Beyond the Angry Child:

Anger Modes—Conceptualization and Treatment

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Abstract

On a practical level, when anger emerges in the treatment room, whether or not directed at the therapist, it can often activate a therapist's schemas, compromise the healthy adult mode, and lead to maladaptive responses. On a theoretical level, recent developments of the mode model in Schema Therapy have elaborated the range and types of anger modes. This paper proposes to elaborate on the mode model as it relates to anger by linking accepted and proposed anger modes across a spectrum of coping responses. Strategies for discerning and confronting the angry/enraged child, the bullying adolescent, the defiantly detached protector, the critical, and aggressive overcompensating modes will offer effective ways to bypass and weaken them. Case vignettes will vividly illustrate these modes while proposing and detailing the specific treatment strategies for each one.

Beyond the Angry Child: Anger Modes—Conceptualization and Treatment

On a practical level, when anger emerges in the treatment room, whether or not directed at us, important emotional messages may get lost in the delivery. Anger can often activate a therapist's schemas and compromise healthy adult responses in the treatment room. The triggering of the therapist's maladaptive responses can lead to stifling the patient's anger too quickly or punitively, subjugating the therapist to the patient's abuse, colluding with a patient's reminiscent early experiences of being ignored or forbidden to express anger, and perpetuating issues of entitlement or insufficient self-control. While not uncommon for clinicians, when faced with a patient's anger, to become overwhelmed with fear, fury, or humiliation, opportunities to effectively confront avoidance, set limits, and to meet the unmet needs – necessary for schema healing – may become thwarted.

On a theoretical level, the mode model in Schema Therapy originally postulates the "angry child" as the child mode in which anger is experienced and expressed (Young, Klosko, & Weishaar, 2006). Recent developments of the mode model have elaborated on the range and types of anger modes, including "the enraged child," the "obstinate child," the "angry protector" - as an avoidant mode type - the overcompensating mode types such as the Bully and Attack mode (Arntz & Jacob, 2013), as well as the anger that is launched at self or others from Critical or Demanding Parent modes. However, in refining an understanding of anger from a mode perspective, a level of complexity can often arise such that labeling and treating such behavior "may be problematic" (Arntz & Jacob, 2013).

This paper proposes to expand the mode model as it relates to anger by linking accepted and proposed anger modes across a spectrum of coping modes in the model, which has been perhaps most comprehensively depicted by Eckhard Roediger's "Mode Map" (2011). Once an

understanding of the anger mode continuum is outlined, we will then go on to offer strategies for identification and differentiation, and for effectively addressing, bypassing and weakening these modes, including how to:

- "Listen" for and recognize the signs of an angry bully, resentful adult, or childlike victim to identify how/when to (a) allow for ventilation, (b) empathically confront, or (c) set limits.
- Enhance an attuned awareness to physical cues indicating *childlike* vulnerability and schema activation; ameliorating painful triggers prior to and during early saturation phases.
- Effectively and creatively utilize "empathic confrontation" to help patients safely experience and express links to the (narrative) emotional messages imbedded in their anger; replacing self-defeating angry reactions with healthy and adaptive responses.

Finally, case vignettes will vividly illustrate these modes while proposing and detailing specific treatment strategies.

A Proliferation of Anger Modes

Young, et al. (2006) describe the Angry Child mode as follows:

> The Angry Child has become enraged. Virtually all young children become angry at some point when their core needs are not being met. Although the parent might punish the child or otherwise squelch the response, rage is a normal reaction for a young child in this predicament. Patients in Angry Child mode vent anger directly in response to perceived unmet needs or unfair treatment related to associated schemas, including Abandonment, Mistrust/Abuse, Emotional Deprivation, and Subjugation, among others. When a schema is triggered and the patient feels abandoned, abused, deprived, or

> subjugated, the patient becomes furious and might yell, lash out verbally, or have violent fantasies and impulses (p. 274).

In contrast with the other modes described by Young, et al. (2006), the Angry Child deals exclusively with anger and how it is generated in response to schemas, and in response to the activation of the Vulnerable Child modes. Other modes associated with anger, beyond the *naturally occurring states* that we find in the Angry Child Mode, would include: Overcompensating Modes—where bullying or aggression and hostility may be presented. This is also the case for the Punitive Parent mode and the Defiantly Detached Protector Mode, for example, which can "angrily punish, criticize, or restrict the child for expressing needs or mistakes" (Young et al., 2006). In these states, anger is used to *invalidate* core (Child mode) feelings as opposed to connecting with underlying negative feelings and ventilating anger. In the case of coping modes (e.g., the overcompensating Bully and Attack mode), anger is used to not feel underlying feelings or self-judgments. In the case of the Punitive Parent mode, when it is active, a patient experiences anger and criticism via internal messages and impressions from childhood interactions with parents and/or other authority figures, but does not actually feel anger as the primary emotion, instead he or she perceives self-judgments and feels fear, shame, guilt, feelings of depression, hopelessness, etc.

Since this initial conceptualization, anger modes have been expanded upon. For instance, the Angry Child mode has been refined into three distinct modes in Arntz and Jacob (2013): the Angry Child, Obstinate Child, and Enraged Child. One way of understanding the relationship between these modes is by the degree to which anger is manifested. The Obstinate Child mode, which is a "subform of the Angry Child," (Arntz & Jacob, 2013, p. 43) experiences anger but does not express it. The Angry Child mode experiences *and* expresses anger, and the Enraged

Child mode experiences "intense feelings of rage that result in uncontrolled aggression" (Arntz & Jacob, 2013, p. 43). In other words, this grouping tends to suggest a spectrum of internal experiencing of anger (from milder to more intense forms) and from less expressive to more direct and obviously destructive behaviors. The Obstinate Child mode may be seen as a precursor to more calculated anger modes as we describe them below, especially since there is a behavioral perception of "stubbornness and pigheadedness" (Arntz & Jacob, 2013, p. 43).

Arntz and Jacob (2013) go on to describe another anger mode categorized under "Avoidance" as the "Angry Protector," which they define as:

> Using a 'wall of anger' to protect oneself from others who are perceived as threatening and to keep others at a safe distance through displays of irritation or anger. Some people with this mode mainly vocalize and display complaints in order to put a distance between themselves and others (p. 45).

The anger here is described as a "secondary, not a primary emotion" (Arntz & Jacob, 2013, p. 61). It is used as a coping behavior in which the therapist tends to feel "attacked and dominated," but doesn't really feel "close interpersonal contact" from the patient when he or she is in this mode (Arntz & Jacob, 2013, p. 61). This applies to the Bully and Attack mode as well, whereby the patient uses "threats, aggression and intimidation to get something they want, or to protect themselves from some real or perceived threat (Arntz & Jacob, 2013, p. 46). The *motivating driver* behind each of these modes is different. The Angry Protector mode primarily keeps others at a distance[i], while the Bully and Attack mode primarily attempts to control and dominate others, even if motivated by a need for protection against rejection, shame, or defectiveness, as in the case of a narcissist.

