ANGER MANAGEMENT FOR ALABAMA PHYSICIANS

Dr. Tickoff is going through an acrimonious divorce and has an estranged relationship with his children. On rounds this morning, he lost his temper, sarcastically cursed a floor nurse, and was pompous and degrading in his behavior toward a patient's son. His behavior was not out of character. It was only more extreme in quality than usual, as his “ticked off” ways are well known around the hospital. No doubt, this behavior was acutely exacerbated by the circumstances of his pending divorce.

Assessment of his own thought process would reveal that he privately reflects and justifies his behavior in such situations by maxims such as, “one has to be tough-minded and knock some heads sometimes to get things done right.” This time he crossed a threshold and his behavior resulted in a formal complaint to the hospital executive committee.

The committee meets, reviews the complaint, and determines that while he may have been technically correct in his dispute with the nurse and the family member, he was all wrong in the way he handled the matter. They decide to refer the physician to the Alabama Physician Health Program (APHP), the confidential advocacy arm of the state medical association. The goals of the program include the (1) early identification, (2) intervention, (3) rehabilitation, and (4) monitoring of physicians with health problems to prevent impairment and improve patient care, and advocacy for the doctor when needed (assuming compliance with the goals of treatment). Additionally, (5) consultation services are provided by APHP to the Alabama Board of Medical Examiners (BME). The APHP recommends referral to a local psychologist who regularly receives similar referrals for evaluation and treatment. Importantly, evaluation should include a thorough physical examination to rule out organic problems, psychological testing, cognitive assessment, and addiction assessment as needed.

Concern over verbal outbursts and disruptive behavior of physicians has become a major focus of groups that monitor the behavior of professionals, such as the APHP. The relative maturity of such a program can be gauged by looking at the various points of service for intervention. The initial area of concern for such a group is typically on alcohol and drug abuse, followed by other Axis I psychiatric disorders (such as depression, bipolar disorder, and others), followed by a targeting of sexual misconduct cases, and culminating with a focus on management of anger and disruptive interpersonal behavior. Alabama’s program is currently providing information and referral for treatment to a number of physicians in this area.

As shown in the graph below, the total number of new physicians referred to APHP increased from 34 in 1991 to 1,234 by December 31, 2001. These physicians are referred for a variety of problems. The initial behavior reported is shown in the chart on the next page. Many of the 208 physicians referred with “disruptive behavior” exhibited inappropriate anger behavior as a primary concern.

![APHP Cumulative Totals Graph]

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<tbody>
<tr>
<td>Referrals</td>
<td>34</td>
<td>288</td>
<td>450</td>
<td>632</td>
<td>735</td>
<td>840</td>
<td>934</td>
<td>995</td>
<td>1064</td>
<td>1144</td>
<td>1234</td>
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During 2001, 255 physicians of the total of approximately 13,000 licensed physicians in Alabama were referred to APHP. The medical director investigates all referrals. Some referrals are inappropriate for the APHP and are referred to the BME, some require no action, and others reveal insufficient information to recommend further evaluation and are placed in long-term observation. All physician files are confidential.

Evaluation, referral, and monitoring of physicians with disruptive behavior is a very time-consuming process. It is estimated that although referrals in this category account for 13% of the total, they probably occupy at least half the time of staff and other resources of the program.

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<tr>
<th>Initial Behavior Reported to APHP</th>
<th>1991-2001</th>
<th>2001</th>
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<tbody>
<tr>
<td>Chemical Abuse/Dependence</td>
<td>780 (50%)</td>
<td>156 (61%)</td>
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<tr>
<td>Disruptive Behavior</td>
<td>208 (13%)</td>
<td>32 (13%)</td>
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<tr>
<td>Quality Care Issues</td>
<td>124 (8%)</td>
<td>18 (7%)</td>
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<tr>
<td>Psychiatric/Psychological</td>
<td>190 (12%)</td>
<td>32 (13%)</td>
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<tr>
<td>BME Licensure Application</td>
<td>134 (9%)</td>
<td>11 (4%)</td>
</tr>
<tr>
<td>Sexual Misconduct</td>
<td>96 (6%)</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>24 (2%)</td>
<td>2 (1%)</td>
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Anger and violence are major societal concerns due to manifestations ranging from verbal insults to road rage, stranger assaults and domestic assaults. Anger has enormous costs. The impulse that felt so right at the time later becomes a tremendous source of regret. Too often, the only way to get the attention of the raging professional is to threaten staff membership or licensure. In other words, it takes a major financial and/or ego consequence to bring about genuine behavior change in this area.

High levels of anger have long been associated with a host of interpersonal problems, health problems, and psychological distress syndromes. Those who are chronically angry tend to relate to others in intimidating and abrasive ways, and, as a result, tend to more frequently experience anger-related consequences, these may include physical damage to self, others, or property; disrupted and terminated relationships; legal problems; lowered self-esteem, shame, regret, depression, and inner turmoil. High levels of enduring and pervasive anger (trait anger) have also been associated with significant health problems, including alcoholism and cardiovascular diseases (essential hypertension and coronary artery disease.)

