

Cognitive-Behavioral Conceptualization and Treatment of Anger

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Anger is conceptualized within a broad cognitive-behavioral (CBT) framework emphasizing triggering events; the person's pre-anger state, including temporary conditions and more enduring cognitive and familial/cultural processes; primary and secondary appraisal processes; the anger experience/response (cognitive, emotional, and physiological components); anger-related behavioral/expressive components; and anger-related outcomes and consequences. Functional/adaptive and dysfunctional/maladaptive anger are briefly discussed along with assessment strategies. Several change-oriented CBT interventions for clients who identify anger as a personal problem and seek therapy for anger reduction are outlined. Many angry clients, however, are not at a change-oriented stage of readiness. For such clients, strategies for increasing readiness and attending to the therapeutic alliance with angry clients are outlined. These principles and strategies are then applied to the case study.

A Working Model of Anger

Anger is a natural part of the human experience. The human nervous system is hard-wired for the experience of anger, and most emotion theorists consider anger one of the basic human emotions. Temperament, neurological, hormonal, and other physiological processes certainly contribute to the experience and expression of anger. Nonetheless, anger arises from the converging interaction of (a) one or more triggering events, (b) the person's pre-anger state consisting of both momentary states and enduring cognitive interpretative processes, and (c) appraisals of the trigger and coping resources (i.e., primary and secondary appraisal; Lazarus, 1991). Anger is an internal experience comprised of emotional, physiological, and cognitive components that co-occur and rapidly interact with each other such that they often blend into a singular experience of anger. Anger also elicits, motivates, and/or is associated with behavioral responses to the situation. That is, anger is an experiential state that is related to but conceptually separable from behavior associated with it, behavior that may or may not be a focus of treatment in cases of dysfunctional anger. Anger also leads to various outcomes for the individual, others around the individual, social systems in which the person exists, and, potentially, the physical environment. Often, it is the nature and extent of outcomes that influence

decisions about whether anger is considered problematic (Deffenbacher, 2003; Kassirer & Tafrate, 2002, 2006).

Triggering Events

Although somewhat arbitrary and certainly not mutually exclusive, anger appears to be elicited by three classes of events. One source is *specific, identifiable external events*. Examples include frustrating or provocative events (e.g., being stuck in traffic), behavior of others (e.g., critical, disrespectful comments), objects (e.g., malfunctioning computer), and the person's own behaviors or characteristics (e.g., making a rude comment or missing an important meeting). These events share several elements. First, people clearly identify the source of anger, often reporting a kind of cause-effect relationship (e.g., "her comments made me mad"). Second, the degree of anger typically seems appropriate to the circumstances (i.e., individuals see the level of anger as proportional and appropriate to the situation).

Some anger is triggered by *a combination of external events and anger-related memories and images*. That is, a situation not only triggers some anger but also a network of anger-related memories that intensify and add to the experience of anger. Often the sources of anger are not easily identified by the person, and anger experienced seems out of proportion or an overreaction to the perceived trigger. Some of the strongest anger reactions of this type are experienced by individuals suffering from posttraumatic stress disorder. For example, victims of sexual assault may react very angrily to innocent touch or encroachment on personal space. Other, less dramatic

but problematic examples are common. A man reacts with intense anger when his partner talks with other men, because a prior partner had an affair, or a person becomes intensely angry in response to mild teasing, because of a history of being teased and put down as a youngster. To understand the nature and intensity of such anger, it is important to identify both the external trigger and the memories and images elicited by it.

Other anger is triggered heavily by *internal stimuli*, both cognitive and emotional in nature. For example, a person becomes angry while ruminating or brooding about past mistreatment, unfairness, or abuse (e.g., ruminating about being overlooked for a promotion or being dumped by a former partner). Intense rumination increases the strength of anger and depression and may lead the person to feel out of control and increase the probability of dysfunctional responding (Nolen-Hoeksema, 2003). Anger also may be precipitated by other emotions such as feeling rejected, hurt, embarrassed, or humiliated (e.g., becoming very angry when hurt by the comments of another). To understand anger in these instances, it is important to identify emotions and/or cognitions preceding anger.

Pre-Anger State

Anger is significantly influenced by momentary and enduring characteristics of the person at the time the triggering event is experienced. The person's immediate emotional-physiological state can impact the probability, intensity, and course of anger. If a person is in a positive mood and feeling good physically, the threshold for anger may be changed such that anger is not elicited at all or the intensity is mild. However, if mood or physical state is negative, then the probability and intensity of anger may increase. That is, being angry increases the probability that a person will respond with further anger in subsequent, even unrelated events (i.e., prior anger exacerbates or transfers to other situations; Zillman, 1971). For example, a parent angered by a phone call overreacts angrily to minor misbehavior of a child. This effect does not appear to be limited to prior anger. Considerable research (e.g., Berkowitz, 1990) shows that many different types of physical (e.g., tired, cold, pain, sick, hung over) and emotional (e.g., hurt, sad, anxious, stressed) states increase the presence or salience of aversive feelings and images and lower the threshold for anger responding. Assessing momentary states is important clinically, because dysfunctional anger may occur primarily when such states are present.

