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<b>14. ABSTRACT:</b> The long-term goal of the research is to provide an effective intervention for the prevention of secondary and escalating effects of poor anger control associated with trauma-related anger problems. The specific objectives are to adapt an existing evidenced-based cognitive-behavioral intervention (CBI) for the treatment of anger to specific needs of military personnel returning from hazardous deployments, and to conduct a pilot study providing preliminary data on the adapted intervention. Progress: Phase I of the study is nearing completion, with 14 participants (12 in CBI and 2 in SI) entering treatment. Anticipated treatment completion rate for CBI is 8 of 12 (66%). Based on Phase I experience, the CBI manual has been modified. Protocol changes have been approved by local IRBs and have been submitted to DOD. The randomized pilot study (Phase II) will begin in the near future.					
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Conclusions N/A

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INTRODUCTION: The long-term goal of the research is to provide an effective intervention for the prevention of secondary and escalating effects of poor anger control associated with trauma-related anger problems. The specific objectives are to 1) adapt an existing evidenced-based cognitive-behavioral intervention (CBI) for the treatment of anger to specific needs of military personnel returning from hazardous deployments, and 2) to conduct a randomized pilot study providing preliminary data on the efficacy and acceptability of the adapted intervention in this population. The first phase involves administering the current (adapted) version of CBI to 8 participants, and a supportive intervention (SI) to 2 participants. Based on our experience with the 10 cases, both manuals will be revised as needed. The second phase will include 50 male and female participants, randomly assigned to receive either CBI or SI.

BODY: Following final human subjects approval by the DOD on February 28 2006, we began phase I of the study. Over the past year, we have accepted 17 participants for inclusion in phase I. Three did not enter treatment (either not returning further calls or changing mind due to job constraints). Of the 14 starting treatment, 12 were assigned to CBI and 2 to SI. Of the 12 CBI participants, 6 have completed, 2 are close to completion, and 4 were non-completers. Two of the 4 non-completers dropped due to high levels of anxiety, making it difficult to sit through sessions and focus on the material (both were referred for alternative treatment). Of the two SI participants, one completed and one discontinued after 10 sessions due to obtaining a job. Termination and 3 months follow-up assessments have been completed for all treatment completers due for assessment.

Based on our experiences treating participants in phase 1, we have made some changes in inclusion criteria to target individuals who we believe are most appropriate for the treatment. For phase II, we will exclude subjects with severe PTSD (CAPS > 70) given our experience that too severe anxiety requires different treatment. We also now assess and require evidence that clinically significant anger problems have persisted for at least 3 months, to avoid spontaneous improvement. We have added a few measures. Changes have been approved by local IRBs and sent to DOD Human Subjects for review.

We have also made extensive changes to the CBI manual based on our phase I experiences. We have reformatted the session material, to make the implementation more user-friendly and feasible. We have increased flexibility for the therapist in implementing strategies as they fit the individual participant. We have conducted a training session regarding the changes for protocol therapists.

We have made smaller changes to the Supportive Intervention Manual as needed.

We have data entry programming and begun to enter data from Phase I.

We have conducted weekly to biweekly meetings of therapists to discuss cases and procedures throughout the past year.

We have two potential study participants scheduled for assessments for Phase II, the randomized pilot study.

#### KEY RESEARCH ACCOMPLISHMENTS:

- o Completion of recruitment for Phase I
- o Nearing completion of treatment for Phase I
- o Completion of post-treatment and 3 month follow-up assessments for participants due

- o Substantial revision of Cognitive Behavioral Intervention Manual
- o Revision of Supportive Intervention Manual

REPORTABLE OUTCOMES: Our Phase I experience shows promise for CBI. Data have not yet been analyzed.

CONCLUSIONS: N/A

APPENDICES:

Revised Cognitive Behavioral Intervention Manual

**COGNITIVE-BEHAVIORAL INTERVENTION**

**Overview of manual    Implementation of the treatment    Tools for CBI  
CBI treatment checklist of skills**

**Sessions 1-14 Adapted from *Stress Inoculation Treatment for Anger Control Therapist Procedures* (Novaco, 2001) for use in USAMRC #PR 04347 “Treatment of PTSD-related Anger in Troops Returning from Hazardous Deployments”**

**Excerpts taken from ANGER, STRESS, AND COPING WITH PROVOCATION, A Patient Instructional Manual (revised in 1999) written by Raymond W. Novaco of University of California, Irvine. Copyright 1999 by Raymond W. Novaco, Ph.D., University of California, Irvine. All rights reserved. No portion of this material may be reproduced in any form without the written permission of the author.**

Revised: 3-23-07

## **Overview of Manual**

This manual was devised to guide therapists to implement a cognitive behavioral treatment to veterans who recently returned from combat, and have PTSD symptoms of hyperarousal, including clinically significant problems with anger. The treatment is meant to be conducted in an outpatient setting and includes the following elements:

- Psychoeducation about responses to trauma, particularly following deployment in a war-zone, trauma-related anger difficulties, stress, and aggression
- Regular self-monitoring of anger frequency, intensity, and situational triggers
- Arousal reduction, including (but not limited to) diaphragmatic breathing, and guided imagery training
- Cognitive restructuring of anger schemas by altering attentional focus, modifying expectations and appraisals, using self-instruction, increasing task-orientation, and decreasing rumination
- Enhancement of behavioral skills in communication, diplomacy, respectful assertiveness, preparatory coping, and strategic withdrawal
- Progressive exposure to anger provoking stimuli including construction of a personal anger provocation hierarchy

It is critical in this treatment that there is collaborative involvement between the therapist and patient. Also, the therapist's approach should be supportive and validating, while at the same time directive and didactic.

### **Rationale for Cognitive-Behavioral Intervention:**

Cognitive-Behavioral Intervention (CBI) is being used in USAMRC #PR 04347, entitled "Treatment of Trauma-related Anger in Troops Returning from Hazardous Deployments," in order to better understand how anger-related treatment can affect and potentially improve combat veterans' functioning. All of these veterans will have trauma-related anger difficulties. CBI will be implemented in the study opposite a clinically relevant comparison condition, Supportive Intervention (SI).

CBI is an adaptation of a cognitive-behavioral anger control treatment developed by Raymond Novaco, Ph.D., an evidenced-based intervention that aims to minimize anger frequency, intensity, and duration and to moderate the expression of anger. The goal of CBI is to increase one's self-regulation of anger. It utilizes a "stress inoculation" approach, which involves therapist-guided, progressive exposure to provocations (including trauma triggers) in session and in vivo, in conjunction with modeling and rehearsal of coping skills. The intervention also involves training in self-monitoring, cognitive reframing, arousal reduction, and behavioral coping. It is believed that by exposing individuals to their anger triggers, while providing them with skills to better

manage their anger, individuals will gain better control of their anger responses.

The SI and CBI conditions are different in several key ways. SI is less structured; the patient has more input into the agenda of the sessions. While patients in this condition will learn basic relaxation techniques, they will not be instructed in specific cognitive and behavioral strategies for dealing with anger, and they will not receive inoculation training. The focus of SI is on managing behavior and feelings in current day-to-day life. SI focuses on problem solving around difficulties resulting from anger and other hyperarousal symptoms.

## **Overview of the Treatment Sessions**

This treatment consists of 14 sessions, each lasting approximately 75 minutes. The manual describes an ordering of interventions, intended to serve as a guide to implementation of the treatment. The early sessions include establishing rapport, developing familiarity with the experience and expression of the patient's anger through assessment, providing training in arousal reduction techniques, and providing psychoeducation about both anger and the common difficulties characterizing the transition to home from a war-zone deployment. Cognitive restructuring constructs are covered first, beginning in session 3 and continuing through 8; session focus then shifts to more behavioral strategies. A key component of Novaco's treatment is Inoculation Training (IT), providing the opportunity of in session experience of anger and mastering reduction of anger via imagery. In the current manual, IT begins in session 7, continuing as long as needed through the remaining sessions. As noted, the session content and order is intended as a guide, and may be altered depending upon each patient's particular needs and progress.

The content of the session guides is as follows:

<u>Session 1:</u>	Overview of study Detailed assessment of anger Arousal Reduction Training
<u>Session 2:</u>	Psychoeducation Arousal Reduction Training
<u>Session 3:</u>	Motivational Assessment Begin Cognitive Restructuring Arousal Reduction Training
<u>Sessions 3 – 8:</u>	Cognitive Restructuring Strategies
<u>Sessions 7 - 14:</u>	Inoculation Training
<u>Sessions 8 - 11:</u>	Behavioral Coping Strategies

Sessions 12-13: Catch-up as needed  
Continued focus on strategies not fully mastered  
Review of skills learned, progress made

Session 14: Continued review of skills  
Anticipation of and planning for obstacles (“relapse prevention”)  
Discussion of termination

## **Implementation of the Treatment**

The order of interventions as described above reflects our experience with implementing the manual during Phase I of the study. The introduction of IT is later than the original manual. This was based on our experience that the sessions were too “packed”, and also that having more time for the monitoring and reviewing of the anger logs facilitates the development of a meaningful hierarchy for IT. However, it is important to note that **the therapist has the option of changing the order of interventions, or spending more or less time on particular interventions, if clinically indicated.** For example, for a patient with little control over anger expression, it might be necessary to introduce strategic withdrawal (time-out) early on, and to begin the IT component earlier. For a patient who tends to avoid confrontation, it may be important to spend more time on communication and assertiveness training. It might take more sessions than allocated to get through the cognitive restructuring strategies. It might be necessary to spend more time on arousal reduction for a patient with severe hyperarousal. While the goal is to cover all of the strategies, it is more important to adapt the focus to meet the patient’s needs (within the bounds of the treatment interventions) than to rigidly adhere to the schedule. The early and late sessions are an exception: it is expected that sessions 1 and 2 will focus on the content described, and that sessions 13 and 14 will include review, anticipation and planning for obstacles, and dealing with termination.

Throughout the course of the treatment, it is anticipated that the therapist will reinforce skills that have been taught in earlier sessions (e.g., in the later sessions where the focus shifts from cognitive to behavioral and IT strategies, the therapist should continue to discuss and reinforce cognitive strategies taught in the first half of the treatment as relevant). The therapist should also provide ongoing positive reinforcement for treatment progress and positive efforts exhibited by the patient.

It is recommended that the Anger Log Sheets be completed and reviewed throughout the course of the treatment. However, if the patient’s anger dissipates to such a degree that the anger log sheets become irrelevant, they may be discontinued.

## **Dimensions of Anger Reactions II (DAR)**

The therapist will administer the DAR at every odd treatment session (e.g., session 1, 3, 5, 7, 9, 11, and 13). After the patient completes the DAR, the therapist should briefly review the form to ensure that all questions have been answered. The DAR is designed

to be used for data collection purposes, not as a treatment strategy. The therapist is not instructed to discuss the DAR responses.

