UNDERSTANDING, MANAGING AND TREATING ANGRY AND AGGRESSIVE PEOPLE: A LIFESPAN APPROACH

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A SOCIAL INFORMATION-PROCESSING ANALYSIS

ENCODING PROCESS

- selectively attend to cues
- hypervigilant for hostile cues
- failure to attend to relevant neutral and prosocial cues

REPRESENTATION PROCESS

- hostile attributional intentional bias
- failure to consider alternative explanations
- underperceive own aggression and overperceive others' responsibility

RESPONSE SEARCH PROCESS – *how to choose goals*

- aggressive responses are most salient in memory
- poor ability in generating prosocial verbal assertive solutions
- implicit "if-then" rules, choose primarily aggressive goals

RESPONSE DECISION PROCESS

- failure to employ consequential thinking
- biased outcome estimates
- place value and derive satisfaction from aggressive behavior

RESPONSE SELECTION PROCESS

- limited experience with non-aggressive responses
- preference for direct action aggressive solutions ("get even")
- scheme activation of intentionality elicits "cognitive scripts" that act as learned guides for aggressive responses

EMOTIONAL VULNERABILITY

- high sensitivity – low threshold for emotional reactions and immediate reactions
- high reactivity – extreme reactions and high arousal
- slow return to baseline – long-lasting reactions

THE NATURE OF ANGER: INFORMATIONAL PROCESSING PERSPECTIVE

How individuals **encode and interpret social cues**, and how they engage in **response search, evaluation** and **enactment**, each influence the development and expression of anger/aggression. Aggressive individuals have **distorted and deficient social information-processing mechanisms**. They have **hostile interpretations, hostile attributional biases, unrealistic expectations**, and **cue-detection deficits** (misread social and situational cues and misread intentions of others) that lead them to experience anger in situations where nonaggressive individuals are more likely to view the situation differently. More specifically, **angry individuals** tend to:

a) maintain a **hostile attributional bias** (blame the cause of an event on the malicious and hostile intentions of another character; contains both the misperception of intent, but also the assumption of hostile motivation - *"She meant for this to happen just to get back at me!"*);

b) be **poor estimators of probabilities** (overestimate the probability of negative outcomes, events, and/or personal resources and underestimate the possibility of positive ones);

c) **misattribute causes** (quickly and automatically perceive events as negative, even when information suggests alternative possibilities); an **exaggerated sense of violation** and **having been wronged**;

d) **presume hostile intent** on the part of others, **be distracted from relevant social cues, choose aggressive responses** to situations, **evaluate aggressive responses as leading to successful outcomes, generate less constructive problem-resolving responses**;

e) **mind read and believe in the certainty of future events** (believe they know what others are thinking, how others will behave, and the consequences of their behavior);

f) **overgeneralize** - use broad constructs when evaluating **time** (e.g., "always", "never") and view **others** as being "stupid, crazy, worthless";

g) use **dichotomous** black and white **thinking** (e.g., victim – aggressor; winners – losers; right – wrong; like me - hate me);

h) use **inflammatory** or **provocative labeling** (use emotionally-charged language, "Idiots", "Jerks", "Waste the oxygen they breathe.");

i) use **catastrophic evaluations** (e.g., "horrible", "awful", "unbelievable", "hate");

