The evolving science of anger management

DAN SHORT

Counselling with a focus on the treatment of anger has become associated with batterer intervention programs. DAN SHORT presents mounting evidence that violence prevention programs based primarily on psychoeducational and cognitive behavioural methods are failing to prevent violence. He suggests that while some blame poor outcomes on those being treated, it is also possible that those responsible for treatment have adopted approaches that are insufficient for this particular problem. Looking to the science of emotion, it can be seen why the use of conscious deliberate cognition to regulate emotion is not effective for individuals who have long periods of intense emotional arousal. The most significant problem is the refractory period during which cognition is governed by emotion, allowing only thoughts that confirm, justify, or heighten the emotion. Short argues that for those with severe anger and rage problems, emotional process work is needed, specifically, the use of emotion to change emotion. The transformation of anger begins with a close and confident observation of what occurs, followed by the introduction of new emotional alternatives, which can then drive new ways of thinking and acting. In this way, we do not over-correct problems of excessive anger by seeking to eliminate it, but rather the experience of this emotion is transformed so it can better serve the needs of the individual and those in his or her life.

When anger becomes a problem, to the point that it interferes with a person's life, the resulting disorder is often characterised by acts of violence and/or verbal abuse. Perhaps this is why counselling with a focus on the treatment of this singular emotion has become associated closely with batterer intervention programs. While the social value of these programs is undeniable, there have been serious questions raised about their practical value (i.e., are they generally effective?). Unfortunately, the field has been characterised by an exceptionally high rate of recidivism (i.e., continued violence and abuse) and attrition (i.e., dropout).

For example, in an analysis of 25 outcome studies, Rosenfeld (1992) found that men, identified as batterers, who completed treatment had only slightly lower rates of recidivism than those who refused treatment, dropped out, or who were arrested and not referred to treatment. In another large study, researchers evaluated the outcomes of 840 individuals receiving treatment from well-established batterer intervention programs that sought to regulate anger using cognitive behavioural interventions. The results indicated that 39% of the participants reassaulted at least once during the 15-month follow-up, 70% engaged in verbal abuse, and 43% committed threats of violence during that time (Gondolf, 1997). In addition to the poor outcomes associated with traditional treatment programs, there is an exceptionally high dropout rate, in some instances as high as 90% (Gondolf & Foster, 1991). Even amongst batterers who are court-ordered, the dropout rates have been found to be as high as 69% (Babcock & Steiner, 1999).

Problems with treatment as usual

Many men who come to batterer intervention programs for anger management have problems not only with excessive intensification of emotion but also excessive deactivation of emotion. At times there is too much emotional arousal, resulting explosive behaviour, and in other instances not enough, resulting in dissociation, difficulty recognising and expressing needs, and inability to draw on social support. For these individuals, regulation of emotion is a solitary endeavour. Some rely on drugs, such as alcohol or marijuana, for their primary means of coping with emotion, while others attempt to regulate emotion using psychological methods such as situational avoidance, self-punishment, or emotional suppression.

Before coming to treatment, many have made statements such as, *"I can't talk about those topics anymore"*, or, *"We are not going to the party because I cannot handle you flirting with other men"* (i.e., the strategy of avoidance). Others will attempt to rectify the problem with harsh consequences, *"I am a complete jerk and hate myself for what I did"*, or some will physically injure themselves

after a violent outburst (e.g., smashing one's head against a hard object), in an effort to change their behaviour and to communicate remorse (i.e., the strategy of behaviour modification using self-punishment). And others attempt to manage the emotion by force of will, as reflected in statements such as, *"Next time, I am going to keep a cool head and not let things get to me"*, or *"I'm done with being angry"* (i.e., the strategy of emotional suppression). Perhaps one of the reasons these strategies fail is that none of them help troubled individuals learn how to benefit from their emotions or how to cultivate healthy emotional connection with others. This is especially problematic because effective self-regulation appears to be dependent on, and emerge from, positive social connection (Johnson, 2013).

