I lash out when I’m angry: Anger Management Training for Abusers

Overview

Anger management training has been a staple in the treatment arsenal of counselors and therapists forever. Any parent who has ever drawn the attention of family and children’s services has likely been mandated anger management classes as part of their care plan before children are returned to their home.

Typically, such classes focus on calming strategies that are designed to help abusers maintain/regain anger control. While critical to the healing process, such calming strategies are only one of three parts to an effective anger management program. Counselors and clinicians would serve their clients better to include mindfulness and empathy, along with calming strategies, in the healing process.

Review of Literature

Kort (2015) confirms the conclusions of social science and criminal justice researchers that most of all non-war related violence stems from learned behavior. Aggressive behavior is learned by observation, imitation, and reinforcement. With time, the behavior becomes ingrained, and violence begets violence. Generally, anger management training involves steps to disconnect anger from aggression and unlearn the violent behavior.

Unchecked anger and aggressive behavior leads to failed relationships at home and at work, the rationalization of identifiable enemies, and the instigation of psychological, physical, and sexual abuse, child and elder maltreatment, ultimately increasing the likelihood of homicidal and suicidal outcomes.

Zimbardo (2007) connects anger to a sequence of triggers, including an emotional state of annoyance, hostility and argumentativeness, and aggression. Uncontrolled anger often stems from frustration or disappointment related to unfulfilled expectations, perceived injustice, and experience of verbal or physical harm. Response to these triggers is intensified by such situational factors as fatigue, drug and alcohol consumption, gang membership, and access to firearms and other weapons. Add psychosocial factors to the mix and violent episodes are commonplace. Bandura (2012) identifies such factors as low self-esteem, poor parental acceptance, inefficient and inadequate parental discipline, unmediated physical punishment and academic failure.

Golden (2016) notes that people with diagnosed antisocial personality disorder have a disproportionately high occurrence of uncontrolled anger and aggression. Unchecked aggressive behaviors like pinching, shouting, verbal and physical threats, intimidation, repeated sarcasm, hostile humor, hitting, throwing objects and overt physical assault are all evidence of uncontrolled anger and aggression.

Calming strategies have long been used for anger management. Historically, Jacobson (1938) outlined the procedure of progressive relaxation. These strategies attend to the immediate, physiological components of an emerging anger outburst. People consumed with anger demonstrate extreme muscle tension, rapid breathing, and cognitive distortion. Deep, diaphragmatic breathing, rather than thoracic breathing, is the first line of defense against uncontrolled anger and aggressive outburst.

Concomitantly, intense anger distorts thinking, judgment, and rationality. Anger outbursts often result from such cognitive distortions as over-underestimations, misattributions, polarized thinking, overgeneralizations, inflammatory thinking, catastrophizing, and expressions of demanding and commanding. Novaco (1979) researched

the benefits of positive self-talk as a calming strategy adjunctive to progressive relaxation and deeper breathing.

More recently, promoting mindfulness has come into its own as a technique for anger management. Brantley (2014) offers a strategic intervention called Mindfulness-Based Stress Reduction (MBSR) that has merit. The procedure promotes self-awareness skills to help the patient stop overreacting to anger triggers and stay in the moment to improve communication with others.

Robinson & Robinson (2016) and Geoveia, et.al. (2016) have identified mindfulness as middle ground between authoritative and permissive parenting styles. Geoveia, et.al. (2016) encourages parents to stay in the moment with their thoughts and feelings, while helping their children to do the same. Mindful parenting affects discipline and correction by focusing on choices and impact, avoiding cognitive distortion and misattribution.

Finally, active listening and empathy have found a place in anger management training. However, most programs promote active listening and empathy for the abuser, as a means of helping that person calm down (Comstock, 2015). While hearing is a physical process, listening requires attention and focus. Altabef, et.al (2017) concluded that counselors are more effective with their clients because of their active listening. The process of active listening reduces the counselor's negative affect toward the client. Burton, et.al (2016) concluded that college students showed greater understanding of self and others in analyzing conflict when they incorporated strategies for increasing emotional awareness into conflict resolution and negotiation.

