

Boiling Point

Problem anger and what we can do about it



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Foreword

Anger is present in all of our lives. We have all 'lost it' with family, friends or work colleagues at some time. I certainly have. But for most of us anger is both good and bad – it is a signal to resolve any difficulties surrounding it, and it can also motivate us. We can all remember the time when an argument cleared the air or when we took positive action because of anger.

Unfortunately this is not true for everyone. For a significant minority of us, anger spills over into our lives too often, disrupting relationships and work. At worst it can result in violence or physical abuse. In families prolonged anger can also cause deep unhappiness and sometimes mental illness. When we hold on to anger too long or when it produces inappropriate aggression it becomes what we call "problem anger". I don't like such labels very much, but we have to find a language to talk about what is a major social problem and is clearly one of the causes of crime, mental illness, loss of productivity and just plain unhappiness in our society.

We are way behind the pace in understanding anger and the responses that can be made to problem anger. Loss, bereavement, sadness and depression are well understood (if often confused) - so too are anxiety, fear and anxiety disorders. The last thing we need is to invent a new mental illness called "anger disorder"; but what we *do* need is a proper understanding of anger and how to respond to problem anger. Interventions that are helpful to real people could turn many lives around and prevent crime, mental illness and family breakdown.

This is not the sort of report that contains easy solutions that come on the back of a lorry. It is too early to come up with these. What we need is a clear commitment to research, information, education and service development work in this neglected area. The costs will be limited but the benefits could be enormous. The alternative of neglecting this issue and letting problem anger continue to grow in our society does not bear thinking about.



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Executive Summary

Definition: For the purposes of this report we have chosen to define 'problem anger' as 'any dysfunctional way of relating to and managing anger that persistently causes significant difficulties in a person's life including their thinking, feeling, behaviour and relationships.'

Background

Mounting evidence links anger with a range of physical, mental and social problems. Chronic and intense anger has been linked with Coronary Heart Disease, stroke, cancer and common physical illnesses including colds and flu, and generally poorer health; as well as increased risk-taking, poor decision-making and substance misuse. Higher levels of anger are related to lower levels of social support and higher stress levels. High levels of anger expression have also been associated with less frequent use of positive coping strategies such as actively addressing problems. Anger has also been linked with mental health problems including depression and self-harm. People describe anger as more likely to have a negative effect on interpersonal relationships than any other emotion.

There is evidence to suggest that societal changes are contributing to a rise in emotional problems. Public polling carried out for this report indicates that a majority of the population believe that people in general are getting angrier. Influential authors quoted in this report have examined life in 21st century Western society and stated recently that we are getting angrier, and that despite 50 years of economic growth in the UK, we are no happier.

However, any changes we are witnessing are unlikely to be in the core structure of our basic emotions. Evolution is a slow process - rapid changes are instead occurring in our social habits, and economic and political circumstances, and how they influence our thinking, feeling and behaviour.

This report is about problem anger, how it affects individuals, families and communities, and what we can do to minimise the harm it causes.

Problem anger

Anger alone is not the problem. It is one of our most powerful and vital tools. It is necessary to our survival as individuals and communities.

The majority of people will experience episodes of anger that are within a usual and healthy range. But a general awareness of more positive ways of expressing and dealing with anger is desirable for the whole population. Learning healthy ways of dealing with anger helps people to look after their mental and physical health, achieve goals, solve problems and nurture social relationships.

However, at the more extreme end of the range, anger can become entrenched in everyday life for some people, with destructive effects. Some people experience anger frequently and intensely, and it interferes with their thinking, feeling, behaviour and relationships, often creating misery for themselves and others. For this group, who might be described as experiencing 'problem anger', getting help could make a massive difference to their well-being, as well as the well-being of people around them.

It is not within the report's scope to suggest a set of guidelines or indicators to determine whether someone does or doesn't need help with problem anger. Anyone who actively seeks help because they feel that anger is causing problems in their life should receive it.

Why isn't problem anger tackled?

Anger has received relatively little attention in the mental health field. A fundamental lack of discussion in the scientific literature indicates that anger has not been considered an emotional issue worthy of scientific conceptualisation and attention. The lack of attention given to anger by researchers naturally has a knock-on effect in clinical practice. Problem anger is still barely conceptualised as a mental health issue.

Sadness and fear, emotions which are entrenched in the conditions of depression and anxiety, have been given much attention in psychology because of a drive to treat depression and anxiety, which are recognised as common mental health problems. At each stage the working models, methods and outcomes have been debated very widely.

The psychology of anger has been left behind for reasons we explore in this report, including the labelling of angry behaviour as 'bad', rather than 'sad' or 'mad', and therefore unworthy of attention and care. Understanding problem anger and, more often, its outward expression in aggressive behaviour have been attempted largely from a criminal justice perspective.

While anger is an emotion and aggression is a type of behaviour, the two are often conflated. This conflation is often cited as a reason why underlying entrenched anger goes largely untackled while aggressive behaviour is punished.

Given this background, it is not surprising that the options for people seeking help with problem anger are limited. We are intervening too late if we can't help people with problem anger before their behaviour requires intensive intervention in the criminal justice system. Commendable work has been undertaken in relation to anger and aggression in criminal justice but we should not wait until lives have been irreparably damaged to intervene. Greater recognition of problem anger could offer many opportunities for positive intervention in the lives of individuals and communities to benefit their physical and mental health and overall quality of life. Anger should be everyone's business.

How can we tackle problem anger?

Despite a widespread lack of impetus to study anger as an issue in its own right, researchers say there are approximately 50 published research studies that have tested some kind of intervention for anger with adults and another 40 relating to children or adolescents. They conclude from these that successful interventions exist for adults, adolescents and children and that they are equally successful for all age groups and all types of populations. This suggests that treatment for problem anger can be effective.

Research commissioned by the Mental Health Foundation for this report reveals that the general public believes anger is an increasing problem in our society, and that we overwhelmingly support the idea that someone with an anger problem should seek help. That help is most likely to be sought from a GP or another health professional.

GPs we interviewed report that they have few options for helping patients who come to them with problem anger – NHS-funded anger management programmes tend to be small, limited and infrequent, where they run at all – and psychology services are not geared towards the treatment of problem anger. Patients with problem anger do not fit the criteria for referral to psychologists in primary care. These tend to focus on people with mental health problems such as anxiety and depression. GPs can refer people to the voluntary sector, but many do not feel confident to do this, either because they don't know what's available or they are not sure the service is suitable or quality checked.

Some responsibility for addressing problem anger lies with researchers, clinicians and policy-makers. Problem anger, despite its sometimes frightening visibility, has often been ignored as an area for research and service provision in the mental health field. The result is that people who might benefit enormously from learning how to manage their anger are not encouraged to come forward, or when they do come forward, they may be offered little or nothing in the way of useful support.

How is problem anger currently being tackled?

Some health professionals are taking the initiative to set up their own schemes, and there are some good examples of anger management courses run either within existing services or by agencies contracted by them, but without systematic support, they are fighting an uphill battle.

A related factor is that people with problem anger often fail to recognise their anger as a problem, or if they do, they are reluctant to seek treatment for it, because they feel ashamed. This is backed up by the Mental Health Foundation's survey results, which find that many more people identify problem anger in close friends and family than in themselves.

The good news is that there are many schemes, run by a variety of organisations – statutory, voluntary and private – which in one way or another are targeted at helping people deal with problem anger. These provide many pointers to good practice. The bad news is that much (though not all) of what is currently on offer are post hoc interventions, to which people are referred because

they have already got into some considerable trouble – at home, work or school, or with the police and criminal justice system. We are waiting too long if we can't help people address problem anger before this has happened.

What needs to be done next?

Our research indicates that as a society we are aware of the problems that poorly managed anger can create, and are in favour of people who experience such problems seeking help. If we can persuade them to seek help, we must also ensure that the help is there for them to take advantage of.

This means taking a number of steps.

We need a clearer conceptualisation of problem anger as an issue to which psychologists and others should address themselves. Investment in further research would help, as would anger awareness campaigns addressed at both health professionals and the general public. We also need a broadening of referral criteria, which would mean improved pathways to treatment for patients who have problem anger.

We need greater training of health and social care professionals to identify, empathise with and treat problem anger among their existing patients or clients to ensure that, when it manifests as part of a complex range of mental health issues as it sometimes does, problem anger can be identified and dealt with as part of any treatment plan.

We need greater acknowledgement of problem anger as a valid reason for referral to health care and greater use of anger screening tools as part of the assessment process. There appears to be some progress being made with this through programmes such as Improving Access To Psychological Therapies, but there is much more to be done. Anger is still too often dealt with as a sub-set of anxiety disorders, meaning that people who do not fit the diagnostic criteria for anxiety disorders won't find their way to the help they need.

We need greater provision of specific programmes of treatment - individual and group, so that everyone who takes the courageous step of presenting themselves to their GP or another health or social care worker with problem anger can receive support for it. This might take the form of anger management groups, or individual/group therapy and might be within the NHS or provided by the voluntary or private sector.

For those whose anger has led to an aggression-related criminal offence, anger management treatment could be made available as a matter of course. Similar programmes could be more widely available for children whose aggressive behaviour has led them into trouble at school.

We also need greater provision of information about and education related to problem anger in schools, in the workplace, in other community settings and in the media. This could be aimed not just at those who have problem anger but all those who come into contact with them, and could include measures to reduce stigma and fear related to anger.

Evidence outlined in this report shows that the sorts of interventions we need to help people with problem anger already exist. Cognitive Behavioural Therapy and other interventions are already used widely for depression or eating disorders and evidence shows that they can also help people with problem anger. While more research is needed to establish the best methods and how to apply them, we already have the means to help many people. But problem anger is not currently a 'way in' to psychological help – either because the general population doesn't recognise it as a legitimate issue for which they can get help, or there isn't a clear route via which health and social care workers and other relevant groups can recognise problem anger and offer the help that is needed.

By making efforts to step up research into the effectiveness of different treatments for problem anger, and to create a wider range of specific pathways to services for people seeking help with their anger, we could begin to bridge this gap in investigation and provision. The possible benefits, which might include increased well-being, a reduction in fear, less crime, improvements in social cohesion, reduced aggression, improved relationships and greater individual and collective emotional literacy, are surely worth making such an effort.

The publication of this report marks the beginning of a public awareness campaign by the Mental Health Foundation. The Foundation is providing information materials for individuals and signposting them to further help.