e) reflect **long-standing** personal **grudges** and **cynicism**

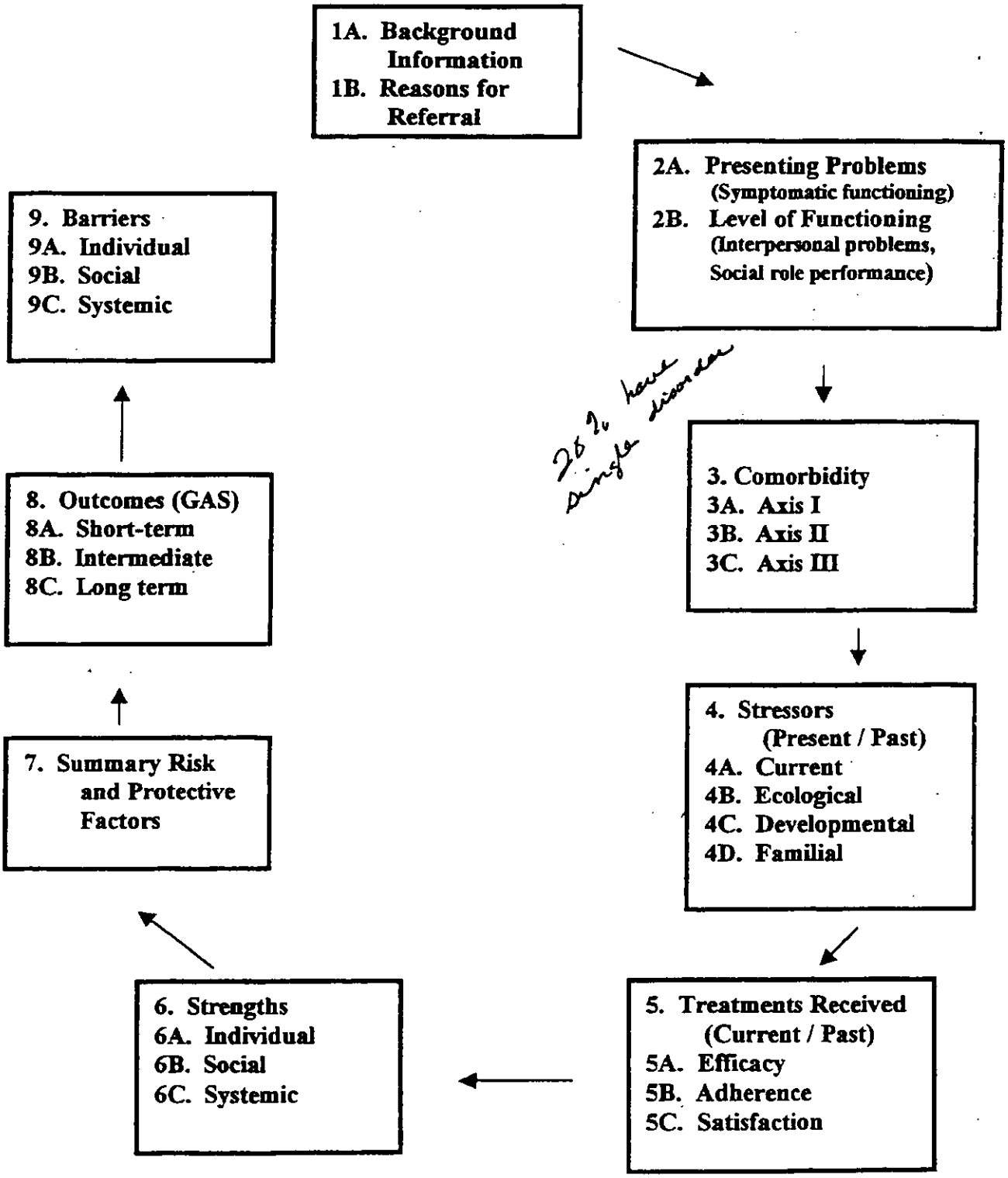
f) the use of anger expression and aggression are the **only ways to get attention** and **gain respect**;

g) they **must release** or **discharge** their emotions of anger (i.e., they hold an **"hydraulic", cathartic-discharge** model of anger expression);

h) views the world as **"negative"** and depicts others as antagonistic, threatening or harmful. Particularly of clinical concern, when the patient evidences **dichotomous thinking** (good-bad, friend-enemy) and refers to **diffuse others**, "They are out to get me."; "They betrayed me." This may lead to a justification position. "If they don't care about me, why should I care about them?"; "They don't deserve the air they breath. I'm expendable and so are they."

