Critical Issues in the Treatment of Anger

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This article proposes that anger has received less attention in the behavior therapy literature than other emotional disorders. Little research exists to guide clinical practice on the effectiveness of interventions to treat anger. Suggestions are made for treating angry clients. These suggestions are presented as researchable hypotheses. It is proposed that angry clients often fail to establish a therapeutic alliance with their therapists. Failure to agree on the goal of changing their anger is the component of the alliance which is most problematic. Strategies to develop the therapeutic alliance with angry clients are proposed. Script theories of emotions are presented as an important tool for understanding clients' reluctance to change and in establishing the alliance with clients of different cultural backgrounds. The creation of new scripts that are acceptable to the client's cultural group is presented as one strategy to establish a therapeutic alliance. It is suggested that the use of exposure based treatment may be a promising treatment for anger.

Anger has become the forgotten emotion. Although there seems to be agreement among mental health professionals that violence is prevalent in America, relatively little is heard about the emotion of anger. Many researchers and clinicians have focused on violent behavior. This article will discuss the emotion that frequently precedes such behavior—anger. Our interest in anger was initiated by a number of problems that arose in treating angry clients. These prob-

lems included finding an appropriate diagnostic category for angry clients, choosing of assessment instruments, forming a therapeutic alliance with clients, and using outcome research to guide our interventions. We turned to the scientific literature for guidance and found relatively little information relevant to the diagnosis or treatment of anger. In this paper we present some solutions we have tried in treating angry clients. In keeping with the scientist practitioner model, we have attempted to state our theoretical notions and treatment recommendations in terms of hypotheses which can be tested. Because little is known about the treatment of anger, we believe that descriptions of clinical strategies are important. However, research is needed to support clinical practice. When there is a dearth of empirical knowledge to guide clinical practice, each client can be approached as a single subject experiment (Barlow, Hayes, & Nelson, 1984).

Throughout the history of medicine and psychology, researchers and practitioners have recognized the negative physical, interpersonal, and social consequences of intense and frequent anger. Despite this awareness, clinical psychology and psychiatry have overlooked anger as a clinical problem. Little progress has been made in defining, understanding, diagnosing, and treating dysfunctional anger. Rothenberg (1971) noted that, "almost invariably, anger has not been considered an independent topic worthy of investigation . . . [which] has not only deprived anger of its rightful importance in the understanding of human behavior, but has also led to a morass of confused definitions, misconceptions, and simplistic theories" (p. 86).

The relatively small number of published articles on anger is noteworthy. We compared the number of articles on anger to those on anxiety and depression. A computer search of *Psychological Abstracts* between 1985 and March 1993 showed that 7,355 articles referenced anxiety, 15,369 referenced depression, yet only 704 referenced anger. Some conceptual confusion also exists. In the psychological literature, terms such as anger, hostility, and aggression are often used interchangeably, and frequently anger is subsumed under one of these other categories. As a result, the similarities and differences between anger and aggression remain unclear. A review of *Index Medicus* for the same time period revealed a similar trend, with 8,850 articles referencing anxiety, 8,352 referencing depression, and only 744 referencing anger. The medical literature also suffers from the same confusion of terms.

Another indication of the lack of attention paid to anger is the absence of a diagnostic category for an anger disorder in DSM-IIIR (APA, 1987) or DSM-IV (APA, 1993). Presently, there are nine categories to diagnose states of depression and nine categories representing anxiety disorders. Although numerous researchers (Deffenbacher, 1993; Novaco, 1985; Tavris, 1989) have called for the inclusion of an anger disorder category in DSM, none has appeared. Elsewhere,

we have proposed criteria for an anger/hostility disorder and a research agenda that could establish its validity (DiGiuseppe, Eckhardt, & Tafrate, 1994).

