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The expression of anger and aggression in an institutional setting.

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THE EXPRESSION OF ANGER AND AGGRESSION IN AN INSTITUTIONAL SETTING

A Dissertation Presented

By

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Psychology Department

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ABSTRACT

The Expression of Anger and Aggression in an Institutional Setting

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This study examined the operations involved in angry behavior among institutionalized, retarded adults. The angry behavior of 20 people, the majority of whom were diagnosed to be moderately retarded, was followed over a period of six months, using the Critical Incidents Technique. A total of 225 incidents were collected by interviewing staff about incidents they had witnessed. Provocations to anger were strikingly similar to those reported for other populations. Major precipitants included: being ordered around or corrected, possessions stolen or lost, territorial disputes and the disruptive behavior of others. Apparent misinterpretation of events was involved in 14% of the provocations. The behavior of the angry person, as distinct from origin, was considerably more deviant: 38% of the episodes involved behavior that would be problematic in an unprotected setting (physical aggression, destruction of property, and self-injurious behavior). Indications were that anger expression, while often extreme by usual societal standards, was not uncontrolled. Purposefulness and mindfulness of consequences were seen in the selection of targets, the "amount" of harm done, and

in the choice of circumstances for the venting of anger. Resident-resident disputes were less frequent but more easily resolved than resident-staff clashes. Most angry episodes were interpersonal in origin and expression (94%). Staff interventions were effective in two-thirds of the incidents in which an interaction was attempted. The most effective interventions were giving direct assistance to alleviate the cause of irritation, distracting or separating disputants, deliberate ignoring of angry behavior, and time-out. The least effective interventions were physical restraint, threats, reprimands, explanations, and counselling (broadly defined). The ineffectiveness of counselling is tentative attributed to timing (i.e., counselling is ineffective when attempted while anger is still on-going).

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CHAPTER I

INTRODUCTION

This is a study of angry behavior. It examines the immediate antecedents of anger, patterns of its expression, and modes of resolution. It focuses on everyday irritations, but in a highly atypical environment (an institution), studying unusual subjects (adult retardates).

Total institutions are set apart from other environments in innumerable ways, of course. Consider a few of the features that may make them unique from the point of view of the experience and expression of anger. The incarcerated person is subject to orders from others (staff) at all times and in all areas of life. Personal power, status, and right to make decisions are at the lowest imaginable ebb. Crowding is the norm, and there can be no guarantee of the safety of personal property. Noise levels are high, opportunities to be alone almost nonexistant. A sizable proportion of fellow inmates are likely to be difficult, disturbed and boisterous individuals. Choice, even at the most mundane levels, is generally unavailable. Caretakers are most often underpaid and undertrained, and may come to share bleak views of the prospects and capabilities of inmates. Inmates in long-care institutions have historically been recipients of brutality and threats of brutality.[1] Long-term care facilities also produce the phenomenon Goffman calls "batch living," an experience most people escape, except perhaps at boarding school or bootcamp (Goffman, 1961).[2]

In short, there is good reason to believe that total institutions represent an extreme environment for the provocation of anger, as well as in other ways. The fact of retardation adds another unusual feature. Before tackling this complicated situation, it may be helpful to review what is known about how anger functions in other populations. This can be done with some dispatch, as the bulk of studies examine aggressive behavior.[3]

How is anger aroused? McKellar (1950) notes two major categories of provocations: interferences with goal-directed activity (the proverbial missing the bus, repeatedly getting busy signals, etc.); and assaults to self-esteem, status, or values (being insulted, contradicted, bossed around, and so forth).

One self-report study (Gates, 1926) catalogues a wide range of situations that are likely to make people mad:

> Unjust accusations, insulting or sarcastic remarks, contradictions, criticisms or scolding, unwelcome advice, others 'knew too much,' 'being bossed' by parents or friends, being teased, work left for subject to do, being kept waiting by friends, 'not invited to the party,' being shoved, stepped on, hat pushed off, seat taken, the sight of others being rude or unjust,. . .refused requests, spilling the ink, being locked out, wrong number, locker, radio or typewriter wouldn't work, umbrella, fountain pen or money lost, clothes injured, glasses or watch broken, hair won't stay up, lights went out, fumbled in dressing or sewing, dog refused to obey, elevator or bus slow, study or sleep interrupted, store not open, physical pain and thwarted hunger (pp. 220-221).

In the classification system she derived from this asserted inventory, Gates pointed out that thwarted mastery efforts account for many episodes of anger, while others are aroused by straightforward frustrations with fewer personality implications. Her system is thus entirely

comparable to McKellar's. Anastasi, Cohen and Spatz (1948) in another self-report study found that most angry episodes could be attributed to inferiority and loss of prestige, or to thwarted plans. Pankratz, Levendusky and Glaudin (1976) include two categories of provocation that fit the dichotomized view of anger arousal outlined above: "put down and personal affrontery" and "restricted role or options." Finally, Maslow (1941) has pointed out that material usually subsumed under the rubric of frustration can be more usefully conceptualized as deprivation or threat.

Anger that is aroused by interruptions fits smoothly into the frustration-aggression hypothesis.[4] The evidence suggests, however, that simple frustration does not account for the bulk of angry episodes, and still less does it account for the more intense and long-lasting forms of anger. McKellar (1950) found that frustrating circumstances accounted for 44% of his angry students, while "personality situations" accounted for 54%. Gates (1926) had her subjects rate the intensity of emotion, and found that obstruction by things tended to produce low levels of irritation, while personality assaults were more likely to produce intense anger. Apparently it is important to augment the frustration-aggression hypothesis with the notion of threats to status or self-esteem, and most researchers have done so.

In short, reasonable agreement exists on the circumstances that are likely to provoke anger. The nature of these circumstances sheds some light on the psychological function of anger. Feeling incompetent, powerless, or inferior is unpleasant, but righteous indignation is rather enjoyable. In addition, anger has an energizing quality which may be helpful in resolving the provoking circumstances.[5]

What is the nature of the objects of angry feelings? As Cason (1930) put it, "people are mainly irritated by the behavior of other people" (p. 27). McKellar (1950) found that people were responsible for nearly 98% of his anger incidents. Gates (1926), who included more minor irritations, still found that people were the main sources of anger 80% of the time, and noted, "not only do people cause anger much more frequently than do things, but the emotion experience is much more likely to be violent in the former than in the latter case" (p. 332). Toch's (1969) study of violence also emphasized that aggressive episodes are interpersonal exchanges. This makes sense, since it takes fellow humans to really threaten mankind's most treasured beliefs and hopes.

The sensation of being truly angered is an ineffable one, but certainly one of life's more powerful experiences. Angry persons are stirred, and operating at a level of energy and personal involvement that is far beyond that of ordinary social interaction. Angry people feel they have been made to look foolish, or deprived of the right to determine the course of events in their lives. How do people act in this intense emotional state? What do they actually do? Generally speaking, they do very little. The most common reaction, in fact, is to do nothing whatsoever: not to tell the offender off, certainly not to strike out at him, but to do nothing.[6]

Angry people <u>wish</u> to do a number of things: people asked to report their impulses when angry say they want to slap, pinch, shake, tear to pieces, kill, slam doors, etc. with monotonous regularity.[7]

Usually these impulses remain at a purely fantasy level. What people do most often, if they do anything to express themselves directly to

their provoker, is to make some form of verbal retort.[8] Another common reaction is to "store" the anger, and express it later in the form of a complaint to a sympathetic listener (McKellar, 1950). Other common responses are to leave the area, or, less frequently, to attack inanimate objects (McKellar, 1950). It appears that adults in this society are remarkably well-socialized with respect to anger management, possibly even over-socialized. Anger is a strong and frequent emotion, but its expression within the population at large tends to be attenuated.

Expressed anger, while not particularly common, is striking when it occurs. Consider the following descriptions from G. H. Hall's (1898-99) classic study:

> I have seen men ordinarily sensible speak with cruel sarcasm and grow absolutely infantile, diffusing bitterness all about and at the smallest provocation in a game of croquet (p. 534).
>
> When my hot and furious temper culminates I tremble and speak out recklessly the first and bitterest thing I know (p. 534).
>
> When I was ill and the doctor came to tell me of my brother's death, I struck him with all my might; and all that is usually grief seemed for the moment turned to anger (p. 535).
>
> If when cracking nuts or driving a nail, I hurt my finger, I am so mad I have to smash something instantly with the hammer. Once my boot, which had been wet overnight, was so stiff in the morning I could not get it on. In rage I pounded it well with my hammer (p. 537).
>
> When violently angry would walk back and forth between two rooms, so as to slam the door. Sometimes she would take a pillow and shake it until exhausted (p. 566).