Ironically, many traditional treatment programs rely heavily on strategies that have the same general objective described above (i.e., inhibit anger). This is not to imply that reappraisal strategies, such as cognitive self-talk, do not work with certain types of anger, or that arousal reduction strategies such as relaxation training are without merit. Rather, while it seems like a logical solution, the overall goal of inhibiting feelings of anger does not yield practical benefits for those who experience intense and rapid anger arousal. While traditional intervention programs also teach valuable relationship skills, these skills are difficult, if not impossible, to implement under circumstances of dysfunctional emotion. A major problem with any technique that involves conscious deliberation is that it requires fairly stable emotional functioning during the time of need.

While emotions that are based on faulty thinking (thus processed in the cortical regions of the brain) can be altered using methods of reason, the type of anger that is most likely to lead to violence occurs rapidly, in response to environmental triggers. In many instances, individuals referred to domestic violence programs report that their anger/rage overtakes them before they have time to think. This is amygdala-based emotional experience, or low-road processing, which initially bypasses the cortical regions of the brain. The anger agenda assumes an entirely dominant position as it affects learning, memory, attention, perception, and inhibition of emotion; all of this occurring before there is time for conscious recognition (LeDoux, 2003; Phelps & LeDoux, 2005). Or, as explained by Ekman (2003), during emotional arousal the mind enters into a refractory state in which conscious cognition cannot incorporate information that does not fit, maintain, or justify the emotion at hand. Instead, individuals tend to discount or ignore personal knowledge that could disconfirm the felt emotion, while also discounting information coming from the environment that does not fit the emotion. Similarly, recent research indicates that emotion affects attribution and explanatory processes (Forgas & Locke, 2005). For individuals with severe emotional disorders, this refractory period (i.e., the time during which emotions control thought) can last for hours, leading to major distortions in the person's judgement, decision making, his perception of his own behaviour and the actions of others, as well as distortions in memory (Forgas & Bower, 1987).

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As an example, a girlfriend of a participant in the batterer intervention program described below, reported that while driving home he reacted suddenly with rage to something she said. He gripped the steering wheel with one hand while he punched her face with the other. Being quick tempered herself; she fought back but was not strong enough to prevent him from pushing her out of his truck, which was still moving at full speed. After walking the remaining three miles to their house, in a dress that was torn and bloody, she found the young man calmly sitting on the porch carving a piece of wood with a Bowie knife. As she stepped onto the porch, he looked her up and down

Illustration: © Savina Hopkins, 2013.

and then exclaimed, *"What the fuck happened to you?"* He had no memory of what had transpired thirty minutes earlier. Later that week, when he came to counselling, he told me about his girlfriend's story, not knowing the event had already been described to me by her therapist. With apparent sincerity, he asked, *"Do you think shit like that could happen and me not remember, or do you think she is making it up?"* After many weeks in counselling, significant changes in this man's behaviour were reported. According to the girlfriend, *"I do not know what his therapist has done with him but he is not the same man...he has never [before] been so kind."* As one might imagine, cognitive behavioural interventions were not relevant to this person's needs. His problems required a multifaceted approach that included motivation strategies, emotional process work, attachment therapy, and traditional techniques such as learning time-out (Short, 2001).

As any who have been seriously angry know, with anger there is an instinctual impulse to move closer to the emotion trigger (Ekman, 2003). The risks associated with acting on this impulse are reflected in the expression, *"You have to learn when to walk away"*. But this is not easy to do, especially while trapped in small confined spaces, such as a car. Still, those who study emotion have described time-out (i.e., removing one's self from the scene) as the first line of intervention (DiGiuseppe & Tafrate, 2007; Ekman, 2003). Having collected self-report data from a wide variety of individuals seeking help with anger management, I too have found that a majority of men and women describe time-out as a helpful 'tool'. When taught correctly, and rehearsed in role-play, this avoidance strategy can be used effectively to remove potentially violent individuals from events or conversations that are about to trigger overwhelming feelings of anger. While the strategy of moving away from environmental triggers provides temporary safety (if both participants are willing to walk away from the interaction), it is still necessary to somehow transform the emotional narrative, otherwise 'unresolved feelings' are likely to return in full force the next time a similar situation is experienced.