In the last 2 decades “anger-management” has consistently begun to appear in professional literature. The treatment mode investigated almost exclusively has been cognitive behavior modification.

Cognitive behavior modification (CBM) is a practical treatment approach based on social learning theory, an approach that utilizes skill acquisition as the primary focus of therapy. This is a distinctly different approach from psychoanalytic therapy, which previously was the dominant theory in most psychiatric/psychologic training programs. The focus of psychoanalytic treatment was typically on resolving intrapsychic distress, thought to often date back to childhood and family-of-origin dynamics. CBM is based in the present and focuses on education and the acquisition of a set of anger management skills as the primary goal of treatment. This approach has been demonstrated to produce consistent, empirically reliable, and practical results.

Treatment protocols have focused on teaching patients to correctly identify their feelings (e.g., frustration versus anger and fear), decrease physiological arousal levels, decrease emotional arousal levels, correct
cognitive distortion, relabel and reframe anger-engendering thoughts, and to learn new assertive social skills that do not infringe on the rights of others. The theoretical basis of this set of intervention strategies is that the participant needs to acquire a new set of management skills rather than resolve inner conflict over childhood issues.

Self-monitoring of one’s emotional state and related thought patterns is the hallmark of CBM. A basic tenet of this approach is that one has to become aware of thoughts and feelings before attempting to change. To this end, a distress barometer is needed. Participants are taught to identify antecedent conditions, related thoughts, and subsequent feelings using a Subjective Units of Disturbance Scale, which is based upon the imagery model of a large thermometer with 0 as “no measurable irritation” and 100 as “homicidal rage.” Patients are then taught to monitor and rate their own responses by assigning a numerical rating that can be then used to assess progress.

Ministers remind us that “hurting people hurt others.” One goal of anger management therapy is to teach about empathy for self and others. Learning the sources of one’s own anger can also help one to understand the sources and context of the anger of others. Even though people act brazenly confident and obnoxiously self-centered when they are raging, their anger is often a complex cover for low self-esteem, negative self-evaluation, and even self-loathing. Thus, if the dictum “hurting people hurt others” is true, learning the dynamics and history of that response style can be an important therapeutic endeavor. More importantly, teaching a self-centered, possibly narcissistic person to truly see a situation empathetically from the eyes of another person is a major therapeutic accomplishment and indicates that the learner is well on the path to increased control.

The alternative to anger expression is not passivity or withdrawal. Rather, the concept of assertiveness embodies the healthiest option available as a choice that actually does more than any other choice to empower the individual. Assertiveness is defined as communication that protects the rights of the individual without treading on the rights of the other person. This type of interaction seeks the goals of the individual without being degrading or unfair in any way. Assertive people are typically described as firm, direct, but calm and fair in their dealings with others. In assertive communication, the individual can verbally acknowledge anger, then calmly express what is wanted from the other party. This type of statement can be said as:

“I feel angry because__________. I want you to ____________.”

The key ingredients are to use “I” statements, calmly express why you are angry and what you want done about it, and avoid name-calling, put-downs, or degrading statements.

The following diagram is often useful in analyzing anger-provoking situations:

A. EXTERNAL SITUATION (Rejection or Put-down)
B. COGNITION (Self-Statements, Thoughts)
C. FEELINGS (Anger, Irritation, Sadness)
D. BEHAVIOR (Acts of Verbal or Physical Aggression)

A simple ABCD diagram is a useful tool that can be quickly used to help a person in the process of situational anger analysis.

Chronically angry people often act as if the B component of this diagram does not exist. For example, Dr. Tickoff finds that his exam room is not properly ready and organized for the next patient. He assumes
that his initial reaction of rage is solely caused by the external situation, without stopping to realize and make the causal connection between the external event (A), his catastrophizing and self-depreciating thought process (B), and his resulting feelings (C) of angry rage, which leads to his verbal abuse (D) of his assistant.

Keeping an anger/situational journal that utilizes such an analysis is the seal of a successful treatment program. Once the person begins to make the connection between events, self-talk, and resulting feelings, the process of analysis tends to be self-perpetuating and takes on a life of its own. Physicians often find the logic of the system appealing and intellectually challenging.

Eckhardt, Barbour, and Davison (1998) compared the actual thought processes of violence and nonviolence during anger arousal. Their results revealed that the men who had a history of marital violence engaged in a unique style of thinking. The men evidenced a pattern of cognitive distortion, irrational beliefs, and dichotomous “all or none” thinking. Their thought patterns tended to magnify the importance of difficult situations and actively misconstrue or otherwise distort interactive situations in ways that more often result in violence.