Baumeister et al. (1996) have noted that a main source of anger and violence is **threatened egotism**, particularly when it consists of favorable self-appraisals. Such **heightened self-esteem may be inflated or ill-founded** and when such **narcissism** is challenged with an external evaluation that disputes this self-view, angry aggressive behaviors may ensue. ***"Narcissists mainly want to punish or defeat someone who has threatened their highly favorable view of themselves."*** Cohen et al. (1996) note that when an event challenges an individual's or a groups' **"cultural code of honor"** (e.g., their status, masculine reputation) individuals are more likely to become upset and angry, especially if such insults occur between friends.

GENERIC CASE CONCEPTUALIZATION MODEL



By 4th session, 70% drop out of Counseling

FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see of I understand:

BOXES 1 & 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

"What brings you here is ..." (distress, symptoms, present and in the past)
"And it is particularly bad when ..." "But it tends to improve when you ..."
"And it is affecting you (how ... in terms of relationships, work, etc.)"

BOX 3: COMORBIDITY

"In addition, you are also experiencing (struggling with) ..."
"And the impact of this in terms of your day-to-day experience is ..."

BOX 4: STRESSORS

"Some of the factors (stressors) that you are currently experiencing that seem to maintain your problems are ... or that seem to exacerbate (make worse) are... (Current/ecological stressors)
"And its not only now, but this has been going on for some time as evident by ..." (Developmental stressors)
"And its not only something you have experienced, but your family members have also been experiencing (struggling with) ..." "And the impact on you has been ..." (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

"For these problems the treatments that you have received were – note type, time, by whom."
"And what was most effective (worked best) was ... as evident by ..."
"But you had difficulty following through with the treatment as evident by ..." (Obtain an adherence history)
"And some of the difficulties (barriers) in following the treatment were ..."
"But you were specifically satisfied with ... and would recommend or consider ..."

BOX 6: STRENGTHS

"But in spite of ... you have been able to ..."
"Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are ..."
"Moreover, some of the people (resources) you can call upon (access) are ..." "And they can he helpful by doing ..." (Social supports)
"And some of the services you can access are ..." (Systemic strengths)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

"Have I captured what you are saying?" (Summarize risk and protective factors)
"Of these different areas, where do you think we should begin?" (Collaborate and negotiate with the patient a treatment plan. Do not become a "surrogate frontal lobe" for the patient.)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

"Let's consider what are your expectations about the treatment. As a result of our working together, what would you like to see change (in the short-term)?"
"How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?"
"What has worked for you in the past?"
"How can our current efforts be informed by your past experience?"
"Moreover, if you achieved your goals, what would you see changed?"
"Who else would notice these changes?"

BOX 9: POSSIBLE BARRIERS

"Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way – any possible obstacles or barriers to your achieving your treatment goals?"
(Consider with the patient possible individual, social and systemic barriers Do not address the potential barriers until some hope and resources have been addressed and documented.)
"Let's consider how we can anticipate, plan for, and address these potential barriers."
"Let us review once again ..." (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment planning. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc.) Maintain progress notes and share these with the patient and with other members of the treatment team.)

ASSESSMENT STRATEGIES FOR ANGER

Explore with the patient where and when he or she becomes angry and why. **Listen to the patient's "story" and acknowledge the legitimacy of his/her account.** Do not interrupt the patient's "story." Rather, paraphrase what you heard and ask if you understood correctly (Thomas, 1998). ***(See questions below.)***

Conduct a **Structured Interview for Anger** (DiGiuseppe et al., 1994; McElroy et al., 1998) Determine the frequency, duration, magnitude of the anger response, range of anger-eliciting situations, hostile outlook, mode of anger expression – anger turned inward/outward. (Ascertain when the patient's anger is too frequent, too intense, too prolonged, unprovoked, or managed ineffectively. Determine whether the patient's angry feelings and aggressive behaviors are commonly impulsive or premeditated and whether it involves anger-related memories, rumination about retaliation and revenge. Determine whether the individual suppresses anger.) ***(See Deffenbacher et al., 1996; Gottman et al., 1995; and Thomas 1997 for a discussion of the negative consequences of suppressing anger or turning "anger-in".)*** Keep in mind that individuals may engage in anger to fend off other feelings such as helplessness, fear, shame, humiliation, betrayal, anxiety, depression ***(See Ornstein, 1999; Paivio, 1999).***

