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Teaching Healthy Anger Management

Sandra P. Thomas, PhD, RN, FAAN

TOPIC. *Teaching anger management in the community.*

PURPOSE. *To describe anger management and offer guidelines for assessing potential participants and teaching healthy behaviors.*

SOURCES. *Drawing from the literature, more than 10 years of quantitative and qualitative studies by our research team, and 5 years of experience in conducting anger management groups, the author presents basic principles of teaching anger management. A model is described for a 4-week group for women.*

CONCLUSIONS. *Anger management has wide applicability to a variety of constituencies for both primary and secondary prevention.*

Advanced practice psychiatric nurses are well-qualified to provide this psychoeducational intervention.

Search terms: *Anger, anger management, psychoeducational interventions*

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In a recent article in a popular news magazine, anger management (AM) was derisively described as “a trendy remedy for criminals as well as mere cranks” (Cloud, 2000, p. 53). High-profile AM “failures,” such as athletes Mike Tyson and Latrell Sprewell and Columbine High School killers Eric Harris and Dylan Klebold, were cited as anecdotal evidence that the “trendy remedy” of anger management is ineffective. This article was disturbing, because it contained numerous myths and misunderstandings of anger management, a psychoeducational intervention that was never intended to remedy the rage of deeply disturbed batterers, vandals, sociopaths, or animal abusers.

It is not surprising that a few AM classes failed to modify the out-of-control behavior of musicians Tommy Lee or Puffy Combs. Yet perusal of any daily newspaper shows that high-quality AM training is much needed to improve the increasingly uncivil interactions in our nation’s schools, workplaces, and homes. A study at Yale University (cited in Malmgren, 2000) showed that nearly one quarter of American workers feel chronic underground anger on the job because of heavy workloads and because they feel betrayed or let down by their employers. Such anger is often displaced, damaging family relationships or, perhaps, the innocent motorist in the next lane.

The purposes of this paper are to (a) describe what anger management is (and is not), and (b) offer guidelines for assessing potential participants and teaching them healthy anger behaviors. Advanced practice psychiatric nurses are well-qualified to provide this psychoeducational intervention. “Anger control assistance” is one of the 40 interventions commonly performed by specialists in psychiatric/mental health nursing, according to the Nursing Interventions Classification (NIC) project at the University of Iowa (McCloskey, Bulechek, & Donahue, 1998). There is a dearth of information in the contemporary nursing literature, however, about the essential principles and elements of AM.

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Distinctions Between Anger and Related Concepts

There is confusion in both popular and professional literature regarding the definition of anger, which must be differentiated from irritation, hostility, aggression, and violence. This confusion is evident in the description of "anger control assistance" in the NIC, which focuses mainly on control of violent acting-out (McCloskey et al., 1998). Therefore, we must begin with conceptual clarification of anger. I define anger as a strong, uncomfortable emotional response to a provocation that is unwanted and incongruent with one's values, beliefs, or rights (Thomas, 1995). Anger incidents are a common feature of everyday life (Averill, 1982) as individuals enact their social roles in families, schools, and workplaces. Anger is evoked by events of greater significance than the minor daily hassles of traffic and slow grocery lines that produce annoyance or irritation. Unresolved angry confrontations with significant others can produce prolonged hurt and resentment. But anger is *not* synonymous with hostility, a chronic mistrustful negative attitude toward people and the world, or aggression, the actual or intended harming of another.

Aggression and violence (egregious forceful or destructive acts) can and do occur in cold-blooded fashion without anger (Thomas, 1998a). And anger expression does not necessarily lead to aggression. In fact, anger expression may even *prevent* aggression—and elicit an apology from the other person (Izard, 1993). Bearing these distinctions in mind, anger management, as discussed in this article aims to promote more effective resolution of common, everyday anger incidents with families, friends, and co-workers. AM interventions cannot be expected to modify egregious aggressive and violent behavior.

