Anger Solutions for Resolving Emotional Dysregulation in Youth

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Abstract

Anger, anxiety, depression, frustration, fear, and other intense emotions can easily hijack one's ability to think clearly, make executive decisions, problem-solve, and communicate one's needs. Traditional anger management programs focus on physical behaviour strategies to mitigate immediate reflexive responses; however, these strategies most often fail to result in lasting regulation of emotion. Applying the principles of Choice Theory and a Solution-focused approach, subjects learn to communicate with self, then to communicate with others with a view to solving the problems that triggered the emotional disturbance, rather than fixing the immediate resulting feeling. Through the lens of various case studies, we will explore the application of these communication strategies (how they were conceptualized, taught, and embedded), and examine the outcomes of applying said tools in various settings. Consistently, subjects report a decrease in emotional dysregulation, an increase in autonomy and agency, a noted development of their ability to problem-solve even in emotionally intense situations, and to effect, through more informed choices and better communication, more positive outcomes.

1. Introduction

Big feelings like anger, fear, happiness, sadness, disgust, surprise, and contempt are common for almost all humans [1]. Research suggests that facial expressions of basic emotions including anger are universally recognizable across cultures and continents. While affective and mood disorders such as anxiety and depression have been studied in-depth, anger remains one of the most misunderstood emotions; it is also the focus of fewer studies than other emotional states.

Emotions originate from the limbic system, the area of the brain located where the subcortical structures connect with the cerebral cortex. The functions of the limbic system include motivation, emotion, learning, and emotional aspects of memory. As the limbic system is connected to the body's endocrine and autonomic systems, it is believed to be a critical element in the body's fight/flight/freeze response [2]. Intense responses to triggering stimuli like anger and fear may hijack executive function, impulse control, problem-solving and decision-making abilities, as the limbic system seeks safety and security, and the body works furiously to minimize the intense emotional response.

Developmental research suggests that cognisant anger expression does not emerge until the age of approximately 12 months, before which only broader responses of distress or irritability are expressed by infants, leaving the interpretation of the expression to the caregiver. It is of note that anger expression only seems to emerge when infants learn to distinguish between "the means and ends" of their actions and they can recognize when their desired outcomes are not presently achievable. Anger presents itself when infants have developed the ability to *make meaning*. Furthermore, meaning making, cognitive development, and learning equip children with the ability to foresee possible sources of frustration and to attach their ability to seek resolutions to the problems (possibly sustained by anger) to achieve their desired outcomes [3].

Anger has historically been conceptualized as a disordering of behaviour and has been labelled as problematic or dysfunctional [4]; volcanic [5], misplaced, or uncontrolled [6]. Conversely, other research describes anger as potentially helpful, useful, or natural [7]. As a result, the treatments that have developed under the over-arching banner of "anger

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management" have focused solutions primarily on behaviour management and diverting attention away from the emotional response. These programs, primarily CBT-based, have recorded limited success, with retention rates for group participants dropping as low as 49% in some settings [8].

While crime in U.S. schools has consistently dropped, the trend regarding juvenile violence over the past several decades tells a dramatically different story. The arrest rate for violent juvenile crime between 1967 and 1997 increased by 143 percent [9]. From 1960 through 1991 the U.S. population saw an increase in overall crime of a mere 40 percent, however, over the same period violent juvenile crime increased by 500 percent; murders by 170 percent, and aggravated assaults by 600 percent.

Successful anger programs have conceptually separated emotional experience of anger from the behaviours chosen to express it. They have further ensured that the content of the program focuses on education around anger experience, emotional expression, assertiveness, and problem solving rather than behaviour management. Finally, successful anger management programs have devised strategies to encourage client engagement throughout the process, ensuring higher rates of completion and success in reducing identified target behaviours [10].

2. The Rationale for Intervention

Within the educational setting, anger is often equated with violence and aggression. The APA's recent task force on violence and aggression in schools [11] noted that over 35% of school administrators, 25% of staff, 30% of teachers and 15% of school counsellors were victims of violence by students during COVID (specifically July 2020 to June 2021). The numbers were even higher for rates of parental aggression.

Since Columbine, the Washington Post submits that more than 300,000 American students have experienced gun violence. Most recently, 10 people in Buffalo, New York died at the hands of an 18-year-old gunman and 19 young children, and two teachers were gunned down by another 18-year-old in Uvalde, Texas.

In Canada, 1/3 of gun violence is committed by someone under the age of 20. While The Ecole Polytechnique shooting in 1989 remains the most tragic school shooting in Canadian history, aggression and deadly violence is sadly becoming more the norm in Canadian schools. According to Global News, in 2006, at Dawson College, Laval, Quebec, an 18-year-old girl was killed, and 20 others were hurt when the 25-year-old gunman shot them with a semi-automatic weapon. At W.C. Jeffreys Collegiate Institute in Toronto, in 2007, a 15-year-old boy died from a single gunshot wound to the chest. Two teens were charged with first degree-murder. In 1999, in Taber, Alberta, a 14-year-old Grade 9 student shot three students; one was fatally wounded. In February 2022, an 18-year-old student died after a shooting at a Toronto [12].