Conduct an **Historical Interview** of when the individual was exposed to anger / aggressive behavior and whether the patient's culture views anger and aggression as valued. Obtain an account from the patient, collateral (others), records of trouble with law, arrests, drunk driving, property damage, threats with and without weapon, physical fighting, loss of job or interpersonal difficulties resulting from anger.

Obtain a **specific account of violent behavior**. Ask the patient to list the most extreme aggressive/violent acts engaged in over the past 6 months (e.g., hitting, physically or verbally assaultive to another person, breaking objects because of being angry or frustrated). Ask the patient to indicate the approximate date, duration (how long the incident lasted) and the time of the day. Barratt et al. (1999) asked individuals to evaluate each aggressive act on a 22 item 5-point scale (definitely yes, yes, can't decide, no, definitely no). Illustrative items include:

Act was planned.
Act was spontaneous.
Act was the result of immediate peer or group pressure.
I was concerned about the consequence of the act for others.
I cannot accurately recall the details of the act.
I was not under the influence of alcohol or other drugs.
My behavior was too extreme for the level of provocation.
I now consider the act to have been impulsive.
I felt guilty following the act.

Use **Imagery-Reconstruction** Procedures -- Analyze anger scenario in terms of frustration level and perceived consequences in the future

Use **role-playing** and **videotape replay** of the patient engaging in anger-provoking situations (Assess problem-solving competence, empathy, perspective-taking, relationship skills)

Use **Gestalt two-chair technique** (Client expresses anger and then changes chairs and expresses how the other person feels and thinks)

Use Self-report Scales: State-Trait Anger Expression Inventory (Forgays et al., 1997; Spielberger, 1988), Anger Inventories (Novaco, 1990) and Buss and Perry's (1992) Aggression Questionnaire. Determine the degree to which anger and aggression are evoked by distant events.

Use **self-monitoring procedures** (Anger Log and Anger Attack Questionnaire, Hassle Log, Diary) ***(See Deffenbacher et al., 1996; Feindler and Ecton, 1986; Fava et al., 1997; Gerlock, 1996; Meichenbaum, 1994)***

The **assessment should be balanced** probing the patient about those occasions when they attempted to control and self-regulate their anger (see Coping Strategies Measure, Novaco, 1995) (e.g., avoid "high risk" situations and conflicts, socially isolate themselves, walk away from "risky" situations, keep busy, hide their reactions, view provocation as a "problems-to-be-solved.") Use **interviewing, self-report scales, and self-monitoring** procedures to have patients describe what they have done to **handle or cope with anger situations**.

Have the patient **observe** and **interview others** on how they handle anger-engendering situations

Assess for the **role of alcohol abuse** (e.g., Use the Addiction Severity Index, McLellan et al., 1992) ***(See Chermack & Giancola, 1997; Meichenbaum, 1994 for a discussion of the relationship of aggression and alcohol abuse and for a list of additional assessment measures)***. The levels of anger and violence are higher in substance abusers ***(Awal et al., 1997)***

Assess for **comorbidity** (psychiatric disorders such as ADHD, antisocial personality disorder, substance abuse, depression, anxiety disorders, psychosis) and medical conditions. ***(e.g., See Fava et al., 1991 for a discussion of anger attacks in depressed patients; See Meichenbaum, 1994 for a list of possible measures of comorbidity)***

INTERVIEW TO ASSESS PAST HISTORY OF VIOLENCE

What is the most violent thing you have ever done?

What happened?

Who was involved?

Who said what?