One could argue that it is more important to attend to overt aggressive behavior rather than the affective state with which it is sometimes associated. However, anger can be dysfunctional independently of aggressive behavior. Spielberger's (Spielberger, Jacobs, Russell, & Crane, 1983; Spielberger, Johnson, Russell, Crane, Jacobs, & Worden, 1985; Spielberger, 1992) research suggests that a common reaction is anger suppression, with no overt expression and a high physiological arousal. This 'anger-in' reaction is thought to contribute to hypertension, cardiac distress, and possibly cancer (Spielberger, 1992). In addition, Averill's (1983) research indicates that only 10% of anger episodes lead to overt aggressive responses. Although this research requires replication with subjects for whom anger is a clinical problem, these findings are consistent with our clinical experience with aggressive and angry adults and adolescents. Only a small percentage, perhaps 2% to 5% of clients' angry episodes co-occur with aggressive behavior.

Another reason for targeting the emotion of anger comes from our failure to notice an improvement in clients' interpersonal relations, even though we may successfully eliminate physical or verbal aggression. It appears that more of the literature focuses on treating aggressive behavior. For example, several behavior therapy texts devote more space and cite more references concerning the treatment of aggression but little attention and fewer references to treating anger (e.g., Masters, Burish, Hollon, & Rimm, 1987; Thorpe & Olsen, 1990). Our clinical experience suggests that anger is often maintained after clients with interpersonal difficulties have eliminated their aggressive behavior. This residual anger can lead to unsatisfactory marital, parental, peer, and job relationships. A reduction of anger also seems necessary to engaging in prosocial behavior. For example, we recently treated a family with a 15-year-old girl who displayed violent outbursts, damaging walls and plates. The adolescent was extremely angry at her parents for divorcing. A behavioral management program that included reinforcement for periods of non-aggressive behavior and response cost for aggressive behavior, quickly eliminated the violent outbursts. However, the adolescent remained extremely angry, displayed no improvement in prosocial behaviors, and continued to suffer from ulcers. Interventions targeting her anger were necessary before the girl mended her relationships with her parents.

A final reason for targeting anger separately from aggressive behavior comes from our work in designing an anger assessment device. Factor analysis for our scale (DiGiuseppe, Eckhardt, Robin, & Tafrate, 1993) indicated that items representing verbal aggression and physical aggression loaded on factors separate from anger. This supports the notion that anger and aggression are different constructs and need to be separately assessed and treated.

Assessment

A thorough assessment of the client's anger and aggressive behavior appears necessary before initiating treatment. It is important to note that some commonly used self-report measures, MCMI2 or 16PF, do not have subscales to measure anger or even aggression. Morey's (1990) Psychological Assessment Inventory does include several aggression scales but not anger scale. The SCL-90 and MMP12 do have anger scales. However, these subscales are less psychometrically strong than other scales in the tests. A few specialized objective self-report inventories for anger also exist. However, there are not many to choose from. Biaggio and colleagues (Biaggio, 1980; Biaggio, Supplee, & Curtis, 1981) systematically reviewed four current scales: the Buss Durkee Hostility inventory (Buss & Durkee, 1957), the Reaction Inventory (Evans & Strangeland, 1971), the Novaco Anger Inventory (Novaco, 1975), and the Anger Self-Report (Zelin, Adler, & Myerson, 1972). She concluded that all the scales reviewed had only limited evidence of validity and thus questionable clinical utility. The poor quality of anger assessment instruments, according to Biaggio, stems from the lack of a firm anger research base and represents the most difficult obstacle to clinical assessment.

Since Biaggio's critique, several measures of anger and hostility have been developed such as the Spielberger State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988) and the Multidimensional Anger Inventory (Siegel, 1985). Both are significant advancements in anger measurement, but are in need of further research with clinical populations. Both measures include subscales for different aspects of anger such as different styles of expressing anger. These have some treatment utility for identifying areas in need of treatment.