## **How to Use this Manual**

The manual is organized by sessions supplemented by tabbed sections devoted to the cognitive and behavioral strategies, including IT. This organization is intended to facilitate flexibility, by not confining the description of interventions to individual sessions. Each session begins with a brief outline of what will be covered in that session followed by a more detailed outline. Most text represents specific instructions to the therapist. Indented text written in *Italic* font with quotation marks around it represents examples of how the material could be presented to the patient. It is not intended to be a word-for-word script for what should be said in session, but rather as a guide. The tabbed sections include notations regarding particular handouts that accompany the material covered. The tabbed sections are noted in the manual as:

Ed – Psychoeducation  
AR – Arousal Reduction  
Cog – Cognitive  
Beh – Behavioral  
IT – Innoculation Training  
Misc – Miscellaneous  
Op – Optional  
Hand – Handouts and Forms  
Read - Readings

**Important Note:** This manual was designed for use with patients who have anger and PTSD symptoms resulting from various types of trauma occurring during combat experience. Thus in the manual the precipitating event is typically referred to by the general term “the trauma.” Wherever possible, refer to the specific traumatic event by name (e.g., fire, bombing, etc.) rather than using the more general term “trauma.”

# TOOLS FOR CBI

CBI has several goals, the primary one being to increase the patient's sense of mastery over his/her anger responses. To this end, several therapeutic tools are utilized. The CBI manual is meant as a guideline to be implemented with flexibility and fluidity, as described earlier. The length and intensity dedicated to each therapeutic component will vary depending on patient strengths, ability to master new skills, and willingness to practice new skills between sessions.

Several core factors need to be established and maintained during treatment in order for it to be successful.

1. Sense of safety

In order for the patient to better learn to manage his/her anger, s/he will need to feel safe experiencing and expressing anger in the therapy setting. Safety, in this case, includes having both the understanding that physical violence will not be tolerated in the therapy setting and that the therapist will be able to manage the patient's expressions of anger. Over time and with practice at the inoculation training exercises, the patient will gradually increase his/her sense of safety with being able to control his/her own anger responses.

2. Support for the patient's worth

The patient will need to feel respected and worthwhile. It is not uncommon for people with anger management difficulties to be criticized by others, and therefore begin to lose self-esteem and a sense of personal self-worth. It is important that the patient feel respected by the therapist. When an individual feels worthwhile, s/he is better able to participate in the process of self-examination and change.

3. Support for the process of change in managing one's anger responses

When engaging in a process of changing one's behavior, it is easy to become frustrated, feel stuck or overwhelmed. The therapist will need to encourage the change process by both expecting change to occur and helping the patient stay motivated and engaged in the therapeutic process.

4. Ability to acknowledge and validate patient's emotions

A key element in any therapeutic relationship is having the patient feel understood, supported, and validated by the therapist. It is possible that the patient is not receiving much validation of his/her anger feelings from others, and it is important that the therapist provide a sense of validation within the therapy setting to assist in the process of change. Remember, an individual can feel angry and still learn to express his/her anger in a new manner.

5. Revision of the patient's values regarding anger and anger expression

In large part, behavioral change in the course of this treatment will stem from a revision of the patient's values regarding anger and aggression. That is, many patients understand what a socially appropriate anger response is for a given

situation, but they have largely not wanted to do it. Since anger has been an established part of their identity, they may be reluctant to surrender it. As patients learn through the course of this treatment to replace antagonistic behaviors with non-angry, effective coping, they will find themselves empowered and become less attached to their old ways of acting.

In addition to the core factors listed above, several therapeutic themes will need to be addressed throughout the treatment.

### 1. Threat

People who experience several symptoms of PTSD view the world around them as unpredictable and unsafe. They are therefore more likely to be hypervigilant in scanning their environment for threats to themselves and those they love. It is common for these people to interpret non-threatening behaviors from others as threatening, and when people feel threatened, they may respond with anger and aggression. A true danger signal may require an aggressive response, but some patients may perceive safe interactions as threatening when they are not intended as such. It will be important to address this issue of perceived threat versus actual danger throughout treatment whenever it comes up in discussion.

### 2. Justification and Entitlement

People with anger management difficulties often feel justified in both their angry feelings and anger reactions, even when their reactions may infringe upon the rights of others. They may also feel entitled to feel and behave in whatever manner they see fit, regardless of social norms and expectations. These senses of entitlement and justification often contribute to anger management difficulties. It will be important throughout the therapeutic process to validate the patient's emotions while at the same time pointing out, if indicated, that his/her justification of problematic anger expression perpetuates the problem. Part of this process will be accomplished by helping the patient develop empathy for others' perspectives and needs.

### 3. Need Structures

Every individual has certain needs and desires that drive their choices of behavior. Identifying each patient's need structures will be helpful in understanding how they contribute to the patient's anger management difficulties. For instance, if a patient has a need to feel in control of situations and his/her environment, this need for control will likely lead to conflicts with those around him/her. Identifying this need structure during treatment, as well as pointing out how it contributes to conflict and anger management difficulties is an important piece of CBI.

# **CBI Treatment Checklist of Skills to be Covered**

## **Psychoeducation**

\_\_\_\_\_ Battlemind

\_\_\_\_\_ Anger

## **Arousal Reduction**

\_\_\_\_\_ Diaphragmatic Breathing

\_\_\_\_\_ Visualization / Mountain Cabin

\_\_\_\_\_ Tranquil Scene

\_\_\_\_\_ Lifestyle Changes

## **Cognitive Strategies**

\_\_\_\_\_ Introduction to A-B-Cs

\_\_\_\_\_ Expectations

\_\_\_\_\_ Attentional focus

\_\_\_\_\_ Stages and components of an anger event

\_\_\_\_\_ Modifying appraisals / Increasing flexibility in appraisal system

\_\_\_\_\_ Self-talk / self-instructions

\_\_\_\_\_ Task-orientation

\_\_\_\_\_ Role Taking / Empathy

\_\_\_\_\_ Rumination

\_\_\_\_\_ Psychological needs

\_\_\_\_\_ Discussion of anger used to establish control

## **Behavioral Strategies**

\_\_\_\_\_ Self-monitoring (using the anger log)

\_\_\_\_\_ Strategic Withdrawal

\_\_\_\_\_ Respectful Assertiveness

\_\_\_\_\_ Preparatory Coping

## **Innocation Training**

### **Optional Strategies**

\_\_\_\_\_ in vivo Exposure

\_\_\_\_\_ Motivational Strategy

\_\_\_\_\_ Behavioral Activation

\_\_\_\_\_ Parenting Strategy

\_\_\_\_\_ Sleep Strategy

# Cognitive-Behavioral Intervention for Veterans with Trauma-Related Anger

## Session 1

**Handouts: DAR**

**Ways of Dealing with Feeling Tense / Uptight  
Tension Meter**

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**Reading assigned: Anger, Stress, and Coping with Provocation**

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**NOTE:** It is important that you take some time before Session 1 to review the patient's assessment folder and familiarize yourself with the veteran's history, etc. This includes reviewing the patient's responses to NAS-PI and other anger measures (STAXI and Overt Anger Scale) to become familiar with the nature of the patient's anger difficulties and to identify possible anger themes.

Goals: get to know the patient better, discuss the study with the patient (including the logistics and the rationale), review limits of confidentiality, do a comprehensive assessment of the patient's anger problems, and review for possible safety concerns (SI, HI, weapons, etc.).

- A. Present an overview of the program (15 minutes)
  - Confidentiality
  - Description of study and treatment approach
  - Answer patient's questions or concerns
- B. Complete patient interview and anger assessment (45 minutes)
  - Identify and discuss anger themes and triggers
- C. Introduce relaxation strategies: Teach Diaphragmatic Breathing (15 minutes)
- D. Assign homework (5 minutes)
  - 1. Listen to relaxation recording daily

### **A. Present Overview of Program and Treatment Procedures Used**

*"Today is our first session together and there are a number of things I would like to cover. First, I want to let you know that you were randomized to the Cognitive-Behavioral Intervention, or the one that focuses specifically on learning new ways to manage your anger.*

*I will explain the goals of the program to you and talk with you about what we will be doing as we work together. Then, I would like to spend most of the session getting to know you and becoming more familiar with the problems you are having, particularly with anger, by asking you some questions about your history, including your past experiences and*

*current situation. Lastly, I will introduce a relaxation exercise and give you a brief homework assignment”*

### **Discuss Confidentiality**

Therapists should note both

- (1) Exceptions to confidentiality for clinical reasons
  - a. Legal responsibility
    1. Danger to self
    2. Danger to other(s)
    3. Abuse of a minor child, an elderly adult, or handicapped person.
  - b. Therapists will also record patient’s attendance as part of the treatment study in the medical file (progress notes in computer), and any relevant safety issues.
  - c. If necessary, therapist may share relevant information with other members of the patient’s treatment team, in the interest of coordinating good clinical care.
- (2) Protection of confidentiality of material such as recordings of sessions and assessments that are related to the research needs.
  - a. Patients will have previously been informed about the procedures for recording the sessions and protection of this material, but it should be repeated here:
    1. Study records are coded and do not contain patient names
    2. Digital recordings are made to ensure good treatment adherence (to ensure the therapist is conducting the treatment per protocol).

### **Ground Rules/ Boundaries**

1. Discuss the **collaborative nature of the treatment**. This is a joint effort to solve any problems s/he has.
2. Ending the session early
  - a. If the session is becoming **too difficult** for the patient, and if the patient is becoming very angry, then the therapist and the patient have the right to **pause the session and/or take a break**.
  - b. The patient has the choice to **withdraw from any session at any time**.

1. Note that this is one of the skills the patient will learn - being able to strategically withdraw from a stressful or anger provoking situation.
3. The patient is encouraged **to ask questions or raise issues at any time**.
4. If the patient is drifting **off task**, or is **avoiding** the work of the session, the therapist will point this out clearly.
5. Treatment success depends on the amount of effort the patient exerts. Discuss that s/he will not improve with anger management if s/he does not do the homework assignments as discussed in session. **Note that s/he will need to work hard**. Think of this as their temporary, **part-time job**. Treatment cannot be done to the patient. **Improvement is created by the patient**.

### **Description of Study and Treatment Approach**

Cover these points to orient patient to the treatment program. Answer any questions.

#### **1. Goal of research**

- learn more about what kinds of treatments are most helpful for adjustment following a hazardous deployment, with an emphasis on managing problematic anger

#### **2. Focus of the anger treatment**

- Improve patient's understanding of the relationship between anger and trauma (combat history) including the contribution of redeployment stressors
- Identify each individual's specific triggers and patterns of response
- Improve patient's ability to control his/her response to anger
- Shift the patient's thinking such that s/he does not become as angry, as often.

#### **3. Treatment strategies**

- Education
- Teach skills for reducing arousal associated with anger and for coping with anger in a positive way
- Monitor anger-provoking situations that occur between sessions
- Create a list of anger triggers and expose the patient to these situations using imagery and role-play in session
- Practice using positive coping both during imagery exercises and in real life

#### **4. Structure/Format of Sessions**

- 14 sessions
- 75 minutes each
- one session per week
- ideally completed in about 14 weeks

Stress the importance of regular attendance at sessions. Establish a set meeting time and indicate that they can discuss any necessary changes as needed.

