The Role of Anger in Offending: A Grounded Theory Analysis of Mentally Disordered Patients

Abstract

The relationship between anger, violence and offending is not well understood, there is debate in the current literature regarding the nature of this relationship. This issue is of importance because of the widespread use of anger management programmes as a means to reduce anger mediated offending. This study specifically examined the role of anger in offending behaviour for patients with co-existing problems with anger and psychosis. Grounded theory was used to analyse patients’ file data from an Anger Management and Emotion Regulation programme in a Medium Secure Unit (MSU). Grounded theory analysis allowed for a theory of offending to be generated, showing what concepts contribute to offending and thereby determining the role anger plays in offending in mentally disordered patients. Anger, mental illness, substance misuse and social issues were recognised as contributing factors to offending behaviour. This provides justification for managing anger in order to prevent reoffending.

Keywords: forensic mental health, qualitative, violence, aggression, offending behaviour.

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**Background**

 Anger can be defined as “a negatively toned emotion, subjectively experienced as an arousal state of antagonism toward someone or something perceived to be the source of an aversive event” (Novaco, 2000, pg.170). It has also been defined as a broader construct consisting of delineated concepts involving personal dispositional systems, either cognitive, physiological or behavioural, embedded in an interdependent network of interpersonal and environmental systems (Robins & Novaco, 1999).

The examination of anger has been recognised as a growing area of research (Wood & Newton, 2003). Novaco (1978) devised a model of anger proposing that environmental circumstances, cognitive arousal and behavioural reactions interact to produce the emotional expression of anger. However, despite the growing number of studies in this area there is still much that is unclear surrounding the emotion of anger and its behavioural expression. Furthermore, the link between anger and offending remains unclear.

This study aims to propose a theory and provide potential avenues for further research into the nature of anger and the role of anger in offending in mentally disordered patients.

**Anger and Offending**

A large number of studies have examined the link between anger and violence. This link has been empirically demonstrated, with a range of populations and settings, including laboratory studies, research with young offenders, noncriminal adults, psychiatric patients and both incarcerated violent and sexual offenders (Loza & Loza-Fanous, 1999a). Researchers have also linked anger to criminal behaviour and reoffending (see Loza and Loza-Fanous, 1999a). Research has also examined how different levels of anger can impact violent offending. Accounts of seriously violent offences suggest that extremely heightened anger, described as ‘fury’ or ‘rage’ is an important contributor to these types of offences (Levey & Howells, 1990). In addition, frustration, which refers to the blocking of a desired goal, and is a similar dysphoric emotion, but a more generalised, less severe type of anger, has also been implicated in violence (Zamble & Quinsey, 1997).

Carmichael and Piquero (2004) consider the distinction of two streams of literature with regards to criminal decision-making; the first considers rational choice, and proposes that offenders weigh up the costs and benefits of actions. The second stream of literature considers situational and emotional factors, and posits that offenders act largely without thinking. This has been corroborated by Chemtob et al. (1997) in terms of anger; “Anger is an antecedent to both impulsive and premeditated violence” pg. 184.

But anger in itself is neither necessary nor sufficient for violence; individuals can be angry and not behave violently, or can be violent without being angry (Howells, 2004). And whilst it has been recognised that there is a link between anger and violence, it is also apparent that the link is not well understood (Jones and Hollin, 2004).

**Anger Management Efficacy**

In response to the recognition of the issues outlined above, anger management programmes have been introduced into many institutions across the USA and Europe. The aim of these programmes is to regulate anger by means of challenging irrational or maladaptive cognitions, through developing an awareness of the consequences of anger whereby enhancing ones ability to control it. Thus, the overall aim of anger management programmes is to reduce aggressive behaviour in general, thereby reducing further violence (Wood & Newton, 2003).