Although self-report measures are adequate for initial screening or on-going measures of improvement, we have found that they fail to reveal sufficient information relevant for treatment planning. We developed a self-report measure of anger (DiGiuseppe, Eckhardt, Robin, & Tafrate, 1993) based on the criteria we have proposed for an anger disorder diagnostic category. Initial data for its internal consistency and construct validity are encouraging but further research is needed. Our initial data yielded separate factors for physiological arousal, duration and frequency of anger episodes, physical aggression, verbal aggression, and holding anger in.[1] Although this measure provides more information, it still does not provide sufficient information for treatment planning.

Because angry individuals often do not see anger as maladaptive, we find that they usually underestimate the occurrence of their anger episodes. Open-ended discussions therefore, fail to reveal relevant information. We recently developed a structured interview for the diagnosis of anger problems.[2] Our inter-

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[2] Requests for copies of the structured interview for anger should be addressed to the first author.

view assesses the frequency and duration of anger episodes, the eliciting stimuli, the frequency of various aggressive behaviors when angry, physiological reactions when angry, the frequency and intensity of anger generating cognitions, and the number of people who have informed the client that he or she has an anger problem. When asked structured questions concerning their anger in specific situations, clients were likely to report greater frequencies of anger episodes than when asked open-ended questions. Specific information concerning the short-term and long-term consequences of their anger is also important. This will help determine if the client views the anger as functional.

Because angry clients often do not perceive their anger as a problem, we recommend assessing clients in a conjoint session with significant others. Family members can provide information about the long-term destructive nature of the client's anger, and offer a different perspective on the frequency, intensity and duration of the client's angry episodes. Research suggests that cross informant information does not correlate highly (Achenbach, McConaughy, & Howell, 1987). However, clinicians may benefit from such information, because it will allow them to develop hypotheses to account for informant discrepancies. Another assessment strategy is to have a significant other fill out the anger self-report form as he or she believes the client would complete it. This provides information on how the client's anger is perceived by significant others and what effect the anger has on the client's interpersonal relationships. Cross informant discrepancies in information often prove interesting and useful. Significant others are likely to reveal information on the questionnaire that they might be afraid to mention in front of the angry client. This information may be denied by the client or the client may actually be unaware of the frequency or nature of his or her anger.

Beginning Treatment: The Problem of the Therapeutic Alliance

Our clinical experience indicates that many angry clients who present for treatment want help changing the target of their anger, not in changing their anger. Spouses, courts, or employee assistance programs often instigate the referral for treatment. As a result, we have often experienced difficulty forming a therapeutic alliance with angry clients (DiGiuseppe, 1991; Ellis, 1977). Our conversations with other therapists who frequently treat angry children, adolescents and adults lead us to believe that the failure to obtain a therapeutic alliance with such patients is common.

Research and theory need to explore the nature of the therapeutic alliance with angry clients and propose why clients with anger disorders have a greater problem forming a therapeutic alliance than do clients with other emotional problems. Bordin (1979) proposed that a successful therapeutic alliance includes three elements: (1) agreement between the therapist and client on the goals of therapy; (2) agreement on the tasks of therapy; and (3) the "bond"—a warm,

accepting, trusting relationship. In psychotherapy supervision, we have often found therapists working hard to change their clients' anger, while at the same time, their clients are working just as eagerly to change the person with whom they are angry. They often stubbornly cling to their anger. The clients fail to agree to change their anger because they do not recognize that their anger is problematic to them or they believe their anger is justified. They may not recognize that any other emotional reaction would be appropriate. Therefore, therapists and clients clash because they disagree on the goal of intervention. The therapist desires to change the emotion, while the patient desires revenge, condemnation, or a change in the transgressor. We propose that clients who come to therapy for anger are less likely to reach agreement on the goals and tasks of therapy than are clients with other emotional problems. There appear to be four issues to consider in forming a therapeutic alliance with angry clients: the clients' beliefs about the nature of anger, the clients' attitude towards changing their anger, the clients' constructs and vocabulary to describe alternative emotional scripts, and the acceptance of the alternative script by the clients' culture.