Arntz and Jacob (2013) caution that it is not always easy to discern the self-defeating behavior of a patient in an angry mode (i.e., Angry Child modes, Angry Protector, or Bully and Attack) because they may become merged or conjointly activated. For example, “the Bully and Attack mode is often triggered when patients are angry because their needs have not been met" (Artnz & Jacob, 2013, p. 60). The authors go on to say that often the way the therapist is able to understand the behavior he or she experiences is by the "countertransference position" (p. 61) of the therapist in terms of connecting with real anger or feelings such as fear, indicating the presence of coping modes (in the patient) (Artnz & Jacob, 2013). In other words, a patient may feel deprived, for example, and angry, as a result (Angry Child mode), but he or she exhibits a coping behavior and behaves in an attacking way, which can make the therapist's initial reflexive thoughts, feelings and behaviors more reactive than receptive to what feels like the calculated nature (i.e., Bully and Attack mode) of the patient's actions.

The authors stress that treatment implications for these overcompensating anger modes is essentially the same, and "it is better to define the mode as a mix of both," (Artnz & Jacob, 2013, p. 61). We propose in this paper that it may not always be the best to take such an approach. Support for this is found in Farrell and Shaw (2012) in which the authors point out the importance of varying treatment strategy based on whether a patient is *exhibiting* Angry Protector or Bully and Attack modes. Treating Angry Protector behaviors requires empathic confrontation, in which early maladaptive schemas and self-defeating behaviors are linked, but that such coping behavior is also understood as limiting the extent to which a patient can get his or her needs met. Bully and Attack mode requires a limit setting approach that emphasizes therapist and patient (or depending on the therapy modality, group member) safety. We argue that a more systematic understanding of anger and a context within which such anger modes can be embedded will help

differentiate between the anger modes that show up in treatment, allowing improved opportunities for effective treatment and schema healing.

In her upcoming book on *Empathic Confrontation* (Behary, in press), Behary further expands on the spectrum of modes associated with anger. What initially started out as a relatively broad understanding of anger modes has been differentiated into the following anger-related stances, as shown in Table 1:

Table 1

Anger-Related Stances

• Angry Child	• Enraged Child
• Cynic	• Bully
• Defiant Protector	• Contemptuous
• Flash-fire Organic	• Blamer
• Controller	• Aggressor
• Demanding	• Punishing
• Humiliating	• Self-Righteous

The following section looks at the profusion of anger modes as they are being identified in the treatment room and places them in a context of understanding to aid in responding to these modes in an effective therapeutic way. The lack of a systematic understanding of anger and differing anger modes - particularly at the coping level - has important implications for treatment.

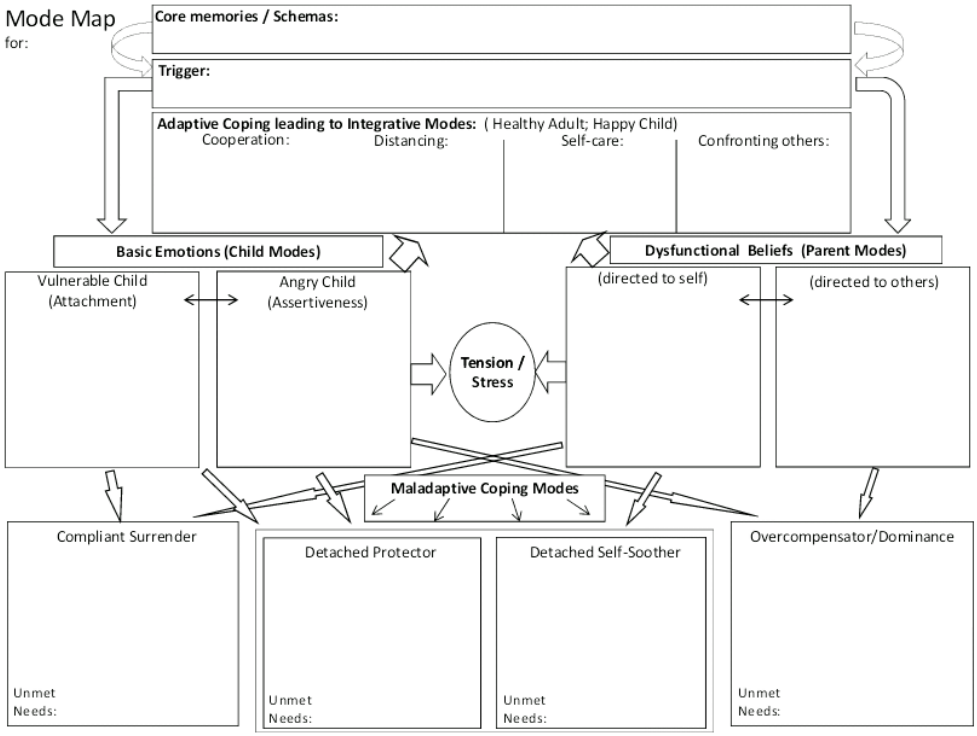
The Mode Map and a Systematic Description of Anger Modes

If we view anger via the lens of the Mode Map (Roediger, 2011, see Figure 1.0), we start to get a clearer picture of anger in its various forms and how it relates to patient behavior. If we start with the Child Modes, we see that anger as reflected by the Angry Child mode is a primary emotion perceived by someone in this mode and a means of asserting control or influence over one's environment (Roediger, October 2013). Anger is a means of calling attention to needs; e.g.,

to be paid attention to, to be treated fairly, and to have basic needs such as physical comfort and nourishment addressed.

We suggest that it also refers to the underlying attachment system and the frustration linked with a child who is unable to get their fundamental emotional needs met like, holding, affection, empathy, praise, and support.

Figure 1: The Mode Map



When we look at Coping modes as they relate to anger, a refined understanding emerges of how anger manifests itself in our patients (beyond the direct expression of the Angry Child mode) and the way in which Child and Parent Modes act to modify the expression and function of anger as it relates to feelings and behaviors in our patients. We propose linking each Coping mode with a type of anger mode as follows:

Table 2

Linking Coping Modes with Anger Modes

Coping Mode	**Corresponding Anger**
• Compliant Surrenderer	• Impulsive/Explosive Anger
• Detached Protector	• Angry Protector
• Overcompensator / Self Soother	• Entitled/Self-Righteous Anger
• Overcompensator/Dominance	• Bully and Attack Mode • Mistrustful/ Over-Controller

Each of the corresponding Anger Modes has been identified in clinical observations, as the following sub-sections describe.

