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# Readiness for anger management: clinical and theoretical issues

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**Abstract**

Anger management methods are a common and successful feature of contemporary cognitive behavioral therapy. Meta-analyses and narrative reviews of the outcome of anger management have been broadly supportive of the view that it is an effective approach. We argue in this paper that an important impediment to the future success of anger management is the failure to fully address the issue of treatment readiness. We discuss distinctive features of anger that make readiness a more important issue than it is for other problem emotions and affects. Relevant theoretical models of readiness are discussed and we review the components of a lack of readiness, including difficulties in establishing a therapeutic alliance. Progress in this area requires greater attention to the measurement and analysis of readiness, to its inclusion as an independent variable in outcome studies and to its clinical modification when readiness is low.
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Anger is one of a range of emotional and affective states that may become problematic to the individual and constitute the reason for seeking therapeutic help. Many such emotions (anger, fear, sadness, guilt, etc.) are not inherently problematic but become so because of their intensity, frequency, or, most importantly, their behavioral effects. Thus, anger, fear, and sadness, for example, are normal emotions, which are often functional for the individual, but have the capacity to cause behaviours (aggression, avoidance, and withdrawal), which

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become a source of distress to the individual or others. The relative importance of distress to self and distress to others to the process of help-seeking may vary for different emotions. Intuitively, for example, it seems likely that help-seeking in relation to an anger problem will often be instigated by others, either directly or indirectly, while help-seeking in relation to fear may be self-initiated. For sadness, on the other hand, the behavioral consequences may be such that concerned others either seek help on behalf of the person or strongly encourage, or even occasionally coerce them into treatment.

Thus, the requirements of the traditional "medical" model of referral to, and engagement in, clinical treatments are often not met in practice. Ideally, clients or patients would have a discrete problem which is distressing to them, which induces them to seek help from a professional and which subsequently motivates them to fully engage in and comply with the treatment regime (a regime proven by research to be effective in eliminating or reducing the problem).

Cognitive behavioral therapies have made significant and widely acknowledged progress as a method for reducing emotional distress of various sorts, even with complex and difficult clients (Tarrier, Wells, & Haddock, 1998). Interventions for anger problems, however, have been relatively neglected compared to those for other emotional disorders (DiGiuseppe, 1999; Howells, 1998; Kassinove, 1995), but, nevertheless, both narrative (Deffenbacher, 1995; DiGiuseppe, 1999; Novaco, 1997; Tafrate, 1995) and meta-analytic (Beck & Fernandez, 1998; Edmondson & Conger, 1996) reviews have tended to conclude that anger management interventions are effective in producing changes on a wide range of outcome variables, at least with some clinical populations. Among the factors identified as impeding progress in clinical treatment are heterogeneity of content of programs (Tafrate, 1995), neglect of anger problems in diagnostic taxonomies (Eckhardt & Deffenbacher, 1995), absence of individual assessment and formulation of anger needs (Howells, Watt, Hall, & Baldwin, 1997), and failure to apply anger management to high risk populations (Howells, 1998).

In this paper, we will address a factor which we believe is likely to have a major impact on anger management program effectiveness—the *readiness* of the client to undertake the therapeutic intervention. Low readiness refers in this paper to presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to impede engagement in therapy and which, thereby, are likely to diminish therapeutic change. The term *readiness* overlaps to some extent with the related concepts of *responsivity* and *motivation*. We will discuss below the distinctions between these terms. In brief, we see responsivity (a term derived from the literature on offender rehabilitation) as largely synonymous with readiness, apart from its sharper focus on program adaptation rather than on the individual. Motivation is a narrower concept and refers to (and provides a summary term for) a cluster of variables that constitute one component of readiness.

First, we address why low readiness might be a particularly important consideration for anger management programs, giving examples of common impediments to readiness. Readiness has received some (Deffenbacher, 1999) but not detailed discussion in the anger management literature. Our discussion and suggestions are influenced by our particular focus on anger problems associated with aggressive and violent outcomes rather than on

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