Beliefs About Anger

The cognitions clients experience while angry may be instrumental in preventing the development of the therapeutic alliance (DiGiuseppe, 1991; Ellis, 1977). Specifically, these beliefs may interfere with reaching an agreement on the goal to change one's anger. These beliefs include:

(1) *Lack of emotional responsibility and other blame*—This refers to the failure to take responsibility for one's emotions and the tendency to assign responsibility for emotions to external events. It is common for angry clients to report, "He (She or It) made me angry." As long as they believe the cause of their anger lies outside of themselves, they are unlikely to act to change their anger. Because someone else is responsible by behaving badly, that other person needs to change.

(2) *Condemnation of others*—In our experience, anger usually occurs with the idea that the target of one's anger is a totally worthless human being. The worthless individual is perceived as deserving one's anger outburst or at least contempt.

(3) *Self-righteousness*—Angry patients usually report believing that they have been treated unfairly. The transgressor is portrayed as morally wrong, while the patient sees him- or herself as the aggrieved party. Self-righteousness involves the dogmatic belief that the transgressor violated an absolute moral principle. Justice and God are on the side of the angry client.

(4) *Cathartic expression*—Many angry clients hold the belief that one must express their anger. Hydraulic metaphors of anger are common in American culture. These ideas promote the notion that anger must be dissipated or it will build up and explode. Clients often believe that holding in their anger will eventually lead to greater anger outbursts and that anger expression is healthy and necessary. This "cathartic expression" notion of anger has failed to gain empir-

ical support but is still popular among the public, and unfortunately, among many therapists (Tavris, 1989).

(5) *Anger expression is an effective way to control others*—Patients are often reinforced for their temper tantrums because significant others tend to comply with their demands. These immediate rewards appear to be offset by the negative consequences of using coercive processes in a relationship. Although significant others often comply, they remain resentful, bitter, and distant. Angry clients appear to commit the error of selective abstraction and only assess the positive, short-term consequences of their anger and are unaware of the long-term negative consequences. This results in their belief that their anger expression is an effective means to control others. The preference for short-term reinforcement and the ignorance of long-term negative consequences of the same behavior is a common human foible.

Attitudes Toward Change

Research investigating the process of behavior change both inside and outside of psychotherapy has identified four stages of attitudes people have about change (Prochaska & DiClemente, 1988). First, in the pre-contemplative stage, people are not even thinking that they want to change. Then, in the contemplative stage, people believe that there may be some benefits to changing and they are prepared to explore the possibility of change. The action stage involves taking specific steps to change. Finally, in the maintenance stage, clients attempt to consolidate the changes they have already made (Prochaska, DiClemente, & Norcross, 1992).

Most consumers of psychotherapy arrive for treatment in the contemplative or action stages. They are willing to explore the possibility of change, or they have decided to change and wish help doing so. Using Prochaska and DiClemente's (1988) model, we observed that most angry clients arrive for therapy in the pre-contemplative stage. They want to change others who make them angry. We predict that research using Prochaska and DiClemente's (1988) stages of change measure would provide evidence for our hypothesis that angry clients are less likely to have reached the decision to change when they arrive for therapy compared to clients with other emotional problems. Prochaska and DiClemente (1988) suggest that active therapeutic processes are not appropriate for persons in a precontemplative stage of change. They suggest utilizing strategies that focus on self-awareness instead.

Psychotherapy clients in the contemplative or action stage may have already gone through a considerable period of self-examination and concluded that they might benefit from change. A recent study by Saunders (1993) indicated that approximately 50% of clients seeking therapy indicated that it took them almost a year or longer to "realize there is a problem." This pre-therapy process is often absent in angry clients whose referral is initiated by others.

