Reducing Anger-Related Offending

What Works

Raymond W. Novaco
University of California, USA

Introduction

Violence imposes a major burden on the well-being of populations, and as we seek to attenuate violence, that ambition naturally reaches for anger control. Violence is a public health problem for which the international scope is clear, as reflected in reports by the World Health Organization (Krug et al., 2002) and by the US Centers for Disease Control and Prevention (CDC) (Center for Disease Control and Prevention, 2006). A national population study in the United Kingdom (Coid et al., 2006) involving 8397 households found that 12% affirm violent behaviour in the previous five years. In addition to the human tragic consequences of violence, there is also the financial burden. A US CDC study that examined violence as a public health problem (Corso et al., 2007) reported that the costs associated with non-fatal injuries and deaths due to violence in the year 2000 were more than $70 billion. More broadly, the implicit costs of violent crime in the United States, in terms of value of lost life and value of injuries, were estimated by Anderson (1999) to be over $574 billion annually, and that is separate from his calculations of crime-induced production costs (e.g., police, corrections, security systems), opportunity costs (lost production) and economic transfers. Soares (2006) estimated the welfare cost of violence across 73 countries and put the yearly costs in the United States at 2.9% of GDP (for comparison, it was 5.7% for Latin America). To take another perspective, for UK National Health Service staff, the National Audit Office (2003) estimate of the direct cost of violence was £69 million or more per year, not counting costs associated with psychological distress, staff morale or staff retention.

While anger is neither necessary nor sufficient for violence, we know intuitively and empirically that violent behaviour is often activated by anger (Novaco, 2011). Social gatekeepers prudently look for ways of reducing violence risk, and anger management programmes have proliferated. The societal call for anger control fits with a quotidian conflict resolution agenda and broadly based quests for interpersonal harmony, including the Nobel Peace
prize, which sometimes goes astray. Anger management programmes abound in correctional settings, both institutional and community, but it is not clearly evident that such programmes are effective interventions for violent offenders. In the reviews by Blackburn (2004) and McGuire (2008), anger management programmes are promissory, and some authors, such as Polaschek (2004, 2006), have questioned their appropriateness as a primary intervention for many violent offenders. Some time ago, Howells (1989) cogently observed that not all violent offenders are candidates for anger therapy and discussed the congruities and incongruities. Indeed, from the origination of anger management as a therapeutic intervention (Novaco, 1975) to its initial implementation with high security forensic patients (Renwick et al., 1997), it was thought to be an adjunctive therapy. It was not meant to supplant either psychotherapy for a client’s larger mental health needs or the multifaceted interventions needed to rehabilitate violent offenders, such as that implemented by Polaschek and her colleagues in New Zealand (e.g., Polaschek et al., 2005). Nevertheless, meta-analytic reviews of interventions for offenders by Landenberger and Lipsey (2005) and by Dowden and Andrews (2000) were sanguine about recidivism reduction associated with programmes that included anger control.

Anger control is a vexing issue, precisely because anger is a normal emotion having survival value. For aggression-disposed individuals and subcultures, it’s a hard sell to dislodge attachment to anger. Humans are hard-wired for anger, and there can be no sensible thoughts to erase it, much as the Stoics and the Victorians tried. Yet, the violence-linked interpersonal and societal harm-doing capacity of anger is unmistakable, as are its manifestations in self-harm. Beyond anger’s violence-engendering faculty, it also can adversely affect prudent thought, core relationships, work performance and physical well-being. Hence, community caretakers, social scientists, clinical professionals and great thinkers seek remedies for it. The problem conditions, however, are not derivative of anger per se, but instead result from ‘anger dysregulation’ – that is, its activation, expression and ongoing experience occur without appropriate controls.

Many violent offenders become attached to their anger routines, which can be oddly satisfying. The psychosocial symbolism of anger (Novaco, 2000) casts it, in one of its Janus-faced forms, as energizing, empowering, signalling, justifying, rectifying and relieving. Hence, interventions aimed at anger reduction might be disparagingly viewed as totalitarian ploys to stifle individuality and the human spirit. Like the coerced cures imposed on fictionalized anti-heroes, such as those in Anthony Burgess’ A Clockwork Orange or Michael Crichton’s The Terminal Man, the term ‘anger management’ might, in an Orwellian sense, connote invasive control over the will to determine one’s own destiny. Social gatekeepers (parents, school principals, employers, police and magistrates), though, are not charmed by the mastery-toned elements of anger, but rather are sensitized to and unsettled by the Janus opposing face social metaphors of anger as eruptive, unbridled, savage, venous, burning and consuming. Thus, a UK public information campaign on problem anger was launched by the Mental Health Foundation (2008). Until recent decades, the turbulent emotions underpinning harm-doing behaviour had eluded clinical focus, having been long ignored in the privileging of other antecedents, such as criminal history, mental illness and psychopathic personality. Anger and its vicissitudes – rage, hate and revenge – have come to the fore, and court-referred ‘anger management’ treatments, as well as prison programmes for it, are now commonplace for many varieties of offending behaviour.

The efficacy of intervention programmes for anger with violent offenders is the core topic of this chapter, but before addressing that, some contextual background is in order. The forensic relevance of anger in its ties to violence and to madness has a long history.
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Historical Backdrop

Systematic attention to anger as a dynamic risk factor for violence has been remarkably slow in coming. In the forensic field, anger eruptions are often cast as symptoms of the person's 'illness'. Yet, anger has long been known to be an activator of violent behaviour. Anger is the prototype of the classical and medieval view of emotions as 'passions' that seize the person-ality, disturb judgement, alter bodily conditions and imperil behaviour. Plato and Aristotle, seeking perfection of character and temperament, viewed moderation in anger as desirable.

Seneca (44/1817), arguably the first anger scholar, understood it as a pernicious and vicious force that makes us destroy one another. Perhaps inspired by Horace, he saw anger as a 'short madness'. Anger's association with mental disorder was also noted by Galen, the physician of Marcus Aurelius, who saw anger episodes as marked by madness (Galen, 1963). Although the involvement of anger in psychopathology is complex (Novaco, 2010a), its relevance for violence and mental disorder has long been known, as has its enlargement as 'wrath' or 'rage'.

Wrath, as linked with loss of rationality and vengeful destructiveness, is an ancient tale with reverberating forensic relevance. The Iliad, the first composition of Western civilization, opens with the anger of Achilles: 'Anger be now your song, immortal one, Akhilleus' anger, doomed and ruinous,...leaving so many dead men – carrion...' (Homer, 2004, p. 5). Achilles was enraged at Agamemnon the Athenian king but followed (obeyed) Athena's advice to stay his sword – divinity inspired anger control; but he remained stewing in his tent while thousands of his soldiers perished in battle. Among those fallen was his close friend Patroclus, the news of which engulfed Achilles in a 'black stormcloud of pain...tore his hair with both hands' (p. 430), and he became 'mad with rage for his friend's death' (p. 468). In an intensity of anger (mēnis) thought to be reserved for the gods, Achilles viciously kills Hector and defiles his body.

