Psychotherapy Volume 38/Fall 2001/Number 3

A COMPREHENSIVE TREATMENT MODEL FOR ANGER DISORDERS

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Since anger can be a frequent and debilitating client problem, it is important for practitioners to have a clear conceptualization of available and effective treatment strategies. This article presents a comprehensive treatment model based on reviews of empirical outcome studies of anger interventions. However, because this outcome literature is relatively small and restricted to a few therapeutic approaches, additional suggestions for therapeutic interventions are presented based on what is known about the emotion of anger. Although our knowledge of anger treatment is still developing, the scientific literature can provide much-needed guidance for working with angry clients.

Although anger is an emotional problem frequently encountered in clinical practice (Lachmund & DiGiuseppe, 1997), we have observed through training and supervision that practitioners are generally less comfortable working with anger-disordered clients than with those experiencing anxiety or depression. One reason for practitioner discomfort stems from a lack of knowledge regarding effective intervention strategies. Despite the concern in our society about the damage created by anger, substantially fewer scientific publications have appeared on anger than have appeared for other troublesome emotions. For every article in the literature on anger over the past 15 years, 10 exist on depression and 7 on anxiety (Kassinove & Sukhodolsky, 1995). Of particular relevance to practitioners is the dearth of treatment-outcome studies, the almost complete lack of standardized assessment instruments that focus on anger as a clinical problem,[1] and the absence of Diagnostic and Statistical Manual of Mental Disorders (DSM) categories for which anger is considered the primary emotional excess (Eckhardt & Deffenbacher, 1995). Thus, we must admit that our understanding of disordered anger and its treatment is limited, which leaves substantial room for growth in our knowledge.

The present article proposes a comprehensive treatment model for working with a wide variety of clients with anger problems. Two approaches were employed in developing the proposed program. First, we reviewed the anger treatment-outcome literature to uncover empirically supported interventions. Second, we reviewed the scientific research on anger to uncover characteristics about the emotion that may guide treatment but are not yet addressed by the empirically supported interventions.

Research on Anger Treatments

To date, five meta-analytic reviews of anger treatments have appeared. Tafrate (1995) and

Portions of this article were presented at the Annual Convention of the American Psychological Association, August, 1999, Boston, MA and Annual Conference of the Middle Atlantic States Correctional Association, June, 2000, Mashantucket, CT.

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[1] One exception is the State-Trait Anger Expression Inventory (Spielberger, 1988), which has some utility in working with angry clients in clinical settings.

Bowman-Edmondson and Cohen-Conger (1996) conducted reviews of published studies of adult subjects, while Sukhodolsky and Kassinove (1997) focused exclusively on investigations of child and adolescent anger treatment. In an attempt to expand the database of relevant studies, Beck and Fernandez (1998) combined the results of studies of school children, adolescents, and adults and included both published reports and doctoral dissertations. Most recently, DiGiuseppe and Tafrate (in press) uncovered additional published and nonpublished studies of adult subjects, including an additional sample of uncontrolled pre-to-posttest investigations, and examined the persistence of treatment effects by the analysis of follow-up data. Several conclusions emerged from these reviews that can contribute to successful programs for clients with disordered anger.

First, optimism is justified. Successful treatments for anger exist with adults, adolescents, and children. Researchers have applied these treatments to college students selected for high anger, male adult volunteers, angry outpatients, spouse abusers, prison inmates, special education samples, and people with medical problems such as hypertension. Anger treatments appear to work equally for all age groups and all types of populations. Anger treatments are also equally effective for men and women. However, this enthusiasm needs to be tempered by an important limitation of the anger-outcome research. Most studies used volunteer participants. Many practitioners treat angry clients who courts, employers, or spouses have coerced into treatment ("You should get help or I am leaving you"). Volunteer participants may not represent the clients who actually arrive at a practitioner's office (supposedly) to receive treatment. Actual clients have less desire for change than do volunteers. We will return to this point later.

