Anger Management for Patients Undergoing Cardiac Rehabilitation

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LEUNG: ***Anger Management for Patients Undergoing Cardiac Rehabilitation.*** *This paper reviews concepts of anger management for cardiac rehab patients that would be covered in the workshop. Studies suggest that anger and hostility are associated with coronary heart diseases. Different theorectical perspectives in understanding and assessment of anger and hostility are reviewed. Different intervention approaches should be delivered according to the different levels of readiness of the patients. Only those who are ready to change are conducted with cognitive-behavioral intervention. The goal of cognitive-behavioral intervention is to modulate the intensity of anger arousal and expression for effective communication and conflict resolution, rather than ventilation of anger itself. Techniques to enhance awareness of emerging signs of anger, to disrupt anger responses, to reappraise the provoking situations and to rehearse these skills will be reviewed in the workshop. (J HK Coll Cardiol 2006;14(Suppl 2):B94-B96)*

Anger management, cardiac rehab

摘要

本文撮要了本屆証書課程中有關幫助心臟病康復者處理憤怒工作坊的重點。研究顯示憤怒和敵意通常都跟冠心病有關。作者回顧了不同理論觀點對憤怒和敵意的理解和評估。對於不同準備階段的患者應採取不同的干預措施。只有那些準備改變的病人可以實施認知行爲干預手段。認知行爲干預手段能夠調節憤怒的強度，表達有效交流和解決衝突，而不等同於單純的泄憤。提高對出現憤怒徵象的認知，阻斷憤怒的反應，重新評估易激怒的情形，並加以不斷重復，以上各重點會在工作坊中介紹出來。

關鍵詞：憤怒處理　心臟病康復

Meta-analyses report consistent association of anger and hostility with coronary heart diseases,[1] despite inconsistencies in the findings of different studies probably because of the difficulty and difference in measuring anger and hostility across studies.[2] Anger and hostility are considered the toxic elements of Type A Behaviour Pattern.[3] They were found to be associated with incident coronary heart diseases and to be predictive of presymptomatic levels of atherosclerosis,[4] with cardiac symptom onset[5] and with increase in heart attack risk of people with pre-existing coronary artery diseases.[1] Anger and hostility are believed to be increasing cardiovascular reactivity by fostering frequent and prolonged blood pressure and heart rate responses to stress, which might contribute to hypertension and atherosclerosis.[3,6] They may also be related to lack of social support[7] and multiple behavioural risk factors, including smoking, alcohol consumption, sodium consumption and inadequate exercise behaviour.[4]

Intervention studies that attempted to modify anger responses in Type A Behaviour treatments[8-10] have showed marked reduction in anger, Type A Behaviour, diastolic blood pressure[11] and even myocardial infarction rates.[8] This paper is a review of the key ideas that would be covered in the workshop on anger management for cardiac rehab patients. The workshop would focus on an anger management intervention framework and introducing techniques that are built on recent empirical understanding on anger and hostility.

At the beginning of the workshop, different

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perspectives in understanding anger and aggressive behaviour would be discussed, which included the Frustration-Aggression Theory,[12] the Cognitive Neoassociation Theory,[13] the Social Learning Theory[14,15] and the General Aggression Model.[16] Frustration-Aggression Theory posits that aggression is a hostile and angry reaction towards perceived frustration arising from perceived threat or blocking of one's goal achievement.[12] The Cognitive Neoassociation Theory is a modified version of Frustration-Aggression Theory.[13] It postulates that aversive events lead to negative affect. The negative affect stimulates various thoughts, memories, expressive motor reaction and physiological responses that are associated with fight and flight tendencies. The rudimentary feelings of anger are associated with the fight tendency, while those of fear are associated with feeling of fear. The cognitive processes including appraisals and attributions, produces more clearly differentiated feelings of anger, fear or both. The Social Learning Theory[14,15] suggests that aggressive behaviour is instrumental and contingent upon anticipated reward. It is also acquired through observational learning, one's expectations and how one construes the world. The General Aggression Model attempts to summarize angry and aggressive behaviour as an outcome of a complex interactive network among personality, situational factors, and internal states (cognitive, emotional and physiological arousal).

Various assessment tools of anger and hostility would then be reviewed in the workshop, with emphasis on using State-Trait Anger Expression Inventory and clinical interview with the cardiac rehab patients. Basing on the Stage-of-Change model proposed by Prochaska, DiClemente & Norcross,[17] patients at different stages are matched with different intervention strategies. Education is the main intervention method for patients who are at the precontemplation stage where the patients have no interest in or have not thought about changing his/her behaviour. Motivational interviewing strategies proposed by Hettema, Steele & Miller[18] might be the best approach for patients who are at the contemplation stage, where the patients are thinking about changing their behaviour but they have not yet ready to take any step to do so. Motivational interviewing is a counselling style that combing supportive and empathic understanding and a consciously directive method for resolving ambivalence in change. Through responses with reflective listening and summaries, the therapist attempts to evoke the expression of the patient's desire, abilities, reasons, and need for change. It is a complex and skilful method that is learned over time, and cannot be explicated thoroughly on this paper due to our focus on the actual intervention strategies, i.e. cognitive-behavioural intervention. Cognitive-behavioural intervention is conducted only for patients who are ready for change.

The remaining part of the workshop would focus on specific cognitive-behavioural intervention components on anger management. Studies showed that expression of anger per se does not always bring relief.[3] The boiler analogy that anger must be ventilated for emotional betterment should be demystified, for instance, by asking the patient to test out the emotional consequences of different levels of anger expression in daily situations. In addition, the psychological need of an angered person to defend against the threat of self-esteem and self-righteousness[19] raised a precaution over anger management intervention. The intervention should be delivered in a way that the patient's self-esteem and self-righteousness should not be perceived as being challenged. Instead of absolute abstinence from anger expression, the goal of the intervention is to enhance an intermediate level of anger arousal and expression,[20] so that effective communication and conflict resolution are to occur.[21] With reference to the idea of "emotional hijacking",[22] rational analysis of the situation and the ability to control one's behaviour are hampered during high level of emotional intensity. Instead, anger control strategies were found to be the most effective at moderate level, but not the most intense level, of anger experience and arousal. An intervention framework on anger management intervention that was proposed by Deffenbacher[23] is introduced. The framework involves the following four phases of intervention: 1) Enhancing personal awareness of anger; 2) Anger response disruption and relaxation; 3) Cognitive restructuring or reappraisal, and humour; and 4) Cognitive and behavioural skill enhancement and rehearsal. To encourage the patients to recognize the bodily, cognitive, behavioural or social signs of

emerging anger, the patients are asked to complete self-monitoring records of anger expression and its antecedents. To disrupt the anger responses, anger control strategies should be applied to modify the causal antecedents of anger episodes. Coping strategies (such as counting to 10, relaxation or time-out) are taught that allow the bodily arousal to decrease and give time to reappraise the situation, before anger escalates to rage.[3] Cognitive restructuring or reappraisal of an event, or the meaning of what's going on, include understanding the offenders' action and motives, reframing harm to self to provocation as accidental and justifiable, and reassignment of blame.[19,24] Cognitive rehearsals, i.e. guided imagery of applying these techniques in a sequential manner, would be conducted with the patients. They are also asked to apply the techniques in real life situations as homework. Review of their performance and difficulties will be discussed in an encouraging and solution-focused manner.

At the end of this workshop, the participants should be able to grasp the basic ideas and skills to conduct an individually tailored anger management intervention for the cardiac rehab patients.

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