Another tragic hero in the Iliad, Ajax (Achilles' cousin), is driven to madness by Athena in his rage against Odysseus. Simon (1978) gives an engaging account of Sophocles' portrayal of the cold wrath of Athena and Ajax's psychotic breakdown, which culminates in suicide. Lansky (1996) highlighted the role of shame in Ajax's psychopathology and views his madness as dissociated narcissistic rage. In Euripides' play, the Madness of Heracles (Hercules Furens in Latin), that tragic hero is driven mad by the goddesses Iris and Lyssa (the latter being madness personified), and in a frenzy, he kills his wife and children (cf. Mikalson, 1986; Simon, 1978). Such rage-without-reason portrayals were not restricted to men, as Euripides and Seneca composed plays of Medea, whose paroxysm of rage at being betrayed by Jason leads her, in vengeance, to kill her children whom Jason fathered. Medea is another shame-rage cycle tale.

Those are just a few classical examples of anger's ties to violence, mental disorder and self-harm that reverberate in the contemporary forensic field. In drafting criminal statutes, Plato differentiated intentional homicide as having greater culpability when driven by angry revenge than by angry impulse (Woozley, 1972). Literary illustrations are Shakespeare's hot-tempered, impulsively violent Tybalt in Romeo and Juliet, and his King Lear, whose easily activated rage accompanied his progressive insanity; there is also Dostoyevsky's Dmitri Fyodorovitch, in Brothers Karamazov, who resorts to irrational, violent solutions in mad rages, and his 'under­ground man' protagonist in Notes from Underground, who ruminates about revenge. Dysregulated anger features in temporary insanity 'heat of passion' defences (Novaco, 2010a).
Anger's generic link to psychopathology is also semantic. Becoming 'enraged' suggests being 'rabid', connoting a diseased state of mind. Being angry, becoming mad and creating Bedlam (echoing the historic asylum) are semantically and metaphorically linked. The classical notion of anger 'passion' posing danger carried through to the eighteenth century, as reflected in Hutcheson's (1742) essay, where he characterized anger as 'a Propensity to occasion Evil to another, arising upon apprehension of an Injury done by him' (p. 75). Early texts in psychiatry (Von Krafft-Ebing, 1905; Tuke, 1892) designated 'excandescentia furibunda' to pertain to the insanity of anger - that is, the loss of mental control or inhibitory central control that was seen to occur during rage episodes. Von Krafft-Ebing saw the condition as indicative of brain abnormalities caused by biological conditions, trauma or structural defects ('idiocy') and stated that 'In such conditions the slightest cause leads to the explosive affect of anger, which, owing to continued reproduction of painful thoughts, is maintained at its height' (p. 56).

A thematic account of anger as portrayed historically and culturally can be found in Potegal and Novaco (2010), and contemporary relevance is easy to track. In preliterate societies, angry malevolent spirits caused misfortune and physical discomfort. Angry gods presented more grave danger, bringing calamities and instilling abject fear. Wrathful gods, and monotheistic deities, become angry about disobedience, disloyalty, disrespect and imperfections. Transposed to the human arena, anger is associated with manhood in warrior cultures, such as the Assyrians, Hittites, Norse/Viking berserkers, Aztecs and Maori. Anger makes for fearsomeness. In psychopathological forms, it erupts in cases of 'wild man' and 'amok' syndromes, the latter involving frenzied violence, as observed by anthropologists in Micronesia and other Pacific Island societies (e.g., Carr and Tan, 1976; Gaw and Bernstein, 1992). Spree murder is, of course, the Western cultural parallel of amok.

Noteworthy in leaving this historical backdrop is a fundamental symbolic structure for understanding anger and aggression, evident since the classical period, which is 'justification'. It is rooted in ancient religious texts, such as the Bible and the Koran, as well as classical mythologies about deities and historical accounts of the behaviour of ancient rulers. Anger, as well, is very much infused with themes of justification, and even righteousness – perhaps prototypical exemplified by God's anger in the Dies Irae (Days of Rage) segment of the Requiem mass (the Latin Mass of the Dead, Missa de Profundis). Grasping the centrality of the justification theme is important for anger assessment and treatment for offender and non-offender populations. What is judged to be a transgression, affront or wickedness is shaped by schema or macro knowledge structures. Threat perception is intrinsic to anger activation. The threat schema of a social group can heighten attention to transgressions or signals of malicious intent. Violations or encroachments might be exacerbated or excused by status variables that mark the action as especially onerous or, alternatively, as forgivable. Retaliatory aggression recruits anger as an energizer. In contemporary pleas of temporary insanity, the 'heat of passion' defence or the 'provocation doctrine' (cf. Horder, 1992, 2005; Novaco, 2010a) is rooted in principles of justified moral outrage, whereby severe provocation provides a moral warrant for retailing in anger, which operates as a passion that overrides reason and defeats self-control. The anger is viewed as an uncontrolled reaction to wrongdoing or perceived injustice.

Because anger is too easily transformed into destructive aggression, it beckons for self-regulation. However, many of those who have anger regulatory difficulties and offend violently are otherwise beset with adversities that attenuate control capacity. High-anger people often lead lives with multiple sources of anger/aggression instigation. While they are architects as well as recipients of their misfortunes, their anger troubles can be reflective of trauma, hardship, chaotic social relationships and mental disorder. When high in avenues of friction, impoverished
in support structures and short in countervailing resources for inhibitory controls, anger easily becomes a default response. The provision of treatment and its evaluation for high-anger persons hinges, importantly, on proficient assessment of the anger problem.

**Anger Assessment**

Referrals for anger treatment or ‘anger management’ often run afoul of the elementary point that, when someone’s violent behaviour is not driven by anger dysregulation, providing therapy for anger is mis-targeted. Some studies of ‘anger management’ programmes conducted in prison settings have tempered their findings of limited efficacy by noting that high-anger level inclusion criteria were lacking (e.g., Eamon, Munchua and Reddon, 2001; McMurrnan et al., 2001; Smith and Beckner, 1993). Not all violent offenders are candidates for anger therapy, and Howells et al. (1997) articulated the importance of individual formulation, needs assessment and attention to cultural factors.

At the outset, it must be understood that people who are in forensic or other custodial settings should be expected to ‘mask’ their anger, as they are unlikely to perceive gain in disclosing it. Instead, they are inclined to respond on a ‘need to know’ basis – telling you what they think they need for you to know. Anger assessment in forensic settings is subject to measurement reactivity. Reactivity pertains to responses obtained in an assessment procedure that are reactions by the person to his or her inferences about the test situation, rather than to the explicit elements of the testing – that is, the person is inclined to produce anger reports in anticipation of what those test responses will mean to some audience. Measurement reactivity is a form of response distortion and constitutes a threat to internal validity, which some anger assessment procedures (Novaco, 2003) try to address. An example of such reactivity occurs in the study by Loza and Loza-Fanous (1999a), who sought to examine anger as a predictor of violent recidivism among Canadian criminal offenders but did not notice that their anger score means approached the lowest possible scores for one of their main anger instruments.

