Understanding the Appropriate Use of Anger

Whereas the Anger Spectrum-1 is oriented toward violence prediction, the Anger Spectrum-2 is oriented toward anger management. The two assessments can be used together and this is especially encouraged where there is a more significant level of anger.

One value of the Anger Spectrum-1 is its ability to diagnose Stored Anger Syndrome. “SAS” will often be associated with Long Term Complex Mood Disorder (LTCMD), the latter representing an intense and complex inter-related combination of anger, anxiety, confusion, depression, grief and guilt. “SAS” on its own almost always predicts parties who take out their anger on innocent third parties and/or tend to over-scale their anger responses where a lower level of response is appropriate. The relatively simple criteria for Stored Anger Syndrome can be found in the Anger Spectrum-1 Interpretation guide.

Anger and guilt together are our social regulatory emotions and managing them involves two primary tasks: rationalizing the express or implied social duties on which they are based and productively acting upon rational duties. See the related intervention guide for more on these concepts.

The first two items on the Anger Spectrum-2 give a quick and rough scaling of how much anger the respondent experiences.

The essential signal/emotion of anger is meant to warn us that someone is hurting us or those things we feel possessive about (including people) or protective toward. Thus, rational anger is based upon the violation of an express or implied social duty others owe us not to hurt us. Items three through six, then, look for determining whether the respondent has a sound sense of that duty. Affirmative responses in this section thus indicate the need for respondents and clinicians to rationalize the respondent’s anger system so that they trust their anger signal and learn to associate it with a duty violation. A rational duty almost always means that true or actual harm has occurred or is threatened.

The second phase of the healthy use of rational anger is productively acting on it (this almost always involves boundary actions) and items seven through ten are oriented accordingly. Affirmative responses in this section are predictive of parties who have a difficult time acting upon anger and taking self-protecting or boundary setting action. While the interventions required are discussed in more detail in the Anger Spectrum-2 Intervention Guide, the general idea is that respondents learn to use their anger to set boundaries with the right people, at the right time and with the right scale.

Clinicians should also learn to discriminate strongly negative responses in this section between those who are “healthy” responders with strong but appropriate boundary systems form those that are over responsive and have issues with managing their anger. Most of the time, as you learn more about your clients in actual situations, this distinction will be obvious based on the “scale” of the response to anger provoking situations.

A final comment on assessing anger. In rarer cases some parties have learned to almost completely disassociate from their feelings of anger. Most clinicians will quickly sense a client/patient who doesn’t get angry about things that most people will. Although these clients sometimes believe this is healthy, the critical thing to look at is whether these client/patients tend to get hurt, abused or violated by others. If they do, and this is most often the case, they will have to learn to “re-sense” the feeling of anger, trust its value, and learn to associate it with a violation of duties and then productively act on it. It is likely to be a long process because dissociation is a defense mechanism most likely to occur where there are severe and persistent levels of abuse or violation.