
ANGER TREATMENT FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

A THEORY, EVIDENCE AND MANUAL
BASED APPROACH

John L. Taylor

*Northumbria University, Newcastle upon Tyne and
Northgate and Prudhoe NHS Trust, Northumberland, UK*

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JLT To Caroline, Olivia and Alexander for their patience and support throughout.

RWN To my mother, Mary Theresa Novaco, whose fortitude, feisty spirit, and independence continue to be a source of inspiration.

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Raymond W. Novaco is Professor of Psychology and Social Behavior, University of California, Irvine, USA. Cognitive-behavioural therapy for anger was pioneered by Ray Novaco, for which he received the Best Contribution Award in 1978 from the International Society for Research on Aggression. Funded by the MacArthur Foundation Research Network on Mental Health and the Law in 1991–1993, he developed new procedures for anger assessment for use with mentally disordered persons, which are here being extended to the developmental disabilities domain. He received the Distinguished Contributions to Psychology Award from the California Psychological Association in 2000. In addition to being programme consultant for the Northgate Hospital anger project, he serves as Research Consultant to The State Hospital in Scotland and for many years served on the Advisory Board of Atascadero State Hospital in California.

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FOREWORD

In the late 1980s and early 1990s, deinstitutionalization was in full swing. Most institutions had rehabilitation and community integration policies with large-scale relocation projects to move people with developmental disabilities into local communities. With the success of these policies and projects came the normal problems of community living. A number of individuals began to be referred back to services because of problems with anger and aggression. It was immediately apparent that behaviour modification programmes and behaviour therapy programmes that had previously been employed in institutions would not always, or indeed often, be feasible in these less controlled settings. At that time, a number of us were thankful for the theoretical analysis of anger and aggression that had been developed by Ray Novaco and that had such practical extensions for treatment. In this way, fledgling anger management programmes developed for individuals with intellectual disabilities. These programmes allowed the personal development of anger control techniques that relied to a much lesser extent on behavioural contingencies and to a greater extent on cognitive control and self-restraint. Since that time, it has become clear, to a significant extent through the work of John Taylor, that anger and aggression are serious problems for this client group and that it has important repercussions for policies, staff and services. John has written elsewhere, and will also review the information in this book, that the effect of client anger on staff morale, self-esteem, and absenteeism is considerable. It is crucial that clients themselves are allowed to develop personal abilities which will enable them to control their own emotions so that they can go about their daily business more effectively in communities, with friends, with family, and at home.

These issues are not merely for philosophical enquiry or academic interest, they are vital to people's lives and it is for these reasons that this book is not only of the utmost practical importance but also timely. John Taylor and Ray Novaco have written a knowledgeable, erudite, and practical text. They review the historical routes of thinking on anger, tracing developments from the eighteenth century to the present day. Their summaries of the way in which different psychological theories have considered anger will be of interest both to the newcomer to the field and to those of us who have worked in the area for some time. They also make careful evaluation of recent research and the effectiveness of individual treatment methods. The greatest value of this book, however, is obviously the extent and detail of the treatment protocols. I have often said in the past that one of the most difficult treatments to conduct and one that requires a high level of skill is the treatment of individuals who are angry. When doing this work, I am always aware that there is a potential for the individual who I am treating to become angry during the session. Treatment therefore requires a good level of clinical skill and knowledge. The background information, research reviews, assessment protocols, and treatment techniques that are all detailed in this text contribute

significantly to enabling us all to become technically equipped to deal with this difficult treatment group. Typically for John and Ray and their attention to detail, they have provided specific chapters on applications with women, and supervision and support of therapists, ably written by Alison Robertson and Bruce Gillmer respectively.

Not only does this book summarize the available information on anger, anger treatment, and people with intellectual disabilities, it enables the individual who has general experience in the field of intellectual disabilities to embark on a well-validated assessment and treatment programme that will be of crucial relevance to their clients. It also marks a significant theoretical advance in the field of anger and anger control. It represents *the state of the art* in anger treatment for individuals with developmental disabilities and I would expect to see a significant effect from this text on the development of treatment services. I certainly hope that it promotes a greater understanding of why our clients (and ourselves) get angry and promotes greater access to treatment.

Bill Lindsay
November 2004

PREFACE

While anger is a normal human emotion and can have a number of positive functions, it is closely associated with aggression, psychological distress and physical ill-health. Thus, anger and associated aggression can carry heavy costs for individuals and for health and social care systems concerned with providing treatment and support to clients with chronic anger control problems. The societal as well as the psychological interest in anger control have a fascinating historical background, which we present in our opening chapter.

The Northgate Anger Treatment Project was established in the male forensic services of Northgate and Prudhoe NHS Trust, a specialist learning disability service located in the North-East of England. The great majority of patients in the forensic services have offending or quasi-offending histories. That is, they have been convicted of carrying out particular offences, or they have well-documented histories of behaviours that, for a variety of reasons, have not been processed through the criminal justice system, but have placed the individual at risk of becoming a convicted offender. The major offence categories for this population at Northgate Hospital are violent offences, sex offences, and fire-setting offences. Many patients have convictions or documented histories of offending behaviour in more than one of these categories.