There are multiple sources of reactivity bias in anger assessment. People who have long-standing anger difficulties are characteristically suspicious and distrustful, and anger testers may be viewed as representative of a threatening system deserving guarded responses. Importantly, the psychosocial symbolism associated with anger (particularly its boiling/eruptive and savage/non-rational aspects) deters respondents from disclosing anger and the actions to which anger might dispose them. Moreover, anger can be a protected part of the person, centrally involving matters of self-worth. Thus, it is not readily revealed or surrendered. As Goffman (1961) helped us to understand, the ‘identity stripping’ features of custodial institutions take away the customary affirmations of the self – a patient once commented in reflecting about life in an institution, ‘All you’ve got is your anger’. Disclosing anger may be perceived to carry the psychological cost of losing power and, what may be for that person, the last remaining symbol of personal freedom and self-worth.

Many instruments have been constructed for the assessment of anger, hostility and aggression. Two reviews provide valuable coverage. Eckhardt, Norlander and Deffenbacher’s (2004) give attention to the range of anger and hostility self-report scales, and Suris et al. (2004) deal with aggressive behaviour measures. The latter article has overlapping coverage of anger and hostility scales; its content is more overview than analytical but does provide a catalogue of measures and their psychometric properties. Additional coverage is provided in Taylor and Novaco (2005), particularly with regard to persons with intellectual disabilities (IDs).
Self-report measures

The three main self-report measures of anger in contemporary forensic studies are the Spielberger State-Trait Anger Expression Inventory (STAXI; Spielberger, 1996), the Buss-Perry Aggression Questionnaire (AQ; Buss and Perry, 1992) and the Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 1994, 2003). The NAS-PI was developed for use with mentally disordered respondents, and it was implemented in the landmark MacArthur project on violence and mental disorder (Monahan et al., 2001). Both the NAS-PI and the STAXI have been validated for use with forensic patients with IDs (Novaco and Taylor, 2004).

Anger psychometric scales are generally ‘nomothetic’ in nature, suited to detecting mean differences with reference to normative data and changes within or between groups following intervention. An alternative and more ‘idiographic’ procedure is the Imaginal Provocation Test (IPT), first developed by Novaco (1975) and more recently extended to hospitalized forensic patients (Taylor et al., 2004). The IPT involves presentation of provocation scenes that the person is asked to imagine actually happening and then to provide ratings on the anger experience and on prospective behavioural reactions to the provocation. The measurement indices are sensitive to change associated with anger treatment (e.g., Chemtob et al., 1997; Novaco, 1975; Taylor et al. 2004). The imaginal provocation procedure is exportable for use in a variety of settings, has minimal logistical requirements and the content of the imaginal scenes can be tailored to the modal types of anger-inducing events for a client group or ultimately to the particular circumstances of an individual client’s anger control problem.

Observation procedures

Anger also can be assessed by staff observation procedures. There are a number of staff-rated measures of behaviour for use in residential settings, which are catalogued in Suris et al. (2004). For the most part, these measures attend to aggression, typically excluding anger. In contrast, the Ward Anger Rating Scale (WARS; Novaco and Renwick, 2003) is a two-part scale (anger attributes are rated on Part B) completed by a staff member who knows the patient and has observed his or her behaviour over the previous week. Novaco and Taylor (2004) and Doyle and Dolan (2006a) demonstrated its validity for anger assessment and the prediction of violence among hospitalized forensic patients, and Cornell, Peterson and Richards (1999) used its anger attributes index (Novaco, 1994) with incarcerated adolescents. A noteworthy perspective on inpatient aggression is the functional analysis approach of Daffern, Howells and Ogloff (2007), whereby anger-driven aggression can be differentiated from other functional types, such as demand avoidance, forcing compliance, obtain tangibles and enhance status.

Staff observation procedures and use of archival records make for a multimethod approach to anger assessment, which is an important principle, not only from a research standpoint but also with regard to case formulation. Nevertheless, client self-report is a central measurement procedure. Anger is a subjective emotion, and the factors that bear on anger reactions and anger control must be uncovered from the person’s cognitive processing and symbolic structures, so as to understand how people construe their anger experiences. Proficient anger assessment, though, is not about tallying numbers on a rating scale. It involves integration of multiple channels of information and is geared towards understanding the psychological deficits associated with the anger dysregulation and problematic behaviour.

Pertinent to anger intervention programmes with offenders, Williamson et al. (2003) have developed an ‘Anger Readiness to Change Questionnaire’. Knowing a person’s ‘readiness for
anger treatment' and responsivity to provided programmes, as Howells and Day (2003) have cogently explained, requires understanding the clinical complexity of cases (e.g., co-morbid disorders), clients' inferences about their problems, clients' personal goals, mandatory treatment issues, institutional/agency factors and cultural and gender differences. To be sure, anger assessment is made more difficult by severe mental disorder and by ID; however, reliable and valid psychometric assessments can be obtained with such clinical populations (cf. Novaco, 1994, 2003; Taylor and Novaco, 2005). The admixture of client and setting conditions bears on client responsivity to provided programmes.

Anger as a Viable Treatment Target in Forensic Settings

Forensic settings are efficient anger factories. In jails, prisons and forensic hospitals, the person is subjected to various ‘mortifying’ conditions (Goffman, 1961), and the social and physical environments of custodial settings are conducive to anger activation (cf. Levey and Howells, 1991; Novaco, 1994). Environmental design, privacy restrictions, limited affordances, resident attributes, staffing levels and unit social climate so often entail aversive elements that could trigger anger in normal, well-adjusted people. Overcrowding alone is an anger-generating adversity, and while the United States leads the world in its rate of incarceration, being five to eight times higher than that of Canada and Western Europe (Walmsley, 2006), concerns about prison overcrowding and failed prisons policy are not unique to the United States. Imprisonment in the United Kingdom between 1997 and 2007 increased by one-third (Ministry of Justice, 2007), and the UK prison system was said to be in crisis by the country’s own Chief Inspector of Prisons (Owens, 2007). Since then, the population in custody in England and Wales has continued to grow from 80,067 at the end of 2007 to 87,531 at the end of March 2012 (Ministry of Justice, 2012).

Prison environments are replete with aggression-engendering elements and are all too thin on prosocial antidotes (Ireland, 2000; Maghan, 1999). Miller (1973) stated that, in adjustment to life in a Florida prison, anger was 'a ubiquitous feeling state, the expression of which itself becomes a method of dealing with depression' (p. 24). Nurse, Woodcock and Ornsby (2003) reported on how environmental factors in a prison in England lead to 'extreme stress, anger, and frustration' (p. 481). Incisive accounts of the short-term and long-term effects of solitary confinement are given by Haney (2003) and by Arrigo and Bullock (2008), which feature intense anger and hostility. Haney found that both irrational anger and ruminations were present among 88% of the prisoners at a California maximum security prison. In Michie and Cooke’s (2006) study with Scottish prisoners, anger, in rigorous multivariate analyses, was the strongest predictor of violence without a weapon. Among over 800 incarcerated juveniles in California, DeLisi et al. (2010) found anger to be predictive of institutional misconduct, including assaults, controlling for a host of background and psychological variables. Similar findings were obtained by Cornell et al. (1999) elsewhere.