These episodes illustrate a number of points about the functioning of anger:

1. Expressed anger has a non-rational quality. Otherwise sane

adults may destroy their own possessions or even hurt themselves in piques of rage.

2. To the outside observer, it often appears that angry behavior is out of proportion to the provocation.

3. Angry people appear to favor tension-reducing modes of behavior.

4. Anger seeks a righting of the balance or retaliation even when this aim is unrealistic (as when the object of anger is literally an object).[9]

5. Anger is readily redirected, i.e., can be expressed to objects other than the originally provoking ones. Anger may also "spread" (cf. the expression, "mad at the world").[10]

The statistical evidence cited earlier suggests that effective controls exist which often spare us the discomfort of fully expressed anger. One of the most frequently cited mechanisms for this control is the simple fear of retaliation. Another example from Hall:

> I can now generally control my naturally strong temper. I think volumes, but say nothing. It would be a luxury to wreak myself upon expression, but I refrain from prudent reasons. I know people would pay me back (p. 568).

Research evidence indicates that people react most judiciously to provocations issuing from people who have status and power.[11] McKellar found that the bulk of aggressive angry responses were directed at animals, objects, and children, targets not capable of effective retaliation. These data indicate that angry expression can be inhibited by expected consequences.

Inner controls also help to block the more extravagant expressions of anger. Outright tantrums are common among young children, but these decrease with age (Fite, 1940). It also appears that experience in coping with disputes helps teach non-aggressive methods of coping with anger. Circumstances that weaken ego controls (fatigue, hunger, etc.) increase the difficulty of maintaining good temper.[12]

Finally, cultural membership influences modes and extent of anger expression. A number of societies permit few physical or direct expressions of anger, although they do tolerate high levels of hostile gossip, sorcery, or other indirect manifestations of anger.[13] Cultural membership also influences targets that are acceptable for the expression of anger.[14]

It appears that cultural sanctions have more impact on how anger is expressed than on how it is aroused. There is some indication, however, that culture can affect what makes you mad in the first place. The Balinese, for example, are apparently free of the western tendency to evince anger when frustrated (i.e., interrupted before completing a goal-directed sequence). Perhaps it would be more accurate to say that they cannot be frustrated since they do not divide life into sequences of striving followed by satisfaction, as we are likely to do (Bateson, 1941).

All of these suggest substantial malleability in the operations of anger. In spite of this variability, it appears to be possible to assess the presence of anger reliably, both internally and with respect to others. Gates (1926) found that people were able to accurately judge how easily they were angered in comparison with others. There is also

evidence that independent raters can agree closely in assessing the presence and extent of anger in others (Hamburg, 1958).

We are now ready to discuss the particular operations of anger among retarded people living in an institution. Since institutions have been demonstrated to be less monolithic than was originally thought,[15] it is important to describe the setting in some detail. The participants in this study live in Cottage A, which is part of the Belchertown State School. The population of the institution as a whole is presently about 600; in the past the census has been as high as 1500.[16] The census drop is attributable to policy decisions dictating the return of retarded people to their communities of origin.

Like many mental retardation facilities and some state mental hospitals, this institution is under court order to improve conditions and treatment offered. As a result, the institution is in a stage of transition. It was once an archetypal "snake pit"[17] complete with overcrowding, minimal treatment, poor health care, inadequate and often harsh supervision, maintained almost totally without connection to the outside world. At this point the facility has been renovated to afford residents more privacy and a more normalized living environment. Nine "employee cottages," of which Cottage A is one, are now used as client residences, offering an alternative to old-style "buildings." Staffing ratios have been greatly improved at both professional and direct care levels.

At the same time, the institution is emptying out. This relieves the crowding; it also means that the remaining population includes a

disproportionate number of very handicapped people. These disabilities, which have held the remaining residents back from community placement to date, may relate to behavior problems, multiple health problems or to functioning level.

It is obvious that the Belchertown State School has many atypical features; these need to be kept in mind in interpreting and generalizing indications from the present study. To complete the description of the specific circumstances of the study, we need to learn a little about Cottage A and its inhabitants.

Cottage A is coed, and usually houses eighteen people at any given time. The majority carry diagnoses of moderate retardation, although a few are considered to be mildly or severely retarded. Although three of the present residents are essentially nonverbal, all are able to communicate effectively with people who know them well. A few are noticeably articulate in being able to express most thoughts and emotions that occur to them. The majority of the residents presently work in sheltered workshops either half or fulltime. Four are retired, and the remainder are unemployed at their own wish or because of physical infirmity. Usually there is an approximately equal number of men and women. The age range is from mid-twenties to nearly eighty. The cottage reflects the population of the institution as a whole in including a greater proportion of handicapped individuals than it did in the past.

The lives led by this group vary widely. Many live busy lives and go out a great deal; while others rarely leave their residence. Some have numerous long-lasting and intensive relationships with fellow residents, or--more frequently--with staff members. Others are loners.

There are alliances and long-standing disputes and rivalries. Some are eagerly waiting to leave the institution, while others refuse to consider the possibility or appear to be unaware that it exists. About half the current group maintain ties with their families. The remainder have few or no family contacts; some have no known family. Most have been institutionalized since early childhood, but a few grew up at home. Several are considered to be "behavior problems" and most have at least occasional difficulty in expressing anger appropriately. Two of the present residents carry psychiatric diagnoses of schizophrenia in addition to their primary retardation.

Their residence is called a "cottage" because it is house-like in having a living room, dining room, kitchen and semi-private bedrooms and bathrooms. These clients have lived in this setting rather than the old-style buildings for one to four years. It is widely felt that clients tend to "improve" in response to moving to a cottage, and this appears to be the case. Many clients who would not have been considered for community placements (which are naturally somewhat competitive) do move after some interval of cottage living.

The other important feature of the environment is the staff. In the case of Cottage A, the staff group includes eleven direct care staff working in three shifts; the cottage director and psychologist (myself); an assistant cottage director, social worker, recreational therapist, several nurses, and a half dozen programming staff. For many residents, staff contacts also include workshop supervisors, and occasionally the unit management staff.

Anger tends to be an interpersonal phenomenon, and for residents,

staff are one of the two major groups with whom they interact at this and other levels. They are uniquely influential in that they are the main people who respond to client behaviors in what continues to be a relatively isolated setting. Their norms, values and constructions for understanding events are the dominant ones. Staff also provide the most viable models for anger expression.[18]

Perhaps the most important aspect of staff influence from this point of view is that the staff culture is itself an irritable one. At one point I tallied up the number of angry complaints that had been made to me about one staff member by another. Each had expressed anger felt toward at least one fellow employee, and for several the figure was three or four ongoing disputes. The remarkable extent of hostile gossip, feuds and squabbles among employees is a favorite topic of staff discussion.[19]

Staff anger levels may be related to the strict hierarchical nature of the staffing system and to the general frustration and felt impotence of employees in the setting. As is the case with resident anger, it may also be related to the sheer relentlessness of the institutional environment. The intimacy of the setting is impressive: staff are involved in every aspect of the resident's life from removing ear wax to planning holidays home. Residents are discussed frequently when they are within earshot. Staff discuss other staff and residents talk about staff, all fairly openly in part because there is no effective means for people to get away from one another.

Then, too, staff have numerous personal ties with each other. In some cases many members of a family all work at the institution. Many

people have fellow-employee friends and roommates. All these factors seem calculated to reduce the boundaries between personal and work codes of conduct, and seem likely to increase levels of irritability. The role of these aspects of the staff culture is not the focus of study, but does constitute important background information.

Considerations relating to the institution and its staffing system make it likely that rates of anger expression and outright aggression will be high. Because of the ongoing transition to community life, socialization skills need particularly close examination at this point. Dealing with anger is an especially problematic aspect of this group's coping skills for several reasons:

1. Chronic explosive behavior may preclude community placement, or doom it to failure if it occurs. This has the effect of keeping the aggressive retarded person part of a pool of increasingly disadvantaged peers, making an already undesirable living situation even more unsuitable.

2. Displays of aggression that are almost unheard of outside institutions are common within them (window-breaking, self-injurious behavior, etc.). It is usually reported that retarded people have a higher proportion of severe behavior problems than the population at large, but the reasons for this discrepancy are unclear.[20]

3. Leaving the effects of institutionalization aside, if this can be done, it seems likely that retardation itself increases the difficulty of coping with inherently problematic emotions like anger. Kaplan and Goodrich (1957) emphasize that anger invites cognitive interpretations of events. People with limited intellectual skills may have more

trouble processing events and a more restricted array of responses once they have achieved some understanding of the situation. Many of the incidents in this study did stem from this kind of misinterpretation. This is not to say that retardates are inherently more violent than others; it does mean that retarded people may need help in coping with angry feelings.

