

Cognitive-Behavior Therapy for Reduction of Persistent Anger

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Although persistent anger is not represented in DSM-IV as a psychiatric disorder, it is nevertheless a significant clinical problem. Based on our experience with both research and clinic patients from a diverse urban population, and drawing on methods utilized by others, we have refined and elaborated several treatment strategies that appear useful for anger reduction. The strategies derive from a counterconditioning treatment model: patients are exposed (either naturally or by design) to situations that may evoke anger; while they apply physiological, cognitive, and/or behavioral methods that can dampen the habitually angry response. The specific anger-reduction methods include: applied muscle relaxation, cognitive reappraisal, inhibition of overresponding, and reversal of underresponding (through acquisition of effective communication and problem-solving skills). Preliminary evidence is presented indicating that anger patients experience significant reduction in the intensity, duration, and frequency of anger reactions after completing 12 sessions of therapy utilizing these anger-reduction methods.

ANGER is the neglected stepchild of the mental health field. Although widely recognized as a significant mental health problem, persistent anger still is not represented by a diagnostic category in the official psychiatric nomenclature (*DSM-IV*; American Psychiatric Association, 1994). In contrast, anxiety and depression—the other two principal negative emotions—have numerous categories and distinctions specified in *DSM-IV*.

Yet, persistent anger has significant psychological, behavioral, and even medical ramifications. Persistent anger causes major emotional suffering for both the person who experiences the anger as well as for those involved with him or her. Persistent anger is associated with risk for cardiac illness (Smith, 1992). Persistent anger also presents dangers from a public safety standpoint, as it can lead to domestic or other forms of violence (Eckhardt, Jamison, & Watts, 2002; Lundeberg, Stith, Penn, & Ward, 2004; Norlander & Eckhardt, 2005). Finally, anger is often a component of other psychological illnesses, such as anxiety and mood disorders, and successful treatment of these conditions may depend on alleviation of persistent anger (Suls & Bunde, 2005).

Unfortunately, as a clinical phenomenon, persistent anger is not as well understood as many other psychiatric constructs. The lack of an official Axis I diagnostic category for an “anger disorder” *per se* has undoubtedly

hampered progress in this area, making it difficult to arrive at empirically based prevalence estimates. The limited evidence available suggests that a legitimate anger disorder can exist on its own, without other psychiatric diagnoses present, and that anger problems are often correlated with other behavioral or social problems such as school or work difficulties, alcohol and drug use, financial difficulties, legal difficulties, and low self-esteem (e.g., Deffenbacher, Demm, & Brandon, 1986; Deffenbacher & McKay, 2000; Deffenbacher et al., 1996). At the same time, evidence indicates that anger can also be associated with specific psychiatric disorders (Suls & Bunde, 2005). Psychiatric comorbidity studies find overlap among anxiety disorders, depressive disorders, and anger problems: a patient experiencing any one of these disturbances is at increased risk for experiencing the others (Fava & Rosenbaum, 1999; Koh, Kim, & Park, 2002; Stavrakaki & Vargo, 1986; Swan, Carmelli, & Rosenman, 1989).

Treatment studies provide further evidence for the clinical connections among anxiety, depression, and anger, as research indicates that pharmacological and psychosocial treatments directed at one symptom area can improve the other two (Suls & Bunde, 2005). For example, selective serotonin reuptake inhibitors (SSRIs), which are effective in treating both anxiety disorders and depression (Dunner, 2001), have been found helpful in the treatment of aggressive behavior in substance abusers (Lavine, 1997) and anger attacks in depressed patients (Fava et al., 1993). In addition, psychosocial treatments directed at one symptom area (anxiety, depression or anger) have been

shown to improve the others (Barrowclough et al., 2001; Borkovec & Ruscio, 2001; Brown, Antony, & Barlow, 1995; Dahlen & Deffenbacher, 2000; Deffenbacher, Dahlen, Lynch, Morris, & Gowensmith, 2000; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000; March, Amaya-Jackson, Murray, & Schulte, 1998).

Clinicians are universally aware that anger is an important and difficult clinical problem in its own right and that, even if a diagnostic category for an anger disorder does not yet exist, an effective treatment is required. Fortunately, the problem has not been entirely neglected by cognitive-behavioral psychologists (Bron-dolo, DiGiuseppe, & Tafrate, 1997; Deffenbacher & McKay, 2000; DiGiuseppe, Tafrate, & Eckhardt, 1994; Novaco, 1975; Williams & Williams, 1994), and treatment methods have proven effective (Del Vecchio & O'Leary, 2004; DiGiuseppe & Tafrate, 2003). Among the methods that have been used and empirically supported are applied relaxation, cognitive therapy, social and communication skills training, as well as approaches that combine these different elements (Del Vecchio & O'Leary, 2004).

With applied relaxation (also called relaxation coping skills training; Deffenbacher, 1995) patients are taught a standard progressive muscle relaxation exercise, which is then refined and shortened through the use of imagery and/or breathing as relaxation cues. Patients next rehearse relaxation coping skills by combining the visualization of anger-provoking scenes with the application of the relaxation response. Patients then extend the application of the relaxation response to real-life anger situations. Studies finding empirical support for applied relaxation include those by Deffenbacher, Filetti, Lynch, Dahlen, and Oetting (2002), and Hazaleus and Deffenbacher (1986).

With cognitive therapy, patients are taught to be aware of how their thinking can either trigger or augment feelings of anger. For example, anger patients commonly misinterpret the motives of others, perceiving malevolent intentions where none exist. Cognitive therapy is designed to help patients identify such distortions and ultimately modify them. Studies finding empirical support for cognitive techniques include those by Dahlen and Deffenbacher (2000), Deffenbacher et al. (2000), and Hazaleus and Deffenbacher (1986).

With social and communication skills training, patients are taught listening skills, compromise strategies, and assertiveness (Deffenbacher, 1995). These skills are then rehearsed in therapy sessions and ultimately transferred to real-life situations. Studies finding empirical support for social/communication skills training include those by Deffenbacher, Thwaites, Wallace, and Oetting (1994), Moon and Eisler (1983), and Rimm, Hill, Brown, and Stuart (1974).

Despite the availability of cognitive-behavioral techniques for treating persistent anger, the methods are not as widely disseminated or taught as those for anxiety disorders or depression, so many clinicians remain unaware of these evidence-based treatments. Moreover, advances in clinical methodology are not readily shared, as regular forums devoted to anger treatment are lacking.

For the past several years, our Behavioral Medicine Program has been offering individual cognitive-behavior therapy for anger reduction both as a clinical service and as part of a randomized clinical trial to study the effects of anger reduction on physiology, specifically, heart period variability. Heart period variability is a noninvasive index of cardiac autonomic modulation linked in children and adults to differences in affect regulation. Anger or hostility is associated with reduction of heart period variability (Sloan et al., 2001), and both anger and reduced heart period variability are, in turn, predictors of cardiac disease (Liao et al., 1997; Smith, 1992; Tsuji et al., 1996). The research, in progress, is therefore designed to determine whether cognitive-behavioral anger-reduction therapy can have a salutary (i.e., heightening) effect on heart period variability.

At this point, we estimate that we have conducted individual therapy with over 200 adult anger patients from our diverse urban area—both research participants and clinic patients, all of whom had no other psychiatric diagnoses—and can share our treatment experiences as well as some preliminary findings. Our treatment approach integrates the empirically validated techniques described above—relaxation, cognitive therapy, and social skills training—but also incorporates certain refinements and elaborations that we have found advantageous. We believe that the resulting treatment package, which we present below in detail, will be useful to other clinicians who are encountering many of the same difficulties in their own patients.

The Patients

The patients are varied, but they all report persistent anger in at least one of four areas: (a) domestic (i.e., interactions with their spouse, partner, or children), (b) interpersonal (i.e., interactions with boyfriend/girlfriend, friends or relatives), (c) occupational (interactions with boss, co-workers, subordinates), or (d) public (interactions with strangers, in stores, on public transportation, etc.). Patients in our clinical trial must have no other psychiatric diagnoses and must meet cutoff criteria involving scores of at least one standard deviation above the normative mean on both the Cook-Medley Hostility Scale (Cook & Medley, 1954) and the Trait Anger Scale of the State-Trait Anger Expression Inventory (Spielberger, Jacobs, Russell, & Crane, 1983).