The Impulsive/Explosive Anger

This mode occurs in patients when a Compliant/Surrenderer mode predominates in dealing with life experiences. Because these patients tend to suppress needs and emotions, including the need to assert themselves (frustration and angry feelings), and may have underlying Insufficient Self-Control/Self-Discipline, Self-Sacrifice, and Subjugation schemas their anger tends to "erupt" and come out intermittently in an impulsive and/or explosive way (Young et al., 2006, p. 242). The expression of their anger is most closely aligned with an Angry or Enraged Child mode. Their outbursts lack the premeditated quality of the other anger modes. Of course, such intermittent outbursts can wreak havoc on relationships in these patients' lives and they may be largely unaware of the processes—at least when they begin therapy—that contribute to such periodic and destructive outbursts that compromise their needs for connection and recognition to be adequately met. It is a rather crude and primitive outpouring of anger that is received with startling power precisely because it is unexpected (given the predominant coping behavior of complying and/or surrendering to one's emotional environment) and highly intense in expression.

The person behaving in this mode rarely gets in touch with his or her need to assert themselves; only when it is unbearable and cannot be held back any longer.

The Angry Protector

This mode is placed within the Mode Map as the corresponding Anger mode to the Detached Protector—a Coping mode that focuses on avoiding and disconnecting from painful emotions. As we move across the spectrum of coping modes, we propose a formulation of angry and defiant protection as a behavior with a strategic function, as differentiated from the natural tendencies formed in the Angry Child mode. The Angry Protector acts as a "wall" (Arntz and Jacob, 2013, p. 45) to prevent the emergence of intolerable emotional experiences. Those who witness such a mode may sense fear or insecurity underlying such manifestations of anger, by way of their own countertransference (Arntz and Jacob, 2013, p. 61). This differs from the Impulsive/Explosive Anger mode, where expression of anger might—depending on the therapist's capacity to avoid their own (distracting) schema activation—elicit sympathy and compassion for the thwarted needs of the patient. It is a brittle form of anger in which the patient desperately guards against having his or her feelings and needs known because of how frightening he or she (without explicit awareness) expects it will be; including fear of shame, emptiness, rejection, devastating sadness, terror, or loneliness.

Entitled/Self-Righteous Anger

This mode has less to do with the “rawness” of directly expressed anger (Behary, in press), in fact it often carries a more passive-aggressive flavor, behaviorally speaking. But patients who exhibit the Detached Self-Soothing mode may often be governed by their Entitlement, authorizing them to engage in self-soothing behaviors (linked to underlying emotional deprivation and loneliness). They may perceive people in their current lives as

depriving replicas of former caregivers. Being in relationship (therapy or personal) with an Entitled/Self-Righteous person can lead to experiences of “offended anger” and resentful reactions. For example, a patient may consistently drink or smoke marijuana; much to the agitation of his partner, and therapist, even though this behavior is really a mask for the unexpressed anger about feeling worthless and unlovable in his partner's eyes. Hence, because he feels his partner rarely responds to his needs, he feels entitled to engage in behavior that will have the “I’ll show you” impact on his partner. Behary (2013) writes about the "deprived-dependent" narcissist who reflects such self-soothing behaviors (and can sometimes flip into "a tyrannical state of meanness" reflecting the anger that covertly operates in connection with this mode) (pp. 20-21). In the literature there is an example of an entitled mode in "Spoiled Annette" (Young, et al., 2006) that points to the Entitled/Self-Righteous Anger Mode. Annette, who is in treatment with a Schema Therapist for approximately six months at the time, meets with Dr. Young. At one point during the session, Annette states "(half-joking) I shouldn't have to do anything I don't want to do, right?" (Young et al., 2006, p. 283). This orientation is a leitmotif that occurs throughout the session with Dr. Young (and is successfully addressed by him). It illustrates an attempt to distract the therapist from the vulnerable inner landscape, and instead express a "spoiled" or entitled mode that is in conflict with her needs for connection and true intimacy. She is ill-prepared to live in the interpersonal world but terrified of disrupting the “constructed” status quo of comfort and “getting her way”. The way the world operates, Dr. Young goes on to explain, includes "reciprocity [in which] the world is set up so that, if you want to get something, you have to give something" (Young et al., 2006, p. 288). This kind of orientation, if not clearly understood by the therapist, can bring up a variety of reactions from impatience to annoyance and dismissiveness, all of which center around an angry reaction toward such entitled behavior. Dr.

Young does an exemplary job of remaining sturdy, and does not become triggered by her efforts to distract and disconnect via the provocation of her modes. Instead, in the role of the “good parent,” he is persistently dedicated to promoting a connection with “Little Annette” and healing her, as shown in the rest of the session transcript (Young et al., 2006, pp. 289-304).

Another variation of this kind of anger mode reflects the "spoiled-dependent" kind of behavior in which self-aggrandizing statements are made that can create a range of anger-related reactions in others who are in this person's life. Behary (2013), again focusing on narcissists, provides examples of such entitled behavior that can elicit varying degrees of irritation or anger in others: “[Such a patient] speaks in long-winded monologues and views himself or herself as an expert on everything who should not be interrupted” (p. 22).

In this example, the person exhibiting an Entitled/Self-Righteous Mode is detached from any appreciation for how his or her "droning on" impacts others, and the frustration/anger others may feel by being treated in a "one-up" or, as if invisible, manner. Essentially someone in this mode does not "own" upsetting and angering feelings but instead does just what he or she wants and is unaware of others’ experiences of distress and anger. For example—consider the patient who continues to get high regularly, and is oblivious to the impact on his partner (e.g., her feelings of abandonment, loneliness, and anger, or fear/resentment about how well he can handle work and family responsibilities). Behind the scenes may be the patient's underlying Emotional Deprivation Schema, a result of absent parents who did not provide, for example, adequate emotional support and limit setting. As a child they may have attempted to express their needs, only to be confronted with a parent who could not respond or provide in an attuned manner. And, although the parent may have had good intentions, they were not fluent in preparing the child to live in a world that is filled with discomfort and joy, give and take.