Even a quick visit to Cottage A reinforces the idea that anger is an important issue there. It is a noisy, squabbly place. While no comparative data are available, any observer notices that there are more disputes and less concern for social amenities than there would be in a dorm or other comparable setting.

CHAPTER II

METHOD

Anger was studied in this setting by interviewing staff about angry episodes they directly witnessed on an ongoing basis. Two-hundred-and-twenty-five incidents were collected using this method, which is called the Critical Incidents Technique (C.I.T.). The C.I.T. is an inductive method of building up generalizations by abstracting them from a large number of concrete events, rather than inferring them deductively from some superordinate concept or definition (Goodrich & Boomer, 1963, pp. 16-17). "The subject is not asked to give generalizations. Instead the investigator derives generalizations from the analysis of specific incidents" (Dennis, 1957, p. 431-432).

The C.I.T. was developed by Aviation Psychology Program in the Air Force for use in the program's attempt to develop criteria for the classification and selection of airmen. The method continues to be closely associated with John Flanagan, who worked on this wartime project. Critical Incident Studies include behaviors for which children are praised in different cultures (Dennis, 1959); interactions between counterinsurgency forces and the indigenous population (Blakelock & Houk, 1967); types of therapeutic interventions with disturbed children (Goodrich & Boomer, 1963); job requirements of store managers (Anderrson & Nilsson, 1964); and evidences of improvement or need for further treatment among mental patients (Flanagan & Schmidt, 1955).

In each case the aim is to sample the full range of the construct, to identify patterns and points of differentiation. As a research procedure, Flanagan states that it makes three requirements:

1. All observations are made with respect to an agreed-upon definition (usually the broadest meaningful one).

2. Only qualified observers are included. (Fleming notes, "The customary procedure in the C.I.T. is to employ observers who are actually part of the situation" (Fleming, 1962).)

3. Only simple judgments are required. According to Flanagan:

> If the sample is representative, the judges well-qualified, the types of judgments appropriate and well-defined, and the procedures for observing and reporting such that incidents are reported accurately, stated requirements can be expected to be comprehensive, detailed and valid in this form. There is only one reason for going further, and that is practical utility. The purpose of the data analysis stage is to summarize and describe data in an efficient manner so that it can be effectively used for many practical purposes (Flanagan, 1954, pp. 327-358).

According to Andersson and Nilsson (1964) interviews produce a larger number of incidents than questionnaires, but the mode of collection does not affect the structure of the data (i.e., the rank correlation between category sizes collected by the two methods was .85). Miller and Flanagan also found that the pattern of incidents was similar for interview and questionnaire data (cited in Flanagan, 1950).

Prompt collection of incidents does appear to be an important factor. Nasey found a bias for reporting dramatic incidents if time periods of more than a few months were involved (Flanagan, 1950). Miller and Flanagan (Flanagan, 1950) reported the number of incidents obtained

using different collection intervals:

daily: 215 incidents

weekly: 155 incidents

bi-weekly: 63 incidents

Clearly a larger proportion of incidents are reported when collection is not delayed.

For this study observers were asked to report examples of angry or aggressive behaviors they saw during the course of the day. Examples were offered to the judge to assure a shared definition of the task (yelling, storming around, pouting obviously, arguing, assaulting). No detailed definition was offered beyond the commonsense meaning of anger. Incidents were included only if some of the circumstances and motivations were understood (i.e., "Stanley lost his thermos and stormed around yelling" would constitute an incident, but "Stanley was storming around yelling" would not). During the interviews, observers were asked what had created the incident, who had been there, what the observer had done about the situation and how it worked out (see Appendix A for a copy of the data collection form).

Thirty-seven staff members provided incidents. This includes almost everyone who is involved with the residents regularly in their residence, plus a few staff from sheltered workshops. For the purposes of the study, all are equally expert in knowing the people involved and in having the opportunity to observe their behavior. This is important, because differences in opportunities for observation may affect which aspects of behavior are reported. In a study of dentistry, for example, Wagner (in Flanagan, 1950) found that critical requirements collected

from patients, dentists and instructors covered different components of the role of the dentist. Because of the similar observational opportunities, and because "expert" judgments were not required, there was no reason to expect disparate contributions from different segments of staff.

Incidents were collected daily whenever possible. The interview was selected over the simpler questionnaire format because many of the judges were not comfortable or skilled in written expression. The interviews were brief, usually five or ten minutes for each incident.

"N" in this kind of study is the number of incidents collected; 225 in this case. Flanagan noted that ideally incidents are collected until 100 fresh incidents produce only two or three new critical behaviors. This criterion would have involved an impractically large number of incidents. Goodrich and Boomer (1963), in their study of clerical interventions with aggressive children, collected 240 incidents, and felt they were able to make meaningful use of their material.

Incidents of angry behavior were probably not equally reported. Incidents occurring outside the earshot of staff, in particular, were automatically excluded. In addition, some low-level disputes were probably overlooked or forgotten by the observers (this happened to me frequently when I was collecting pilot observations). In fact, a striking aspect of the data collection process was the difficulty staff experienced in recalling angry episodes. When asked for incidents a staff member would often report one or two, then state that that was about it. If I had time to stay and talk for a while, in the course of conversation the observer would say, "I thought Duncan was going to brain Dora

last night; she was driving him nuts with her racket", or "Bill is really something. I tried to explain to him what you say when you answer the telephone and he went nuts on me; yelling and hollering." This phenomenon was very common; probably over half the incidents in the study were initially reported in this off-hand fashion. It appears that angry exchanges are sufficiently frequent in this setting to take on a quality of invisibility.

While close to 100% of serious clashes were undoubtedly reported, observers would be unable to convey all the particulars of minor disasters on a "bad day." All these features of the data collection make quantitative statements about absolute frequencies of incidents unreliable.

On the other hand, the reported incidents should be valid and relatively undistorted. The observers were in the best position to note the relevant behavior. Even a carefully trained observer would have been unable to collect the data because of communication difficulties. Observers were relatively unlikely to alter the behavior they were observing, since they were familiar care-takers going about their ordinary duties, which have always included making reports on resident behavior. In short, while the domain of angry behavior may not have been sampled in an entirely random way, the behaviors reported should be entirely germaine.

Of the 37 staff members contributing incidents to the study, 13 were professionals (psychologists, social workers, nurses, program directors) and the remainder were direct care staff (attendants and cooks). The staff had been asked to tell me about any arguments,

fights, tantrums or loss of temper. These directions were apparently clear and understandable, as no incidents were contributed which did not appear to be instances of anger.

As a check on the reliability of the data, it is possible to examine incidents which were reported by more than one staff member. There were 46 such incidents, and 43 of them were described in gratifyingly similar ways by the different reports. The other three incidents were reported in substantially different ways by reporters:

1. In one incident, one staff member reported that a resident had thrown a knife, while another indicated that he had merely threatened to do so. It turned out that the staff who said that the knife had not been thrown had actually witnessed this part of the incident, while the other reported was relying on resident reports.

2. One staff member indicated that the provocation for an angry incident was that the resident was out of tobacco. Another observer added the interesting observation that a staff member had been teasing the client by calling his girlfriend a "peanut head," thus changing the picture of what had aroused the anger.

3. One observer reported that the angry resident had ripped the coat rack off the wall in the course of an angry incident. Another staff member (again an actual witness) felt that he had simply stumbled against the rack as he was storming out of the cottage.

If incidents which are observed by staff can be assumed to be similar to those with more than one witness, it can be projected that approximately 7% of the incidents would contain distortions or errors. This means that over 90% of the incidents can be taken to be adequately re-

ported, and suggests satisfactory reliability.

Treatment of Data

The incidents were categorized in the following ways:

1. Provocations. In most cases, provocation was determined by the observing staff member's judgment of the conditions for anger, although in many cases the resident's statements about the reasons for anger were also the basis of the categorization. More than one provocation was involved in 10% of the incidents. No clear provocation could be determined with 9% of the incidents.

2. Angry behavior. Incidents were divided into those involving verbal expression only; aggressive expressions of anger; and physical expression of anger limited to throwing or destroying objects.

3. Interventions. As staff described their responses to the angry person, interventions were rated as effective or ineffective. Effective interventions produced immediate easing of tensions in the observing staff member's judgment. Ineffective interventions failed to make an impact or occasionally made matters worse. Often two or three interventions were attempted before an effective approach was determined.

4. Outcome. Resolutions of the angry situation were rated as successful, unsuccessful, or neutral. In incidents with successful outcomes, the angry episode ended in less than 15 minutes, or was entirely resolved without further incident (even when they took longer than 15 minutes). Neutral outcomes left the angry person sulky and irritable, but produced no further angry incidents. Unsuccessful outcomes involved production of further incidents by the angry person(s). Outcome was

also rated to be unsuccessful if the resident(s) involved continued to be actively irritable and argumentative even when no specific further incidents were identified.