All patients complain of significant distress arising from their anger reactions, either because the feelings themselves are aversive, or because their relations with other people or their ability to function effectively is impaired. Almost all patients describe the problem as long-standing. Some patients are characterized by uncontrolled, angry outbursts, but others experience their anger more privately, with few outbursts. For most, significant anger, whether expressed outwardly or not, occurs almost daily. Four vignettes (below) provide examples of patterns we have seen.

Anger Vignette 1

A 38-year-old man, who worked as an office machine technician, reported extremely stormy relations with his live-in girlfriend as well as ongoing conflict with his work supervisor. Regarding his girlfriend, the patient described a pattern of constant arguments arising from his dissatisfaction with her handling of household tasks. Much of his anger, he said, stemmed from his feeling that she was a sloppy housekeeper and unable to manage the simplest responsibilities. As an example, he cited her attempt to get a phone line installed. She had set up the appointment but, having been delayed at the supermarket, did not arrive home in time to greet the telephone installer. When the patient learned, upon arriving home from work, that the line had not been installed, he became furious, kicking furniture and berating his girlfriend for her incompetence. The arguing and yelling over this incident continued for several hours. There were several such incidents every week. On one occasion in the past, neighbors summoned the police.

At work, the patient experienced constant conflict with his supervisor. He believed his supervisor viewed him with contempt, acting as though the patient was “some kind of thorn in his side.” In addition, the patient felt that the supervisor favored other workers over him, giving them easier assignments or showing them more understanding when they ran into difficulties. The patient complained that when things went wrong on the job, the supervisor was quick to accuse him, and the patient was equally quick to establish that the supervisor “didn’t know what he was talking about.” When he was not overtly quarreling with his supervisor, the patient’s attitude toward his supervisor was silently combative. As the patient described it, “it’s just a job to me, and I make sure he knows it.” The result was continuous, almost unbearable, tension on the job.

Anger Vignette 2

A 41-year-old woman, a public relations executive, reported outbursts of anger both at work and in public. As she put it, “One of these days I’m going to be either fired

or arrested.” At her job, she berated secretaries for any perceived deficiency in their work. For example, on one recent occasion, when a document was not prepared by the time the patient expected it, she became furious and screamed at the secretary, “What’s wrong with you? Didn’t I tell you I needed this? Don’t you pay attention?” When the secretary gave legitimate reasons for the delay, the patient yelled, “I don’t give a sh*t about your miserable excuses; I just want it done.” Then she returned to her office and fumed. The patient had already lost several secretaries due to her abusive behavior. By the time she entered treatment, she had been placed on probation at work.

In public, similar displays of temper occurred. If someone did something she didn’t like—talk too loud on a cell phone, show her less than full “respect” at a checkout line, take up too much room on the bus—she became incensed and verbally abusive. Once, while buying an airline ticket, she felt the ticket agent was not making sufficient eye contact. This angered her so much that she called the agent “worthless” and refused to transact any further business until she could deal with another agent. When the agent informed her that no one else was available, the patient refused to budge and would not allow any other customers to be served until a supervisor was summoned from another building to serve her.

Anger Vignette 3

A 25-year-old woman who worked as an advertising sales agent for a magazine reported daily tension and anger at work. The anger was rarely overt; rather, she harbored chronic resentment toward both her superiors and co-workers. A consistent pattern involved her taking deep offense whenever an error in her work was brought to her attention. For example, when notified by her superior of an incorrect entry in a contract she had prepared, she thought, “That bitch! I help her out with something, and all she can do is complain about what I did wrong. I’d like to see her do these contracts without making mistakes.” The patient also resented having to assist a less capable co-worker who occupied the desk next to hers; she believed it was unfair that she should have to “lower” herself to help someone else, especially as she had not received a promotion reflecting her greater capabilities. In dealing with these situations, the patient avoided displays of temper; in fact, overtly, she communicated no dissatisfaction at all. Instead, she adopted a persona that she referred to as the “ice princess.” She maintained a haughty distance from superiors and co-workers and engaged in minimal communication, deliberately inhibiting any facial expression except for a barely perceptible sneer (“to let them know I have no use for them”). She said she knew she must be viewed by others as difficult and

sullen, but she had no interest in having good relations with the people at work. At the same time, she was clearly tense and unhappy at her job.

In her personal life, the patient had a volatile telephone relationship with her long-distance boyfriend, who was spending a year at school in Europe. The recurring theme was: he would not “commit” to any future plans together despite her continuing efforts to get him to do so. Many conversations involved her screaming at him to “get his act together” and then ended with her slamming down the phone in her frustration over his evasiveness about their future.

Anger Vignette 4

A 30-year-old man, a truck driver for a medical equipment company, reported almost daily anger at his girlfriend, with whom he had been living (along with her 10-year-old daughter) for about a year. The anger derived from his persistent concern that she might cheat on him, or at least flirt with other men. He would call her a dozen times per day at her job (as a nurse) in order to ascertain that she was indeed at work. Needless to say, she found this highly intrusive; however, if she failed to come to the phone, he would become angry and start phoning more insistently. Then, when she did come to speak with him, he would demand that she explain any delay. Sometimes he would call her co-workers, seemingly just to chat, and ask leading questions about his girlfriend’s activities, to see if their report contradicted any of her claims. If he detected what he thought was a contradiction, he would confront her with the evidence when he came home in the evening, and a prolonged argument would ensue.

His suspiciousness also led him to demand that his girlfriend go nowhere without him on weekends. Even when he was with her, he would closely monitor her demeanor to see if she was showing any interest in other

males. If he detected any friendliness (for example, in her interaction with a store clerk), another angry argument was in store.

When applying for treatment, the patient stated he knew his anger and suspiciousness were irrational—he had no legitimate cause for suspecting his girlfriend—but he found he was unable to restrain his behavior or his feelings in spite of this knowledge. He said the same pattern characterized his previous relationships, and was usually responsible for the breakups.

The Theoretical Treatment Model: Exposure-Based Counterconditioning

We label our treatment “anger reduction” as opposed to “anger management” therapy because the goal of treatment is not just to help patients manage their angry feelings, but more important, to get them to stop *feeling* anger most of the time. Our cognitive-behavioral conceptualization of persistent anger is represented by Figure 1.

According to the model, most anger events involve three main components: (a) the triggering event, (b) the person’s internal reaction (involving cognitive appraisal of the triggering event and physiological arousal), and (c) a behavioral or verbal response.

Regarding cognition, the model posits that anger patients develop characteristic patterns of thinking about many external events or experiences, which then drive their physiological arousal and their behavior. The thinking pattern seems to involve a persistent interpretation of events based on a sense of aggrievance: the idea that one has been treated unfairly, improperly, or that some other offense has been perpetrated. An additional element seems to be the belief that such unfairness or impropriety cannot be tolerated or allowed to stand, and must be confronted in some way (DiGiuseppe, Tafrate, & Eckardt, 1994; Novaco, 1975). The consequences of these thoughts, according to the model, are both emotional and

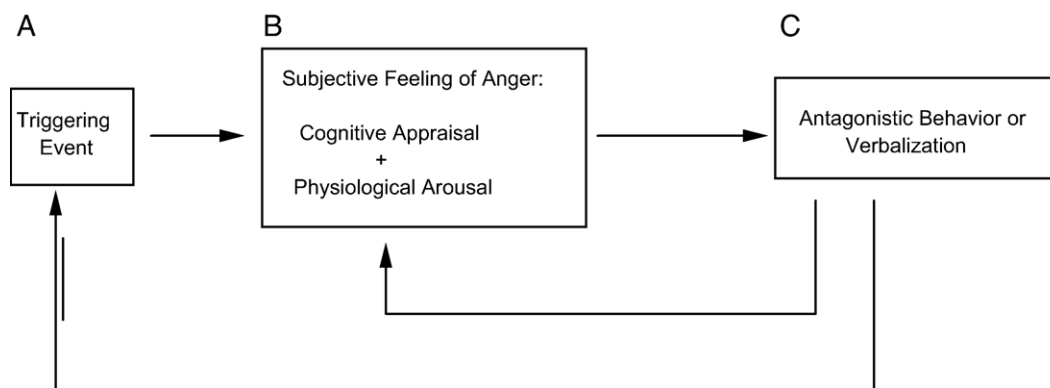


Figure 1. Cognitive-behavioral conceptualization of persistent anger.

behavioral. From an emotional standpoint, the main consequence is arousal of the autonomic nervous system, which, when combined with the foregoing cognition, produces the subjective experience of anger. From a behavioral standpoint, the emotional reaction disposes the individual toward action, specifically, action of an antagonistic nature.