Second, the improvement is consistently of a moderate to large magnitude. Average effect sizes across all outcome measures and intervention strategies ranged from .67 (Sukhodolsky & Kassinove, 1997) to .99 (Tafrate, 1995) with most reviews reporting a grand mean of around .70 (Beck & Fernandez, 1998; Bowman-Edmondson & Cohen-Conger, 1996; DiGiuseppe & Tafrate, in press). However, the magnitude of change achieved with symptoms of anger appears smaller than with other clinical problems. The upward range of effect sizes falls short of the upward range of effect sizes reported in meta-analytic reviews of treatments for anxiety and depression. For example, in comparing treated subjects to no-treatment controls, effect sizes greater than 1 (for Cohen's d statistic) have been reported for subjects suffering from anxiety disorders across a variety of outcome measures and studies (Chambless & Gillis, 1993). Several meta-analytic reviews of treatments for depression, using the Beck Depression Inventory as a common outcome measure, have reported effect sizes greater than 2 (Dobson, 1989; Gaffan, Tsaousis, & Kemp-Wheeler, 1995). As Norcross and Kobayashi (1999) lamented, we cannot treat anger as successfully as we do other emotional problems.

One reason limiting the potential for large treatment effects is that anger has not been systematically studied as a clinical problem. Treatment development has been largely based on adapting strategies that have been successful for clients suffering from other disorders, predominantly anxiety disorders (Bowman-Edmondson & Cohen-Conger, 1996). This approach ignores the potential for developing treatment protocols that target the key symptoms of anger-prone individuals. Epidemiological and descriptive studies of clinical anger experiences have not been conducted. Thus, new creative interventions may yet be discovered.

A third finding is that treatment effects appear to last. Most studies held their posttest gains at follow-up, and some even improved more at follow-up (Bowman-Edmondson & Cohen-Conger, 1996; DiGiuseppe & Tafrate, in press). Treatments that maintained their effectiveness tended to incorporate multiple interventions into one protocol, such as cognitive restructuring and relaxation. Arnold Lazarus's (1989) notion that multimodal treatment produces the most long-lasting change appears to apply to anger management.

Fourth, anger outcome studies reveal change on a variety of dependent measures, not only on self-reports of anger (Bowman-Edmondson & Cohen-Conger, 1996; DiGiuseppe & Tafrate, in press). Researchers have reported moderate to large effect sizes on physiological measures, self and other reports of positive and assertive behaviors, and self and significant other's ratings of aggressive behavior. This last finding may be the most important. Spouses and other family members should see changes from our interventions.

Thus, anger interventions may play an important role in mending families.

One disappointing finding concerning effects across dependent measures emerged from Sukhodolsky and Kassinove's (1997) meta-analytic review of anger treatment for children. They reported little change on measures completed by the peers of the children who received anger treatment. Two interpretations of these results are possible. First, perhaps peers represent the most valid measure of behavior, and people really do not change. This seems unlikely since parents, teachers, and unbiased observers all report large changes in these studies. Second, perhaps peers stigmatize angry people, and retain their stereotype despite changes made in therapy. This would indicate that angry adolescents may need to function without anger outbursts over long periods of time and also develop a history of positive interactions in order to counteract perceptions and repair relationships. Perhaps the difficulties associated with changing negative peer evaluations has led some children to turn to violence as an outlet for cumulative failures to be accepted by others. Clearly, a better understanding of the emotional and thinking processes of children who engage in group violence against their peers is needed.

The fifth conclusion, based on meta-analytic reviews of anger treatment, is that symptom to treatment-modality matching has not been supported. Clinicians often try to match an intervention to the client's primary symptoms. This comes from the generally accepted notion that the treatment modalities will affect their corresponding outcome measures. Therefore, cognitive interventions would affect cognitive measures more than behavioral or physiological measures; and physiological treatments, such as relaxation training, will affect physiological measures more than cognitive or behavioral measures. This matching effect emerged in the early days of behavior therapy with anxiety. We found no such effect in anger treatment (DiGiuseppe & Tafrate, in press). In fact, cognitive interventions produced larger changes on physiological measures than did progressive muscle relaxation. Cognitive restructuring also produced similar changes on self-report measures of cognition, affect, and ratings of aggressive behavior. No data exist to support the intuitive idea that one should prescribe treatment for an individual with an anger-management problem based on the symptom pattern presented.