There have also been increasing reports of death by suicide of children and youths who experienced severe bullying from their peers, the most notable of these cases perhaps being that of Amanda Todd who died by suicide in 2012. For those children who survive bullying and peer-to-peer violence, mental health problems including post-traumatic stress disorder, anxiety, depression, and adjustment disorder may persist for years following exposure to the aggression [13]. It would be reasonable to posit that early interventions applied within the context of the existing educational system might prove helpful in stemming the tide of apparently increasing violence and aggression in schools.

Despite much of traditional anger management focusing its research on behaviour management rather than emotional expression or problem resolution, in recent years there has been a shift towards helping people to learn effective skills for expressing and resolving anger.

A meta-analysis of 20 articles of school-based interventions for anger and discovered an overall effect size of 0.31. A second meta-analysis evaluated 18 articles, finding an overall moderate effect size of 0.61 in cognitive-behavioral anger management intervention outcomes for children in special education. Candelaria et al. reported on additional research, which specifically examined the effects of CBT-based anger management therapies for children and adolescents and finding an overall effect size of 0.67 [8].

Candelaria et al further conducted a meta-analysis of 60 articles comprised of both published and unpublished research. Programs that were included in the above study were categorized into four types:

(1) coping skills training such as the *In Control* program

(2) emotional awareness and self control such as the strategies used in the SCARE (Student-Created Aggression Replacement Education) program

(4) relaxation strategies Candelaria et al. 599 including breathing techniques; and,

(5) role plays or modeling activities.

The first significant finding suggests that anger management interventions reduced children's negative emotional and behavioral outcome measures of anger, aggression, and loss of self control when compared to the control group. Furthermore, no statistically significant mean effect size differences

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were found according to the type of anger management program, suggesting that the anger management interventions reviewed were equally effective, except for role-play or modeling. Thus, anger management programs focused on coping skills training, emotional awareness, self-control, problem solving, and relaxation were statistically effective; whereas no significant intervention effect was found when role play was the central focus of the intervention for CBT -based programs. No significant intervention effects were found regarding duration of treatment length or the time that the intervention was offered.

3. The Anger Solutions Process

Given the rising rate of violence in adolescents, which in turn negatively impacts the school experience for students, faculty, administration, and the broader community, offering programs within the school setting that focus on emotional expression (assertiveness) and problem-solving rather than behaviour management may result in a reduction of aggression or violence to have one's emotional needs met.

The Anger Solutions Program [14] approaches anger as a primary emotion that emerges when needs are unmet, boundaries have been violated, or rules have been broken. The program's goals include but are not limited to:

- Significant reduction in target behaviours identified by each participant
- An increase in pro-social behaviour
- An increase in participant self-esteem and assertiveness
- A decrease in the use of aggression, violence, or other risk-taking behaviours

Using a multi-modal approach, Anger Solutions combines aspects of rational-emotive behaviour therapy, cognitive behaviour therapy, solution-focused therapy, reality therapy, and dialectical behaviour therapy. The content of the program includes psychoeducation about emotions, anger styles, learning how anger develops through a Choice Theory lens, verbal and non-verbal assertiveness, problem-resolution, listening skills, forgiveness/acceptance, and releasing the physical energy of anger. Using the Psychiatric Rehabilitation Model of "teach/practice/practice", participants are given ample opportunity to rehearse and acclimate to each aspect of communication and problem-solving skills. Role playing is included as an essential component of skill rehearsal.

Raw data collected from various Anger Solutions providers (mental health, addictions, correctional, and community service programs) produce consistent findings of an above-average rate of participant retention (approximately 80%) for groups running 8 to 12 weeks, and success rates (attainment and long-term sustainability of program goals) of 80% [15]. No formal studies have been conducted within an educational setting to determine the efficacy of Anger Solutions. The following presents three individual studies of the effectiveness of the Anger Solutions approach in school-aged youth.

4. Three Case Examples

"Yoshi": This eight-year-old boy was the middle child in a sib-line of three. He had been labelled a problem child by both his family and his school and had been diagnosed with conduct disorder. He identified himself as having a strong sense of principle; if the rules applied to him, then the same rules had to apply to everyone else. All members of the family of origin struggled with dysregulated emotions; however, Yoshi bore the weight of the blame for any family conflict. His target behaviours were identified as (1) acting out, yelling at peers or teachers, (2) running away from his classroom or the school property, and (3) physical aggression towards peers or siblings.