Methods

A range of research methods were used to compile the data for this report, including:

- A review of existing literature on anger, anger problems, aggression and clinical approaches to problem anger
- A survey completed by a nationally representative, quota-controlled sample of 2000 people carried out by YouGov
- Site visits to and interviews with key stakeholders including providers of anger management courses and therapies; psychologists; GPs; charitable organisations providing advice, guidance and other services to the general public and individuals who have experienced and sought help for problem anger

Key findings

- GPs report that they have few options for helping patients who come to them with problem anger
- There are some good examples of NHS-funded anger management courses and others being run by voluntary organisations, as well as private sector providers
- Where NHS services do not exist GPs can refer people to voluntary sector providers and others, but often aren't confident to do so
- There are approximately 50 published research studies that have tested some kind of intervention for anger problems with adults and another 40 relating to children or adolescents, and researchers have concluded that successful treatments exist for adults, adolescents and children
- Almost a third of people polled (32%) say they have a close friend or family member who has trouble controlling their anger
- More than one in ten (12%) say that they have trouble controlling their own anger
- More than one in four people (28%) say that they worry about how angry they sometimes feel
- One in five of people (20%) say that they have ended a relationship or friendship with someone because of how they behaved when they were angry
- 64% either strongly agree or agree that people in general are getting angrier
- Fewer than one in seven (13%) of those people who say they have trouble controlling their anger have sought help for their anger problems
- 58% of people wouldn't know where to seek help if they needed help with an anger problem
- 84% strongly agree or agree that people should be encouraged to seek help if they have problems with anger
- Those who have sought help were most likely to do so from a health professional (such as a counsellor, therapist, GP or nurse), rather than from friends and family, social workers, employers or voluntary organisations
- Generational differences are striking. Older people are less likely to report having a close friend or family member with an anger problem or to be worried about how angry they sometimes feel or that they have trouble dealing with their own anger, than younger people
- There are striking regional differences in responses to our anger polling – especially between Scotland and other parts of the UK

Recommendations

Anger studies and interventions for problem anger are in their infancy. Research, analysis and an established evidence base are critical in relation to problem anger before a detailed strategy can be developed. At this stage the Foundation recommends:

1. Action : Carrying out a meta-analysis of evidence on problem anger and related interventions

Who should do it : This should be done by a respected institution such as the Cochrane Collaboration or the York Centre for Reviews and Dissemination

2. Action : Carrying out an economic analysis of the impact of problem anger covering health, social care, criminal justice and quality of life

Who should do it : A number of research institutes, universities and charitable trusts have the potential to make this happen

3. Action : Undertaking an evaluation of existing anger management resources

Who should do it : This should be commissioned by the Department of Health in concert with the Department of Justice and the Department for Children, Families and Schools.

4. Action : Mapping out local anger resources including anger management courses, psychology services that take anger referrals, and any other sources of information and advice. This must be done at a local level using a multi-agency approach. This information must then be provided by Primary Care Trusts to GP practices and by the Probation Service to probation officers.

Who should do it : Local authorities; local health commissioners and providers; social care providers, education providers, probation workers and local voluntary sector organisations, including those involved in youth work and neighbourhood renewal, with support from local and national funding providers

5. Action : Provision of pathways for people who seek treatment for problem anger, however they engage with services. Problem anger should not be tackled only as a subset of depression or anxiety, and screening tools and treatment programmes must take account of this.

Who should do it : Improving Access to Psychological Therapies; psychology services; mental health providers

6. Action : Provision of more information about and education related to anger management in schools, in the workplace, in other community settings and in the media. This should include measures to reduce stigma and fear related to anger and admissions of problem anger. This should be included in general approaches to mental health and wellbeing, for example as part of a PSHE curriculum in schools, but a stand alone awareness campaign about seeking help for anger is also needed.

Who should do it : A public awareness campaign should be co-ordinated by the NHS, but other stakeholders in information provision and awareness-raising include the Department for Children, Families and Schools, the Department for Work and Pensions, as well as individual employers and education providers

Section 1: Background

1.1 Introduction

Human emotions are vital to our survival but they can also do us harm. Emotional problems contribute enormously to the burden of human suffering, and learning to cope with our emotions is not straightforward. Anger is one of the most basic emotions. Alongside happiness, sadness, fear and disgust, it has played an important part in our evolution. It is pervasive and powerful. It is also widely misunderstood and ignored.

Mounting evidence links anger with a range of physical, mental and social problems. Anger has been associated with problems in relationships, including social, family and working relationships.¹ People describe anger as more likely to have a negative effect on interpersonal relationships than any other emotion.² Chronic and intense anger has been linked with Coronary Heart Disease³, stroke⁴, cancer⁵ and common physical illnesses including colds and flu, and generally poorer health⁶; as well as increased risk-taking, poor decision-making⁷ and substance misuse.⁸ People who are chronically angry die younger and are six times more likely than others to die of a heart attack.⁹ The most visible consequences of anger are aggression and violence. Higher levels of anger are related to lower levels of social support¹⁰ and higher stress levels.¹¹ High levels of anger expression have also been associated with less frequent use of positive coping strategies such as actively addressing problems.¹² Anger has also been linked with mental health problems including depression¹³ and self-harm.¹⁴ In the United States, most murders are committed because of or during arguments.¹⁵

Anger alone is not the problem. It is one of our most powerful and vital tools. It is necessary to our survival as individuals and communities. It has been and can be a powerful force for good in the world. But evidence suggests that it can do harm to individual and community health and well-being, and it can contribute to violence and tragedy. We can and should look for help with anger when it is causing us or others harm.

1.2 When is anger a problem?

Outward expression of anger in modern life seems to be commonplace. According to surveys, 45% of us regularly lose our temper at work, with half of us having reacted to computer problems by hitting or screaming at our PCs, or screaming at or abusing our colleagues. More than 80% of drivers claim to have been involved in road rage incidents, while the incidence of 'air rage' went up by 400% between 1997 and 2000.¹⁶

At the more extreme end of the range, aggression can become entrenched in the everyday lives of some people, with destructive effects. According to Department for Education and Skills figures, the total number of school suspensions rose by 45,000 (13%) in 2005.¹⁷ Suspensions for physical assaults on pupils increased by more than 11,000 and on adults by nearly 2,500. According to the TUC, one in five workers is subjected to violence at work.¹⁸ The estimated total cost of domestic violence to society in monetary terms is £23 billion per annum¹⁹, and every third day a woman is murdered at home, often by her spouse.²⁰

1 Tafrate and Kassonove 2002; Kassonove, Roth, Owens and Fuller 2002, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

2 DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

3 Williams, Paton, Siegler, Eigenbrodt, Nieto, et al., 2000, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

4 Everson, Kaplan, Goldberg, Lakka & Sivenius, 1999 Stroke 30, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

5 Butow, Hiller, Price, Thackway, Krickler, et al., 2000, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

6 Adams, 1994; VanderVoort, 1992 Psychology and Health, August, 2005,

7 Kassonove, Roth, Owens and Fuller, 2002, Aggressive Behaviour 28, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

8 Awalt and Reilly 1997 Journal of Psychoactive Drugs 29, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

9 Quoted at <http://www.jeanniehorsfield.com/anger.htm>

10 Awalt and Reilly 1997 Journal of Psychoactive Drugs 29, DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

11 Diong and Bishop 1999, Psychology and Health, August 2005

12 Ibid

13 Clay, Anderson and Dixon, 1993, Journal of Counseling Psychology, Vol. 43, 1996

14 Mental Health Foundation, Truth Hurts, 2006

15 Source: FBI, Supplementary Homicide Reports, 1976- 2005. <http://www.ojp.usdoj.gov/bjs/homicide/tables/circumstab.htm>

16 The Sunday Times Magazine, July 16 2006, quoted at <http://www.angermanage.co.uk/data.html>

17 The Independent 14 April 2007

18 TUC, June 2001, quoted at <http://www.angermanage.co.uk/data.html>

19 Quoted at http://www.womensaid.org.uk/landing_page.asp?section=000100010005

20 <http://www.steppingstonesuk.com/anger.htm>

It is important to recognise however, that not all anger is 'problem anger', and that not all 'problem anger' necessarily leads to aggressive acts. For the purposes of this report then, we define 'problem anger' as 'any dysfunctional way of relating to and managing one's anger that persistently causes significant difficulties in a person's life including their thinking, feeling, behaviour and relationships'.

The majority of people will experience episodes of anger that are within a usual and healthy range. For these people, learning how to deal with anger more effectively is desirable. Evidence outlined above suggests that learning 'healthy' ways of dealing with anger helps people to look after their mental and physical health, achieve goals, solve problems and nurture social relationships.

However, some people experience anger frequently and intensely, and relate to that anger in a way that interferes with their relationships, often creating misery for themselves and others. It is this group that could be described as experiencing 'problem anger', and getting help with dealing with their anger could make a massive difference to their well-being, as well as the well-being of people around them. "Anger is a response to a perceived threat," says Jeannie Horsfield, director of the Manchester-based organisation Steppingstones UK, which specialises in anger management. "But anger itself is not the problem; the problem for most people is the *inappropriate expression of their anger and the damage this causes in their own lives and to the people in their lives*. It can manifest itself in physical, mental and verbal assaults, relationship break-ups and bullying, frequent irritability and social withdrawal."

1.3 Anger as a mental health issue

The last century has seen a turnaround in the way that we understand health and illness in Western societies. The focus of healthcare has shifted to accommodate mental as well as physical ill-health. We are more aware of the damage that mental health problems can do to individuals and families. One in four British adults experiences at least one mental health problem in any one year,²¹ and Mental Health Foundation research has put the overall cost of mental ill-health at almost £100 billion a year in the UK.²²

But the field of mental health is not devoted solely to identifying and managing mental illness. The Mental Health Foundation believes strongly in the promotion and protection of good mental health for all. Keeping people mentally healthy is every bit as important as helping them when they experience mental health problems. Working to prevent mental health problems represents a sound and sensible investment of public money. Despite this, comparatively little emphasis is placed on promoting mental health and preventing mental illness in the UK.

Getting help with managing anger is a good example of how individuals might protect and promote their own mental health. But anger has received relatively little attention in the mental health field. A systematic search of one scholarly database by two anger researchers revealed 1,267 articles in the area of 'diagnosis and depression', while they found 410 similar articles relating to anxiety, and just seven related to anger. According to the academics DiGiuseppe and Tafrate: 'The almost complete lack of discussion in the scientific literature indicates that psychology has not considered anger to be an emotional problem worthy of clinical conceptualisation and attention.'²³

Similarly, there are relatively few assessment instruments for anger, and little treatment-outcome research.²⁴ So, according to DiGiuseppe and Tafrate: 'Although research...affirms the negative influences of anger on one's health, work, effectiveness, interpersonal relationships and propensity to aggression, anger is rarely regarded as a debilitating emotion to the same extent as anxiety and depression.'²⁵ While the Mental Health Foundation would argue that anxiety and depression are clinically constructed illnesses and anger is an emotion, there is an important point being made here. Sadness and fear, emotions which are entrenched in the conditions of depression and anxiety disorders, have been given much attention in psychology because of a drive to treat depression and anxiety, which are recognised as common mental health problems. Gold-standard research has been invested in to establish and grow the evidence base for treating depression and anxiety, and empirical evidence is mounting all of the time. At each stage the working models, methods and outcomes have been debated very widely. Anger, on the other hand, with 'problem anger' as its entrenched, dysfunctional form, has not received anything like the same amount of attention.

21 Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. Psychiatric Morbidity Among Adults Living in Private Households, 2000 London: The Stationery Office

22 The Economic and Social Costs of Mental Illness, The Sainsbury Centre for Mental Health (2003), updated and extended from England to UK in The Fundamental Facts, The Mental Health Foundation (2007)

23 DiGiuseppe and Tafrate, Understanding Anger Disorders, Oxford, 2007

24 Ibid

25 Ibid

The psychology of anger has been left behind for reasons we will explore later, including the labelling of angry behaviour as 'bad', rather than 'sad' or 'mad', and therefore unworthy of attention and care. Understanding of anger and, more often, its outward expression in aggressive behaviour, is usually attempted largely from a criminal justice perspective.