A number of meta-analysis studies have assessed the effectiveness of anger management programmes (e.g., Beck & Fernandez, 1998; DiGiuseppe & Tafrate, 2003; Del Vecchio & O’Leary, 2004; Sukhodolsky, Kassinove & Gorman, 2004). Their findings suggest that anger management programmes produce a “significant and moderate improvement compared to untreated subjects” (DiGiuseppe & Tafrate, 2003, pg. 70). The positive effects of anger management were consistent across different populations, including; abusive parents, undergraduate students, veterans with posttraumatic stress disorder, school children, abusive spouses, inmates, juvenile delinquents, clinical adolescents and forensic in-patients. Implications were described by Beck and Fernandez (1998) as providing clinicians treating patients with anger problems with evidence to substantiate their choice of cognitive behavioural, cognitive or relaxation therapy in the treatment of anger.

Other researchers, however, question the link between anger and violence. Walker and Bright (2009) suggest that anger should not be the focus of intervention at all, noting that some studies have found no relationship between anger and violence, and recidivism. Loza and Loza-Fanous (1999a) found no differences across four anger measures (Reaction to Provocation, Novaco, 1994; Aggression Questionnaire, Buss & Perry, 1992; Self Appraisal Questionnaire, Loza, 1996; State-Trait Anger Expression Inventory, Spielberger, 1988) between violent and non-violent incarcerated offenders. Loza and Loza-Fanous (1999b) claim that previous research has portrayed the relationship between anger and violence as misguided, misunderstood and anecdotal. These findings cast doubt on the appropriateness of anger management programmes in their attempt to reduce violent behaviour in offenders.

However, it should be noted that many of the studies used in the meta-analyses were conducted using students as participants. Students were overrepresented in these analyses, and thus, their ecological validity may be questioned because their effectiveness may not generalize to other populations (Sukhodolsky, Kassinove & Gorman, 2004).

**Anger Management in Forensic Settings**

Considering the scope of this report a further examination of the studies using forensic in-patients is warranted. One such study used in the meta-analyses was by Stermac (1987); this study evaluated the efficacy of a short term cognitive behavioural anger control programme with 40 forensic in-patients, 28 of whom were diagnosed as having Antisocial Personality Disorder, 4 of whom were recognised as having substance misuse problems. Compared to participants in the control group, those in the treatment group scored lower on post intervention measures of self-reported anger after six one-hour sessions of stress inoculation and cognitive behavioural treatment.

Another study by Rhoades (1988) evaluated the effectiveness of Novaco’s stress inoculation approach to anger management. It was found that those in the treatment condition showed significantly reduced anger levels. Thus, these two studies provide evidence for the effectiveness of anger management programmes specifically for forensic in-patient populations.

**Anger Management and Mental Disorder**

Jones and Hollin (2004) provided more justification for the use of anger management with mentally disordered offenders; the study examined 8 patients detained in a high security psychiatric hospital, 3 of these had a diagnosis of Borderline Personality Disorder, 5 had a diagnosis of Antisocial Personality disorder. The anger management programme was a 36-week cognitive-behavioural treatment that had been specifically designed for mentally disordered offenders. The results showed a significant reduction in anger frequency during the treatment and after a 4-week follow up, which supports the use of this type of programme with mentally disordered offenders.

The previously discussed studies examined the effectiveness of anger management on mentally disordered offenders (i.e., Stermac, 1983; Rhoades, 1983; Jones & Hollin, 2004) with either Antisocial or Borderline Personality Disorders. Haddock et al. (2004), however, noted that to date no studies had examined anger management for in-patients who had co-existing problems with psychosis. This is of importance because of the proposed link between psychosis and violence.

**Anger Management and Schizophrenia**

Monahan (1992) stated, “Throughout history and in all known societies, people have believed that mental disorder and violence were somehow related.” This link has been examined empirically, and has been shown to have an even higher rate among schizophrenic patients compared to those with other mental disorders such as anxiety (Swanson et al. 1996). Other studies, however, have found the opposite effect, with discharged schizophrenic patients having a lower rate of violence compared to those without schizophrenia (Haddock et al., 2004). Thus, a firm conclusion cannot be made concerning the nature of the link between schizophrenia and violence “The relationship between schizophrenia [and violence] is unclear” pg. 78.

