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Patient Anger: Insights and Strategies

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OBJECTIVES

- Recognize signs of patient anger
- Identify sources of patient anger
- Describe strategies for addressing and managing patient anger

Introduction

Anger is a natural human emotion and as such, virtually every genetic counselor will inevitably encounter it in their patients. Schema et al. (2015) found that 95.7% of surveyed genetic counselors experienced patient anger directed at themselves. Moreover, nearly 20% of these genetic counselors reported having been concerned about their safety during an episode of patient anger. Their findings underscore the universality and potentially problematic nature of patient anger in genetic counseling.

Despite its universality, anger can prove challenging to manage in the clinical setting, as responding effectively to patient anger may not come naturally to the genetic counselor. Unaddressed or ineffectively managed patient anger may have deleterious effects on genetic counseling processes and outcomes (McCarthy Veach et al. 2018). It is therefore critical that the genetic counselor be able to recognize patient anger, identify its triggers or causes, and address the anger to maintain a productive genetic counseling session.

Definitions of Anger

To better understand anger, it is valuable to consider definitions of this affective state. Deffenbacher (1999), a counseling psychologist, defines anger as:

> "...a feeling state, varying in intensity from mild annoyance and irritation through frustration and anger, to fury and rage. Physiologically, anger consists of sympathetic arousal, increased

Genetic Counseling Practice: Advanced Concepts and Skills, Second Edition. Edited by Bonnie S. LeRoy, Patricia McCarthy Veach, and Nancy P. Callanan.

> muscle tension, release of adrenal hormones, and other elements of the 'flight' or 'fight' response" (p. 298).

Schema et al. (2015) used a more concise definition from Baty (2010), a genetic counselor:

> "Anger is '... an emotional state that varies in intensity from mild irritation to intense fury and rage'" (p. 125).

The above definitions highlight several important concepts. First, individuals may experience different degrees of anger. Second, Deffenbacher's (1999) inclusion of the physiological components of anger draws attention to anger as a natural reaction that has evolved in humans as one response to distressing external or internal stimuli. As explained by Novaco (2016):

> "Anger can mobilize psychological resources, energize behaviors for corrective action, and facilitate perseverance. Anger serves as a guardian to self-esteem, operates as a means of communicating negative sentiment, potentiates the ability to redress grievances, and boosts determination to overcome obstacles to our happiness and aspirations" (p. 286).

Reactions to Anger

Expressions of anger often cause others to feel scared or otherwise threatened, and to act defensively. They may desire either to strike back or to withdraw. Genetic counselors are no different in this regard. Responding professionally to angry patients may be challenging, as one's reactions are not only intellectual, but also visceral. Reacting toward patient anger the way one would in personal situations, however, may be irresponsible, unproductive, and/or unprofessional.

Hill et al. (2003) investigated challenges anger can pose to the productivity of a psychotherapy session. The researchers concluded that anger directed at the therapist could disrupt the therapy process, particularly if the therapist's reaction is to feel angry, hurt, confused, guilty, anxious, or incompetent. Chui et al. (2016) similarly found that therapists might be more likely to themselves become more negative when faced with negative client affect. This same study found that therapist negative affect was related to a decline in clients' rating of the working alliance and session quality, therefore creating a vicious cycle. When counselors have negative feelings, they may have difficulty responding effectively (empathically and objectively), which may cause escalation of the conflict or render the session ineffective. Therefore, although challenging, it is essential that the genetic counselor effectively engage with patient anger to maintain a focus on achieving the goals of the genetic counseling session.

This does not mean, however, that one's personal experiences with and reactions to anger have no bearing on how practitioners perceive, manage, and express their emotions in professional contexts. Hill et al. (2003) also found that having a true reaction to a client's anger may improve the relationship with the client, even when that reaction shows a therapist's own feelings of frustration and annoyance. The authors hypothesized that therapist genuineness may lead to an improved relationship with the client. They speculated that the client may appreciate the authenticity of the response and may use it as evidence that the therapist is invested in the session and client. These findings suggest that genetic counselors need to engage in a delicate balancing act when responding to patient anger; they must be genuine, empathic, and objective in their reactions while maintaining a professional front.

The ways in which one maintains a productive genetic counseling session must, of course, be tailored to an individual counseling situation, patient characteristics, and counselor characteristics. Nonetheless, literature in genetic counseling, medical, and psychological professions offer some insights and generally effective strategies for professional practice. This chapter discusses insights and strategies for maintaining a productive genetic counseling session when patients are angry. Together these resources contribute to a framework for understanding and responding to patient anger. In particular, they describe why patient anger develops, the targets of patient anger, how patients express anger, and the challenges posed by patient anger.

Reasons Patient Anger Develops

How and why patient anger develops depends on many factors. For best possible outcomes, genetic counselors should consider the source(s) of a patient's anger and recognize the function(s) it may serve.

Situations that can precipitate anger include grief, loss of control, loss of health, and betrayal (Rueth and Hall 1999). Genetic counselors in Schema et al. (2015) reported that the most common trigger of patients' anger was their difficult situations. Additional triggers included unfavorable test results, logistical challenges (e.g. transportation and parking), and when patients perceived the genetic counselor as insensitive, flippant, condescending, or too directive. Importantly, anger may also serve an important coping purpose, and it is a well-recognized element of the grieving process (McAllister et al. 2007; Novaco 2016; Rueth and Hall 1999).