Other aspects of the pre-anger state are enduring interpretive filters for information processing. Some are the familial/cultural messages about anger and anger expression (Thomas, 2006). Cultural and family groups

communicate basic norms or messages about how and when anger is to be experienced, forms of acceptable and unacceptable expression of anger, and appropriate/inappropriate targets for anger expression. Internalized familial/cultural rules regarding anger significantly influence how triggers are coded and how anger is experienced and expressed. It is, therefore, important to put anger in its familial/cultural context. For example, as may be the case with the client discussed later, if the person's familial/cultural background is accepting of intense angry, hostile, revengeful, and retaliatory thoughts and imagery and aggressive responding, then these modes of being are likely to seem normal and appropriate, no matter what others in the present context may think. Another aspect of culture involves conflict between norms of different groups (e.g., one group supports loud, emotional verbal exchanges in close proximity to others, whereas others consider such intense emotion and behavior as aggressive, insensitive, and impolite).

Anger is also related to enduring ways of thinking about the world (Deffenbacher & McKay, 2000; Kassino & Tafrate, 2002). Anger tends to be elicited by a trespass on one's personal domain (Beck, 1976), violations of personal values, codes of conduct, and rules for living (Dryden, 1990), a blameful attack on important self-schema or ego identity (Lazarus, 1991), and/or frustration of important goal-directed behavior. When such cognitive constructs are flexible and based on personal preferences, then mild to moderate levels of anger likely ensue when they are challenged, threatened, or frustrated. However, as these become more rigid and overly inclusive, then anger becomes more intense and behavior potentially more aggressive. That is, intense, perhaps dysfunctional anger is more likely when personal desires become demands and commandments, when values and rules for living cease to be personal preferences and become rigid dogma imposed on others, when expectations become absolute, inviolate standards, when identities and personal domains have no resiliency, and when goal-directed behaviors become imperative rather than preferential.

Appraisal

Anger triggers are appraised in terms of the situational context and the person's pre-anger state, both momentary and enduring elements (Deffenbacher & McKay, 2000; Kassino & Tafrate, 2002). The nature of the appraisal process breaks down into two classes of appraisal—primary and secondary (Lazarus, 1991). Primary appraisals are directed toward the trigger and its characteristics. Intense anger and potential mobilization of aggressive behavior follow appraising the event as a violation of values and expectancies, a trespass on one's personal domain, an assault on one's ego identity, and/or an

unwarranted interference with the pursuit of one's goals. Put simply, the person makes the judgment that something did or could happen that should not happen.

The probability and intensity of anger increase if events are also appraised in any of the following ways (Deffenbacher & McKay, 2000; Kassinove & Tafrate, 2002, 2006). The event is (a) intentional (i.e., someone did it on purpose vs. it was accidental or just in the natural course of things), (b) preventable or controllable (i.e., the event could have been and therefore should have been controlled vs. it was accidental or just a benign outcome of events), (c) unwarranted (i.e., unjust, unfair, and/or undeserved vs. fair, deserved, and/or happenstance), and (d) blameworthy (i.e., someone or something is not only responsible and deserves pain, punishment, and suffering vs. an accurate appraisal of responsibility, but without the need for punishment). Triggers are more likely to elicit anger when they are attributed to an "enemy." Anger intensifies as people respond to the characteristics of the negative label or group status in addition to situational characteristics (e.g., someone is coded as a jerk, ass, or a member of a hated group). Anger also increases when the person overappraises the importance of the event and negative outcomes (i.e., awfulizes), codes events in highly polarized, negative ways (i.e., dichotomous thinking), attributes malevolent intent to the perceived source of anger (i.e., hostile attributional bias), and/or engages in images and thoughts of revenge and punishment (Deffenbacher & McKay, 2000; Kassinove & Tafrate, 2002, 2006).