Given this background, it is perhaps not surprising that the options for people seeking help with anger are limited. But we are intervening too late if we can't help people with anger before their behaviour requires intensive interventions in the criminal justice system. Greater recognition of anger problems could offer many opportunities for positive intervention in the lives of individuals and communities to benefit their physical and mental health and overall quality of life. Anger must be everyone's business – including primary care workers.

This report is not designed to argue for new diagnostic categories to take account of anger as a 'disorder', although some researchers and clinicians are strongly in favour of this.²⁶ But problem anger contributes enormously to mental health problems, whether or not it constitutes a formal diagnosis in itself. We also want to understand the role that healthy expression of anger plays in mentally healthy individuals.

Research commissioned by The Mental Health Foundation for this report reveals that as a general public we believe anger is increasing in our society, and that we overwhelmingly support the idea that someone with an anger problem should seek help. That help is most likely to be sought from our GP, or another health professional. And yet, because problem anger has received relatively little attention as outlined above, pathways to help are few and far between. GPs report that they have few options for helping patients who come to them with an anger problem – NHS-funded anger management programmes tend to be small, limited and infrequent, where they run at all – and psychology services are not geared towards the treatment of anger.

The result is that problem anger may frequently be left unaddressed, perhaps until the person experiencing it loses their job, experiences a breakdown in their relationship or in extreme cases, harms someone else and comes to the attention of the criminal justice system. According to Mike Fisher, from the British Association of Anger Management: 'You have a desperate population whose only way of dealing with these strong feelings is by addictive behaviour or taking medication for depression. We get hundreds of enquiries daily by email, as well as calls from local councils, doctors, youth offending teams, social services, court services, HR departments and of course from private individuals, and they've got nowhere to turn. Nobody wants to fund it or invest in it. It only ever gets dealt with when someone who's committed a crime or beaten someone up is actually found guilty, and then they're on a six-month waiting list for programmes within the probation service – if they're lucky.' Clinical psychologist Jeffrey Deffenbacher says: 'We have too long ignored or avoided treating clinical problems of anger, particularly those in the mild-to-moderate range. These are often the anger reactions that influence health, relationships, vocations and a sense of self, but do not necessarily force people into therapy.'²⁷

Anger is not of course a subject solely for clinical psychologists. We should be aiming for a broader understanding of problem anger and need to enable a much wider audience across the health and social care spectrum to take it in.

1.4 What can be done about problem anger?

This report has two related aims – to raise awareness about anger and how to deal with it among the population as a whole, and to encourage the development of more options and pathways for those people who might benefit from help with problem anger. There are grounds for optimism with regard to both of these aims. Our poll results (set out in detail in section 3) indicate that we as a society are aware of anger as an issue to be addressed, and are keen to see it tackled in a positive, rather than just a punitive, manner. Meanwhile, our interviews with both professionals and patients reveal an enthusiasm for dealing with problem anger, and support for help being offered on a much wider basis. However, for now, studies on anger interventions remain in their infancy, services are few and far between, and awareness about how to access the services that do exist is low.

Widespread concern about problem anger revealed by our research is a strong indicator that the time has come for those in health and social care and the general public to develop a better understanding of how to deal with anger in the healthiest ways possible. This report aims to kick-start that process by revealing the public sensibility towards anger and the treatment of problem anger, examining the academic literature on anger, exploring how problem anger is currently addressed by health professionals, and offering examples of good practice in the field. Our guiding principle is that everyone can benefit from taking account of how they deal with anger and how they can do it better. And that anyone who seeks help because they feel that anger is causing problems in their life should receive that help.

²⁶ Di Giuseppe and Tafra, 2007, *Understanding Anger Disorders*, Oxford, 2007

²⁷ Tavis C, *Anger: The Misunderstood Emotion*, Simon & Schuster, 1989

At the same time as launching this report the Foundation is running a public awareness campaign to encourage people to learn to cope better with anger.

It is aimed at:

1. Anyone who feels anger more frequently and more intensely than they would like
2. Anyone who is worried about their own or a loved one's anger and how they behave when angry
3. People who have recently been through an incident where their anger got out of control and they did something they regretted
4. Anyone who has suffered a 'loss' in their life due to their own or someone else's anger
5. Anyone who may be on the verge of seeking help for any mental health problem or is concerned about the mental health of a loved one.

Improving awareness of anger and how to deal with it could lead to many benefits. We have already seen how anger is linked to many of the most pressing social problems we face, and so it seems logical that by learning how to manage anger appropriately, we might reduce the enormous cost – personal, societal and economic – of those problems. By providing improved access to support for those people whose anger is most troublesome, and by encouraging everyone to learn to manage anger appropriately, we might be better equipped to cope with, and live well despite, the inevitable stresses of 21st century life.

Section 2: Theories on anger

2.1 What is anger?

Anger is usually considered to be one of the core human emotions. While there are hundreds of emotional states, researchers have posited a few universal 'basic' emotions that have helped the human race survive. According to one influential pair these emotions are happiness, anxiety, sadness, anger and disgust.¹

Emotional states (sad, happy, angry, afraid) describe the way we feel, a result of a combination of physical, mental and social factors. These emotions help define our reactions to situations - if we feel unsafe we may be afraid and flee, if we feel cared for we may be happy and sociable. The emotions help us decide how to act at every turn. Emotions are products of mind and body, and are extremely sensitive to our environment.

Emotions have a strong physical basis: some experts argue that, because each emotion has evolved for a different survival strategy, each has a separate physiological response consistent with a particular strategy.² In other words, each feeling prepares the body for a different action. The physical, psychological and behavioural aspects of our emotions cannot be separated. While they have a powerful physiological presence, emotions are influenced by thoughts - our reasoning and deduction can cause anger, fear or excitement to increase or dissipate.

Anger is closely linked to the 'fight, flight or freeze' mechanism that we employ in response to a threat. It is the emotion that predominantly allows us to select 'fight' from these three basic options.

Anger keeps our bodies and minds stimulated and ready for action, due to its arousal of the sympathetic nervous system.³ The resulting increase in heart rate, blood pressure, blood flow to voluntary muscles, blood glucose level, breathing rate, sharpness of the senses, and sweating, are needed for an alert or emergency.

Researchers have found that anger results in more sympathetically-aroused sensations than any other emotion except fear.⁴ This means it enables us to work very hard physically and mentally to put right a perceived 'wrong'. This has been described by behavioural psychologists as our 'biological attack system'.⁵

2.2 Why do we get angry?

Anger has evolved for good reason. Throughout our individual and collective history, survival has depended on the energy and motivation generated by feelings of anger, triggering our desire to fight for change.

It is important to note that 'fight' and 'attack' do not in this context mean acts of physical aggression, but any response to a stimulus that is designed to right a perceived wrong.

The spurs for anger that we have today are much the same as the ones our ancestors had: we or our loved ones may be under physical threat, we may have suffered a blow to our self-esteem or place within a social group, we may be losing a battle for resources, someone may have violated a principle that we as individuals or in a group hold to be valuable, or we may be thwarted or interrupted when we are pursuing a goal.

In groups and communities, anger has a 'policing' function. This is why it is often referred to as 'the moral emotion'.⁶ Collective rules of anger have been found to serve societies⁷ - and there are strong dictates collectively for what we can justifiably get angry about. A major function of anger in society is maintaining order and codes of behaviour.⁸

However, some of the emotional responses that our ancestors developed to enable them to cope with their everyday situations can seem confusing when we experience them in our everyday situations, especially if we don't understand their origins, or why

1 Oatley, K. & Johnson-Laird, P.N. (1987). Towards a cognitive theory of emotions. *Cognition and Emotion*, 1, 29-50.

2 Di Giuseppe and Tafate, 2007, *Understanding Anger Disorders*, Oxford, 2007

3 Ibid

4 Ibid

5 Beck, AT. *Prisoners of Hate: The Cognitive Basis of Anger, Hostility and Violence*

6 Tavis C, *Anger: The Misunderstood Emotion*, Simon & Schuster, 1989

7 Tavis C, *Anger: The Misunderstood Emotion*, Simon & Schuster, 1989

8 Tavis C, *Anger: The Misunderstood Emotion*, Simon & Schuster, 1989

they are triggered in particular situations. For example, the feeling of overpowering rage some people experience when public transport lets them down and they are on their way to an appointment. Or the impotent frustration we may experience when our computer repeatedly crashes and thwarts our progress with a work assignment. Every individual has a different set of triggers that may have been primed in our history to deal with a different situation. An angry response can thus be activated in 'inappropriate' situations, causing what may seem to be an irrational emotional reaction.

How we process our thoughts and feelings are key factors in dealing with the challenges of life. If we learn negative ways of coping this can create a vicious circle, as we are likely to teach these to our children.

2.3 What makes us angry?

Several researchers have looked at which stimuli tend to result in anger. S Mabel in 1994 constructed one of the widest studies to date. After reviewing 900 stimuli and reducing these to 360, he administered a questionnaire to a cross-section of people. His resulting analysis produced 10 distinct stimuli:⁹

1. Interruption of goal-directed behaviour when time is important
2. Experiencing personal degradation or unfair treatment and being powerless to stop it
3. Being treated unfairly, unkindly or in a prejudicial way, whether or not one is present
4. Being the object of dishonesty or broken promises, being disappointed by others or oneself
5. Having one's authority, feelings or property disregarded by others
6. Being ignored or treated badly by a significant other
7. Experiencing harm because of one's negligence towards oneself
8. Being shown by others' behaviour that they do not care
9. Being the object of verbal or physical assault
10. Being a 'helpless victim'

2.4 Are we getting angrier?

Many observers believe that societal changes are contributing to an overall rise in emotional problems. Oliver James and Professor Richard Layard are two influential authors who have both examined life in 21st century Western society. James has recently stated that we are getting angrier¹⁰ and Layard that despite 50 years of economic growth in the UK, we are not happier.¹¹

However, any changes we are witnessing are unlikely to be in the core structure of our basic emotions. Evolution is a slow process - rapid changes are instead occurring in our social habits, and economic and political circumstances, and how they influence our thinking, feeling and behaviour. According to researcher Carole Tavis: 'The stresses of urban life are highly stimulating: frustration, noise, crowds, alcohol and sports do not instinctively generate anger, they generate physical arousal which, when coupled with a psychological provocation, can become the feeling of anger. Most of us don't realise how often we are agitated by the background stimulants of our lives.'¹²

"The pressures of modern day life put enormous stress on families, relationships, individuals and organisations," says Jeannie Horsfield. "The result is we increasingly witness and experience greater levels of anger, frustration, irritability and stress."