Psychiatric hospitals have been known for decades to have long-standing problems with assaultive behaviour by patients against other patients and against staff (e.g., Depp, 1976; Foster, Bowers and Nijman, 2007; Fottrell, 1980; Haller and Deluty, 1988; Nijman et al., 2005; Whittington and Richter, 2005). Assaultive behaviour by patients seriously impairs treatment milieu, results in restrictions and diminished chances for discharge, constitutes risk for harm among staff and has considerable financial cost in workers’ compensation claims and
employee turnover. A number of studies have now shown anger, a dynamic variable amenable to treatment, to be predictive of assaultive behaviour by forensic patients during hospitalization (Doyle and Dolan, 2006a; Linaker and Busch-Iversen, 1995; Novaco, 1994; Novaco and Taylor, 2004; Wang and Diamond, 1999) and in the community after discharge (Doyle and Dolan, 2006b; Doyle et al., 2012; Monahan et al., 2001; Skeem et al. 2006; Swogger et al., 2012). Taken together with the findings for anger activating assaultiveness among prisoners, there is a solid rationale for anger therapeutic intervention.

Challenges for Anger Treatment with Offenders

The survival functions of anger and aggression thwart efforts to change offending behaviour. People with severe anger problems are often reluctant to change routines that have 'worked' for them, which, from a system's theory perspective (cf. Novaco, 2007), can be seen as exhibiting inertia. However, many people with anger/aggression problems are too readily viewed as 'treatment-resistant' cases. When faced with a 'Formula One anger case, it is easy to be unsettled by the person's volatility and history of so much having been tried with so little result. However, Howells and Day (2003) scuttled the 'treatment resistance' notion by asserting instead that the treatment engagement problem be understood as a matter of client 'readiness'. In their discussion of impediments that are prevalent in forensic and correctional contexts, it can be seen that low readiness is not only about the client's disposition but also about characteristics of the treatment situation that can impede engagement in therapy. Among the issues that Howells and Day (2003) discuss in this regard are the complexities of cases (e.g., multiple co-morbidities), goals and expectations of the institutional setting, clients' inferences about their anger problem, treatment being mandated and ethnic/cultural/gender differences. Monahan and Steadman (2012) turned the 'treatment resistance' characterization completely on its head by arguing that, for the vast majority of people in the criminal justice system who have serious mental disorder, the situation is one of 'client-resistant services'.

Treatment of anger proceeds successfully when two thresholds are met: (i) when the client recognizes that costs of anger outweigh the benefits of anger/aggression habits, and (ii) when the client commits to engage with the therapist. Treatment engagement, of course, may be followed by disengagement, necessitating re-engagement efforts. Many scientist-practitioners working in the criminal justice and forensic psychology fields have called attention to the value of motivational interviewing (Miller and Rollnick, 2002) to facilitate treatment engagement, and parallel procedures have been part of a 'preparatory phase' of cognitive-behavioural anger treatment (Novaco, 1997; Renwick et al., 1997; Taylor and Novaco, 2005).

Many offenders who have anger regulatory difficulties have long been beset with adversities that attenuate control capacity. While they have been architects of many of their misfortunes, their anger troubles can be reflective of trauma, economic hardship, chaotic social relationships as well as mental disorder and substance abuse. The prevalence of trauma and post-traumatic stress disorder (PTSD) among prisoners has been insufficiently studied (Goff et al., 2007); yet, it is clear that such conditions are higher than normal among incarcerated populations and are especially problematic for females (Cauffman et al., 1998; Huang et al., 2006; Komarovskaya et al., 2011; Pollack et al., 2006; Zlotnick, 1999). Given the relationship between, PTSD and anger (Orth and Wieland, 2006), high levels of trauma may account for the higher levels of anger found among female prisoners and forensic hospital patients (e.g., Archer and Haigh, 1997; Novaco, 1997; Sutter et al., 2002). Among female
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prisoners, anger is substantially related to self-harm and suicide attempts (e.g., Chapman and Dixon-Gordon, 2007; Milligan and Andrews, 2005).

The embeddedness of anger in an admixture of adversities sharply distinguishes this emotion in offender populations from the anger reactions observed in the subject pools of university laboratories in analogue studies. Achieving change in clinically problematic anger dysregulation is a bit more complicated than offering distraction, supplying a cool drink, hitting a hop bag, being a ‘fly on the wall’ or providing mitigating information about a perceived slight from an experimental confederate – all of which far too many psychology lab researchers wax on about clinical relevance. Garden-variety anger reactions, whether laboratory grown or real life based, are qualitatively different from those rooted in long-standing distress. For those high in avenues of friction, impoverished in support structures, beset with delusions and depression and short in countervailing resources for inhibitory controls, anger easily becomes a default response that catalyzes an overdetermined act of aggression. It carries the aura of repelling threat and provides fortification of self-worth. With seriously angry people, simply engaging them in the process of treatment is fraught with many obstacles, and their readiness for anger treatment often must be fostered therapeutically.

Anger Treatment with Offenders: Background and Empirical Challenges

Injunctions for ‘anger management’ have taken many forms in recent decades, from the judicial proscriptive to the satirical. Yet, anger control has been a societal agenda since classical philosophers grappled with the regulation of inner life and the enhancement of virtue. The military strategy writings attributed to Sun Tzu saw anger as a fault upon which military commanders could capitalize. The Stoics precluded the viability of anger, as readily seen in the writings of Seneca and Epictetus. Roman and Greek philosopher/historians, such as Cicero and Plutarch, also sought eradication of anger in the quest for tranquillity of mind. Roman poets Horace and Juvenal saw anger as marked by madness and foolishness. Pre-dating the Greek and Roman Stoics were Buddhist teachings about the path to enlightenment, seeking to train the mind to gain inner strength. Original cognitive-behavioural therapies (CBTs) were influenced by Stoic proscriptions, and new wave CBT approaches, such as ‘Mindfulness’ or ‘Acceptance and Commitment Therapy’, have forerunners in Buddhist ideas – if drawn to seeing remedies for anger in acceptance and compassion, there is much of value to be gleaned from Hanh (2001).

Since the origination of ‘anger management’, as it was then called (Novaco, 1975), nine meta-analyses on the effectiveness of psychotherapy for anger have been published (Beck and Fernandez, 1998; Del Vecchio and O’Leary, 2004; DiGuiseppi and Tafrate, 2003; Edmondson and Conger, 1996; Gansle, 2005; Ho, Carter and Stephenson, 2010; Saini, 2009; Sukhodolsky, Kassinove and Gorman, 2004; Tafrate, 1995), which overall have found medium to strong effect sizes, indicating that approximately 75% of those receiving anger treatment improved compared to controls. When various therapies are examined, CBT approaches have greatest efficacy. However, many of the studies that qualify for meta-analytic review (by virtue of control group conditions) have not concerned patients with serious clinical problems or violent behaviour. Thus, the strictures of meta-analyses allow for the inclusion of studies with normal functioning college student volunteers, minimally screened for anger problems, while excluding clinical case series studies with clients having demonstrable psychopathology and violence
histories. Pertinent to the forensic field, there are a number of case series studies that bolster confidence in anger treatment efficacy with offenders (e.g., Bornstein, Weisser and Balleweg, 1985; Burns et al., 2003; Haddock et al., 2004; Lindsay et al., 2003; McMurrant et al., 2001; Nomellini and Katz, 1983; Renwick et al., 1997).