Haddock et al. (2004) made an attempt to clarify the link between anger and violence in patients diagnosed with schizophrenia in a paper examining case studies of three inpatients in a low secure setting. This study integrated cognitive behavioural therapy for psychosis with cognitive behavioural therapy for violence. Reduced measures of anger were found on both self-report and independently rated anger scales following cognitive behavioural strategies, including; psychoeducation, self-monitoring, cognitive restructuring, arousal reduction strategies, examination of appraisals and meaning of anger, role play and imaginal exposure, and consolidation of coping strategies. This paper is the first to show the effectiveness of cognitive behavioural therapy with inpatients in this type of setting who have co-existing problems with psychosis; although the results are positive, further evidence is required before generalisations can be made, considering the small sample.

The link between psychosis and aggression, whatever the precise association, has been shown to be exacerbated by substance misuse (Wallace et al. 1998). Haddock et al. (2004) discuss two possible reasons for this; they argue that it may be due to substance misuse interfering with engagement with treatment, or substances contributing to increases in psychoticism, which could enhance anger. This highlights substances as an important variable for consideration, as recognised by Awalt, Reilly & Shopshire (1997); levels of anger and violence are higher in substance abusers than in the general population.

**Rationale and Aims.**

It is apparent that the link between anger and violence, already recognised as complex, could be influenced and confounded by many other variables. This may become problematic when attempting to reduce violence and recidivism via means of anger management interventions because it is unclear what the causal factors for violence may be.

Many studies examining the efficacy of anger management programmes have made reference to the link between anger and violence (Robins & Novaco, 1999; Levey & Howells, 1990; Beck & Fernandez, 1998; Jones & Hollin, 2004). However, the nature of interventions should not be based on a complex link that is not sufficiently understood. This highlights the need for an in-depth analysis of what aspects are contributing to violent offending in mentally disordered offenders, the role that anger plays in violent offending in this population, and the suitability of anger management programmes. This issue was also recognised by Loza and Loza-Fanous (1999a), with reference to all populations, “In the absence of decisive evidence regarding the link between anger and violent behaviour…the issues of treating anger may be over exaggerated or possibly unwarranted.” pg. 493.

The current study employed grounded theory analysis to examine the role that anger, as well as other contributing factors, play in violent offending in mentally disordered offenders with a diagnosis that falls within the schizophrenic spectrum. Grounded theory is theory derived from data, a researcher does not start with a preconceived theory in mind, rather a researcher begins with an area of study and allows theory to emerge from the data (Strauss and Corbin, 1998). The use of grounded theory is most appropriate when existing theory is inappropriate or inadequate (Tilley & Brackley, 2005), as is the case with the suitability and efficacy of anger management programmes for in-patients with co-existing problems with psychosis. Grounded theory analysis will allow for a theory of offending to be generated for a population of in-patients, showing what concepts contribute to offending and thereby determining the role anger plays in offending in mentally disordered patients. Also the dimensions of anger could be presented, opening further avenues for research and providing further concepts for consideration within anger management programmes.

**Method**

**Description of Anger Management and Emotion Regulation Programme**

The Programme is run in a Medium Secure Unit. It is primarily a cognitive behavioural programme based on Novaco’s model of anger. It consists of 17, 2-hour weekly group sessions, and 1-hour weekly individual sessions. Full details are given in Appendix A.

**Methodological Approach**

 Data for this study was collected from patient’s anger management programme file notes. The data was analysed in detail using grounded theory. The data used was from case notes of sessions relating to the lead up to patients’ index offence, in order to develop theory regarding the factors that influenced their offending. This allowed theory to be developed from participants’ views and opinions, rather than inferring what factors contributed to offending.

**Participants**

 Male forensic in-patients (N=7) attending an Anger Management and Emotion Regulation Programme within a Medium Secure Unit (MSU) were asked to participate in this study by the programme coordinator. Patients were detained under section 37/ 41 of the Mental Health Act (1983). Of those undertaking the programme, 1 did not consent to participate, 6 agreed to participate, with a mean age of 39.2 years, S.D. = 12.0, with a range of 27-57. The average length of stay was 2 years, 8 months. Patient information is summarised in Table 1.