Given the forensic histories of this population, the Trust's Department of Psychological Therapies and Research has designed, developed and implemented offence-specific assessment and intervention programmes aimed at reducing the risk of future offending behaviour and thereby facilitating rehabilitation of patients from in-patient hospital services to community-based facilities. Based on the 'what works' meta-analysis literature concerning recidivism rates for offenders, sex offender and fire-setter treatment programmes have been developed and implemented with reference to number of key principles (McGuire, 1995, 2002). This has involved the development of treatment interventions that are cognitive-behavioural in nature, are responsive to the learning needs of clients, focus on the criminogenic aspects of the clients presenting problems, take into account the level of risk presented by clients, and attend to issues of programme integrity. Based on the evidence available for non-developmentally disabled (mainly adolescent) offenders, it has been suggested that interventions incorporating these principles are likely to be more effective than those that do not, and could reduce recidivism rates significantly. The development of the anger treatment procedures within a 'what works' framework is described further in Chapter 7.

The issue of programme integrity is central in delivering successful psychological intervention programmes. In order to avoid threats to integrity, interventions need to be based on sound theoretical frameworks that have empirical evidence to support them. The therapists implementing the interventions need to be well trained in both theory and delivery aspects, and the use of manualized protocols to guide the delivery of interventions is an important

factor. Therapist training, along with supervision, support and other process issues, are discussed in depth by Bruce Gillmer in Chapter 10.

In addition to the offence-related reasons for developing an anger treatment approach for patients in the Trust's forensic services, given the association between anger and a range of psychological conditions and poor general health, it was anticipated that by helping patients with their anger problems, their general psychological and physical well-being would be improved and they could be more amenable to, and have additional resources to cope with, the demands of other offence-specific treatments, e.g. group-based sex offender therapy. Further, many patients are willing to discuss temper control problems early in their rehabilitation, compared with, for example, sexual aggression. Therefore, by beginning with a problem that has salience for the patient and is relatively unthreatening, therapeutic relationships and trust can be built that facilitate more offence-focused work at a later stage. In this way anger treatment can be viewed as adjunctive therapy rather than as a stand-alone encapsulated procedure. A guiding framework for anger dysregulation and cognitive behavioural anger treatment is set out in Chapter 2.

When psychotherapeutic approaches have been made available to people with developmental disability and emotional problems, too frequently they have been applied without reference to empirically-based research. When treatment has been ineffective, there has been a tendency to attribute this to the characteristics of the clients with disability, rather than to the limitations of treatment techniques (or the therapists delivering them). In Chapter 4, the lack of evidence for effective psychological therapies for emotional and mental health problems among people with developmental disabilities is discussed.

Taking into account these factors and influences, the Northgate Anger Treatment Project aimed to achieve two main goals within the Trust's forensic services. First, to investigate the nature, scope, and patient needs in relation to anger control problems. This was to be done through a service-wide anger assessment study, the results of which are described in Chapter 6. Second, the effectiveness of a cognitive-behavioural anger treatment developed specifically for this population was evaluated in several concatenated controlled outcome studies. The methods, design, procedures, and results of these studies are described in considerable detail in Chapters 5 and 7. Most importantly, included in this book is the anger treatment protocol that we have constructed and implemented. Chapter 8 contains the six-session treatment preparatory phase, and Chapter 9 is the 12-session treatment phase. Handout/exercise sheets used to support the delivery of the treatment protocol are also provided as Appendices, and online at our dedicated website www.wiley.com/go/angertreatment

While the focus of the Northgate Anger Treatment Project has been on people with offending and quasi-offending histories, the underlying theoretical framework, principles, and procedures, and the results of the supporting empirical studies apply equally to people with developmental disabilities with anger control problems but who have not necessarily come into contact with the criminal justice system and those who live in less secure, supervised, and non-institutional settings. Our belief is that if these approaches can be effective and can benefit clients with chronic, deep-rooted anger problems often associated with significant histories of neglect and abuse, then they can be at least as effective and potentially beneficial to clients with less severe problems. However, this is an empirical question that requires further investigation and enquiry.

Similarly, the assessment and treatment approaches presented in this volume have been developed with men with developmental disabilities. It would be remiss to assume that women with developmental disabilities experience anger in the same way as their male counterparts, or that their response to treatment will be the same in all respects. For these reasons the Anger Treatment Project has been extended to the women residing in the Northgate forensic services. In Chapter 11, Alison Robertson describes the anger assessment and treatment studies that have been conducted with this population and sets this within the context of gender-specific issues relating to the experience and expression of anger.

Finally, we need to explain to readers the reasons for our choice of terminology in the title of this volume and to describe the client population with whom we are concerned. In the United Kingdom the term 'learning disability' is commonly used to describe people characterized as: (1) having significant sub-average general intellectual functioning as measured on standard individual intelligence test; (2) having more difficulties in functioning in two or more specified areas of adaptive behaviour than would be expected, taking into account age and cultural context; and (3) having experienced the onset of this disability before the age of 18 years. These criteria are broadly those included in the *International Classification of Diseases* (ICD-10; World Health Organization, 1992), the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) and the American Association on Mental Retardation (AAMR) diagnostic classification systems. The terms 'mental retardation' and 'intellectual disability' are commonly used in North America and Australia respectively to refer to the same syndrome.

One reason for attempting to define disability is to have descriptive terms that help communities of interest to communicate about phenomena in such ways that convey shared understanding and meaning. For this reason the term 'developmental disability' is used throughout this volume to describe the participants involved in the development of the anger assessment and treatment procedures presented. It refers to the definition given in the United States Developmental Disabilities Assistance and Bill of Rights Act (2000) and is a broad concept covering the equivalent terms of mental retardation, learning disability, and intellectual disability commonly used in North America, the United Kingdom, and Australia, respectively. In general terms, developmental disability means a severe, chronic disability of an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains the age of 22 years; (3) is likely to continue indefinitely; and (4) results in substantial functional limitations in three or more areas of major life activity.