Studies by our research team (Thomas, 1993; Thomas, McCoy, & Martin, 2000; Thomas, Smucker, & Droppleman, 1998) as well as others (Tice & Baumeister, 1993) indicate that anger is an unpleasant, distressing emotion for most people, often commingled with anxiety and guilt. One study showed that people have fewer successful strategies for controlling anger than for any other

emotional state (e.g., fear, anxiety, sadness, other strong feelings) (Tice & Baumeister). Historical and cultural injunctions regarding age- and gender-appropriate emotional expression complicate the resolution of angry interchanges. For centuries, anger was considered a sin, a weakness, or a madness, and the residues of each of these pejorative conceptualizations remain evident in popular parlance (Thomas, 1990). Almost never do our female study participants report that they feel good about the way they manage anger, whether they suppress it or vent it outwardly (Thomas, 1993; Thomas et al., 1998). Men and women both decry the failure of their anger outbursts in bringing about the desired responses from other people (Thomas, McCoy, et al.; Thomas, Smucker, et al.). Discomfort with anger and unresolved conflicts may become the impetus for some clients to seek professional assistance.

Unfortunately, few individuals have had the opportunity while growing up to observe role models displaying constructive anger behavior. For men and women, gender role socialization inculcates poor AM skills. The ability to handle anger effectively fits within the rubric of "emotional intelligence," which has been defined as the capacity to perceive emotion, integrate it in thought, and understand and manage it (Mayer, 1999). In my view, intelligent anger management does *not* mean eradication of anger, as proposed by Ellis (1976). Complete elimination of angry emotionality is neither possible nor desirable, because anger has self-protective functions such as maintaining boundaries and mobilizing courage to correct injustices. Intelligent anger management means that one can (a) modulate excessive physiological arousal, (b) alter irrational antagonistic cognitions, (c) decrease environmental stimuli, and (d) modify maladaptive behaviors that do not lead to problem solving.

Basic Principles of Teaching Anger Management

Psychoeducational interventions such as AM are not therapy; the leader functions as teacher and coach, not as therapist. Psychoeducational interventions create the potential for behavior change by increasing knowledge,

providing a new perspective, and giving clients opportunities to learn and practice specific tools and strategies. AM training is delivered customarily to groups, because anger is such an interpersonal emotion (Anderson-Malico, 1994; Wilson, Davidson, & Reneau, 2000). Techniques such as the "empty chair" do not permit individuals to maintain eye contact with another human while learning to control their breathing and the quaver in their voice when they say they are angry. Clients best learn to express their angry feelings when others are available to support, empathize, provide feedback, and role-play problematic conflicts in encounters. Behavioral practice in the safety of a group gives clients greater confidence that they can enact new anger behaviors in real-world situations. Concurrent introspection, using an anger journal or log, usually is recommended as well.

Review of the literature indicates that cognitive-behavioral (CB) and rational-emotive (RE) interventions have received the most research support (Thomas, 1998b). Most books and manuals, however, have failed to take gender differences into account. This deficit became apparent when I began developing a model 5 years ago for psychoeducational groups with women. While the classic tenets of RE (e.g., Ellis, 1976; Dryden, 1990) and CB approaches (e.g., Beck, 1976; Reeder, 1991) remain valuable, the irrational cognitions that are so strongly emphasized in RE and CB classes are not the predominant triggers of women's anger. Our research showed that women's anger is fueled primarily by substantive violations of their core values. Their anger arose in circumstances of powerlessness, disrespectful treatment, and lack of reciprocity in their most important intimate relationships (Thomas et al., 1998). The strongest theme throughout our decade-long program of quantitative and qualitative research with more than 600 women was *powerlessness*: Women wanted someone or something to change, but they could not make that happen, thus fueling an impotent anger. Sometimes women could not even get significant others to listen to them, which is surely the epitome of powerlessness (Bultemeier & Denham, 1993; Thomas et al., 1998).

While women did have some irrational expectations from time to time (e.g., "My husband should *know* what I want and need; I shouldn't have to *tell* him"), we concluded that women's anger generally appeared rational and justifiable, given the situations of recurrent injustice they described. It is not irrational to expect to be listened to and treated with respect by significant others.