Less apparent in the literature is the benefit of teaching abusers how to active listen and encouraging their empathy for their victims. Skeen (2016) makes a concerted effort with teens, promoting essential life skills including active listening, assertiveness, clarifying language,

the art of apology and compassion. Abusers could benefit from such lessons as well. Robinson (2016) identifies a specific toolbox of communication skills to promote teachable moments in families, reducing the risk of abusive behavior. Laviola, et.al (2017) just concluded an interesting study with mice. They reduced the concept of empathy to emotional contagion and measured the social transmission of emotional states in mice exposed to painful stimulus. Low empathy is a hallmark of such psychiatric problems as conduct disorder, antisocial personality disorder, and narcissistic personality disorder. Their study concluded that low empathy led to limited sensitivity to punishment, shallow or deficient affect, and reduced physiological reactivity to environmental stressors.

With human subjects, however, our patients can be taught how to be empathic with their victims and how to active listen them, contributing to a reduction in violent outbursts (Robinson, 2016).

Thus, collectively, it is time to put calming strategies, mindfulness, and empathy/active listening consistently and equally into intervention strategies for anger management training.

Components of Effective Anger Management

Anger is a universal feeling. All people feel anger. What they do with it is where problems can arise. Neurochemically, anger is the result of sensory perception transferring cognitive input to the prefrontal cortex where irrational thoughts are generated. When filtered through the hippocampus and the amygdala, intense feelings are attached and an impulsive anger outburst is born.

Eleven year old Alec comes flying inside from playing in the back yard one late Fall Saturday afternoon. The screen on the kitchen door bangs shut as he races inside. Alec doesn’t stop to close the back door, and a blustery wind sweeps into the house.

Alec's dad is watching his favorite football team lose, again, on the television. He's already killed one six-pack of beer, the last bottle dangling from his finger. The wide receiver drops a touchdown pass and dad jumps up, screaming at the TV. Alec is heading for his bedroom to retrieve his own football so that he and his neighbor playmate, Bryan, can play catch outside. Alec stops in his tracks as he passes by his dad, ranting about the dropped pass. He hesitates for a moment, as his dad settles back into his seat. Then Alec hurries to his bedroom, retrieves the football, and begins to scurry back outside.

"Boy, get me another six-pack from the fridge," dad bellows as Alec passes by him in the living room.

"I can't, Dad. Bryan is waiting for me," Alec stops and briefly explains. "I gotta go." Alec knows his dad drinks too much and doesn't want to help him drink more.

"What?" dad erupts. "Who do you think you are talking to me like that?" He grabs his son's arm before Alec can leave and pulls him back to him.

"Ow, Dad stop. You're hurting me."

"You don't get me that beer and you will be in a world of hurt."

Alec pulls his arm away. "Whatever."

Dad snaps Alec's arm back, backhands him across the face and yells, "You don't talk to me like that. I am your father." Alec melts into tears, holding his swelling jaw. "Get me my beer and then go to your room." Alec slinks away in defeat.

Alec's mom has left his dad once already because of his anger outbursts and alcoholism. Alec knows about child abuse from school, but he is afraid to speak up, fearing this time child services will take him away. Alec's dad seems to be in a world all his own, in complete denial.

In this typical scenario, hopefully the dad's behavior again comes to the attention of authorities before major injury or death occurs. Child and family services will mandate anger management and parenting classes before children can be returned to the family. If dad wants his wife and son back, he will get into alcoholism recovery and take the mandated parenting classes. He also will get into anger management therapy.

The blustery gust of cold air in the house, his favorite football team pulling a bonehead play, and Alec being distracted from dad's demands all form perceptions that his senses pick up and transfer to his prefrontal cortex as irrational thought. Neuro transmitters convey the message to his amygdala, where feelings are processed. His hippocampus triggers a fight, flight, or freeze context for the feelings. Fueled by the irrational thoughts and intense negative, self-centered feelings, his fight context wins out and leads to his angry outburst as a stress release mechanism.

As his therapist, my goal is to help Alec's dad first de-construct this precipitating event, embrace the control he doesn't think he has over the process, and equip him with coping tools that empower him to parent better and to move his life from surviving to thriving.