Antagonistic behavior is thought to have two important consequences, leading to the feedback loops in Figure 1. First, the very act of behaving antagonistically is considered to fuel a person's angry feelings. In support of this idea, laboratory studies have shown that body and facial responses characteristic of a given emotion, including anger, augment the subjective experience of that emotion (Adelmann & Zajonc, 1989; Berkowitz, 1990). Second, antagonistic behavior affects the environment in ways that can create further angry feelings. In particular, antagonistic behavior provokes antagonism from others, thus creating additional triggers of anger, and a resultant disposition to act even more antagonistically in return. The escalating series of events can produce a highly stressful experience, even a physical altercation, which, aside from its immediate physical and emotional consequences, strengthens the individual's belief that the world is an antagonistic place.

As with anxiety disorders, the treatment model is essentially a counterconditioning one. In simple terms, the idea is to have the patient enter into contact with anger-provoking stimuli while applying various methods (physical, cognitive, and behavioral) to dampen the usual angry reaction. With repeated experience, including more and more successful application of anger-reduction skills, the patient's emotional reaction to formerly anger-provoking stimuli ultimately becomes more neutral.

Treatment Components

Our cognitive-behavioral treatment protocol involves 12 weekly individual therapy sessions, and includes six categories of methods: (1) psychoeducation, (2) self-monitoring, (3) cognitive restructuring, (4) behavior therapy (including behavioral anger reduction guidelines, problem solving, and behavioral exposure), (5) relaxation and visualization exposure, and (6) in vivo exposure. Although our treatment manual offers a session-by-session sequence in the delivery of methods, clinicians have the flexibility to alter the sequence and to give greater emphasis to some methods over others, as clinical judgment dictates. However, the treatment protocol stipulates that, whenever feasible, all methods be introduced and followed up at some point in the therapy, and that the implementation of a given method conform to the manual's specifications. Thus, our approach

attempts to incorporate both scientific rigor and clinical flexibility.

Psychoeducation

Psychoeducation, which is conducted mainly in the initial session, involves explaining to the patient our conceptual model of persistent anger and the cognitive-behavioral treatment approach that is implied. To assist with this, we explain to patients the concepts in Figure 1. In presenting the model, the clinician draws the patient's attention particularly to the elements B (cognition) and C (behavior).

Regarding *cognition*, we tell patients that the feeling of anger is to a certain extent determined by the way a person interprets or thinks about the triggering situation. This notion often has to be approached delicately with anger patients. Unlike most anxious or depressed patients, anger patients can be resentful of the implication that their emotional reaction might derive from a problem in perception. Therefore, we illustrate the point with a nonthreatening example, usually outside the scope of the patient's current complaints. For example, the clinician might describe a fairly generic situation, such as failing to get a reply after saying "good morning" to a co-worker. The clinician then explains that different feelings might result depending on how one interprets the co-worker's lack of response. For example, if the patient believed that the co-worker failed to respond because the co-worker considered himself superior to the patient, then the patient would likely experience some anger or resentment. On the other hand, if the patient believed that the co-worker was distracted or upset, then the patient would probably have a more neutral reaction. Most anger patients can recognize from this example that they would probably feel less anger if they felt their co-worker was distracted as opposed to ignoring them deliberately. The clinician points out that it is impossible to know for sure the actual reason why the co-worker failed to reply, but by thinking flexibly (i.e., recognizing a range of possible reasons), the feeling of anger can be lessened.

Regarding *behavior*, the clinician explains that how a person conducts him- or herself in a situation can also determine how much anger is ultimately experienced (the feedback arrows in the figure). The most obvious case is when angry behavior antagonizes another person, leading to an escalation of interpersonal conflict. The less obvious (or less well-known) aspect for patients is the effect that angry behavior has on their own emotions. We explain to patients that, contrary to popular belief, "letting it all out" usually does not reduce anger. Indeed, when people behave in an angry fashion, their subjective sense of anger is often amplified, whereas more neutral behavior tends to quell anger.

At this juncture in psychoeducation, some patients get concerned (if not alarmed) that we are leading up to the idea that they will have to start subjugating themselves to the will of others as a means of overcoming their anger. Indeed, part of the problem with patients who have persistent anger is that they see no middle ground between total submission and unbridled combativeness. Therefore, we sometimes must hasten to explain that the therapy will not demand that the patient renounce his or her right to self-expression, as suppressing legitimate grievances actually fuels anger in the long run. However, therapy does entail learning how to replace angry forms of expression with more neutral approaches.

Finally, the clinician notes that the model identifies *physiological arousal* as a component of anger. This physiological arousal, we explain, involves activation of the autonomic nervous system and can be felt in a number of organ systems. It may take the form of: heart palpitations, sweating, trembling, muscle tension, tightness in the stomach, or other symptoms. The patient is asked, "What are the physical symptoms you are most aware of when you're angry?"

After having explained the cognitive, behavioral, and physiological factors in persistent anger, the clinician explains that specific treatment methods are directed at each factor. Regarding the physiological aspect, the treatment entails certain physical relaxation exercises designed to reduce nervous system arousal. Regarding the cognitive aspect, the treatment will involve: (a) learning to identify patterns of thinking that the patient has developed that may be contributing to anger, and (b) learning alternative ways of thinking that produce less anger. Regarding the behavioral aspect, the patient will learn different ways of handling provocative situations, ways that are both less likely to foster angry feelings, and that also will be more effective in getting problems solved.

The clinician also explains that various exercises will be staged for developing these skills. The exercises involve visualization, role-playing, and real-life exposure to problematic situations in which the patient applies relaxation, cognitive, and behavioral skills. The patient is told that, with these real-life (in vivo) exposures, not only will the patient's anger-reduction skills get better, but with more positive experiences arising from proper application of coping techniques, the patient will acquire different (more positive) associations to formerly provocative situations (counterconditioning). As a result, anger will no longer be the automatic response when these situations arise.

Self-Monitoring

At the first session, the clinician introduces a *self-monitoring* form and explains that, henceforth, the patient

will keep daily track of all significant feelings of anger. The form follows a standard cognitive-behavioral format, in which patients enter the following information concerning each anger reaction: date, time of day, triggering situation, immediate thoughts about the triggering situation, behavior in the situation (and the result), intensity of anger reaction (1-to-10 scale). A patient is asked to record feelings that are at least a 3 on a 1-to-10 scale. However, if items of 3 or greater are not occurring every day, then the patient is asked to record episodes of more minor anger (annoyance or irritation), as even trivial incidents can provide therapeutic material. In introducing the self-monitoring procedure, it is important for the clinician to explain that the recording will be restricted to cases where the patient had an outburst or some other overt anger response. With many patients, actual outbursts reflect only a small portion of their angry feelings, and important clinical material will be neglected if only overt reactions are recorded. Therefore, patients are told that any significant *feeling* of anger should prompt an entry on the self-monitoring form.

Cognitive Restructuring

Cognitive restructuring therapy follows familiar principles, and is cued by incidents reported in the patient's self-monitoring form. For each incident, the therapist begins by trying to understand the patient's train of thought through persistent (but gentle) questioning. Often the question, "What is the problem with that in your view?" will draw out the patient's thinking. For example, a patient reported that she was angry because her boss had asked her to start helping out a co-worker who was struggling with his work. In response to the therapist's questioning, the patient's thinking ran along the following lines: "This is outrageous. I have plenty of other things to do. This shows no regard for me on the part of my boss. It's not my fault that he (the co-worker) is such an incompetent sh*t, and it's not right that I suffer on account of it."