McAllister et al. (2007) speculate that patient and family member anger is a reflection of the "existential unfairness of nature" (p. 2655) that goes beyond anger solely at their current circumstances. It is common for patients to ask "Why me?" Anger may also be a reaction to feelings that one is to blame.

Some patients may use anger as a strategy, conscious or unconscious, to obtain a desired outcome (Lazarus 1991). Similarly, some patients knowingly use "pseudo-anger" to manipulate healthcare providers, for instance, to make the provider feel guilty or sorry for them, which may in turn result in the patient's desired outcome, preferential treatment, or other advantages (Izenberg 1992). Examples of desired outcomes include being seen earlier, having a desired test ordered, or having paperwork or other needs moved to the top of the work queue.

Patients may also use anger to regain control of a situation. Genetic counselors in the Schema study (Schema et al. 2012, 2015) expressed that many patients are completely out of their element in the healthcare setting. Some may have no knowledge of science or biology, making even basic explanations or concepts very difficult to understand. Patients who have had little exposure to healthcare settings or those who have had traumatic experiences in healthcare settings may find even relatively minor procedures or illnesses threatening. Feeling ill at ease and out of control may intensify when patients are facing very difficult, life-altering situations. A genetic counselor interviewee in their study stated:

> I think that anger is a way, for many of them, a way to try and exert some control in a situation where they feel they don't have any control over ... there's a sense that they've lost control of their body. Once they have surgery, things are going to happen to them that they just can't control fully. I think the medical setting, for a lot of patients, makes them feel they are not in control... Anger, in a strange way, is a way of asserting some control. It's not maybe the best way to do it, but at least temporarily, it gives you a sense of control.
>
> (Schema et al. 2012, p. 59)

Anger is not always a means to an end. Anger can also be precipitated by an actual or perceived personal insult to the patient's ego, plan, or comfort. Patients' anger may be more pronounced when they view these insults as unwarranted or unjustified. Intentional or preventable offenses may be particularly insulting. In these cases, patients regard the target of their anger as blameworthy, and thus deserving of punishment for the offense (Lazarus 1991).

Dalenberg (2004) found that common reasons for patient anger in trauma counseling were therapists' failure to fully understand or acknowledge the patient's experiences or feelings, or that the patient perceived the therapist to be insensitive to them. Some patients even had a perception that the therapist did not believe their experiences or minimized them. Granek et al. (2018) similarly found that anger can arise when patients perceive a physician as being insensitive or tactless.

Some patients' may be more prone to anger (Schema et al. 2015), and anger may be more common when the counselor–patient relationship is lacking in some way. In a psychotherapy study, Hill et al. (2003) found client dissatisfaction and anger are more likely a reflection of the client's personality and the quality of the therapist–client relationship rather than reactions to any error or actual transgression made by the therapist. Other studies echo these findings, suggesting that patient anger is more likely due to negative aspects of the patient–physician relationship than any actual malpractice (Virshup et al. 1999). Research also suggests that any negative physical state of being, including even seemingly trivial states such as hunger, may increase the probability of an anger response (Berkowitz 1990).

Some authors argue that patient anger is precipitated in part by increasingly understaffed healthcare clinics. Thomas (2003) asserted that when providers are "spread too thin" the resulting depersonalization of care manifests in patients' feelings of vulnerability and powerlessness. Granek et al. (2018) concluded that underfunded healthcare systems with limited resources can contribute to patient anger and to providers' inability to handle the patient's anger effectively. Izenberg (1992) noted that patients must often wait to be seen, sometimes for hours, in uncomfortable rooms with many other patients. This can be especially frustrating to patients who do not understand triage or other "bureaucratic necessities" and perceive the system as unfair. Izenberg encouraged providers to consider the patient's environment during an anger response.

Ambiguity comprises a particularly relevant trigger of patient anger. Lack of a clear answer has been shown to trigger anger in psychotherapy patients who believe their therapist did not give direct answers (Dalenberg 2004). These results are important because genetic counselors often are unable to give their patients a concrete answer. McAllister et al. (2007) found that a delay in diagnosis, or even a delay in a desired evaluation or test, caused patient anger. The authors noted that for some patients, even bad news may be better than being left "in limbo" (p. 2657). They hypothesized that a positive test result or diagnosis affords the patient and families a sense of control and direction that is not available when they are left with uncertainty or the unknown.

Anger as a Symptom of a Medical Condition

For genetic counselors (and other healthcare providers), a symptom of a medical condition can be a particularly important direct or indirect cause of patient anger. This has been referred to as *phenotypic anger* (Stevenson et al. 2015). Anger may result from emotional instability caused by the condition itself, a medication taken to treat a condition, and/or the stress of dealing with an underlying condition. Recognizing when anger is a symptom of a medical condition or its treatment may help healthcare providers better understand, manage, and respond to it (Stevenson et al. 2015).

Genetic counselors need to be aware that anger, hostility, or aggression may be part of the phenotypic spectrum of some conditions. Huntington's disease serves as a model of a medical condition associated with phenotypic anger. In a study completed prior to the discovery of the gene responsible for Huntington's disease, Baxter et al. (1992) found that anger and hostility were significantly higher in patients at high risk for Huntington's disease (as determined by PET scans and genetic markers) as opposed to those at lower risk. These findings suggest anger is a function of the disease phenotype itself, more than the psychological distress of being at risk. Additionally, more common non-Mendelian psychiatric conditions include anger or irritability as a diagnostic criterion (DiGiuseppe and Tafrate 2010).