CHAPTER III

RESULTS

What Provokes Anger?

What has been learned about the structure of angry interactions from these staff reports? The first question is the mode of anger arousal: What provokes anger in this setting? It will be particularly important to note any features that make this population "different" with respect to anger arousal, since these may be the areas requiring special planning and treatment. Major provocations to anger are summarized in Table 1.

By far the most common irritant is being "ordered around" by the staff. Being on the receiving end of orders is an extraordinarily common part of the lives of institutional inmates. They are told when to get up, when to eat, when to bathe, do chores, go to work, change their behavior, and so forth. Many staff orders are met with cheerful compliance, but sometimes they are met with anger:

> Bill was in the kitchen fixing himself a sandwich. A staff member told him to stop, since it was almost dinner time. Bill immediately started yelling.
>
> Lorraine had been involved in an angry incident early in the morning but she recovered her spirits and headed off to work in an off-grounds workshop. When she arrived, she was asked to return to the cottage for a bath (which was definitely indicated). She had words with her boss, punched her, and pounded on a window.
>
> Cathy was about ready to leave for school when a call came from the dental office for her to go for an appointment.

Table 1

Major Provocations to Anger

Provocation	Number of Incidents	Percent of Incidents*
Staff control behavior through orders, requests, confrontations or corrections of behavior, limit-setting	81	36
Having a need that is not met	24	11
Disputes over territory and the use of space	24	11
Unknown provocation**	21	9
Having a possession stolen, or abused, or losing something	14	6
Hurt feelings	13	5
Disruptive behavior by another client	12	5
Being verbally attacked by another resident	10	4
Being physically attacked by another resident	10	4
Jealousy of staff attention to another resident	9	4
Being ignored, or having a need ignored	9	4
Plans cancelled or changed	7	3
Difference of opinion with another resident	5	2
Being interrupted in a conversation or activity	5	2
Frustration with objects	3	1
Being teased	3	1
	230	

*A single incident can have more than one cause, as when a staff order interrupts ongoing activity.

**While completely mysterious incidents were excluded from the study, ones which illustrated coping or interaction mechanisms were included even when the specific provocation was not clear.

> Someone told her she had to go to school late, and she screamed and stamped her foot. (Note: Her irritation was not due to the fact of a dental appointment, per se, since she has a crush on the dentist and ordinarily enjoys her visits there.)

Adult behavior in this culture is rarely subject to direct, bald orders, although it may be effectively controlled in other ways. In the institution, the sequence, "staff member gives order--resident responds", is an extremely common one. Angry responses are only one category of reaction to orders, which may also be accepted, circumvented or ignored. Receiving orders, justified or not, is cited as an irritation in other populations as well (see p. 2); residents differ from normals in this area only in that they presumably have many more opportunities to experience this provocation.

In addition to issuing direct orders, staff are frequently in the position of correcting errors clients make:

> I spoke to Dora about having hung up on someone on the phone. She immediately gave Cathy a shove and called her a "fat cow."
>
> Cathy took a drink of juice from her glass, then poured the rest back into the container. A staff member spoke to her about the unsanitary nature of this practice, and she screamed.
>
> Bill showed a staff member a card he had received and said, "Look, this is from me." The staff member responded, "This is <u>to</u> you, not from you." Bill got mad and started yelling.

Usually the staff corrections involved were not arbitrary or unwarranted; the resident's behavior often demonstrated the need for training. The point again is that criticism is irritating, particularly when it implies failure. This may be particularly true for retarded people,

who are likely to have substantial personal histories of failure. The retarded are certainly not alone, however, in reacting irritably to correction (see p. 2).

Residents are subject to correction in another way as well: they are often reprimanded for "misbehaving." This intervention often produces anger in a resident who may have been behaving badly, but not necessarily angry at the outset:

> A staff member caught Bill rifling Edgar's room. The staff member reprimanded him about invading privacy and stealing, and Bill became enraged.
>
> Henry went into Jackie's room, and plopped himself down on the bed. Staff asked him to leave, as Jackie wasn't dressed. A lengthy angry episode ensued.
>
> As we left the store last night, we noticed Duncan had helped himself to a Playboy bunny inflatable doll without paying for it. We insisted he return it, which he eventually did, but boy, was he mad.

Residents most frequently become angry at staff when staff attempt to control their behavior in the ways outlined above. There are other, lower frequency causes for anger at staff by residents. Staff sometimes cancel plans, or fail to respond to residents' needs:

> Two staff had gone out shopping, and had promised to pick up some batteries for Henry's radio, but they forgot to do so. Henry was very upset and offended by this.
>
> Dora asked me to help her get dressed. I told her I would if I had time, but it turned out I didn't. When I told her this, she threatened to kill me, break a window, etc. Someone else helped her, and she calmed down.

Sometimes staff tease residents, and if they hit a sore point, the result may be anger:

A staff member jokingly told Bill that all birthdays in May had been cancelled. As Bill's birthday is in May and he looks forward to it from Christmas on, he got mad.

A staff member teasingly called Duncan's girl friend a "peanut head." This really offended him, and he got mad at his provoker.

Who Are the Targets of Anger?

At this point we have described the bulk of provocations to anger without reference to fellow inmates. In fact, the majority of angry episodes were directed at staff (see Table 2). Peers can, of course, be irritating in a variety of ways: they may take possessions, invade personal space, appropriate staff attention, make verbal or physical attacks on one another, tease, argue, make a racket, and so forth. These provocations are summarized in Table 3.

In this study the largest proportion of angry incidents between peers were related to three issues:

1. The use of space. Incidents were created over the use of bathroom facilities, space at the dinner table, intrusions into bedrooms, and by people bumping into each other.

2. Verbal or physical attack by another resident. Combined, these provocations account for about one incident in five. The first strike may or may not have been angrily directed at the resident who responds angrily, since some of these episodes were created by misinterpretations or misdirection of affect. In any case, one natural response to being on the receiving end of an attack is to strike back.

3. The obnoxious behavior of another resident. In most cases this boiled down to disputes over noise levels.

Table 2

Director of Residents' Anger

Direction of Anger	Percent of Incidents
Anger directed at staff	57%
Anger directed at peers	37%
Anger directed at environment	6%

Table 3

Provocations in Disputes between Residents

Provocation	Number of Incidents*	Percent of Incidents
Use of space	24	27
Misdirected to peer	13	18
Physical attack	10	14
Misinterpretation	10	14
Verbal attack	9	13
Obnoxious behavior of another client	9	13
Jealousy of staff attention or other's privileges	4	6
Order from a peer	3	3

*Sums to less than the 84 incidents involving peers because some incidents had idiosyncratic provocations.

Provocations created by peers were in the minority. These peer disputes will be discussed in detail later, but at this point it is sufficient to note that peer arguments, like ones with staff, were entirely ordinary in their origin.

It appears that retarded people get mad for much the same reasons that anyone else does. Most angry behavior is non-rational (i.e., the behavior of drivers in gas lines); the point here is that retarded people are no more irrational in their anger arousal than anyone else. This is encouraging in terms of anger management with this population, in that it suggests a common base of experience.

It is interesting to note that the staff, as they reported incidents, did not believe the provocations to be lawful. Often they would begin a report by saying, "I don't know what got into so-and-so" and follow this with an entirely sensible account of why the person in question was bothered. Comments such as, "You never know what will set these people off," were common.

In having these perceptions, the staff may be responding to the fact that provocations in the situational sense do not always produce actual irritation. A given staff order, for example, will sometimes result in compliance, while at other times it will produce loss of temper. This makes the anger look random, although it continues to belong to a class of recognized irritants.

The same point actually applies to non-retarded populations as well. An opportunity to be provoked may be passed up at on some occasions, but results in irritation if one is tired, over-stimulated, hungry, or if possible sources of irritation have piled up. It is easier

to identify classes of events that are likely to produce anger than to predict with any certainty the occasions on which anger will occur.

There was one exception to this general rule that institutionalized retardates lose their tempers for the same reasons that the rest of us do. This exception relates to what Kaplan and Goodrich (1957) call the cognitive conditions for anger. According to their theory, anger does not arise until the potentially angry person has construed the situation to be a deliberate insult to him/her. With the aggressive children they studied, they found that this interpretive stage often went awry; i.e., the children interpreted events as being deliberately directed against them when this did not appear to be the case to others. This proneness to misinterpret (or perhaps overinterpret) events could be seen at Cottage A as well:

> Jane took a picture of herself from Cathy, who had it as part of a language book. Jane became angry when the picture was returned to Cathy, to whom it belonged. She couldn't figure out why if it was a picture <u>of</u> her, it wasn't <u>her</u> picture.
>
> Duncan and Harvey walked past each other in the living room. Duncan suddenly yelled at Harvey not to push him around--he wasn't going to put up with it. It seemed much more likely that the incident had been accidental, since Harvey is very unstable on his feet. (Note: Harvey was new to the cottage at the time of the incident.)
>
> Cathy got mad at Andrea because she thought the latter was wearing a pair of her knee socks. It took her a while to understand that the socks were similar to hers, but were not her pair.

