SMGroup

SM Emergency Medicine and Critical Care

Article Information

Received date: Apr 10, 2017
Accepted date: Apr 17, 2017
Published date: Apr 19, 2017

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Perspective

The Anger Quotient

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Globally, the elderly are succumbing to anger. This anger has multiple etiologies but a common cause. It starts with a fundamental frustration in their living condition. How we manage their anger in the clinic, Emergency Department, or hospital will determine the success of our intervention.

Failure to address the anger underlying the elderly individuals' illness or trauma can disable the therapy. The intervention may not be psychological, it can be medical. First, we must explore their anger, its antecedents, its nature, and its triggers.

During one's working life, we face frustrations. These frustrations are typically suppressed to maintain or advance one's position. Even when we do act out to manage those frustrations, we may struggle against our actions in doing so, or the outcome. This occurs even in home makers as they belabor their decisions in child rearing, expenses, or other activities. Some manifest as regrets, others as outcomes that result in guilt, depression, and ultimately circle back to anger.

In the elderly, the most common cause for anger has to do with the inability to perform a task they were able to do easily when they were younger. These do not have to be complex tasks; in fact the simpler the task the more anger is produced, particularly if they discover a new impairment in their senses along the way.

You already know this, and see it every day. What you may not know is that those same people have an emotional set point. Their affect may be happy and upbeat, sad and serious, dejected, and even hopeless. While the roller coaster of life may alter that set point temporarily for a day or two, they return to their base line in short order.

Some prefer to be around happy folks, others not so much, but we all try to avoid the angry. This is why some of the most difficult patients are those with reflex sympathetic dystrophy. Their pain makes them angry. Similarly, chronic pain, when it is poorly managed leads to long standing simmering anger. Those individuals seek an outlet, and it is often misguided.

The amount of success or failure we have in life has little bearing on our anger quotient. What does is how we adapt to our circumstances. This adaptation may be physical, psychological, or spiritual. This adaptation may alter the emotional set point, but more often it alters the pattern of decisions we make. Which is why some people can't seem to get out of their own way, while others breeze through life without a care? This also leads to a schism between the anger men bear and that which women bear (and is unaffected by sexual orientation, as transgender men suffer in the same way as traditional men).

The burden of anger geriatric men carry is often identity based, particularly if they were professionals in their working life. We now live long enough in modern society that we can have if we so choose, two or more careers, but most are locked into one career. Our world view as men is predicated on our career, and when we retire we lose our carefully cultivated self-definition. The thought of starting over from the bottom is often beneath our dignity. Set adrift some find solace in previous hobbies, or find new ones, and talk about the good old days. Others become deeply depressed as a consequence of unrelieved anger in losing their career standing and identity. Moreover, they are angry as they become increasingly irrelevant as the world moves on without them. This is often seen in athletes at an earlier time than business men.

Geriatric women on the other hand carry their anger based on their relationships. The regrets about their choices with husbands, lovers, and offspring continuously plague them. It is often couched in desire. Attraction to the bad boy, the addict, or the replication of a father figure is some examples, but there are others, some that are more subtle and insidious.

The problem is that identity becomes embedded in this desire matrix, and when the desire is malignant, and it is repeated in the attraction to different individuals either as mates, partners or lovers, self anger simmers and evolves. Sometimes it is the fault of the significant other, sometimes it is the fault of the woman, or even both. What remains is a core of bitterness that is self destructive, even though it is masked in layers upon layers of moods, personal aspects, and accommodations.

If age is the best test of sanity, where core personalities are revealed as the defenses are sloughed, then the elderly reveal themselves most when they are stressed. A critical illness or a visit to the

How to cite this article Raymond KA. The Anger Quotient. SM Emerg Med Crit Care. 2017; 1(1): 1004.

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Emergency Department exposes the depth and breadth of their anger quotient. Where they aim that anger can enable or disable our ability to provide their health care.

We also have to reflect on our own anger triggers in the process. To say to ignore the needles or insulate ourselves from the trigger is not always possible or meaningful. We can't always side step the anger directed at us. It is healthier to react than suppress, the human resources approach is not always the best for all concerned. Time outs for both ourselves and the patients can relieve or aggravate the situation as mental loops can become spirals of emotion. Time outs may also be fatal in terms or morbidity and mortality in the ED or ICU.

To take a cue from martial arts we must go with the blow rather than resist or deflect it. Reflect their anger so they hear what they are saying. Limit injury by working through misunderstandings. Often explaining procedures or tests is all that is needed to clear issues up. However, dialing the anger down to a level of receptive understanding is needed first. Managing anger out of sequence will result in an aborted attempt.

We may not have time to get to the foundation of the anger, but we can scratch the surface to allow care to move forward. Success in care may simply be a result of removing or displacing a patient's anger as the body feeds on anger and succumbs to the self destruction the anger portends. Then applying gentle interventions corrects the course and restores the homeostasis.

The anger quotient is set at different levels and has varying trigger points based on the individual's circumstances and the course of their history. Perhaps in the future it will be the sixth vital sign, quantifiable, and even modifiable by electro-neuro modulation. For now we should assess and address the anger quotient in our elderly and other target populations with each encounter.