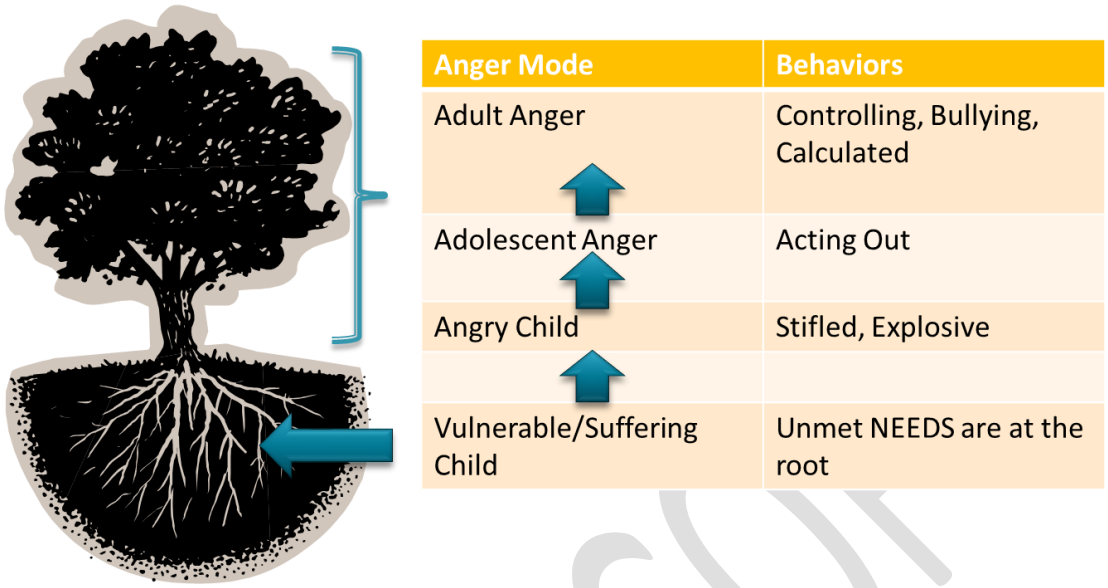
This poor limit setting and praise (only) for high performance can lead to a "green-lighting" of entitled behavior, condoned by the parent (or perhaps ignored), and blatantly problematic in later relationships where such behaviors block emotional connection and reasonably satisfying reciprocity.

The Bully and Attack Anger Mode

The anger modes associated with the Overcompensator Modes include the Bully and Attack mode in which a person uses “threats, aggression, and intimidation to get something they want or to protect themselves from perceived or real harm.” (Arntz and Jacob, 2013, p. 46) This mode can show up on its own or as part of, for example, the mistrustful Overcontroller mode, which seeks to "control others' behavior out of suspicion" and may involve aggressive behaviors (Arntz and Jacob, 2013, p. 46). In this case, anger is used as a means of control and to address underlying feelings of deprivation and defectiveness, which are largely outside of the realm of awareness. Narcissists frequently exhibit this mode when they are in contact with other people. The anger that shows up is instrumentally intended to allow them to feel in control of and perhaps superior to others. Often the countertransference position that others will experience is one in which they feel fearful, intimidated, or threatened. It is the most callous expression of anger across the spectrum of anger modes and points to an underlying Vulnerable Child mode where feelings of fear, loneliness, and shame may predominate.

If we look at Coping Modes as they relate to Anger Modes, we see a spectrum of motivational drivers, from explicit anger and explosive rage to implicit attempts to dominate others. The following figure (Figure 2) summarizes key behavioral factors and how they change across the spectrum of Anger modes in a way that we are calling the “Tree” model, for its obvious developmental parallels:

Figure 2: The "Tree" Model



Addressing Anger Modes in the Treatment Room

With this more robust understanding of anger modes comes the call for how to promote more effective ways for patients to address underlying feelings and needs rather than being trapped in counterproductive coping modes. "Classic" anger management strategies (see Table 3 below) do not really add enough durability to the change phase:

Table 3

"Classic Anger" Management Strategies

• Primal Scream	• Catharsis
• Count the Ten / Time Out	• Exercise
• Keep a Journal	• Avoid Triggers
• Meditation	• Medication
• Rational Approaches - DBT	

By and large these strategies are blunt instruments that don't promote a deep enough understanding of the anger mode a patient is in and the impact it has on him/her and others. Encouraging any one of these approaches without this understanding is a limitation to effective

outcomes: e.g., encouraging exclusive exercises such as physical strength-building may incline a patient prone to bullying outbursts to see this as an even more effective means to control others while keeping his or her shameful, lonely child self securely tucked behind layers of muscle, and thus out of reach from others who can tend to his or her needs!

Because it is crucial to label the anger mode that shows up in the treatment room—one that links the mode to early experience and early maladaptive schemas—we want to begin right away to understand what conditions and interactions activate the anger mode in a patient. Stepping back, we suspect that the average "human"—regardless of whether they are schema-driven or not—are likely to experience some degree of anger, agitation, and frustration, given the conditions presented in Table 4; while those experiencing schema-driven reactions, under these conditions, may flip into longstanding self-defeating reactive patterns:

Table 4:

Common Activating Conditions/Appraisals for Anger Modes

• Betrayed	• Blamed
• Criticized	• Rejected
• Manipulated	• Ignored
• Deprived	• Judged
• Punished	• Stifled
• Controlled	• Misunderstood
• Abused	• Humiliated
• Mocked	• Subjugated
• Threatened	• Charged

This may not be an exhaustive list, but is representative of many of the most common activating conditions and behaviors for anger modes and self-defeating patterns of response. Now let us take a subset of these that apply to the therapeutic relationship, which is illustrated in Table 5:

Table 5

Common Anger Activating Conditions in the Therapy Relationship

• Being Interrupted	• Exposing Vulnerability/Emotions
• Feeling Judged/Pushed by the Therapist	• Feeling Not Special Enough
• Feeling Not Adequately Praised	• Feeling Misunderstood by the Therapist
• Suspicious about Therapist's "Caring"	• Vacation Days / Sick Days / Lateness
• Therapist Appears Bored or Frustrated	• Therapist Seems to Take Sides with Partner

It is an important first step for the therapist to be aware of these triggering conditions. They provide clues to the patient's behavior in the treatment room when a patient manifests a particular reaction, i.e., expresses a particular anger mode. As we will see in the case illustrations, this activating condition intertwines with the patient's schemas and coping modes to create a unique response. However, anticipating or being able to reconstruct activating conditions is a key way for therapists to bypass a "low road" reaction (Siegel, 2003, p. 156) in which the intensity of emotional reaction prevents the possibility of reflection and empathic understanding.

Just as there are activating conditions for the patient, as the above table illustrates, the therapist is also at risk for being activated by the expression of patient anger modes during the session. Patient anger can be an activating condition for reactive versus receptive response patterns in therapists. Table 6 illustrates less than optimal therapist reactions to patient Anger Modes.