Table 1.

*Participant Information.*

**Procedure**

All participants undertaking the Anger Management and Emotion Regulation Programme at the MSU during June 2011 were given the opportunity to participate. The programme was run, and the data gathered by a Chartered Forensic Psychologist. Participants were given an information sheet in order to assist them in making a decision as to whether they wished to participate in the study. Participants were then given a written consent form in order to gain their written consent to take part in the study as well as granting access to their file notes. The file data was then analysed and participants were debriefed.

**Ethics**

 Participants were deemed to have capacity to consent by their responsible clinician prior to being given the information sheet and consent form. Participants were informed of the purpose of the study and that they were under no obligation to participate. Also participants were explicitly informed that should they decide not to participate their medical care or legal rights would not be affected. Participants were informed of their right to withdraw from the study at any time without giving a reason and without their medical care or legal rights being affected. As this study used file data it was not necessary for the researcher to have any direct contact with the participants. As such, the participants were not required to do anything additional when agreeing to take part in the study. All participant data was anonymised and no personal information that could be used to identify a participant was written in this study. Data was kept securely in an encrypted folder on a password-protected laptop, and was destroyed once the study was completed. Participants were debriefed once the study was completed.

 The study received ethical approval from the University of Kent Psychology Ethics Committee and the NHS Research Ethics Committee.

**Analytic Strategy**

 The study used Grounded Theory as its method, following the methodology presented by Strauss and Corbin (1998). The file data was analysed line-by-line for each participant using open coding. Researcher concepts and in vivo codes, i.e. words taken verbatim from the data, were created from the evidence in the file for one patient. The next patients’ data set was then examined; this found support for existing codes and evidence for new codes. When a new code was discovered, previous data was then re-examined to ascertain whether support for the new code was evident. Concepts were created and modified from the codes as appropriate during the course of the analysis.

 Axial coding was then used; concepts were related to each other to form categories, and their subcategories. This reassembled the data that was fractured during the open coding stage.

 Selective coding was then used to integrate the data and refine the theory. One category was defined as the core category around which all other categories were related.

Memos were made during the course of analysis in order to follow the development process.

**Analysis**

**Open Coding**

 A number of concepts, along with their dimensions and properties were identified in this stage of the analysis. These are presented in table 2.

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| Table 2*Concepts identified from open coding, which participants show evidence for them, and their properties/ dimensions* |

**Axial Coding**

 Several concepts were related conceptually and grouped together into categories. Five main categories were established, around which all other concepts are based. These are; Anger, Mental Illness, Substances, Social Issues, and Consequential Feelings.

 The category of anger was split into two subcategories, impulsive anger and non-impulsive anger. Impulsive anger comprised of the concepts; acting on impulse, lack of control and immediate reciprocity. Non-impulsive anger comprised of the concepts; prolonged reciprocity, prior beliefs, rumination, and fear.

 The category of mental illness comprised of the concepts; paranoia, hallucinations, lack of insight, lack of control and restlessness, these can be produced solely by mental illness.

 The category of Substances was split into two sub-categories, alcohol and drugs. The concepts in this category were; paranoia, hallucinations, lack of insight, lack of control and restlessness, i.e. the same concepts as mental illness, but through different causes, solely by substances. Whilst these concepts can be influenced by either substances or mental illness independently, they can be also be influenced by a combination of substances and mental illness.

 The category of social issues was comprised of the concepts; vulnerability, isolation and relationship arguments. Betrayal was included as a sub-concept of relationship arguments, poverty was included as a sub-concept of vulnerability.

 These categories, although distinct considering their properties, dimensions and subcategories are by no means isolated, categories relate to each other, and combine into unique combinations; depending on the degree to which an individual offender presents evidence for each category i.e. taking influence from Gestalt psychology (Schultz & Schultz, 2007); the combinations of categories will equal more than the sum of the categories themselves.