Patients with an underlying diagnosis or individuals caring for a patient with an underlying diagnosis may be easily triggered to anger. This may be particularly true of chronic conditions, but even relatively minor medical conditions have the potential to disrupt a patient's or family's emotional stability. Trost et al. (2012) contended that anger occurring to "right a wrong" is a natural response and therefore may be common in cases of a wrong that cannot be righted (e.g. chronic pain, or a genetic condition). Izenberg (1992) identified genetic conditions as being especially taxing because they may have a greater "symbolic meaning" than other conditions because they are passed down through families. Baty (2010) notes that feelings of loss related to a genetic condition may contribute to anger, including loss of a loved one, loss of freedom, loss of health or fertility, or loss of the fantasized child.

Other studies focus on anger associated with the diagnosis of a particular genetic condition including hereditary breast and ovarian cancer (Lynch et al. 1997), androgen insensitivity syndrome (Slijper et al. 2000), Ehlers-Danlos syndrome (Lumley et al. 1994), and cancer diagnoses requiring stem cell transplant (Gerhart et al. 2015). These diagnoses were found to be distressing and may result in patient anger. Physical pain and discomfort have been associated with higher levels of patient anger (Gerhart et al. 2015; Scott et al. 2016). Interestingly, Gerhart et al. (2015) found that when the patient had low perceived support from healthcare providers, anger and physical discomfort were positively associated. This same correlation was not seen, however, when patients had high perceived provider support. The authors concluded that high positive provider support "buffered" the relationship between anger and physical distress (Gerhart et al. 2015).

In a study of parents of children with Prader-Willi syndrome, van Lieshout et al. (1998) found parents expressed more anger toward their children than parents of children with either Williams syndrome or fragile-X syndrome. These findings suggest that anger may be a function of the child's condition-specific characteristics to a greater degree than the stress of having a child with any genetic condition.

Targets of Patient Anger

The target of anger may be the genetic counselor or other healthcare provider, a family member, or the patients themselves. The patient or family may also be angry at God, or may have another existential or abstract target for their anger. One genetic counselor interviewed by Schema et al. (2012) explained:

> ...whether this is anger at a specific occurrence, whether it's angry at somebody else, whether this is anger at the universe or God or some ethereal cosmos about why bad things have happened in your life. (p. 60)

The target of anger may or may not be the true trigger of the anger. For example, the target may be the messenger or the "bearer of bad news." Indeed, Schema et al. (2015) and McAllister et al. (2007) found

that patient anger as a coping response to living with a genetic condition is commonly directed at the information giver, regardless of whether that individual is a healthcare professional or a family member. Family members may also direct their anger at the genetic counselor instead of a sick family member who may be the true trigger of the anger. As genetic counselor participants expressed:

> It's like, "Well, I [the family member] could be angry at [my sick spouse], or I could be angry at the people who can't help me fix this." So it's better for her to be angry at us [the genetic counselors].
>
> (Schema et al. 2012, p. 58)

> Getting angry at a genetic counselor is a safe thing to do, rather than yelling at your spouse or yelling at your child.
>
> (Schema et al. 2012, p. 58)

When anger and conflict arise among family members, these dynamics warrant special consideration. Caring for a patient with an underlying genetic condition may be challenging for the parent or other caregiver for numerous reasons including the emotional toll of having a sick relative and the burden associated with providing constant care. Anger directed toward family members may occur due to learning one or more family members did not disclose important health information (McAllister et al. 2007), or when there are disagreements about decisions surrounding management or testing (Schoeffel et al. 2018).

Schoeffel et al. (2018) found that what they termed *decisional conflict* might be particularly evident and consequential in prenatal genetic counseling sessions. Examples of decisional conflict between prenatal couples included disagreement about whether a screen or test should be performed on the pregnancy, termination versus continuation of pregnancy, and birth planning. Numerous precipitating factors increased the chance of conflict, including "incongruent" coping styles (when one member of the couple's coping style is anger and the other's is not), and the presence of others in the session (e.g. grandparents of the fetus) who may take sides when there is disagreement. One element that contributed to the complexity of decisional conflict is the decision ultimately is the pregnant woman's, as she is the patient. This element may be even more likely to provoke conflict when the male is regarded as the sole decision-maker. Conflict between couples is not just limited to decision-making as Schoeffel et al. (2018) further found it can occur throughout the genetic counseling session. Examples include a couple criticizing one another's family members during pedigree taking, or conflict occurring before the session and "spilling over" into the session.

How Patients Express Anger

Some of the ways in which individuals non-verbally express anger appear to be widespread and even universal, being present even in young children. These include facial flushing, movement of the brow inwards and downwards, narrowed eyes, flared nostrils, and clenched jaw (Novaco 2016). Yet there is also wide variation in both non-verbal and verbal expressions of anger. While some individuals may behave aggressively (e.g. directly and in a threatening manner), others will express anger in more passive ways (e.g. indirectly, and/or subtly). For example, some may yell or become physical, while others may seem to be indifferent, cold, apathetic, or sarcastic. The ways in which patients and family members express their anger depend on many factors including individual differences (e.g. personality traits), family dynamics, culture, gender, and context.