Pronouncements such as these can sometimes seem daunting to a clinician who is trying to conduct cognitive therapy along conventional lines (e.g., Beck, 1995), in which the therapist draws upon evidence in order to challenge a patient's excessively negative interpretation of a situation, with the goal of arriving at a more accurate, or at least more balanced, interpretation. The difficulty with anger patients is that appealing to the evidence goes only so far. This is because their negative cognition usually entails a subtle blend of two distinct issues: issues of fact and issues of fairness (DiGiuseppe et al., 1994). Issues of fact in this patient's thinking are exemplified by thoughts such as: "I have plenty of other things to do"; "This shows no regard for me on the part of my boss"; and "It's not my fault that he is so incompetent." Issues of fairness are raised in such

thoughts as: “This is outrageous [that I have to do this]”; and “It’s not right that I suffer . . .”

For issues of *fact*, the traditional cognitive approach—treating thoughts as hypotheses to be weighed against the evidence—serves the clinician adequately. In this particular case, the clinician can explore with the patient the validity of the thought, “I have plenty of other things to do” with respect to the patient’s actual capacity to absorb the task of assisting the co-worker. Through gentle discussion, the patient conceded that, although she did indeed have plenty else to do, it was not an extreme hardship to assist the other person. Similarly, the patient could be persuaded that the boss’s decision to give her this additional work showed not so much a lack of regard, but quite possibly, a high regard, as he clearly had great confidence in her abilities. The statement, “It’s not my fault that he’s so incompetent” is moot because, as a factual matter, it is patently true. However, it carries the implication that the patient has no responsibility to help remedy her coworker’s shortcomings, which crosses over into the domain of “fairness.”

Fairness is the main cognitive sticking point with anger patients. Much of their anger derives from the idea that they are not being treated fairly, or that other people are behaving improperly, or that some other form of injustice is being perpetrated. Thus, they may believe that the work at their job is not being apportioned fairly, that their friends are not treating them properly, that their girlfriend/boyfriend or spouse is not giving them the attention they deserve, that other passengers are taking up too much room on the subway seat, or are talking too loudly in the elevator, etc. Even if the patient is not the direct target of an affront, he or she may take offense at the mistreatment of others.

Conventional cognitive restructuring that relies on consideration of “the evidence” to counter a patient’s distorted thinking often does not help with beliefs such as these because propositions about fairness, propriety, or justice generally cannot be resolved by evidence (DiGiuseppe et al., 1994). What sort of evidence would resolve the question of how loudly people have a right to speak in elevators, or how much attention a woman has a right to expect from her husband? Sometimes a fairness question may seem to have a partial solution in evidence, as when a patient asserts it is not fair that she be given certain tasks in her job. In such a case, the therapist might ask the patient to refer to her job description to see if the new duties are covered; if the duties are not explicitly covered, the therapist could try taking a more nuanced approach, suggesting that the new duties are perhaps implied in the job description, and so on. This might succeed as far as it goes, but it is predicated on demonstrating that the situation is indeed fair and leaves the larger issue—the patient’s excessive

need for fairness—untouched. It is this excessive need for fairness that brings anger patients continually into conflict with other people.

Of course, a therapist could try to liberalize the patient’s concept of fairness—trying to get the patient to see more things as “fair”—but we have generally found that discussions along these lines with anger patients are not productive. Attempts to modify a patient’s concept of fairness often lead to useless wrangling over what is and is not fair, and ultimately runs the risk of putting the therapist on the side of people with whom that patient is having conflicts. Perhaps the greatest problem with such an approach is that it tends to validate the patient’s misguided idea that having fairness in the world is the key to relief from frustration. Why else would a therapist try to get the patient to see more things as “fair”?

In order to become less angry, patients must ultimately learn to tolerate unfairness (or what they perceive to be unfairness). The unspoken message (automatic thought) that often accompanies patients’ feelings of anger is actually two messages: (a) “This is unfair” and (b) “*I cannot tolerate it.*” It is the latter proposition that needs to be refuted through cognitive methods. To help patients see that they can indeed tolerate various forms of unfairness, it is often helpful to focus on the practical impact of various incidents that the patient has labeled as “unfair.” For example, one of our patients reported that someone cut ahead of her while she was standing at a grocery checkout counter and that she (the patient) felt furious about it. The therapist might propose the idea that the so-called offender did not realize her error, but ultimately, therapy has to deal with the possibility that there was no error at all—that the offender was indeed taking advantage. In this case, the therapist can ask the patient to assess the practical consequence of losing her place on line, as illustrated by the following dialogue:

THERAPIST: How many items did this other person have?

PATIENT: A lot—I think she had at least 10.

THERAPIST: How long did it take to ring those items up?

PATIENT: I didn’t exactly time it, but it seemed like I had to wait a long time.

THERAPIST: Well, let’s estimate—how many minutes does it take to ring up 10 items and handle the payment, bagging, etc.

PATIENT: I suppose you could figure 2 minutes to ring them up, maybe another 2 for the rest of it.

THERAPIST: Therefore, this particular incident led to 4 minutes of delay—perhaps 5.

PATIENT: I guess that’s true.

THERAPIST: How important were those 5 minutes to you? Did you need to be somewhere else?

PATIENT: I was on my way home after work. I wasn't planning to do anything there except sit around and watch TV.

At this juncture, the therapist needs to proceed gingerly, so as to avoid appearing to demean the patient by implying that her feelings (and her free time) do not matter, and, therefore, she should just learn to take what others dish out. Accordingly, it is important to set forth a parallel principle, which entails a novel way of looking at things for most anger patients. The principle is: the patient is *too* important, and has too much self-respect (or could have), to allow herself to be troubled by the minor transgressions that others commit. This is often an alien concept to anger patients, who typically consider the measure of their self-respect to be their willingness to oppose or confront other people's misconduct. However, the sense of obligation to oppose others erodes patients' self-respect in the long run because it sets up an impossible standard. When the patient fails to speak up (which is often wise), she feels like a weakling; and when she does speak up, and other people do not give her the satisfaction she seeks (as is often the case), she feels demeaned and ineffectual. The cumulative effect is general resentment of other people, who continually (although inadvertently) seem to put the patient in an unsolvable quandary.

It is ultimately an enormous relief to anger patients to adopt the perspective that it is not a personal failing to disregard other people's misbehavior. However, this alteration in outlook is usually achieved gradually, through a combination of cognitive and behavioral methods. To broach this cognitively, it can be helpful for the therapist to propose that the patient does not need or deserve the inconvenience of dealing with other people's misconduct, especially when the impact on the patient is minor or trivial. Specifically, the idea is that the nuisance of confronting another's misconduct—or even focusing on it—is often greater than the nuisance of the misconduct itself. Following is an example of a therapist-patient dialogue that aims to restructure the patient's thinking along these lines:

THERAPIST: So, the inconvenience [caused by the other shopper] was only about 5 minutes, and it sounds like you didn't have a great need for those 5 minutes anyway.

PATIENT: True.

THERAPIST: How strong was your emotional reaction to the situation?

PATIENT: Pretty strong. I mean, all I could think about was what a bitch she was for cutting in. And then I said something to her to that effect.

THERAPIST: What was her reaction?

PATIENT: She said something rude back.

THERAPIST: And then what.

PATIENT: I didn't say anything more, but then I felt even more furious. I was keyed up about it for the entire trip home. Even after I was home I kept thinking about the situation and trying to come up with other things to say to her.

THERAPIST: So the whole thing had a pretty strong impact.

PATIENT: Yes.

THERAPIST: Let me ask you this. If someone had said to you, "I can relieve you of this bad feeling; all you have to do is cut out 5 minutes of television tonight", would you take that deal?

PATIENT: Yes, that would sound like a good deal to me. I hate feeling that keyed up for so long.

THERAPIST: Well, then, I guess the point I would make is that maybe you could look at the situation this way: that such a deal was more or less available to you at the time.

PATIENT: You mean, if I had said to myself, "Her getting ahead of me in line just means 5 minutes less of TV tonight, and nothing more", and then I just let it go at that, I wouldn't suffer so much.

THERAPIST: Yes. I know it's easier said than done, but that's the basic idea.

In the next dialogue, the patient's assumptions about the necessity of confronting other people begin to surface, as she questions whether it is acceptable just to let the misbehavior pass. The therapist then tries to help the patient to see restraint as a strength, rather than a weakness:

PATIENT: But shouldn't I say something to her?

THERAPIST: Why?

PATIENT: I mean, she's doing something wrong. Why should I let her walk all over me?

