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A Systematic Review on Effect of Behaviour Therapy on Anger and Aggressive Behaviour

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INTRODUCTION

The purpose of this meta-analysis was to look into the efficacy of CBT-based anger management interventions in reducing recidivism among adult male offenders. A bibliographic database search, a hand-search of references from similar studies, and an electronic search on relevant Correctional websites were used to select studies. The rates of general and violent recidivism were the outcome measures of interest. These were regarded as indicators of long-term behavioural change. Risk ratio analysis was used to analyse studies that included relevant data. The overall effect of exposure to CBT-based treatment on general recidivism was 0.77, indicating a risk reduction of 23%, whereas the overall effect on violent recidivism was 0.72, indicating a risk reduction of 28%. The meta-analysis also looked at the effects of treatment completion versus attrition groups. Through risk ratios, the effects of treatment completion on general recidivism were 0.58, indicating a 42% risk reduction. The risk ratio for violent recidivism was 0.44, indicating a risk reduction of 56%. To investigate the significant heterogeneity observed in the results, subgroup analysis based on treatment modality and risk of bias analysis were performed on the selected studies. Overall, anger management appeared to reduce the risk of recidivism, particularly violent recidivism. Moderate-intensity anger management had a greater effect on violence reduction than high-intensity correctional programmes. Adolescence, also known as puberty, is regarded as a time of 'storm and stress.' Adolescents during this stage have difficulty controlling their emotions and may act defiantly and unexpectedly. This could lead to a slew of social issues. Children and adolescents lack the necessary skills to recognise and cope with emotions in general, and anger in particular.

DESCRIPTION

This frequently results in aggression, bullying, and other disruptive behaviours. When children encounter difficulties with peers or are unable to meet academic demands, these behaviours are frequently displayed in school. Interpersonal difficulties and behavioural issues result from a lack of effective problem-solving skills. Due to a lack of effective social problem-solving strategies, aggressive children and adolescents resort to weak, ineffective, and antisocial solutions. They are also unable to assess or evaluate the outcomes of these solutions. These children believe that an antisocial solution and aggressive behaviour are appropriate ways to solve the problem. As a result, it is critical to intervene before they internalise maladaptive behaviours, which can lead to inefficient problem-solving and antisocial behaviour. The most common reasons for referring adolescents to mental health services are uncontrollable anger, aggression, severe acting out, and disruptive behaviour.

Anger is a negative affective state characterised by increased physiological arousal, thoughts of blame, and a proclivity for aggressive behaviour. Frustration or interpersonal provocation is common causes of anger. It can also range in intensity from mild annoyance to rage and fury and last for minutes to hours. Anger expression (i.e., an individual's tendency to show anger outwardly, suppress it, or actively cope with it by employing adaptive anger control skills) is distinguished in factor-analytical studies. Improving anger control skills is a primary goal of child-directed CBT approaches that teach coping skills for anger and frustration as part of a larger repertoire of emotion regulation strategies. Over the last ten years, factor-analytical studies of ODD symptoms have revealed a distinct dimension of irritability defined by three symptoms: Frequently loses his

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temper, is easily irritated, and is frequently angry and resentful. As a result, ODD symptoms are now classified into three categories: Angry/irritable mood, argumentativeness/defiant behaviour, and vindictiveness, emphasising both the emotional and behavioural aspects of this disorder. Longitudinal studies have found that irritability symptoms in childhood are linked to mood and anxiety disorders later in life, whereas defiance and vindictiveness predict later behavioural problems. Growing recognition of irritability in childhood psychopathology and research on severe mood deregulation has resulted in the addition of a new diagnostic category, disruptive mood deregulation disorder, to the DSM-5. The primary symptoms of DMDD are frequent temper outbursts and irritable or depressed mood between temper outbursts that last for the majority of the day almost every day. Temper tantrums can take the form of verbal rages and/or physical aggression toward people and property. In randomised controlled trials, PMT and CBT have been well studied in children with disruptive behaviour disorders, and studies involving the transdiagnostic approach to CBT for anger and aggression are currently underway.

CONCLUSION

More research is needed to develop treatments for other types of aggressive behaviour that have received little attention in clinical trials. Further research into the role of callous-unemotional traits in response to behavioural interventions and treatment of irritability in children with anxiety and mood disorders is also warranted. Anger/irritability and aggression are two of the most common reasons for children and adolescents to seek mental health treatment. PMT is a type of behavioural therapy that aims to improve family interaction patterns that produce antecedents and consequences that maintain the child's anger and aggression. CBT is another well-studied psychosocial treatment for children and adolescents with anger and aggression. Children learn how to regulate their frustration, improve their social problem-solving skills, and role-play assertive behaviours that can be used instead of aggression during conflicts during CBT. Outpatient mental health centres can provide both PMT and CBT in the form of time-limited psychotherapy.