Table 6

Therapist Reactions to Anger Modes

Client Anger Mode	**Possible Therapist Feelings * "Counter-transference"**	**Therapist Coping Modes ** **
Explosive Anger	Anger Guilt	Punitive Parent, C/S, DP, DSS
Angry Protector	Fear Anger	C/S, DP, DSS, PP

	Guilt	
Entitled/Vengeful Anger	Anger, Disgust	C/S, PP, Demanding Parent
Bully and Attack	Fear Anger	C/S, DP, DSS, underlying VC PP, Angry Protector, underlying AC
* Defined as Anger, Sadness, Fear, Disgust, Joy, Surprise (per Ekman 2007) and Guilt. Bodily sensations and thoughts are also relevant.		
** C/S = Compliant Surrenderer; DP = Detached Protector; DSS = Detached Self-Soother; VC = Vulnerable Child; PP = Punitive Parent; AC = Angry Child		

It is therefore very important that the therapist focus on maintaining a healthy adult mode in the face of a patient's activated anger mode. This can be accomplished by anticipating patient anger modes based on activating conditions along with the therapist's understanding of the patient's schemas and coping modes that reside in the deeper "story"—a story that the therapist maintains with an empathically "felt" sense. For example, a patient who experienced early emotional deprivation, subjugation, and was forced to inhibit all emotion, constructs a compliant/surrender survival-coping mode. As the therapy relationship becomes a safe place for the stifled (inner) child, the therapist might expect eventual manifestations of anger that range from resentment to the impulsive/explosive anger of the child. To effectively meet the unmet needs of the child, the therapist will welcome and embrace the arrival of this coping mode and allow room for ventilation and empathy, as a corrective emotional reparenting experience. Ultimately the therapist, in a "good parent" mode, guides the patient to develop a more reasonable and sturdy voice for the anger that houses the important underlying emotions and early unmet needs.

But obviously not all anger modes can be anticipated, and nor is it possible for therapists to always maintain a healthy adult mode in the face of such behavior. This is particularly true when you are triggered by behavior that activates your own schemas and coping modes. The following

exercise (see Exercise 1) is offered as tool to allow you to move from a triggered, "low road" state to a more reflective, healthy mode.

Exercise 1: Re-establishing your Healthy Adult Self *

1) Take a few deep breaths, adjust yourself in your chair to a comfortably seated position and close your eyes.
2) See if you can conjure up a place in your mind that feels secure, calming, soothing… safe. Make this image as vivid as possible, taking in the sights, sounds, smells, and sensations in your body. Allow yourself to relax, rest, in this space for a few moments before placing this image in a corner of your mind; where you can return to it whenever you need to.
3) Imagine an encounter with someone from your past who is triggering for you – this works best with a family member from childhood but you can also choose a particularly difficult encounter with a patient. Take a few moments now to re-experience the angry behavior, noting your body sensations, feelings, and thoughts in reaction to this anger.
4) Continuing with your eyes closed, consider how you were affected by this encounter with anger? Can you see the "little you" burrowed beneath this experience, something familiar about this feeling that resonates in the core of you? Perhaps you find the "little you" cowering from a seemingly powerful and scary other, who may also seem threatening and callous? Perhaps it's a feeling of personal rage for a knowing sense of being deprived, abused, or neglected yourself. What schemas are you experiencing, how do you protect yourself as a little one? What mode do you find yourself shifting to?
5) Make the image as vivid as possible and look closely at the face of "little you". What does he/she need?
6) Imagine stepping into this scene as your healthy, adult self. What would you say or do for that little girl or boy who is experiencing such uncomfortable, perhaps terrified, reactions? How do you bring him or her back to a sense of safety and calmness so that he or she can go back to being sturdy and secure?
    A. Does the "little you" need a hug… some words of comfort… encouragement… to know that you are able to set limits on anyone who attempts to stifle, scare, or hurt him or her?
    B. Look closely, with all of your sensory awareness attuned to see and appreciate this "little you" in your story, the one who couldn't easily feel a sense of secure love and attachment in their world?
7) Continue to re-parent yourself, and place the "little you" in a secure and safe place that you have conjured up in the early part of the exercise (if appropriate). Or just tuck them in and hold them close to you in the here and now of your sturdy adult self.
8) Now, from your wise and healthy adult mode: return to the original image with the "angry other" and see, from this stance, that you may be better able to say what you need to say

or do (set limits, confront, invite, console, redirect, empathize).

9) Watch how the "angry other" reacts to your sturdy and "real" approach.
10) Check in with your feelings, body sensations, and thoughts. What else may be needed to keep the healthy adult fortified and the little you safe and secure?
11) Taking a few slow, deep breaths, allow yourself to come back to the room.

*Adapted from Training Exercise: "Group Imagery Exercise to Identify Schemas", Young and Behary (2014)

It will be important to use this exercise alone and in supervision/therapy to practice moving from a triggered place back to a sturdier, healthy stance. Other self-care factors that make you susceptible to being triggered by patient's anger may also need to be addressed such as your workload, regularity and quality of supervision, sleep quality, physical health, etc.

Assuming that the therapist is in a Healthy Adult mode, how then does he or she develop a capacity to identify the anger mode that the patient is in? In this part of the encounter with an angry patient, it is important to LISTEN carefully to (hearing, seeing, sensing) the anger, or the "refrain" that seems to best fit his or her behavior and the story within. It may then be possible to link the refrain to the driver behind it and then use your clinical observation skills to recognize the mode the patient is in. The following table (Table 7) is a summary of the broad categories of refrains and drivers and how they relate to anger modes:

Table 7

Anger Mode Refrains and Drivers

Refrain	**Driver**	**Anger Mode Category**
- "I hate you"	• Helplessness	➢ Childlike Victim (Impulsive/Explosive)
- "I'll show you!"	• Unfairness	➢ Adolescent Bully (Bully and Attack)
- "How dare you!"	• Defensiveness	➢ Resentful Adult (Angry Protector)

Other refrains might be "I deserve to!" or "I won't let them get me!" The first refrain may link with *emotional deprivation* as the driver, and the Anger Mode is Entitled/Self-Righteous. The second refrain might link with extreme *mistrust-abuse* with a driver of protection; the corresponding mode may be the Mistrustful/Overcontroller.

Once you have identified the likely anger mode, it is important to recognize that the treatment approach is based in the patient's unmet needs. For example, the Angry/Enraged Child (Impulsive/Explosive Anger) mode may be an indication of a child whose parent(s) did not adequately meet their emotional needs, for example, abandoning him or her in states of drinking and intoxication, working long hours, or exploiting a child's inborn desire to please his or her parent. Thus the patient needs a safe space where the angry child is invited to express the frustration and rage for painful and grievous experiences. The therapist empathically understands and validates this anger, linking it to and differentiating it from the parent's current experiences. Table 6 summarizes the main strategies – the Case Illustrations section will provide detailed examples.

Table 8

Treatment Implications

Mode	**Approach**
- Angry/Enraged Child	➢ Invite, Empathize, Link
- Angry Protector	➢ Empathically Confront
- Angry Punisher/Demanding Critic	➢ Set Limits

Table 9 summarizes in greater detail the recommended treatment approaches (right-most column) depending on the anger modes that are present in the treatment room.