Clients best learn to express their angry feelings when others are available to support, empathize, provide feedback, and role-play problematic conflicts in encounters.

Further, much of women's anger is suppressed or somatized, rather than vented outwardly. Anger is inconsistent with the perpetually pleasant feminine ideal. From an early age, girls in western cultural context learn to mask anger, as shown in a study of third-, fifth-, and seventh-grade children (Underwood, Coie, & Herbsman, 1992). As they move toward the adolescent years, the societal pressure to stifle their anger is further intensified, as shown in Brown and Gilligan's (1992) longitudinal study. Women who characteristically suppress their anger, or express it through somatic symptoms such as headaches, must learn to recognize it, embrace its power, and express it directly in words (without guilt). Clearly, these women need a different set of skills than people whose anger is an explosive, volatile force that must be contained. Therefore, a program aiming for anger *reduction* or *eradication* is inappropriate for them.

Our research findings suggest that anger management for women should be tailored to address their most salient anger issues, rather than proceeding from a premise that standard CB class content should be delivered to everyone. Nor should "women" be considered a

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monolithic category. The concerns of midlife women often are quite different from those of women in their 20s. Women who work in the home have a different set of daily frustrations from those who work in a corporate environment. Likewise, the cultural context must be taken into account. For example, research by our team revealed that the anger of African-American women is different in several respects from that of Euro-American women: In fact, their anger cannot be fully understood without considering the racism to which they are subjected daily (Fields et al., 1998). Therefore, AM for African-American women must include strategies for coping with racist treatment (Wilson et al., 2000). Research is scant on the anger experience of other ethnic/racial groups, but it is clear, nonetheless, that AM must be tailored sensitively to the age, gender, role responsibilities, developmental level, race, and culture of the group members. To date, there are few published articles on the modification of AM for diverse populations.

Indications and Contraindications for Anger Management

When is anger management indicated? Most experts agree anger is a problem when it is too frequent, too intense, too prolonged, or managed ineffectively (Thomas, 1998a). There are a number of validated assessment instruments, such as the Spielberger State-Trait Anger Expression Scale (Spielberger, Reheiser, & Sydeman, 1995), but clinicians may find them too expensive and time-consuming for use in practice settings. Moreover, most questionnaires are scored by computing the frequency of certain behaviors, which omits consideration of the relational context of anger episodes. As Jack (1999) points out, the same behavior (e.g., slamming a door) has a very different meaning when a person is alone than when the door is being slammed in the presence of another person to cut off further communication. Anger behavior patterns should be carefully assessed prior to AM group participation. Assessment guidelines are shown in Table 1. When clients participate in exploration of the issues

Table 1. Guidelines for Assessment of Anger Management Participants

1. What is the client's usual proneness to respond angrily (hot-headed vs. slow to respond)?
2. How intense is the angry emotionality?
3. What is the duration of a typical anger episode? minutes, hours, days?
4. How does the client usually express anger? Is it suppressed or directed outward in physical actions or verbal behavior? How does the client feel about his/her style of anger expression? What are some of its consequences?
5. Does the person ruminate about the grievance, rekindling anger again and again?
6. Are there irrational beliefs fueling the anger (beliefs about the way other people *should* behave or about the way a fair world *ought* to operate)?
7. If the anger is kept to oneself, what barriers prevent its expression?
8. If the anger is directed outward, does the person make a clear, forthright declaration of the anger to the person who provoked it?
9. Does the person engage in yelling, screaming, threats or profanity when angry?
10. What triggers the anger? What is it about? What are the recurrent themes, patterns?
11. What strategies are used to control temper and cool down? Humor? Meditation? Physical exercise?
12. To what degree is anger creating problems for this client in the workplace or intimate relationships? Has the client ever harmed self or others when angry?
13. What defense mechanisms come into play? intellectualization, projection, isolation?
14. How does the current angry behavior compare to the person's usual pattern?
15. What did the client learn about anger while growing up? Rules for anger display vary greatly among cultures. Gender role socialization is another strong influence.
16. Is anger somatized in headaches, gastric distress, or other physical symptoms?
17. Is the discomfort of anger medicated through alcohol, drugs, or cigarettes, or food binges?
18. With whom does anger most frequently occur? Are there any commonalities among the provocateurs? Are transference phenomena evident?
19. In a situation of recurrent conflict, what would the client like to be different? Is it possible for the client to understand the other person's position on the issue?
20. Who will support the client's efforts to try new anger behaviors? Who may attempt sabotage? How will the client respond to saboteurs?