Landenberger and Lipsey's (2005) meta-analysis of 58 studies of the effects of CBT programmes on recidivism of adult and juvenile offenders found that 20 of those studies incorporated anger control as a treatment element. After controlling for method variables, participant characteristics, quality of implementation and CBT emphasis, their regression model found that having an anger control component in the intervention was significantly related to the effect size for reduced recidivism. Landenberger and Lipsey defined 'anger control' as 'training in techniques for identifying triggers and cues that arouse anger and maintaining self-control' (p. 466). Similarly, the meta-analysis by Dowden and Andrews (2000) of 35 primary studies of correctional treatment programmes had found those that targeted 'negative affect/anger' were positively and significantly associated with effect size in reducing violent recidivism. To be sure, the incorporation of an anger control component in a broader intervention programme (such as 'Reasoning and Rehabilitation' or 'Aggression Replacement Training') is of course different from a focused anger therapeutic intervention which then receives focused evaluation of its efficacy; yet, those two meta-analytic reviews certainly provide a boost for the value of delivering anger treatment to violent offenders. However, despite these meta-analytic results concerning studies with offenders, plus the supportive findings from the nine meta-analytic studies including non-offenders, there remain reasons for doubt about the efficacy of treating anger with forensic populations. There are several challenges in this regard.

Anger may be 'irrelevant'

One challenge came from the Canadian prison study by Loza and Loza-Fanous (1999b), who, in effect, asserted that anger was irrelevant to the criminal behaviour and treatment needs of violent offenders. They obtained a random sample of 271 males incarcerated in Ontario institutions and compared violent with non-violent offenders, and then rapists with non-rapists, using four anger instruments. While showing that violent offenders and rapists were much more likely to be recommended for an anger programme by case managers, they found no significant differences in assessed anger between their offender categories, with the exception that the violent offenders had lower anger on one of the measures (NAS Total). Loza and Loza-Fanous thereby concluded that it is fallacious to treat anger. Their claim of the irrelevancy of anger was, unfortunately, picked up by others (e.g., Serin, Gobeil and Preston, 2009; Walker and Bright, 2009b), but insufficient attention was given to the actual data. In the Loza and Loza-Fanous (1999b) study, as with their other study published that year (Loza and Loza-Fanous, 1999a) with virtually the same sample, the Mean scores on the anger measures are suppressed, showing signs of anger measurement reactivity (cf. Novaco, 2010b). For example, the Mean score on STAXI Trait Anger for the violent prisoners is 14.45 – yet, the possible score range on that scale is 10–40. That Mean score for Trait Anger is nearly one standard deviation below the STAXI norms for males. Similarly, the Loza and Loza-Fanous (1999b) Mean NAS Total score for the violent prisoners is 68.52 – yet, the possible score range is 48–144. So, their prisoner-reported anger (like that in another Ontario prison study, Mills and Kroner, 2003) is also quite low in that instrument’s score range and in comparison to its standardization norms for offenders (cf. Novaco, 2003) and to other studies with prisoners using the same measures in three other countries (Baker, Van Hasselt and Sellers, 2008; Lindqvist, Daderman and
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Hellstrom, 2005; Sutter et al., 2002) as well as in another study in Canada (Ford, 1991). It is then dubious to deem anger to be irrelevant to the criminogenic needs of violent prisoners, when the prisoners’ anger reports are plausibly suppressed or ‘masked’.

Indeed, one must establish whether anger treatment is relevant. Low anger scores on psychometric measures may be a product of masking, or they may be due to the absence of anger, as discussed earlier in conjunction with violent offending and as can be seen in McMurran et al. (2001) in their discussion of one of their cases.

**Anger treatment is ‘weak’**

A more formidable challenge to the value of anger treatment with prisoners comes from studies by Kevin Howells and his colleagues with male prisoners in Australia. Straightaway, it should be noted that their prisoner study participants indeed had high anger scores and violent offence histories, that they attended to treatment programme fidelity and that programme recipients showed gains in anger control knowledge. Their news for the efficacy of the programmes, though, was not reassuring. When Watt and Howells (1999) conducted two small sample studies evaluating a prison anger management programme in Western Australia, they found no effect for the treatment condition compared to the control condition in either study and no change in anger. The treatment programme was ten 2-hour sessions over five weeks. Howells et al. (2005) then followed with a study of 285 prisoners in South and Western Australia, again evaluating the same type of programme and involving follow-up assessments. Although they found declines in anger over time and the treatment group showed more improvement than the control group, the between-group effects were not significant. They did, however, find that ‘treatment readiness’ significantly moderated change in anger. Greater readiness for treatment was associated with significant declines in anger in the anger treatment condition and significant increases in anger in the control condition.

Heseltine, Howells and Day (2010), in another study with Australian prisoners, concluded that the anger management programme did not have a significant impact on experience of anger or behaviour, except for gain in knowledge; but they did find that high-anger prisoners in the treatment condition improved in social functioning, clinical problem level and self-harm risk. In that latter study, the authors noted that there were lower levels of anger overall than in previous studies, and there was a 30% attrition rate. Howells et al. (2005) speculated that the poor showing for the efficacy of the treatment may have been due to poor motivation of participants – which can be found noted in other failed treatment studies with offenders (e.g., Valliant, Jensen and Raven-Brook, 1995). Beyond the motivation issue, Howells et al. questioned whether the treatment was sufficiently intensive, noting that the length of their programme (20 hours) stands in contrast to the 50-hour programme of Dowden, Blancette and Serin (1999) in Canada. They conjectured that the complexity of problems that characterize high-risk offenders, as Howells and Day (2003) and Novaco (1997) have highlighted, interferes with establishing a working therapeutic alliance. Dealing with multilayered clinical problems does require more treatment time than brief anger management programmes provide.

**Anger treatment does not ‘reach’**

Walker and Bright (2009b) put forward a view that, for violent people in clinical and forensic settings, anger management falls short of client treatment needs. That article sprung from one just prior (Walker and Bright, 2009a) that centrally implicated the arrogant/aggression
('macho') protection of low self-esteem in the activation of violence. Their central argument is that the cognitive models underpinning 'anger management', which rely on information-processing frameworks for understanding anger, citing those of Beck (1999) and Novaco (Novaco, 1994; Novaco and Welsh, 1989), have omitted the importance of the deeper concepts of shame, humiliation and damaged pride or low self-esteem. They assert that CBT approaches to anger have missed 'working at the level of personal meaning' (Walker and Bright, 2009a, p. 7). Their formulation stresses core beliefs of vulnerability and negative self-schemas. Fundamentally low self-esteem is covered up by machismo, which spurs violence and falsely inflated self-esteem. As non-violent behavioural alternatives are viewed as weakness, the situational threat and the threat of embarrassment are averted by violent attack. For Walker and Bright (2009a) and Walker and Bright (2009b), the central focus of therapy is to build self-esteem, and the goal of therapy is to help patients relinquish violence to protect self-esteem and to build a more enduring sense of personal respect. They have done well in calling attention to the importance of shame and perceived vulnerability in the activation of anger and violent behaviour, and they give a fair account of the informational processing frameworks; however, they are too quick to characterize CBT anger treatment as being entailed by information processing (i.e., ignoring CBT arousal reduction and behavioural components), and they have missed seeing that cognitive restructuring is certainly about working on the personal meaning of anger episodes and their sequelae.