Our sixth finding is that the majority (approximately 80%) of all published and nonpublished treatment-outcome studies on anger were delivered in a group format (DiGiuseppe & Tafrate, in press; Tafrate, 1995). We speculate that the many practitioners who treat angry clients work in correctional facilities, substance programs, hospitals, residential centers, and schools and regularly conduct anger-management groups. Group and individual interventions appear equally effective on measures of anger. However, an individual treatment format appears to be even more effective for increasing positive behaviors and is also consistently associated with decreasing aggressive behaviors (DiGiuseppe & Tafrate, in press). Thus, for programs that target the reduction of anger-related aggression and aim to increase behavioral skills, individual therapy appears preferable.

Seventh, in reducing aggressive behaviors, protocols that used treatment manuals and integrity checks (to ensure that therapists followed the manual) produced higher effect sizes than ones that did not use manuals or integrity checks (DiGiuseppe & Tafrate, 2001). If one is interested in reducing anger that leads to aggressive behavior, we recommend manualized, structured interventions and supervision to ensure that treatment is delivered in a consistent manner. Unfortunately, we believe that many practitioners who work in correctional settings with aggressive clients tend not to adhere to structured interventions. Several protocols for practitioners (Deffenbacher & McKay, 2000; Kassinove & Tafrate, in press) and clients (McKay & Rogers, 2000) are currently available.

Finally, the vast majority of the empirical literature on anger treatment investigated behavioral, cognitive, or cognitive-behavioral therapies. The most widely supported anger treatments are: (a) relaxation-based interventions such as progressive muscle relaxation (Novaco, 1975), anger management training (Hazaleus & Deffenbacher, 1986), and systematic desensitization (Evans, Hearn, & Saklofske, 1973; Rimm, DeGroot, Boord, Heiman, & Dillow, 1971); (b) various forms of cognitive restructuring such as self-instructional training (Moon & Eisler, 1983), cognitive therapy (Deffenbacher, Dahlen, Lynch, Morris, & Gowensmith, 2000), and rational-emotive behavior therapy (Tafrate & Kassinove, 1998); (c) behavioral skills-training interventions (Deffenbacher, Thwaites, Wallace, & Oetting,

1994); and (d) combinations of these three approaches (Deffenbacher, McNamara, Stark, & Sabadell, 1990a). The literature also suggests that incorporating exposure strategies, learning new skills in the context of anger triggers, is likely to produce an increase in effectiveness (Grodnitzky & Tafrate, 2001; Tafrate & Kassinove, 1998). In our most recent review we found two studies that evaluated mindfulness meditation, which can be considered a Buddhist intervention, and only one study that included Yalom's (1985) process-oriented (or experiential) group therapy (Deffenbacher, McNamara, Stark, & Sabadell, 1990b). Adherents of other theoretical orientations have abstained from empirical corroboration of their effectiveness with angry clients. We found no psychodynamic, family systems, gestalt, or client-centered research studies upon which to draw. The absence of so many theoretical orientations from the outcome-research literature has resulted in a limited view of anger. Obviously, we can learn much from a more diverse anger-treatment literature.

Characteristics of Anger

Because anger has received so little attention in the scientific literature, reviewing aspects of anger that differentiate it from other emotions may be helpful. This may provide insights into features of anger that therapists can incorporate into interventions not already included in the existing anger-outcome literature.

Distinguishing Healthy from Disturbed Anger

Anger is one of the most frequent of human emotions (Scherer & Wallbott, 1994). It is unlikely (and also undesirable) that we can achieve interventions that eliminate the emotion of anger as recommended by the Roman philosopher Seneca (Brasore, 1958). Without anger we would fail to recognize problems and take corrective action. Psychotherapy has traditionally relied on the dimensions of frequency, intensity, and duration for guidance in determining whether anger is either healthy or disturbed. Nevertheless, quantitative dimensions may sometimes fail to discriminate adaptive from maladaptive anger. Someone who is the victim of a frequent or enduring moral transgression may experience intense or frequent anger, yet respond adaptively.