In addition to learning disability, the concept includes other conditions that do not necessarily involve significant sub-average intellectual functioning such as autism, epilepsy, and some other neurological conditions. The definition of developmental disability also focuses on functional limitations and life-long support needs that should be individually planned and co-ordinated. The assessed levels of intellectual functioning of the participants involved in the treatment and research programme described in this volume, and the inclusion of people with conditions other than learning disability, mean that the term developmental disability provides the best description of the population involved in these studies. However, in describing research conducted by others in a range of settings across a number of continents,

whenever appropriate, and when it makes sense to do so, the terms used by authors in their reports to describe the participants involved in their studies are used.

John L. Taylor
Raymond W. Novaco
October 2004

There is a dedicated website for this book at www.wiley.com/go/angertreatment, containing the handout exercise sheets from the Appendix. These are available to readers to view and download.

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In addition to the Northgate Anger Treatment Project core team, comprising Professor John Taylor, consultant clinical psychologist, Professor Ray Novaco, programme consultant and advisor, Dr Bruce Gillmer, consultant clinical psychologist, Ian Thorne, forensic psychologist and Alison Robertson, consultant clinical psychologist, a large number of colleagues have contributed to this work in many different ways in the past five years, and we extend to them our considerable gratitude.

Claire Guinan and Nicola Street worked steadfastly as research assistant psychologists on the assessment and outcome study phases of the project. More recently Sarah Matthews, Danielle Wilson, and Sherley Tordoff, research assistants, have skilfully managed and maintained the programme databases.

Our Forensic Psychology Division colleagues, Melanie McKenna, chartered forensic psychologist, Sam Bainbridge, senior occupational therapist, and Kirsty Lowe, consultant clinical psychologist, have treated a number of patients as part of the development of the intervention as a routine clinical programme in the service. A host of assistant psychologists working in the department for fixed periods have collected and collated assessment data *and* delivered the treatment protocol to clients. These include Ginny Avery, Tracy Belshaw, Helen Clothier, Louise Dixon, Andrew Dunn, Jennifer Lane, Sarah Richardson, Angela Simcox, Nicola Street, Pauline Summerfield, Rachel Turnbull, Angela Watson, and Danielle Wilson. A number of trainee clinical psychologists from the University of Newcastle Doctorate in Clinical Psychology programme have also been involved in the delivery of the treatment as part of their placement experience in the department, including Debra Hall, Lene Rasmussen, Jennifer Gracie, Tom Christodoulides, and Vicki Grahame.

Our nursing colleagues, with direction and leadership from Paul Thornton, forensic services manager, and Graham English, forensic nursing programme co-ordinator, have provided unstinting support for the programme in terms of completion of endless informant-rated measures, support for individual patients engaged in anger treatment and implementation of maintenance programmes. Our psychiatrist colleagues, led by Professor Gregory O'Brien, clinical lead for forensic services, have also provided a good deal of support and encouragement throughout. The Executive Directors of Northgate and Prudhoe NHS Trust, particularly Dr Anthony Perini, medical director, have facilitated this development and provided the financial support without which it could not have taken place.

Our department secretaries, Pat Blakely and Wendy Hart, have been willing helpers in terms of preparation of materials and reports for the anger treatment project. Many thanks also to Sherley Tordoff for proof reading the manuscript and references, and for collecting new data regarding the maintenance of anger treatment gains.

We especially thank our colleagues and collaborators Dr Bruce Gillmer and Alison Robertson for contributing important chapters concerning therapist training, supervision, and the treatment process and anger treatment for women with developmental disabilities, respectively. At John Wiley & Sons Lesley Valerio and Dr Vivien Ward, and more recently Gillian Leslie, Claire Ruston, and Ruth Graham have been supportive, helpful, and considerate during the production of this book. But finally, and most importantly, we are grateful to and deeply thank our patients and clients (past and present) who involved themselves in this project and gave permission for the results of their assessments and treatments to be collated and used to evaluate this new treatment approach.

ANGER AND AGGRESSION: CONCEPTUAL BACKGROUND AND HISTORICAL PERSPECTIVE

OVERVIEW

An efficacious approach to anger treatment must be grounded in a coherent view of anger and how this normal emotion can become 'disordered'. Anger is a captivating, unsettling, and oddly satisfying emotion. Activated in our surround, it commands attention and alertness for potential danger. Triggered within us, it provides empowerment yet can otherwise be cause for apprehension or shame. Anger is embedded in our hard-wiring for survival and perseverance. In response to oppressive circumstances, its expression is often tension-relieving. Recurrent anger, however, adversely affects emotional and physical health and is disruptive of social relationships that sustain personal well-being. Overridingly salient, perhaps, is anger's linguistic, symbolic, and empirical connection to aggression, which impels societies to seek remedies for its control.

Anger is indeed a perplexing emotion, and there is a multi-level ambivalence about its control. It is part of the human fabric and the diversity of personality, often garnering delight as well as disapproval. As a subjective experience, it curiously has self-serving qualities that can carry a gratifying aura, particularly in the service of retaliation. Thus, we do appreciate its functionality, but nevertheless recognize its commonly troublesome products. Precisely because it is associated with subjective distress, detrimental effects on personal relationships, health impairments, and the manifold harmful consequences of aggressive behaviour, interest in anger control prevails as a human welfare and societal concern.

Providing clinical interventions for persons having recurrent anger problems is a challenging enterprise. This turbulent emotion, ubiquitous in everyday life, is a feature of a wide range of disorders encountered by mental health and social service professionals in diverse settings. It is commonly observed in various personality, psychosomatic, and conduct disorders, in schizophrenia, in bipolar mood disorders, in organic cognitive disorders, in impulse control dysfunctions, and in a variety of conditions resulting from trauma. The central characteristic of anger in the broad context of clinical problems is that it is 'dys-regulated' – its activation, expression, and ongoing experience occur without appropriate

controls. Alternatively stated, in such clinical conditions, there is a substantial incongruence between anger engagement and the requirements for optimal functioning, both in the short term and in the long term.