We have known about the interrelationships between shame, anger and violence since Sophocles wrote Ajax. Medea's violent rage is also about shame, as noted earlier, along with Dostoevsky's *Brothers Karamazov*, which features rage and violence that spring from shame and humiliation (cf. Moran, 2009). Yet, shame has indeed been neglected as a salient theme in the study of anger among offenders, and it is crucially important with regard to trauma populations, such as victims of domestic violence and sexual assault, as well as combat veterans. Thomas Scheff, who has been broadly influential in advancing the sociological perspective of mental illness, has otherwise written about shame–rage spirals or shame–anger loops (Scheff, 1988) and, collaborating with Retzinger, has extended the shame–rage connection to understanding violence (Retzinger, 1991; Scheff and Retzinger, 1991). In the forensic domain, Morrison and Gilbert's (2001) study of male Special Hospital patients found that shame in both primary and secondary psychopaths was related to anger in provoking situations of humiliation and rejection and to acting out aggression. They suggest that secondary psychopaths, who are unable to project a confident, dominant image, 'suffer attendant feeling of shame, anger, and seething resentment' (p. 345). In exploring shame, self-blame and anger, Gilbert and Miles (2000) developed a 'sensitivity to put-down scale', which is highly populated by the type of items that appear on anger provocation inventory measures. Shanahan, Jones and Thomas-Peter (2011) found that violent offenders categorized by cluster analysis as 'anger disordered' had higher shame and lower self-worth. They concluded that anger can serve as a protective reaction against shame and low self-worth. That assertion, however, has long been part of the functionalist contextual perspective on anger and its treatment (cf. Novaco, 2007) that guides CBT anger treatment.

Are there clinical problems or psychological deficits that CBT anger treatment does not reach? That is most certainly the case, and this author's treatment manuals have long badged the therapeutic procedure as 'an adjunctive treatment for a targeted clinical problem'. That has most certainly been the case in representing its application to combat veterans (Novaco and Chemtob, 1998) where anger dyscontrol occurs in conjunction with trauma and to its use with offenders (Novaco, Ramm and Black, 2001). Regarding offenders, Novaco, Ramm and
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Black (2001) differentiated general clinical care for anger, anger management and anger treatment. We stated that ‘this anger treatment approach views anger dyscontrol as relating to the historically constituted core needs of the person, to ingrained psychological deficits in self-regulation, and to bio-medical factors’ (p. 292) and highlighted themes of self-worth. The designated importance of self-esteem can be traced back to being the second of nine core propositions for ‘anger management’ (Novaco, 1975). What one reaches, though, is certainly in part dependent on how far and long one stretches, and many anger control interventions have been insufficiently intensive, as discussed earlier. To be sure, anger will surface in various forensic populations in forms that require more than CBT anger treatment. For example, Milligan and Andrews’ (2005) study of women prisoners found anger to strongly differentiate those who self-harm, to be significantly related to shame and to be significantly associated with self-harming behaviour, controlling for childhood abuse. Anger treatment will not reach many of the needs of such clients.

Illustrative Anger Treatment Programmes with Offender Populations

In lieu of a comprehensive review of focused anger treatment studies with offender populations, a chronological narrative of illustrative studies with control groups is presented here, giving attention to important issues, topical content, types of intervention, populations and settings. Although the anger treatment interventions vary across studies, those selected are CBT based, which is in accord with the Andrews (1995) and Andrews (2012) general responsivity principle.

The first three controlled studies of anger treatment with offenders were conducted by Schlichter and Horan (1981), involving male adolescents in a correctional facility, by Feindler et al. (1986), with institutionalized adolescent males in a psychiatric treatment facility, and by Stermac (1986), involving court-referred male adult forensic inpatients on remand for psychiatric assessment. The treatment used by Schlichter and Horan (1981) was the CBT stress inoculation (SI) approach (Novaco, 1977, 1980) implemented in twice-weekly individual sessions over five weeks. Their research design compared SI to relaxation treatment and to a no-treatment control. Both treatments produced significant reductions on anger measures compared to the no-treatment condition, but only the SI treatment resulted in significant reductions in verbal aggressive behaviour in provocation tests. Stermac (1986) also followed the SI approach to anger treatment, implemented in a six-session individual format. The patients who received the anger treatment were compared to control patients who received an eight-session psycho-educational group treatment. She found significant declines in anger, reduced self-denigration and improved stress-coping strategies to be associated with the anger treatment, compared to the control condition, but there were no aggressive behaviour criteria in her study. Feindler and her colleagues delivered the treatment in a group format, which is fully elaborated in Feindler and Ecton (1986) and has had independent demonstration of effectiveness (e.g., Nugent, Champlin and Waunmaki, 1997). In the Feindler et al. (1986) study, half of the adolescents at the psychiatric treatment facility had voluntary status and were not court remands. Their anger treatment augmented the early Novaco anger control approach with elaborated self-monitoring, social problem-solving, assertion techniques and self-evaluation procedures. They found anger treatment group effects for increased reflective thinking and self-control, decreased aggressive behaviours in role-play tests and lower rates of rule violations and restrictions.
Each of these three studies showed that anger treatment reduced anger, two found behavioural change in role-play testing, but only one demonstrated behavioural change on non-analogue criteria, and the rule violations in the Feindler et al. study were not exclusively due to aggressive behaviours (stealing and elopement were also rule violations). Therefore, it was not established that anger treatment reduced violent behaviour.

In the next decade, there were a number of anger management studies in prison settings, most without satisfactory research methodology, such as having a comparison condition or a robust assessment battery. Descriptive accounts of anger management programmes with female prisoners also appeared (e.g., Fitzharding, 1997). The empirical projects were primarily conducted with males. One such study (Serin and Kuriychuk, 1994) reported reduction in aggressiveness, but the measure and analysis were unclear. Hughes (1995), for a group-based programme with maximum security prisoners, had a partial control condition and reported encouraging results for post-release four-year follow-up data. Compared to those who did not complete or receive the anger management, the programme participants had significantly higher coping skills ratings by case management officers and longer latency to re-arrest; their percent convicted for violent crimes was marginally \((p=0.07)\) lower. Hughes also found significant pre- to post-programme reductions on many anger and anger-related measures.

A substantial programme for anger management was implemented in Canadian prisons in the 1990s that had effects on recidivism. Dowden, Blancett and Serin (1999) compared a sample of 110 male federal inmates who were treated in the programme (delivered in 25 two-hour sessions) to a matched untreated group and obtained significant differences in non-violent and violent recidivism, but only for the \((N=56)\) higher-risk cases. Dowden and Serin (2001) did more extensive analyses, including a programme dropout comparison group and an array of risk predictor control variables (viz., an overall prison programme performance index, age, time at risk in the community, offence history variables and institutional incidents). Logistic regression analyses on post-release outcome (success/failure) found that anger management programme completion was associated with success, controlling for the array of control variables. They also examined whether programme participation was associated with reduction in institutional incidents, but no significant gains resulted on that criterion.