9 Mabel S, Journal of Social and Clinical Psychology, 13 (2) Di Giuseppe and Tافrate, 2007, Understanding Anger Disorders

10 Observer, 18 March, 2007

11 Layard, R, Happiness, Penguin, London, 2005

12 Tavis C, Anger: The Misunderstood Emotion, Simon & Schuster, 1989

2.5 Are some people more angry than others?

The psychologist CD Spielberger has suggested making a distinction between emotional 'states' and 'traits'.¹³ States are individual episodes of an emotion, whereas trait refers to the tendency to experience the emotion frequently and intensely. Spielberger applied this distinction to anger and developed a measure that assesses anger as state and trait. His theory predicts that people who score high on trait anger will (a) experience the state of anger more frequently and more intensely, (b) experience anger at a wider range of provoking stimuli, (c) express anger more negatively and cope poorly with anger and (d) experience more dysfunction and negative consequences of anger in their lives.

In short, some people are far more likely to react with anger to a range of situations and experiences.

In one US study separating individuals into high-trait anger and low-trait anger people, anger-prone individuals were more than twice as likely to have been arrested and three times as likely to have served time in prison.¹⁴

It is a common assumption that there are gender differences when it comes to anger. However, research suggests that men and women experience and express anger at a similar frequency, with similar intensity, and for similar reasons. It may be, however, that men are more likely to display aggression, which is sometimes conflated with anger.¹⁵

2.6 What is the relationship between anger and aggression?

Anger and aggression can exist independently of one another. Anger can be described as an emotional state, while aggression is a type of behaviour. In most other areas of psychology and health we distinguish very clearly between feelings and behaviours, but there remains a widespread tendency to conflate anger and aggression.¹⁶ We wouldn't conflate the behaviour of withdrawal (i.e. avoiding people and situations) with the feeling of anxiety, for example, but anger and aggression are often considered together. However, you can be very angry in the short and long-term with few or no outward displays of aggression.

This conflation is often cited as a reason for why anger goes largely untackled while aggressive behaviour is punished. Aggression is often adopted by an angry person in order to put right the situation they're angry about. But feelings of anger are much more common than aggressive actions.¹⁷

13 Di Giuseppe and Tافrate, 2007, Understanding Anger Disorders

14 Di Giuseppe and Tافrate, 2007, Understanding Anger Disorders, Oxford, 2007

15 Ibid

16 Ibid

17 Ibid

2.7 Are we developing new forms of anger?

The media has developed a tendency to invent new angry emotional states to match social trends or technological inventions. The past decade has seen 'road rage', 'air rage', 'parking rage' and 'net rage', as outlined in section one of this report. None of the basic behaviour described is new, nor does it indicate that individuals are changing in their emotional responses to problems. Similar provocations for anger have long been prevalent. Circumstances that are more common in the 21st century are causing us to look at them from particular angles and sometimes, to think they are new. We believe that common understanding of the forces behind current trends and daily events is limited by a lack of discussion of emotions in public debate.

Following are three such examples, with some background information about what behavioural, evolutionary and social psychologists have suggested about them:

Rage

The idea of 'rage' attached to common, everyday annoyances is commonly offered up in news stories. Shopping rage, trolley rage, PC rage, call-centre rage, even 'pavement rage' have been presented as modern-day plagues.

In fact the patterns of anger and aggression that underlie these phenomena have been around for thousands of years, and have been explored and understood by theorists and clinicians. The triggers for many of these types of rage are well understood thanks to the frustration-aggression hypothesis presented by researchers before the second World War.¹ This proposed that frustration was the cause of all aggression, although there have been a number of revisions to the theory since the 1930s. It is the most widely accepted method of explaining the anger and aggression that ensue if we are interrupted while trying to achieve a goal.

It stands to reason that humans need a powerful mechanism to help them overcome obstacles that get in their way, especially when trying to meet basic needs such as finding food, shelter or a mate. How else would our ancestors have been able to save themselves from becoming distracted, and where would they get the energy for removing or overcoming obstacles?

It's useful to remember that the same powerful mechanism that allowed our ancestors to remove the boulder or tree blocking his path is at work when our train breaks down and we are on our way to attend an appointment. The same frustration pathways alert our nervous system and physically arouse us.

¹ Dollard, Doob, Miller, Mowrer and Sears, (1939). *Frustration and Aggression*. New Haven, CT: Yale University Press

Threats to ego and status

In the 1980s, Harry Enfield, when playing one of his most popular characters, wore a t-shirt that read 'Did you spill my pint?'. Catherine Tate plays a character today who asks: 'Are you disrespecting me?' Both of these capture a recurrent phenomenon: anger-provocation caused by insult; disparagement, or transgression of a boundary.

Gang-related violence among teenagers has led to media speculation about a 'respect' culture dominating street behaviour codes. But anger related to the demand for respect is not unique to current generations of young people. Aaron T Beck's work has been devoted to the evolution of cognitive (thinking) patterns, and why groups have such strong behavioural codes. Says Beck: "Disparagement, domination and deception, which represent threats to our status in a group and diminish our self-esteem, do not in themselves constitute dangers to physical well-being or survival. Yet we often react just as strongly to a verbal attack as we would to a physical one, and become just as intent on retaliating."¹

At the centre of this is the tension between the egocentricity that has been necessary to individual survival and the thinking patterns we have developed to co-operate and live in communities. At one time, anyone who was excluded from their band would have risked attack from predators and denial of basic necessities such as food.

Within groups our standing is therefore very important, as perceived slights may alter our position in the 'pecking order'. According to Beck, the very capabilities we developed to protect ourselves - self-esteem and notions of group 'standing' - can hinder us if they are overactive in the modern age. He proposes that a further extension of this is what we would now view as a 'code of the streets', which means individuals need to be able to 'respond promptly to any insult, real or imagined, to forestall being regarded as too soft to resist a more aggressive attack.'

Another well-known anger theorist, RS Lazarus, proposed that, when threatened, people appraise whether they have the resources to overcome the offence by attack. If we believe that we are strong enough to repel the offender, then anger and attack are more likely to occur.² If the offender is perceived as stronger, then anger is less likely, and fear and escape more likely. This offers an explanation for why an angry incident might be more likely to occur if the perpetrator is carrying a weapon. They are less likely to choose 'flight' when they are armed for a fight.

1 Beck, Aaron T, Prisoners of Hate, The Cognitive Basis of Anger, Hostility and Violence, 2000, Perennial

2 Lazarus, RS. Emotion and Adaptation, 1991

Moral outrage

Anger is not unique to individuals. Studies have looked at group anger, and how we adopt collective feelings of outrage. Theorists have often presented anger as the 'moral' emotion¹, and a body of literature exists on the anger that results from a perception of immorality, or an individual going against a fervently held or sacred code.

Evolutionary psychologists have written extensively about the moral codes that we have adopted as groups to ensure survival.² This ability to adapt and hold as sacred particular types of behaviour has been inherited from our ancestors and gives us the ability to abide by rules, laws, religious and moral codes, or professional practice guidelines.

Revenge against people who break the rules and codes that we hold to be sacred are punished in the criminal justice systems of most societies, while the breaking of a moral code has been one of the stimuli for anger throughout evolutionary history.

1 Tavis C, Anger: The Misunderstood Emotion, Simon & Schuster, 1989

2 Beck, Aaron T, Prisoners of Hate, The Cognitive Basis of Anger, Hostility and Violence, 2000, Perennial

Section 3: The Mental Health Foundation survey

3.1 Introduction

In order to find out more about our attitudes towards and understanding of anger, The Mental Health Foundation commissioned YouGov to carry out a survey of adults aged 18+. This took place in January 2008 among a sample size of 1,974 people. The poll asked respondents about their experience of anger and how well they are able to manage it, about problem anger in people close to them, about their perception of anger in our society as a whole and about their knowledge of support available for people who have difficulties with problem anger. The results are presented below:

3.2 Survey results (Table of results see appendix 1, page 32)

Our experience of anger in ourselves and those around us:

- **Almost a third of us (32%) say we have a close friend or family member who has trouble controlling their anger.** This is higher among women (35%, compared to 29% of men), young people (36% of those aged 18-24, compared to 29% of those over 55), people in social grade C2DE (34%, compared to 31% of ABC1s) and people living in the Midlands and Wales (36%, compared to 29% of people living in London).
- **Less than one in eight of us (12%) say that we have trouble controlling our own anger.** This is higher among women (13%, compared to 12% of men), young people (20% of those aged 18-24, compared to 7% of those over 55) and people living in Scotland (17%, compared to 9% of those living in the South of England).
- **More than one in four of us (28%) say that we worry about how angry we sometimes feel.** This is higher among men (31%, compared to 25% of women), younger people (38% of those aged 18-24, compared to 17% of those over 55) and people living in Scotland (38%, compared to 24% of those living in the North of England).
- **One in five of us (20%) say that we have ended a relationship or friendship with someone because of how they behaved when they were angry.** This is higher among women (26%, compared to 14% of men), middle-aged people (25% of people aged 45-54, compared to 14% of those aged 18-24), people in social grade C2DE (22%, compared to 18% of ABC1s), and people in Scotland (24%, compared to 18% of those living in the North of England).

Anger in society:

- **64% of us either strongly agree or agree that people in general are getting angrier.** This is higher among older people (68%, compared to 50% of those aged 18-24), people in social grade C2DE (66%, compared to 63% of ABC1s), and in London and the North of England (67%, compared to 56% of people living in Scotland). **Only 6% of us disagree or strongly disagree that people in general are getting angrier.**

Getting help for anger problems:

- **Fewer than one in seven (13%) of those people who say they have trouble controlling their anger have sought help for their anger problems.** Those who have were most likely to seek help from a health professional (such as a counsellor, therapist, GP or nurse), rather than from friends and family, social workers, employers or voluntary organisations.
- **58% of us wouldn't know where to seek help if we needed help with an anger problem.** This is higher among women (61%, compared to 54% of men), young people (70% of people aged 18-24, compared to 40% of those aged 35-44), and people in social grade C2DE (61%, compared to 55% of ABC1s)
- **84% of us strongly agree or agree that people should be encouraged to seek help with their problems with anger.** This is higher among women (87%, compared to 81% of men), older people (87%, compared to 82% of people aged 18-24), and people in social grade C2DE (86%, compared to 83% of ABC1s).

3.3 Analysis

These results suggest that difficulties and fears around problem anger loom large in many of our lives, with the majority of us of the opinion that society as a whole is getting angrier (64%) However, they also indicate that while we recognise and are concerned about problem anger in others – almost a third (32%) of us saying that we have a friend or family member who has difficulty controlling their anger – far fewer of us believe we have anger problems of our own – less than one in ten (12%), even though many more of us admit to worrying about how angry we sometimes feel (28%). This bears out the testimony of clinical practitioners, who report that people with problem anger sometimes fail to recognise that their anger is an issue that requires attention.¹

The results also show that we are overwhelmingly in favour of people with problem anger seeking help (84% of us strongly agree or agree that people should be encouraged to seek help for problems with anger). However, most of those who identify as having an anger problem (58%) do not know where to go for help, and only a very small percentage (13%) have actually tried to get help for their problems. Again, this bears out the testimony of people working in the field, who report that pathways to help for people with problem anger are either non-existent or unclear, while many people are reluctant to seek help, perhaps because anger is a problem of which the person is not aware, or is not willing to do anything about, or because of the sense of shame they feel about having a problem with anger (see section 4). This suggests that much work needs to be done on encouraging people with problem anger to seek support, through awareness campaigns to help people identify their anger and appreciate the potential benefits of learning to manage it, through reducing stigma, through improved provision of services for people with problem anger, and through improved signposting of services in health and social care and the voluntary sector. It is interesting to note that most people who seek help do so from a health professional, suggesting that health service settings are those most likely to attract suitable candidates for services (as opposed, say, to employers or social services, with whom potential candidates for treatment may be less willing to engage).