Who was hurt?

How bad were the injuries?

Let me see if I understand what exactly happened. So, if I were there watching this incident what would I have seen and heard?

Were you using alcohol (or drugs) at the time of this violent incident?

What about the other people (person) who were involved? Were they using alcohol or drugs?

Was there a weapon involved in the incident?

How do you feel about this incident now?

What plans do you have regarding the other persons(s) involved in the fight?

Are you thinking about getting even (revenge)?

What could you do if you were confronted by ... ?

Is there someone who could help mediate the fight (act as a go-between)?

What can <u>we</u> do to make sure you are safe and that you don't hurt someone else or yourself?

When you leave here (office, hospital), where will you go?

ASSESS FOR THE PATIENT'S PAST HISTORY OF VIOLENCE

(Look for patterns of violence. Remember that a past history of violence is the best predictor of future violence.)

Obtain patient's account of prior violence and obtain corroborative information.

- *What is the most violent thing you have ever done?*
- *What happened?* **(Appraise for perceived intentionality and justification explanations. Ascertain whether the aggressive behavior was instrumental, namely, planned, purposeful, goal-directed and predatory and evidences emotional detachment, as compared to reactive and highly emotional. Predatory violence characterizes psychopathic individuals and is particularly dangerous because it may occur without warning signs. Note level of hostility, stalking behavior, and delusional jealousy.)**
- *Who was involved?* **(Ascertain whatever the victim was a family member, acquaintance, or a stranger. Violence toward family members tends to be less severe.)**
- *Who said what?* **(Assess whether past violence was precipitated by an interpersonal interaction which diminished the patient's heightened sense of self-esteem?)**
- *Who was hurt?*
- *How bad were the injuries?*
- *Let me see if I understand what exactly happened. So, if I were there watching this incident what would I have seen and heard?* **(Ascertain whether there were any of the following warning signs or preassault behaviors.) Did the patient evidence any of the following behaviors?**
    - **Verbal abuse (swearing)**
    - **Raised voice**
    - **Threats (suspiciousness)**
    - **Standing uncomfortably close to victim and using threatening gestures**
    - **Agitation, irritability and restlessness**
    - **Behavior was disorganized**

KEEP THESE WARNING SIGNS IN MIND IN DETERMINING RISK OF CURRENT VIOLENCE, AS WELL AS THE FOLLOWING PSYCHIATRIC SYMPTOMS.

Were you using alcohol (or drugs) at the time of this violent incident?

What about the other people (person) who were involved? Were they using alcohol or drugs?

(Note that amphetamines, PCP and alcohol diminish behavioral controls and that stimulants can predispose individuals to violence through disinhibition, grandiosity and paranoia. Keep in mind that the combination of substance abuse and psychopathology is more volatile than either alone.)

Was there a weapon involved in the incident? **(Obtain a weapons history as outlined below and determine if currently, the patients has ready access to guns.)**

How do you feel about this incident now? **(Note a lack of empathy for others, coupled with anger is a risk factor.- Ascertain whether the patient evidences any remorse for past violence or conveys any empathy or compassion for others. Determine if the patient is planning to retaliate or get even.)**

What plans do you have regarding the other persons(s) involved in the fight? **(Do a careful assessment of possible future victims.)**

Are you thinking about getting even (revenge)?

What could you do if you were confronted by ... ?

Is there someone who could help mediate the fight (act as a go-between)?

What can we do to make sure you are safe and that you don't hurt someone else or yourself?

When you leave here (office, hospital), where will you go? **(Assess for living setting, access to weapons, substance abuse, peer influences, ongoing familial conflict, supervision, access and willingness to receive ongoing treatment, relationships with therapeutic and prosocial agents.)**

(As suggested by Philip Resnick, 2003)

"THE HIGHER THE NUMBER OF PSYCHIATRIC DIAGNOSES, THE GREATER THE RATE OF VIOLENCE, ESPECIALLY WITH CO-EXISTING SUBSTANCE ABUSE."