Individual Personality Factors

The genetic counselors in Schema's study (Schema et al. 2012, 2015) described a variety of ways in which patients express anger toward them. Behaviors ranged from cursing, yelling, screaming, and personal threats, to condescending and passive aggressive statements as well as non-verbal behaviors such as acting uninterested in the information the genetic counselor shared. Both Schema (Schema et al. 2012, 2015), and Schoeffel et al. (2018) in their study of prenatal couple conflict, partially attributed differences in expressions of anger to individual differences. These differences included patient temperament (e.g. being quick to anger), defensiveness, and personality characteristics like hostility, being highly strung, anxious, type A, and more verbal. Genetic counselors in the Schema et al. (2012) study also suggested that for some individuals anger might be a more socially acceptable emotion to share, with one counselor noting:

> Others might turn towards crying instead, but I think it tends to be more socially acceptable to be angry, especially if you're considered to have a stronger personality. (p. 57)

Family Factors

Baty (2010) discusses family dynamics as a possible contributing factor to anger. For example, an individual's role within a family may be the "anger expresser." Schema et al. (2015) found that in a number of cases anger arose from someone who accompanied the primary patient to the session. These findings are a reminder about the importance of paying appropriate attention to other individuals present in the appointment. Moreover, even when a patient is alone in a session, genetic counselors should help them consider what the information may mean to family members, both medically and emotionally. This may be particularly true in genetic counseling because of the hereditary nature of many conditions, meaning the information is directly applicable to other family members.

Izenberg (1992) argued that when the patient is a child there may be additional family factors contributing to anger including limited knowledge of parenting skills, anger directed at the child, tensions within the family, and guilt. Guilt may be particularly relevant in the case of genetic conditions, where the conditions may be passed down from parents.

Cultural Factors

Cultural differences influence how individuals express anger, as well as how genetic counselors or other healthcare professionals perceive their anger. For example, what one culture views as an angry behavior may not be perceived as anger in another culture (Bond 2004). This may be in part because the processes leading up to angry (or even aggressive) behavior differ across cultures; and providers may not be as astute in recognizing these early signs of anger in patients whose cultural backgrounds differ from their own. Additionally, views of socially acceptable and expected behaviors vary across cultures (Bond 2004), further complicating how healthcare professionals should manage anger.

Granek et al. (2018) compared and contrasted oncologists' views of cultural differences in expression of anger. They described, for example, how the Kaluli of Papua New Guinea freely and openly express anger, while the Ukta Eskimos rarely express anger. The authors concluded that not only are there cultural barriers in the expression and perception of anger, but also language barriers that can impede effective communication. Such barriers are particularly common in culturally diverse areas in which a large number of both patients' and healthcare providers' first language is not the dominant geographic language.

Gender

As summarized by Novaco (2016), although men and women experience comparable levels of anger intensity there may be important differences in how they are provoked to anger and how they express anger. A number of genetic counselors in the Schema et al. (2015) study noted gender differences in how patients express anger. For example, some specifically commented that anger is a more socially acceptable public emotion for men, and that men may feel they cannot express other negative emotions like grief, sadness, or fear publicly. More generally, as reviewed by Novaco (2016), males are more likely to be angered by impersonal triggers and behavior causing physical harm, whereas females are more likely to be angered both by personal triggers (i.e. behavior by someone close to them) and by insensitive or condescending words or behaviors. Gender differences in expression of anger may be particularly apparent in some male-dominated cultures or families.

Context. The ways in which patients express anger may vary as a function of context. While most of the examples discussed thus far concern reactions within genetic counseling sessions, some patients may express anger outside of the session, for instance, over the telephone. While such anger may be due partly to receipt of test results or other follow-up information by phone, it may also reflect passive aggression or discomfort patients feel expressing their anger in person. Patients may also have "delayed anger" expressions, threatening to sue or taking other legal action against the counselor, practice, or hospital after the genetic counseling session.

Challenges Posed by Patient Anger

Although patient anger may serve important purposes, it may also be detrimental to a genetic counseling session. Schema et al. (2015) found that in approximately half of the situations described by the surveyed genetic counselors, the anger essentially ended the relationship or the session's effectiveness. These findings underscore the challenging nature of anger. Patient anger may disrupt the counselor/patient relationship (DiGiuseppe and Tafrate 2010; Gerhart et al. 2015; Hill et al. 2003; Scott et al. 2016; Trost et al. 2012), and impede information giving and informed consent. Patient anger may negatively affect healthcare providers, both emotionally and physically, and have legal or financial consequences. Anger may be particularly challenging for students and novice genetic counselors to manage.

Baty (2010) suggests an angry patient may not be fully present during a genetic counseling session. This may mean the patient is not hearing the information, and/or is not thinking critically about it. Angry patients may also be more likely to resist treatment or have delayed or impaired acceptance of their own diagnosis or a diagnosis of a genetic condition in their child. Baty argues that repressed or indirect anger may lead to a decrease in the patient's quality of life.

Smith and Antley (1979) identify several different ways in which anger creates barriers to informed consent and other aspects of genetic counseling. First, highly emotional states can interfere with the reception of information, resulting in diminished ability for patients and family members to absorb or recall the information discussed. Smith and Antley also suggest that patients may not always express their anger directly to the genetic counselor but instead circumvent the counselor altogether and express their displeasure to the physician. This patient behavior puts a strain on all relationships involved. Finally, the authors suggest some patients may express their anger by resisting care, canceling or missing scheduled genetic counseling appointments, and/or mentally "checking-out" during the genetic counseling session.