Yoshi was introduced to the Anger Solutions decision-making and problem-solving tools during therapy, and they were implemented in real time whenever Yoshi found himself in crisis. Using these tools, Yoshi came to understand that the choice to act out was more likely to yield undesirable outcomes than the ones he was aiming for. He took an active role in working through his problems and learned to take ownership of his emotional states. Coupled with changes to his educational setting (a more supportive, less judgemental school), and some coaching to his parents, Yoshi saw a marked decrease in all his target behaviours, and he discontinued therapy prior to his 9th birthday.

"Navid": This client attended therapy from the age of 9 to 12 years. The initial cause for referral was encopresis and school refusal. When he began therapy, he was non-verbal and non-responsive to treatment efforts. Identified target behaviours included (1) lack of self-care and poor toileting habits (2) refusal to complete home-school work, and (3) refusal to attend school on-site. The elements of Anger Solutions were introduced incrementally, with the preliminary focus resting on identifying emotional states. As rapport and trust grew with the therapy process, Navid began to initiate verbal communication, albeit very timidly.

Additional aspects of the program, particularly the decision-making/problem-solving model were introduced, with a heavy emphasis on choice theory as

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a tool to empower the client. In time, he was able to communicate openly and comfortably in therapy, and to voice his concerns about returning to school. A plan was set in place to address the target behaviours of concern, and with support from the therapist and his family, he was able to return to school to complete his studies. Once he was fully integrated into the school setting, he discontinued treatment. He graduated elementary school and began his high school career without any marked difficulty.

"Jared": Jared sought out Anger Solutions therapy at the age of 24 (college/university age). At intake, he noted that he had been "in jail, on bail, or on probation" for the previous ten years of his life. His reported target behaviours included (1) using substances to medicate/dull his emotions (2) verbal aggression (3) physical aggression (breaking things of value), and (4) financial abuse (taking family finances to purchase drugs or alcohol). At intake, Jared was separated from his wife and child, unemployed, couch surfing, and one day out of a 72-hour detoxification program.

The Anger Solutions program was employed in full, over a period of fifteen weeks. Each week, a different module of the program was explored, with the expectation of homework completion in the form of skill acquisition, skill application, or skill rehearsal. Marked improvements in Jared's attitude and behaviour were noted by week five of the program. By the end of week seven, he had made significant gains in reconciling with his wife and had secured full-time employment. Upon completion of the program, Jared had seen a significant reduction in all target behaviours.

Jared's progress was monitored for ten years following his completion of the program. He reported two incidents of relapse with drugs; in both cases, he utilized the Anger Solutions decision-making model to recognize his relapse and chose to immediately discontinue his substance use (once cold turkey; the second time he admitted himself into a rehabilitation program). For the ten years following the program, Jared did not return to his previous behavioural target behaviours of verbal or physical aggression or financial abuse.

5. Implications for Further Study

Can these results be replicated on a larger scale in elementary, secondary, and post-secondary settings? Raw data gathered from various mental health, addictions, and community agencies over the course of twenty years suggest that the application of the Anger Solutions model for children, youth, and young adults, may result in higher incidences of pro-social behaviour, a reduction of identified target behaviours, and fewer maladaptive expressions of anger within the school setting.

Anger Solutions is currently adapted for school-aged children (7-12), youths (13-17), and adults (18+). Current incident reports could be evaluated to determine the number of aggressive or violent behaviours conducted within the school setting in a time frame of three months. Incident reports following implementation of Anger Solutions programming would then be examined to determine any measurable difference in overall student behaviour.

It might also be useful to deliver Anger Solutions to an experimental group, and generic anger-related course work to a control group to measure the impact of Anger Solutions in changed behaviour and shifts in student attitudes towards violence and aggression to solve their problems.

Challenges to furthering this line of inquiry include developing and maintaining partnerships with educational institutions at all levels (elementary, secondary, and post-secondary), securing funding to proceed with the research, and structuring the experiments and the program delivery to ensure consistency across all groups, while minimizing any confounding factors that might mire the research outcomes.

6. Conclusion

With the steady rise of youth aggression and violence within education settings and in the broader community, a workable solution is needed to help children, teens, and young adults to regulate, express and resolve their emotions effectively and safely. Existing programs such as SCARE and *In Control* address the behavioural aspects of anger management with some success. Traditional anger management programs do not focus deeply on beliefs, attitudes, and healthy emotional expression, leaving room for further and more lasting change in student subjects.

The case studies provided suggest that Anger Solutions may prove to assist young people with a more holistic approach, addressing beliefs, attitudes, emotions, and behaviour, while placing the responsibility for choices and the subsequent consequences firmly in the hands of each student. Further study is needed to determine the efficacy of Anger Solutions programming for shifting student behaviour away from aggression and violence towards more pro-social means to meeting emotional needs and resolving problems.

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