Power and Control: Anger Management's Worst Nightmare

Where the focus is on maintaining power and control, there can be no anger management. By definition, anger is a secondary feeling 98% of the time. That is, there is another primary feeling that is masked by anger almost all of the time. The only form of anger that is a primary feeling is righteous indignation. Ironically, people who witness physical child abuse experience righteous indignation toward the abuser. What the abuser did to that child is just…not…right.

Unfortunately, anger is the most socially acceptable negative feeling available to us, so we go there a lot, to avoid admitting to the primary negative feelings. People would rather admit to feeling angry

than to admit feeling disrespected, hurt, lonely, unloved, and other negative feelings that are covered by the anger.

Anger fuels power and control at the expense of relationship. Angry parents have power and control over their children because the children fear a pending anger outburst and will do anything to avoid their parent's wrath. These children comply and tolerate their parents, counting the days until they are out on their own. As adults, they often become the parents they don't want to be, because of the negative role modelling. They also are at higher risk for drug and alcohol abuse, poor school performance, unhealthy and abusive marriages, and job termination.

When an abusing parent makes the choice to yield power and control and to promote healthy relationship with their child, they experience genuine healing and hope for the future. How does an abuser get there?

Tools for Healing: Calming Strategies, Mindfulness, & Empathy

As therapist to an abuser, start and stay in the present. You are modelling where you want your patient to go. After Alec's dad makes it to my office, I start by helping him deconstruct the precipitating event. After confirming all of the details as he lays them out, I ask respectfully, but pointedly, "So, how did that work out for you?"

Alec's dad hopefully would admit the obvious, but my question could ignite another angry outburst from him. If so, I would stay with him through that outburst, help him use calming techniques, and assess the better, more positive outcome for him. I would note my choice for relationship with him over power and control, even though he is court mandated to see me, and invite him to let me take him on a journey from surviving to thriving in the family relationships that mean most to him. Hopefully, a therapeutic alliance is formed.

Calming Strategies

The first series of interventions need to be about developing effective calming strategies. These strategies empower your patient to exercise control over the impact of his immediate circumstances. Life events typically generate a sense of feeling helpless, powerless, and out of control for abusers. They use verbal, physical, and emotional aggression to assert that which they feel they lack. Calming strategies are the mechanisms by which abusers can regain their lost sense of power and control by focusing on that over which they actually have power and control --- their breathing and their thought processes.

Over my 40+ years of clinical practice, I have developed a protocol for patients to establish a quieting response, or QR, which is useful in addressing stress, worry, and panic. These feelings often are the primary ones that an abuser masks by anger outburst. In the vernacular, I call it "Chillin' Out."

After establishing the context and impact, I help patients first control their heart rate. Through guided imagery, even reliving the abusive precipitants, they notice an increase in their heart rate. Through instruction on taking deeper breaths, they notice a decrease in their heart rate. For many abusers, having control over such a seemingly simple physical measure is a breath of fresh air (pun intended).

Using the QR protocol, I walk them through the psychological components of smiling inwardly and with their eyes, which brings their perspective back to the present, helping them look inwardly, rather than outwardly. I explain the impact of trading "what if" thoughts, which generate doubt, anxiety, and anger, for "I wonder" thoughts, which generate curiosity. I then have them attach a positive outcome to their "I wonder" statements, generating hopefulness. Lastly, in the form of a 1-2 page narrative, I help them develop a baseline reference for a five

sensory calming circumstance, either from life experience or from imagination.

In therapy and in life, the longest distance we all travel is from our head to our heart, about 18 inches. With this in vivo experience of an effective calming strategy, your patient knows what to do. Believing this strategy will consistently work involves rigorous practice in real life circumstances.

With protocol in hand, your patient is instructed to practice QRs fifty times per day. After he protests at this burden, remind him that 50 such deep breaths actually takes only 5-7 minutes daily. Over time, help him develop contrasting lists of "what if" statements and "I wonder" statements, referring to their thought process about ongoing life stressors. Finally, help them actually write down a five-sensory description of a place or circumstance where life doesn't get any better than this. Help them go there in guided imagery, establishing an anchor and reference point for positive outcome to ongoing life stressors.