raised by these questions, self-awareness is heightened and specific goals for the AM class can be formulated. As in other behavioral interventions, precise identification of target behaviors is important.

Researchers have reported positive outcomes of AM with delinquent adolescents (Feindler, 1995), college students (Hazaleus & Deffenbacher, 1986), high-anger drivers (Deffenbacher, Huff, Lynch, Oetting, & Salvatore, 2000), African-American women (Wilson et al., 2000), New York City traffic agents (Brondolo, Hough, & Rabinowitz, 2000), individuals with learning disabilities (Rossiter, Hunnisett, & Pulsford, 1998), combat veterans with post-traumatic stress disorder (Gerlock, 1994), cardiac patients (Davidson, 2000), and incarcerated women (Smith, Smith, & Beckner, 1994). It is logical to presume that AM has a greater likelihood of success when participation is voluntary rather than court ordered. However, some therapists believe even court-ordered AM can have value. This invites the question: When is anger management *contraindicated*? The following exclusion criteria are suggested: paranoia, organic disorders such as neurological conditions, acute psychosis, and severe personality disorders characterized by violent acts toward self or others. People who are in the process of working through rage engendered by severe trauma, such as physical or sexual abuse, should not participate in AM classes unless they are receiving concomitant individual psychotherapy. Generally speaking, short-term psychoeducational approaches are not recommended for individuals whose anger is deep-seated and chronic.

Length and Format of Anger Management Programs

In the literature, AM sessions typically range from three (Smith et al., 1994) to eight sessions (Deffenbacher, 1995; Moore, Adams, Elsworth, & Lewis, 1997). Determining the number of sessions depends on the type of participants (students, workers, inpatients) and resources (especially funding) for delivery of the program. When AM is offered to intact groups in work sites or education settings, you may have the luxury of 10 to 12 weeks. In the community,

most people cannot set aside the time to be involved for more than four class meetings. My group sessions for women, offered through my university's noncredit catalogue, are 2-hour sessions held in the early evening hours in a classroom on the university campus for 4 weeks (Table 2). Groups range in size from 8 to 15 participants.

A fee of \$50 to \$65 for four sessions (or a 1-day workshop covering the same content) seems reasonable and affordable for most women. Sessions involve lectures on didactic content, role-playing, and small and large group discussions. Meeting once per week is ideal, allowing for completion of homework assignments between classes. Class meetings often begin with participants sharing successful outcomes of their homework assignments.

While a 4-week intervention is relatively brief, and women often express regret that the sessions are ending, most admit their busy lifestyles would not permit continuing to travel to the university for additional weeks of classes. Precedent for offering brief group interventions may be found in the writings of Yalom (1985) and others. In more than one instance, class members have spontaneously exchanged telephone numbers at the last session so they could continue meeting. Some women benefit from additional training in assertiveness, relaxation, or problem-solving skills, while others may find effective parenting classes or conflict-resolution workshops useful. Clients who are employed can be encouraged to avail themselves of worksite continuing education or employee-assistance programs. Approximately half the women in a typical AM class are already involved in psychotherapy (often referred to the class by their therapists), and it is not uncommon for others to decide to undertake some type of counseling to gain a deeper understanding of the issues they have begun to grapple with during the class.