While researchers who argue for the use of emotion suppression strategies note that individuals high on features of borderline personality disorder self-reported having a 'better day' while using emotional suppression, during a three day period (Chapman, Rosenthal, & Leung, 2009), they fail to document what happened a few days later, when this temporary fix stopped working. Those who have experience in domestic violence know that it is not uncommon to hear reports of successful attempts to suppress anger for two or more weeks, before the inevitable blow-up. This eventual discharge is likely to occur even when the suppressed anger is no longer relevant to the immediate situation (Ekman, 2003). Contrary to the study listed above, there is greater evidence that the suppression of emotion is associated with an increase in negative emotions, greater stress, and increased problems with physical health (Dalgleish, Yiend, Schweizer, & Dunn, 2009; Kiecolt-Glasser, McGuire, Robles, & Glasser, 2002; Pennebaker, 1995, 1997; Pennebaker, & Francis, 1996). For these reasons, in programs that focus on explosive anger, some type of emotional process work is indicated.

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Using emotion to change emotion

The finding that emotion can be used to effectively change emotion has been documented in various independent studies (Davidson, 2000, Fredrickson, Mancuso, Branigan, & Tugade, 2000). This is particularly true when negative emotion is exposed to positive emotion. For example, Fredrickson et al., (2000) found that resilient individuals cope by recruiting positive emotions to undo negative emotional experience. The same researcher found that the experience of joy and contentment produces faster cardiovascular recovery from negative emotions than a neutral experience (Fredrickson, 2001). And perhaps most relevant to anger management, awareness and conscious articulation of bodily felt experience have been shown to down regulate emotional arousal (Lieberman et al., 2004; Schore, 2003). The core principle behind this approach to anger management is that increases in emotional range not only down regulate anger, but also lead to greater capacity for reasoned thought and responsible behaviour. Similarly, increases in emotional awareness provide a foundation for self-monitoring, which in turn increases one's capacity for self-governance. As argued by Greenberg (2012), *'Without conscious articulation, the depth, range, and complexity of emotion cannot develop beyond its instinctual origins'* (p. 700).

Processing anger

When behaviours, or the emotions associated with the behaviour, are frightening to the care professional, there can be a rush to change. Under such circumstances, there is an unconscious avoidance or shutting down of the feared emotion, in this case, anger. If the client's anger has been dangerous, then it is natural for the therapist or counsellor to not want the client angry during treatment. However, the findings of affective neuroscience indicate that emotions, and affect, must be evoked to effect change (Högberg, et al., 2011). In cases of anger management treatment, it is the negative emotion, anger, which must be processed first. While doing this, professionals should resist the urge to fix problems and correct beliefs instantly. Instead, there is an acceptance of what is happening in the moment, and an attempt to understand the client's logic (Johnson, 2004). When an environment of acceptance and safety is established successfully,

clients become more willing to share personal information and to reflect nondefensively on their emotional experiences (Fosha, Siegel, & Solomon, 2009; Short, 2001). Because emotion is fast, when process work is conducted in a slow methodical manner, gaps are created into which new thoughts or other emotions easily pour. As explained below, it is the strategic introduction of positive emotions, such as compassion (or opposing negative emotions, such as remorse or regret) that distinguishes scientifically informed helpers from those who are merely good listeners.

It is essential to note that optimal emotional processing involves emotion activation combined with some type of cognitive processing of the activated experience (Greenberg, 2002). While emotional arousal is achieved readily by requesting a detailed narrative of some past emotional experience (e.g.,*"Tell me what was happening when you became angry?" "What sensations occurred in your body as the emotion became stronger?"*), cognitive processing is achieved by requesting an analysis of events (e.g., *"Why did you become so angry?" "What were you hoping to achieve?" "What mistakes did you make?" "What effect did you have on others around you?"*). This type of reasoned thought is most likely to succeed if questioning moves the subject away from reliving the event to a new position of looking at the event as an outside observer. If the proper questions are asked during reflective processing, then a diversified emotional experience is created as additional emotions are aroused.[1] Unlike inhibitory strategies, the goal is not to shut-off the experience of a particular emotion but rather to increase the amount of choice and responsibility for how one feels, thinks, and acts.