Some theorists (Tangney et al., 1996) have suggested that the goals of anger discriminate best between adaptive and disturbed functioning. Constructive goals refer to maintaining a friendship, maintaining or asserting authority, causing a change in the anger instigator's behavior, or resolving the problem. Malevolent goals refer to getting revenge or to hurting the anger instigator. Selfish or fractious goals refer to getting the anger instigator to comply with one's wishes or letting off steam to feel better. Bowlby (1973) employed the phrase "anger of hope" for constructive anger and the phrase "anger of despair" for malevolent goals. People with secure emotional attachment styles, as defined by Bowlby (1973), seem to have constructive goals, and, therefore, have more functional anger experiences. People with anxious-ambiguous attachment styles have dysfunctional anger derived from malevolent goals and show avoidance of active confrontation and rumination of hostile thoughts (Mikulincer, 1998). Such qualitative aspects of anger may provide additional information concerning disturbance and clearer therapeutic goals.

There is also evidence to suggest that individuals with clinical anger problems are likely to experience a variety of negative consequences related to their anger episodes. Their anger is likely to be associated with verbal and physical outbursts, substance use, damage to relationships, and negative long-term outcomes (Tafrate, Kassinove, & Dundin, 2001). Thus, reviewing the costs of anger can serve as an additional dimension for distinguishing healthy from disturbed anger reactions.

Angry clients see themselves as the victims of injustice. Therefore, they often reject the goal of eliminating their anger. Teaching angry clients the distinction between adaptive and destructive anger may be a useful first step toward change. Some clients have great difficulty viewing their anger as a problem because they are focused on attaining revenge against a transgressor. Focusing on reducing the desire for revenge remains an unexplored intervention. Creating awareness that revenge extracts great costs (to the avenger) and ultimately provides little satisfaction may also be an important goal in treatment.

Motivation for Change

Many people feel little desire to change or control their anger. The only emotion people wish to change less is joy (Scherer & Wallbott, 1994). This feature of anger poses the greatest problem for therapists. We often say that angry clients do not come for therapy; they come for supervision. They have tried to change their bosses, cowork-

ers, or partners and failed. They come to us for advice on how to change their transgressors or to vent about being the target of unfair treatment. Angry clients often have difficulty forming an alliance with counselors because of failure to agree on the goals of therapy. Therapists want to change their clients' anger, and clients want to change their instigators or get revenge.

The stages-of-change model (Prochaska, Norcross, & DiClemente, 1994) suggests that people who do not wish to change are in the precontemplative or contemplative stages of change. People who take active steps to change are in the action stage. The most productive therapies consider interventions aimed at the person's stage of change. Unfortunately, most angry clients fall in the precontemplative stage of change. The most frequently used and researched interventions (cognitive and behavioral interventions discussed earlier) are designed for those in the readiness or action stages. Perhaps this also explains why anger treatments fail to attain the large effect sizes achieved for depression and anxiety. In addition, many practitioners may not find the scientific treatment literature particularly instructive, given that it does not address how to prepare and motivate clients to change their angry reactions.

Anger treatment researchers can learn much from studying the successful interventions used with other behaviors people are reluctant to change, such as substance-use disorders, impulse-control disorders, and other addictions. Miller and Rollnick (1991) designed motivational interviewing strategies to help those who are ambivalent about wanting to change their substance abuse. Initial sessions of anger treatment might focus on helping angry clients to understand the destructive nature of their anger and to construct alternative emotions and behaviors (DiGiuseppe, 1995). To date no empirical outcome studies have appeared that use a motivational component for reducing anger.

Empathy

No one likes to hug a porcupine. People usually fail to elicit empathy from others when they experience anger (Palfai & Hart, 1997). This suggests that since psychotherapists are people, we may often fail to experience empathy for angry clients. Indeed angry clients may engage in behaviors that practitioners find personally abhorrent. Also, the intensity of a client's anger reaction may be out of proportion to a particular transgression. Therapists may be quick to focus on the client's overreaction and not validate the client's perceptions of being unfairly treated. Even clients with anger problems are likely to experience some situations where anger is likely to be an appropriate response. Thus, therapists may be quick to dismiss the client's reaction instead of exploring appropriate and effective means of expressing anger in specific situations. Lack of therapist empathy is likely to result in failure to achieve a productive working alliance.