### **5. Inform patient about VA's emergency procedures**

- during business hours (Mon-Fri 8:00AM-4:30PM) may call 457-3077 to ask to speak to therapist or other provider for help
- after business hours and on weekends, call 401-273-7100 x0 and ask for psychiatrist on call or go directly to Emergency Department.
- define crisis: VA does not have a hotline. Only request to speak to psychiatrist on call or go to Emergency Department if the patient feels s/he is in danger of harming self or other

### **B. Patient Interview and Assessment of Anger**

[TAB-

Misc]

**Have patient complete DAR and review it to ensure all questions are answered.**

### **C. Introduction to Relaxation Strategies**

1. It is important at this early stage to engage the patient in a discussion about his/her awareness

of the differences between being uptight or tense and calm and relaxed.

*“As we’ll talk about in more detail next session, a big part of the experience of anger is physiological arousal. That is, when you are angry, you often feel a lot of tension in your body. For example, your heart rate may increase, your muscles may tense, your breathing may become more shallow, etc. This may be especially true for people who have lived in a combat zone for extended periods of time and have experienced this hyperarousal on a daily basis. Many people bring this hyperarousal home with them and continue to feel watchful/on guard and on edge. Has this been your experience (increased sense of hyperarousal)?*

*A large part of this treatment will involve becoming more aware of what is going on in your body (the amount of tension), and learning to lower your overall tension level. This may be especially useful for dealing with anger because if we can lower our arousal level, we are better able to think clearly about a situation. I’m sure you’ve heard of the example of counting to 10 before reacting. This makes sense because it gives us time to calm down before responding to a situation – while counting to 10, our arousal level will likely drop and our response may be more thoughtful. Does this make sense?*

*So, the first thing I'd like to do is go over an example of something that may influence are tension levels..."*

- a. Ask about an **activity** that the patient does which s/he finds relaxing
- b. Prompt the patient to explain **why or what makes this activity relaxing**
  - The learning point is that **attending to, concentrating on, and doing certain things can affect how we feel**. That is, we have some choice and can begin to control how we feel.

2. Relaxation Training: Diaphragmatic Breathing [TAB-AR]

3. Complete Handout: Ways of Dealing with Feeling Tense / Uptight [TAB-Hand]

**D. Assign homework**

1. Listen to **relaxed breathing recording** at least once daily.
2. Read **Anger, Stress, and Coping with Provocation** reading

## Session 2

### **Handouts:**

**Battlemind: Actions you can take**

**Battlemind Brochure**

**Tension Meter**

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**Reading reviewed: Anger, Stress, and Coping with Provocation**

**Reading assigned: Arousal, Agitation, and Mood**

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Goal: Complete **psychoeducation** and provide further instruction on relaxation strategies.

- A. Discuss reaction to the first session and homework (5 minutes)
- B. Present agenda for the session (1 minute)
- C. Review Homework from last week (10 minutes)
- D. Complete Battlemind Psychoeducation (30 minutes)
- E. Complete Psychoeducation on anger and assertiveness (10 minutes)
- F. Complete Relaxation Training: Imagery – Mountain Cabin Exercise (15 minutes)
- G. Assign homework (2 minutes)
  - 1. Practice relaxation daily
  - 2. Read **Reading: Arousal, Agitation, and Mood**
- G. Discuss reactions to session content (5 minutes)

### **A. Discuss Reaction to Last Session**

1. Ask the patient how s/he felt about the first session and respond to any questions / reactions.

### **B. Present Agenda For Session**

1. Review the homework from last week.
2. Complete Psychoeducation on Battlemind training and assertiveness/anger
3. Complete relaxation training of a new relaxation technique for him/her to practice at home.

### **C. Review Homework from Session 1**

1. Inquire about relaxation practice at home between sessions
  - a. check on frequency and success of home practice
  - b. encourage and praise patient for practice that was completed
  - c. review importance of daily practice
2. Review the reading homework later when completing Psychoeducation

**Note to Therapist:** In every session, the therapist should give the patient positive reinforcement for completing homework assignments. Much attention should be given to work well done. By completing the homework, the patient is taking initiative and demonstrating commitment to change and improve his/her anger management.

**D. Complete Battlemind Psychoeducation** [TAB-Ed]

\*make this an interactive dialogue between you and the patient - avoid lecturing

\*encourage the patient to discuss his/her feelings, thoughts, and behaviors since returning home

**E. Complete Psychoeducation on anger and assertiveness** [TAB-Ed]

1. Review **Anger, Stress, and Coping with Provocation** reading together and discuss

2. If the patient did not read it, ask him/her to read it this week between sessions

**F. Complete Relaxation Training: Imagery-Mountain Cabin Exercise** [TAB-AR]

**G. Assign homework**

1. Listen to relaxation recording at least once per day.
2. Review **Battlemind Handout: Actions you can take**
3. **Reading: Arousal, Agitation, and Mood**
4. Have them attend to the kinds of things that trigger anger for them

**H. Discuss reactions to session content**

1. Inquire about patient reactions to hearing this psychoeducation.

2. Encourage patient to discuss any general reactions to the therapy and specific reactions to the material presented

## Session 3

**Handouts:** DAR  
Benefits and Costs of Anger / Aggression  
A-B-C Worksheet  
Anger Logs  
Tension Meter

**Reading reviewed: Arousal, Agitation, and Mood**

**Reading assigned: Causes of Anger**

Goals: Discuss motivation for change, begin cognitive restructuring, continue relaxation training, and introduce the anger log.

- A. Discuss reaction to the last session (1 minute)
- B. Present agenda for the session (1 minute)
- C. Review Homework (10 minutes)
- D. Discuss motivation to change anger reaction (10 minutes)
- E. Begin Cognitive Restructuring (A-B-Cs, Appraisals and Interpretations) (30 minutes)
- F. Complete Relaxation Training: Tranquil Scene (15 minutes)
- G. Introduce Anger Log (5 minutes)
- H. Check-in on how patient feels treatment is progressing (2 minutes)
- I. Assign homework (2 minutes)

**Have patient complete DAR and review it to ensure all questions are answered.**

**A. Discuss patient's reaction to the second session.** Ask the patient how s/he felt about the second session.

**B. Present Agenda For Session**

- Review homework
- Discuss the patient's motivation to change
- Begin cognitive restructuring
- Continue relaxation training
- Introduce Anger Log
- Assign homework

**C. Review Homework from session 2**

1. Inquire about relaxation practice at home between sessions (Breathing and visualization)
  - a. check on frequency and success of home practice
  - b. encourage and praise patient for practice that was completed
  - c. review and correct technique as appropriate.

- d. review importance of daily practice
2. Review the **Reading: Arousal, Agitation, and Mood** together and ask what the patient learned from it
    - b. if the patient did not read it, ask him/her to read it this week between sessions
  3. Inquire about reactions to **Battlemind Handout: Actions you can take**
  4. Inquire what s/he learned from attending to the kinds of things that trigger anger for him/her
  5. If homework was not completed, discuss reasons and motivational issues.

**D. Discuss the patient's motivation to change his/her management of anger**

1. Discuss the costs and benefits of his/her current anger management style using the **Benefits and Costs of Anger / Aggression** handout
2. Discuss what aggressive behaviors are acceptable to the patient
  - a. example: many patients will say they will not hit a woman (which indicates they can control their aggression)
    1. inquire whether it is acceptable to the patient to throw objects, invade people's personal space, chase a car off the road, yell at people, etc.?
  - b. discuss the idea of whom the patient wants to be / how they wish they could act as opposed to how they currently act
    1. this helps the patient begin to develop an identity for him/herself of someone who can manage anger in a healthy manner
  - c. inquire whether there is someone in the patient's life the patient wishes s/he could be more like
    1. What about them did you admire?
    2. How did they handle their anger?

**E. Begin Cognitive Restructuring by explaining A-B-Cs, appraisals, and interpretations**

[TAB-  
Cog]

**Note to Therapist:** It will likely be important to the patient's progress to identify core schemas or underlying psychological needs. You should not ask about this directly, but if particular themes arise repeatedly in treatment, you should investigate further. As it is relevant and appropriate in all future sessions, look to identify and discuss core schemas, or deeply held beliefs, which likely impact the patient's ability to change his/her anger behavior.

One way to identify them is when a patient holds certain expectations in a very rigid manner. If this occurs, inquire more to see what beliefs could be driving the expectations. Another clue is the extent to which the intensity of the anger is out of proportion to the provocative event.

When core schemas become apparent, discuss them with the patient and relate them to the patient's expectations and anger intensity. When relevant, provide psychoeducation about how an individual's psychological needs and strongly held beliefs impact his/her interpretation of events, emotional response to events, and subsequent behavior.

Some common core schemas could include: need for control, need for admiration, need to be right and be respected for one's opinions, etc..

**F. Complete Relaxation Training: Tranquil Scene**

[TAB-  
AR]

**G. Introduce Anger Log**

[TAB-  
Misc]

**H. Check-in on how patient feels treatment is progressing**

1. Ask patient how s/he feels about the treatment thus far. Address any concerns. Offer praise as appropriate for commitment to therapy / attendance and work well done.

**I. Assign homework**

1. Listen to relaxation recording daily. Practice relaxation strategies as often as possible.
2. Complete anger log daily and/or whenever patient becomes angry.
3. **Reading: Causes of Anger**
4. Give patient **A-B-C Worksheet** and ask him/her to complete the bottom row of boxes with an event that takes place during the week.

## Session 4

**Handouts: Anger Logs**

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**Reading reviewed: Causes of Anger**

**Reading assigned: How to Regulate Anger – Techniques of Anger Management**

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Goals: Continue cognitive restructuring.

- A. Present agenda for session (2 minutes)
- B. Briefly review homework (10 minutes)
- C. Review anger log events (15 minutes)
- D. Continue Cognitive Restructuring (40 minutes)
  - Review A-B-C, appraisals / interpretations
  - Introduce expectations - *Prior to beginning the session, read through the end of the*  
*Expectations Tab*
- E. Review relaxation strategies (5 minutes)
- F. Assign Homework (3 minutes)

### **A. Present agenda for session**

- Review Homework
- Review anger log events
- Continue cognitive restructuring
- Review progress with relaxation and assign homework

### **B. Briefly review homework**

1. Ask patient about his/her progress with relaxation strategies, including frequency of practice.
2. Discuss the reading **Causes of Anger** together.
3. Inquire whether s/he was able to complete the log.
4. Discuss completion of A-B-C Worksheet
5. Discuss any reactions and questions
6. Encourage and praise patient for practice that was completed

### **C. Review anger log events**

[TAB-Misc]

### **D. Continue Cognitive Restructuring**

1. If not already completed while reviewing the anger log entries, **review** the primary components of cognitive theory/restructuring as they relate to anger
  - a. Feelings of anger are caused not only by external events themselves, but by the **meaning** the events have for us.
  - b. **How we think influences how we feel.**
  - c. Review the "A-B-Cs" (Antecedent events, Beliefs, and Consequent behavior) to

explain cognitive mediation (Ellis would say, "We think that A causes C, but it is B that causes C).

*“Recall that last week we talked about the connection between thoughts and feelings? It can often feel as though events cause us to feel a certain way – but as you learned last week, your thoughts about the event play a very important role in determining how you feel.*

**2. Select examples from the patient’s anger logs and use the events to illustrate the role**

**of perception and interpretation.** Try to get the patient to consider alternative appraisals of the event, giving examples if necessary.

**3. Introduce Expectations**

[TAB-Cog]

Prior to beginning the session, read through the end of the Expectations Tab.