Table 9

Therapeutic Responses to Anger Modes

Client Anger Mode	**Possible Therapist Feelings * "Countertransference"**	**Therapist Coping Modes**	**Therapist Healthy Adult/Limited Reparenting Response **
Explosive Anger	Anger Guilt	Punitive Parent, C/S, DP, DSS	HA/LR via ventilation and guidance, mode dialogs and role playing imagery
Angry Protector	Fear Anger Guilt	C/S, DP, DSS, PP	HA/LR via EC, bypassing the Detached Protector
Entitled/Vengeful Anger	Anger, Disgust	C/S, PP, Demanding Parent	HA/LR via EC, and mode dialoging
Bully and Attack	Fear Anger	C/S, DP, DSS, underlying VC PP, Angry Protector, underlying AC	HA/LR via limiting expression of mode and setting consequences
* Defined as Anger, Sadness, Fear, Disgust, Joy, Surprise (per Ekman 19xx) and Guilt. Bodily sensations and thoughts are also relevant.			
** C/S = Compliant Surrenderer; DP = Detached Protector; DSS = Detached Self-Soother; VC = Vulnerable Child; PP = Punitive Parent; AC = Angry Child; HA = Healthy Adult; LR = Limited Reparenting; EC = Empathic Confrontation			

Case Illustrations [ii]

In this section, I ([Author's name deleted]) will illustrate how to (a) identify each of the anger modes, (b) develop a treatment strategy to promote mode awareness and schema healing and, (c) address therapist pitfalls such as schema activation, based on cases in my own practice. I will use my name, instead of the pronoun, for ease of reading.

Impulsive/Explosive Anger Mode

When Bob, a 55 year old married man, had first come in seeking treatment with [Author's name deleted], he presented with a child-like demeanor that emphasized how lost he felt in his

relationship with his wife, of many years. He was under threat of constant criticism from her, including minutiae like accusations over dents and scratches in home furniture and being characterized by his wife as dependent on her for vocational guidance, while scolded for presumably being unable to observe basic rules of hygiene and orderliness. Bob, short in physical stature, and with a soft, child-like voice, often presented as a meek victim, and his childhood history pointed to being deprived and ignored as a latchkey kid to a single parent, whose taciturn nature and need to support the family financially left him at the mercy of a grandmother who intimidated him with yelling and - sometimes - physical aggression.

Bob badly wanted to get out of the relationship he felt trapped in with his wife, but also relied on her as someone who cared for him more actively than he had ever experienced in his emotionally malnourished and scary childhood. He initially presented in Detached Protector mode with an underlying Lonely Child mode. It was some time before [Author's name deleted] met the Impulsive/Explosive anger mode toward his wife that he kept in check in therapy. Perhaps this was because the therapeutic connection was nurturing in a way he hadn't encountered before and didn't trigger feelings of rejection or disconnection, reflected in his Subjugation and Emotional Deprivation schemas.

At home, Bob's Impulsive/Explosive Anger mode was eliciting an even stronger reaction from his wife, whose narcissistic behaviors tended toward bully and attacking, including scathing diatribes that he would record and bring in to share. In working with Bob, [Author's name deleted] used imagery to address his bullying grandmother and absent mother (and abandoning father), and the focus became validating "little Bob's" needs to be noticed and cared for and to be protected from abusive behaviors. Imagery involved "Little Bob" (safely – with [Author's name deleted] protecting him) ventilating feelings towards his grandmother and mother, constantly

reinforcing his rights and his needs, the validity of his feelings, and working on *how* to meet those needs (i.e., breaking the pattern of building up and then exploding into anger or rage toward his wife, which then created a counter-productive response in her of further criticism and contemptuousness). Bob now reports an enhanced ability to express his feelings with his wife from his healthy adult mode, and is a more effective advocate for his vulnerable side, reducing the triggering of early maladaptive schemas and corresponding angry modes.

[Author's name deleted] recognized that Bob's anger was rooted in a childlike expression of unmet needs and noxious experiences, as the Impulsive/Explosive Anger mode indicates. [Author's name deleted] was able to address this mode via imagery and role-playing strategies that lead to Bob's expression of needs, in the marriage, being delivered through a mature and healthy mode. As the Angry and Vulnerable Child modes were nurtured and thus healed, outbursts were reduced and Bob was able to offer more thoughtful and measured requests for his wife to respond to his need to feel valued by her and safe in her presence. He was also able to put forth the necessary leverage for her to engage in her own work, or risk losing the relationship.

Angry Protector Mode

In one of the first meetings with Ralph, an early 50s IT professional, [Author's name deleted] became aware of a kind of anger that was sharp and discordant and created a sense of caution in him about how he would react as we continued to explore his reasons for coming in to treatment, which centered around social isolation. As he described his "on-again, off-again" relationship with a much younger woman, he used the terms laced with anger, such as "I hate her!" And then, in a sudden fashion, "she's a bitch! A cunt!" The derogatory and very vile manner he used to describe his partner had an intentional quality to it. He would often burst into the treatment room, quickly revealing a dramatic mode shift. In addition to the revulsion

[Author's name deleted] felt when he heard these words, [Author's name deleted] noticed a shift in his body toward a more defensive, protective posture and felt an increase in vulnerability although the comments Ralph made were not directed at [Author's name deleted].

[Author's name deleted] carefully noted his reaction and the way in which it cut him off from caring for Ralph. [Author's name deleted] barely knew him as a patient at this point and knew very little about his partner. He decided to look for an opportune moment to address his anger, such as when he might more directly express it toward [Author's name deleted] himself. [Author's name deleted] hypothesized that Ralph used an Angry Protector mode to keep him disconnected from his shamed and lonely Child, and it was a key impediment to him leading a richer, more connected, and less isolated life. (Addressing this mode without having data points, like a comprehensive history, to gauge its strength first might prove counter-productive.)

In the next four to five sessions [Author's name deleted] worked via imagery to establish a bond between his "healthy adult / good parent" role and the patient's child self—one that was sad, lonely, and felt defective and unlovable. At times during these sessions, Ralph would return to disparaging his partner through angry verbal pronouncements, but again these were peripheral in nature and he seemed to accept and appreciate the reparenting experienced in the imagery and the early assessment phase.

However, [Author's name deleted] did not have to wait too long before the Angry Protector mode surfaced and was more directly aimed at him. During the session [Author's name deleted] began to explore the origins of Ralph's negative views of people that would shield him from having to meet new people and face potential ridicule, which triggered for him an Anxious and Shameful Child mode that had its roots in a mother who would routinely blame him for anything that was disorderly or not done properly at home. It seemed that a coping mode was

constructed to protect his (Vulnerable Child) through put-downs, negativity and skepticism. [Author's name deleted] and he explored this coping mode in imagery work—one that was rigidly in place within his personality around the time he first began dating. Based on the uncaring treatment he recalled during this imagery—despite [Author's name deleted]'s efforts to champion his feelings of hurt and anxiety—he mentioned that he felt "unsupported" by his girlfriend and associated this kind of treatment with one of his siblings, who remarked years later about Ralph as a child, "I thought you were a total loser—that's what mom always led us to believe." Ralph associated this with the kind of conditioning that his mother did to his sister and brothers.