Studies of physicians have shown that angry patients may be more likely to be noncompliant and less likely to pay (Izenberg 1992; Markman 1976). There is also a risk of damaged property or vandalism in some patients' expressions of anger (Granek et al. 2018).

Studies have shown that patient anger affects genetic counselors and other healthcare providers, both professionally and personally. Schema et al. (2012) speculated that patient anger threatens the genetic counselor's identity as a helper, patient advocate, counselor, or educator. Genetics counselor participants in this study explained:

> I think counselors like to see themselves as kind, caring, helping kinds of people. Most of us have gone into this profession because we like to help people, but we also we derive satisfaction from helping people, so when a patient says, "Gee, you've been helpful. I feel so much better now" or "I've learned so much. I appreciate it. You've been a big source of support for me." That feeds our sense of who we are. Anger does the opposite of that, because it really challenges who we think we are, and it challenges what we believe about the work that we do and how we do it. So it can be really threatening. (p. 63)

> Maybe it's just the overall genetic counseling personality that we have, is that we don't want patients to be mad at us, we don't want people to be upset with us even if we weren't the cause of their anger. We have just a specific personality that we need to have everyone happy and have everyone connect with us. (p. 63)

Patient anger directed toward healthcare providers has been shown to contribute to reduced job satisfaction, poorer job performance, decreased morale, burnout, and turnover (Granek et al. 2018; Quine 2001; Smith and Hart 1994; Stevenson et al. 2015). Smith and Antley (1979) assert that in response to patient anger genetic counselors may feel defensive or angry, which may further distance the patient from the genetic counselor and the session. Schema et al. (2015) concluded that experiences with angry patients can "haunt" genetic counselors for many years. That said, however, it is noteworthy that genetic counselors may also recognize these difficult emotions as important contributors to their professional growth (Resta 2002; Wells et al. 2016). As Resta (2002) writes:

> "A tough lesson for me to learn has been that difficult patients, awful counseling sessions, and awkward encounters offer the best opportunities for professional growth and development" (pp. 19–20).

Potential effects of patient anger extend beyond emotions, as they may adversely affect the healthcare providers' physical well-being. In one study of nurses working in psychiatric care, these experiences were found to prompt some providers to make poor health choices including consumption of junk food, alcohol, and/or the use of tobacco (Stevenson et al. 2015). Importantly, some angry patients may turn violent which can result in physical harm to healthcare providers or other patients (Stevenson et al. 2015). Repeatedly dealing with angry or violent patients may also result in less provider compassion for future patients (Stevenson et al. 2015).

As mentioned earlier, an angry patient may be particularly challenging for newer genetic counselors and students in training. Some insights may be drawn based on studies of mental health counselors. Based on an extensive literature review, Sharkin (1989) concluded that mental health counseling students or trainees have more difficulty with client anger and manage client anger differently than their

more experienced colleagues. Counseling trainees were more likely to withdraw from and show reduced empathy toward angry clients. In contrast, more experienced counselors responded to angry clients in a more accepting and positive manner which partly may be due to feeling less surprised or less threatened by them. Experienced counselors also had fewer negative feelings and perceptions regarding angry clients than inexperienced counselors, and they were less likely to respond with their own anger.

Sharkin (1989) also concluded that certain student characteristics influence how effectively they manage patient anger. For example, trainees with high anxiety were more likely to be defensive than their peers with lower anxiety, and fear of losing control over the session resulted in students' failure to adequately explore clients' anger. Sharkin also found counseling trainees who had a higher need for approval were less likely to address patient anger than trainees with a lower need for approval. An additional finding was that trainees who tended to express their own anger more directly in other situations were more likely to confront and explore clients' anger.

Sharkin and Gelso (1993) obtained similar results in a related study. They found that counseling students who were more "anger-prone" or who self-reported being more uncomfortable with anger tended to experience greater discomfort in dealing with patient anger and were more likely to respond with anger themselves. They also found that older trainees were less likely to respond with anger than younger trainees of similar counseling experience levels. Thus, age, independent of counseling experience, appeared to be positively associated with more effective responses to client anger.

Practice Applications

Patient anger in genetic counseling is inevitable due to the serious, complex, and taxing nature of medical genetics. Furthermore, anger can play an important role in a patient's coping response. Therefore genetic counselors must learn to effectively recognize, address, and manage patient anger. Schema et al.'s (2015) genetic counselor participants recommended several strategies: anticipate and plan for patient anger and, when feasible, reduce external stressors likely to precipitate unproductive patient anger; use assessment skills to discern, to the extent possible, sources of the patient's anger and strive to not take patient anger personally; acknowledge the anger directly and respond in a controlled but genuine way; and protect one's self emotionally, legally, and physically when encountering angry patients. Employing these strategies may not only help to achieve the genetic counseling session goals, but also potentially allow patients an opportunity to express, explore, and work through their emotions. The following sections contain detailed description of these strategies.