For persons with developmental disabilities, their life circumstances and psychosocial experiences, from childhood onward, are conducive to the activation of anger. Moreover, the environmental settings in which many reside are intrinsically constraining and limited in satisfaction. Recurrent thwarting of physical, emotional, and interpersonal needs can easily activate anger; cognitive functioning deficits readily impair effective coping with frustrating or aversive events; and impoverished support systems curtail problem-solving options. For decades, however, a prime treatment target for persons with developmental disabilities has been their ‘challenging behaviour’, which focuses away from internal emotional distress. As was so aptly stated by Blunden and Allen, ‘very few intervention plans actually teach people with learning difficulties socially acceptable ways of expressing anger or frustration, and challenging behaviour may be the one way in which people in such circumstances can exert control over the way in which they live’ (1987, p. 39).

Because anger is a common precursor of aggressive behaviour, it can be unsettling for mental health professionals to engage as a treatment focus, regardless of its salience as a clinical need. Because seriously angry people tend to be treatment-avoidant, engaging them in the therapeutic enterprise is often hard-going. Efforts to achieve clinical change are challenged by the adaptive functions of anger as a normal emotion and by its ties to symbolic structures having high personal, familial, and social group relevance. Anger routines have identity attachment qualities and are not easily relinquished. The oppositional nature of many high-anger clients results from anger being entrenched in personal identity, derivative of traumatic life history, associated with personality or mental disorder, and unmitigated by soothing social influences. Intellectual functioning deficits clearly add to the challenges of anger regulation from the standpoint of both clients and those who seek to help them therapeutically.

In this book, we address the assessment of anger and the provision of anger treatment for persons with developmental disabilities. Our approach is cognitive-behavioural in orientation, and while it is grounded in an extensive clinical research project with hospitalized forensic patients, the proffered content and overview are more broadly based. Our attention to anger is mindful of the entanglements of the clinical problem in this client population – namely, the conjunction of developmental disability, impoverished family background, early conduct difficulties, substance use, serious offence history, institutionalization, re-offending, amalgamative emotional distress, and recurrent challenging behaviour for mental health care staff. Innovations and evidence in the existing literature point to achievements in the assessment and treatment of persons having such multi-layered difficulties in regulating anger and aggressive behaviour, and this bodes well for extensions to clients with less severe anger problems and less resource impairment.

THE SOCIETAL CALL FOR ANGER CONTROL

Proscriptions for anger control have been plentiful since classical philosophers sought rational control over the emotions, which were then understood as passions that seized the personality, disturbed judgement, and imperilled behaviour. Pre-dating the Greek and Roman Stoics were Buddhist teachings about the path to enlightenment, seeking to train

the mind to gain inner strength. Anger control has been a vexing issue addressed in disparate ways by Buddhists, Stoic philosophers, Psalmists, Scholastics, philosophers of the European Enlightenment, Jonathan Swift, American colonists, Victorians, Existentialists, early North American psychology, Dr Spock, Dale Carnegie, sensitivity trainers, Zen masters, and psychodynamic and cognitive-behavioural therapists, to name an assortment of promulgators.

Interest in anger control gained prominence in recent decades both in the general culture of Western societies and in broad clinical psychology literature. In many countries, the call for 'anger management' is commonly encountered in news/entertainment media, as well as in directives from social gatekeepers seeking to rectify someone's troublesome behaviour. In the popular press, road rage metastasized into air rage, cinema rage, golf rage, rink rage, surf rage, trolley rage, and royal rage. Anger management became a frequent prescription given by judicial officers, school administrators, mental health system directors, and prison and probation authorities. Its diffusion is exemplified by the many self-help tradebooks written by clinical practitioners, the subtitles of which reflect the quest for wellness through anger control (e.g., Carter, 2003; Colbert, 2003; Cullen & Freeman-Longo, 1995; Davies, 2000; Harbin, 2000; McKay, Rogers, & McKay, 1989). Advances in academic research and in evidence-based psychological treatment provided the springboard for the societal consciousness-raising, which has now included a Hollywood production on the topic. Perhaps it is too cynical to state that anger problems are commonly trivialized, but it seems fair to conclude that, unless serious violence is involved, anger therapy is viewed with less gravitas than therapy for depression.

The designated recipients of real-life anger interventions have been highly diverse in problem condition, e.g., domestic violence perpetrators, traffic offenders, children with conduct problems, quarrelsome neighbours, explosive felons, and persons with various psychiatric disorders being offered anger management as supplementary care. Anger treatment gains for clients having a wide range of clinical disorders have been reported in case studies and multiple baseline studies, which will be presented later. In contrast, a great many recipients of anger treatment in controlled studies have been college student volunteers, which unfortunately results in such studies with quasi-clinical clients receiving disproportionate attention in meta-analyses. As six meta-analyses have now been published (Beck & Fernandez, 1998; Del Vecchio & O'Leary, 2004; DiGuiseppe & Tafrate, 2003; Edmondson & Conger, 1996; Sukhodolsky, Kassinove, & Gorman, 2004; Tafrate, 1995), there oddly may be more meta-analyses of anger treatment than the number of high quality clinical trials justify.