**E. Review relaxation strategies.**

*“As we’ve discussed, it’s important to be able to manage your level of physiological arousal.*

- *What have you found works best for you so far?*
- *What obstacles get in the way of your using and/or practicing these techniques?*

**F. Assign Homework**

1. Continue practicing **relaxation** using recording as often as possible.
2. Continue recording in the anger **log**.
  - Emphasize the importance of continuing to self-monitor anger experiences and intensity using the log.
  - Encourage patient to listen to him/herself “with a third ear” to recognize private speech that accompanies their anger reactions.

*“Also, it is important for you to start paying attention to the things you say to yourself when you are angry. For instance, some people say to themselves, ‘I’ll show him who’s right’ or ‘I can’t back away from this situation’ etc... During this treatment we will focus, among other things, on what you say*

*to yourself. This week, as you pay attention to what triggers anger for you, also pay attention to what you are saying to yourself when you get angry. We'll discuss this more next week.*

3. Read **How to Regulate Anger – Techniques of Anger Management** reading

## Session 5

**Handouts: DAR**  
**Stages of an anger event**  
**Anger stages diagram**  
**Anger Logs**

**Reading reviewed: How to Regulate Anger – Techniques of Anger Management**

Goal: Continue cognitive restructuring.

- A. Present agenda for session (2 minutes)
- B. Review Homework (15 minutes)
- C. Continue Cognitive Restructuring: (55 minutes)
  - Review Expectations
  - Introduce Attentional Focus and Components of Anger Event
- D. Assign homework (5 minutes)

**Have patient complete DAR and review it to ensure all questions are answered.**

### **A. Present agenda for the session**

- Review Homework
- Continue Cognitive Restructuring
- Assign Homework

### **B. Review homework**

1. Inquire about patient's success with completing relaxation exercises.
2. Review and discuss **How to Regulate Anger – Techniques of Anger Management** reading

3. Review patient's log entries. [TAB-Misc]

- a. Work to understand the patient's experience of the anger event. Focus specifically on self-monitoring of private speech and any anger-inducing thoughts.

**Note to therapist:** When reviewing the log events, review and apply previously covered cognitive restructuring concepts (A-B-Cs, expectations) and the role these factors are playing in the anger experienced. Continue to look for themes and patterns of anger arousal.

### **C. Continue Cognitive Restructuring**

1. Review expectations discussed last session.
2. Introduce Components/Stages of an Anger Provocation [TAB-Cog]

3. Introduce Attentional Focus  
Cog]

[TAB-

**F. Assign homework**

1. Continue practicing relaxation strategies.
2. Continue completing anger log sheets.
3. Prescribe that the patient moderate arousal intensity this week when becoming angry, striving  
to keep anger at low to moderate levels. Suggest s/he:
  - a. examine anger triggers and appraisal of events when s/he becomes angry
  - b. attempt to modify appraisals.

**Session 6**

**Handouts: Self-Talk  
Coping by Self-Instruction  
Task Orientation vs. Self Orientation  
Anger Logs**

**Reading assigned: Self Instructions**

Goal: Continue Cognitive Restructuring.

**A. Present agenda for session** (5 minutes)

- Review homework
- Complete cognitive restructuring
- Assign homework

**B. Review homework** (10 minutes)

1. Inquire about patient's experience and success with utilizing relaxation strategies and moderating degree of arousal in the past week

2. Review Anger Log and briefly discuss anger experiences during the week. [TAB-Misc]

a. Focus review specifically on:

- What expectations may be present, and how they may be influencing anger. Consider whether expectations may be unrealistic or too rigid.
  - Coping strategies for anger triggers
- *“Did you notice any specific anger cues, or signals that you could identify that can help you realize that you’re starting to become angry?”*
- *“What coping strategies did you use when you became angry?”*
- *“Were you able to moderate the intensity/degree of arousal?”*

**Note to therapist:** When reviewing the log events, review and apply previously covered cognitive restructuring concepts (A-B-Cs, expectations, attentional focus,

etc.) and the role these factors are playing in the anger experienced. Continue to look for themes and patterns of anger arousal.

**C. Cognitive Restructuring** (50 minutes)

1. Introduce use of **Guided Self-Talk** (self-statements and self-instructions) [TAB-Cog]

2. Introduce and explain **Task-Orientation** [TAB-Cog]

**D. Assign homework** (10 minutes)

1. Continue home practice of relaxation and completing anger log sheets.

2. Continue to moderate arousal intensity when becoming angry

3. Review all handouts covered in today's session.

4. Read **Self-Instructions Reading**

5. Implement coping strategies developed during session as needed throughout the week.

- While discussing homework, predict the likelihood of anger-provoking situations arising during the upcoming week.
- Develop a self-instruction strategy for coping with these events.

**Session 7**

**Handouts: DAR**

**Task Orientation vs Self-Orientation**

**Anger Hierarchy**

**Anger Dairies**

**Reading reviewed: Self-Instructions Reading**

Goals: Continue cognitive restructuring and develop IT hierarchy

A. Present agenda for session (1 minute)

B. Review homework (10 minutes)

C. Continue cognitive restructuring (role taking) (15 minutes)

D. Develop hierarchy for inoculation training (45 minutes)

E. Check-in on how patient feels treatment is progressing (2 minutes)

F. Assign homework (4 minutes)

**Have patient complete DAR and review it to ensure all questions are answered.**

**A. Present agenda for today's session**

- Review homework
- Continue cognitive restructuring
- Develop hierarchy for inoculation training

- Assign homework

### **B. Review homework**

1. Check on relaxation practice at home and ask what has been most useful.
  - a. While doing this, foster the patient's perception of self-control (i.e., the way in which s/he can actively exert control over emotions by using the relaxation strategies).
2. Review the log entries and discuss the self-monitoring exercise. [TAB-Misc]
  - a. Help patients discriminate between anger triggers and responses in an attempt to help them prevent becoming angry in situations that do not warrant the response. Inquire about use of self-talk during anger events and ability to use the task-orientation perspective..
3. Go over the **Self-Instructions Reading** together and discuss
4. Inquire about any questions or thoughts regarding the handouts covered in the last session and reviewed for homework.
5. Check on the patient's ability to implement the coping strategies discussed in last session (e.g., use of self-instruction, changing thoughts to include task-orientation perspective)
  - a. Discuss use of self-instruction strategy in the past week.
    1. What worked best?
    2. Were there any unexpected positive or negative consequences?

### **C. Cognitive Restructuring**

1. Continue to develop the "**task-orientation**" theme as a coping strategy in conjunction with modification of appraisals.

*Reminder:*

**Task-orientation** refers to staying focused on desired outcomes and involves actually changing undesirable situations

**Self-orientation** organizes events in terms of threat

2. Introduce the idea of role-taking (empathy, taking others' perspectives). [TAB-Cog]

### **D. Introduce and begin development of hierarchy.**

[TAB-IT]

1. Explain rationale and process for creating a hierarchy. Answer any questions.

**E. Check-in on how patient feels treatment is progressing**

- Ask patient how s/he feels about the treatment thus far.
- Address any concerns.
- Offer praise as appropriate for commitment to therapy / attendance and work well done.

**F. Assign Homework**

1. Have patient attempt role-taking (“putting yourself in another person’s shoes” or “seeing the world through their eyes”).
2. Review hierarchy scenes developed thus far and add anything new
3. Continue home practice of relaxation strategies and implementation of new coping strategies
4. Continue completing anger log sheets.

## Session 8

### **Handouts: Anger Hierarchy Anger Dairies**

Goals: Complete cognitive restructuring, finish IT hierarchy, and conduct inoculation training utilizing behavioral coping strategies.

- A. Present agenda for session (2 minutes)
- B. Review homework (10 minutes)
- C. Cognitive Restructuring (rumination) (20 minutes)
- D. Complete Hierarchy (20 minutes)
- E. Facilitate Inoculation Training (20 minutes)
- F. Assign Homework (3 minutes)

#### **A. Present Agenda for today's session**

- Review homework
- Complete cognitive restructuring
- Complete inoculation training hierarchy
- Conduct Inoculation Training
- Assign Homework

#### **B. Review Homework** (Review hierarchy scenes later in session when discussing hierarchy.)

1. Inquire about relaxation practice at home, fostering patient's sense of self-control.
2. Discuss role-taking assignment
3. Review Log [TAB-Misc]
  - a. Attend specifically to ability to use task-orientation and role-taking.
4. Give praise for work done well.

#### **C. Cognitive Restructuring**

1. Discuss rumination and post-event preoccupation with the provocation [TAB-Cog]

#### **D. Complete anger hierarchy**

1. Finish construction of anger hierarchy [TAB-IT]

#### **E. Facilitate Inoculation training**

1. Facilitate inoculation training [TAB-IT]

#### **F. Assign homework**

1. Continue relaxation practice at home and completing anger log sheets.

2. Prescribe that the patient try to minimize rumination by shifting attentional focus and using coping imagery
3. Instruct the patient to attend to internal and external signals of anger (e.g., racing heart beat, sweating, face becoming red, voice getting louder, etc.) and to explicitly try to use them as cues to cope constructively.

## Session 9

### Handouts: DAR Anger Logs

Goals: Review arousal reduction, introduce behavioral coping, do final check on hierarchy, and conduct inoculation training.

- A. Present agenda for session (2 minutes)
- B. Review homework (5 minutes)
- C. Discuss arousal regulation (5 minutes)
- D. Behavioral coping skills (35 minutes)
- E. Facilitate Inoculation Training (15 minutes)
- F. Assign Homework (3 minutes)

**Have patient complete DAR and review it to ensure all questions are answered.**

#### **A. Present Agenda for today's session**

- Review homework
- Review arousal reduction
- Discuss behavioral coping
- Conduct inoculation training
- Assign homework

#### **B. Review Homework**

1. Inquire about relaxation practice at home, fostering patient's sense of self-control.
2. Review Log. Discuss the patient's anger experiences since the last session. [TAB-Misc]
  - a. Probe for what patient learned during the week about effective coping strategies
    1. Inquire about patient's success at attending to internal and external signals of anger and explicitly using them as cues to cope constructively
    2. Discuss what self-instructions and behavioral coping skills were useful when anger cues were noticed
    3. Inquire about success with **minimizing rumination** by shifting attentional focus and by using coping imagery
  - b. Praise patient for making gains in anger control, however small.

#### **C. Review of Arousal Regulation**

[TAB-AR]

1. Review acquired relaxation skills and discuss the efficacious elements.

#### **D. Introduce Behavioral Coping skills**

1. Introduction to Behavioral Coping

[TAB-Beh]

2. Behavioral Alternatives to Anger Escalation [TAB-Beh]

3. Strategic Withdrawal [TAB-Beh]

**E. Facilitate inoculation training** [TAB-IT]

**F. Assign Homework**

1. Continue home relaxation practice and completing the anger log sheets.
2. Have patient implement behavioral strategies as alternatives to escalating anger, including strategic withdrawal. -- "Negatives lead to more negatives" is a useful self-instruction.