Anger was created by a misinterpretation of events in about 14 percent of the incidents of anger between clients. The most common misinterpretations were the belief that an offending action was deliberate

when it looked accidental to others; and the belief that possessions had been stolen when they turned out to be misplaced. This latter category may not represent a serious misinterpretation, since theft is common at the institution, and if something is missing it may well have been stolen. In any case, it appears an inability to process events effectively is not typically implicated in arousing anger in the retarded person. This type of misinterpretation, however, is the one type of provocation which is not typically reported in non-clinical populations.

How Is Anger Expressed?

Once anger is aroused, how is it expressed? Among normal populations, as indicated earlier, anger tends to go unexpressed, or it is expressed to someone other than the offending party. When anger is expressed directly, it is usually in the form of a verbal retort; physical manifestations of anger (aggression) are very rare in adults in the course of everyday life. In this setting the picture is very different.

There are several unusual features of anger expression among this group, but the most striking is the frequency of intensely and fully expressed anger. In 38% of the incidents, the manifestations of anger were judged to be of sufficient intensity to be problematic in an unprotected setting. This figure includes actual violence, destruction of property, throwing things. Fifteen percent of the incidents involved direct physical aggression, including slapping, punching, kicking, pinching and shoving. Three percent of the episodes involved self-injurious behavior (SIB) although none were serious (see Table 4).

Consider a few examples of angry expression:

Table 4

Mode of Anger Expression

Mode	Number of Incidents	Percent of Incidents
Verbal manifestations only	138	61
Property damage, throwing things	46	20
Physical aggression directed at others	34	15
Physical aggression directed at self	7	3

Harvey was again late for going out with his student companion. She finally told him she was leaving without him. He told her she couldn't get away with this; he planned to kill her. He followed her downstairs with hairbrush in hand, went up to her yelling and struck her with it. Another staff member restrained him, and Harvey's anger turned against him. Harvey spit at him and threatened to bite. He made numerous "Let me up or I'll. . ." threats. He calmed down unexpectedly when a different staff member came in and suggested a walk.

A staff member was walking Jane to the shower with her walker. Jane wanted to go into her room instead of continuing on to the bathroom, but she needed a shower and the staff member insisted. Jane screamed, cried, yelled, and refused to move under her own power. Once she got there she started banging her hand on the radiator. Another staff member, who hadn't been involved in the original dispute, came in to help her, and she was fine after the shower.

Dora put up a stink about putting on her nightgown, and I had to force her off the couch. She scratched my arm pretty good and didn't settle down while we were there.

Duncan and Harvey had a fight this evening over a soap dish. Harvey found it and claims it's his. Duncan says it's his, that he bought it when he went shopping. Duncan threw the first punch. Harvey responded with the second plus a kick. They were separated, and went off their separate ways.

A staff member was questionning Lorraine about having missed work with the dubious excuse that her period was starting. Lorraine repeatedly claimed that this was a perfectly good excuse, while the staff member pointed out that women everywhere work when they have their periods, etc. The discussion became heated, and Lorraine headed for a window, which she probably would have broken if she hadn't been restrained.

In each of these incidents it is easy to empathize with the resident's irritation. The unusual quality is supplied not by the fact of anger, but by the manner of its expression. This exaggerated quality may be present even in incidents which do not involve outright aggression.

Duncan was up in arms this morning. He threw his new clothes down in the basement, saying he didn't want them. Told a

staff member he'd kill her and throw her in the dump. Turns out he's out of tobacco. We made arrangements to get some and he's better now.

Lorraine wanted to make herself a cup of tea. The cook asked her politely to wash her hands. Lorraine got all upset, threw a chair across the room, started crying, screaming, banging things around. She wasn't allowed to have tea until she straightened out her act, which she did fairly quickly.

Again, the reactions go beyond what would be expected in community settings, or perhaps even in people's homes, where they may be freer to act cross and unreasonable. The high proportion of aggressive or excessive anger reactions cannot be attributed to intensity of provocation to any great extent. We have no measure of whether this population is more sorely provoked than others, although we may suspect that this is so. We can take a rough look at the relationship between intensity of provocation and intensity of anger expression within the study group, however. Aggressive outcomes are apparently only loosely tied to the original producer of anger (see Table 5).

Whatever the reasons for aggressive or destructive outbursts, qualities of the provocation provide little explanation. Aggression does appear to be a slightly more likely outcome where the anger was aroused by orders or by the irritating behavior of others.

The first inclination is to view these angry responses as losses of control. They may in fact represent such failures, but there are several indications that they should not be seen exclusively in this light. In the first place, these apparently uncontrolled episodes are patterned in their selection of objects for angry expression. The selection is quite uniformly in favor of "safe" victims, ones who are not too likely

Table 5

Comparison of Provocations for Incidents Involving Verbal Manifestations Only with Those Involving Aggression or Destructive Behavior

Provocation	Percent of Non-aggressive Incidents	Percent of Aggressive or Destructive Incidents
Physical aggression	4	6
Verbal attack	6	1
Waiting	4	6
Jealousy	4	5
Hurt feelings	6	4
Disputes over possessions	4	2
Disputes over use of space	12	1
Unmet need	15	5
Unknown provocation	7	13
Irritating client behavior	2	10
Cancelled plans	4	1
Client order	2	0
Competition	2	1
Being interrupted	3	1
Frustation with environment	0	3
Physical interference	1	2
Teasing	2	0
Misinterpretation	38	2
Order, correction, limit-setting	30	36

to retaliate. This principle could be seen vividly when residents turned anger which had clearly been originally directed at a staff member onto an available peer:

> I spoke to Dora about having hung up on someone on the phone. She immediately gave Cathy a shove and called her a fat cow. She was reprimanded and left the area temporarily--no further incidents.
>
> A staff member asked Dora to take her laundry downstairs. She refused, and minutes later asked for a cup of tea. She was told she could have it as soon as she'd taken her stuff downstairs. Edgar walked by, and she shook her fist at him, saying, "See this! See this!" Edgar ignored her, and she went out minutes later--no further problems.
>
> Lorraine was asked not to make her own cup of tea, as she had a suspicious looking rash and wasn't supposed to be in the kitchen. She felt she was being told she was a baby, and in the insuing tantrum she struck three other clients.

This type of motivated misdirection of anger occurred in about 6% of the incidents. Half of these were of the kind described above, in which anger originally felt toward staff was directed at peers. Residents would also occasionally take staff to task rather than experience more threatening feelings:

> Dora was waiting for a visit from her elderly sister. Because of driving conditions, the sister called to postpone the visit, and I relayed the message to Dora. She started yelling that, "No one wants me to see my sister," and made various threats (to break a window, move back to her old building, bite me, etc.). She remained upset for hours.

Another indication that angry expression is orderly and motivated more than uncontrolled is that speaking up vigorously often gets the desired results. This could be seen in some of the episodes cited above. Duncan <u>did</u> get his tobacco after his tantrum, for example. This is not

to advocate for withholding what is wanted when there is a tantrum involved, necessarily, but to point out that the consequences of losing one's temper are not always unfavorable. This may be particularly true in this setting, where you often need to scream just to be heard.

Not all anger is redirected to peers. Attacks on staff members do occur, but these too have a directed quality. Of 18 episodes in which a resident physically attacked a staff member, only two involved staff above the direct-care level, and one of these incidents was minor. In part, of course, this relates to the fact that direct-care staff are simply more available as targets a greater proportion of the time. On the other hand, professional staff are disproportionately likely to serve as disciplinarians, bring bad news and set limits. Higher status staff can certainly evoke anger, but expressing anger in aggressive form to someone with the power to meet important needs must often seem unwise. This phenomenon is similar to the tendency to attack peers even when the original target was staff. Both of these tendencies reflect the capability to judge the risks in expressing anger, and to cut losses when necessary.