Three studies that did find reductions on institutional behaviour measures are Ireland (2004), Jones and Hollin (2004) and Bus, Stefan and Visu-Petra (2009). Each of these studies involved a group-based therapy programme. Ireland's (2004) intervention was 12 one-hour sessions, delivered by two staff facilitators over a 3-day period to young male prisoners. She evaluated this brief programme, which is conspicuously psycho-educational in nature, by comparing 50 participants to 37 wait-list control subjects on self-report and staff-rated outcomes. Treatment effects were obtained on self-reported reduced angry thoughts, feelings and behaviour and on reduced angry behaviour as rated by staff. Isolating the 22 participants who improved the most, she found that they had the highest proportion of violent offences, which, like the findings of Dowden et al. (1999), is consistent with Andrews's (2012) risk principle. Bus, Stefan and Visu-Petra (2009) implemented a programme said to be similar to Ireland's (2004), but in 12 weekly 2-hour sessions. Conducted in a maximum-security prison, those who received the anger management programme, compared to a control group, had significant reductions in anger (STAXI), decreased aggressive behaviours as rated by staff and a reduced number of disciplinary incidents, although statistical tests were not reported on the latter two criteria.

Three other early studies, albeit with aggressive youths in non-forensic facilities, Saylor, Benson and Einhaus (1985), Dangel, Deshner and Rasp (1989) and Wilcox and Dowrick (1992) obtained modest-to-strong anger treatment gains. Each used a modified SI treatment, and they were small sample studies.
In contrast to the brevity of Ireland’s intervention and the Bus, Stefan and Visu-Petra’s extension of it, Jones and Hollin (2004), with eight males at a high-security forensic hospital, implemented a 36-week, 2-hour group programme that was supplemented by a 1-hour individual CBT. That group-plus-individual hybrid approach had been disseminated from the State Hospital Scotland, where it was initiated by the present author and his colleagues. Although the Jones and Hollin (2004) study did not have a control group, its involvement of personality-disordered violent offenders is noteworthy. They reported clinical-level reductions on STAXI, NAS and AQ anger measures, plus much reduced verbal and physical aggression incidents, the latter being recorded and coded by nursing staff on a daily basis from pre-treatment to eight weeks post treatment. Thus, there is some indication, with this study and that of Bus, Stefan and Visu-Petra (2009), that anger treatment can reduce aggressive behaviour in long-term care facilities, but the evidence here is not robust.

While there have been a few uncontrolled studies of anger management with female offenders (e.g., Fitzharding, 1997; Robertson, 2005; Wilfley, Rodon and Anderson, 1986), as well as programme descriptions by other writers, there have been two studies with control conditions. Eamon, Munchua and Reddon (2001) implemented a 12-week, CBT group intervention with women in a Canadian federal prison. Compared to a treatment-as-usual control group, those who received anger management had significant gains in anger regulation (NAS), and marginally significant reductions on multiple anger disposition measures (NAS and AQ). For the treatment recipients, there were many significant pre-post reductions on various anger scores. Also, the number of disciplinary charges decreased significantly for the treatment group, but not for the control group. The second controlled study was done by Goldstein et al. (2007), which concerned female juvenile offenders, compared a nine-week, two sessions per week, group-based anger management to treatment-as-usual, with random assignment to conditions. Medium-to-large effect size reductions were observed in anger and aggression measures (AQ), but there were no behavioural criteria.

The most fully assessed anger treatment study with offenders is that of Taylor et al. (2005), which was conducted with male forensic hospital patients having IDs. The intervention was an individually based, modified SI anger treatment, the full 18-session protocol for which is given in Taylor and Novaco (2005). It was delivered in twice-weekly sessions by qualified, chartered psychologists. The protocol included a six-session preparatory/motivational phase for fostering treatment engagement and building basic skills, such as emotion awareness, self-monitoring, relaxation strategies and goal setting. The treatment condition was compared to an anonymously assigned, matched waiting-list control condition where treatment-as-usual was received. Assessments on multiple anger self-report instruments (NAS, PI and STAXI) and a staff-rated measure were obtained at screening, pre-treatment, post-treatment and four-month follow-up. In the mixed-model repeated measures analysis, significant differences in favour of the anger treatment were obtained on NAS and PI measures, and marginal effects were obtained for STAXI measures. Staff-rated anger declined more strongly through follow-up in the treatment condition but not at a statistically significant level. Further evidence of anger treatment gains with these patients were reported by Taylor et al. (2004) for an IPT, including parallel gains for the control group occurring following their completion of treatment.

Hospital assaultive behavioural measures were not incorporated in those studies (Taylor et al. 2002, 2004, 2005), but we have now found, for a cohort of 50 patients, significant

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1. A detailed protocol for anger treatment at the State Hospital Scotland is given in Walker, Novaco, O’Hanlon and Ramm (2009), along with supplementary resources for patients and treatment staff.
reductions in physical assaults, comparing the 12-month interval prior to anger treatment with the 12 months after it. Generalized estimating equations controlled for age, gender, IQ, length of stay and violent offence. Further, we have found that those reductions in physical assaults were associated with reductions in anger and increases in anger regulation that occurred in anger treatment (Novaco and Taylor, 2013). Evidence for anger treatment lowering incidents of aggressive behaviour in the community for ID clients is provided by Lindsay et al. (2004).

Two additional anger treatment studies are noteworthy, one because of its innovative approach (drama therapy), and the other because its client population (combat veterans), while not forensic, is nevertheless highly relevant. Blacker, Watson and Beech (2008) implemented a combined CBT and drama-based treatment with adult male violent offenders in six UK prisons. The treatment was given in a nine-day course, delivered in three 3-day blocks with two sessions per day. Their single group pre-post design found significant reductions across the subscales of the STAXI, which was the only instrument used. Previously, a related but not CBT-structured drama therapy programme was evaluated by Reiss et al. (1998). Conducted at Broadmoor Hospital with 12 male patients having violent histories, they found post-treatment reductions in anger on the STAXI and on another anger inventory. Theatre has been relevant to the psychology of anger and anger dyscontrol since the plays of Seneca and Shakespeare noted earlier. John Osborne’s Look Back in Anger in 1956 famously initiated a movement in British theatre and sparked the expression of ‘angry young men’. The psychological aspects of anger and violence on the stage, including what derives from the Stanislavski system, are elucidated by Konecni (1991). From a clinical standpoint in working with offenders, one value of involving clients in stage plays is that it provides them the opportunity to examine, express and learn about anger in a mode that is less likely to activate their threat-protective defences.

The combat veterans study by Marshall et al. (2010) concerned veterans (not from contemporary wars) with PTSD and antisocial personality characteristics, who received care through US Department of Veterans Affairs clinics. Anger is prevalent among combat veterans, for whom it is a violence risk factor (Novaco and Chemtob 2002; Novaco et al., 2012). The efficacy of individual SI anger treatment with combat veterans with severe PTSD and severe anger had previously been established (Chemtob et al., 1997). The Marshall et al. (2010) treatment was a CBT group intervention delivered in 90-minute weekly sessions for 12 weeks. They obtained, in multilevel modelling analyses, reductions in anger (STAXI) and in physical aggression, the latter evaluated by self-report, comparing a three-month interval prior to treatment with the three-month treatment interval. Antisocial personality characteristics were associated with smaller decreases in trait anger and physical aggression. While this latter study did not have a control group, it does provide support for the value of anger treatment with clients having serious psychological disorder and histories of aggressive behaviour.