**Session 10**

<p><b>Handouts: (Sessions 10 -11)</b></p> <p><b>Three Types of Anger Expression</b></p> <p><b>Verbal and Nonverbal Assertive Communication</b></p> <p><b>Assertive Messages and Reflective Listening</b></p> <p><b>Anger Analysis Sheet</b></p> <p><b>For Homework: Assertive Communication Analysis Sheet</b></p> <hr/> <p>Goals: Introduce assertiveness and conduct inoculation training.</p> <p>A. Present agenda for session (2 minutes)</p> <p>B. Review homework (10 minutes)</p> <p>C. Behavioral coping (40 minutes)</p> <p>    Respectful Assertiveness</p> <p>D. Facilitate Inoculation Training (15 minutes)</p> <p>E. Assign Homework (5 minutes)</p>
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**A. Present Agenda**

- Review homework
- Behavioral Coping
- Inoculation Training
- Assign homework

**B. Review homework**

1. Inquire about relaxation practice at home, fostering patient's sense of self-control.
2. Review Anger Log sheets
3. Check on patient's success at implementing behavioral strategies as alternatives to escalating anger, including using strategic withdrawal.

4. If time permits, discuss the coping strategies that the patient finds effective and continue to develop a repertoire of self-instructions.

**C. Behavioral coping**

1. Respectful Assertiveness

[TAB-  
Beh]

**D. Facilitate Inoculation Training**

[TAB-  
IT]

**E. Assign Homework**

1. Continue practicing relaxation and completing Anger Log sheets
2. Prescribe that the patient make an effort to communicate anger constructively and to self-monitor the process.
3. Have patient use respectful assertiveness in situations of annoyance or social friction
4. Complete Assertive Communication Analysis Sheet

## Session 11

**Handouts:** DAR  
Three Types of Anger Expression  
Verbal and Nonverbal Assertive Communication  
Assertive Messages and Reflective Listening  
Anger Analysis Sheet  
For Homework: Assertive Communication Analysis Sheet

Goals: continue work on behavioral coping and complete inoculation training.

- A. Present agenda for session (1 minute)
- B. Review Homework (15 minutes)
- C. Facilitate Behavioral Coping (35 minutes)
- D. Facilitate Inoculation Training (20 minutes)
- E. Assign Homework (4 minutes)

**A.** *Give reminder that treatment will be ending soon – 3 more sessions before termination*

**Pre** **Have patient complete DAR and review it to ensure all questions are answered.**

### **t Agenda**

- Review Homework
- Facilitate Behavioral Coping
- Facilitate Inoculation Training
- Assign Homework

### **B. Review Homework**

1. Inquire about the patient's degree of success with
  - a. practicing relaxation
  - b. communicating anger constructively and self-monitoring the process
  - c. using respectful assertiveness in situations of annoyance or social friction
2. Review the anger log sheets and discuss anger events of the past week, checking on frequency, intensity, and duration.
  - At this point in treatment, considerable progress should have been made on each of these parameters, although it may be the case that anger intensity remains high on some occasions or that it still may linger with a patient's preoccupation tendencies.

### **C. Facilitate Behavioral Coping**

1. Continue assertiveness training [TAB-Beh]
2. Preparatory coping [TAB-Beh]
3. Dealing with repeated provocation [TAB-Beh]

### **D. Facilitate Inoculation Training**

[TAB-IT]

### **E. Assign Homework**

1. Continue practicing relaxation and completing anger log sheets
2. Continue to use behavioral coping strategies to defuse anger situations

3. Have patient attend to behaviors and cognitions that escalate anger
4. Utilize preparatory coping in a potentially challenging situation this week.

## Sessions 12-13

### Handouts: DAR (session 13 only) Anger Logs

These sessions are included to allow for catching up as needed, continued focus on any areas not yet mastered, and completion of inoculation training for any remaining problematic situations, which essentially defines the conclusion of treatment.

Session 13: Remind the patient that the next session will be the final session of the treatment. Facilitate the scheduling of the post-treatment assessment session.

Goals: review skills already learned, address areas where the patient needs more work, and complete as much of the provocation hierarchy as possible.

- A. Set Agenda (2 minutes)
- B. Review Homework (5 minutes)
- C. Review skills already learned (10 minutes)
- D. Continued Focus on any Areas Needing More Work (20 minutes)
- E. Discuss arousal reduction (10 minutes)
- F. Complete inoculation training (20 minutes)
- G. Assign Homework (5 minutes)

**Have patient complete DAR and review it to ensure all questions are answered.**

### A. Set Agenda

- Review Homework
- Discuss cognitive restructuring and behavioral coping topics
- Discuss arousal reduction
- Complete inoculation training
- Assign Homework

**Session 13:** Remind the patient that the next session will be the final treatment session.

Quickly discuss and address any termination issues that the patient initiates, though do not allow this discussion to sidetrack the session. Explain that there will be ample time during the next session to address any concerns.

## **B. Review Homework**

1. Check on home practice of relaxation
2. Inquire about the patient's degree of success with implementing each of the skills
  - a. Behavioral coping skills: strategic withdrawal, preparatory coping, respectful assertiveness, role-taking, defusing and not escalating anger situations (e.g., attending to behaviors and cognitions that escalate anger)
  - b. Cognitive Restructuring skills: monitoring expectations, being task-oriented, using self-instructions, minimizing rumination, shifting attentional focus, attending to internal and external signals of anger and explicitly using them as cues to cope constructively
3. Review the anger log sheets and discuss anger events of the past week, checking on frequency, intensity, and duration

## **C. Review skills learned thus far in treatment**

[TAB-Misc]

## **D. Continued Focus on any Areas Needing More Work**

Use relevant tabs as needed

## **E. Arousal Reduction**

1. Suggest lifestyle changes that will enhance relaxation above and beyond the specific relaxation strategies practiced throughout this therapy. Some supplemental activities could include:
  - a. physical exertion (i.e., aerobic exercise, yoga, tai chi)
  - b. meditation or self-hypnosis
  - c. aesthetic appreciation (i.e., music, painting, gardening)
  - The goal of any activity chosen should be to lower arousal and tension, as well as mitigate the activation of anger.

## **F. Facilitate Inoculation Training (if needed)**

[TAB-IT]

## **G. Assign Homework** (5 minutes)

1. Continue practicing relaxation and completing anger log sheets
2. Patient should continue practicing cognitive restructuring techniques and behavioral coping skills discussed during this session.

## Session 14

Goals: Address any unresolved questions or concerns that the patient has, review skills learned and treatment progress, address relapse prevention issues, and discuss termination issues.

A. Set Agenda (2 minutes)

B. Review Homework and respond to any patient questions or concerns (10 minutes)

C. Review Skills Learned and Treatment Progress (20 minutes)

D. Anticipate and plan for obstacles or set backs (10 minutes)

E. Discuss Termination (30 minutes)

### **A. Set Agenda**

- Review Homework and respond to any patient questions or concerns
- Review Skills Learned and Treatment Progress
- Anticipate and plan for obstacles or set backs
- Discuss termination

### **B. Review Homework**

1. Check on home practice of relaxation and review anger log sheets
2. Inquire about the patient's degree of success with implementing the cognitive restructuring techniques and behavioral coping skills which were rehearsed between sessions.
3. Respond to any questions or concerns the patient has that have not been adequately explained thus far.

### **C. Review Skills Learned and Treatment Progress**

[TAB-

Misc]

(See tab “Session 14 Review of skills and progress, relapse prevention”)

### **D. Anticipate and plan for obstacles or set backs**

### **E. Discuss Termination**

1. Encourage discussion of feelings about leaving the treatment and/or the therapist
2. Discuss his/her future plans
3. If necessary, arrange referrals
4. Discuss Follow-Up Assessment

*"We appreciate your participation in the program. You have now completed the treatment phase and you are ready to move into the follow-up phase. In the follow-up phase, we will follow you for another three months to monitor your progress. Your attendance at the follow-up session is important because you will provide us with feedback on the helpfulness of the program. This information will be used to develop the best possible treatments for individuals who experience anger and irritability as a significant part of their readjustment home process."*

## 5. Termination: Saying Goodbye

a. When you are saying goodbye to the patient, it is important that you find something

positive to say to him/her. The following are suggestions:

- *"I have enjoyed working with you and wish you much luck in the future."*
- *"It's evident that you are feeling better and although you were skeptical, it seems that your hard work paid off."*
- *"You had some difficult weeks there, but you persisted with courage and patience and your efforts paid off for you."*
- *"You mentioned that you were disappointed that you had not made more progress in the program. I'd like to tell you that it is not unusual for patients to express the same feelings, and then discover that they are able to implement new behaviors as time goes on."*
- *"It takes time to digest and process what happened to in treatment. You may continue to feel better and make strides with your anger as time goes on, especially if you continue to use the things that you have learned."*
- *"I want to tell you that you have put a lot of hard work into your treatment and you have made a lot of (some) gains."*
- *"I know this program was difficult for you to complete. In fact there were a few days (weeks) when you wanted to discontinue with your treatment. But you stuck with the program and made some progress."*

## 6. Discuss the follow-up evaluation and any future treatment plans/needs

- Confirm with the patient that the post treatment assessment is scheduled and remind him/her that the evaluator cannot know what kind of treatment s/he received. Remind him/her that s/he will be paid for this evaluation.
- Discuss any future treatment plans/needs

## **COGNITIVE STRATEGIES**

Introduction of Cognitive Restructuring  
Expectations  
Components/Stages of an Anger Provocation  
Attentional Focus  
Modifying Appraisals  
Guided Self-Talk  
Task Orientation  
Role taking/Empathy  
Rumination and post-event preoccupation  
Cognitive Restructuring Wrap-up

# Introduction of Cognitive Restructuring using A-B-Cs

**Handout: A-B-C Worksheet**  
**Reading: Causes of Anger**

## 1. Explain primary components of cognitive theory/restructuring as they relate to anger

- a. Feelings of anger are caused not only by external events themselves, but by the **meaning** the events have for us.
- b. **How we think influences how we feel.**
- c. Our expectations and goals shape how we perceive events.
- d. It may be useful to use Albert Ellis' explanation of "A-B-C" (Antecedent events, Beliefs, and Consequent behavior) to help get across the idea of cognitive mediation  
(Ellis would say, "We think that A causes C, but it is B that causes C).

*"Now we're going to talk about the role your thoughts play in your anger. You may often think that a certain event or person has "made" you angry, right? It can often seem as though our feelings come about in response to events that happen. But, there is actually something that takes place in between the external events and our feelings...something else that influences the way events affect our feelings – our thoughts. The thoughts we have in response to a situation can play a big role in how we feel about the situation."*

*"We can think of it in terms of A-B-C's. "A" stands for antecedent event, "B" stands for Beliefs, and "C" stands for Consequent behavior. An antecedent event is the event that occurs which starts the anger episode, and consequent behavior is the way you behave in response to the situation (both the way your body responds and what you actually do). Let's use an example to make this more clear."*

## 2. Present and discuss the following example(s) to help the patient understand the way in which thoughts can influence feelings and behavior.

*"If you're standing in the main entrance of this VA hospital and someone grabs and pushes you from behind, what would your initial response be?"*

- a. Discuss their physiological/behavioral/cognitive responses.

*“Now imagine that when you turn around prepared to react, you realize that it’s an elderly gentleman who staggered, lost his balance, and was grabbing his chest in pain. How would that information affect how you respond, think, and feel about the situation?”*

b. Discuss how the meaning of/reason for the grabbing and pushing impacts one’s emotional and behavioral response.