 Consequential feelings was an isolated category, it did not comprise of any concepts; i.e. the concept of consequential feelings did not relate to other concepts and was identified as a category in its own right. This is because feelings regarding a crime after it has been committed obviously could not influence it. Although not a contributor to offending, it was felt that this should be included in the theory as it may contribute to the possibility of future offending behaviour.

**Selective Coding**

 The core category that emerged from the data was ‘An inability to think clearly and/or rationally’ this was the category around which all other categories were based [apart from consequential feelings]. This core category was present in all of the data, although it could have been produced via different combinations of some or all the major categories. It is this inability to think clearly and/or rationally that is considered to be the basis of offending in this population of offenders. This is shown in figure 1.

*Figure 1*.

Diagram representing the theory of offending in mentally disordered patients.

**Discussion**

 The results of the grounded theory analysis show that offending in mentally disordered offenders was facilitated by an inability to think clearly and/ or rationally. This is influenced by combinations of; anger, mental illness, substances, and social issues.

It is apparent, from this theory, that anger does contribute to violence and offending within this population of mentally disordered offenders who have co-existing problems with psychosis, this is in accordance with Jones and Hollin (2004), and opposes the proposals made by Loza and Loza-Fanous (1999a). Therefore the theory shows a justification for attempting to reduce anger in the rehabilitation efforts for this population. Once this has been established the focus shifts to achieving a better understanding the nature and properties of anger for these individuals, and how to improve anger management programmes.

 The complexity of the contribution of anger towards violence and offending, as recognised by Jones and Hollin (2004), is highlighted by the fact that many other contributors were found in the analysis, i.e. there was not a straightforward relationship showing that solely anger causes violence and offending. Rather it is presented in this theory as a contributor, accompanying several other factors, to the category of ‘an inability to think clearly and/ or rationally’, which causes violence and offending.

Several aspects of anger explained in the introduction were also found in the analysis. Showing a strong link with the existent literature; the distinction between ‘impulsive anger’ and ‘non-impulsive anger’ is in accordance with the impulsive/ premeditated distinction made by Chemtob et al. (1997). This suggests that anger is not a single phenomenon, but in this theory is presented as distinct types, which could be tackled separately through anger management programmes.

Within the angry emotions concept and lack of control concept, support for the levels of anger suggested by Levey and Howells (1990) and Zamble & Quinsey (1997) was found. Extremely heightened anger as well as a lower level of ongoing anger was an important contributor to offending. This shows anger as a spectrum, with differing levels of severity; and that offending behaviour can be influenced by anger of differing intensity.

The analysis also proposed several dimensions of anger that could help to inform the relationship between anger and offending for this population. The concepts described in the results section: lack of control, reciprocity, prior beliefs, fear, and rumination all contributed to anger, further quantitative analysis could be conducted to examine these aspects and their relevance to a larger group of participants.

The proposed theory suggests that mental illness and substance misuse also contributes to an inability to think clearly and/ or rationally, alongside anger. This supports the findings of Wallace et al. (1998) and Haddock et al. (2004). Furthermore social issues were also found to contribute. This suggests that anger problems should also be examined and managed in these contexts, as they were additive to the offending behaviour i.e. as a part of anger management programmes, mental illness, substance, and social issues, and how these can relate to anger could be incorporated.

The isolated ‘consequential feelings’ category may also be an important consideration when reducing further offending, this also warrants consideration for inclusion in anger management programmes, and could fall under protective factors during programmes.

There are however limitations of this study which should be considered. The case notes that were examined were not collected with this study in mind, the data was collected as part of the Anger Management and Emotion Regulation programme. Furthermore the notes will have gone through a process of interpretation as mental health professionals summarise what participants have said for their file notes.

Also, although this study allowed for a theory to be developed from participants’ own thoughts regarding their offending, there are concerns over the validity of the data; during the programme it is possible that social desirability effects could have influenced the data.