Anticipate Patient Anger and Reduce External Stressors

Being prepared to encounter an angry patient can be beneficial for genetic counseling processes and outcomes. Genetic counselors should think objectively about a patient's situation and understand that anger and resistance may be related to the patient's medical condition, difficult situation, and/or be part of a coping response. This strategy will help counselors avoid being taken by surprise and may help them work through these issues early in the session. Anticipating the possibility of anger will allow genetic counselors to watch for and note early and/or subtle signs of anger before patients' emotions escalate.

Genetic counselors can also work to reduce some of the external factors that precipitate stress and subsequent anger for some patients. These factors include long wait times to schedule a visit, being seen late, confusion and frustration about insurance policies, driving in cities or in areas unfamiliar to the patient, and parking. In our busy and complex healthcare system, reducing all stressors may be unattainable, but genetic counselors can work to improve the issues within their control.

Reducing the stress caused by external factors may include something as simple as sending out directions, clear parking instructions, or information about general traffic patterns or construction projects in the area. These strategies may be especially helpful in centers that serve a large geographic area and for patients who are unaccustomed to travel in the area of the healthcare center. Genetic counselors can also try to reduce the amount of patient wait time by working on order entry, requisition paperwork, or other administrative tasks prior to patients' arrival or scheduled appointment. When waiting is unavoidable, clearly communicating the expected wait time and apologizing for the wait can be effective strategies for preventing or diffusing patient anger.

Genetic counselors should watch for early signs that a patient might be more likely to be angry. Some patients who are resistant may be inclined toward anger. Behaviors suggesting resistance include not completing requested forms prior to the appointment, missing multiple scheduled appointments, or arriving late for a scheduled appointment. Other possible indications of anger include high patient anxiety during prior encounters or conversations, and documented anger, poor coping, or anxiety in the patient's medical record.

Finally, genetic counselors should maintain open communication with the referring physician. The referring provider may have insight into the reasons for patient anger and/or past experiences with the patient's anger which may help the genetic counselor better prepare and plan for a session. It may also be prudent for genetic counselors to document their experiences with an angry patient. This may be important for legal reasons, as discussed below, as well as to give other providers a heads up about a potentially angry patient. When documenting, however, the genetic counselor should be cautious not to bias the medical record by insensitive or flippant remarks. Preconceived impressions of a patient might hinder rapport between the patient and future providers.

Anticipating and watching for patient anger can be helpful in some, but not all cases. Indeed, in the Schema et al. (2015) study, participants reported the presence of warning signs in only in a small number of situations. Thus, advance preparation for patient anger is not always possible.

Recognize the Source(s) of Patient Anger

Baty (2010) and others advise that genetic counselors avoid taking patient anger personally. This may be easier said than done, however. As mentioned earlier, an angry patient, especially one who is directing anger at the genetic counselor, can be an insult to the counselor's identity as a helper, genetics expert, and patient advocate. Awareness of the sources of the patient's anger (and one's own reaction to it), and recognizing the functions the anger serves, may be helpful. Also noted earlier in this chapter, common contributing factors to patient anger are the difficult situations patients find themselves in and their reactions to those situations, as well as aspects of their underlying medical condition. As one genetic counselor shared in Schema et al. (2012):

> I think with time I've realized that, oh my gosh, these people are just in horrible circumstances, and they're angry and they need some object for their anger to go [off] on sometimes, and it's not

> fair, it's horribly unfair, and so they're not necessarily mad at me per se, as much as it's just a crappy situation, and that's how people respond to crappy situations – they just lash out here and there. (p. 53)

Baty (2010) further cautions genetic counselors to recognize and manage the potential for counter-transference when dealing with angry patients. She asserts that counselors need to be cognizant of their own emotional reactions and keep them in check in order to best serve the patient.

Studies from the nursing literature have found that nurses are better able to connect with patients and are more frequently able to ascribe patient anger to an underlying cause (i.e. fear and anxiety) when they focus their attention on those factors rather than blaming the patient (Smith and Hart 1994). Genetic counselors can use this same strategy effectively. Similarly, Deffenbacher (1999) recommends recognizing that, "understanding clinical anger means putting it in a cultural context" (p. 297). This means one must consider the patient's anger from the perspective of their culture and family dynamics. A patient's behavior may not seem appropriate from the genetic counselor's perspective, but when considering the patient's background it may be an appropriate behavior or response to the situation. Deffenbacher also stresses that client anger must be considered a function of many factors, and not simply a response to the most obvious trigger.

Recognize Anger and Address it Directly with a Controlled, Genuine Response

Recognition of patient anger may be obvious in the case of direct expressions of hostility. But as noted earlier, not all patients will display their anger in this way. Therefore the genetic counselor should attend to more subtle displays of anger including passive aggressive or sarcastic comments, silence, or acting uninterested in the information. The patient's body language may also offer clues about his or her emotions. An angry patient may have crossed arms, be turned away from the genetic counselor, have clenched fists, display an angry facial expression, and/or avoid eye contact.

A recurring theme in the literature is that practitioners should not ignore patient anger. For instance, Dalenberg (2004) found that the least satisfying response to anger, as reported by clients, was the failure of the therapist to respond to their anger. Clients interpreted this non-response as an indication the therapist did not care. Instead, genetic counselors should recognize, address, validate and explore the patient's anger.