Secondary appraisals are directed toward personal coping resources. When people have rich, flexible coping repertoires, anger is likely mild to moderate and coping adaptive. However, there are at least three secondary appraisals that increase the probability of elevated anger (Deffenbacher & McKay, 2000). First is the sense of being overwhelmed, overtaxed, and unable to cope (e.g., "I just couldn't cope. I couldn't take it any more!"). Such appraisals often reflect an underappraisal of the person's capacity to cope. The person feels overwhelmed and anger escalates. Second is the invocation of a narcissistic rule that the individual should not have to experience, deal with, or handle negative experiences (e.g., "Nobody should have to take or put up with this crap"), what rational-emotive therapists call low frustration tolerance (Dryden, 1990). Righteous anger viewed as appropriate and attributable to others follows. Such anger is justified and externalized, because it is attributed to external events that should not happen. A third anger-supporting secondary appraisal is when the person (perhaps from cultural/family norms or individual rules) codes anger, and potentially aggression, as appropriate responses to the situation (e.g., a person sees intense anger and verbal assault as appropriate when disrespected). Such anger is experienced as ego-congruent and not a problem, even

though it may be a problem for others or social systems in which the person exists.

Anger

Events processed and appraised in these ways elicit cognitive, emotional, physiological, and behavioral reactions. These co-occur, often reciprocally influencing and reinforcing each other. Anger is viewed as the cognitive-emotional-physiological experience and is distinguishable from the behavioral response when angry (Deffenbacher & McKay, 2000). Cognitively, clinical levels of anger often involve thoughts and images with an exaggerated sense of violation and being harmed, externalization of the source of anger, attributions of malevolence or intended harm from others, minimization of personal responsibility, overgeneralization, inflammatory labeling, and thoughts/images of retaliation, retribution, denigration, and the like (Deffenbacher & McKay, 2000; Kassinove & Tafrate, 2002, 2006). Emotionally, anger is a feeling state varying from little or no anger to mild feelings such as annoyance and irritation through moderate anger and frustration to severe anger, fury, and rage. Physiologically, anger can be a cool or cold experience, but generally involves sympathetic activation (e.g., elevated heart rate, hot sensations, tense muscles).

Behavior When Angry

What people do when they are angry depends greatly on the situation, the intensity and nature of anger experienced, their expressive repertoires, and reinforcement histories in the situation (Deffenbacher & McKay, 2000; Kassinove & Tafrate, 2002; Spielberger, 1999). Especially when anger is mild to moderate, anger may lead to adaptive, constructive, positive, prosocial behavior. Anger may be expressed in ways that effectively communicate feelings and problems, are a positive expression of self, and lead to positive coping and potential resolution of the situation (e.g., appropriate expression of feelings and issues, problem solving, clarification and strengthening of relationships, assertive negotiation of changed behaviors, appropriate limit setting, etc.). However, as anger increases in intensity and in the saliency of negative cognitions, the odds of dysfunctional expression increase. Aggression is one form of expressing anger and is generally designed to express strong dissatisfaction and displeasure, intended harm, and/or to threaten, intimidate, control, or seek revenge upon another person, object, or system. Many angry individuals do engage in physical or verbal assault on others and property. Others, when angry, may indirectly but aggressively express their anger through subterfuge, sabotaging, starting rumors, pouting, stalling, and disrupting the action of others. Other anger-related behavior may be dysfunctional, but not necessarily aggressive (e.g., inappropriate withdrawal, becoming intoxicated, driving recklessly, etc.). How the

person behaves when angry should be assessed as it too may need to be a target of intervention.

Functional and Dysfunctional Anger

Not all anger is dysfunctional or problematic. To the contrary, anger may be the result of an accurate appraisal of a threatening, aversive, disrespectful, or otherwise negative condition, be a mild to moderate experience, and activate positive constructive behaviors. Such anger is not likely experienced negatively and may lead to a sense of self-efficacy and self-empowerment and potentially to positive outcomes for self and others. Determining the point at which anger becomes problematic or dysfunctional is clearly a judgment call. However, as anger intensity, frequency, and/or duration increase, so does the likelihood of anger costing the individual. As these happen, people may feel out of control, negative about themselves, guilty and ashamed, overwhelmed, and distressed. Habitual anger elevation is also associated with a variety of health problems. Anger can also elicit and motivate various damaging behaviors and negative consequences (e.g., injury to self or others during impulsive actions, damaged relationships, legal consequences, property damage, difficulties at work, etc.; [Dahlen & Martin, 2006](#)). As frequency, intensity, and duration of anger increase, as forms of expression become more aggressive or otherwise destructive, and as the consequences to self and others become more negative, anger is likely to be judged by the person and/or others as dysfunctional or disordered ([Deffenbacher, 2003](#); [Kassinove & Tafrate, 2006](#)).

Understanding and Assessing Anger

In order to develop and implement effective interventions, therapists and clients must develop a shared understanding of the client's anger triggers, appraisals, experiences, behavioral responses, and outcomes. At present, two general approaches for assessing and understanding anger predominate.