Other limitations include authors’ personal preconceptions, values and beliefs, which may have had an influence on the interpretation of data. Also, respondent validation was not sought leading to a potential ‘lone researcher’ bias. Attempts were made to keep these factors to a minimum; evidencing concepts from the data, and not having a preconceived conclusion in mind would have contributed to this. The aim of this study was to propose a theory and provide potential avenues for further research, rather than providing evidence for or against a specific hypothesis. This would have helped reduce these concerns.

Another important point to stress is that this study was conducted with a small number of participants on a very specific population, so the theory proposed can be considered to be in it’s infancy, it cannot be generalised to other populations and requires continuing research to develop it further.

This study does not provide evidence for or against the efficacy of the methods used in attempting to reduce anger. This study highlights the necessity of reducing anger in the effort to reduce offending, and highlights some possible dimensions of anger that may be of importance in doing this. Because this study was qualitative and conducted using a small sample it was concerned with identifying theory and proposing further theoretical areas of investigation.

There are several implications of the proposed theory; firstly as anger was found to be a contributing factor to the core category within offending, this theory provides justification for attempting to reduce anger problems in offenders detained in medium secure settings who have co-existing problems with psychosis. Secondly, the theory proposed in this study also explains several possible exacerbating factors which contribute to the core category, alongside anger. Thirdly, the theory provides insight into the nature of the contribution of anger to offending, adding further theoretical debate for the inclusion of these issues into anger management programmes.

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**Appendix A**

**Description of Anger Management and Emotion Regulation Programme**

**Programme Information**

The Anger Management and Emotion Regulation Programme was devised to meet the needs of a medium secure forensic population, thus patients with over control issues of anger and those with high levels of anger. The programme was initially piloted and is currently being evaluated. The evaluation will be completed at the end of 2009. The programme has been used with both male and female patients.

The programme is based on Novaco’s model of anger. The group consists of seventeen, 2-hour weekly group sessions, and 1-hour weekly individual sessions. The programme is primarily cognitive behavioural based. It also draws on stress inoculation techniques, relaxation including the use of imagery and mindfulness techniques, relapse prevention, and role play. Other learning tools are also used where appropriate such as videos. Exercises are undertaken in large and small groups depending upon the learning task.

**Pre-assessment & psychometrics**

Patients are assessed for the group to determine their suitability. A semi-structured interview questionnaire is used to gain information relating to anger and to ascertain other issues such level of motivation to change, denial and minimisation issues, and expectations of the group. A battery of psychometrics is used to assess each patient’s progress during the group. Pre-group, mid-group, and post-group anger measures using the STAXI-2 are taken as a means of assessing change during the course of the group. Follow-up measures are also taken. Other measures used are the Anger Rumination Scale (Sukhodolsky, Golub, & Cromwell, 2001), Beck Depression Inventory (BDI-II) and Beck Anxiety Inventory (BAI).

During the course of the group, progress is assessed in various ways: level of engagement, comprehension, completion of homework, and ability to recall new material and skills and to apply it. The facilitators take process notes during the group, and a post group assessment form is completed following each group, and patients are rated in several areas (e.g. level of engagement, comprehension, and presentation). A form is completed during each of the individual sessions with the patient to ensure that there is consistency in terms of the material that is being discussed, and that the material that is taught during the previous group is being reinforced. Homework exercises are taken up during this time and any difficulties patients experience during the group are discussed. Patients are also asked to keep an anger diary so that they can learn to monitor their own anger.

The weekly individual sessions serve to identify any areas that patients may be having problems with and to reinforce the material and skills that are being taught. Patients are also encouraged to discuss other relevant issues that may be interfering with their progress during the group (e.g. anxiety, voices) and/or other anger related issues that they do not wish to discuss in the group.

**Overview of group sessions**

Each session begins with a review of the previous session and homework is taken up. Relaxation takes place during the last 30 minutes of each session. The group are introduced to several types of relaxation throughout the course of the 17 weeks. Patients are asked to rate their tension/stress in their body before and after the relaxation sessions.