*“The behavior remains the same – you were pushed and grabbed from behind, but your understanding of the reasons for why you were pushed and grabbed changed.”*

*Another example of this could be when you’re lying in bed at night trying to sleep and you hear a noise in the house. You may interpret the noise as a possible intruder coming to rob your house. If this was the case, you’d probably have a rush of energy and adrenalin, feel threatened or angry, and take action to defend yourself and your property. On the other hand, if you heard the noise and interpreted it as a sound the cat makes when he knocks a book off the kitchen table, then you would likely not feel the physiological and emotional changes you would if you thought you were being robbed. And, you likely wouldn’t try to defend yourself. The beginning situation remains the same in both instances – there’s a noise in the house when you’re lying in bed at night. However, the way you interpret the noise has tremendous physiological, emotional, and behavioral consequences.*

**3. Work through one of these examples again on A-B-C Worksheet to ensure patient understands the use of the A-B-C method and how cognitions affect feelings and behavior.**

**4. When this is clear, select a provocation event from the patient's diary and discuss it in terms of how his/her thoughts impacted his/her feelings and behavior.**

*“Let’s choose an example from your diary to better understand how your thoughts are impacting your feelings of anger and behavior. ... OK, in that example:*

- *What were you thinking when it was happening?*
- *What were you primarily paying attention to?*
- *How do you wish it had progressed?*
- *How did you wanted the issue to be resolved?*
- *What is your understanding of what happened?”*

a. Once you have reached an understanding of the patient's perception of the event, try to modify the appraisal of it.

1. encourage patient to generate alternate ways of interpreting the situation

*“It’s hard to think of things differently, but can you see any other ways to understand or interpret what was happening?”*

2. If the patient has trouble generating alternative interpretations or meaning from the events, help by making suggestions.

b. Using the same diary example, uncover anger-facilitating thoughts

1. Help the patient make the connection between the thoughts (things s/he says to him/herself) and the anger level.

A. it may be helpful to give an example of “had X thought occurred, how

would you have felt differently than had you been thinking Y thought”.

*“Now, with that same situation, remember how you said you were thinking... (use specifics of the event to prompt). What do you remember saying to yourself? How did those thoughts influence your emotion level - did your thoughts help to calm you down or make you more angry?”*

*“What kinds of things could you have said to yourself instead, that would have helped you to calm down in that situation?”*

*“Thinking about anger events, and all the factors that contribute to them, in this way is very useful! This process is similar to how professional athletes picture themselves going through the motions prior to a competition. When you prepare yourself adequately for challenges that lay ahead, and review them after the fact, you are better equipped to manage them in a way that you wish.*

# Expectations

**Readings: Causes of Anger**  
**How to Regulate Anger: Techniques of Anger Management**

After reviewing the A-B-Cs, explain how people's expectations and goals shape how they perceive events.

**1. Introduce the idea that patients' expectations can lead to anger when they are unrealistic and ineffective for problem-solving.**

a. Using the same (or if appropriate, a new) anger-provoking situation, identify the patient's expectations for the people and situation and call attention to the characteristics that increased anger arousal.

*“Are these expectations realistic? Too high?”*

*“Do these expectations prime you to focus on anger?”*

*“Are these expectations conducive to problem solving?”*

b. Explain that unrealistic expectations (of self and others) increase people's frustration.

1. High expectations are only problematic when they are not adjusted to fit the situation.

**2. People must be able to adjust their expectations according to the needs of the situation in order to increase their ability to cope with challenging situations.**

3. Help patients see the dysfunctionality of certain expectations without suggesting that they compromise their personal values.

*“Having high expectations is great! The only time they become difficult is when they do not fit the situation. For instance, let's say someone has an 8 year old son who is not very athletically talented. If the boy's parent expected him to be a star baseball player, it would be an inappropriate expectation. When the boy didn't make the Little League team, how would the parent feel?”*

*Right - the parent would probably feel pretty disappointed and frustrated because s/he wanted him to not only make the team, but be a star! The expectation, which didn't fit the situation, increased the parent's frustration and anger level.*

*What would be a better expectation – one that won't lead to frustration?"*

4. Give an example that relates to combat history (i.e., people being late or making mistakes during war may mean death or survival for you or others, but often these things aren't life or death here at home.)

*"Sometimes our expectations come from our combat experiences. For instance, when fighting in combat, it frequently has life or death consequences if a person makes a mistake. Therefore, you may now have the expectation that people around you should not make mistakes. This expectation, though understandable in combat, is unrealistic in your current day-to-day life. Having this expectation in today's environment will lead to heightened arousal and increased anger. You need to be sure that both your expectations and responses fit the situation as much as possible (i.e., are not over-reactions)."*

## **2. Try to relate expectations to underlying psychological needs or core schemas.**

If core schemas or underlying psychological needs have already been identified and discussed with the patient during or prior to the expectation discussion, examine how these core schemas/psychological needs impact the patient's expectation of others (e.g., need to control, perfectionism).

There are some common themes presented by this population. For instance, it is common for veterans who recently returned from a hazardous deployment to express the notion that "they earned respect" and should be treated with more respect than they are given by the general public. An individual's sense of justification to anger and entitlement to be treated in a particular manner can impact his/her expectations.

**A piece noted earlier in the manual is relevant here:**

## **Justification and Entitlement**

People with anger management difficulties often feel justified in both

their angry feelings and anger reactions, even when their reactions may infringe upon the rights of others. They may also feel entitled to feel and behave in whatever manner they see fit, regardless of social norms and expectations. These senses of entitlement and justification often contribute to anger management difficulties. It will be important throughout the therapeutic process to validate the patient's emotions while at the same time pointing out, if indicated, that his/her justification of problematic anger expression perpetuates the problem. Part of this process will be accomplished by helping the patient develop empathy for others' perspectives and needs.

## **Components / Stages of an Anger Provocation**

**Handouts: Stages of an Anger Episode**

**Anger Stages Diagram**

**Readings: Self-Instructions: Coping by Talking to Yourself**

### **Identify Components of Anger-Inducing Situations**

- a. Explain that anger-provoking situations occur as a sequence of events that leads to increased anger arousal.
  1. Treatment will teach the patient to handle anger episodes part by part, instead of trying to cope with an entire anger episode all at once.
  2. The sequence includes:
    - events that take place prior to becoming angry
    - feelings aroused by the event
    - interactions with the person/situation
    - lingering thoughts after the anger episodes is over
  3. Explaining the stages of anger allows the situation to be broken down into different components which **increases the chances for successful coping**.

**Note to Therapist:** This is another aspect of the treatment that seeks to make an otherwise confusing and overwhelming emotional state into an experience that the patient can control.

- b. Go over an example from the diary using **Stages of an Anger Episode handout**

*“So, let’s take the example you wrote about in your diary.... I want you to notice that the anger episode was not an event that happened all at once. Instead, there were several factors that went into how upset you became and how the situation turned so negative. There are many instances in the sequence where you could choose to manage your anger differently before it escalates. By doing this, you will feel more in control of your anger and you will be making decisions to manage your anger in a way in which you can be proud.”*

c. Review Anger Stages Diagram

## Attentional Focus

**Readings: Causes of Anger**  
**How to Regulate Anger: Techniques of Anger Management**

1. Select an example already discussed in session or from patient's anger diary and examine it for attentional focus.
  - a. Determine salient cues that precede or elicit anger reactions.
  - b. Discuss how attending to highly charged cues or "triggers" increases anger
    - By continuing to focus on triggers, the patient is allowing him/herself to be controlled by the situation and the anger
    - By shifting attention away from anger escalating cues, s/he will be in more control of his / her reactions
2. Provide examples of attentional focus.
  - a. Paying attention to anger-provoking stimuli increases anger

*“Let’s say you know someone who irritates you every time you see them. It may be something about the way they look or the way they talk. When they come to talk to you, if you pay attention to the thing that irritates you (e.g., like their whiny tone of voice or the scowl on their face), you are likely to feel irritated and get angry. However, if you instead focus on the words they are saying and ignore the thing about them that irritates you, you will tend not get as upset.*

*Another example of this could be the person who always wants to talk about the same topic with you...the topic you’ve come to dislike discussing. When you see this person, if you start thinking about how much you don’t want to discuss that topic and how you just know they’re going to want to talk about it, then you will get upset before you even interact with this person. Instead, when you see this person, if you start to focus on other aspects of him/her or try to think of other topics you’d rather discuss, you will be less likely to become upset.”*

- b. Use hypervigilance as an example to explain attentional focus.

*"While you were overseas, you developed the ability to notice everything going on in your environment (cars on the roads, pedestrians carrying packages or with their hands in their pockets, who's in front and behind you). The purpose of this hyper-awareness, or what we call hypervigilance, is to keep you safe. It allows you to anticipate potential threats and respond to them quickly. This becomes an instinct. Now that you are home, you may continue to notice everything going on around you and to feel uncomfortable in crowds or when someone is behind you, etc. You may be constantly checking and scanning for potential threats. The problem is, when you focus your attention in this way, you are more likely to find something to be threatening that may not be. This may lead you act aggressively when the situation does not call for it.*

*Attentional focus refers to this concept. What you pay attention to will affect how you think, how you feel, and what you do. If you pay attention to things in the environment that have a potential to be unsafe, then you feel less safe and more anxious."*

# Modifying Appraisals – Increasing Flexibility in Appraisal System

## Reading: How to Regulate Anger: Techniques of Anger Management

### 1. Strive to develop greater flexibility and balance in the patient's appraisal system.

- the patient's antagonistic appraisals of events are highly automatic and stem from unidimensional perceptions of events.

Choose 1-2 recent anger provocations and examine them in alternative ways, particularly with regard to the motivations of other people and their behavior.

- The consideration of alternative views will need to become operative in the actual situation before it will mitigate anger, so this must be applied in the inoculation training.
- Key themes that are likely to be involved in the anger appraisal system are *justification and needs for personal control*.

*“As we've discussed before, there can be numerous ways to view the same situation. Let's try to examine some recent anger events to see if there are alternative ways to interpret and appraise the situation.”*

### 2. Strategies for when an anger reaction is more intense than the situation warrants

- Try to determine the significance of the situation
- Ask whether this situation is relevant to their survival

**Note to therapist:** When seeking to modify appraisal structures, automatic self-talk must be discussed and altered in order to create a new appraisal of the situation (e.g., instead of the other person attempting to disrespect or belittle the patient, perhaps s/he was simply offering an alternative opinion).

## Guided Self-Talk

**Handouts: Self-Talk**

**Self-Instruction: Coping by Talking to Yourself**

**Reading: Self-Instructions: Coping by Talking to Yourself**

### 1. Introduce use of self-instructions (*guided self-talk*) as a way to improve anger control.

*“As you have learned, what we say to ourselves impacts how we feel. When we change our self-talk, or what we say to ourselves, our responses, feelings, and behavior can also change. We use self-talk continuously, often without even being aware that we do it. For that reason, we call it automatic self-talk. In learning how to better manage our anger, we need to become experts in our automatic self-talk. A key to managing anger differently, is changing our self-talk. We’re going to discover how you can use self-talk as a method for helping cope with your anger.*

*Let’s look at some handouts to better understand how this can work.”*

### 2. Read through and complete Self Talk Handout to better explain the use of self-talk and self- instructions

- a. use this handout also to link the use of self instructions to cognitive restructuring, arousal regulation, and behavioral coping

**Note to therapist:** When seeking to modify appraisal structures, automatic self-talk must be discussed and altered in order to create a new appraisal of the situation (e.g., instead of the other person attempting to disrespect or belittle the patient, perhaps s/he was simply offering an alternative opinion).