There are several psychometrically sound, self-report instruments assessing anger-related constructs. [Spielberger's \(1999\)](#) State-Trait Anger Expression Inventory (STAXI) is perhaps the best known. It provides brief, reliable measures of state anger (i.e., current anger feelings), trait anger (i.e., general propensity or tendency toward anger), and four measures of anger expression (i.e., *anger-out*, outward, generally aggressive expression; *anger-in*, suppression of anger reactions and harboring grudges; *anger-control-out*, managing and reducing negative behavior; and *anger-control-in*, ways the person reduces angry feelings). The STAXI measures general response tendencies, but does not provide a sense of the triggers or context of anger, the consequences or outcomes of anger expression, or the cognitive/imagery aspects of anger.

[Novaco's \(2003\)](#) Anger Scale and Provocation Inventory provides additional information. It provides self-reports regarding classes of triggers for anger (e.g., unfair or disrespectful treatment, frustration, annoying habits of others), anger-related cognitive involvement (e.g., rumination), arousal experienced (e.g., intensity and duration of physiological arousal), anger-related behavior (e.g., types of aggressive behavior), and self-regulation efforts (e.g., calming down and cognitive restructuring activities). This measure thus provides a more detailed picture of the individual's experience in general, but does not provide a measure of typical anger consequences or outcomes. [DiGiuseppe and Tafrate's \(2004\)](#) Anger Disorders Scale was designed to provide information that could be closely related to anger disorders. It provides measures of five domains: (a) *provocations domain* taps a range of potential triggers for anger and ranges from fairly situation specific to more generalized; (b) *arousal domain* addresses the duration of anger episodes and the length of problem anger; (c) *cognitive domain* assesses common anger-involved cognitive processes such as rumination, impulsiveness, and suspiciousness; (d) *motives domain* assesses common goals for angry behavior such as tension reduction, coercion, and revenge; and (e) *behavioral domain* measures common ways anger is expressed.

Such self-report instruments provide a great deal of information quickly and can be linked to norms so that a person's standing on a dimension relative to his/her peers can be established. Such instruments can serve several positive functions. They provide a general picture of the person's anger experiences and a place from which to interview to gather more specific information (e.g., "When you were reporting your angry feelings on the questionnaire, were there some recent very angry episodes that came to mind?"). They provide good measures for outcome research where several individuals are being assessed and information aggregated. They can also provide stimuli and norms from which to engage the person in motivational interviewing to increase awareness of one's issues and readiness (see later section). Understanding of readiness for anger reduction interventions may also be supplemented by employment of the brief Anger Treatment Readiness to Change Questionnaire ([Williamson et al., 2003](#)).

While providing many benefits, these nomothetic approaches have at least two drawbacks for CBT. First, they are open to self-report biases (e.g., over- or underreporting). This may particularly be a problem in low-readiness individuals where denial, minimization, and externalization are high and in situations where a variety of other contingencies (e.g., sentencing or continued employment) may influence self-report beyond an accurate self-assessment. Second, they do not provide a detailed picture of specific problem anger episodes. Yet, it is an understanding of these events that

has the greatest direct relevance to designing a specific intervention plan.

Understanding of specific episodes is perhaps best done through more intensive, idiographic methods (Deffenbacher & McKay, 2000; Kassino & Tafrate, 2002; Tafrate & Kassino, 2006). In these assessments, clients recall specific incidents of anger, and the therapist explores and clarifies the nature of the triggers → appraisals → anger experience → behavioral action → anger outcomes with the client. Different formats (e.g., reviewing an anger log, a free recall of a recent anger episode, a visualization of an anger episode, or role-play of a problem event) might be employed to assist the client to access the nature of the event and those “hot” cognitive, emotional, and behavioral responses to it. The therapist interviews the client carefully to identify the nature and themes of the episode. Reviewing several anger episodes generally leads the client to become more aware of his/her anger reactions, the therapist and client to develop a shared understanding of problem anger, and the therapist develops hypotheses about effective anger-reduction strategies, which can be mapped onto the client's anger and other characteristics, including readiness for change-oriented interventions.

CBT Interventions for Anger Reduction

There is beginning empirical support for CBT interventions for anger reduction (e.g., Deffenbacher, 2006; Del Vecchio & O'Leary, 2004; DiGiuseppe & Tafrate, 2003). Theoretically, different CBT interventions target different aspects of the trigger → appraisal → anger → behavior expression → outcome sequence. For example, although rarely sufficient in itself, many interventions involve self-awareness enhancement so clients become more aware of triggers, experience, expression, and consequences of anger. As clients become more aware, they can implement existing coping skills and initiate strategies developed in therapy.