Furthermore, when an emotional memory state is reactivated by means of conscious attention, it temporarily enters into a labile state, during which the emotional memory is amenable to change. This is known as

memory reconsolidation (Högberg, et al., 2011; Moscovitch & Nadel, 1999). Because it is the emotion memory structures that govern the automatic arousal of emotion in future situations, when the memory trace of the past is changed, future responses, under similar conditions, are also transformed. This is why it is important to encourage clients to recall past episodes of anger. However, during this process additional opposing emotions (e.g., compassion) are activated simultaneously, resulting in altered memory structures. Because memory reconsolidation occurs only after a memory is activated, it follows that emotional memories have to be activated during treatment in order to change them.

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Emotions that mitigate anger

A recent pilot study by this author indicates three emotions in particular that may be a good target for elaboration in anger management work due to their negative relationship to anger (i.e., these emotions seem to oppose one another). The strongest is compassion (r=-.70, n =12) followed by joy (r=-.68, n=25), followed by pride (r=-.64, n=12). Although a common expectation is that remorse will have a negative relationship with anger, this has not been supported by the data (r=.08, n=12). Similar to these results, other researchers have found that increases in self-compassion in the general population significantly predicted decreases in psychiatric symptoms, interpersonal problems, and personality pathology (Schanche, et al., 2011). There is also some evidence that anger and pride are opposing emotions with anger associated more closely with failure and pride associated more closely with success (Tausch & Becker, 2012).

In many instances, men who are identified as batterers have a highly restricted range of emotional expression. Perhaps as a result of social conditioning, these men only seem comfortable expressing anger or triumph. During treatment, when deeper emotional exploration is facilitated, it sometimes becomes apparent that anger was serving as a universal response, replacing other emotions, such as sadness or shame, that the individual seeks to avoid. Once the more situationally appropriate

1 For those interested in a structured method for conducting anger management process work, Dr. Short has created a worksheet that can be completed during therapy or sent home with the client as a homework assignment. Available online at www.iamdrshort.com/anger.

emotions are made available, the capacity for problem solving expands, as new thoughts and behaviours are made available. On the flip-side, some emotions are associated closely with anger and may serve to increase its intensity and/or duration. Ekman (2003) has identified three emotions that occur frequently in conjunction with anger: fear, disgust, and guilt. My own research supports a close relationship between anger and disgust during intense emotional episodes (r=.73). Fear and guilt do not yet appear to be related closely to anger, though at the time of this writing, the sample size was still small (n=12).

Because of the potentially close connection between anger, fear, and disgust, emotional process work on any of the three is indicated when seeking to improve anger management. It should be noted that the relationship between anger and hatred is also high (r=.72, n=25), though hatred is not classified as an emotion but rather a combination of visceral affect and attitude that does not behave as true emotions do (Ekman, 1992, 2003) and therefore hatred is not an appropriate target for emotional process work. Hatred might be better addressed through interventions designed to foster attitudinal shifts or through interventions designed to create attachment and bonding.

Outcome data

In an unpublished study, Short (1994), studied treatment outcomes from a neophyte batterer intervention program. This program included emotional process work intended to increase emotional awareness and diversification of emotional experiencing and recall. At the time, this effort marked a radical departure from standard treatment based on CBT and psychoeducational models. In this new approach, emotions targeted for increased fluency included compassion both for self and for others. Remorse and self-consciousness were also targeted for increase in frequency and duration. These emotions were connected to situational factors in the home, at work, or any other setting where anger was occurring. This process work was conducted during a portion of each and every visit. Thus triggers were analysed as feelings of anger were processed. After three months of counselling, there was a dramatic decrease in occurrences of anger and rage, with 83% of the participants' self-reported progress confirmed by outside observers during confidential interviews (i.e., typically a wife or girlfriend). In this study, progress was defined as no longer using acts of physical aggression. Amongst this relatively large group of successful outcomes, 50% of the outside observers reported 'remarkable' changes in behaviour that extended beyond the cessation of violence. Unfortunately, the rate of attrition for this period was still relatively high, with 44% of the men who came to the program at least once, failing to complete the program.