THERAPIST: But I think, as we discussed, the idea that she's "walking all over" you is not really true as a practical matter. The 5-minute delay is trivial.

PATIENT: I suppose. But how can I let her just get away with it?

THERAPIST: What's wrong with letting her get away with it?

PATIENT: Well, shouldn't I stand up for myself?

THERAPIST: I suppose a person should stand up for herself, but I wonder what "standing up" for yourself really consists of in this situation. Since it's so troublesome to confront the person, and you feel so stressed afterward, maybe standing up for yourself means identifying your real interest in the situation and not letting someone else get you sidetracked. What would you say is your real interest in the situation?

PATIENT: I guess it's just buying my things and getting out of there with a minimum of fuss.

THERAPIST: That sounds right to me. So maybe standing up for yourself means making a mental calculation that it's not worth your time, effort, and emotional energy to bother yourself with people who don't really matter to you.

PATIENT: That makes sense. Taking that approach sort of lets me off the hook.

The discussion allows the patient to shift her perspective somewhat. She begins to view the idea of disregarding other people's minor misconduct as a matter of self-interest and, therefore, as possibly a reflection of strength as opposed to weakness. The patient can think of herself as occupying a higher plane, i.e., rising above the fray as opposed to being dragged into it. Ultimately, by adopting this view and putting it into practice, the patient's sense of well-being is no longer placed so squarely in the hands of others; she feels more in control and, ultimately, less resentful of other people because they no longer have the same power over her feelings. Of course, this change of perspective is not accomplished right away. In our judgment, behavioral experience (see below) proves critical in bringing about the shift.

Behavior Therapy

Cognitive enlightenment goes only so far. Behavioral experience is ultimately essential in getting patients to think and feel differently in potentially anger-provoking situations.

The behavioral changes we promote apply to two (opposite) types of activity. The first type of activity, which needs to be reduced, can be termed *overresponding*. Overresponding generally involves patients' attempts to get other people to behave, think, and/or feel in ways that the patient (but not the other party) believes is necessary and correct. Examples include: demanding that a new girlfriend stop talking to all other men; requiring that a grown daughter show a greater desire to visit her parents; insisting that another passenger in the subway not take up so much room; refusing each morning to show an employment ID to the security guard because "she should recognize me by now" (and expecting the guard to accept this); insisting that a child always remember to hang up her coat after she comes home from school (when countless trials have established that the child cannot remember this without prompting). In our estimation, these behaviors fuel anger and frustration in part because the patient receives no recompense for his or her (often extensive and insistent) efforts. The frustration is compounded because the patient believes (falsely) that he or she is obligated to put forth such efforts and is weak and/or a failure—either that, or the other person is bad—if such

efforts do not succeed. Additionally, these behaviors tend to antagonize other people, leading to interpersonal conflict, which compounds the angry experience and confirms the patient's view of the world as a difficult and antagonistic place. In short, the patient tries to control the uncontrollable and frustrates both himself and others in the process.

The second type of activity consists of behaviors that the patient needs to increase. These are the efforts that the patient actually *should* be making on her own behalf. Anger patients often fall into a pattern—which can be termed *underresponding*—of failing to inform other parties of their legitimate needs or problems out of fear that the other party will get angry or be offended; as a result, problems do not get addressed for days, weeks, or even years. Examples include: refraining from informing the boss that the patient cannot stay at work beyond a certain hour (so the patient just stays without comment); not telling a co-worker that a certain requested task is outside of the patient's duties (so the patient just grudgingly keeps doing the task); not telling a relative that it is a hardship to babysit her children on particular days (so the patient just babysits and suffers the hardship). Readers may wonder, how do patients who fail to restrain themselves in so many other (useless) circumstances, stifle themselves so decidedly in these? The answer, we feel, is that anger patients generally engage in more self-restraint than self-expression—they could not survive otherwise! But, when they do express themselves, they do so indiscriminately (and vehemently) and, as a result, they are branded as volatile. However, most of the time, patients just seethe internally, feeling largely paralyzed as they cannot make distinctions between cases when speaking up serves a purpose and when it does not. And, when they do speak up in justifiable circumstances, their approach is often combative; so, rather than solving problems, patients find they just create more difficulties for themselves.

Behavior therapy is designed to address both areas—overresponding and underresponding—through various methods.

Treatment of overresponding. To help patients curtail overresponding, we discuss appropriate criteria for acting on "problems" with other people. The criteria are similar to those suggested by Williams and Williams (1994). First, we suggest that patients ask themselves whether the problem is *important*, meaning important in a practical sense. We do not accept the notion that an issue is important simply because it angers the patient, or because of "the principle of the thing" (criteria that anger patients often apply). Instead, we encourage patients to start measuring the importance of issues according to their purely practical impact. Some patients may balk a little at this approach, feeling that they are being asked to

compromise their principles (“Taking up two seats in the subway is wrong. I don’t care if another seat is available!”). However, we counter with the notion that patients have been far too wedded to their principles (or expectations or requirements, etc.) up until now, and it has resulted in chronic stress, frustration, and conflict. We explain to patients that in order for them to become less stressed, they will need to be less focused on “principle”, maybe ignoring it entirely if matters of high morality are not involved.

In the meantime, the new gauge that patients are to apply to problematic situations is a purely pragmatic one: how much does it actually interfere with anything I need or want to do? In applying this standard, patients can find themselves coming up with some surprising answers. For example, regarding the subway passenger who takes up too much room, the patient may well conclude that the interference is trivial, as the patient can get to her destination with or without a seat; likewise, regarding the young daughter who can’t remember to hang up her coat, the parent may decide that it is no disaster if the coat lays on the floor; as for the security guard asking to see the patient’s employee ID, the patient will likely recognize that it requires minimal effort to display the card.

Such realizations, however, usually have only a mild impact on a patient’s feelings. To achieve substantial and lasting reductions in anger, behavioral change is needed. Specifically, patients must begin actually to *conduct* themselves in a manner that reflects the purely pragmatic importance of the problem. Thus, if the patient concludes that a situation has minimal practical import, then no matter how much anger it provokes, the patient is to refrain from deliberate efforts to fix or confront it. In our view, this therapeutic directive is analogous to response prevention for obsessive-compulsive disorder (OCD) (see also [Brondolo et al., 1997](#), for a similar view). In behavioral treatment of OCD, patients force themselves to refrain from behaviors (e.g., hand-washing) that arise in response to an inappropriate fear (e.g., fear of contamination from dirt). By refraining, the patient’s anxiety eventually subsides in the absence of the behavior (washing) and, ultimately, a new (more neutral) feeling is attached to the previously feared situation (dirt on the hands). As a result, the patient no longer feels compelled to wash in these circumstances.

A similar effect is achieved, in our experience, when patients refrain from confronting situations that provoke anger, but which have little practical consequence. By restraining their response, patients’ anger eventually subsides in the absence of confrontational behavior, and more neutral feelings get attached to the situations involved. As we explain it to patients, “if you conduct yourself as though the situation doesn’t matter so much, eventually your feelings will catch up with your behavior;

you will start to *feel* that the situation doesn’t matter so much.” So, in the case of the patient who is angered at her daughter’s inability to remember to hang up her coat, we advise that she cease berating her daughter over her memory lapses. Instead, the patient is to accept that her daughter cannot remember this consistently, and the patient behaves accordingly. Thus, the patient is given the choice of either leaving the coat on the floor, hanging it up herself, or pleasantly asking her daughter (without rebuking her) to hang the coat up (“Sweetie, could you hang up your coat, please?”). With repeated trials, in our experience, the patient feels greater acceptance of her daughter’s limitations, and ultimately experiences little or no anger when she observes her daughter forgetting.

Patients who are instructed to refrain from over-responding in a specific situation must also refrain from what might be termed “covert” overresponding. For example, although the patient who is angered at another subway passenger’s hogging of space may refrain from overt action, the patient may nevertheless overrespond internally by closely scrutinizing the offender and conducting a mental narrative of the offender’s contemptible nature. When patients do this, anger does not subside in the situation, and can even be driven to greater heights, so the exposure has no therapeutic value. Therefore, we caution patients against covert overresponding in situations where inaction is deemed appropriate. To assist with this, we suggest patients follow two steps when feeling angered. First, patients should briefly remind themselves of the cognitive reformulation that describes the trivial impact of the situation (e.g., “I’m getting off the subway in four stops; it’s a short ride and I usually don’t get a seat anyway”; also, “greater crimes have been committed on the subway”). Second, patients should cease focusing on the issue any further and, instead, direct their attention to other matters—their newspaper, their plans once they leave the train, etc.—anything that will provide a competing focus of attention. By following this procedure, patients’ anger has a better chance of subsiding in the situation, leading to more neutral associations to that type of situation over time.