Approach and Impulsivity

Anger, more than any emotion except joy, produces a strong tendency to approach eliciting stimuli rather than to avoid the triggering event (Scherer & Wallbott, 1994). This tendency to approach anger triggers often results in angry clients engaging in destructive behaviors. Therefore, therapists would be prudent to assess for dangerous and risky behaviors. Angry clients often need impulse control interventions as part of their anger treatment to prevent destructive actions. Avoidance and escape strategies can be implemented early in treatment to prevent aggressive behaviors or prevent additional negative consequences or losses.

Close Interpersonal Relationships

People target most of their anger episodes toward others they know well, like, or love more than toward strangers (Kassinove, Sukhodolsky, Tsytsarev, & Solovyova, 1997; Tafrate et al., 2001). When we speak to professional groups on anger, we always ask the audience to remember their last family or marital therapy session, and to raise their hands if the primary affective excess in that session was anger. Most of the hands rise. Clinicians appear to confront anger in the context of family-related problems more than in individual ones. Surprisingly, the family and marital therapy literature fails to address anger.

In preparing this article, we consulted the table of contents and indexes of several influential marital and family-therapy texts. Anger never appeared in the table of contents. Only 2 of the 20 books mentioned anger in the index. These entries reflected passing references to anger but not major discussions. Despite the ubiquity of anger in family-therapy sessions, we do not have a family-systems literature to draw on for treatment implications. Robins and Novaco (1999) are the first authors to approach anger from a systemic per-

spective. Perhaps we should also approach the treatment of anger from a systems approach, include significant others in our assessments, and conduct conjoint therapy sessions.

Damaged Interpersonal Relationships

People perceive anger as negatively affecting their interpersonal relationships more than any other emotion (Scherer & Wallbott, 1994). Succinctly put, anger damages interpersonal relationships. Angry clients are often embroiled in conflicts, and systemic analysis is often required to understand the damage they have done in order to plan to rebuild their social networks. Overcoming one's anger problems does not automatically rebuild the relationships damaged by anger. Perhaps angry people need to recognize and prepare to make restitution to rebuild their damaged relationships, in a manner similar to the 12-step programs recommend for those with substance-abuse problems.

Like-Minded Peers

People with anger problems frequently associate with others who share their acceptance and expression of anger (Robins & Novaco, 1999). This may result in a peer environment that reinforces anger. Such a situation will likely influence the angry person into believing that his or her anger is not a problem, resulting in little motivation to change. Successful therapy may involve helping the client to become aware of the influence of their peer group and perhaps promote a change in favor of establishing relationships with others who deal more effectively with their emotions.

Low Self-Esteem

Reading the clinical literature on anger and speaking to practitioners reveals the popularity of the idea that low self-esteem causes anger. Not surprisingly, many practitioners often target low self-esteem when attempting to treat anger. Our own search of the scientific literature has failed to find any empirical evidence to support this idea. A recent investigation actually reveals the opposite in that anger follows perceived threats to high, unstable self-esteem (Baumeister, Smart, & Boden, 1996). High unstable self-esteem refers to extremely positive self-evaluations that persist or rebound despite feedback from the external world that they do not warrant such grandiosity. People may be more prone to anger and aggression when they believe they are better than others and their special qualities are not being recognized. Practitioners, who work with aggressive individuals such as spouse abusers, adolescent bullies, and prison inmates, often observe that these types of clients possess a grandiose sense of superiority and entitlement (Baumeister, 2001). Of course, not all high self-esteem leads to anger and aggression. However, clients who present with personality disorders such as antisocial personality disorder (conduct disorder for adolescents) and narcissistic personality disorder may be most at risk (Bushman & Baumeister, 1998). Narcissism involves the passionate desire to think well of oneself. Not all people with high self-esteem are narcissistic, and not all narcissists have high, unstable self-esteem.

Anger also includes a greater experience of power or potency than the eliciting threat (Scherer & Wallbott, 1994). Most theorists believe that anger is associated with cognitions involving positive self-efficacy. Thus angry clients may be convinced that their aggressive tactics will resolve their problems. They may fail to see the additional problems anger causes and fail to accept that they cannot have their way.