The risk of violence is increased by:

Threat /control-override symptoms

(1) mind feels dominated by forces beyond control
(2) feelings that thoughts are being put into your head
(3) feelings that there are people that wish you harm

Violence is more likely if delusions are:

(1) persecutory (paranoid)
(2) systematized
(3) preceded by fear or anger (e.g., escalatory fear in paranoid patients)

More violence is tied to delusions than hallucinations. Hallucinations that evoke negative emotions (anger, sadness, anxiety) generate more violence.

Manic patients are likely to become assaultive when limits are set or when provoked.

Violence can result when the patients reacts in despair by striking out against other people. Note presence of self-destruction and suicidal behavior and suicidal ideation.

Panic attacks may also be associated with aggressive behavior.

PTSD – Veterans with PTSD have a higher incidence of violent aggressive acts. Flashbacks may include threatening triggers or threatening hallucinations. High incidence of substance abuse and avoidance to numb feelings with accompanying irritability. Unemployment increases the risk of acting out behaviors.

Antisocial Personality Disorder and developmental history of conduct disorder.

Consider the role of neurological disorders (symptoms of recurrent headaches, altered consciousness, history of head injuries, and marked mood changes).

ASSESS FOR WEAPONS HISTORY

Have you ever owned a weapon (gun)?

If so, what weapons have you owned?

Do you own a gun (weapon) now?

What kind of gun do you own now?

Where do you keep your gun?

Have you ever threatened (inured or killed) a person with a weapon?

What happened?

Have you moved your gun (weapon) closer to you in the recent past (e.g., from your closet to your bed)?

What led you to do this?

Do you have any concerns about having a gun in your possession?

What concerns do you have?

How can <u>we</u> address these concerns, together?

ASSESS FOR DEVELOPMENTAL HISTORY

The History of Violence and Weapons History should be supplemented by a Developmental History of Violence in both the patient and the patient's family ***(See Meichenbaum, 2002 for a discussion of what items to cover in such a history.)***

For example, important items to cover include:

(1) Brutality or violence sustained by a child from a parent, particularly a brutal father.

(2) History of criminal and court arraignments. (Age at first arrest is highly related to persistence of criminal offending.) Obtain a delinquency history.

(3) Being a bully, or victim of bullies, or both.

(4) School failures and truancy.

(5) History of substance abuse.

(6) Fist psychiatric hospitalization by age 18. Obtain a treatment history to corroborate patient's account, and response to previous treatment and treatment nonadherence history.

(7) History of low frustration tolerance, impulsivity, inattentiveness, inability to tolerate criticism, tendency to formulate superficial relationships and dehumanize others.

(8) Evidence of lower IQ, less education employment and residential instability, raised in lower SES environment where there is a high incidence of street violence and domestic violence. Note the pattern of inter-generational and familial rates of violence

(9) Obtain a work history and explore frequency of jobs and reasons for termination.

(10) Violence peaks in males in late teens and early 20s.

BASED ON THIS INFORMATION LIST RISK AND PROTECTIVE FACTORS AND SPECIFIC MANAGEMENT/TREATMENT STRATEGIES

EXAMPLE OF TREATMENT/MANAGEMENT PLAN

Risk Factors	Protective Factors	Treatment Management Plans
1. Psychosis (threat/control override symptoms)	1. Living with mother – ongoing supervision	1. Provide ongoing support for mother
2. Past comorbid substance abuse	2. Not currently abusing alcohol	2. Treat psychotic behavior (medication) and ensure treatment adherence
3. Past history of violence (early onset, lost jobs because of violence)	3. Attending follow-up groups and active case management	3. Work with group therapist and case manager on cognitive behavior therapy
4. Victimization, history of physical abuse (but not currently PTSD)	4. No specific victim	4. Engage patient in prosocial leisure activities and paltime school activities
5. Male in early 20s	5. No immediate access to guns	
	6. Not in acute phase of illness	
	7. Reactive and not predatory aggressive behavior	