The results also reveal some significant variations among different sections of the population. Women are more likely to say they have a friend or family member who has trouble controlling their anger (35%, compared to 29% of men), and slightly more likely to report an anger problem of their own (13%, compared to 12% of men). Women are also more likely to have ended a relationship or friendship because of how the person behaved when they were angry (26%, compared to 14% of men), and to agree that people should be encouraged to seek help with their problems with anger (87%, compared to 81% of men). However, men are more likely to worry about how angry they sometimes feel (31%, compared to 25% of women). This suggests that men are less able to recognise and talk about angry behaviour in themselves or others, even though they are much more likely to be worrying about the strength of their angry feelings.

Generational differences are striking. In general, the older you are, the less likely you are to report having a close friend or family member with an anger problem (36% of 18-24s, 29% of over 55s), the less likely you are to be worried about how angry you sometimes feel (38% of 18-24s, 17% of over 55s), and the less likely you are to say you have trouble dealing with your own anger (20% of 18-24s, 7% of over 55s), but the more likely you are to say that people are becoming angrier in general (68% of over 55s, 50% of 18-24s). All of which appears to reinforce the position commonly articulated that anger is especially a problem for the younger generations. Meanwhile, people in the middle age ranges (25-54) are more proactive when it comes to situations relating to anger, with those in this age group with an anger problem more likely to have sought help (14-17%) than either the eldest or the youngest (7-9%), and most likely to have ended a relationship or friendship because of how the person behaved when they were angry (21-25 % of 25-54s, compared to 14-18 % of 18-24s and over 55s). This has been borne out generally in many studies which have found that we experience anger less frequently and intensely as we get older.

There are interesting regional differences too. People living in Scotland are almost twice as likely to report having trouble controlling their anger as those living in the South of England excluding London (17%, compared to 9-13% in the rest of England and Wales), while those in Scotland also say they are far more likely to worry about how angry they feel (38%, compared to 24-29% in England and Wales), and to report having ended a relationship or friendship with someone because of how they behaved when they were angry (24%, compared to 18-20% in England and Wales). However, people living in Scotland are much less likely than the rest of us to say that people in general are getting angrier (56% strongly agree or agree, compared to 63-67% in England and Wales). It's tempting to argue that people in Scotland are angrier than those in England and Wales, but it could also be that they are simply more aware of their relationship with anger than those living further south. The Government in Scotland has made more significant investment in recent years in promoting mental health and positive attitudes to mental health than the rest of the UK and this fact may be linked to our findings.

¹ DiGiuseppe and Tafra, *Understanding Anger Disorders*, Oxford, 2007

There are variations in the results from those in different social classes, although these are small. People in social grade C2DE are more likely to report having a close friend or family member with an anger problem (34%, compared to 31% of ABC1s) and more likely to have ended a relationship or friendship because of how someone behaved when they were angry (22%, compared to 18%). They are more likely to think that people in general are getting angrier (66%, compared to 63% of ABC1s) and more likely to advocate encouraging people with an anger problem to seek help (86%, compared to 83% of ABC1s). Those in social grade C2DE with an anger problem are also less likely to know where they could go for help (39%, compared to 45% of ABC1s). However, while one might expect that those people at the less privileged end of the social spectrum might have more reason to feel angry, the impression from these results is that the experiences of and attitudes towards anger are not greatly different across the social spectrum.

3.4 What do these results tell us?

We know that one in four of us will experience a major mental health problem at some point in their life, most commonly depression and/or anxiety, and there is now general agreement among health practitioners, academics, the voluntary sector and government policy-makers that this is an area that requires urgent action – hence the considerable extra funding (£170 million in 2010/11)² recently allocated for improving psychological services for common mental health problems. These results indicate that although problem anger is less well identified and is not necessarily framed as a mental health condition, it affects a similar number of people, and is a cause of concern for many more of us. Moreover, as a society, we are broadly in favour of encouraging people with problem anger to seek help. In the next section, we will examine what options are available to them.

2 <http://www.mhchoice.csip.org.uk/>

Section 4: Approaches to working with problem anger

4.1 Problem anger and how it is tackled at the moment

Among those the Mental Health Foundation interviewed for this report, there was general agreement that options for helping people with problem anger are limited. As we saw from our survey, the most likely first place for people to seek out help is their doctor's surgery. And yet, according to Dr Caroline Chew-Graham, the Royal College of General Practitioners' mental health clinical champion, there are few options open to GPs for helping patients who seek help with their anger. She says: "There is currently little anger management treatment available to patients who consult their GP. Patients with anger management problems do not fit the criteria for referral to a Primary Care Mental Health Team. These tend to focus on people with mental health problems such as anxiety and depression. GPs can refer people to the voluntary sector, but many do not feel confident to do this, either because they don't actually know what's available or they are not sure the service is suitable or quality checked."

This view is backed up by Jonty Heaversedge, a GP based in Southwark, South-East London. "When people ask for treatment because they're angry, there's nothing that I'm aware of that will specifically help them with that. It isn't the same as someone coming in and saying: "I'm feeling low or depressed" or if they were having panic attacks – I'd be able to find something individual for them there and then. So where people have identified that they're getting very angry at work or at home and they're unable to cope with that, I feel at a bit of a loss. Either I've got to try and unravel it and see that they might benefit from some form of therapy and hope that will help them to deal with their anger, or I can try to work with it as a GP. And even if you say: "I could send you to a counsellor to deal with some of the other things you've got going on and you might benefit, they won't necessarily understand that". It would be great to have a specific referral for the anger so you could refer them for the problem that they had identified."

Even when GPs refer patients on to Mental Health Teams, perhaps for other conditions, there may also be little they can offer specifically to help them address their problem anger. Indeed, the lack of available services was what inspired one team, based in North Essex, to set up an anger management programme of its own (see also pull-out interview in section 5). "We felt there was a gap in the service," says Adewale Ademuyiwa, of the Waltham Abbey Community Mental Health Team. "We were getting a lot of referrals for anger problems and we didn't have anywhere to send them."

It is encouraging that some health professionals are taking the initiative to set up their own schemes, and there are some good examples of anger management programmes run either within existing services or by agencies contracted by them (see section 5), but without systematic support, they are fighting an uphill battle. For example, the Waltham Abbey anger management programme is of short duration (7 weekly classes) and runs only 2-3 times a year. It has not been easy to recruit participants – "initially we were expecting a flood of referrals, but it's been quite the opposite," says Ademuyiwa – and participants "need more follow-up than we can afford to give them". Ademuyiwa thinks the low attendance may be caused by the sense of shame people feel around having anger problems, but it could also be due to the inevitably limited nature of the service offered and lack of awareness about its existence. Certainly having an anger management programme available on an occasional basis is better than nothing, but it may not be enough to encourage an often-resistant group into treatment. "We've had a couple of posters up in the surgery for both anger and stress management groups," says Dr Heaversedge, "but they've been on specific dates so unless your problem happens to coincide with the particular course that's running, you're stuck. Courses are less flexible both in terms of timing and in terms of the style in which they're done, and not everyone is open to working within a group. I know that that can be a good way of running anger management, but I've still got to get a patient to do it. With anger, people must reach quite a significant point to come to their doctor and say: "I have a problem", so I hate the fact that I have to say: "Well done" for coming in, I'm not sure what we've got available, I might be able to offer you something in about 6 months", or "Let's wait and see if a course comes up some time next year on anger management."

Dr Chew-Graham highlights a useful NHS self-help guide ('Controlling Anger')¹ which contains local contacts for patients, and the NHS direct website includes information on a range of self-help methods for anger management (exercise, breathing techniques, relaxation), plus details of help that might be available via the health service (counselling, CBT, anger management or domestic violence programmes). It also recommends that 'if you are unable to deal with your anger issues, speak to your GP for advice or a referral for treatment'² But that referral is unlikely to be specifically for treatment tailored for dealing with anger, and, unlike for commonly recognised mental health problems, there are no NICE (National Institute For Clinical Excellence) guidelines to aid health professionals and policy makers. As Mike Fisher says: "Often you'll get referred directly to your GP so there is an assumption that the GP is going to sort you out but then he says: "Sorry, I can't help you". That reinforces the desperation."

1 Available at www.patient.co.uk/showdoc/27001309/

2 www.nhsdirect.nhs.uk/articles/article.aspx?articleid=1890

Of course, there are pathways to referral for problem anger other than through GPs. When pupils are referred to behavioural units and criminals enter the prison system they may be offered help for aggressive behaviour.³ (see section 4.4 for case studies). Anger management provision, or aggression replacement training (ART) as it is sometimes known, may be recommended as part of sentencing following conviction for aggressive acts. According to probation service ART programme tutor Regina Moriarty: "An offender who has committed an act of impulsive (non-premeditated) aggressive behaviour may be recommended, as part of their sentence, to attend an ART programme, particularly if they have similar previous offences." However, while useful, it would surely be preferable if anger management training could be offered as a preventive measure, rather than a post-hoc response to a criminal offence.

Some people may be willing to pay privately to attend programmes run by organisations such as BAAM, or be offered financial support to attend such a programme by their employer. However, for many people, this is not an option: "We get thousands of people logging onto our website, looking at our prices and getting scared away," says Mike Fisher. "People don't know where to turn – it only ever gets dealt with when someone who's committed a crime or beaten someone up is actually found guilty, and then they're on a six-month waiting list for programmes within the probation service – if they're lucky."

4.2 Why isn't problem anger widely treated?

Anger, as an issue in its own right, has received little attention in the field of psychological therapies.

Anger also receives few mentions in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), the diagnostic manual used by British and American psychiatrists, and is missing from the official DSM list of mental disorders.⁴ Researcher and author Carole Tavris confirms: DSM IV contains many categories of 'mood disorders': depression; fears and phobias; and many varieties of anxiety including panic attacks, agoraphobia, post-traumatic stress syndrome, chronic anxiety, obsessions and compulsions - but problems with anger are nowhere to be found.⁵ "The people who shaped the mental health field did not typically treat angry and aggressive clients," say DiGiuseppe and Tafrate. "Aggressive behaviour was defined as criminal behaviour and left to law enforcement and correctional institutions."⁶

It is important to point out here that this report is not designed to argue for new diagnostic categories to take account of anger as a 'disorder'. Problem anger contributes enormously to mental health problems, whether or not it constitutes a formal diagnosis in itself and interventions are needed to help people avoid developing mental disorders that may become entrenched. Helping people understand that problem anger has a dramatic effect on their quality of life and may even provide them with the catalyst for getting help to improve their emotional or mental health is an important part of mental health promotion.