A standard treatment package would include the following components:

I. Complete history and physical, as well as appropriate lab work in order to rule out metabolic or any other possible pathophysiological explanations for poor anger control (e.g., “Twinkie” defense).
II. Complete psychosocial history, mental status exam, and psychological testing to rule out the co-morbidity of other psychological problems.
III. Learn self-monitoring and begin to keep a log/journal of situational triggers (external events or situations) with regard to frequency, intensity, and verbatim records of the actual thoughts (internal responses).
IV. Design a personalized anger provocation hierarchy based on the results of the self-monitoring work done in III.
V. Training in Progressive or Cue-Controlled Relaxation to increase sense of self-control and to decrease physiological arousal.
VI. Cognitive Restructuring – Use of Reframing and modification of expectations, appraisals, and use of alternative self-instructions to modify the focus of attention and resulting thoughts and feelings.
VII. Training in assertiveness and behavioral coping strategies to increase communication skills.
VIII. Practice new anger coping strategies through visualization or actual role-playing of progressively intense anger arousing scenes from the personal anger hierarchy.
IX. Practice new anger coping strategies with real-life situations and record scenarios in anger log.
X. Continue to work through different daily and weekly anger experiences through individual and group therapy experiences.
XI. Use of aerobic exercise to buffer effects of stress and to defuse anger.
XII. Use of serotonin agents such as Sertaline (Zoloft) or Fluoxetine (Prozac) to quell inner rage and to promote easier “letting go” of angry ruminations.

To accomplish many of these goals, a weeklong workshop at the University of Alabama at Birmingham, which awards 34 hours of Category I CME credit, has been developed for physicians.
with disruptive behavior. The workshop, titled “The Physician Enrichment Workshop,” has been very well received, and long-term outcome studies are planned.

The objectives of the workshop include:

1. Promote physician behavior change by combining didactic instruction, personal examination and problem solving.
2. Understanding stress and its effects on physician behavior.
4. Understanding healthy and appropriate boundaries among staff, colleagues and patients.
5. Identify family of origin issues that contribute to unwanted behavior.
6. Communication skills – understanding relationships.
7. Become aware of the concept of “emotional intelligence” and cognitive behavioral modification.
8. Understanding of anger and its consequences.

One to two hour-long sessions during the week include:

**Understanding Group:** Johari’s Window, Feelings Chart.

**Communication:** Participants learn about problems and solutions in communications, define concepts, styles of communication/listening, pairs of participants will practice reflective listening, examples of reflective listening.

**Physician Psychology:** Psychological dynamics of the physician.

**Family of Origin Impact:** Family roles: implications for health professionals with a description of the roles of hero, lost child, scapegoat, and mascot. This will include identification of strengths and growing edges for the health care professional.

**The Nature of Abuse:** An overview of physical, emotional, religious/spiritual, and sexual abuse.

**Experimental Structures:** Group participants will be led through role plays/structures to highlight the dynamics of systems (organizational and familial).

**Anger:** Lecture and discussion about the nature of anger. This will include examining self-destructive patterns. Group Exercise: Participants will investigate personal attitudes about anger, identify triggers and solutions.

**Chemical Addiction and Behavioral:** the cycle of addiction.

**Behavioral Addiction:** Sex, Eating and Gambling

**Burnout:** Symptoms

**Balance:** the art of managing the unmanageable, exercise in understanding personal balance.

**Personality:** Conflict or Concede, Myers Briggs

**Sexual/Emotional Health:** A lecture identifying appropriate and inappropriate sexual boundaries, and the importance of maintaining healthy professional boundaries.

**Depression:** Review results of Becks Inventory.

**Trauma and Grieving:** Physician heal thyself? A description of trauma and grieving and caregivers caring for themselves.

**Emotional Intelligence:** Understanding and identifying emotions, cognitive behavioral techniques and assignments.

**Courage to Change:** 12 Step process: a formula for change.

**Spirituality:** A Look at a Spiritual Balance.

**Final Planning Session:** Implementation – A personal plan to accomplish goals.

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In the workshop setting, with a maximum of 10 participants utilizing group therapy, physicians with histories of disruptive behavior seem to make much progress in a short period of time, assisted by peer modeling and peer pressure to address relevant issues. Each attendee is assigned a staff person who develops a report regarding their attendance and participation at the workshop and recommendations. This information is communicated to the attendee during and at the conclusion of the week.

Physicians are sometimes taught in residency training that being aggressively conscientious about patient care is the only way to guarantee high levels of compliance with high standards of patient care. The problem with this approach is that current standards do not allow the physician the leeway or luxury of verbal assaults on others, regardless of the situation involved. Instead of modeling aggressive behavior, training programs need to focus on teaching appropriate assertive communication techniques. In this way, residency program directors can combine insistence on high levels of patient care with teaching firm but respectful patterns of interacting with nursing staff and other allied health care professionals. This approach will guarantee healthy patterns of communication and decrease the likelihood of dealing with licensure boards or hospital executive committees.

References