The call for 'anger management' has perhaps been far too prevalent, and those ready to be proficiently responsive far too few. Nevertheless, mental health professionals in many service delivery domains have now become familiar with client anger problems and have explored diverse approaches to improving their clinical care capacity in this regard. Dissemination of programmes has occurred in schools, clinics, hospitals, and prisons, especially of cognitive-behaviour therapy (CBT) interventions, implemented with varying degrees of systematization. As reviewed by Taylor (2002a), anger treatment also took hold in the field of intellectual disabilities, including CBT, as well as other modalities. Because the general procedures of CBT are relatively accessible, attempts to apply this mode of treatment to anger can easily miss important elements of this therapeutic approach, from the clinical problem formulation, to the complexities of cognitive restructuring, and to the details of stress inoculation work with provocation hierarchies. To facilitate improvements in service

provision, this book presents a full anger assessment and treatment protocol, buttressed by clinical material and procedural tools to enable effective implementation for persons with developmental disabilities.

As an important backdrop, the historical context of psychological interventions for anger will be broadly overviewed to cultivate a differentiated understanding of the anger construct. Being versed in the conceptual complexities will foster adeptness in assessment of anger problems and provide a firmer grasp of core elements of CBT anger treatment. Implementation of the anger treatment ultimately requires proficient flexibility and nuances in protocol application. One must ‘breathe life’ into a treatment manual (Kendall, Chu, Gifford, Hayes, & Nauta, 1998). An enriched understanding of anger and aggression provides a grounding for the identification of anger problem dimensions, points of leverage, and treatment avenues.

AN ENCAPSULATED HISTORY

Early psychology

Since the writings of Charles Darwin, William James, and Walter B. Cannon, anger has been viewed in terms of the engagement of the organism’s survival systems in response to threat and the interplay of cognitive, physiological, and behavioural components. It is an elementary Darwinian notion that the adaptive value of a characteristic is entailed by its fitness for the environment (Darwin, 1859); if the environment changes, that characteristic may lose its adaptive value, and the organism must adjust. Thus, the activation of anger may usefully serve to engage aggression in combat and to overcome fear, but, in non-combat environments (and even in combat ones), anger is often maladaptive. Many theories of emotion have enlarged upon the Darwinian view of emotions as reactions to basic survival problems created by the environment and upon Cannon’s (1915) idea that internal changes prepare the body for fight or flight behaviour. These core ideas are exemplified in Plutchik (1980), as well as in Lazarus (1968). From Cannon to Lang (1995), emotion has commonly been viewed as an action disposition. As well, emotional expression is understood to have communicative value, which Darwin (1872) recognized and which has received extensive research attention from Ekman (2003), Izard (1977), and others.

Anger was prominently addressed by Darwin (1872), both throughout that volume and in a chapter detailing its vicissitudes (i.e., defiance, indignation, rage, and hatred). However, anger had long been the subject of scholarship in philosophical writings, from the classicists, such as Aristotle and Seneca, through Augustine, Aquinas, Hobbes, Spinoza, Nietzsche, and Sartre – to do some leapfrogging over time. To summarize the work of philosophers on anger would be a daunting task, and on the classicists there is a masterful book by Harris (2001) and a splendid edited volume by Braund and Most (2003). Regarding intellectual ancestry highly pertinent to what is presented in this book, it should be noted that a conception of anger as a product of threat perceptions, as having confirmatory bias characteristics, as being primed by aversive precursors, and as having social distancing effects can be found in the writings of Lucius Seneca (44/1817), who was Nero’s tutor and is perhaps the first anger scholar.

In the field of psychology, G. Stanley Hall’s (1899) important monograph sought to move us beyond the predominantly philosophical analyses that prevailed at that time. To

this end, he distributed a questionnaire in a national mailing that produced 2,184 returns. His questionnaire asked for descriptions of sensations, symptoms, overt acts, mental correlators, cognitive constructions, and palliatives associated with anger reactions. He distilled the responses into various content categories: causes, physical manifestations, 'vents', reactions, control, and treatment. Despite Hall's rich account, no programmatic work followed. In the ensuing decades, there was a peppering of diary studies of anger experiences (cf. Novaco, 1986), some introspection experimentation (e.g., Richardson, 1918), and some prescient clinical writings in the nascent field of psychosomatic medicine (e.g., Alexander, 1939; Miller, 1939; Saul, 1939) that called attention to the relationship of anger to blood pressure. No paradigm for research came to the fore, nor was there a prevailing conceptual framework – anger had no conceptual salience for Freud and his followers. Hall (1915) asserted that every Freudian mechanism applies to anger as well as to sexuality, yet anger remained neglected.

As there is no better metaphor for anger than hot fluid in a container, it is surprising that interest in anger and blood pressure slipped into abeyance until a burst of laboratory research occurred in the 1950s (e.g., Ax, 1953; Funkenstein, King, & Drolette, 1954; Oken, 1960; Schacter, 1957). There was dormancy again until the important field research of Harburg and his colleagues (Harburg et al., 1973; Harburg, Blakelock, & Roeper, 1979) on anger and essential hypertension, which importantly highlighted person–environment interactive variables and provided impetus for the study of anger as a public health issue. These clusters of research on anger and cardiovascular processes and disease are noteworthy – while developments in several areas of psychology have fuelled our contemporary interest, it was especially research in health psychology that served to spur attention to anger that had merely flickered since Hall's (1899) effort to advance psychological work on this subject.