Apparently aggressive wishes in this population are effectively controlled by anticipated consequences. Aggressive behavior also reflects environmental control. During the entire course of the study, there was only one aggressive incident that occurred outside the institution. While it is true that residents spend the bulk of their time within the confines of the institution, most go on some kind of outing at least two or three times a week, and seven of the clients in this study worked outside the institution during at least part of the period

covered by the study. Given hours-in-institution and hours-in-community it would certainly be reasonable to expect some serious incidents to have occurred in the community. Going out is highly valued, and no staff member will take a resident out if misbehavior seems likely, and this undoubtedly controls behavior in the community to a large extent. It appears, however, that well-socialized behavior outside the institution also reflects a grasp of community standards. Clients who routinely misbehave in their living areas are appalled at the thought of public bad manners:

> Maria was hospitalized in the community. A visiting staff member teasingly asked her if she'd been breaking windows and raising hell (activities she is notorious for at the institution). Her eyes got round and she said in a shocked whisper, "Not here!"

Three points are implied in the above:[21]

1. Residents do not express anger in an extreme manner when it is manifestly in their interest not to do so.

2. People who are participating in valued activities may not have much potential for being provoked (i.e., some circumstances are more inherently irritating than others).

3. Residents can discriminate and respond to available standards, whether these are appropriate or inappropriate.

Outcome of Angry Episodes

A final suggestion to the same effect is a note about the outcome of the episodes: People simply did not get hurt. One cut wrist (from breaking a window), a bloody nose and a few scratches were the only ac-

tual injuries reported from 225 incidents, many of which look like wild-eyed rows on first inspection. Extreme threats and bluster are common; serious assault is not. These episodes could almost be seen as fragments from a play, in which everyone has a part, and usually plays it through within the confines of the role. Not only is the performance essentially harmless; it also produces marked psychological gain:

> As a performer, the angry person is claiming qualities and attributes that are socially valued. The demonstration of anger advertises potency, expressiveness and determination. . . . The demonstration of anger can thus be a strategic move to foster and protect one's public image (Novaco, 1976, p. 25).

There is another perspective on angry behavior that may be useful to consider. It was pointed out earlier that wishes to scream and yell and act bizarre are an integral part of angry feelings in us all. We are apparently all motivated in the constraint we actually show by an anticipation of consequences. What <u>are</u> the consequences for the study group? Why <u>not</u> express anger openly there? People do not get hurt--episodes generally stop short of real disaster. Expressing rage may help, and it almost certainly will not hurt. In other words, most of the usual motivations for sitting on anger are weakened or missing. Where these motivations do operate, as they do on outings, resident behavior is "within normal limits."

To add further perspective to the interpretation of anger expression, it is useful to consider the issue of how incidents "turn out." Part of the answer to this question has already become apparent: insofar as people are not injured, outcome can be taken to be successful.[22]

To get a clearer idea of the course of angry interchanges, incidents were divided into those with successful, unsuccessful or neutral outcome. To be defined as successfully resolved, an episode had to meet one of two criteria: either it ended without renewed flair-ups within 15 minutes; or the reasons for anger were dissolved (even when this took longer than 15 minutes). Unsuccessful episodes were long-lasting or led to further incidents. Neutral outcomes included instances in which some tension remained, but this tension did not develop into any further disputes or outbursts.[23]

A summary of the outcomes of incidents is reported in Table 6. Clearly the most common outcome is for episodes to be resolved successfully: this occurs about twice as often as unsuccessful outcomes. Peer disputes were more frequently resolved successfully than ones involving staff. Peer disputes had successful outcomes 70% of the time, while staff disputes were successfully resolved in 59% of the episodes. This difference is significant ($\chi^2 = 6.43$, $p < .02$; see Table 7). These figures slightly underestimate the difference between the two types of disputes, since instances in which anger was presumably originally directed at staff but was expressed to peers were included as peer disputes.

In some ways this relative ease of resolution seems paradoxical. In peer disputes, residents are often subject to gratuitous insult or even physical assault which is frequently misdirected or based on a misinterpretation of events. There are two major factors which may account for the relatively benign course of peer disputes.

At the beginning of the report, a distinction was made between an-

Table 6

Dispute Outcomes

Outcome	Number of Incidents	Percent of Incidents	Percent of Aggressive or Destructive Incidents
Successful	132	59	60
Unsuccessful	62	28	25
Neutral	31	14	15
Total	225	100	100

Table 7

Outcomes: Staff vs. Peer Disputes

	Successful	Neutral	Unsuccessful
Staff	59% N = 66	8% N = 10	33% N = 42
Peer	70% N = 48	9% N = 17	20% N = 8
Internal*	60% N = 12	5% N = 12	35% N = 4

*"Internal" disputes are those in which the angry person had a non-animate target (busy telephone, lost possessions, etc.).

gry episodes that relate to the thwarting of needs (frustration) and those that originate in assaults on the personality and its worth. Peer disputes belong primarily to the former category. Residents may take each other's possessions and get in each other's way or create disturbing rackets. They may also create the need for practical defense through their attacks on one another. Seldom, however, do they evoke feelings of true powerlessness or otherwise assault basic sense of self-worth. Residents occasionally try to boss each other around:

> Cathy started to the kitchen to get an evening snack. Both Harvey and Edgar told her it was too early so not to do it. She shook her fist and yelled at them. There was no staff intervention and she quieted quickly.

These efforts produce irritation: "You aren't the boss of me" is a common rallying cry by residents both to each other and to staff. When the remark is made by one client to another, however, it is true, and this takes much of the sting out of the anger.

One reason for the easier resolution of peer disputes, then, may be that they are not truly as provocative in the first place. Another reason that peer arguments work out well may be that they can be expressed openly and directly as a rule. There is no need for passive strategies like going "on strike," and usually little reason for redirecting anger to safer objects. Peer disputes have a strong "tit for tat" quality.

Some of the features discriminating successfully and unsuccessfully resolved incidents have already been discussed. These include the object of anger and the type of provocation (simple frustration vs. personality threat). It is interesting to note that episodes that reach

the point of aggression or destructiveness are resolved as readily as those that involve more moderate forms of expression (see Table 6).

Staff Interventions

To complete the analysis of the resolvability of anger, it is necessary to consider the activities of the staff. The staff's role is certainly not limited to helping to end angry incidents: many incidents would not have occurred to begin with if staff did not make demands on residents. These demands may be related to expectations of socialized conduct or the fulfillment of institutional routines. Occasionally staff provocations are arbitrary or ill-considered but most staff behavior did not appear to be anything like deliberately provocative.

One role of staff interventions, therefore, is to produce the conditions for anger. How do staff function when they move to help resolve anger? Staff members attempted to influence the course of angry episodes 78% of the time. These helping (or controlling) efforts proved effective in about two-thirds of the incidents where they were attempted. A distinction is made here between a successful resolution and an effective intervention. A successful resolution, as described earlier, refers to a quick or complete cessation of hostilities. An effective staff intervention is one which has the immediate effect of altering angry behavior in the desired direction. These concepts are closely related, but some incidents in which staff members made effective interventions nonetheless went on to an unsuccessful resolution. Much more commonly an episode was successfully resolved in spite of ineffective staff interventions (see Table 8).

Table 8

Effectiveness of Staff Interventions into Angry Disputes

Intervention	Number of Cases	Percent Effective
giving assistance	20	90
distracting/separating	20	80
ignoring resident	13	77
time-out	23	74
correction	15	60
threats, warnings	8	50
counselling	33	45
reprimand	23	30
explanation	22	19
physical restraint	7	14
no intervention	56	--

Clearly the most effective intervention, one which almost always works, is to eliminate the reason for anger. The specific types of assistance staff may give include finding missing objects, repairing things that would not work, and providing alternative ways of handling problems.

Somewhat surprisingly, simply separating disputants or distracting their attention proved almost as effective. This type of staff intervention includes such staff behaviors as suggesting that the disputants go their own ways, sending an angry person on an errand, or suggesting alternative activities. Required separations are not included here (see the time-out category).

Ignoring angry behavior often proved effective. Interventions were categorized here only when the reporting staff conceptualized ignoring the behavior as a true intervention ("We gave her the silent treatment," etc.); otherwise not attending to behavior was included under "no intervention." The use of ignoring as an active intervention was most common in episodes that staff felt were attention-getting ploys.

Time-out as an intervention consisted of sending the angry client to his or her room for brief periods. Time-out was not used for simple verbalization of anger, but only when misbehavior (stealing, etc.) or abusive and aggressive behavior was involved. By definition, then, this category includes many of the more serious incidents, so it is interesting that this intervention effectively ended anger three-quarters of the times it was employed.[24]

Correction as an intervention included withholding privileges or denying requests contingent on appropriate behavior; requiring that re-

sidents make amends ("pick up that cup you threw"), and suspending clients from work because of disruptive angry behavior.

Staff interventions consisting of threats or warnings were similar in some ways to efforts at correction, except that they were cruder and less clinically justifiable. Included here are such staff statements as, "I'll send you back to M Building"; "I'll take your pipe away"; etc. These maneuvers differ from correction in that they are arbitrary, i.e., not intrinsically related to the specific angry behavior.