Cognitive interventions target anger-engendering thoughts and images, dysfunctional familial/cultural assumptions, biased appraisal and information processing, and the like. Clients are assisted in identifying anger-engendering cognitions and to replace them with realistic, value-based, coping self-instruction. Cognitive restructuring and problem-solving interventions thus address the cognitive elements of anger and provide assistance in developing anger-reducing self-dialogue and imagery and guiding one's self through provocative situations in calmer, more task-focused ways. These cognitive coping skills are rehearsed in therapy and extended into real life via homework and other contracted experiences. Cognitive interventions have proven effective with angry-involved medical patients, angry

community volunteers, generally angry college students, and angry drivers (e.g., Dahlen & Deffenbacher, 2000; Deffenbacher, Richards, et al., 2007; Novaco, 1975; Tafrate & Kassino, 1998).

Relaxation interventions have a different conceptual focus, targeting elevated emotional and physiological arousal. These interventions train clients in the development and deployment of relaxation coping skills with which to lower emotional and physiological arousal and approach situations in calmer manner, thereby freeing other skills and competencies that are present when calm. Relaxation coping skills are practiced to lower anger arousal within sessions (e.g., to reduce anger elicited by visualizing anger-arousing scenes or during an anger role-play). Relaxation coping skills are then applied *in vivo* for anger control. Relaxation interventions have shown significant effects with groups such as anger-involved medical patients, angry community volunteers, angry drivers, angry college students, and incarcerated individuals (e.g., Deffenbacher, Richards, et al., 2007; Diaz, 2000; Haaga et al., 1994; Novaco, 1975).

Behavioral interventions target habitual behavioral expression patterns, identifying and strengthening positive skills for angering situations (e.g., skills in respectful, noninterruptive listening, problem clarification and resolution, assertive emotional expression, constructively giving positive and negative feedback, appropriate limit setting, taking a time-out, conflict-management skills, aggression-incompatible behavior, etc.). These skills are rehearsed in anger-arousing circumstances within and between sessions until the individual has a broad, flexible repertoire of ways of handling previously angering situations. Self-efficacy increases and emotional arousal and negative consequences decrease as the person has more effective ways with which to handle provocative situations. Behavioral skill enhancement interventions have proven effective with generally angry college students, angry drivers, and angry, conflict-laden families (e.g., Deffenbacher et al., 1996, 2007; Stern, 1999).

Interventions can be combined, as in Novaco's (1975) pioneering work on stress inoculation applied to anger. Combined interventions target multiple aspects of dysfunctional anger, integrate them into a multifaceted treatment rationale, and develop, hone, rehearse, and transfer these anger management skills to real-life anger-provoking situations. For example, cognitive-relaxation, cognitive-behavioral, and cognitive-relaxation-behavioral combinations have successfully lowered anger in angry community volunteers, generally angry college students, angry drivers, individuals experiencing intermittent explosive disorder, caregivers of persons with dementia, veterans suffering from PTSD, military personnel with anger problems, young mothers at risk for child abuse, substance abusers, and angry offenders

(e.g., Chemtob et al., 1997; Coon et al., 2003; Dahlen & Deffenbacher, 2000; Deffenbacher et al., 2002; McCloskey et al., 2008). Combined interventions may also seek to take advantage of naturally occurring associations among elements of anger experience and expression. One example is the relationship between cognitions and behaviors. Although there is a general positive association between angry/hostile cognitions and forms of anger expression, some types of cognitions are more highly correlated with specific forms of anger expression. For example, with regard to anger while driving, highly negative, pejorative labeling type thoughts are more highly associated with verbally aggressive anger expression (e.g., yelling at another driver), and revengeful/retaliatory thinking is more highly associated with use of the vehicle to express anger (e.g., cutting another driver off; Deffenbacher, Kemper, & Richards, 2007). This suggests that cognitive and behavioral links should be identified, altered, and rehearsed together in cognitive-behavioral interventions. Altered cognitive processes can guide, moderate, prompt, and reinforce new adaptive behavior, much as old dysfunctional cognitive-behavioral sequences functioned.

In summary, there are several promising singular or combined CBT interventions for anger reduction. Meta-analyses and outcome reviews (e.g., Deffenbacher, 2006; Del Vecchio & O'Leary, 2004; DiGuiseppe & Tafrate, 2003) provide several intervention-relevant conclusions. First, angry individuals receiving CBT fare better than untreated individuals. CBT interventions, like those reviewed above, hold promise for anger reduction. Second, treatment effect sizes are generally moderate to large, suggesting meaningful change as well. Third, treatment effects are maintained over short- and long-term follow-up, suggesting sustained treatment effects. Even with sustained effects generally, therapists should consider maintenance enhancement interventions (e.g., booster sessions, sustained homework assignments, brief follow-up phone or personal contact), which would focus on continued efforts, because some clients tend to drift back toward earlier patterns while others tend to make gains on their own. Fourth, different interventions appear equally effective. There is no gold standard for CBT-based anger reduction. To some, this might suggest a common intervention or a kind of one-size-fits-all conclusion. Others (e.g., Deffenbacher, 2006; Tafrate & Kassinove, 2006) suggest a different use of the empirical literature. More specifically, these authors suggest that therapists should carefully identify the characteristics of an individual's experience and anger expression, and map, in a kind of menu-driven way, empirically supported interventions onto the client's experience. For example, relaxation interventions might be employed for heightened emotional/physiological arousal, cognitive restructuring

for inflammatory labeling and demanding, and time-out skills for impulsive verbal aggression.