Nascent aggression research

Research on aggression in personality and social psychology was substantial following the famous *Frustration and Aggression* monograph (Dollard, Doob, Miller, Mowrer, & Sears, 1939). Oddly, this body of research, for the most part, ignored anger; indeed, the word 'anger' is virtually absent in Dollard et al. (1939), appearing rarely and only incidentally, as in a footnote that refers to a diary study monograph by Goodenough (1931). In accounting for the activation of aggression, Dollard et al. relied on the term 'instigation', a hypothetical internal motivational state, rather than give attention to anger. The empirical agenda of experimental psychology in observable events resulted in a preference for the study of aggressive behaviour over the emotion of anger, which was seemingly more elusive and unsuitable for the positivistic programme.

Frustration was understood by Dollard et al. as a measurable goal-blocking – its intensity was seen to vary with the importance of the goals ('strength of the goal response'), the degree of interference with the goal response, and the number of response sequences frustrated. Its empirical locus was outside the person. The inherent ambiguity of the term, which certainly connotes an internal state, and the over-generality of its application ultimately weighed against its utility in accounting for aggression. As Buss stated, 'It is difficult to imagine a behaviour sequence in which some drive is not suffering interference, especially when security and comfort are included as drives' (1966, p. 153). Pertinent to later cognitive appraisal formulations of the dynamics of anger and aggression, research by Pastore (1952)

and Cohen (1955) had shown that the experience of frustration did not uniformly provoke aggression but that the ‘arbitrariness’ of frustrations was an important mediating factor.

The landmark book by Buss (1961) did indeed give attention to anger (e.g., a chapter on anger physiology), but being strongly inclined toward positivism (Buss defined aggression as ‘a response that delivers noxious stimuli to another organism’, *ibid.* p. 1), he did not designate anger as an antecedent to aggression. In was Berkowitz (1962), in his important book, who argued for giving greater focus to anger as the emotional response mediator of frustration–aggression relationships. He used ‘anger’ in lieu of ‘instigation to aggression’ and asserted that it would be profitable now to consider this emotional state as the mediating condition. For example, one of his distinguished students, Geen (1968) later showed that when frustration is personalized or is exacerbated by insult, the resulting anger and aggression are proportionately greater. Oddly, although Berkowitz (1962) argued for the value of anger as a central mediating variable, he gave relatively little attention to it in the remainder of the book after his discussion of frustration–aggression propositions. In subsequent decades, Berkowitz also changed his view of the role of anger as a determinant of aggression, instead asserting that ‘negative affect’ was the central mediator (Berkowitz, 1990, 1993).

In the experimental laboratory research that evolved from the frustration–aggression hypothesis (see also, Feshbach, 1964, 1971), as well as the development of social learning theory (Bandura, 1973), the pre-ordained focal topic was aggression, and anger remained a secondary subject. Feshbach’s approach to aggression also reflected the positivistic bias that excluded anger as a primary research topic. He asserted that ‘aggressive drive’, an intervening variable specified in Hullian terms (a mediating response-drive stimulus), motivated aggressive behaviour. He distinguished anger from aggressive drive, which was said to be facilitated by anger. Thus, the motivation for aggression was ascribed to a hypothetical condition having no organismic or phenomenological referents, which thereby diverted attention away from internal states. Similarly, Bandura’s (1973) social learning theory analysis relegated anger to a secondary position of importance. He adopted a general arousal model in accounting for the disposition for aggression, asserting that any source of emotional arousal would increase its probability, and while he certainly incorporated anger in his pioneering book, it had no featured status. In this genre of research, attention given to anger in experimental psychology occurred predominately with regard to it being a laboratory precondition manipulated to instigate aggression. In the aggression theories of Berkowitz, Feshbach, and Bandura, respectively, anger arousal is assigned response-energizing, response-motivating, and response-activating functions. Anger was viewed in each of their theories as an emotional response that facilitates aggression, rather than as a necessary condition, which remains the standard position among aggression scholars.

We will return to mainstream aggression research after first discussing psychoanalytic writings and some important concepts that it has bequeathed pertinent to our understanding of anger and its regulation.

Psychoanalytical theory

The heuristic source of the frustration–aggression hypothesis was psychoanalytic theory, but anger was a sparse topic in psychoanalytic writings (cf. Novaco, 1986). Freud, in his many works, never provided a coherent view of anger. Menninger (1938), one of Freud’s primary

exponents, presented many clinical and journalistic stories of persons who 'boil over with rage' and later asserted that the human child 'usually begins his life in anger' (Menninger, 1942); but he did not give explicit attention to anger and rarely used the word in his books. Similarly, the treatise on aggression by Hartmann, Kris, and Loewenstein (1949) virtually omits the word 'anger' – it appears in one incidental comment in describing hypothetical behaviour of a child. Their concern was with the integration of libido and aggression, and their conjectures were consonant with the frustration–aggression hypothesis. Anna Freud's (1949) article on aggression in that same volume (originally a paper presented at the Royal Society of Medicine in 1947) had emotional development in its title, but the word 'anger' does not appear anywhere in the text. She too was preoccupied with the fusion of the libidinal and aggressive instincts. For example, in describing pathological aggressiveness of young children who had distressed family backgrounds, who had been exposed to war, or who had been in institutions or camps, she states: 'Closer observation shows that the pathological factor in the cases is not to be found in the aggressive tendencies themselves, but in the lack of fusion between them and libidinal (erotic) urges' (ibid., p. 41). For her, the pathology was located in the blocking of emotional libidinal development due to impaired object relations. It is as if anger was a triviality.

