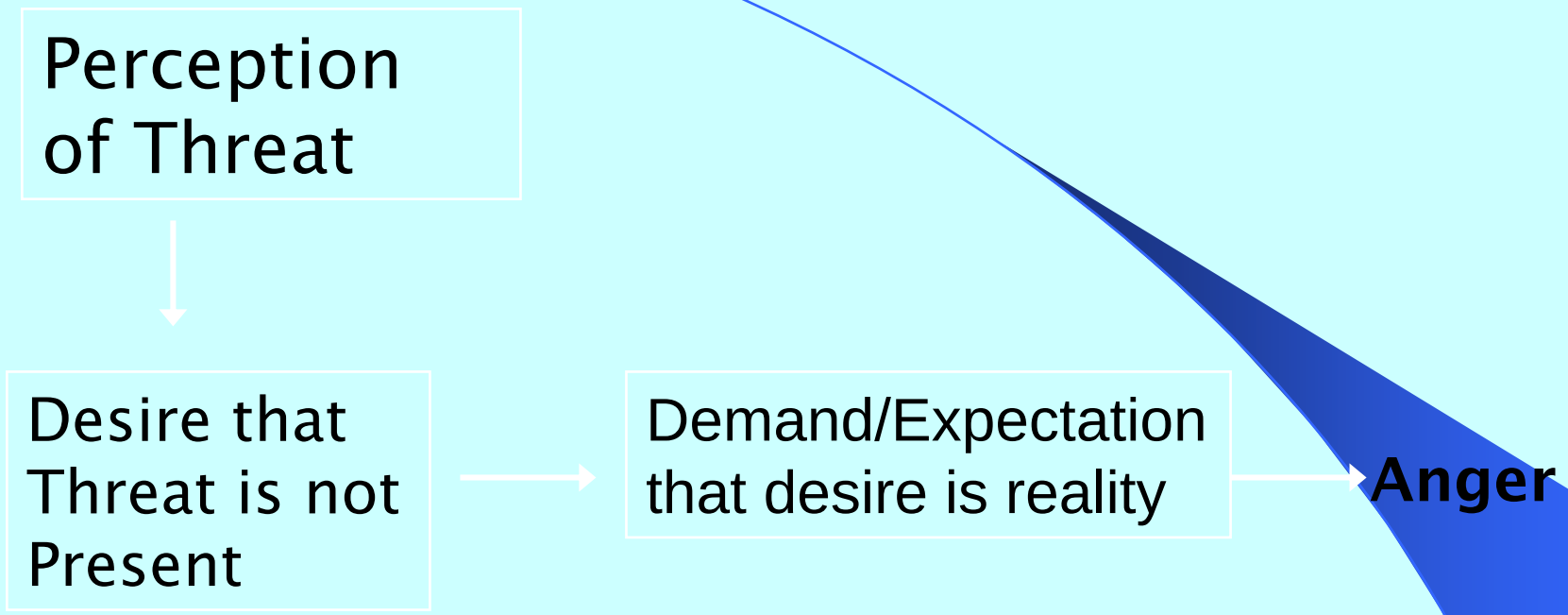


Figure 8.4
External Attribution for Blame and Self-Efficacy May Trigger Anger-In or Anger Out.



- Figure 8.5
  Desires and demands and Anger



Self Esteem?

- Anger is believed to result from low self esteem?
- Research does not support this.
- Low Self esteem leads to depression.
- How can low self-esteem lead to both depression and anger?

Self Esteem?

- Anger results from perceived threats to high, unstable self esteem (Baumeister, Smart & Boden, 1996). It is not necessarily high self- esteem, but narcissism that leads to anger and aggression. Narcissism involves passionately wanting to think well of oneself. Not all people with high self-esteem are narcissistic, but narcissists appear to have high self-esteem. Threats to self-esteem in narcissists results in increased anger and aggression (Bushman & Baumeister, 1998). Teaching self-esteem does not necessarily lead to narcissism, but it could.

Self Esteem?

- Anger includes a greater experience of power or potency than the eliciting threat (MacKinnon & Keating, 1989). Some theorists believe that anger is associated with self-efficacy.
- Roseman (1984) says that when people experience anger they believe, "...aversive events are not necessary or uncontrollable."
- Fridja (1986) noted that, "Anger implies hope."
- Several authors note that anger triggers problem solving activities to overcome obstacles to goal attainment. (Averill, 1982; Mikulincer, 1998; Scherer, 1984).

Self Esteem?