CBT, Readiness, and the Therapeutic Relationship

These CBT interventions are based on the client identifying anger as a personal problem and being committed to anger reduction (i.e., action- or change-oriented interventions). However, many angry individuals externalize the sources of their anger and do not accept, much less own, their anger as a personal problem. For example, the person may have rigid familial/cultural or personal rules that dramatically escalate the sense of violation and trespass and lead to very intense anger. Yet, anger experienced seems appropriate to this perceived reality. Experience may have led to hostile attributional bias wherein others are suspected of malevolent motives and doing negative things on purpose, another attribution which increases anger. Angry individuals often engage external attributions of cause (i.e., their anger and behavioral reactions are attributed to things outside themselves and therefore justified). They often deny anger is a problem or at least minimize its importance. Angry individuals also often engage in marked blaming in which others are seen as responsible agents and which increases anger and mobilizes revenge and punishment. They may also code others with various negative labels that de-individuate them, escalate anger, and may justify aggression. Often overlooked are sources of reinforcement that strengthen and maintain both anger and dysfunctional behavior. For example, anger and associated behavior may be culturally and/or personally sanctioned and reinforced when they occur. They may be self-reinforced (e.g., a sense of power, control, and not being taken advantage of) when angry and striking back. They may be reinforced externally by others (e.g., coworkers supporting anger and aggression toward a supervisor). Situation anger-related behavior patterns may be strengthened by negative (e.g., anger is an aversive state, and behaviors that reduce anger are strengthened by its reduction or behavior may terminate negative conditions) or positive (e.g., coercion of another to do what one wants) reinforcement. In summary, these cognitive and reinforcement processes tend to elevate and justify anger, externalize the source of anger, decrease the person's sense of personal contribution and responsibility, strengthen situation → anger → behavior → outcome linkages and, on occasion, support aggressive or other dysfunctional responses.

When these processes are strong, anger (and associated behavior) is not likely to be seen as a personal problem. Rather, is viewed as a justified, reasonable response attributed to external causes. Personal anger management or reduction is not a goal. From the angry

person's perspective, other people and situations should change, not them. Change-oriented CBT interventions are at best irrelevant and more likely viewed as wrong, insulting, and misguided (i.e., person feels blamed, misunderstood, and attacked, and is being told he/she is wrong). Such angry individuals may be brought to therapy by others (e.g., spouses, employers) or come to get others off their back and mitigate the consequences of their anger. However, their goals and interpretations of events are not consistent with change-oriented interventions. Therapists would do well to attend carefully to these processes and two other issues—the therapeutic alliance and readiness for change.

Such angry individuals generally are at a precontemplative stage of change (Prochaska, Norcross, & DiClemente, 1995). Anger may be either externalized or identity- or role-congruent (i.e., anger is part of personal identity or consistent with role, such as parent or authority figure). Either way, anger is not viewed as a personal problem. Research on transtheoretical models of change suggests that interventions should be adapted to this stage of readiness (e.g., motivational interviewing; Miller & Rollnick, 1991), if clients are to be moved to where change-oriented interventions become relevant.

This recommendation is consistent with focusing on the therapeutic alliance, which consists of a quality relationship marked by high empathy and rapport, agreement on therapeutic goals, and agreement on therapeutic means. Angry clients may make rapport difficult. They tend to be angry, abrasive, intimidating, accusatory, and discounting of the therapist. They may hold values and interpretations that therapists find negative, if not abhorrent (e.g., attitudes toward women of some angry men). Nonetheless, it is important that therapists listen carefully, empathetically, and respectfully, clarifying the person's sense of anger and how it comes to be. It is strongly suggested that the therapist attempt to identify the angry person's sense of hurt and being the victim of unreasonable conditions. Using open-ended inquiries, empathic emotional and content summaries, and attempts to clarify underlying emotional themes will enhance the probability that the client feels listened to and understood. Therapists do not need to agree with the angry person's perspective, any more than they would with a suicidal person's sense of hopelessness and wish to die. However, they should communicate a clear sense of the angry person's feeling of pain, hurt, and rejection, being the aggrieved party, being one abused and mistreated, and being misunderstood and misinterpreted. Doing so is necessary to build trust and relationship from which to explore issues further and address readiness.