Among the psychoanalytic writers who thought that Freud overemphasized libidinal frustration in the etiology of the neuroses was Horney (1939) who conjectured that hostile impulses toward parents may be aroused in the child in many ways, including lack of respect, injustice, unreasonable demands, unreliability, coercion, and manipulation. It is not surprising, then, that in the camp of psychoanalysis, it was one of her disciples, Rubin (1969), who gave anger top billing. Rubin's book was written in colloquial style. He advocated an outlook on anger that recognized its normality. However, he was preoccupied with the blocking, freezing, twisting, subverting, or otherwise 'perverting' of anger and hence leaned a bit far in the ventilationist direction. His overstating of the adaptive value of anger expression is readily seen in the 103 questions he puts forward at the book's end to prod the reader towards a healthier outlook on anger.

The first psychoanalytic authors to grant anger some priority were Redl and Wineman (1951, 1952), whose theoretical framework for their work with children posited an impulse system and control system hydraulic model, within which disorders of anger were understood in terms of breakdowns in the control system. Despite the cogency of their work, anger remained an undiscovered topic in psychoanalytic writings. Crocker's (1955) lengthy case study of a highly aggressive 13-year-old boy, with 'severe temper tantrums', which was published in the flagship journal, *The Psychoanalytic Study of the Child*, was approached in formulation and in treatment in terms of ego mastery of libidinal development – indeed, to an astounding degree. Saul's *The Hostile Mind*, (1956), in effect picks up where Freud (1930) had left off in *Civilization and Its Discontents*, viewing 'hostility' as the motivating force for human destructiveness – essentially, by-passing anger. There are many examples of the inattention to anger by psychoanalytic scholars in the decades after Freud. In Rochlin's (1973) scholarly book that examines aggression as viewed by psychoanalytic theory, the vantage point is narcissism – anger is not indexed and is sparsely mentioned. Bowlby's (1969, 1973) treatment of the subject is sparse. In his first volume on attachment, he briefly touches on anger in commenting about the reification of 'feeling' terms in discussing appraisal processes; in his second volume, it occupies a very small proportion of the text, despite its inclusion in the book's subtitle. Bowlby saw anger as functional when it served to fortify attachment bonds and dysfunctional when it weakened them.

As noted above, Rubin's (1969) book was an exception, being fully devoted to anger, and this is also the case for Madow (1972). However, as he himself says, 'no attempt is made in this book to distinguish between "aggression," "hostility," "rage," "resentment," and "anger"' (ibid., p. x). Madow's chapter on the *causes* of anger rests on frustrations of the pleasure principle and the societal demands for its surrender, and his analysis of societal violence turns on frustrations associated with deprivation and competition. The more recent book, *Rage*, by the psychoanalyst, Eigen (2002), describing case studies of psychoanalytic therapy, is near-tabloid in presentation and offers no conceptual framework.

Psychoanalytic theory gave scant attention to anger, but it was the inspiration for the frustration-aggression hypothesis, which in turn was the springboard for a wealth of research on human aggressive behaviour. Even psychoanalytic concepts, such as catharsis and repressed anger/hostility, which have been mired in empirical controversy far too complicated to address here, have influenced our understanding of anger and aggression, if only in being foci of debate and empirical investigation.

THE EMERGENCE OF ANGER IN PSYCHOLOGICAL RESEARCH

The post-FA field

In the decades after the frustration-aggression monograph, anger was for the most part an incidental topic in studies of human aggression. Berkowitz (1962) had flagged up the value of anger for this genre of research, but he gave it little coverage. Even Geen, one of Berkowitz's top intellectual offspring, who found significance for anger in the study on types of frustration noted earlier (Geen, 1968), soon thereafter was pursuing a general arousal model in accounting for aggressive behaviour (Geen & O'Neal, 1969), minimizing the relevance of anger. In the well-regarded book on aggression by Johnson (1972), anger is not in the subject index, and he gives it sparse treatment in two paragraphs of the book. In his chapter on the 'Control of Aggression', the word 'anger' is not to be found. In was in this historical context that Novaco (1975, 1976) argued for the importance of anger and anger control as subject matter, as it was paradoxically much discussed colloquially but rarely studied scientifically.

Several prominent aggression researchers (namely, Hokanson, 1961a, 1961b; Konecni, 1975a, 1975b; Zillmann, 1971; Zillmann & Bryant, 1974) did give anger a highlighted focus. It has centrality in Konecni's model of aggressive behaviour and in Hokanson's research on the physiology of catharsis. With the exception of their work, and that of Zillmann on arousal states, anger's status in aggression research through the 1970s was that of a nearly inconsequential phenomenon. There is a somewhat parallel situation in contemporary research on violence risk factors for psychiatric patients, as anger is just beginning to be identified as an important dynamic variable, as will be discussed in Chapter 6 concerning anger assessment.

Zillmann has contributed importantly to our understanding of the anger-aggression relationship (see especially Zillmann, 1979, 1988), and his key discovery was that of 'excitation transfer' effects (Zillmann, 1971). This idea and phenomenon are that arousal ('excitation') residues from a prior activating event can combine with arousal activated by some present event, thus transferring the undissipated arousal to that present event. This transfer then enhances or intensifies the experience of anger and the potentiation of aggressive behaviour,

when cognitively guided by cues of anger/aggression. Transfer effects are not conjectured to occur when the residual arousal is attributed to non-provocation sources. In a series of studies (see also Zillmann, Katcher, & Milavsky, 1972) involving physiological and behavioural measures, but no explicit anger measure (observation of anger came in debriefing interviews), he and his colleagues found that arousal residues from prior, non-provocation sources (physical exercise or erotic films) intensified subsequent aggression in the context of anger provocation. To put it simply, and to paraphrase Zillmann and Bryant (1974), someone who is already aroused 'blows their top' more readily than someone who is not already aroused.