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The outcome study was later repeated with similar results (recidivism=21%, attrition=49%). It is important to note that in this second study 100% of program participants reported being violence free, even though it was later discovered that at least two of the individuals had been arrested again for violence. This underscores the importance of collecting outcome data from a third-party, rather than self-report. For these two studies, the person collecting the data was a female volunteer who was elderly and kind, with advocacy training so that she could help female respondents recognise and report behaviour they may not have previously considered violence. The volunteer was in no way involved in the treatment program thus reducing the probability of biased interviewing.

At least one other program, which has shifted the treatment emphasis to increased emotional awareness and to empathy training (within the context of a DBT model) has reported similar success rates with dropout as low as 15% and recidivism at termination as low as 10% (Fruzzetti & Levensky, 2000), though this study does not indicate if the data was derived from self-report or third-party observations.

Summary

In sum, there is mounting evidence that violence prevention programs based primarily on psychoeducational and cognitive behavioural methods are failing to prevent violence. While some blame poor outcomes on those being treated, another possibility is that those responsible for providing treatment have adopted approaches that are not sufficient for this particular problem. Looking to the science of emotion, it is not difficult to see why the core principle of CBT (i.e., using conscious deliberate cognition to regulate emotion) is not effective for individuals who have long periods of intense emotional arousal. The most significant problem being the refractory period during which cognition is governed by emotion, allowing only thoughts that confirm, justify, or heighten the emotion. This is not to say that there is no place for CBT in anger management, however, its utility needs to be put into perspective.

For those with severe anger and rage problems, emotional process work is needed, specifically, the use of emotion to change emotion. When an activated emotion is exposed to an opposing emotion, the new emotional experience leads to the construction of new narratives resulting in a new set of thoughts, behaviours, and memories (Greenberg, 2012). This may be due in part to a reorientation of attention in which there is a spontaneous reappraisal of what is occurring. This reappraisal quickly ends the emotional behaviours (Ekman, 2003) and is more likely to occur when noncomplementary emotions are activated.

As science evolves and adjustments are made to existing programs, it is

important not to over-correct. For example, there are some valuable psychoeducational components in traditional programming, such as teaching time-out, training in conflict resolution, problem solving, and relationship repair. These are necessary in anger management work, but not sufficient. Following the same logic, it is doubtful that emotional process work alone would produce the best outcomes. This view is at least partially supported in an outcome study by Carryer and Greenberg (2010) who found that during the treatment of depression, the optimal rate of emotional arousal was 25% of the time in a given session. If this is generalisable to anger management work, it would mean that 75% of the session could still be dedicated to psychoeducational components, cognitive therapy, or other forms of treatment that address attitudinal issues and problems with attachment.

Perhaps the greatest obstacle to including emotional process work in treatment is the professional's own unconscious aversion to this frightening and potentially destructive emotion. Very few individuals wish to be exposed to another person's anger or rage. For those professionals who seek to cope with unresolved feelings of anger through suppression, this type of work is not a good fit.

From my own experience (Short, 2001) and the science at hand, the transformation of anger begins with a close and confident observation of what is occurring, followed by an introduction of new emotional alternatives, which then drive new ways of thinking and acting. In this way, we do not over-correct problems of excessive anger by seeking to eliminate it entirely, but rather the experience of this emotion is transformed so that it can better serve the needs of the individual and those in his or her life.

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AUTHOR NOTES

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Dr. Short's many years of research and analysis of the work of Milton H. Erickson, M.D., his tenure as Associate Director of the Milton H. Erickson Foundation, and five years as Editor of the Milton H. Erickson Foundation Newsletter make him a serious scholar on the subject of Erickson's work. He has published numerous professional papers on the topic of brief therapy, and has coauthored *Hope and Resiliency*, with Roxanne Klein, Ph.D., and Betty Alice Erickson, M.S., which has been translated into Spanish, French, German, and Italian. Dr. Short's areas of special interest include growth-oriented brief therapy, the clinical applications of hypnosis to chronic or change resistant problems, and counselling for other health care providers.

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