Client and therapist may not yet fully agree on the goals and means of therapy. As clients are invited repeatedly to give examples of anger from their perspec-

tive and to tell their story, and as therapists listen carefully and communicate nonjudgmentally their understanding, therapy is likely meeting at least one client goal (i.e., to be understood and not blamed or criticized). This relationship also provides the basis for moving toward more contemplative readiness tasks, shifting generally to the consequences of anger and how anger is achieving the client's goals. The general task is for the client to answer, in a very personal way, the question, "Is anger getting me what I want?" For example, therapists might pose this question and then explore many examples of the benefits and costs of anger. Angry individuals often report immediate benefits of anger (e.g., stood up for self, expressed self, was not taken advantage of) and some short-term negative outcomes (e.g., felt out of control, stupid, or guilty, made others not like him/her, made others counterattack or withdraw). Both kinds of consequences are important to acknowledge and clarify, because short-term positive consequences are often very powerful. Clients can be asked to describe long-term or distal positive and negative consequences. Many clients can identify long-term negative consequences (e.g., lost relationships, work problems, health difficulties, legal problems), but cannot identify long-term positive benefits. With repetition of examples, a 2 (positive vs. negative) $\times$ 2 (short- vs. long-term) anger consequences matrix can be introduced. Clients may see that they are achieving some short-term positive goals at the expense of short- and long-term negatives. In an open-ended way, therapists can then ask clients how they could achieve short-term benefits without paying the short- and long-term prices.

Interpersonal consequences might be explored by asking clients how they think others feel when treated in the ways they typically respond. They might ask others how they feel when they (clients) are angry or keep a log or diary of other's reactions to their anger. The angry person's impact on others might be explored through an adaptation of a Gestalt two-chair technique. In one chair, clients feel and express their anger as they typically do. Then, clients move to the other chair and experience how they feel and want to respond when being the object of their anger expression from the other chair. Debriefing of such activities focuses on the consequences to others who receive their anger and on whether this is the kind of impact they want.

Understanding anger consequences might be facilitated by extra-therapy self-monitoring wherein the person tracks examples of anger and anger expression and the positive and negative consequences. Discussion of self-monitoring would add to answering whether/how anger and its expression are achieving the client's goals. Another strategy involves soliciting and clarifying examples in which the person encounters provocative

situations but does not respond angrily. These provide potential positive skills and resources and contrasts with negative outcomes. Whatever the methodology employed, increasing the client's awareness of his/her anger, the consequences of that anger, and exploring how/whether this is reaching the client's goals is often necessary to decrease the externalization of anger and to increase motivation to address anger.

This emphasis on a quality relationship, rapport, and nonjudgmental exploration of consequences is likely congruent with some of the client goals (i.e., feeling understood). There still may not be agreement on the means of therapy. Angry clients often want the therapist to make the others stop mistreating them and treat them the way they "should" be treated. However, this is rarely possible. The strength of the therapeutic alliance is used to explore and test the notion that others should change and the cognitive assumptions underlying it. It is suggested that therapists stay open-ended and explorative. For example, therapists might ask clients if therapists have the power and control to make others change. Repeated explorations usually suggest not and may lead to a version of the elegant vs. the practical solution (i.e., the elegant solution is that others change vs. the practical solution is what the person can do when others do not change). Such explorations often raise protests that situations are "unfair," "not right," "unjust," and "not as they should be." The therapist may agree with the client, but these themes should be explored in an open-ended manner. Therapists supportively acknowledge events are not as clients wish, but inquire as to why they should be. Resistance is likely. The goal is not to convince clients they are wrong, but to validate their wants, explore the limits of their thinking, soften their demands, and help them accept that undesirable things sometimes happen to them.

Open-ended inquiries are also used to explore other relevant issues. For example, a series of "And then what would happen?" questions might be used to explore implied catastrophes. This can be followed by inquiry into how bad ultimate consequences would be and how the person would cope with them. Often, the actual reality is not nearly as bad as the anticipated or implied one, and the person's coping is much better than thought. Inquiries like "Where is the evidence for that?" or "Help me understand how that follows" may be used to explore possible overgeneralized, negative conclusions that often fuel anger.

Paradoxes, such as the paradox of control, can be explored. For example, clients are asked if they always do what others want. The answer is usually an incredulous "no." The therapist asks why not. Clients explain they do not want to do what others want and are free to choose. The paradox is then clarified, namely, clients reserve the

right not to comply with others, but insist others must comply with their mandates. Further exploration clarifies that others too are free to choose, even wrongheadedly and self-defeatingly. If the alliance is strong, therapists may ask pointed questions such as, "And who appointed you God?" This is followed by a discussion of the notion that God gets to list commandments, but people only get to want and prefer. Clients can then use the godlike "shoulds" and "oughts" as cues to shift to statements of preference and lower the demands that instigate intense anger.