The central question concerns whether anger associated with narcissism results from low self-esteem and self-efficacy or high self-esteem and self-efficacy. Some theorists suggest that narcissism is a defensive reaction to a low opinion of oneself (Kohut, 1971, 1978). Thus, high self-esteem associated with anger reflects anger's defensive function against depression. In the psychoanalytic literature this is referred to as the compensating theory of narcissism. In an alternative conceptualization, Millon (1981) proposed that narcissists develop because of constant reinforcement and spoiling, which gives them a false sense of entitlement and overconfidence. Whether the high self-estimations of angry clients are defensive or genuine remains an interesting controversy in the field.

Only a few anger-outcome studies have included measures of self-esteem. Those that have included such measures have reported that self-esteem remains unchanged even when large treatment gains are observed on measures of anger and aggression. The hypothesized connection between self-esteem and anger has remained unfounded, and successful anger treatments fail to change self-esteem. Perhaps the role of low self-esteem as a mediator of anger and a target of

intervention should be abandoned until research supports any proposed mediating influence.

Forgiveness

Anger is a moral emotion. Anger episodes are often triggered by violations of moral codes, and involve the perception of injustice or grievance against oneself (Tedeschi & Nesler, 1993) or, the perceptions of another's blameworthiness (Clore & Ortony, 1991; Clore, Ortony, Dienes, & Fujita, 1993). The cognitive component of anger often includes condemning others. Most mental health professionals have ignored this dimension of anger in treatment. Forgiveness appears crucial to the treatment of anger because so much anger arises from condemning those who have trespassed against us.

A literature independent of psychotherapy has evolved on forgiveness. This research suggests that people have difficulty forgiving because of some common myths. The phrase "forgive and forget" is one example. People have difficulty forgetting. If they cannot forget, perhaps they have not forgiven, so they remain angry. Forgiveness occurs when people learn that remembering those trespasses against them is human (conditioning to negative stimuli is never forgotten—see LeDoux, 1995). So forgiving is not forgetting. Forgiveness is also a conscious decision and does not gradually and passively take place. Only recently, researchers in the area forgiveness have added measures of anger to their studies, and so far the results have been successful (International Forgiveness Institute, 1998). While most of us who have studied or developed treatments for anger have disregarded forgiveness, it is often incorporated into the philosophies of religious or spiritual institutions. As the Lord's Prayer says " . . . forgive us our trespasses as we forgive those who trespass against us." Perhaps those who follow their faith can teach us about overcoming anger.

Proposed Core Components of the Comprehensive Treatment Model

The anger-research literature, and the results of our own and others' research reviews, direct us to a core set of intervention strategies to be included in a comprehensive anger-treatment program. We recommend the following components for working with clients with a wide variety of anger problems.

1. *Cultivate the therapeutic alliance.* Anger does not stimulate empathy. Also, angry clients frequently want to vent about their perceptions of unfair treatment and want to change the behaviors of the source of their anger rather than their own emotional reactions to them. This may negatively affect attaining agreement on the goals of therapy, which is an important aspect of the therapeutic alliance. Therefore, therapists need to validate angry clients' sense of transgression early on in the treatment process.

2. *Address motivation for change.* As mentioned above, people often do not wish to change anger. Angry clients need to focus on the distinctions between functional and dysfunctional anger, and become aware of the negative consequences for them of their dysfunctional anger reactions. Conflict regarding the goals of therapy appears more likely to occur with angry clients than for those with other affective excesses. Self-monitoring procedures will help angry clients realize how frequently they get angry and how often they reap the destructive consequences of anger.

3. *Manage physiological arousal.* Anger often causes immediate and high physiological arousal. Lowering bodily tension before focusing on other aspects of the treatment will help the client better attend to subsequent interventions.

4. *Foster cognitive change.* Angry clients are prone to distortion and exaggeration concerning aversive life events. Cognitions concerning blame, unfairness, demandingness, and suspiciousness are also common in anger experiences. Helping clients foster realistic and accurate perceptions, as well as a more flexible cognitive philosophy, leads to emotional and behavioral change.