An additional, related principle is the need for patients to refrain from postmortem analysis of anger-provoking situations. Anger patients, when they get angered, often carry the experience with them long after the situation has passed ([Simpson & Papageorgiou, 2003](#)). They continue to analyze it, dissect it, replay it in their minds, and thereby maintain a heightened level of arousal in association with the experience. When patients do this they are, in effect, resensitizing themselves to the provoking stimulus and thereby strengthening angry associations to conflict situations. Accordingly, we instruct patients to note when they are ruminating along these lines and, quite

simply, to stop themselves. Although *thought stopping* is notoriously challenging in behavior therapy (as thoughts tend to be under less voluntary control than behavior), patients generally find that they do have some control over their thinking if they make an attempt. Even partial success is therapeutic. Thus, if the postmortem analysis can be limited to 15 minutes, as opposed to the customary 2 hours, then less resensitization occurs.

To assist patients in thought stopping, we suggest steps similar to those indicated (above) for covert overresponding. The first step is simply for the patient to become aware as soon as possible when rumination has taken over mental activity. After awareness is achieved, the next step is for the patient to develop a brief cognitive reformulation of the situation in question (e.g., “A rude person in a store is not a matter I need to concern myself with”). The third step is to refocus thoughts on an alternative (constructive) subject or activity.

Situations that have practical importance: (a) Control vs. No Control, (b) Costs vs. Benefits.

(a) Control versus no control. Many of the situations that cause patients anger have little practical importance. However, many other situations actually do matter to some degree, or at least the patient cannot be convinced otherwise. For example, a mother whose grown daughter does not visit her with the expected frequency will not be persuaded that this does not matter. And the worker who does not get the raise she expected knows that the money certainly matters. Still, even a situation with practical importance leaves room for overresponding. In our view, a patient’s behavior constitutes overresponding whenever the patient engages in persistent efforts to influence a situation beyond the level of influence that the patient actually possesses. Therefore, to help patients identify overresponding in situations that have true practical import, we help them to start making distinctions between what they can and cannot control. For example, we point out to patients that they have control over their own efforts—what they do and say—but they do not have control over results, in particular, other people’s behavior, thoughts, or feelings. Unfortunately, people with anger problems often feel that they have to control everything in order to meet the demands of a situation. Thus, the mother not only invites her daughter to visit, but also tries to manipulate her feelings by critiquing her past visiting record so as to shame her into visiting more often. Putting aside the dubious value of a visit obtained by shaming an unwilling party, such efforts are to be shunned from an anger treatment perspective because they represent overcontrol. The person who attempts to

exercise this level of control finds herself engaged in unrewarded behavior which, if it persists, will frustrate both herself and the other party. Thus, response prevention therapy in this case consists of the mother’s issuing periodic invitations to her daughter, but refraining from persistent efforts to alter her daughter’s feelings or conduct. By resisting these efforts, the patient’s angry preoccupation with the issue can be reduced.

A comparable approach applies in the case of the employee who feels she should have been offered a raise. The patient is advised to identify the aspects of the situation over which she actually has control, and to limit her efforts accordingly. For example, she has control over the information she conveys to her superiors, but not over their reaction or decision. Therefore, from a behavior therapy standpoint, the patient might be advised to (a) inform her superiors of her feeling that she is due a raise, and (b) inform them of her reasoning. However, the patient is advised to refrain from persistent efforts to press her case when encountering clear resistance. To do so, in our view, represents fruitless effort to control an outcome, and is to be shunned as overresponding. If more money is essential, then the patient is advised to exercise other forms of control that she possesses, such as seeking another job.

Patients generally find it a relief to be released from the (self-imposed) obligation to press their case to the bitter end. The task of discussing a raise feels manageable—as opposed to belligerent—when the patient accepts that she only has to communicate certain information and does not have to battle for a particular outcome. Therefore, tension is minimized upon entering the situation and, by adopting this approach consistently, calmer associations to conflict situations develop over time.

(b) Costs versus benefits. Once the limits of control are established and accepted, anger patients can still overrespond by failing to take into account the costs versus benefits of exercising control in a given situation. Just because one has control does not mean it automatically should be exercised. Unfortunately, anger patients often view it as a given that control should be exercised whenever it is available, and they will do so without regard to the costs. For example, a high-level executive will order her assistant to stay late, to bring her coffee, to respond to e-mails after hours, etc., just because these things would be marginally useful and the executive has the power to command them. Yet, the executive fails to consider the cost in employee ill will, and ends up with a resentful and antagonistic worker whose “attitude” infuriates her. The long-term result is a pattern of combative and angry relationships with subordinates and others.

To counteract this overuse of control, traditional problem-solving therapy (D’Zurilla & Goldfried, 1971) is helpful. With this approach, the therapist asks a patient to (a) identify a problem or goal, (b) generate various possible solutions or strategies, and (c) evaluate the costs vs. benefits of various solutions and strategies. For example, one goal for a problem-solving exercise could be “obtaining a cup of coffee at work.” The patient is asked to evaluate the cost versus benefits of various possible strategies—going to the cafeteria oneself, ordering in, asking a subordinate to get it. Naturally, the therapist will focus particularly on the costs of strategies that involve exercising control over someone with whom the patient is having interpersonal difficulties. The therapist helps the patient to see that, even in terms of her own self-interest, there may be a more effective way of getting a cup of coffee than ordering her subordinate to do it. Costs include: the subordinate’s feeling demeaned, the subordinate’s being drawn away from work that is more useful to the executive, unpleasant interaction, possible loss of the employee as resentment builds, loss of prestige in the company, etc.

Ultimately, through repeated cost-benefit analyses of various interpersonal scenarios, the patient becomes more attuned to the costs of exercising control over other people. Behaviorally, the patient is advised to seek other methods of achieving goals whenever benefits of exercising control are small in comparison to potential costs.

It is often challenging for anger patients to resist exercising control. Anger patients often view it as a form of weakness not to assert their interests whenever possible. However, patients can ultimately get comfortable with restraining themselves through behavioral experience. The overbearing executive gets her own cup of coffee, allows her employee to leave at a reasonable hour, waits until morning to get questions answered and, with repeated trials, becomes more accepting of these practices. The new pattern gains further momentum as interpersonal relations improve.

Treatment of underresponding. As discussed earlier, anger patients are subject not only to overresponding, but also to underresponding: not expressing themselves or exercising control in cases when it is actually appropriate to do so. What often inhibits the patients is their (well-founded) concern that they will end up antagonizing other people and making matters worse for themselves. The guidelines developed for overresponding (above) actually help patients with underresponding as well, because patients learn the distinction between appropriate and inappropriate circumstances for self-assertion. Specifically, self-assertion is considered appropriate in cases when: (a) the matter is important, (b) the matter (or some aspect of it) is subject to the patient’s control, and (c) the likely benefits of exercising control

exceed the costs. Armed with these criteria, patients feel more secure about asserting themselves in appropriate circumstances, and often will start to do so spontaneously. However, the question of exactly *how* to assert themselves in a conflict situation requires further attention, as anger patients often lack appropriate skills. For this reason, established methods of *assertiveness training* can be useful. This training, as traditionally described, is designed to help individuals achieve “honest and relatively straightforward expression of thoughts and feelings” while remaining “socially appropriate” and considerate of “others’ feelings and welfare” (see Galassi & Galassi, 1978; Masters, Burish, Hollon, & Rimm, 1987, p. 125).

Our own approach to assertiveness training for anger patients actually distills much of assertiveness down to one basic principle, as anger patients seem to regulate their behavior most successfully when they have extremely clear-cut guidelines. The principle we set forth is this: If it is appropriate to assert yourself in a given situation, *be practical as opposed to personal.*

Practical vs. personal (focusing on goals vs. feelings). In discussing this principle with patients, we explain that most conflict situations—situations where the patient feels mistreated, wronged, or otherwise opposed—contain both personal and practical elements. The personal element is the patient’s feelings toward the other party; the practical element is the specific goal that the patient needs to accomplish apart from these feelings.