Behavioral experiments may be employed to assess the validity of certain thoughts. For example, clients who think that others will take advantage of them if they show weakness might agree to admit to doing something wrong each day for a week and observe what others do. Alternatively, every day they could initiate an unprompted positive comment (which might be a sign of vulnerability or weakness) and see what happens.

Interventions such as these have several goals. They assist clients in identifying their personal desires. They also help clients accept that undesirable events often happen and may prevent them from achieving what they want. Finally, they assist clients in accepting that they may have little control over negative events, but can exercise great control over how they feel about and react to such events. These therapeutic activities are consistent with a contemplative phase of change (i.e., considering that maybe I have a problem). If successful, clients may conclude that anger is not getting them what they want and become ready for action-oriented interventions through which they can better achieve what they want, even when the world is not always helping out. However, not attending to the therapeutic alliance and readiness in ways such as those described often leads to serious breaches in the therapeutic relationship, resistance, and perhaps premature termination.

Application to the Case Study

The client, Mr. P (Santanello, 2011), is not a good candidate for change-oriented CBT interventions. In prior therapy, he failed at a relaxation intervention and did not see the relevance of that intervention. He does not conceptualize anger as a personal problem or seek help for it. Motivation for therapy appears low and not self-directed; he is in therapy primarily to reduce pressure from others. However, it would be important to clarify why he is coming for therapy now, because there may be some positive themes to develop from those reasons.

Other cognitive characteristics also make him a poor candidate. He does not trust others and has a hostile attributional bias in which others are perceived as out to harm him, for which anger and defensive aggression are reasonable responses. He appears to have familial/

cultural sanctions for being angry and aggressive in protection of self (i.e., anger- and aggression-related messages in his family of origin and neighborhood). Anger, defensiveness, and aggression seem natural and appropriate to him. He appears to hold a number of rigid, perhaps dichotomous, overgeneralized cognitions which, when triggered, lead to an exaggerated sense of threat and vulnerability. Some cognitive themes are not totally clear, but from the material provided, a therapist could listen for issues of powerlessness, control by others, others taking advantage of him, vulnerability or weakness being catastrophic, being a man means being angry and attacking, perhaps preemptively, rigid demands for fairness, insistence on not having to deal with negative events, and the like. His anger appears highly externalized (i.e., not due to anything he does, but how others treat him). He may also have deficits handling interpersonal conflict, frustration, and provocation. If this is true, exploring alternative ways he might get what he wants will likely follow best on the heels of supporting him in identifying ways in which anger is not getting him all he wants.

The course of therapy is likely to be uneven. He is likely to be angry, abrasive, intimidating, accusatory, and challenging to the therapist. Five additional, general suggestions for the therapist are offered to help therapists survive and deal effectively with clients such as this one.

1. *Avoid being judgmental, negative labeling, and blame.* Therapists need not like all client characteristics, but they can accept them as client thoughts, feelings, and behaviors. Negative labels and put-downs may lessen therapist anxiety and frustration, but are likely to be picked up by the client, even if they are not explicitly articulated. Clients often already feel judged and rejected and are highly sensitive to these dynamics.
2. *Avoid avoidance.* Redirecting therapy away from anger and contentious issues may momentarily lower therapist discomfort, but make clients feel not listened to and understood. Difficult as it may be, stay with and explore the anger issues. Stay open and nondefensive and reflect the client's experience back to him.
3. *Do not take it personally.* These are just the characteristics of the client. They may cause difficulties in other relationships and situations, so why should they not be directed toward the therapist. It is not about the therapist; it is about the client.
4. *See the angry person's characteristics as potential assets.* Many angry individuals are confrontational and argumentative. Therapists would do well to see these as characteristics that may be harnessed in other directions—for example, to have the client be self-confrontational and self-argumentative with his thoughts, feelings, and behaviors. He can be assisted to confront his issues head-on and get in his own face as he does with others.
5. *Be gently tenacious.* Angry clients can be wearing. Be ready to hang in there with them. There are few quick fixes. Therapists should be ready to recycle themes, issues, and examples repeatedly until clarity, understanding, and acceptance are achieved. If change-oriented strategies are employed, therapists should be willing to rehearse things multiple times. It often takes many repetitions to make new cognitive, affective, and behavioral strategies second nature. Perhaps like a puppy pulling on a cloth toy, therapists should be ready to sink their teeth into the fabric of the client's life, warmly and playfully hang on, growl occasionally, and repeat as necessary.

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