MENTAL ILLNESS AND VIOLENT BEHAVIOR: PREDICTION OF VIOLENCE

Diagnosis and assessment take on particular importance when clinicians are called upon to make judgments about the likelihood or prediction of violent behavior. Binder (1999) thoughtfully addresses this question. She begins by proposing that the question should be rephrased from ***"Are the mentally ill dangerous?"*** to a more complex question. After reviewing the research literature, she concludes that clinicians should formulate a different and a more complex question, namely,

> ***Which mentally ill patients are dangerous, under what circumstances, in which phase of illness with which comorbid diagnosis, while considering whether they have a history of violence and whether they are compliant with treatment.***

Which – **male**, **young** and **lower SES** have an increased risk of violence, **apart from their psychiatric illness**. (N.B. clinicians tend to overpredict violence in nonwhite patients and underpredict violence in women. **A history of violence is also predictive of future violence**.)

What circumstances – when placed in an environment that "pulls for" and that values violence. Do the current circumstances allow for **adequate monitoring** for drug and alcohol uses; has there been a **strong therapeutic relationship** established; what is the **likelihood of potential victims** (Family members with whom they are living and who are setting limits on them are the most likely victims, as well as individuals who are in the caretaking role.).

Phase of illness – when the patient's illness is in an active **acute phase**, there is a greater likelihood of violence. **Symptoms** such as high levels of thinking disturbance, hostility, suspiciousness and agitation - excitement are more valuable in predicting violence than is the patient's diagnosis. These symptoms should be systematically assessed using a Standardized Rating Scale such as the Overt Aggression Scale (See Steadman et al., 1998). (Note that agitation in depressed patients can be a side-effect of anti-depressant medication.)

Comorbid diagnosis – there is a high correlation between substance abuse (especially alcohol abuse) and violence; also delusional jealousy (See Silve et al., 1998).

Compliant with treatment – treatment nonadherence such as not taking medication, not attending therapy session. When patients are actively involved in collaboration with the treatment process and when a strong therapeutic relationship has been established, the likelihood of violence is reduced (See Beauford et al., 1997).

When clinicians take these factors into consideration and when they feel **confident**, they are more often accurate in their judgment about violence. Moreover, the prediction of

violence (like the prediction of the weather) is more likely correct in the **short term**, than over the long haul where situational circumstances that are distal can change.

In **summary**, the clinician needs to consider **a number of risk factors for aggressive behavior** that include:

a) **Substance/alcohol abuse** (see Hoaken et al., 1998 and Lau et al., 1995 for a review of how alcohol affects executive (frontal lobe) cognitive functioning and how alcohol acts as a mediator of aggression. (See Chermack & Taylor, 1995, for a consideration of how expectancy effects come into play.);

b) **Antisocial personality**; (Note that the rate of mental illness is 2 to 3 times higher among those incarcerated in jails than in persons in the general population, and that the mentally are disproportionately arrested compared to the general population. 40% to 50% of patients in the mental health system have an arrest history [Roskes et al., 1999]).

c) **Presence of comorbid psychiatric disorders** (incidence of violent/homicidal behaviors are highest in patients with comorbid disorders (Asnis et al., 1997). **The risk of violence is most** evident when symptoms are **acute** (Steadman et al., 1998) and among **mentally ill individuals with coexisting substance abuse** (Eronen et al., 1998);

d) **Presence of psychotic symptoms**, especially those that threaten a person or that involve delusional thinking and intrusion of thoughts. These are known as **threat-control-override symptoms** where individuals see violence as a justified defense or retaliation against harmful or manipulative actions that the person believes to be directed against him/herself. 8% to 22% of psychiatric inpatients have had assaultive episodes within the past 2 weeks prior to their hospitalization (Mulvey, 1994).

e) **Presence of self-destructive and suicidal behavior**;

f) **Availability of weapons**;

g) **Response to previous treatments**.