Treatment Gains with Offenders: Does Anger Treatment Reduce Aggressive Behaviour?

Although some studies with prisoners have not found anger reductions to follow anger control interventions, the illustrative studies reviewed here, as well as many others, have demonstrated that self-reported anger does decline following intervention programmes. Anger reductions were not obtained in the prison-based studies of Howells and his colleagues, nor in one by
Serin, Gobeil and Preston (2009), but numerous studies with incarcerated men and women have reported reduced-anger treatment gains. Programme evaluative research with forensic hospital patients and with adolescents in residential treatment facilities, illustrated by studies reviewed in this chapter, typically has found reduced anger following treatment. Also in the forensic domain, significant anger treatment gains have been obtained with child abusing parents (Nomellini and Katz, 1983; Sanders et al., 2004) and with aggressive drivers (Deffenbacher et al., 2002; Sanders et al., 2004). One can say with reasonable confidence that anger management or anger treatment interventions are successful in reducing anger levels in offender populations, provided that the treatment recipients have certified anger regulatory problems. When anger treatment is applied to persons for whom the treatment target is absent, the outcome evaluation enterprise is dubious.

Regarding whether therapeutic interventions for anger have been successful in reducing aggressive behaviour, the evidence is less clear. One first must be mindful that a behavioural criterion is something independent of the subject’s self-report, for example, ‘physical aggression’ scales on self-report instruments, such as the AQ, are not behaviour. Further, while verbal aggression is behaviour and is antagonistic, it is qualitatively different from physical aggression, which is targeted harm-doing. Physical aggression is the prime criterion for offender populations. Most anger intervention studies have simply not included measures of physical aggression or violence, much less re-offending. Of the studies reviewed in this chapter, reductions in aggressive behaviour were obtained in Feindler et al. (1986) (lowered rule violations), Hughes (1995) (lowered re-arrest and violent crime), Dowden et al. (1999) (lowered violent recidivism), Ireland (2004) (reduced angry behaviour rated by staff), Bus, Stefan and Visu-Petra (2009) (reduced aggressive behaviour and disciplinary incidents), Jones and Hollin (2004) (reduced verbal and physical aggression incidents), Lindsay et al. (2004) (reduction in role-play angry behaviour and assaultive incidents in the community) and Novaco and Taylor (2013) (reduction of physical assaults in hospital). Anger intervention studies aimed at female offenders have not had physical aggression criteria. While the evidence for anger treatment lowering physical aggression is relatively sparse, it is reassuring that, in considering multifaceted offender programmes, the meta-analyses by Landenberger and Lipsey (2005) and Dowden and Andrews (2000) did find reduced recidivism to be associated with the programmes having an anger control component.

**Major Methodological Issue**

Many issues concerning research methodology surface in this literature, which cannot be elaborated here. Various methodological shortcomings can be gleaned from what has been presented, such as inadequate specification of study sample inclusion criteria, small sample sizes, substantial variation in treatment programmes, insufficient articulation of treatment protocols, inadequacy of control group conditions, high drop-out rates and absence of follow-up assessment. The major problem, though, that merits imminent attention is the all too common deficiency in the anger/aggression measurement protocol.

Treatment outcome evaluation designs will often be driven by the exigencies of the service provision context, which can limit possibilities for study samples, treatment comparison conditions, assessment opportunities and can affect attrition (e.g., when patients are discharged from hospital before treatment or follow-up are completed). However, what is too prevalent
in the literature on anger control interventions, both with offenders and non-offenders, is an impoverished anger assessment set. Many studies exclusively assess anger by self-report instruments, and, of those, few studies have a measurement set that provides a look at whether there is convergence in multiple validated self-report instruments. Anger is a construct having cognitive, somatic and behavioural referents (Novaco, 2000). No set of operations will exhaust the meaning of that construct; but if we wish to infer that treatment has produced a beneficent change in anger disposition, we must do better in capturing the referent criteria, in scrutinizing our observation base and in establishing assessment standards for treatment evaluation.

**Concluding Perspective**

Anger is neither necessary nor sufficient for violence, but it is part of the confluence of multilevel risk factors affecting violent behaviour, and its relevance has been insufficiently prioritized. Anger and its vicissitudes – rage, hate and revenge – are drivers of violent offending, as established empirically in forensic contexts. Studies conducted with violent offenders in institutions (prisoners and hospital patients) and in the community (discharged patients and offenders on probation) have implicated anger as an activator of aggressive behaviour, as has been found with other forensic populations (e.g., perpetrators of domestic violence and road driving violations). Anger dysregulation is prevalent among those in forensic settings; for example, for all adult patients (N = 4246) in California’s five State Hospitals, 35% were rated by their primary clinician as someone who ‘gets angry and annoyed easily’ (Novaco, 1997). To the extent that anger operates as a relevant antecedent variable in assaults by those who are institutionally detained, whether in a hospital or a correctional facility, it serves as a focus for intervention.

Importantly, anger treatment interventions are congruent with the well-known Risk–Need–Responsivity (RNR) principles articulated by Andrews (1995) and Andrews (2012). According to the Risk principle, higher-risk offenders should receive more intensive correctional programming than lower-risk offenders. The Need principle holds that risk reduction efforts must focus on criminogenic needs, or changeable factors that predict crime and violence. The Responsivity principle holds that correctional programming should be delivered in a format that matches, or is responsive to, the learning styles of offenders. Anger dysregulation raises violence risk, anger is a dynamic variable that is responsive to treatment, and cognitive behavioural anger treatment has a structured social learning format that is readily adaptable to client populations, including those with IDs and psychoses.

Because anger is a common precursor of aggressive behaviour, it can be unsettling for mental health professionals to engage as a treatment focus, regardless of its salience as a clinical need. Moreover, the anger dysregulation problems of offender populations are complex, having been shaped by the conjunction of impoverished family backgrounds, developmental disabilities, early conduct problems, substance use, institutionalization, amalgamative emotional distress, recurrent offending and prior disconnects with mental health care staff. Their anger is often intermingled or entangled with fear, sadness, shame and disappointment. When seeking to access their anger, the probe hits upon the admixture of distressed emotions and negativistic schemas within which the anger is nested. Clinical research has brought forward advances in anger assessment that should be better utilized by service providers and study teams.

The provision of anger control treatment is an adjunctive therapy. Especially with forensic populations, it is best done as part of a multifaceted treatment programme. The rewards for
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anger and aggression are in the present. The rewards for their control are in the future. Without a stake in the future, there is little reason for someone to control violent behaviour or to adopt prosocial values. Anger treatment requires a centered and supportive therapist and a sufficiently resourced and cohesive therapeutic environment. Beyond anger control, if the aim is to reduce violent offending, an elaborated account of the complexities and the prospects is provided by Dvoskin et al. (2012).

The cognitive-behavioural treatment of anger has been shown to have applicability to a wide range of client populations and many clinical disorders. Prisoners and hospitalized patients with long-standing aggression histories, mental disorder and even IDs can be engaged in CBT anger treatment and have been shown to benefit. While the therapeutic mechanisms underlying treatment gains are not clear, nor their sustainability or generalizability, we are fortified in seeking further advances in providing remedies for anger dyscontrol.

References


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