Genetic counselors should deal with patient anger directly, and not ignore or gloss over it. As healthcare providers, genetic counselors have a duty to remain professional and respectful when communicating with patients. Using the term coined by psychologist Carl Rogers, genetic counselors should strive to treat their patients with *unconditional positive regard* (Rogers 1957). Unconditional regard can prove challenging when dealing with an angry patient who may not be reciprocating respect. The genetic counselor's natural response to anger may be to lash out or return angry feelings. As stated earlier, having a genuine emotional reaction to an angry patient is natural. Genetic counselors, however, must be aware of their feelings, recognize where they are coming from, and respond to the patient in a professional manner. A participant in Schema et al. (2012) noted:

> I think it's challenging because you're being confronted, and it's uncomfortable, and you have to be the bigger person because you're the provider. And I think that's tough to piece away the personal part of it and the provider front. (p. 64)

Some authors recommend responding to patient anger as the counselor would to any other patient emotion, and attempting to understand and work through the undercurrent of emotions leading to it (Hill et al. 2003). A participant in Schema et al. (2012) illustrates these recommendations:

> Use all those good listening skills to allow the patient to express whatever it is they're upset about, however inane it seems to be. Let them say it, let them get it out, and then use those reflective phrases, "Now I understand that you're upset about this ....I hear you saying this"... and allow them to hear themselves and to talk about it. You might be the first one who has taken the time to do that. So listen to the whole story. (pp. 71–72)

Genetic counselors should address the anger directly but calmly and avoid responding defensively (e.g. with their own anger or justification). A calm response might include stating your observations to the patient or asking the patient questions about their feelings or thoughts. Therapists surveyed by Brattland et al. (2018) similarly recommended staying calm, expressing understanding and support, and inviting further dialog when faced with negative client feedback. A genetic counselor in the Schema et al. study (2012) advised:

> You need to stop and, for lack of a better word, *call them on it*. Address it, say, "I'm sensing this.... Can we talk about that? Is there something that we can do about that?" Give them an opportunity. And they may be just angry, and we can't do anything about it. But we need to address it, identify it, and give them a forum to discuss their concerns. (p. 66)

Simply acknowledging a patient's grievances may help diffuse anger by making the patient feel heard and creating a "safe space" for the patient to share their emotions. The genetic counselor should listen and validate the patient's feelings or complaints, which may alleviate tension. A genetic counselor in the Schema et al. study (2012) advised:

> ...really give them an opportunity to talk, and listen to them and try to understand what is the root cause of that anger, and then to validate it- to validate it- and to let them know that [anger] is a very normal emotion; that they're absolutely justified in feeling that way. (p. 66)

The genetic counselor should be careful, however, not to diffuse the anger too quickly, as it can be a useful segue into further exploration of the patient's emotions that may be pertinent to the session goals. The genetic counselor can explore the cause of the patient's anger, and recognize that anger may be masking other emotions the patient is less comfortable displaying (e.g. sadness, grief, guilt, embarrassment). Baty (2010) recommends genetic counselors respond in ways that help patients regain a sense of control of the situation. Their responses may include aiding in the patient's reappraisal of the situation by helping them be more self-aware of their emotions and responses. Genetic counselors may also help patients harness their anger for a productive outcome, for example, encouraging the patient to participate in a support group or become involved in a charity or advocacy organization.

In situations in which a patient's anger is justified, such as a long wait time or when a mistake is made, genetic counselors should not hesitate to apologize for any part they or their clinic may have had in contributing to patients' grievances. McCord et al. (2002) found high patient satisfaction when physicians not only apologized to the patient, but also took responsibility and ownership of the problem. Therapists

surveyed by Brattland et al. (2018), similarly endorsed acknowledging and when necessary, apologizing for, any contribution they may have had to the client's grievance. Of course, placing blame on another staff member or provider may be a tempting strategy in the moment, but it is an inappropriate and unproductive strategy. Accepting personal responsibility will help the genetic counselor maintain a professional front and prevent "collusion" in the patient's anger caused by disparaging another provider.

Reeder et al. (2017) found that some surveyed genetic counselors experienced countertransference in reaction to intense patient affect (e.g. experiencing a desire to avoid the emotions). The self-reflective and compassionate genetic counselor will recognize and set aside her or his countertransference to remain empathically engaged with patients and their situations. The genetic counselor can help the patient work through anger by offering insight about the patient's situation and in some cases, perhaps helping them realize the true source of their anger. As articulated by a participant in the Schema et al. (2012) study:

> Sometimes, just asking them how you can help them, because they're not expecting that. So I think if you put yourself out there and ask, "What can I do for you now?" Sometimes that really helps them refocus. I'll say to them, "I'm going to do everything I can to help, and I do want to help you." And just remind them that you're on their side. (p. 69)

Finally, the genetic counselor should recognize when a patient cannot or will not move past his or her anger, and be able to continue with the session, but perhaps with modified goals. For example, as opposed to ensuring the patient has a comprehensive understanding of the genetic testing process, inheritance, disease natural history, and significance of all possible test results, the genetic counselor may instead wish to focus on the most important take-away messages. For patients who are unable to move past their anger, or for those whose anger is deeply-seated or tied to a deleterious coping response, the genetic counselor should consider offering a referral to a clinic social worker, psychotherapist, or other mental health expert, or connecting the patient with a peer support group.

Protect Oneself and Others Physically, Legally, and Emotionally

By nature, many genetic counselors are inclined to put the patient's needs first. However, in certain relatively rare situations, the genetic counselor may need to prioritize protecting oneself physically, legally, and emotionally. As noted earlier, Schema et al. (2015) found that nearly 20% of surveyed genetic counselors had feared for their safety when confronted with an angry patient. Those situations involved aggressive and potentially violent patients or family members.