To take an example, a patient might go to a store and buy an item that turns out to be defective. The personal element in the situation is the feelings that patient has toward the store and its personnel for selling him defective merchandise. The practical element is the goal of getting the defective merchandise replaced, or the purchase refunded. In handling such situations, anger patients tend to give undue weight to the personal element. For them, it is not sufficient to get a replacement or refund; in addition, they must air their displeasure and, indeed, cannot conceive of handling the situation another way. Thus, they hunt down the store manager, rebuke him for stocking defective merchandise, insist that he admit fault, demand an apology and otherwise assert their minor moral complaints or grievances. The problem is, the personal approach to conflict resolution is so emotionally punishing that many patients eventually give up trying to deal with conflict entirely, and fall into a pattern of neglecting their legitimate interests (at least until they get so fed up that they resort to overresponding again).

To help patients feel more prepared to assert their legitimate interests, we recommend that, for the time being, they abjure all personal complaints or criticisms in conflict situations and, instead, focus solely on

efforts that serve their practical goals. Thus, when the patient returns an item to the store, the only permissible verbalizations are those that involve (a) explaining the problem with the merchandise, and (b) inquiring as to the store's procedure for handling the issue. Because anger patients often cannot restrain their impulse to challenge the fairness of a situation, we often portray the patient's assignment as the carrying out of an experiment. By viewing it as an experiment, the patient often can achieve enough emotional distance from the situation to follow the guidelines.

It also helps to rehearse the approach in the therapy session, utilizing role-play and modeling in which the therapist assumes the patient's role, and the patient assumes the role of his (perceived) antagonist. The therapist then demonstrates how to take the practical approach in various circumstances.

The therapist can also give examples of the difference between a personal vs. a practical response to various hypothetical situations, such as below:

- *Sample situation:* You call the phone company to get an error on the phone bill corrected.
Personal approach: "There is an error on my phone bill. How did this happen? This is such a nuisance."
Practical approach: "There is an error on my phone bill. Can you tell me how to get it corrected?"
- *Sample situation:* Your pharmacist says a prescription is not ready (at the time promised).
Personal approach: "You said it would be ready by now. Why isn't it?"
Practical approach: "When do you think it will be ready?"
- *Sample situation:* Your boss piles on additional work just before it's time to leave for the day.
Personal approach: "What are you doing? Can't you see how late it is. I have a personal life, too, you know."
Practical approach: "I'm afraid it's too late for me to finish this today. I already had plans to leave at 5:00. I'll have to finish it tomorrow."
- *Sample situation:* Co-worker keeps interrupting you.
Personal approach: "Why do you keep interrupting me? Don't you realize how much I have to do? It's impossible to get anything done when you keep coming in here."
Practical approach: "I'm really too swamped to talk right now. I'll be free in a couple of hours. Can I talk to you then?"

It is often a revelation for patients to hear the practical manner of handling things. Many anger patients could not imagine handling a conflict without expressing their personal resentment, as if it were a given that they must do so. However, once they implement the

practical approach a few times and experience its effectiveness, they feel encouraged enough to assert themselves more regularly, and are no longer such underresponders.

In addition, patients find they ultimately feel much calmer in taking the practical versus the personal approach, contradicting the common wisdom among anger patients that they have to "let it all out" in order to feel better in a conflict situation. In truth, they feel better (and calmer) when they are more in control, both of themselves and the process, and the practical approach affords them this benefit.

Taking the practical versus the personal approach is a special case of the control principle discussed earlier: limiting effort to those aspects of a situation that one can reasonably influence. When patients take the practical approach, they are focused on the tangible, achievable goals contained within a conflict situation. When they take the personal approach, they are focused on ruling another person's feelings (trying to induce shame, guilt, humiliation, etc.), an effort that rarely goes according to plan.

Relaxation and Visualization Exposure

By the second or third session, we train patients in standard, progressive muscle relaxation. We usually begin with an eight-muscle tension-relaxation exercise, adapted from [Barlow and Cerny \(1988\)](#). The clinician conducts the full exercise in the session (it takes about 15 minutes) and records the instructions as they are spoken to the patient. The recording is then taken home and used by the patient for daily practice. Once the clinician judges that the patient is obtaining reliable relaxation effects from this exercise (usually requiring 1 to 2 weeks of daily practice), the patient is trained in shorter exercises involving (a) passive relaxation of four muscle groups (without tension), (b) breathing-cued relaxation, (c) word-cued relaxation (using a word cue such as "relax" or "calm"), and (d) Image-cued relaxation (using a relaxing image from the patient's own experience). These latter methods are adapted from [Deffenbacher and McKay \(2000\)](#), where a more detailed description of the techniques can be found. Drawing on the patient's preferences among the four brief methods, we fashion a brief personalized exercise that the patient is instructed to practice a few times a day, as well as to begin applying when experiencing angry emotions.

To assist the patient in the application of relaxation techniques, and also to further the counterconditioning process, several sessions include exercises involving visualization of anger-provoking situations combined with application of the relaxation response (as adapted from [Deffenbacher & McKay, 2000](#)). Initially, only moderately arousing situations are chosen, but ultimately, the most intense, anger-provoking situations are utilized.

The specific protocol for our visualization-relaxation exercise is as follows:

1. The patient closes his/her eyes, and the therapist describes the anger provoking-situation in detail, for 1 to 2 minutes.
2. The patient then is given about 30 seconds to visualize the situation in silence, while trying to achieve as high a level of anger arousal as possible.
3. The therapist instructs the patient to let "your mind go blank", and then guides the patient in the application of a brief relaxation procedure.

In later sessions, a cognitive reappraisal step is added after Step 3. In this final step, the patient returns to visualizing the original scene (while still in a relaxed state), and then silently applies an appropriate cognitive reappraisal of the situation, as prompted by the therapist (based on earlier discussion with the patient). A more detailed protocol can be found in [Deffenbacher and McKay \(2000\)](#).

In Vivo Exposure

Naturally occurring events may not provide patients with sufficient therapeutic exposure to anger-provoking stimuli. For many patients, in vivo exposure exercises will be helpful in increasing the number of therapeutic experiences. In vivo exposure involves deliberate, scheduled contact with anger-provoking situations, with the patient applying the cognitive-behavioral anger reduction skills described above. Such therapeutic exposure, when conducted programmatically, can result in progressively more neutral feelings becoming attached to the stimuli involved (in a manner analogous to exposure and response-prevention therapy for OCD).

However, in comparison to exposure for anxiety-provoking stimuli, in vivo exposure to anger-provoking stimuli can be harder to arrange, as the elicitation of the target emotion (anger) often depends on the cooperation of others (e.g., a patient can go to a restaurant with reservations for 7:00 p.m., but there is no guarantee that the maitre d' will cooperate with therapy by not having a table ready until 8:00 p.m.). Therefore, the best strategy is often to have the patient increase contact with situations that have relatively higher probabilities of provoking anger, such as taking a heavily trafficked route every day (for patients who get angry at other drivers), returning items to a store (for patients who are oversensitive to their treatment at the hands of customer service), talking to a hated co-worker several times a week, deliberately having a girlfriend carry out tasks that bring her into contact with other men (for the male patient who normally gets angry and jealous at this). The essence of these exercises is (a) entering or creating the designated situation and (b) applying pertinent anger-reduction skills.

So, for the jealous patient who normally fumes at the idea of his girlfriend talking to other men, an exercise might involve accompanying his girlfriend while she carries out various transactions with male functionaries (e.g., having the oil changed in her car), while the patient's job is to (a) formulate an appropriate cognitive appraisal ("Women have contact with strange men all the time; it has nothing to do with romance"), and (b) refrain from overresponding. Overresponding in jealousy cases typically involves scrutinizing the social interaction for signs of "over-friendliness", questioning of the girlfriend as to her feelings about the other male involved, critiquing her manner of interaction, etc.