### 3. Briefly read through Self-Instructions Reading to demonstrate how self-instructions can

**be used at different stages of anger arousal to improve anger management**

- to prepare for a confrontation
- to cope with a confrontation

- to cope with arousal and agitation
  - to reflect on a conflict in a useful manner
- a. review lists and examples of self-instructions from this reading

#### 4. Develop self-instructions collaboratively with the patient.

**Note to Therapist:** Ensure that self-instructions stem from the patient's personal experience and are tailored to fit each situation (are not general phrases repeated regardless of the situation).

*“Let’s develop some new self-instructions that you could use, and we can use the example we just spoke of when doing the handout (Handout 7.2). What do you think would have been a useful and realistic thing to say to yourself when this situation was occurring?”*

*“Think of the self instructions that you came up with in relation to this situation. Remember the self-talk you were actually using when the situation occurred. Do you see a difference? Can you see how the actual self-talk you were using increased your anger arousal while the self-instructions we developed here will help you to think about the situation differently? This will, in turn, help you to not become as angry and cope with your emotions without losing control. When you think about something differently, you will feel differently, and will therefore be able to better control your behavior.”*

- a. Review and complete **Self Talk Handout** in session and assign detailed review for HW.
1. Record examples of personalized self-instructions on this handout.

#### 5. Explain how self-instructions can be used to initiate relaxation.

- a. Self-instructions can shift one’s focus from anger provoking material to relaxing imagery, breathing control, and relaxing tense muscles.
- b. Work to further develop patient’s anger control imagery.

*“You can actually use self-instructions to remind yourself to use relaxation – breathing, PMR, or imagery. What you say to yourself could either increase or decrease your anger and level of arousal. How do you think you could use self-instructions to better manage and cope with your anger?”*

#### 6. Explain that self-instruction and breaking the provocation event into stages can be used as *prevention strategies*.

- a. Emphasize that **the point of anger control is not so much a matter of "what do you do when you get angry" but how to not get angry in the first place.**
- b. Explain how use of self-instructions allows for greater personal control and constructive coping.
  1. This is a salient aspect of the “task-oriented” cognitive-behavioral skill to be emphasized next.

*“You now see the benefit and importance of using self-talk to help you manage your intense emotions, and you already understand that anger events are not one single event, but rather a sequence of many small events which can escalate and culminate in an anger episode. Knowing that you could intervene at any given point during the anger episode gives you more control over the situation once it is occurring.*

*Let’s switch and discuss how you can use these strategies to prevent yourself from responding to situations with such intense anger. One main goal of anger management is to understand how to better control your anger when you get angry. Another goal is to know how to prevent yourself from getting angry in the first place. You can use your self-talk and other coping strategies (those that you have already learned and more which you will learn in future sessions) to prevent yourself from becoming angry in many situations. Let’s use an example from your diary to illustrate this.”*

- c. Select a recent high anger event and attempt to modify the cognitive systems. (Selecting a high anger event insures a strong personal investment and a desired goal.)
  - Examine the dysfunctionality of the expectations and appraisals linked with the anger episode.
    - “What were your expectations about this situation? Were they realistic”
    - “How did you interpret the other person’s behavior?”
    - “Did you feel threatened? Were those feelings/appraisals justified given the situation?”

- Identify desired outcomes

If harming the other person was a goal, help the patient identify other outcomes more in his/her long-term best interest.

- “What was it that you really wanted to accomplish in this situation?”

- *“What was the outcome that you wanted?”*
- *“How could it have worked out well for you?”*

## Task Orientation

**Handout: Task Orientation vs. Self-Orientation**

**Readings: Anger, Stress, and Coping with Provocation**

**How to Regulate Anger – Techniques of Anger Management**

Introduce and explain *task-orientation* as a strategy for managing anger

- Explain and contrast being "task-oriented" with being "self-oriented."
  - **Self-oriented** refers to organizing perceptions of events in terms of threat, which leads to emotional arousal.
  - **Task-oriented** refers to staying focused on desired outcomes, which involves actually changing the undesirable situation.
  - Changing one's orientation will both minimize anger and also change the circumstances that produce anger.

*“Like we discussed in an earlier session, instead of seeing provoking events as threats that call for attack, we can view them as problems calling for a solution. Being task-focused can help us to think about how to change a bad situation.”*

*“Learning to become task-oriented is a central goal of this treatment because it will allow you to prevent much of your anger arousal from happening.”*

- Complete **Task-orientation vs. Self-orientation Handout**

As anger provoking situations are discussed, remind patient how to switch from being self-oriented to being task-oriented.

Work to reframe the appraisal of the event from a ‘threat that requires attack’ to a ‘problem that needs to be resolved.’

*“Often when we become angry, we feel threatened or attacked. One useful strategy is to change our view of anger provoking events from a ‘threat that requires attack’ to a ‘problem that needs to be resolved.’ Let’s apply that to this situation. How could you re-state this situation in terms of a problem that needs to be resolved?”*

## **Role Taking / Empathy**

Introduce the idea of role-taking (empathy, taking others' perspectives).

- Build on earlier discussion of helping patient modify his/her appraisals and expectations.
- Spend several minutes providing examples for patient about how to do this.

*“Each of us looks at the world through our own pair of glasses. Learning to understand things through the other person’s point of view can help prevent anger and keep it from becoming too intense. Try to put yourself in the other person’s shoes; see the situation from their eyes and in terms of their needs and responsibilities. Know where the other person is coming from, and remember, to the other guy, you are the other guy. Very importantly, consider how your expression of anger will affect that person.”*

*“When you think about an anger event, ask yourself:*

- *How does the other person feel?*
- *What are they thinking?*
- *How did they want this situation to play out? Is this what they wanted?*
- *How are they responding to my reaction?”*

## **Rumination and post-event preoccupation with the provocation**

1. Remind patient of work done on attentional focus and anger cue salience.

- a. choose a recent provocation example
- b. closely examine the attributes of the situation and the behavior or features of the provoking person.
- c. help the patient to understand how giving primary attention to these attributes thereby *slants* or *pre-sets* his/her own experience in the direction of anger and loss of control.

- The patient brings anger on him/herself by focusing on triggers.

d. Extend this work on attentional focus to *rumination and post-event preoccupation with the provocation*.

- Help the patient to see that by *continuing to dwell* on the provoking event s/he becomes his/her own enemy and defeats the ability to do something constructive.
- Anger pre-occupation and rumination can be seen as "mind pollution" that pre-empts the capacity to enjoy life.

*“The more you focus on triggers, or parts of the situation that increase anger, the more angry you will become. This is true both during and after the situation. It is not uncommon for people with anger problems to ruminate or stew about an anger event long after it is over. Stewing about an anger situation is not only unproductive, it also maintains and increases your anger. Spending unconstructive time thinking excessively about a person or event that angered you is like “mind-pollution” in that it means you expend precious energy on negative emotions and impairs your ability to focus on more positive and enjoyable aspects of life.”*

- Elicit patient’s reactions to this rumination and post-event preoccupation notion

2. Link the use of attentional focus with increase (vs. loss) of control

a. help the patient to see that becoming angry and staying angry (by ruminating) involves a loss of control.

- It defeats the patient's ability to process information, think clearly, and solve problems with planned action
- For example, if they are ruminating and maintaining anger toward a particular person, they have lost control by dedicating too much time to someone negative

3. Encourage patient to monitor for rumination, and to identify strategies to decrease rumination when it occurs (e.g., breathing exercise, distraction etc).

4. If rumination is a repeated pattern associated with the same person, inquire why they wish to continue a relationship that is negative for them.

*“Given that you know that interacting with and thinking about this person only brings you negative affect (i.e., anger, anxiety, grief), why are you choosing to continue spending so much time with someone who makes you feel bad?”*

# Cognitive Restructuring Wrap-up and Discussion of Control

## 1. Continue developing greater flexibility and balance in the appraisal system.

Review recent anger episodes and examine:

- how the patient is placing exaggerated importance on the situations
- their infusion with anger-activating themes, e.g. entitlement and justification
- discuss any presenting themes of the patient's sense of "being offended" or "being owed something" and any self-worth issues
- *threat-related elements*  
At this point in treatment, the patient should be able to deal much more effectively with the painful feeling of vulnerability associated with anger that functions as character armor.

*“Let’s take a look at some of your recent anger events...why don’t you select one that seems important to you. (Review that event.) Often times people get upset by an event that seems important at the time, but later seems less important. When you were in this situation, how important did it feel that you get the outcome you wanted? Why did it seem so important? Now, in retrospect, what do you think about it? Was this situation worth all the distress you let it cause?”*

*Let’s also look at your personal triggers for this event.*

Review the anger-activating themes such as entitlement, justification, and ways the patient’s self-worth was wrapped into this situation.

*How were your needs and expectations playing a role to increase your anger? It is important to realize that these factors have little to do with how the other person was actually behaving.*

*Finally, as we’ve discussed, anger often stems from feeling hurt or threatened. What other emotions do you think you were feeling in this situation. It can be easier to experience*

*anger than experience hurt, fear, or threat. Let's discuss how you may have been feeling threatened in this situation."*

**Note to Therapist:** It may be difficult to stay focused on the threat theme as the patient may discuss several issues that can steer the conversation in a different direction, e.g.

1. appraisals of unfairness and disrespect, which can pull for the fortifying aspects of anger
2. utility of anger as an empowering strategy
3. themes of injustice, which can distract the patient from experiencing and feeling vulnerable

Reassure the patient that the new coping skills s/he is learning will supply resources that will replace the anger.

## 2. Discuss the concept of control.

- a. explain that anger stems from a need to establish control
  - anger is often used to coerce the world to be the way the patient wants it to be
- b. reiterate that the new coping skills replace a function served by anger (to control) patient
  - 1. the treatment has involved several aspects of anger control (ways the patient can better control him/herself, not the external world)
    - prevention of anger activation (controlling **frequency**)
    - regulation of anger arousal (controlling **intensity and duration**)
    - execution of coping behavior (controlling **mode of expression**)
  - 2. as personal efficacy for dealing with problem situations is augmented in treatment, the patient will have an increased sense of personal control which will reduce the need for anger.