Genetic counselors have a professional and ethical responsibility to act in their patients' best interests. They also have a responsibility to consider their own needs and the needs of others in the clinic. In cases involving aggressive and potentially violent patients or their significant others, personal safety as well as the safety of other clinical team members and other patients is primary. The genetic counselor should first remove her- or himself from the immediate area (e.g. exit the room). This strategy has an added benefit of allowing the patient to take a "time-out" and perhaps calm down. The genetic counselor should not hesitate to call a security officer(s) when confronted with a potentially violent patient. Not only can the security officer physically restrain the patient if necessary, the presence of a security officer may help the patient realize they need to keep themselves and their behavior in check.

As angry patients may be more likely to sue than other patients (Virshup et al. 1999), the genetic counselor should be aware of and prepared for this possibility. Detailed documenting of interactions with the

patient can be helpful in justifying the genetic counselor's actions, clinic decisions, etc. Genetic counselors should also seek out resources within their institution to help them understand their legal rights and for assistance in learning the steps for properly documenting such situations. It may also be judicious for genetic counselors to document interactions with patients who exhibit less intense forms of anger, especially when their anger does not dissipate, and/or does not seem to have a reasonable cause. As noted earlier in this chapter, documentation is not only important for legal reasons, but it also gives other providers a "heads up" about a potentially angry patient.

Finally, genetic counselors must protect themselves emotionally. Genetic counseling can be stressful, depleting, and grueling (cf. Bernhardt et al. 2009, 2010). Angry patients, regardless of the target of their anger, may be particularly distressing. Genetic counselors may find it helpful to debrief with colleagues after an encounter with an angry patient. Studies have shown that providers who share these experiences with a supportive listener have lower blood pressure, lower levels of stress and depression, and better general health than those who do not (Thomas 2003).

A number of studies have found that genetic counseling colleagues are an important source of support (cf. Wells et al. 2016). For instance, peer supervision/consultation (e.g., Lewis et al. 2017; Zahm et al. 2008) can promote deliberate practice, by allowing genetic counselors to reflect upon their reactions and responses to patient anger and contemplate ways to respond to angry patients in the future. Moreover, open conversations with colleagues may help reduce any stigma, shame, or guilt genetic counselors might feel due to their encounters with an angry patient.

Conclusion

Encountering angry patients can be challenging for the genetic counselor. An angry patient may be less receptive to the information being discussed, and their anger can disrupt the exchange of information and flow of the session. Thus, anger may hinder accomplishment of the genetic counseling session goals. The genetic counselor should be mindful of the potential for anger, determine the source(s) and target(s) of the patient's anger, and recognize whether and how the anger is impeding genetic counseling goals. They should consider the possibility that anger is a coping response, and anger may be masking other emotions that are relevant to session goals. The genetic counselor who is able to remain calm, address the anger directly, and explore the patient's emotions may find that anger can have a net-positive effect on genetic counseling processes and outcomes.

Summary Points

- Anger can be part of a patient's grieving process and serve as a coping mechanism.
- Patient anger can be precipitated by many factors, both in and out of the genetic counselor's control.
- Patients display their anger in different ways related to factors such as personality traits, family dynamics, cultural influences, gender, and contextual factors.
- Anger may be related to a patient's underlying diagnosis and/or treatments.
- Anger can be detrimental to an effective and productive genetic counseling session.
- Effectively managing patient anger may be particularly challenging for genetic counseling students or novice genetic counselors.

- Unproductive patient anger may be reduced by working to alleviate outside stressors, when feasible.
- Anticipating situations in which patient anger may occur can help the genetic counselor effectively manage this emotional response.
- The genetic counselor should be mindful to not take the patient's anger personally.
- The genetic counselor should address patient anger in a genuine, empathic and professional manner.
- Identifying and offering additional resources (mental health providers, support groups) may aid in the management of patient anger.
- Genetic counselors must protect themselves and others physically and legally when dealing with extreme cases of patient anger.
- Genetic counselors need effective coping strategies (e.g. peer supervision/consultation) to deal with the emotional ramifications of patient anger.
- Although challenging, when managed effectively, patient anger has the potential to have a net-positive effect on genetic counseling session processes and outcomes.

Learning Activities

Activity 6.1 Reflecting on Your Own Anger in Everyday Life

Working independently, think about a time when you were angry with your spouse, significant other, or close friend or family member. Provide written responses to the following questions.

- Why were you angry?
  - What was the "simple" or surface cause of your anger?
  - Were there other past experiences that contributed to your anger?
  - Would the same behavior/event/situation have made you angry if instead of a significant other or close friend or family member, it was an acquaintance? Why or why not?
- How did you express your anger?
  - Were you direct with your expression of anger?
  - Did you become aggressive or raise your voice? Or were you more cold, sarcastic, or passive aggressive?
  - Would you have responded differently in this situation if you were angry with an acquaintance instead of a significant other or close family member?

Instructor Notes

How does this exercise relate to encountering and managing patient anger in the clinical setting?

- Recognizing underlying reasons for anger or past history that is precipitating the anger.
- Understanding that anger is not always communicated in the same way by every person and in every situation.

Estimated time: 20 minutes