Healing calming strategies form the first defense against impulsive anger outbursts.

Mindfulness

Mindfulness is a trendy topic in psychology nowadays. However, it can also form the heart of anger management. Where calming strategies help patients feel empowered to do something constructive with their anger, mindfulness helps them focus on the context and locus of control of their anger.

To the extent that your patient can be in the moment with their thoughts and feelings, they are more likely to be in control of their feelings and less likely to have an anger outburst.

A visual image helps explain this perspective. I ask patients to stretch their hands out to each side, parallel to the ground. The midpoint

of your stretched hands is the present. The span to your left is the past, while the span to your right is the future. I add an emotional perspective and contend that depression often comes from living in the past, while anxiety often comes from fearing the future. Because we all have the power to choose our perspective, I encourage patients to close the span of their outstretched hands to the midpoint, which is the present in their lives.

With this visual image, patients are more comfortable focusing on their present observations and feelings, exercising healthier, rational thoughts and accepting their immediate feelings. The calming strategies and mindfulness together cool down the hot spots in their hippocampus and amygdala, easing the need for impulsive reaction and giving them time to sort out the precipitating event.

In therapy with me, Alec's dad goes back to the precipitating event. The more he explains what happens, the faster he talks, and the more irrational he becomes. I encourage him to slow down, take deep breaths, be in the moment, and understand all that he is feeling, while he reviews what was going on, what he said to Alec, what Alec said to him.

My role in the process is to help Dad stay on track, break down the events into more manageable pieces, look at those pieces from a variety of possible perspectives and options, sort it all out, and effect healthier parenting. No small task, and likely multiple sessions. His behavioral prescription between sessions is to keep Alec and his wife up to speed on what he is learning, practice QRs daily, and keep a journal of days' events and attending feelings. He is also to rank each day accordingly in his therapeutic journal on a 1-10 scale from uncontrollably angry (1) to at ease, responsive, and engaged with family (10). These measures help him feel empowered to overcome his anger issues and to move his parenting from power-based to relational-based.

As Dad's journal numbers begin to climb on the 1-10 scale, I will ask him, "What's working so well for you these days?" These kinds of questions help move his attention from what's wrong to what's right in his family. As he struggles, having good days and bad days, I tell him that I have some tools he could use to promote the good days for him and his family. Would he like that? Asking his permission maintains his authority and empowers him to make good decisions about the healing process. His taking ownership of the process increases the likelihood of his following through, making positive changes in perspective, choices, decision-making, and breadth of affect.

Empathy

Learning to and expressing empathy for our patients is the bread and butter of every clinician. When patients feel heard, they are brought into the healing process and more likely to make substantive changes that calm their feelings and improve their relationships. Passing that skill onto our patients helps them understand the impact of their words and actions on the ones they love, moves their family perspective from power to relationship, and lowers the likelihood of anger outbursts.

While the words empathy and active listening are interchangeable, I prefer introducing patients to active listening. The phrase connotes engagement with the speaker, conveying helpful feedback to the speaker, and turns a "me/you" exchange into an "us" journey in bringing family interaction back into balance. Active listening is often seen as a subset of empathy, where there is family focus. When parents engage in active listening, they both retain their authority and also come up beside their children to help them work out the tough spots.

Searching for empathy also calms the potential upset of the amygdala and moves the hippocampus away from fight or flight mode, and toward the freeze mode, where there is time to make better assessments of the danger level.

Most patients have heard of and feel well versed in the art of empathy. However, here is another place where the longest distance a person travels is the 18" from the head to the gut. Knowing what empathy is and embracing it as a communication tool are entirely different matters.

Thankfully, in addition to encouraging patients to practice active listening with their family between sessions, as their therapists, we role model active listening during each session. When your patient "gets it" and feels heard by you, pause your counsel and ask, "Did you see what I just did there?" Help your patient identify your words and the process, asking how that felt to him. This, then, empowers him to take that tool home and use it effectively with his family. He then can ask his family how helpful his active listening was to them in dealing with the circumstances.