Counselling attempts, broadly defined, were frequently attempted, but were effective less than half the time. Examples of counselling interventions are attempts at persuasion, interpretations of other clients' behavior, advice, and administering sympathy.

Reprimands were interventions in which the staff said, "You stop that," or "That's no way to act" without specifying a contingency for non-compliance. Not surprisingly, this type of intervention was effective less than one-third of the time, and then usually in minor incidents which would most likely have been quickly resolved in any case.

Explanations were attempts to clarify the situation for the angry resident: "He can do that if he wants"; "The reason you can't go shopping is that so-and-so is out sick"; "The store isn't open now"; etc. In giving their observations staff often expressed hopelessness about the utility of explanations ("I explained it to him, but of course it didn't do any good"). Sometimes staff expressed the opinion that explaining just makes matters worse, and in fact this form of intervention was rarely effective.

The least effective intervention that was used with any frequency

was physical restraint. Physical restraint was only used when the situation was out of control, and almost never successfully terminated the incident. Although sometimes necessary to prevent injury, restraint is almost inevitably seen as a fresh provocation, and is never the intervention of choice.

In reviewing the major types of action staff are likely to take in angry situations, it appears that those that are aimed at defusing anger are strikingly more effective than those which seek to confront it directly. The most effective interventions were removing the provocation, distracting or separating angry individuals, ignoring behavior, and placing the misbehaving angry person in time-out. All of these interventions focus on taking the heat off, and they work very well, even when they have punitive overtones, as in the case of time-out.

The most surprising aspect of staff interventions was the relative ineffectiveness of counselling and explanations. Some of these efforts, of course, may be ill-timed or clumsily executed, but it seems unlikely that this could be the whole explanation. It may be that these kinds of interventions keep the resident focussed on the anger-producing situation, and make it difficult to relinquish the anger. Counselling and explanations are also likely to call upon the angry person to reinterpret the basis for anger ("He didn't mean to hurt you," etc.) and this may be difficult for people with limited cognitive skills. Counselling efforts were the most common intervention, and often occurred as part of a chain of staff reactions. The staff might start out saying, "You knew _____ was upset. Why start picking on him now?" If this proved ineffective (as it often did) they might go on to say something like, "Why

don't you leave _____ alone and go down to pick up the mail?"

Under what circumstances do staff choose not to intervene? Not surprisingly, they are less likely to intervene in minor disputes. Only 13% of the incidents in which there was no intervention involved aggression, self-injurious behavior, or other problematic manifestations of anger, although these types of behavior occurred in 38% of the total pool of incidents. Staff are also less likely to intervene in peer disputes than in ones involving staff. There was no intervention for 30% peer incidents, but only 19% of staff disputes ($X^2 = 3.24$, short of significant at .05 level).

Staff are apparently able to make appropriate judgments about when to leave well enough alone. About 60% of all incidents were successfully resolved, regardless of whether there was any staff intervention.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This has been a study of the way anger operates: what arouses it, how it is expressed, how it is resolved. Anger is not a subject that has received close study; when it has been considered, it has usually been approached as a subsidiary of the concept of aggression. Here a nearly opposite approach has been adopted: anger has been treated as the central issue, with aggression seen as one possible outcome of anger. In adopting this stance, it is important to point out that the only aspect of aggression that has been examined is what has been called "hostile aggression" (Feshbach, 1964), "impulsive aggression" (Berkowitz, 1974), "angry aggression" (Buss, 1961), or "irritable aggression" (Moyer, 1968). Other facets of aggression that have been described (e.g., instrumental aggression, Buss, 1961) relate less clearly and directly to the concept of anger.

Anger and aggression have been approached here at what Goodrich and Boomer (1963) describe as an intermediate level of theorizing. Discussion goes beyond concrete observations but stops short of general theorizing.

Overview of Results

Provocations to anger for this population were found to closely parallel those reported for "normal" populations. The range of provocations was broad, as in the case of other groups: delays, interruptions,

receiving orders, being corrected, being ignored, competing for space or attention, and so forth.[25] Researchers have divided provocations into those based on threats to personality, and those involving frustrations. These classes of irritants overlap considerably, but serve as a rough classification here as well (Pankratz et al., 1976).

The only area in which this group of retarded subjects responded in an unusual way to potential irritants was in misinterpreting the basis for anger. This usually took the form of treating what appeared to be accidental circumstances as deliberate affronts. There are two possible explanations for this phenomenon:

1. Background levels of irritants must be presumed to be extremely high in the institution. A person who is already feeling cross and irritable may have more difficulty discriminating the "reasonableness" of anger as a response to a particular annoyance. Other research has indicated that the piling up of aggravations makes loss of temper more likely.

2. There is some rather sketchy evidence to the effect that developmental disability may be accompanied by delay in what Kohlberg calls "moral development." One facet of moral development is learning the discrimination between accidental and deliberate events. These classes of events are treated differently by older children and adults, but are regarded as equivalent by young children, who are inclined to focus on the effect of behavior to the exclusion of its motivation. It may be that some of the subjects in this study have not completely reached the level of cognitive development making this "ethical" distinction possible.

Misinterpretation of irritations accounted for a small proportion of the incidents, however. The generalization that anger is aroused in this group in the same way that it is in others remains basically valid. It is in the area of anger expression that the group here differs from the population as a whole. In spite of wide differences in personal styles among the subjects, three-quarters of them produced at least one incident of aggressive or self-injurious behavior during the course of the study. Thirty-eight percent of the incidents collected here would have been problematic in unprotected settings because of their aggressive or destructive nature. This intense expression of anger could not be linked directly to the nature or severity of the original provocation, but was lawful in several ways:

1. Targets of aggression tended to be "safe" (peers or less powerful staff members).

2. Aggressive expression fell short of serious harm in all cases.

3. Aggressive behavior was not produced in situations where it would have been disadvantageous to the angry person. Another implication here is that aggressive behavior was controlled by existing standards in the situation.

As is the case with other populations (cf. Toch, 1969), anger and aggression were found to be largely interpersonal phenomena. Ninty-four percent of the incidents involved anger at another person. Staff were the most common targets. Anger directed at staff and peers differed in several ways:

1. Anger experienced toward peers tended to be directly expressed and assumed a tit-for-tat quality.

2. Anger directed at peers was more often resolved successfully than anger at staff.

3. Peer disputes required staff intervention less frequently.

However lawful this direct expression of anger may be, its heightened frequency and intensity require some explanation. Behavior problems and aggression have been reliably reported to be more common among retarded populations, and these problems become more marked as the degree of impairment increases. Since retardation is far from a unitary phenomenon, diverse explanations are entirely possible. An important unifying theme, however, would be the issue of communication. Difficulties in the communication process are a universal aspect of retardation, both because of the cognitive deficits, and because retardation is so often accompanied by speech and hearing deficits. Toch (1969), in his treatment of violent interactions between criminals and the police, points out that aggression represents failure of communication. It is most common among inarticulate people, and specifically under conditions which strain or paralyze other communicational options.

Suggestions for Future Research

The need for greater clarification of the communicational/interpersonal facets of anger expression is underscored by this study. Again Toch's study (1969) is valuable to the analysis. He found that the approach of responders to angry people was essential to understanding the outcome of the interaction. In the present study, these responders were reporting angry episodes, and thus were unlikely to be able to specify nuances of their own style as these may have contributed to the develop-

ment and outcome of the situation. It would be useful to repeat this kind of study with observers who were in a position to report on the total interactions, rather than focussing entirely on the conduct of the angry person.

Clinical Implications of Anger and Its Management

The material gathered here suggests several facets needed in approaches by helpers to angry people in this kind of setting. The first and overwhelmingly most important implication of the data is the need for sensitivity in dealing with a person who considers him/herself to occupy a powerless position. Most angry episodes can be attributed to perceived helplessness in some way: being ordered around, kept waiting, losing control over possessions or use of personal space, and so forth. No conclusive evidence is available, but it is reasonable to speculate that the degree of sensitivity shown by staff is a major factor in arousing anger and in determining its subsequent course.

Solid evidence on the utility of specific clinical interventions is available. The most effective approaches involved helping the angry person get distance from the anger situation, physically and psychologically. This strategy worked in a large proportion of the incidents, even when the expression of anger had reached a high pitch.

This need for distance and defusing may account for the low success rate of counselling approaches to angry people. "Counselling" encompasses a wide range of staff activities, but focussing on the angry events and emotions is central to all of them. The data clearly demonstrate that this kind of focus is not helpful during the heat of anger.

This is an issue of timing: counselling efforts after a "cooling down" period appear to be heard better, and are not experienced as provocative.