Researchers report that anger research is increasing, but that the current scientific foundation is not even at the levels seen in the 1970s for depression and anxiety. But they nevertheless assert that: "Despite anger's absence from the official DSM list of mental disorders, people seeking mental health services seem to present with problematic anger reactions at the same frequency as they report problems with depression and anxiety."⁷

Human fear of, and distaste for, the anger of others, may also be a factor discouraging treatment. 'Possibly anger is a more unpleasant emotion to confront than anxiety or depression,' say DiGiuseppe and Tafrate. 'It often leads to intimidating behaviours and evokes fear in others. Perhaps mental health professionals avoid the study of anger because, as a profession, we generally dislike working with angry clients and prefer more docile clients, such as those with anxiety or depression.'⁸ Interestingly, this is a view backed up 'on the ground'. "When we started our anger management project," says Adewale Ademuyiwa, 'a lot of my colleagues weren't very happy with it, because people believed that we were going to bring in a flood of people who would be difficult to deal with, and that we wouldn't be able to accommodate them or cope with the demands of that client group. There's an assumption that angry people will be dangerous. That hasn't been the case, but the stigma around anger makes us back away from these people.' Mike Fisher agrees: "Anger is a hot potato. We're all afraid of dealing with it, focusing on it, and managing it."

3 Examples include Aggression Replacement Therapy, Controlling Anger & Learning to Manage it

4 Di Giuseppe and Tafrate, *Understanding Anger Disorders*, Oxford, 2007, Tavris C, *Anger: The Misunderstood Emotion*, Simon & Schuster, 1989

5 Tavris C, *Anger: The Misunderstood Emotion*, Simon & Schuster, 1989

6 Di Giuseppe and Tafrate, *Understanding Anger Disorders*, Oxford, 2007

7 Di Giuseppe and Tafrate, *Understanding Anger Disorders*, Oxford, 2007

8 Ibid

Jeannie Horsfield says that many health professionals don't feel they are qualified to deal with angry clients: "There aren't that many practitioners who are skilled and trained and able to work in the field. I get counsellors who refer clients on to us because they need anger management and it's something they don't feel qualified to deal with." Dr Heaversedge also cites lack of training as an issue: "For someone like me, with an interest in mental health, it'd be helpful to be able to find some training courses. I was doing some work as a therapist with a patient who specifically had anger issues, and I wanted to find a course where I could get a bit of training, and the only thing I could find was within the prison service. Whereas in the community with people who haven't already offended in some way, I haven't been able to find anything."

A related factor is that people with problem anger may not seek help— they perhaps don't recognise their anger as a problem, or if they do, they are reluctant to seek treatment for it, because they feel ashamed. This theory is borne out by the Mental Health Foundation's survey results, which find that many more people identify problem anger in close friends and family than they do in themselves. "More people probably have issues with anger than they realise," says Adewale Ademuyiwa. "And they seem not to want to let anybody know about it." Their tendency is perhaps also to defend themselves by blaming others. However, this does not mean that they are not suffering, or cannot be helped. 'We do not concede that clients with anger problems fail to seek treatment services,' say DiGiuseppe and Tafrate. 'Angry clients often fail, however, to identify themselves as the problem and fail to seek individual therapy. They come as members of families and seek help for marital, family or parent-child conflicts. When angry clients arrive for treatment in a family, they usually want to change the targets of their anger rather than themselves. Clinicians may perceive angry patients as more resistant to treatment and therefore experience less empathy and interest in helping them.'⁹ They also say that people who are angry and aggressive are often coerced into treatment by the courts, employers or families, so that while psychotherapeutic interventions can produce a quick decrease in aggressive behaviour, the anger remains. But if people with problem anger are more resistant to seeking help, isn't that all the more reason to focus attention on raising awareness of the issue and devoting attention to treatment pathways for it?

4.3 The evidence base for working with problem anger

Despite the lack of impetus in mental health to study anger as an issue in its own right, DiGiuseppe and Tafrate say there are approximately 50 published research studies that have tested some kind of intervention for anger with adults and another 40 relating to children or adolescents.¹⁰ They concluded from these that 'successful treatments for anger exist with adults, adolescents and children (and) that anger treatments are equally successful for all age groups and all types of populations...the average amount of change per treatment is of a moderate to large magnitude...(although) the upward range of the effect sizes in treatment is less than the upward range of effect sizes reported in meta-analytic reviews of treatments for anxiety and depression.'¹¹

They also conclude that "treatment effects appear to last...most studies held the gains accomplished at post test, and some even showed improvement at follow-up."The change is not only reported by the participants themselves, but also by those around them, such as spouses and family members.¹² The majority of the studies examined focused on volunteer participants participating in a group therapy format, although DiGiuseppe and Tafrate found individual anger interventions to be more effective.¹³

They found that the most widely supported treatments for problem anger included relaxation training, cognitive restructuring and self-instructional training, rehearsal of new positive behaviours to resolve conflict such as assertiveness training and aggression-replacement training, and multi-modal treatments that include cognitive and behavioural interventions.¹⁴ This seems to suggest that treatment for problem anger can be effective, although clearly it would also be of benefit for greater attention to be focused on carrying out further research.

9 Di Giuseppe and Tafrate, *Understanding Anger Disorders*, Oxford, 2007

10 Ibid

11 Ibid

12 Ibid

13 Ibid

14 Ibid

4.4 What could be done to improve options for people with problem anger?

The good news is that there are many schemes, run by a great variety of organisations – statutory, voluntary and private - which in one way or another are targeted at helping people deal with problem anger. Some of these schemes are profiled in detail in section 5, and these provide many pointers to good practice. The bad news is that much (though not all) of what is currently on offer are post hoc interventions, to which people are referred because they have already got into some considerable difficulty – at home, work or school, or with the police and criminal justice system.

However, our survey suggests that a far wider range of people experience anger problems, and it is clear that for most of them, pathways to treatment are few and far between. How could this be addressed?

Firstly, we need a clearer conceptualisation of problem anger as an issue to which health and social care providers should address themselves. Some narrowing of the gap between the level of research carried out to conceptualise and treat depression and anxiety as compared to problem anger would help, as would anger awareness campaigns addressed at both health professionals and the general public. We also need a broadening of referral criteria, which would mean improved pathways to treatment for patients who have problem anger.

We need greater training of health professionals to identify, empathise with and treat problem anger among their existing patients or clients in order to help ensure that problem anger, when it manifests as part of a complex range of health or mental health issues, can be identified and dealt with as part of any treatment plan.

We need greater acknowledgement of problem anger as a valid reason for referral to emotional and psychological support and greater use of anger screening tools as part of the assessment process. There appears to be some progress being made with this through programmes such as Improving Access To Psychological Therapies (see section 5), but there is much more to be done.

We need greater provision of specific programmes of treatment, individual and group, to help people deal with their problem anger, so that everyone who takes the courageous step of presenting themselves to their GP with an anger problem can receive support for it. These might take the form of anger management programmes, individual or group therapy and they might be within the NHS or provided by the voluntary or private sector. Provision of specific training for practitioners wishing to become 'anger specialists' would enable them to become more adept at dealing with problem anger and give general practitioners an opportunity to refer to someone specifically trained in working with problem anger. Appropriate follow-up mechanisms to ensure maintenance of gains should be put in place.

For those whose problem anger has led to an aggression-related criminal offence, anger management treatment could be made available as a matter of course. Similar programmes could be more widely available for children whose aggressive behaviour has led them into trouble at school.

Finally, we need greater provision of information about, and education related to, anger management in schools, in the workplace, in other community settings and in the media. This could be aimed not just at those who have problem anger but everyone, and could include measures to reduce stigma and fear related to anger.

It is never too early or too late to learn about anger management techniques, as the benefits of mastering them can be far-reaching. According to Mike Fisher: "All the time we hear people say: "If I'd have known about this when I was in school, my life would have been very different." If you can teach the skills before there's a crisis, that can be profoundly transformative."

Section 5: Services which deal with problem anger – case studies and interviews

The provision of services for people with problem anger may be limited, but projects do exist. In this section we offer a range of interviews across the spectrum of problem anger treatment...

1. The Waltham Abbey Anger Management Programme, run by the North Essex Mental Health Partnership and Epping Forest Primary Care Trust.

This programme, running 2-3 times a year, was set up after securing funding from the NIMHE Trailblazers scheme, and won a special commendation in the service delivery category of the East of England NHS Innovation awards. As well as the programme itself, the scheme offers discounted access to local gyms, exercise being seen as an effective means of working with angry feelings. Adewale Ademuyiwa is a community psychiatric nurse with the North Essex Primary Care Trust, and helps run the scheme:

“We have two groups, one for adults, and one for young people, and we get a mix of men and women, with about 10 people on each course. Schemes like ours are quite rare – we have noticed other groups trying to set things up in relation to anger management, such as in day hospital wards, but what we hear is that we are the main group in the area. Most referrals come through GPs, although sometimes we get self-referrals, or calls from neighbours and partners. We started with a six-week course, but it’s now seven, as we found that six wasn’t enough – we were rushing through too many things. By the end of the course people feel like they’ve learned a lot and made changes, and can see a more positive future in terms of their relationship with their anger, although it would be useful to be able to offer longer-term support – time is short and we’re not able to follow up and find out how they continue using the learning.”

Simone Baldwin, 38, attended the anger management programme in Waltham Abbey after seeking help from her GP:

“I went to get some help was because it was affecting my marriage - I was arguing with my husband and I would get violent – I’d lose my temper and lash out physically. He was drinking so I’d think: “This isn’t my fault, you’re the one who’s drinking” and then we’d have a big argument and I’d lash out. Luckily he doesn’t hit me back, and that’s why I thought: “This isn’t on, I need help”, because I couldn’t help myself. It got to the point where I’d say to him “Can you leave me alone?” because I could feel myself going and I couldn’t control it.

I phoned the doctor and asked: “Are there any courses you can do?” It was a bit of a last resort - I couldn’t think what else to do. They said I’d have to come in and speak to the doctor, so I did. I had to wait quite a long time - I went to see the doctor in February and I didn’t get on the course until September.

I thought it was quite a short course for these sort of problems to cover so I didn’t learn as much as I’d wanted to, and I’d have liked more time, but even if you take one thing away then it’s good. For me one of them was learning that it’s ok to feel anger, but it’s how you deal with it that’s the answer - that was really helpful. I also learned that some things make me more angry than others – if somebody blames me and it’s not my fault that’s when I get really angry - afterwards I’d wish I could have reacted more maturely and got my point across in a different way.

I’ve suffered from anger for a lot of years but I just thought that’s how I am – I didn’t really realise that I had an anger problem. One of the things I said on the course was it was almost like I don’t want to change, I don’t want to get rid of my anger because I would lose the person I am - it was such a big part of me and how I expressed myself. Recently I’ve got more aware about it and I’ve realised I don’t like that part of me. We went back to my childhood and had a look at where it comes from, which was quite interesting, it’s made me understand more.

There were only four others on the course – all men - and one guy didn’t come back after the second time - I think it’s probably harder for men, they find it harder to talk about things so sometimes.

My husband and I did split up but we’ve now got back together and I’ve been fine – though I’m on my best behaviour. There’s only been one incident where we started bickering and I was like: “It’s all starting up again” but I went into the kitchen and just thought: “No” and did actually calm down, so that was good. Then I went back in and we started talking – there was a point he was trying to get across which was quite valid but because he’d had a drink I was getting defensive. So, I did find the course helpful, although it’s one of those ongoing things that you have to keep working at.”