5. *Implement behavior change.* Angry clients often have deficient repertoires of behaviors and a substantial degree of automaticity associated with overlearned reactions. Learning and practicing new responses helps introduce clients to alternative behaviors and ultimately build in more effective reactions to challenging situations. We strongly recommend that therapists employ some type of exposure, such as exposure to imaginal scenes of anger triggers or actual role-plays of anger triggers, to provide a meaningful context for rehearsing new behavioral skills (Brondolo, DiGiuseppe, & Tafrate, 1997; Tafrate & Kassinove, 1998). Exposure helps the person repeatedly face the eliciting stimuli and learn new, calmer responses.

6. *Teach relapse prevention.* Given the automaticity of anger, low motivation to change anger, the likelihood that anger-triggering events

will prevail, the tendency to see one's anger as justified because the target has violated moral rules, and the impossibility of totally avoiding anger, we perceive the possibility of relapse as high. Anger problems share many characteristics with substance abuse. Therefore, we believe that angry clients can benefit substantially from learning how to react to lapses in their anger-control skills.

Additional Components to Consider when Treating Angry Clients

Additional components may also be necessary to tailor treatment to the characteristics of a particular client. The following is a list of interventions to consider incorporating into a comprehensive model.

1. *Manage impulsive behaviors*. Clients with anger problems often arrive in treatment because their anger reactions have already resulted in or are contributing to some type of impending loss (e.g., relationship, job, interactions with the criminal justice system, etc.). In some cases, an important first step in treatment is to prevent further losses from occurring. Thus, teaching clients avoidance and escape strategies regarding their ongoing anger situations may be critical. While clients may be ambivalent about changing their anger, those facing serious consequences often see the wisdom of formalizing a plan for the short term. Although avoidance and escape strategies are useful for preventing short-term losses, they are unlikely to provide clients with new skills for better managing their anger in the long term.

2. *Incorporate forgiveness*. Clients who present with a rigid focus on attaining revenge because of a perceived or real transgression may fail to make progress with many of the treatment strategies discussed. Their thoughts and desires for revenge will interfere with achieving a therapeutic alliance since their goals of revenge differ from the therapists' goals of anger reduction. The incorporation of forgiveness interventions that target the desire for revenge and the thoughts of condemnation of others may be necessary to augment the treatment plan. Several successful preliminary studies on teaching forgiveness have appeared, and these interventions can be added to anger-control treatment programs.

3. *Consider systemic interventions*. Clients who present with marital and/or family violence or conflict experience their anger in a family or systems context. Since people often direct their anger at significant others it is important to consider the social system or context in which the anger occurs. Such considerations may include having significant others provide assessment data on the client's anger, share their perceptions of negative consequences related to the client's anger, and participate in some sessions.

4. *Catalyze restitution/reintegration*. The negative systemic effects of anger on interpersonal relationships can become entrenched because family members remain distant or estranged from the angry person. Angry clients have destroyed interpersonal relationships and may have self-selected for anger-supporting environments. A focus on rebuilding relationships through positive caring goes a long way to encourage systemic change.

5. *Provide environmental supports*. As noted above, angry clients may have created a support group that reinforces their anger. Thus, clients who belong to social groups that encourage or support their anger may benefit from environmental change. Becoming aware of the social support for anger, attempting to avoid such groups, and establishing new relationships may further reduce anger.

6. *Develop a therapy format*. If you wish to influence affective driven aggression, develop and use treatment manuals and check that therapists follow them. Also, utilize an individual therapy format rather than group therapy.

Concluding Comments

Anger is an emotional problem frequently encountered by practitioners in a variety of mental health settings. Although many questions remain about anger and its treatment, the current scientific literature has much to offer in guiding clinical practice. The strategies outlined in the present article are proposed as a menu of options practitioners can draw upon to develop treatment programs for individual clients. While the proposed strategies are not an exhaustive list of all possible effective interventions, they represent those that are most promising given our current state of knowledge. As anger becomes formally recognized as a clinical problem worthy of treatment, we hope that comprehensive, empirically supported programs will be developed for specific client populations.

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