My model for AM with women (see Table 2) was developed using both clinical literature and research findings. It was designed to be used in conjunction with a training manual I developed (Thomas, 2000). Now that our study of men's anger is completed (Thomas et al., 2000), I anticipate developing a similar manual for psychoeducational groups for men. Gender-specific interventions are necessary because our data from women

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Table 2. A Model for a 4-Week Psychoeducational Group on Anger Management for Women

Week I. Introduction to anger and the relational nature of women's anger

A. Didactic components

- Definition of anger, distinctions among irritation, anger, hostility, aggression, and violence
- Brief overview of the research findings on anger's causes and unhealthy manifestations (e.g., overeating, substance use, headaches)

B. Experiential components

- Get-acquainted exercises
- Self-assessment of anger, using paper-and-pencil tests
- Sharing personal anger situations in dyads
- Goal-setting

C. Homework: Begin keeping the anger log, reflect on core values being violated, meaning of recurring anger in relationships.

Week II. Anger expression styles and empowerment principles

A. Didactic components

- Reframing anger as a catalyst for personal and professional empowerment (i.e., enhanced ability to take action and resolve problems)
- Anger management techniques for women who suppress and for those who too readily express anger
- Tactics for lowering physiological anger arousal (e.g., relaxation or vigorous activity) and decreasing rumination (e.g., thought-stopping)
- Assertiveness, negotiation, and bargaining strategies

B. Experiential components

- Sharing incidents from anger logs with the group
- Behavioral practice of new approaches to handling these incidents (e.g., discussion in triads, selected exemplars discussed in larger group as well)

C. Homework: Select one thing to address assertively in the coming week; record experience and outcomes in journal.

Week III. Women's anger at work (omitted if most women in the class are homemakers)

A. Didactic components

- Factors involved in women's anger at work
- Passive-aggressive behavior in the workplace
- How to defuse angry situations with customers, colleagues, students, etc.
- How to take productive action on grievances or harassment through assertiveness and coalition forming.

B. Experiential components

- Reports on homework (successes as well as failures)
- Role-playing a work-related situation in triads
- Selected exemplars discussed in larger group).

C. Homework: Use principles presented in class in a workplace situation.

Week IV. Women's anger in intimate relationships (can be tailored to needs of the group)

A. Didactic components

- Factors involved in women's anger at significant others (e.g., spouses, ex-spouses, friends, relatives, children)
- Strategies for achieving conflict resolution and relationship reciprocity
- Releasing old anger (from childhood, divorce, etc.) through forgiveness, peace talks, and healing rituals

B. Experiential components

- Review of homework assignment outcomes
- Termination activities (each woman shares one thing she learned in the class and a goal for continued skill practice)

Note: Members of the class commonly suggest modifications to this general outline. A group containing a large percentage of mothers may want to spend time on parenting issues; a group with a preponderance of divorced women may want to spend an entire class on divorce-related anger. Units on these, and many other topics, are included in the treatment manual.

and men indicate very different cognitions, perceptions, and meanings of anger experiences. Clinicians are encouraged to report outcomes of delivering these manualized interventions, and suggest needed refinements and modifications, thereby contributing to the growing empirical literature in nursing on anger management.

Conclusion

A hallmark of the recent mental health report from the office of the U.S. Surgeon General (U.S. Public Health Service, 1999) is its emphasis on prevention and health promotion, a clarion call for psychoeducational

interventions in the community. Anger management is one such intervention, notable for its wide applicability to a variety of constituencies for both primary and secondary prevention. For example, AM techniques are needed desperately by teachers and parents. Community sites such as schools, churches, libraries, and social clubs provide convenient venues for workshops and classes. For some individuals, improved health may be an important incentive for participation.

Training in anger management promotes better physical health as well as mental health. For example, anger discussed in a constructive way has a beneficial effect on blood pressure (Thomas, 1997a; Davidson, MacGregor, Stuhr, Dixon, & MacLean, 2000). Further, people who regularly discuss their anger have better general health, higher sense of self-efficacy, less depression, and lower body mass index (i.e., less obesity) (Thomas, 1993; Thomas, 1997b; Thomas & Williams, 1991), and it is logical to predict their interpersonal relationships will improve when anger episodes are constructively resolved. Advanced practice psychiatric nurses should be in the vanguard of health professionals offering this worthwhile training program to their communities.

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