- Circumplex models of emotions suggest that anger is a high energy activation negative emotion, as opposed sadness, which is a low energy activation, negative emotion (Larsen & Diener,1992; Russell, 1980).
- Anger is the perception of an injustice or grievance against oneself (Tedeschi & Nesler, 1993).
- The perceptions of an other's blameworthiness (Clore & Ortony, 1991;1993) not self blame.
- No studies exist relating build self- esteem and reducing anger.

What Cognition To Challenge

- Our research showed that demandingness is rated most often and the highest on the Anger Episode Record.

Challenging Schemas

- Demands or schemas are cognitive expectancies about reality.
- Expectancy - reality - discrepancy leads to emotional arousal.
- Assimilate - keep the schema intact.
- Accommodate - change the schema.
- Anger results from Assimilation

Challenging Core Schema

- Not all schema accommodations lead to anger.
- The most problematic is the schema concerning the existence of things we want.
- We confuse what we want with the reality of what is.

Thought Experiment

- Imagine someone who you love and have known for a long time, a parent, mate, a sibling child, friend.
- Is there something that they do regularly that really angers you?
- Imagine that person engaging in that act.

Thought Experiment

- Have you ever had these thoughts while angry with this person?
- “I cannot believe that he or she did it again.”
- “How could he or she do it again?”

Thought Experiment

- These cognitive responses show shock.
- Count how frequently the person has done the act.
- Multiple by how much time you know them.
- They have done the act you are angry at hundreds of times, yet you cannot believe they have done it again!

Thought Experiment

- My spouse leaves the milk out on the counter every morning before work.
- How often? About 5 times per week.
- How long? We have been married for 13 years.
- She has done it 5 x 52 x 13 = 3,380 times.
- So, why are you still surprised.

Challenging Core Schema

- Demands are schemas about the reality of preferences or desires.
- Thus, we are two cognitions here.
- The desire that something occurs.
- The expectancy that it will.

Challenging Core Schema

- First, teach the client the distinction between the preference/desire and the schema/expectancy that something will or must occur.
- Second, posit or reinforce the preference/demand.
- Third, challenge the schema/expectancy/ demand that the preference must occur

Challenging Core Schema

- Fourth, develop a rational replacement idea.
- Just because I want X to happen does not mean that it must.
- This realization is often followed by problem solving to attain X or cope with no X.

Forgiveness/Revenge

- This forgiveness literature suggests that people have difficulty forgiving because of some common myths like “forgive and forget”
- People have difficulty forgetting. If they cannot forget, well may be they have not forgiven.
- Forgiveness occurs even when remembering those trespasses against you is human, (conditioning to negative stimuli is never forgotten -LeDoux, 1996).

Forgiveness/Revenge

- Forgiveness is also a conscious decision and does not gradually come over you. Only recently have the forgiveness researchers added measures of anger to their studies and so far the results have been successful (International Forgiveness Institute, 1998). Thus, most treatments for anger have left out forgiveness, which is often part of religious or spiritual institutions.

Forgiveness/Revenge

- The incorporation of forgiveness interventions may add to the cognitive component of anger treatment. Several successful outcome studies have appeared teaching forgiveness and these interventions could be added to anger control treatments.

Forgiveness/Revenge

- Spiritual forgiveness.
- Reattribution of blame by recognition of factors that “caused “ the perpetrator to act.
- Implosion? Let the image continue and assess if it satisfied.

Exposure Treatments
Conceptualizing Exposure as an Intervention for Clients With Anger Problems

- Evidence for classical conditioning of anger and exposure based emotional processing.
  No evidence for emotional processing.

- Evidence for instrumental conditioning.

- Instrumental conditioning wins

Exposure Treatments

- Exposure based on classical conditioning would
  - Have maximum arousal experienced
  - Hold the exposure of the image to sustain arousal for a long time until there is a reduction in arousal.

Exposure Treatments

- Exposure based on instrumental conditioning would:
  - Have new, different or incompatible emotional response paired with the trigger/stimulus that had aroused anger.
  - Reinforce that new response

Exposure Treatments

- Types of exposure.
- Imaginal
- video
- role play
- role play with coach
- and eventually in vivo

Reasons Exposure May Have Been Neglected for Anger

- Concerns about clients harming the practitioners?
- Concerns about the intervention causing harm to the client?
- Concerns about damaging the therapeutic relationship?

Contact Ray DiGiuseppe

Department of Psychology

St. John's University

Jamaica, NY 11439

digiuser@stjohns.edu