Footnotes

[1]See for example the Springfield Union's expose on conditions at Belchertown State School, which ran from March 1 through March 8, 1970.

[2]"Batch living" as the name implies refers to herd execution of routines of daily living. Implicit in this phenomenon is the requirement of rigid conformity.

[3]In spite of the fact that aggression is by most definitions observable behavior, it has proved a conceptually difficult area of study. This is partly because the notion of aggression is heavily value-laden. Generally defining a behavior as aggressive does not simply describe its qualities, but implies the illegitimacy of the action (see for example, Feshbach, 1971, who comments on the differences in ascription of the label "aggression" to the following activities, a comment which is focussed on the relatively delimited notion of violent aggression:

> It includes the physical abuse of a child by a parent, the injury to property and person inherent in so many criminal acts, the eruption of rage and destructiveness in a previously conforming adolescent. To these we may also add the violence exerted by the state, at home, in its efforts to maintain conformity to the rule of law, and abroad, in its efforts to pursue its national interest. Further instances of violence are the destruction of property and manifestations of abusiveness by some college student radicals, the more subtle forms of aggression through which men of one color manage to humiliate and degrade men of another color, and, at another level, the violent fantasies sometimes expressed in dreams and in drama.
>
> It is evident that the range of behaviors subsumed under the category of aggression and violence encompasses actions that differ in their dynamics and morality (p. 281).)

Most theories of aggression discriminate between angry aggression and instrumentally aggressive acts in which the aggressor is attempting to get something he or she wants with force. This paper addresses only the former grouping. "Aggression" will be used here to refer to forms of angry expression which involve physical attack on others. Throwing or breaking things, or strong verbal attack are not included in this definition, but are considered separately as "destructive" behavior. The tag "aggressive" is not used because it is a pure construct or because it has extensive explanatory power, but as a means of separating out a clinically very important set of behaviors. It is vital clinically to distinguish words from acts, which is why verbal expressions are treated separately in spite of both having an "aggressive" quality in the broad sense of the word.

The question, "How do you know if someone is angry?" is relatively clear-cut. People identify the emotion in themselves and others fairly reliably (see Gates, 1926 and Hamburg et al., 1958). The emotion is accompanied by reliable physiological changes and characteristic modes of activity (Hall, 1898-99; Hamburg et al., 1958; Russell & Mehrabian, 1974).

The question, "How do you know when someone is being aggressive?" is much less meaningful. Among dependent measures of "aggression" used in the literature, as reviewed by Tedeschi and Smith (1974), are: delivering an electric shock to another person, as a teaching tool; choosing to play with one toy rather than another; retention of aggressive content presented in a film; negative evaluations of others of one sort or another, giving TAT responses which are judged to be hostile or ag-

gressive; and tardiness to school. It is difficult to believe that there would be a single functional utility to these assorted behaviors.

In short, the concept of aggression has troublesome excess meaning. It is used here for its everyday communicational value, with the definition limited as above.

[4]For a critical discussion of the frustration-aggression hypothesis see Sargent (1948).

[5]The defensive nature of anger is supported by a correlation between fear and anger responses reported by Anastasi (1948). John Dollard made a similar point when he noted that "aggressive responses are apparently powerfully motivated by fear" (1938, p. 18). Similarly Raymond Novaco in "The Functions and Regulation of the Arousal of Anger" (1976) indicates that "the arousal of anxiety is at times undoubtedly associated with the arousal of anger. Fear stimuli elicit anger as a defense" (p. 1124).

No one questions that fear and anxiety are aversive states. Anger, however, can successfully externalize difficulties, and this makes it sufficiently gratifying to present treatment problems for clinical approaches to chronic anger.

[6]McKellar's subjects experienced but did not express anger in 56% of the episodes. In his introspective study he expressed anger to the offending person about half the time. Gates' data did not permit a clear assessment of the frequency of unexpressed anger.

[7]Impulses of this intensity were reported for more than one-third of Gates' incidents. Since in this study subjects reported instances of anger occurring in a single week, it appears that aggressive fantasies

are a frequent part of experiencing anger.

[8]Angry persons verbally confronted provokers in 41% of Gates' data and in 28% of McKellar's.

[9]When aggressed against, people reciprocate the amount of harm done. They also calibrate the frequency (Helm, Bonoma, & Tedeschi, 1972). In an interesting study, Kane found that nonprofessionals do not even define reciprocated harm-doing as aggressive (Kane, 1973).

[10]This point is made without implying agreement with the concept of displacement as developed in the context of the frustration-aggression hypothesis. According to this theory, if anger cannot be expressed to the provoker, it will be expressed to persons sharing similar qualities, with parameters set by guilt, fear and anxiety. For a critique of the notion of displacement, see Bindra (1959).

[11]See, for example, Cohen (1955) and Graham, Charway, Honig, and Weltz (1951).

[12]See, for example, Redl (1951).

[13]See, for example, Briggs (1975), Loggan (1943), and Hallowell (1943).

[14]See Goldfrank (1943). Goldfrank points out that the pattern among the Teton was intense and highly rewarded out-group aggression, combined with amicable in-group relations. When these Indians were defeated by the white man, this culturally sanctioned system could no longer function, and in-group hostility increased. When there were later opportunities for warfare, the original pattern reemerged.

[15]Zigler and Balla (1977) found that the "effects of institutions are extremely complex, depending on the individuals preinstitutional

life experience and the particular institution under consideration" (p. 4).

[16]For a detailed description of the institution as a physical environment, see Knight, Weitzer, and Zimring (1978).

[17]An expose of conditions at Belchertown during that period was published in the Springfield Republican, in consecutive articles which ran from March 1 to March 8, 1970.

[18]The effectiveness of modelling in teaching patterns of aggressive behavior, at least, has been amply documented (see for example Bandura, Ross, & Ross, 1961). Presumably people also take their cue in expressing anger, as distinct from aggression, from the conduct of important people around them.

[19]I presented the proposed study to the staff in small groups. I would say in the course of the presentation that I was interested in studying angry exchanges and arguments. In each group there was joking as to whether client or staff anger would be the focus of study.

[20]Beier summarizes the issues involved here:

> It is generally agreed that mental retardates as a group have a higher incidence of behaviour disorders than is found in the general population. This association between retardation and behavioural disorders has been of continuing and increasing interest and their coexistence in the same individuals raises several basic questions regarding this relationship. The major hypotheses regarding this association are as follows: (1) Behavioural disturbances occur among the mentally retarded for the same reasons that they occur in persons of normal intelligence. (2) Both behavioural disturbance and mental retardation are the results of basic pathological states of dysfunctions of an anatomical, neurological, endocrinological, or biochemical nature. (3) The mentally retarded, because of their deficiencies and their inadequacies, are subject to more stresses, frustrations, and conflicts, and are consequently more liable to develop behavioural disorders. (4) Many cases

> are labelled "mentally retarded" though they are primarily emotionally disturbed, and the intellectual deficiencies are essentially the result of such disturbances. (5) The mentally retarded, because of their maturational lag, are slower to incorporate notions of right and wrong into personal value systems and are deficient in internal controls (in Parashan, 1976, p. 110-111).

[21]In this line of reasoning we are invoking incidents that did not happen as evidence that what looks like uncontrolled behavior is actually lawful.

[22]The lack of injuries may be related to the fact that the population is high functioning, by institutional standards. Serious aggressive episodes are more common in severely and profoundly retarded populations (Ross, 1972).

[23]To get data on the reliability of these categories, it would be necessary to have:

1. direct observation of incidents by the collector; or
2. two interviewers.

This was not available in the present study.

[24]Time-out was also found to be an effective intervention by Hamilton, Stephens and Allen (1967) in a study of severely retarded institutionalized women. Their interpretation that it is the punitive quality of time-out that alters behavior is brought into question by the finding in the present study that non-punitive forms of "defusing" also have a constructive effect.

[25]Strong "territorial imperatives" have been noted in the mental retardation literature for other groups of institutionalized retarded (see for example Paluck & Esser, 1971). Presumably this strong defense

of turf is related to the nature of the institutional environment. This supposition is greatly strengthened by the ELEMR Project results, which emphasize the importance of control over environment (see Knight, Weitzer, & Zimring, 1978).

APPENDIX A

Data Collection Sheet

Incident # _____

Staff Reporting_____

Other staff involved_____

Resident(s) involved_____

Time of incident_____

Location_____

Incident_____

_____

_____

_____

_____

_____

_____

_____

_____

Other residents present_____

Quality of atmosphere before incident_____

_____

_____

How was incident handled_____

_____

Effect of intervention

Resident's mood before incident

After incident

What set _____ off

Staff's view of incident

Resident's view of incident

Further flare-ups of residents involved:

refer to Incident #_____

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