**Session 1: Introduction to anger management & emotion regulation**

This session focuses on engagement issues in group (e.g. anxiety, motivation), group rules, methods & techniques used and expectations of group, homework and relaxation. Participants are taught an emergency technique-BUS (breath, unwind, space).

**Session 2: Motivation to change**

This session looks at what is motivation, issues that interfere with it, how lack of motivation affects us, how to overcome de-motivation, and cycle of change. We also look at other issues that can block therapeutic progress.

**Session 3: Denial, minimization, and justifications**

This session introduces the concepts of denial, minimization, and justifications. They are asked to identify times when they have denied and minimized issues.

**Session 4: ‘What is anger?’**

This is the introductory session to anger management. The session serves to explain and explore with the group members ‘what is anger & aggression’; the costs and benefits of anger; common misconceptions of anger management; what makes other people angry; and monitoring anger. Group members are introduced to the anger thermometer in order that they can learn to monitor their anger levels.

**Session 5: ‘Making sense of our thoughts’**

This session focuses on thoughts and how to monitor them. The session introduces the different types of thinking errors and the group members are introduced to a cognitive behavioural tool-the T-TAB model, consisting of triggers, thoughts (negative and positive), arousal, and behavioural responses.

**Session 6: ‘Making sense of our emotions’**

This session serves to explain what is emotion? It also looks at being able to recognise emotions, convey our emotions, and deal with difficult emotions. The evolutionary model is used here to depict and explain emotions e.g. an animal attacking. Some physiological aspects are discussed here.

**Session 7: The physiological component of anger**

This session explains where physiological arousal comes from, how to identify it, and ways to manage it. Group members are introduced to anger hierarchies. Group members are asked to list three of their own anger provoking scenarios, a low level, moderate level, and high level.

**Session 8: ‘Personalising anger’**

This session serves to explain where our anger originates from by examining the evolutionary process of trauma, as well as looking at childhood anger and the impact of early traumatic experiences. This session incorporates some Schema Therapy concepts.

**Session 9: Self-attacking behaviour, shame and anger**

This session serves to explain the role of self-attacking style of behaviour and shame and how this relates to anger.

**Session 10: Alternative thinking=alternative behaviour**

The group is introduced to PALS (‘pile in’, ‘active communication’, ‘let it go’, and ‘suppress and simmer’, the four most common ways of responding to an angry situation. Role play is introduced in this session and group members are asked to act out a low level anger scenario from their anger hierarchies.

**Session 11: De-escalation and self-monitoring**

The group is introduced to de-escalation techniques, e.g. CLINK skills (‘calm but concerned’, ‘listen’, ‘say I not you’, ‘negotiate a solution’, and ‘keep it going’. They are also asked to practice more role play.

**Session 12 & 13: Anger as a risk factor for violence & aggression**

These two sessions aim to explore the role that anger plays in violence and aggression. Other topics covered are: frustration & aggression, differences between instrumental and angry aggression, and aggressive personality. Group members are also asked to talk through the role of anger and aggression leading up to their index offence.

**Session 14: Relapse prevention: Managing our anger and aggression**

Group members are introduced to the relapse prevention model and how this applies to anger e.g. high-risk situations, and other related factors e.g. mental health issues. Group members are asked to devise a relapse prevention plan.

**Session 15: Handling criticisms: Assertiveness**

This session focuses on definitions of assertiveness, dealing with criticism, why people fail to assert themselves, and steps to assertiveness. Group members are asked to role play scenarios demonstrating effective and ineffective assertiveness skills.

**Session 16: Review**

This session serves as a review of the group material. Relaxation is practiced during the second half.

**Session 17: Quiz**

In the final session, group members are asked to demonstrate their knowledge and skills that they have acquired during the course of the group. Group members are divided into two teams and a fun quiz is held. Following this they are presented with a certificate.

**Final report**

At the end of the group a very detailed report is written. This includes the results of the psychometrics, group and individual work. Also included in the report is a psychological formulation of the individual’s anger and other relevant risks that they might pose along with a list of recommendations.