2. The Swindon anger management programme, run by the Avon & Wiltshire Partnership NHS Trust.

The programme comprises six two-hour sessions over six weeks. "We describe them as evening classes rather than therapy groups," says Annette Law, deputy head of primary care mental health services. "The content is largely anger control, and it's primarily for people who operate at a short fuse and get themselves into explosive interactions. It looks at recognising the build-up of anger, and there is some emphasis on relaxation techniques and getting in there early to stop anger reaching exploding point. It's a cognitive behavioural framework, looking at the way thinking styles exacerbate the tendency to experience anger and ways of modifying that, and underlying attitudes that people prone to anger tend to hold and ways of tackling those. People tend to hold very black and white views – and they have a strong entitlement bias – "It's not fair, it should be fair and something should be done about it." We also cover communication and assertiveness skills."

Clients self-refer; the service doesn't accept third party referrals because a willingness to participate and motivation to change is a prerequisite to their effectiveness. They are, typically, from lower social classes and younger, in their 20s and 30s - about two-thirds are men. "They are fairly socially disadvantaged and not that good at communicating their needs, and that often gets expressed through frustration in inappropriate anger. They come because their jobs are at risk because they keep shouting at their line manager or walking off in a huff. Or their partner has told them their anger is a problem, and they will have to get help or she's going to leave. Quite a few come because they've been told they can't have access to their children unless they do something about their anger."

It is not easy to recruit participants for the programme, of which the service runs about six a year, for 12–15 people on average. "That's about half as many people as for our building self-esteem courses and much fewer than the stress and mood management course, although the latter includes an element of anger management."

3. Steven Davis (not his real name) attended an anger management programme at St Ann's hospital in North London. Here is his report of his experience:

"From the ages of 17 to 25 I had massive aggression problems. I'd suffered from depression for a long time and I'd find it difficult to have a civil conversation with people without shouting - that was intimidating for them and made them feel uncomfortable. I remember one time I was on a bus coming home and this guy was mouthing off about mental health – my mother had always been very ill when I was young so I started getting angry and shouting back. Eventually I punched him in the face and got chucked off. Another time I was having an argument with community support officers and the police had to be called and I nearly got arrested for breach of the peace. It was all because they'd stopped me riding my bike on the pavement, even though everyone goes on the pavement at that bit. I just lost my temper. I'd also start on bouncers – by the age of 23 I'd been banned from a lot of the clubs in the town where I was living.

Sometimes I'd go way beyond anger and feel totally wild and it would take hours afterwards to calm down. I'd cry a lot, not because of what I'd done or said but because I didn't know how to deal with the outpouring of emotions and this was when I was very likely to self-harm. Once I ended up slitting my wrists – that's when my GP and psychotherapist put me in the anger management programme.

The course was once a week for three hours, and it was about three or four months long. At first it was quite scary, there were about seven of us, aged about 19-45 and I felt like: "I don't want to be doing this". But we started talking about our anger and it was quite funny because each of us was like: "I can't believe you people get so crazy about the same stupid things I do". You get to talk about what happened when you were younger and you learn to recognise emotions before you get angry – they made us write a list of all the things that made us angry and think of all the steps up to the point where we got angry and think about what the emotions were, so you can see your triggers. It was difficult at first but after a while the techniques really help. It's just a question of staying with the first emotion and rationalising it in your head and not immediately losing your temper. It also taught me how to argue with people properly – so rather than immediately calling them names or making accusations, you can say "I'm really pissed off that you've done this and I'm angry". If someone's late for something, you can ask them why rather than just thinking: "You're always late, you fucker" and immediately jumping at them. Since then I've lost a lot of my aggression – you have to keep practising but I don't lose my temper very often anymore, and it was the anger management that really calmed me down, so I'd recommend it."

4. Rainer-React, run by the national charity Rainer.

Rainer-React is a new project run by the national charity Rainer that works with young people aged 10-16 considered to be 'at risk' of becoming involved in anti-social behaviour or crime. Much of their work focuses on helping the young people deal with problem anger. The scheme covers parts of Essex, the Isle of Wight, and Lewisham and Greenwich in south London, and project workers are based in local police stations, where they receive referrals from the police and schools. Rainer-React builds on an earlier pilot scheme, known as the Rapid Action Project (RAP), which was a huge success. Of 400 children seen in its first year, none have been in trouble with the police again. Nearly three-quarters (70%) showed improved anger management. The workers offer the young person support within 48 hours of referral, in the form of weekly one-to-one sessions, group work and family interventions, for up to six months.

Harriet Lovegrove is a project worker covering the Uttlesford district from a base in Saffron Walden:

"A lot of our work focuses around anger management. One of the ways I deal with this is by working with the young person to try to establish the reasons for the anger, then looking at strategies to tackle it and take control of it. One boy experienced his father hitting his mother when he was very young. Now, if he sees anyone being bullied he steps in and gets into a fight. The real seed of the anger is that he feels he has to be a protector. We have one-to-ones, we talk about what happens when he gets into these fights, what he is feeling at the time and when he has felt these feelings before. He has said that he is scared his anger is controlling him, so we look at the times when he has had arguments with his mother or someone else close to him, and he hasn't hit out, to show him there have been times when he has taken control of it. Often they turn their anger inward, on themselves. They're self-harming, taking drugs, drinking, and taking extreme risks. Then it becomes a pattern of behaviour that is hard to get out of. Another of the boys I'm seeing uses anger as a safety mechanism. He was bullied when he was younger and found that if he got really angry he scared people away. So yes, you need to look at strategies for coping with the anger, but the source of the problem is equally important. Coping strategies won't be effective if you haven't dealt with the source, and of course the strategies will vary depending on the source. I don't use any one therapeutic model. I'm just helping them to work out what the problem is and fit the pieces together."

5. The Improving Access to Psychological Therapies Programme, run by the Department of Health and the Care Services Improvement Partnership (CSIP).

According to its website, the Improving Access To Psychological Services programme seeks 'to deliver the government's 2005 General Election Manifesto commitment to provide improved access to psychological therapies for people who require the help of mental health services' and to respond 'to service user's requests for more personalised services based around their individual needs.' The programme aims to test the effectiveness of providing increases in evidence-based psychological therapy services through two national demonstration sites (Newham and Doncaster) and a network of local sites in each of eight CSIP Regional Development Centres.

While the programme primarily focuses on common mental health problems such as anxiety and depression, deputy director Matt Fossey says that problem anger comes within that. "Anger is something we looked at when defining anxiety disorders, so if people have an elevated level of anxiety around anger, we will look at that within the clinical set-up. The therapist would pick up that there was an issue around anger and if it was proven to be a significant clinical challenge then the person would be stepped up and receive more intensive interventions. That could be within the context of counselling or it could be a referral to an anger management course."

Fossey says that if problem anger was suspected as an issue, it could be tested for, and points to the sample anger questionnaire that can be found on the IAPT website (see www.mhchoice.csip.org.uk/psychological-therapies/-iapt-commissionerled-pathfinder-sites/resources.html). "As our services are established and people come into them, we're looking to help them enter into recovery for their particular conditions," says Fossey, "and if anger was one of the issues they had then we would be able to ensure they were signposted in the right way."

The IAPT programme aims to treat an extra 900,000 people, train at least 3,600 new therapists and enable all GP surgeries to have access to a psychological therapies service, with dramatically reduced waiting times. However, will the fact that anger is being addressed only as a subset of anxiety mean that people with problem anger who may not feel 'anxious' are not offered access to services? And for those whose problem anger is deemed worthy of attention, will there be a service for them that's sufficiently specific? "It is pretty early days yet," admits Fossey. "But anger is an issue that needs to be picked up, and it's about ensuring that as our programmes develop we can see appropriate pathways growing. To start with we'd be working with the existing services, but a lot of these services might best be provided by the voluntary or private sector – we know that within the NHS itself the provision may be limited. It's about having the right type of interventions and the right type of people delivering them."

6. The anger management programmes, run by Steppingstones UK

Steppingstones UK is one of a few independent sector organisations in the UK providing specialist anger management programmes. Based in Manchester, it offers group and individual coaching to clients including commercial businesses and health and social care providers. "Our programmes provide the opportunity to understand how anger plays a part in your life and teach healthy ways to control, express and manage it," says Jeannie Horsfield, Steppingstones UK's director.

'Anger Mastery' is offered as a two-day intensive or a ten-week evening programme. Its content includes recognising anger triggers, identifying anger styles, how to express anger in a clear, clean and healthy way, identifying and interrupting negative emotional cycles, controlling thoughts and mistaken beliefs, managing regressive, historical anger, stress and current anger, and learning effective coping and calming strategies.

Steppingstones also offers bespoke programmes tailored to businesses and organisations. 'It's fantastic seeing how our programmes work in organisations, getting teams working and clearing things up using conflict resolution tools. It builds up a more honest and intimate team.' Businesses are, she says, increasingly realising that programmes like those offered by Steppingstones are an effective, and cost-effective, way of meeting their duty of care to employees and restoring flagging motivation and performance.

7. The NCH-Foundations programme, run by NCH

NCH-Foundations was set up in Manchester by the national parent organisation NCH to provide floating support to families at risk of eviction because of anti-social behaviour. Families are referred mainly by housing officers, but also by social services, or schools, and families also refer themselves.

Gill Atkin is deputy director and a project worker. "There is a lot of anger," she says. "They don't like the way they live and they don't know what to do with the anger and so they use it destructively. Everyone has taken advantage of them - they are often victims as well as perpetrators of anti-social behaviour. They are put in a two-bed house with six children, the teenagers need their own space, and the dad's frustrated. A lot comes down to self-esteem and confidence. They don't think they are worthy of better. I say: "You need to talk to the landlord about this," and they say: "I am not saying anything, he'll kick us out because we owe him £20". And then they turn around and belt the kids. We try to get them to channel that anger into something more positive.

The first thing we do is get the family in to make a meal and sit down and eat it together, to get the communication going. Often their home isn't in a state to cook a meal. There is no communication. There's just lots of angry chaos. They'll have the TV on and they'll be shouting and swearing at each other. Mum thinks of herself and the children think of themselves, so everyone is out for themselves, and it's everyone else's fault. We get them to sit down and start chatting and talking. We try to get them to see the benefits, that they don't have to shout and swear.

We spend a lot of time showing them we care, going out with them, and the anger then changes to doing something positive. "I am going to college, I am not going to stand for this." Then we start challenging them. We tell them it has been rubbish but you can live through it, challenging their strengths and showing them the anger is good if it's channelled the right way, into making their future better.

NCH-Foundations also runs more formal classes: self-esteem, parenting, healthy eating, DIY, sewing classes, relaxation. "If we gave the class a title like anger management they would run a mile, so we say we are having a ladies morning and then we say this week we are going to talk about anger. Anger management is about getting them to recognise at what point they are going to blow and what they can put in its place. We teach them to take time out, exercise, boxing, swimming. We tell them anger isn't bad unless it's destructive."