It was difficult for [Author's name deleted] to refocus Adult Ralph on Little Ralph, who was so often blamed for things he didn't do, despite not having the guidance to support an understanding of appropriate behavior. Ralph encountered difficulties at home and school. The imagery session ended with Ralph's adolescent side feeling sad and confused, thinking: "I've had a lifetime of almost no understanding and no support!" [Author's name deleted] worked with him at the end of the imagery session to help him express what he needed, as it related to his experience as an adolescent as well as in his current relationship and friendships. But Ralph's Scared and Lonely Child was also triggered, and with unease and reminiscent shame, he turned to [Author's name deleted] and said, "I don't know where all this is headed? What is this (kind of therapy) gonna do for me?! These things that we do, where will they lead?" As he was saying this, he looked at [Author's name deleted] with an intensity and irritability that was markedly absent prior to this. [Author's name deleted] recalls experiencing it as a confrontational affront, as if Ralph were erecting a strong and impermeable wall, visible in his affect, body language and critical speech. At this point, [Author's name deleted] was able to identify the Angry Protector

mode that was surfacing in Ralph and remain in a calm enough state to ask him if he could characterize the tone and the language of what he just said. This kind of mindful communicating was key in helping re-establish a rapport that the sudden activation of the Angry Protector coping mode had placed in jeopardy. They arrived at a label for how he communicated, and he agreed that "Skeptic Mode" was a good way to characterize his behavior. [Author's name deleted] then went on to ask him where this mode came from, which had a dual effect of focusing us on what might have been triggered for him from their interaction and where he had developed such a mode.

[Author's name deleted] pointed out to Ralph, in debriefing, that the imagery had revealed a time in adolescence in which this kind of coping mode had been firmly rooted in place in response to the instability and anxiety he experienced throughout his earlier childhood. Because [Author's name deleted] remained calm and was free of his own schema activation, he was able to pursue, with Ralph, the effect of this Coping mode on Little Ralph. Because Ralph sensed that [Author's name deleted] was familiar with this kind of Coping mode in a way that allowed it to be examined instead of reacted to, he was able to give expression to the Sad and Disconnected Child, and say that he really wanted to find a way to feel less sad and lonely and more able to be around people without this Coping mode cutting him off. He said this with tears in his eyes.

[Author's name deleted] took the opportunity to reinforce his concern for Little Ralph; that while he knew there were clear reasons for the Skeptic Mode to have developed, when it shows up, Little Ralph is perhaps initially relieved but in the end left feeling scared and anxious. Little Ralph, he pointed out, wants to belong and be accepted by others, and this mode has kept him consistently from getting that need met, and together they would have to figure out who he can trust to care for him and really "get" him. This was an important turning point in the therapy

and exemplified the importance of addressing anger modes, in this case the Angry Protector, in a way that promotes the proven effectiveness of limited reparenting.

Entitled/Self-Righteous Anger Mode

Tamara is a married mother of one pre-adolescent child with a history of detached self-soothing behaviors, including chronic marijuana use and admits to "a few" episodes of cocaine use in her mid-twenties post-college. She has reported significant dissatisfaction in her marriage and came in to treatment with little incentive to change her substance use behaviors.

Although she would often complain about her husband as the treatment continued, she would go through periods of heavier substance use (primarily marijuana, but also alcohol) that concerned [Author's name deleted] and correlated with her inability to confront her relationship. At times she would behave angrily in therapy for no apparent reason. [Author's name deleted] continued to experience a level of annoyance with her lack of progress and drug use, tempered by her heart-breaking stories of emotional deprivation at the hands of her alcoholic mother—a mother who would regularly forget to make meals for her. Tamara also felt abandonment by her father, whose career as a business consultant left him with little time at home.

[Author's name deleted]'s attempts to encourage her to confront her husband's perfectionistic demands and criticisms would generally have little traction. She would often come in feeling low, having smoked (or drank) more to compensate for the sadness and shame triggered by her husband's bombastic onslaughts, which were not infrequent.

[Author's name deleted] shared that he grew up close to where Tamara had grown up as a child. She immediately identified his as living in a "better" neighborhood, and internalized

[Author's name deleted]'s intention to disclose this as a means for taking pity on her. Tamara was from the "other side of the tracks" and therefore assumed [Author's name deleted] might view her as not being able to "hack" (her words) what people from his area could. At times in session she would allude to this difference in their upbringing as having different correlated status as if those from [Author's name deleted]'s neighborhood were "more capable" of dealing with the world in general, despite [Author's name deleted]'s self-disclosing intention to connect with her experience.

Feeling increasingly frustrated by this dynamic, [Author's name deleted] chose to confront Tamara with his growing concerns over the status quo of unhealthy and entitled self-soothing and avoidant behaviors she was engaged in. The script of the Empathic Confrontation [Author's name deleted] engaged in is as follows:

> [Author's name deleted]: Tamara, I can't help but be concerned about how badly you - Little Tamara - feel after a run-in with your husband and how you inevitably detach from this pain by your preferred mode of coping, which is to self-soothe by smoking or drinking more and staying up alone late or going to your marijuana dealer's house and getting stoned while enduring her (the dealer's) mean comments.
>
> Tamara: [slowing the pace of her speech and making consistent eye contact, guiltily but acknowledging his concern at the same time] I know.... I feel trapped. [Suddenly shifting into Entitled Anger Mode] But you expect more out of me than I can handle, I'm not able to stand up to my husband and [alluding to our respective home towns] you're pushing me to be someone I'm not, to do something that maybe you can do, but I can't. Besides I smoke for other reasons, like how it helps me with my weight.

[Author's name deleted]: [Ignoring her comment about weight, which seemed to be a distractor] Tamara, I understand that this side of you, who was deprived and neglected, feels it necessary to avoid all emotional pain, especially when triggered by your husband's behaviors, and "she" further protests that you have a right to act this way because of all the suffering in your life at the hands of your mom, your dad, and "growing up on the wrong side of the tracks" near where I grew up.

Tamara: [Listening, nods slightly to acknowledge my point.]

[Author's name deleted]: I don't think this part really helps the little you, the lively and open, feeling little child in you to get her needs met; to feel safe, be heard, and feel good enough about herself.

Tamara: Yes that's true. I just want to tell her [i.e., Little Tamara] what's the use in trying. And I want to tell you that, too.

[Author's name deleted]: I know, and I think what happens is that you get caught in a trap of telling others this, and they react angrily, or in ways that discount you and your needs.