Often the therapeutic value of the in vivo exposure can be enhanced by having the patient engage in *uncharacteristically benevolent* behavior in situations that ordinarily provoke anger. Anger sufferers often maintain a defensive or hypervigilant posture in a potentially inflammatory situation, feeling that they must be constantly on guard, as though a generous or benevolent action will put them at a disadvantage. Thus, when driving, they avoid showing other drivers any special courtesies; in crowds, they strive to get ahead of other people edging toward the same door; in competitive sports, they avoid praising others for a game well-played or cannot bear giving another person the benefit of the doubt on a questionable call; when kept waiting due to some unavoidable problem, they fume to themselves and signal displeasure rather than voicing conciliatory statements. For people exhibiting this pattern, *exposure to the avoided (i.e., benevolent) behaviors themselves* can be therapeutic, as it helps patients learn that these behaviors can be engaged in without dire consequences (e.g., appearing weak, getting taken advantage of, and the like). In addition, from a counterconditioning standpoint, benevolent behaviors (including benevolent or conciliatory verbalizations) tend to be incompatible with angry emotions and, hence, can exert an inhibiting effect on the anger an individual might otherwise feel in the situation. Therefore, engaging in the benevolent behavior, however forced, has at least three benefits: (a) it exposes the patient to a class of behaviors that he or she anxiously avoids (thus desensitizing the patient with repetition), (b) it inhibits angry emotions in the context of the situation itself (allowing the patient both to feel and function better in the situation), and (c) when applied repeatedly, it establishes new associations (i.e., feelings of benevolence and generosity) to previously provocative situations. An example of an exposure contrived along these lines might involve having a patient (who is subject to road rage and typically employs a competitive driving style) display the epitome of driving etiquette. Thus, the patient is instructed to drive to work in a high-traffic situation and focus on showing the

utmost consideration to other drivers, pausing to let others enter the roadway ahead of the patient, avoiding all honking, maintaining a polite distance from other cars (if the patient normally tailgates), keeping in one lane (if the patient's usual impulse is to get ahead of other drivers), and so on.

In devising in vivo exposures, the clinician should give precise guidelines for all the parameters—exactly what the situation or activity will consist of, how long it will last, how frequently it should be conducted, the coping skills to be applied, etc. Often the contrived nature of the exercises allows patients to comply more successfully with therapeutic guidelines than they might in spontaneous situations, so in vivo exercises can have special advantages for patients who have trouble complying with guidelines day-to-day.

Preliminary Outcome Data

Clinical impression suggests that the vast majority of patients who complete this form of anger-reduction therapy are substantially improved at the conclusion of treatment. To assess this empirically, we have looked at preliminary outcome data available from a group of 34 patients who completed 12 sessions of anger-reduction therapy with one of the first two authors (E.E.G. or F.A.T.). Patients were self-referred, complaining of significant anger problems for which they wanted treatment. They had no other psychiatric diagnoses, and met psychometric cutoff criteria described earlier. The four case vignettes presented earlier are drawn from this sample. The mean age of these patients was 30.3 ($SD=6.7$); 68% ($n=23$) were female. The ethnic composition was 56% Caucasian ($n=19$), 18% Asian ($n=6$), 15% African American ($n=5$), and 12% Hispanic ($n=4$).

In assessing outcome, we had patients complete the Anger Situation Rating Questionnaire (Deffenbacher & McKay, 2000) at both the beginning and end of treatment. The questionnaire asks patients to describe “the one ongoing situation that creates the greatest feelings of anger for you now” and then asks patients to characterize their anger reaction by indicating: (a) how much anger they typically experience in the situation (using a 0-to-100 scale, where 0 = little or no anger and 100 = maximum level of anger they could ever experience); (b) how many times per month they experience the situation; (c) how long their anger typically lasts when they become angry in the situation; and (d) how much their anger in the situation interferes with their life (where 0 = no interference and 100 = extreme interference).

Paired t -tests were used to assess change from pre- to posttreatment (Note: tests are two-tailed; missing data reduced the sample size to $n=32$ for some tests). For the first variable (intensity of greatest anger situation), the mean (0-100) rating at pretreatment was 73.8 ($SD=17.5$)

vs. 59.1 ($SD=25.4$) at posttreatment, $t(33)=3.264$, $p<.01$. For the second variable (frequency of greatest anger situation), the mean reported number of anger events per month at pretreatment was 14.2 ($SD=12.8$) vs. 7.8 ($SD=8.3$) at posttreatment, $t(31)=3.033$, $p<.01$. For the third variable (duration of reaction to greatest anger situation), the mean reported duration at pretreatment was 5.6 hours ($SD=14.6$) vs. 1.2 hours ($SD=4.2$) at posttreatment, $t(31)=4.722$, $p<.001$ (data log-transformed to reduce skewedness). For the fourth variable (interference produced by greatest anger situation), the mean (0-100) rating at pretreatment was 61.2 ($SD=27.5$) vs. 35.8 ($SD=28.4$) at posttreatment, $t(31)=4.285$, $p<.001$.

Thus, significant changes were reported by these patients on all four variables upon completion of treatment. Patients were reacting less strongly to anger events (both intensity and duration), were experiencing fewer anger events, and were reporting substantially less interference from anger in their lives. Most dramatic was the large reduction—from about 5 hours to 1 hour—in the average duration of patients' reported anger feelings in reaction to their most potent triggering event. This 80% reduction represents a very meaningful change in patients' emotional lives.

Summary and Conclusions

Although persistent anger is not represented in *DSM-IV* as a psychiatric disorder, it is nevertheless a significant clinical problem. Persistent anger causes emotional distress, overlaps with anxiety and depression, can lead to violence, and is a risk factor in cardiac disease. Based on our experience with both research and clinic patients, and drawing on methods utilized by others (Brondolo et al., 1997; Deffenbacher & McKay, 2000; DiGiuseppe et al., 1994; Novaco, 1975; Williams & Williams, 1994), we have refined and elaborated several treatment strategies that appear useful for anger reduction. The strategies derive from a counterconditioning treatment model: patients are exposed (either naturally or by design) to situations that may evoke anger, while they apply physiological, cognitive, and/or behavioral methods that can dampen patients' habitually angry response. With consistent application of methods, patients become progressively more skilled, experience less anger, and ultimately acquire more neutral associations to formerly anger-provoking situations. The specific anger-reduction methods include: applied muscle relaxation, cognitive reappraisal, inhibition of *overresponding*, and reversal of *underresponding* (through acquisition of effective communication and problem-solving skills).

The thrust of this article has been to describe the treatment approach with patients who have persistent

anger without other, complicating psychiatric diagnoses. However, many of the patients we see have additional psychiatric disorders: anxiety disorders, depressive disorders, or other clinical concerns such as relationship problems or parent-child interaction problems in which anger plays a role. In our experience, the anger treatment methods can usually be incorporated into an ongoing cognitive-behavioral treatment protocol without disrupting or detracting from the treatment for the other conditions. Like most cognitive-behavioral therapists, we generally have all patients maintain ongoing self-monitoring records. Therefore, to assess potential anger problems, we instruct all patients we treat, regardless of diagnosis, to report any "negative emotion" (anxiety, anger, depression) according to the standard behavior-analytic format (triggering event, automatic thoughts, behavioral response, and result). This allows patients to keep track of anger events alongside other emotional or behavioral events. In therapy sessions, the clinician applies relevant anger treatment strategies as indicated, whenever a troublesome or unwanted anger response is noted. The feasibility and efficacy of such an approach was shown in a study of cognitive-behavioral treatment for generalized anxiety in elderly patients who were tapering anxiolytic medication. In this study, patients improved significantly on both anxiety and hostility scores from the Symptom Checklist-90 (Derogatis, 1977) following treatment with a protocol that included monitoring of anger reactions alongside anxiety reactions, and application of anger or anxiety reduction methods as indicated (Gorenstein, Papp, & Kleber, 1999).

Many clinicians receive no formal training in anger-reduction methods. Nevertheless, the ability to ameliorate persistent or even periodic anger is a crucial clinical skill. The methods described illustrate specific approaches that should assist clinicians in acquiring this expertise.

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- This work was supported in part by R01 HL63872 (RPS) from the National Heart, Lung, and Blood Institute and by the Nathaniel Wharton Fund.
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Received: October 27, 2005

Accepted: July 5, 2006

Available online 23 March 2007