*"As we've talked about before, people often can use their anger as a way to control other people or the outcome of a situation. For example, if you are displeased with the way someone is treating you, you may become angry and act aggressively in an*

*effort to make the other person stop what s/he is doing. Anger can sometimes intimidate others into doing what you want in the short term, but in the long run, using anger to try to control others backfires because it makes people not want to be in relationships with you. Also, the potential negative consequences are high (e.g., jail, etc.). We cannot control the external world and other people. Our goal is to have better control over ourselves.*

*This anger treatment teaches several new skills which increase your control over how you experience and express your anger. By using the techniques to prevent some of your anger, you gain control over how often you become angry. By practicing the relaxation techniques and being able to regulate your arousal levels, you gain control over the intensity and duration of your anger (how long it lasts). And by using the coping skills of assertiveness, time out strategy and the several others we've discussed, you gain control over the way in which you show your anger. As you continue to make progress in using these skills regularly, your control over yourself will increase such that your need for anger will reduce. Remember, in situations of provocation, unregulated anger reduces your control; it doesn't increase it."*

## **BEHAVIORAL STRATEGIES**

Introduction to Behavioral Coping  
Behavioral Alternatives to Anger Escalation  
Strategic Withdrawal  
Respectful Assertiveness  
Behavioral Coping for Repeated Provocation  
Preparatory Coping

# Introduction to Behavioral Coping

## 1. Introduce and explain behavioral coping.

*“The next area where we will focus is called behavioral coping, meaning learning new ways to behave. These new skills (e.g., preparatory coping, using your new skills to prevent anger arousal, learning and practicing constructive anger expression, etc.) will improve the way you manage your anger. When you utilize all your new skills together (relaxing your body, thinking differently, and behaving differently), you will succeed at managing your anger in a way more to your liking! One key to this treatment is understanding that you must use all of these various skills in order to manage your anger differently.”*

- Being task-oriented leads to an improvement in behavioral coping skills.
- Behavioral coping means being able to problem-solve more effectively.
- Minimizing anger involves knowing what to do to correct/better manage situations of provocation.
- Reinforce the idea -- as they become more effective in coping, their need for anger and their anger arousal will progressively diminish.

*“To become more task-oriented, we are going to focus on developing skills to help you cope with anger-provoking situations. As you get used to managing these situations, you’ll notice that your anger response will decrease – you won’t feel the same amount of anger as you used to in similar situations.”*

## 2. Give examples of behavioral coping skills that will be taught in this treatment

- Behavioral Alternatives to Anger Escalation
- Strategic Withdrawal
- Respectful Assertiveness
- Behavioral Coping for Repeated Provocation
- Preparatory Coping

## 3. Anticipate obstacles and discuss process of change

- Encourage the patient to begin to *anticipate obstacles* to their efforts.
- Discuss potential *obstacles to effective coping* (e.g., things that are likely to happen)

- that will get in the way of achieving anger control)
- In unraveling such obstacles, allow the patient's sentiment to unfold (i.e., do not put up resistance that will shut-down their disclosure).

*“There are usually obstacles that make changing our own behavior challenging. You now know several ways of managing your anxiety and arousal level, and you have several strategies for how to express you anger in a constructive fashion. However, there will be times when it will be difficult for you to use these strategies.*

- *What types of obstacles or situations can you foresee which will get in the way of your using your new skills?*
- *What traits about yourself do you think may make this change process harder?*
- *How can you address these issues and plan for these types of situations arising?*
- *You have worked hard here and have learned many things. What can you do to improve the likelihood of success at expressing your anger differently than you have in the past?*

*Let’s review the reasons why you’re working to change how you express your anger.*

- *How will making these changes improve your relationships, work life, overall quality of life?”*

#### **4. Reiterate that behavioral coping can be used to prevent anger problems**

- Point out ways in which these new coping skills can **prevent** anger
- Being able to anticipate problems and strategically plan ways to manage the problems can prevent intense anger and non-constructive anger expression.

# Behavioral Alternatives to Anger Escalation

## 1. Discuss the *escalation of provoking behaviors and anger*.

- a. Review how anger episodes, particularly those of high intensity, often involve a **sequence** of antagonistic moves, increasing in intensity.
  - negatives lead to more negatives.
- b. Select an example provocation scenario where escalation has occurred
- c. Examine alternatives to escalation
- d. Elicit ideas from the patient about constructive coping during anger episodes

**Note to Therapist:** It is important to get the patient engaged in generating the behavioral alternatives, as those formulated by the patient will fit with the behavioral context and with his/her resources.

## 2. Present some behavioral alternatives to escalation. Examples:

- a. **strategic withdrawal:** removing oneself from the anger-provoking situation
  - This is imperative when anger intensity is quite high and behavioral options are limited, especially when the other person is entrenched in their own anger and is refractory to conciliatory moves.
  - Withdrawal from the situation is also important when the patient is unlikely to be able to moderate anger intensity and the costs of acting in anger will be severe.
  - Strategic withdrawal is not equivalent to disengagement or avoidance. It is more like a "time out" for a cool-down period until the patient can re-engage constructively at a later time.
- b. **respectful assertiveness:** enabling the patient to maintain poise and control in the face of disrespectful, obnoxious, or repeatedly rude behavior by others.
  - Verbal communication skills are essential for the assertiveness to be effective.
  - The patient can develop a repertoire of "things to say" in conjunction with the hierarchy situations.
- c. **diplomacy:** expressing neutralizing sentiment, empathically validating the other person's position, and/or seeking a mutually satisfactory solution.

**3. To reinforce the value of using strategies to prevent escalation, encourage the patient to anticipate the consequences of poorly managed anger**

- promote the idea of *anticipating the consequences of angry behavior*
- help the patient anticipate what will happen to both him/herself and others as a result of unregulated anger

# Strategic Withdrawal

Discuss *strategic withdrawal* as a useful coping behavior (it's *strategic* because the patient is using strategy to determine how and when to best employ this technique)

## 1. encourage patient to use a "time-out" in such situations.

- this can be done explicitly by a calling time-out as done in sports or implicitly by quietly leaving
- with recurrent conflict with a partner, the time-out can be an agreed-upon procedure that provides a cool-down period during which both parties can regroup to approach the problem more sensibly at an arranged later time.

## 2. discuss what should occur during the strategic withdrawal interlude.

- lower arousal level
  - use deep breathing, relaxation imagery, and calming self-talk
- take a walk/exercise to get fresh air and remove oneself from the situational anger cues
  - In contrast, going for a drive is a bad strategy because the demands of driving raise physiological arousal (due to the aggressive cues in driving situations) and add to the risk of displaced aggression and unsafe driving.
- remind him/herself that rumination and preoccupation will fuel anger and be unproductive
- once arousal has decreased, move into a task-oriented mode
  - focus on how to achieve a constructive outcome to the situation
  - choose a behavioral strategy that will effect the desired outcome
  - anticipate obstacles to the solution
- with lowered arousal and a behavioral strategy aimed at obtaining a constructive outcome to the anger situation, return to the situation to resolve the conflict

- insure that other involved person/people are equally prepared to reasonably discuss the conflict
- implement preparatory coping strategies, self-instructions, and additional behavioral coping strategies
- if exaggerated or unregulated anger arises again, use strategic withdrawal (time out) and repeat process

## **Respectful Assertiveness**

**Handouts: Three Types of Anger Expression  
Verbal and Non-verbal Assertive Communication  
Assertive Messages and Reflective Listening  
Anger Analysis Sheet**

**For Homework: Assertive Communication Analysis Sheet**

**Reading: Anger, Stress, and Coping with Provocation**

**1. Introduce the importance of communicating anger in an assertive, constructive, solution-oriented manner.**

*“One of the most important coping skills you will learn is communicating effectively or constructively about anger. Let’s talk about the difference between constructive or assertive and non-assertive ways of communicating about anger.”*

**2. Discuss the three types of anger expression using the Three Types of Anger Expression Handout**

- You may choose to review a past log example to highlight and discuss differences in assertive or constructive vs. non-constructive examples of anger expression.
  - *“For example, let’s discuss this log example. You expressed your anger first by...”*
  - *“Was that a constructive or non-constructive way of expressing your anger (i.e., did it increase negative anger expression or work to solve the problem at hand)?”*
  - *What types of behaviors do you see in other people that escalate your anger (cursing, raising voice, name calling)?*
  - *“What would be some constructive ways to express your anger in*

*this situation?”*

**3. Discuss key concepts of assertive expression of anger using the handouts:**

- **Verbal and Nonverbal Assertive Communication**
- **Assertive Messages and Reflective Listening**
- **Anger Analysis Sheet**

a. Explain that for assertive communication to work, the patient must approach the discussion at an appropriate time (e.g., both people involved are ready and willing to listen to each other, no one is rushing to leave the situation due to time constraints, etc.).

**4. Focus on anger communication and do optional role-play of an anger event**

a. Conduct a provocation role-play, with the therapist taking the role of the provoking person.

- After completing the role-play, reverse roles with the patient
  - The therapist should polarize the anger expression by first enacting a very unconstructive anger venting and then enacting a passive response as a contrast.
  - Ask the patient to consider a constructive response that is somewhere between being out of control and being passive.

b. Discuss the patient's typical ways of communicating anger.

- Be sure to acknowledge contextual variation that you know from earlier assessments.

**5. Model effective communication of anger while emphasizing task orientation.**

a. Re-examine the patient's *role-taking skills*

- Discuss patient's ability to take the perspective of the other person in the role-play.
- Link the role-taking ability to flexibility in appraisal structure (i.e., help the patient understand the value of considering alternative ways to interpret a situation.)
- Remind patient to be task-oriented (i.e., maintain focus on solving the problem).

**6. Discuss consequences of alternative behaviors**

a. Have the patient think through the consequences of alternative behaviors (i.e. different ways of expressing anger when angry)

b. Note the possible outcomes of various forms of anger communication for themselves and for others.

**7. If additional assertiveness work is needed, see Optional / Supplemental Handouts for Assertiveness Training found in the Optional TAB.**

## Behavioral Coping for Repeated Provocation

Examine ways the patient can manage a situation of repeated provocation (e.g., repetitive or continuous aversive behavior directed towards him/her).

Discuss how to maintain coping efforts in the face of a continued aversive behavior that seems to justify a strong anger response.

- a. choose a situation from the hierarchy and magnify it, if needed
- b. urge the patient to generate the coping strategy, pulling for his/her collaboration
- c. discuss responses that would *not be effective* ways of coping
  - threats
  - harsh blaming
  - profanity
  - humiliation or put-downs
  - patronizing or mocking
  - rude dismissals
  - taunting
  - inviting escalation
- d. review some potential scenarios with the patient, creating a *montage of what not to do*
  1. discuss the consequences of these poor anger control responses for both the patient and the target.
- e. discuss effective coping strategies
- f. formulate two or three positive ways of handling the problem situation such that constructive outcomes are achieved.

## Preparatory Coping

**Reading: Self-Instructions: Coping by Talking to Yourself**

Discuss **preparatory coping**, which means

- a. thinking constructively and positively about situations
- b. using self-instructions in an effort to prevent anger arousal.

*“Preparatory coping means you prepare yourself for potentially negative situations before they occur. This is much like the example we discussed in the past of how professional athletes practice running certain plays (or how figure skaters will practice trouble spots in their routine) over and over trying to anticipate difficulties and fix them before the problems arise during the game (or competition).*

*In the case of anger, the goal is to try to think positively about potentially challenging situations. For instance, can you think of any situations that may happen this week that could be anger producing? OK, so before you go to (repeat the situation), spend some time thinking about a positive way to manage the situation. Also, imagine the event going smoother than you’re currently assuming it will go. Create some self-instructions relevant to this situation which will help you cope with any anger that may be aroused.”*