Zillmann's excitation transfer concept is important because it provides a theoretical and empirical base for understanding how exposure to stressors, both acute and ambient, can predispose the person to respond angrily when faced with a minor provocation. For persons with developmental disabilities, the sequential experience or accumulation of aversive events can easily occur. When problems, conflicts, or disappointments remain unresolved due to resource limitations, the arousal residue can amplify anger in response to a subsequent thwarting. This concept highlights the need for arousal reduction techniques as part of a therapeutic programme.

Studies of anger in the fields of emotion and stress

A major boost to the study of anger occurred through the ascendancy of emotion in the agenda of psychological research, and the scholarship of Averill (1982, 1983) was particularly important. Great pioneers in the field of psychology, William James (1890) and Walter B. Cannon (1915), had given attention to anger in their efforts to understanding psychophysiology and emotion as an action impulse, but its relevance was subsidiary to concern with general principles. With the advent of behaviourism, from Watson to Skinner, anger was generally off the radar, being a within-the-skin subjective phenomenon. The behaviouristic emphasis that characterized the work that flowed from the frustration-aggression hypothesis, as discussed above, bypassed anger as emotion.

Following the seminal work by Hall (1899), about which the reader might now have even greater appreciation, there were a number of self-report diary studies done with college students, including that of Gates (1926) with women in New York (Barnard College), Stratton (1926, 1927) with males and females in California (Berkeley), Meltzer (1933) with males and females in Oregon, and Anastasi, Cohen, and Spatz (1948) with Barnard College women. A much more intensive investigation, which concerned young children, was reported in a very fine monograph by Goodenough (1931). These studies were conducted to ascertain normative patterns of anger, but the research samples were limited in generalizability (cf. Novaco, 1986, for a review of this body of research). Averill's (1983) work would correct that shortcoming.

Two other notable exceptions to the anger research dearth decades, and which incorporated sample variation, were the little known studies by Landis, Ferrall, and Page (1936) and by McKellar (1948, 1949). Landis et al. were inspired by Stratton's (1926) research, (rudimentary as it was) relating anger to disease, and they conducted a questionnaire study (anger and fear) with both college students and hospitalized psychiatric patients in New York. Relevant to points that will be addressed in our chapter on the assessment of anger, the college students reported higher anger than did the psychiatric patients, and female patients reported

more anger than did male patients. Landis et al. also found that anger significantly correlated with the number of physical diseases among the psychiatric patients, but not among the students. McKellar (1948) conducted both an introspective study (as did Richardson, 1918), with himself as subject over 47 days, and questionnaire studies with adult education students in the London area. This was followed by a multi-stage interviewing study with male soldiers and female college students (McKellar, 1949). He was insightful about the complexities of anger and its activating conditions, and he asserted that 'behaviourist and operationist type' methods were insufficient for the study of anger and aggression, 'in view of the frequency of the non-expression of experienced anger' (1948, p. 155).

To be sure, there was substantial psychological scholarship on emotion (e.g., Cannon, 1931; Gray, 1935; Hebb, 1946; Leeper, 1948; Wechsler, 1925; Zangwill, 1948), but that work addressed the subject generically, as theorists struggled to define and demarcate emotion, emotional experiences, and emotion-driven behaviour. Anger would be mentioned, but not given a concerted focus. Later emotion theorists, especially Izard (1977), certainly featured anger, but his research, and that of other prominent theorists (e.g., Ekman, Friesen, & Ancoli, 1980; Plutchik, 1980) primarily concerned facial expressions. Tomkins (1963) virtually ignored anger; also, the term appears in only a few lines in the book by Mandler (1975) on the psychology of emotion and stress.

The field of human stress offered another potential avenue for anger research, particularly given the bridge provided by Lazarus (1966, 1967), most centrality with regard to the concepts of threat, appraisal, and coping, which interfaced with the study of emotion. Arnold (1960) had already proffered the appraisal concept in the emotion field, as pertaining to what she called the 'estimative system' involved with the experience of emotional states and the impulse to action. However, in the stress field, the affective state that received most attention was anxiety, and rarely anger. Even in the book by Lazarus and Folkman (1984), anger is a sparse topic. It is astounding that in the field of posttraumatic stress disorder (PTSD), anger has been given little priority (see Novaco & Chemtob, 1998) despite its phenomenological salience in PTSD and its demonstrable empirical relevance, particularly for combat-related PTSD (Novaco & Chemtob, 2002). Nevertheless, in the 1970s, stress emerged as a rubric under which a wide variety of adaptation-related phenomena were investigated.

Psychological approaches to stress, as compared to those in the medical field, gave considerable emphasis to cognitive mediational processes and had a person-environment interactive focus. The research and theorizing done by Lazarus and his students, most notably Averill (1973), as well as by others, such as Glass and Singer (1972), strongly drove the cognitive mediation theme that became a core focus of research on anger and on the development of cognitive-behavioural interventions for anger problems (Novaco, 1975). As well, cognitive-behavioural pioneers, particular Meichenbaum (1977), laid the groundwork for the refinement of anger treatment and the formulation of the stress inoculation approach (Meichenbaum & Novaco, 1978). It was in this sea of influences that Novaco (1979) put forward a perspective on the cognitive regulation of anger and stress, and first implemented the stress inoculation approach for anger problems (Novaco, 1977a, 1977b).

The significance of Averill's (1982, 1983) work in advancing anger research and theory is unmistakable. He conducted multiple community and college sample studies that mapped normative data on various components of anger episodes, including background conditions, targets, objectives, intensity, duration, perceptions, continuing reactions, and also responses to the anger of others. Beyond his exceptional studies of the 'everyday experience of anger', he set forth a theory of anger that differs markedly from other thinking