Most parents spot the symptoms of their child being sick and having a fever. They know how to address the illness to bring the fever down, whether that's bed rest, chicken soup, or other means. After Dad has a good idea of what active listening is and how to use it with family members, I introduce the concept of children showing an emotional fever. Such symptoms as attitude, disrespect, mood, acting out can be seen as evidence of emotional fever. When Dad makes this connection, he will be less likely to take his child's words and actions personally, which fuels abusive behavior, and more likely to use active listening to calm him down, which fuels healthy relationships.

Also, to encourage a positive mind set and help your son make good choices, I would encourage Dad to ask his son, "Alec, this isn't like you. What else is going on?" Usually this question stops the child in his tracks because it is so unexpected. It also encourages a cognitive search of possible precipitants for his aberrant words and behavior. Sometimes, kids grow silent with this question, not knowing what to do. I share with parents that, when your essay question goes unanswered,

switch to a multiple choice question. You know your son well enough to come up with 4-5 possible scenarios that could be the cause of his upset. Presented with options, children usually pick one, and then you can active listen and problem-solve the upsetting circumstances

Finally, active listening is pivotal not only when your child is showing an emotional fever, but also when you need to confront him on his bad choices. Most parents, especially ones with anger issues and anger management problems, skip the active listening and go straight to punishment. Such authoritarian bullying leaves children with low self esteem, brooding resentment, and fantasies of passive-aggressive payback.

However, after stopping your child's bad words/actions, when you switch to active listening, your child feels heard, more understood, and will engage in mutual problem-solving to avoid recurrence of the offense. Your child then becomes more accepting of both your parental authority and the punishment you dole out. With joint problem-solving, your punishment become a measured dose of natural consequence to your child's offenses (for example, putting change into a cussing jar, as opposed to washing a child's mouth out with soap).

Summary and Conclusions

The therapy relationship a clinician has with a patient who is referred for anger management needs to mirror a healthy parenting relationship. Tools such as active listening, effective confrontation, and mutual problem-solving are experienced in the therapy office, from which your patient can transfer use of those tools to his family.

Too much goes into the making of an angry abusing parent for calming techniques alone to effect meaningful change. Because a parent wants his kids returned to his home, and because most also have good intentions about not repeating their abusive offenses, such patients will take the anger management class and give lip service to learning calming

techniques. They will then check off the box on their agency care plan and expect their kids to come home without further agency involvement. Calming techniques alone can induce serenity on the surface, while turmoil roils underneath.

Unfortunately, recidivism is very high in these circumstances because developing calming techniques alone is insufficient for lasting change. Adding mindfulness and empathy to the mix, with lots of practice, increases the likelihood of lasting, positive change.

Back in the day, strategic family therapists concluded that we are drawn to the familiar, even if it is unhealthy. Healing comes from when we move from the unhealthy familiar to the healthy unfamiliar and stay there long enough for it to become familiar. Therapists are charged with equipping your patients with the tools for healthy family interaction and their staying in therapy long enough for these tools to become second nature for the abusers. Identify, practice, teach, and role model the tools of calming strategies, mindfulness, and empathy for your patients.

John Holt (2017), an early educational philosopher, identified 4 developmental stages in education that apply also to therapy and the healing process. Abusers, and other patients, have issues of which they are unaware. This is the stage of unconscious ignorance. A precipitating event occurs which brings the issues into awareness, generating a conscious ignorance. That is, I have a problem, but I don't know what to do about it. This is when agency involvement occurs for abusers and referral is made for therapy. Most of therapy is a process of moving from the stage of conscious ignorance to conscious awareness. That is, I have these problems and I'm using these tools to deal with them. When use of these tools becomes automatic to emerging circumstances, patients move to the final stage of healing, that of unconscious awareness, where problems are history because patients are using tools before situations become problems.

As your patient enters the stage of unconscious awareness, I encourage a planned, structured family therapy session. Here, the abuser gets feedback from family members about noticed changes in their behavior, and bonds are re-affirmed. Taking time in therapy to address calming strategies, mindfulness, and empathy will make it more likely that changes and healing will be lasting.

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