NCH-Foundations works with families for up to two years. "Usually when we close a case we close it successfully," Atkin says. "They start backing off when they are ready. They start finding a new set of friends. They won't be home when we call; they'll be down the library, or at the child's school, volunteering. Some volunteer to work with us, helping to run classes, or babysitting. It can be exhausting work, but there is nothing more rewarding than when a mother rings and says: 'Today I told Gareth I loved him. We had tea together, it's great.'"

8. The anger management group, the Priory Hospital, Roehampton

Peter van den Berk co-facilitates the anger management group at the Priory Hospital in Roehampton. He says it is the most well-attended of all the groups on offer, with a regular attendance of between 15 and 18 people.

The group meets once a week for six weeks, on a rolling programme. Some people return for a second six week programme, to refresh or reinforce what they have learned. The sessions cover raising awareness and insight into anger, how it affects you, and why, managing physiological responses to anger, and practical skills that will help people express and manage anger appropriately. The group uses role-play and practical tools for expressing and managing anger. Van den Berk has devised the mnemonic 'ASDA':

- Appropriate – the appropriate expression of anger – at the right time, in the right place, towards the right person, and in the right amount
- Spontaneous – don't suppress or bottle up your anger
- Assertive – express yourself assertively (ie. respect the other person's rights as well as your own), instead of passively or aggressively
- Direct – say why you are feeling angry.

The group learns to recognise when they become angry, and develop ways to lower the emotional temperature and stay calm. 'We suggest people take a deep intake of breath and picture a traffic light with the red light flashing. People say they find this helpful in making them stop and think. But it can be a long-term process to recognise that their behaviour is not working for them, that it may give them immediate relief or release but it isn't a helpful response. The group is really just a starter for these people, and they will go on to see someone one-to-one for individual therapy.'

9. Relate – working with anger in relationships

Relate, the national charity providing counselling, sex therapy and relationship education for couples and families, often encounters anger when clients come for help. "We start with the context," says practice and training consultant Rose Mary Owen. "It would be unhelpful to use anger management to address situations where there is abuse and violence and where this is used to control one partner. In these situations, the skills acquired through anger management can be used to oppress the other person further."

Where Relate can work with the couple is where the anger comes unexpectedly, in response to clear triggers. "For example, a young couple – they are finding their feet within the relationship, and a child comes along, and that may well cause an explosive situation and they come to us for help. We deconstruct the incident that brought them to us, to understand what happened, what were the stages that led to the outburst. We would be looking for them to recognise where they could have made a different choice, and that making that choice was their responsibility. We work to help them recognise the steps before they get to that point and what they can do in the future to manage themselves.

Once we have established that confidence base, we move to the next phase where we look at the roots of the anger response in the individual's own family. We use genograms, looking at thoughts, beliefs and behaviours around power, control, who can speak, in their family. We help them locate where their ideas come from, and to understand they can make different choices to behave in a respectful way to their partner."

But they are not looking to squelch anger as an emotional response. "Anger carries energy," says Owen, "It's a natural response to injustice. With some couples the problem is that they are not able to express their anger, and that can leave them treading on eggshells. Building an ability to feel and express anger in a healthy, respectful and non-oppressive way can help shift the blocks in a relationship."

Women are, Owen says, less likely to express anger through aggression. "In my experience it is true that females tend to turn their anger inward and against themselves by taking responsibility for the situation, taking the blame. Women tend to turn it inwards into self-harming, and men turn it outwards and act it out in some way. In women the anger can become depression, because societally the messages are still there that anger isn't acceptable in females."

Section 6: Conclusion

In this report we have highlighted the case for improving and broadening awareness of the emotion of anger and how to manage it, among both health professionals and the general public. We have also highlighted that while there are many examples of practitioners incorporating approaches to dealing with problem anger in their work, pathways to treatment that focuses specifically on working with problem anger are rare. This is despite the fact that problem anger causes difficulties for a large number of people.

Anger, as we have seen, has played a vital role in human evolution, and the Mental Health Foundation is not suggesting that we pathologise it. However, when misunderstood and misdirected, it can cause great misery, both for those with problem anger, and for those around them, and problem anger is implicated in a wide range of social and economic costs. Our research indicates that as a society we are aware of the problems that poorly managed anger can create, and are in favour of people who experience problem anger seeking help. If we can persuade them to seek help, we must also ensure that the help is there for them to take advantage of.

This means adopting a two-pronged approach. First, we can, as individuals and as a society, begin to develop a more mature approach to anger, which recognises its power, its valid uses, the responsibilities associated with it, and the difficulties it can bring up, both in ourselves and in others. The media has a particular responsibility in this area, as the creator and conduit for much of the information we receive about anger. However, schools, workplaces, community groups and centres and individual homes are all locations where information about anger and anger management could usefully be disseminated and discussed. As previously mentioned, The Mental Health Foundation will be taking a lead in this area, and this report will mark the launch of a year-long Anger awareness campaign devised and directed by the Foundation.

The second area of responsibility lies with researchers, clinicians and policy-makers. We have seen how problem anger, despite its sometimes frightening visibility, has often been ignored as an area for research and service provision in the mental health field. The result is that people who might benefit enormously from learning how to manage their anger are either discouraged from coming forward, or when they do come forward, they may be offered little or nothing in the way of useful support. By making efforts to step up research into the effectiveness of different treatments for problem anger, and by creating a wider range of specific pathways to services for people seeking help with problem anger, we could begin to bridge this gap in investigation and provision. The possible benefits, which might include increased well-being, a reduction in fear, less crime, improvements in social cohesion, reduced aggression, improved relationships and greater individual and collective emotional maturity, are surely worth making such an effort.

Appendix 1. Survey results

Sample Size: 1974

Fieldwork: 15th - 17th January 2008

Mental Health Foundation	Are you?		Age						Social Grade		Region				
	Total	Male	Female	18 to 24	25 to 34	35 to 44	45 to 54	55 +	ABC1	C2DE	London	Rest of South	Midlands and Wales	North	Scotland
All GB Adults	1974	948	1026	217	382	329	345	701	1066	908	415	395	474	513	178
Unweighted Sample	1974	960	1014	214	371	318	344	727	950	1024	397	489	414	501	173
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

Do you have a close friend or family member who has trouble controlling their anger?

Yes, I do	32	29	35	36	35	32	33	29	31	34	29	31	36	32	34
No, I don't	63	66	61	59	61	65	61	66	65	61	69	65	58	64	60
Don't know/ prefer not to say	4	5	4	5	4	4	5	4	4	5	3	4	6	4	6

Do you ever worry about how angry you sometimes feel?

Yes, I do	28	31	25	38	36	37	25	17	28	28	27	27	29	24	38
No, I don't	70	66	73	59	60	59	74	81	70	70	70	71	69	74	59
Don't know/ prefer not to say	2	3	2	3	3	4	1	1	2	2	3	2	2	2	3

Would you say that you have trouble controlling your OWN anger?

Yes, I do	12	12	13	20	16	15	11	7	12	12	13	9	13	11	17
No, I don't	85	85	86	76	80	82	87	92	85	85	83	89	84	87	79
Don't know/ prefer not to say	3	4	2	5	4	3	2	1	2	3	4	2	2	2	3

ALL GB Adults who say they have trouble controlling their own anger

239	110	129	43	61	49	38	48	129	110	54	34	64	56	31
246	117	129	43	62	46	38	57	117	129	55	47	57	58	29
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

You previously said that you do have trouble controlling your own anger...

Have you EVER sought help with controlling your anger?

Yes, I have	13	13	13	9	17	14	17	7	13	13	15	10	11	17	8
No, I haven't	85	85	86	90	83	86	78	90	86	85	84	90	89	82	83
Don't know/ prefer not to say	2	2	1	2	0	0	4	4	1	2	1	0	0	1	9

ALL GB Adults who say they have trouble controlling their own anger and sought help

31	14	16	4	10	7	7	3	17	14	8	4	7	10	2
35	14	21	5	11	7	6	6	18	17	11	5	6	11	2
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

Which, if any, of the following areas did you seek help from with controlling your anger? [Please tick all that apply]

From a friend or family member	22	15	28	20	29	3	32	22	32	10	34	21	38	6	0
From a health professional (such as doctor or nurse)	49	44	54	48	65	21	79	0	51	47	26	52	70	40	100
From a counsellor or therapist	70	67	72	8	82	83	68	78	81	56	56	58	79	71	100
From an employer	7	8	7	0	22	0	0	0	7	8	0	0	0	23	0
From a social worker or arbitration service	7	8	7	0	11	10	7	0	4	11	0	0	17	11	0
From a charity or other helpline	15	3	24	0	33	15	0	0	15	13	5	30	31	8	0
I read about how to help myself	18	11	24	0	25	30	7	11	21	13	18	0	48	6	0
Other	3	0	5	24	0	0	0	0	0	6	0	0	0	9	0
Can't remember	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

ALL GB Adults have not sought help with controlling their anger

204	93	111	38	50	42	30	43	111	93	45	31	57	46	26
207	100	107	37	51	39	31	49	98	109	43	42	51	46	25
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

Would you know where to get help from if you sought to control your anger?

Yes, I would	42	46	39	30	36	60	39	46	45	39	34	56	37	43	51
No, I wouldn't	58	54	61	70	64	40	61	54	55	61	66	44	63	57	49

Mental Health Foundation	Are you?		Age					Social Grade		Region					
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Unweighted Sample	1974	960	1014	214	371	318	344	727	950	1024	397	489	414	501	173
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Have you ever ended a relationship or friendship with someone because of how they behaved when they were angry?															
Yes, I have	20	14	26	14	21	22	25	18	18	22	20	20	20	18	24
No, I have not	77	82	73	81	75	76	73	80	79	75	77	77	76	80	74
Don't know/ prefer not to say	3	4	2	5	4	2	2	3	3	3	2	3	5	2	2
To what extent do you agree or disagree with the following statements? [Please tick one option on each horizontal row]															
'People should be encouraged to seek help for their problems with anger'															
Strongly agree	33	26	40	28	28	27	34	40	31	36	33	31	32	36	32
Agree	51	55	47	54	56	57	47	47	52	50	49	54	53	48	53
Neither agree nor disagree	12	15	10	12	12	14	15	11	13	11	15	12	10	12	13
Disagree	1	1	1	1	2	2	2	1	1	1	1	2	1	1	1
Strongly disagree	1	1	0	0	1	0	1	0	1	0	0	0	0	1	0
Don't know	2	2	1	5	2	0	1	1	1	2	2	1	2	1	2
'People in general are getting angrier'															
Strongly agree	15	12	18	9	14	14	15	18	13	17	17	14	16	15	9
Agree	49	52	47	41	49	51	51	50	50	49	50	49	47	52	47
Neither agree nor disagree	27	27	28	34	25	28	29	26	28	27	26	27	28	26	37
Disagree	5	6	5	7	9	5	3	4	7	4	4	7	5	5	5
Strongly disagree	1	1	1	2	1	1	0	0	1	0	0	0	1	1	0
Don't know	3	3	2	8	3	1	2	2	2	3	3	3	3	1	2

Mental Health Foundation

About the Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. If you would like to make a donation, please call us on 020 7803 1121.

If you would like to find out more about our work, please contact us.

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