Tamara: [Sadly] Yes, my husband sometimes just lashes out at me by calling me an "addict" and "worthless."

[Author's name deleted]: So you've got this part that just acts no matter the impact on others, and generally *they* end up feeling your upset and anger while you might smoke, or stay up late watching TV, or stay out until really late at night.

Tamara: Yeah.

[Author's name deleted]: Would it be okay if we did some work using chairs with this part of you and Little Tamara?

Tamara: Yes.

[Author's name deleted]: Thank you, you've done good work staying with me and being willing to look into this part of you....

A segue occurred then to mode-chair-work in which the Entitled Anger Mode is replaced by a healthier adult mode.

Overcompensating Anger Modes

This mode is typically associated with narcissistic—and often male—patients such as Tom, who was three years into a painful divorce process when he and his wife, Karen, came to see [Author's name deleted] for couples counseling. Tom is an imposing man—six feet tall and barrel-chested—who works as a general contractor/developer elaborating planning for large scale real estate projects but also, who uses his brawn for dealing with rough conditions and stubborn workers at the job site. He has a legal bent to his thinking and tended to dwell excessively on divorce proceedings and attempts his wife had made to have supervised visitations of their teenage son.

Tom entered [Author's name deleted]'s office on the first session in what might be described as a hostile state, with an angry and suspicious look on his face. His deep voice and imposing physical build presaged his opening words: "I'm not sure why I'm here. I've said everything and she's [his wife] said nothing!" The statement was made in an angry tone, along with accompanying facial gestures, and it brought up a range of feelings in [Author's name deleted], including feeling intimidated by his delivery, but also—importantly—a feeling of sadness that was masked—*almost* obliterated—by his tone. It was an important part of the strategy for connecting with Tom's Vulnerable Child mode to notice this part of him being expressed *despite* the clear and obvious presence of the Bully and Attack (Anger) Mode. If you

read his words carefully you'll also get a sense for how subjugated and unheard he feels ("I've said *everything*,...she's said *nothing*") emerging from his underlying Lonely Child.

As this was our first session, Tom moderated his tone, perhaps sensing in [Author's name deleted] a willingness to connect with the Little Lonely Boy under all that armor, and [Author's name deleted] was able to elicit how much Tom missed his wife's presence in his life.

The following individual session with Tom was anything but easy. Tom's Bully and Attack Mode was fully engaged, which is how his wife characterized many of his interactions with family and professionally, unless he was in a depressive state, in which case he would lay for days on the couch at home, doing very little.

Tom, without any preliminaries, started the session with:

> Her [Karen's] father has filled her with poison against me. She needs to stop listening to his lies and drop these divorce proceedings! I'm not doing any of this [he makes a broad sweeping gesture encompassing my office) unless she does so!

Tom's tone of voice was angry and his face turned pale as he said this, not to mention how his large frame seemed to shake and grow in stature. He was in fight mode and his body complied to enhance the effect.

Having seen how animated Tom could get in our previous session, and sensing the very lonely and shameful-feeling boy underneath, [Author's name deleted] asked Tom to slow down and tell him what happened between sessions that lead him to such an extreme conclusion - they had talked about creating a better parenting connection between him and Karen in the first (conjoint) session, not reversing the divorce. Tom's response was: "I'm completely repulsed and disgusted by your entire profession! You're all the same, just like the last therapist."

At this point [Author's name deleted] felt attacked and that with Tom's Bully and Attack Anger mode active, very little progress could be made to move him toward healthier coping, and there was a danger of validating this mode and reinforcing its reflexive use in Tom's relationships were he not to confront him on this in an empathic way. So he did:

> Tom, I'm frankly offended by what you said about my 'entire profession' and by association, me. That kind of talk is devaluing and ultimately will lead others in your life to avoid and leave you. And I think that's what's been going on for you with Karen for a long time. I'm at least trying to help you have some kind of connection with her [i.e., parenting] and this kind of behavior isn't helping.

Tom sat there for a moment, looking somewhat stunned - or at least pausing enough to let [Author's name deleted]'s statement register. Tom softened somewhat - although still reflecting some of the devaluing tone of a moment ago, and said: "Well, what do *you* propose we do instead [if you're so smart]?!

[Author's name deleted] said to him gently and candidly, focusing on the lonely little boy that had been abandoned by one of the most important people in his life: "Tell me about Karen and what she *means* to you.... Tell me *why* this is so upsetting." As it turns out, this was a turning point in the therapy, and coupled with the earlier empathic confrontation, elicited in him the following tearful response: "You see, I've lost my best friend for the past 30 years...." The tone of Tom's voice was soft and sad, none of the anger of the previous exchange was there and he had shifted into his Lonely Child Mode. [Author's name deleted] was able to point this out to him in the session at that time and used this exchange in subsequent sessions to bring him back to his feelings of loss, sadness and shame connected to the divorce and his childhood.

Ultimately it should be noted, Tom struggled to stay out of maladaptive coping modes and elected to discontinue treatment prematurely. During later sessions, he would often alternate between a Conning and Manipulative Overcompensating Mode (Arntz and Jacob, 2013, p. 46) and the Bully and Attack (Anger) mode. These modes were firmly entrenched and often resulted in him attempting to dictate treatment by cancelling individual sessions and wanting to have conjoint sessions with Karen. He would then end up in Bully and Attack mode toward her and [Author's name deleted] during these conjoint sessions, which necessitated limit setting (on [Author's name deleted]'s part), such as having him leave the treatment room to maintain a safe environment.

In Conclusion

> In the beginning you may not understand the nature of…anger, or why it has come to be. But if you know how to embrace it… it will begin to become clear to you.
>
> - Thich Nhat Hanh (2008, p. 1)

In this paper we have highlighted the importance of understanding the kind of anger that can show up in the treatment room, ways to avoid therapist maladaptive responses, and ways to promote successful treatment that will lead to schema healing and address the specific underlying unmet needs that are associated when different anger modes manifest in therapy. Patient anger can lead a therapist to enter into maladaptive coping modes of his or her own that are protective or over-compensatory in nature. These modes can thwart experiences inside (and ultimately) outside therapy that help a patient change his or her prevailing modes from less flexible coping stances to more healthful, adaptive, and attuned ways of exploring feelings and getting their needs met. It is our hope that this paper contributes to differentiating anger modes and their

corresponding treatment strategies and places patient anger squarely in focus as a rich entry point for experiential, cognitive, and behavioral work in session as well as a means of enhancing the therapy relationship.

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[i] We note that the Angry Protector Mode can also exert a controlling influence on a therapist's willingness to engage via intimidation or veiled intimidation.

[ii] The illustrations here have been derived from practice and supervision work and reflect typical treatment situations but are not associated with actual patients.