Advances in anger management

Researchers and practitioners are examining what works best for managing problem anger.

BY JENNIFER DAW HOLLOWAY

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Rob comes to therapy at the urging of his wife. He's prone to angry outbursts--especially while driving. He says things such as, 'I'm not doing anything unsafe, it's that jerk in front of us who's going too slow, who made me slam on my brakes.' He admits he spends a good portion of his day angry at one thing or another.

Most practicing psychologists have seen plenty of angry patients like Rob in therapy. While most recognize problematic anger in their patients, they may or may not be clear on how to treat it.

Psychologist Howard Kassinove, PhD, of Hofstra University, says the number of patients he saw clinically for problem anger just didn't correspond with the relative lack of attention to it in the academic literature. "Anger has been an understudied emotion," he says. "I was in clinical practice for more than 25 years. An enormous number of people come in with anger problems, but the literature base is small, there are no anger diagnostic categories and psychology textbooks rarely mention anger."

Diagnosing problem anger

Most normal people experience anger a few times a week, says Kassinove. According to a 1997 study by him and his colleagues, 58 percent of anger episodes include yelling or screaming. And less than 10 percent involve physical aggression. Even then, the aggression is usually mild and consists of throwing small objects, such as pencils, or shoving. Anger can even be positive (see page 44). But what characteristics define problematic or dysfunctional anger versus normal anger?

A study published last year by Kassinove, R. Chip Tafrate, PhD, and L. Dundin in the Journal of Clinical Psychology (Vol. 58, No. 12) found that people with high trait anger have anger reactions that are more frequent, intense and enduring. They also tend to report more physical aggression, negative verbal responses, drug use and negative consequences of their anger. In general, their anger negatively affects their relationships, their health and their jobs.

Such anger that "disrupts or interferes with sense of self or normal routines" could warrant therapy, says Colorado State University psychologist Jerry Deffenbacher, PhD.

Anger experts note, however, that unlike most clinical problems, there is no diagnostic category for anger. "The DSM doesn't have any diagnostic categories where anger is the presenting issue," says Deffenbacher. "We don't have any parallel diagnoses." So, he adds, the degree to which anger becomes a real problem is "a fuzzy call."

Some psychologists--among them Raymond DiGiuseppe, PhD--are working to fill this diagnostic need. DiGiuseppe, chair of the psychology department at St. John's University in New York, is conducting research to validate a set of criteria for an anger diagnosis. But that still leaves open the question of tailoring the treatment to the diagnosis. "Given all the different distinctions we have about anxiety disorders, they help us develop more treatments," says DiGiuseppe. "We have no such distinction for anger. Everyone gets the same treatment."

Though some experts believe an anger-related diagnostic category could be helpful, others argue against it. Some say it isn't necessary because anger may be a symptom of another disorder. Others argue that a distinct anger diagnosis could be used wrongfully in court, for example, to explain--and perhaps create a defense for--criminally violent behavior.

Techniques to reduce anger

Diagnostic categories or no, psychologists are still faced with treating anger in the therapy room. Yet how are they to do that?

"I think there are three strategies or combinations of them that have the most empirical research behind them," says Deffenbacher. The strategies--relaxation, cognitive therapy and skill development--are new applications of existing concepts, he says.

Since the 1980s, he and his colleagues have been studying whether cognitive and relaxation techniques affect anger. Angry college students and drivers in his studies reduced their anger levels from the 85th percentile to normal levels on Spielberger's Trait Anger Scale, using relaxation. "You can't be calm and relaxed and pissed off as hell at the same time," Deffenbacher jokes.

Here's how the relaxation technique works: Clinicians train patients in progressive relaxation until they can quickly use personal cues, such as words, phrases or images--one woman learned to visualize a cross--to relax in an anger-inducing situation.

"We have people identify what makes them very angry. With drivers, for example, when people flip them off or go too slow," says Deffenbacher. "Then we have them visualize that intensely for a minute or two and then help them relax...so they get angry and then relax it away. We do that over and over again." By the end of approximately eight sessions, the patients should learn to relax themselves, without therapist assistance.

"The analogy I like to use is it's like weight loss," he says. "They come in and get [rid of] a lot of anger. I don't want to see them angry again, so we shift the focus to maintenance and prevention eventually."

Cognitive therapy--in which psychologists help patients see alternative ways of thinking and reacting to anger--is another helpful treatment strategy, says Deffenbacher.

"A lot of ways in which we think when we're angry make situations worse," he explains. "Suppose you're driving to work and you get cut off. You think, 'You idiot,' about the other

driver. But you could think 'Whoa, that was an accident waiting to happen.'" He also recommends focusing on compatible and appropriate behaviors with patients. "If I'm an abusive parent, I may need parenting skills. If I'm an angry driver, I need safe driving skills," he says. Any of the three techniques, or any combination of them, takes "practice, practice, practice," says Deffenbacher.

The combination of techniques also seems to produce the most positive effect. For example, several of Deffenbacher's studies with angry college students, including one in 1996 in Cognitive Therapy and Research (Vol. 20, No. 6), using a cognitive-relaxation intervention showed that anger was lowered for most participants--with effect sizes of 1.0 generally, which is statistically significant.

Kassinove and Tafrate, co-authors of "Anger Management: The Complete Treatment Guidebook for Practitioners" (Impact, 2002), envision similar combinations of interventions in a model that incorporates four stages of change:

* Preparing for change. Deffenbacher agrees this stage is often overlooked but is key to success. Kassinove says clinicians need to start by helping patients increase their motivation and awareness of their anger.

* Changing. This stage includes assertiveness training, avoiding and escaping from anger-invoking situations, and a "barb exposure technique" that triggers patients' anger and then teaches them to relax.

* Accepting and adjusting. At this point, patients are taught how to reconceptualize their anger triggers, forgive others and avoid carrying a grudge against those who might anger them.

* Maintaining change. It's best to conclude treatment with a long-term plan. New triggers might re-ignite anger, so we try to include relapse prevention training, Kassinove advises.

The future of anger reduction

As researchers continue their search for effective treatments, emerging evidence suggests that some treatment types work better than others with problem anger. For example, most research now says that catharsis--"letting it all out"--isn't helpful and, in fact, may increase a person's hostility, according to a 1999 study by psychologist Brad Bushman, PhD, and colleagues, published in the Journal of Personality and Social Psychology (Vol. 76, No. 3).

And DiGiuseppe says that his own meta-analytic review has found group therapy to be less effective than individual therapy. "Group members tend to reinforce each other with their anger and antisocial attitudes of expressing it," he explains.

There are many other areas worthy of exploration, say DiGiuseppe and Deffenbacher, such as the use of motivational interviewing, readiness to change and the role of revenge in problem anger.

And though there is a growing body of literature on anger reduction, researchers need to step up their attention to anger treatment and diagnosis, according to Kassinove and Tafrate. The development of diagnostic criteria for anger won't happen until the experience of anger is better understood, they say.

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