Alternative Emotional Responses

Ellis' rational emotive behavior therapy (REBT) (Ellis, 1989; Ellis & Di-Giuseppe, 1993; Walen, DiGiuseppe, & Dryden, 1992) posits that people may fail to target any emotion for change because of the lack of semantic precision in the language they use to express emotions. Anger is a particular problem in this regard. The use of the word anger includes a wide range of affective states ranging from annoyance to extreme rage and numerous behavioral responses. Although other standard English words may fall in the same arena as anger, such as rage, fury, annoyance, and irritation, they are not commonly used and their meaning is not precise. In comparison, American English clearly makes the distinction between the distressed emotion of depression and the experience of sadness. Also, anxiety, which is an emotional response to imagined threat, is differentiated from concern or apprehension, which are less disturbed reactions to real problems. We propose that the lack of common usage of words representing non-disturbed or disturbed emotions in the anger arena prevents people from distinguishing between disturbed and non-disturbed affective experiences. Clients' initial reactions to the suggestion that they change their anger are often shock or disbelief. One client recently responded with surprise to the suggestion that he target his anger for change. He readily admitted that he never considered not feeling angry because he did not know another emotional reaction with which to replace his anger.

Most people, including clients and therapists, would consider anger as varying along one quantitative continuum. They conceptualize anger along one axis from mild to severe. The REBT theory maintains that emotions differ not only on a quantitative continuum, it posits that adaptive and maladaptive variants of each emotion exist that differ qualitatively. Emotions differ in phenomenological experience, social expression, behavioral predisposition, and physiologic arousal (Izard, 1989). Of these aspects of emotion, only physiological arousal is a quantitative continuum. Hypothetically, anger emotions could differ in terms of disturbed and not disturbed phenomenology, effective or ineffective social expression, moderate or intense physical arousal, and adaptive or maladaptive behavioral predispositions. Therefore, individuals would be able to experience emotions that differ for all possible permutations of these four factors. There are not a large enough number of words in our language to describe these variations in angry emotions, but different emotions would be qualitatively different according to Ellis (1977), not just quantitatively different.

Accepting Anger as a Treatment Target

Recognition that changing one's anger is a goal of therapy usually requires two insights. First, clients recognize that their present emotion (i.e., anger) is self-defeating and dysfunctional. Second, clients can conceptualize an alternative emotional reaction that is socially and personally acceptable to them. These

two insights may be prerequisites to formulating a therapeutic alliance for any problem (Walen, DiGiuseppe, & Dryden, 1992).

Accepting one's anger as a target for mental health intervention requires that one recognize at least two different anger related emotional alternatives. The first, adaptive nondisturbed anger (or what Ellis, 1977, refers to as annoyance), has several components. The cognitive components of this emotion acknowledge that the person was aggrieved and that the transgressor's action was wrong but that it is not catastrophic. Experientially, this emotion feels like a negative affect in the anger arena. It might lead to clear assertive communications of his or her feelings and desires. It could lead to any other adaptive behavior that avoids victimization in the future. If no adaptive behavior was readily available in the person's repertoire, this emotion may lead the client to consider and evaluate new responses. Also, this state would not lead to the disruption of the person's functioning. Such an emotion may involve moderate but not excessive affective arousal.

The second type of anger, dysfunctional or clinical anger, leads to a more painful experience. It includes a more intense, hostile, and attacking form of social expression, which might cause more long-term problems. Clinical anger may interfere with problem solving and prevent consideration of more adaptive behavior that avoids victimization in the future. Finally, it would involve high physiological arousal.

Some support for the view that people can distinguish between disturbed clinical anger and non-clinical, functional annoyance comes from Averill (1983). His data suggest that people view anger as a more intense emotional experience than annoyance and they also view anger as a more serious or inappropriate emotional reaction.

The REBT theory of emotions is similar to the script theories of emotions (Abelson, 1981; deSousa, 1980; Fehr & Russell, 1984; Sabini & Silver, 1982; Tomkins, 1979). Script theories suggest that cultural groups share common expectations for set patterns of behavior in which given emotions are anticipated reactions to a sequence of events. For example, in some subcultures adolescents are expected to defend their honor and fight if someone insults them. In other social groups, adolescents would consider the same insults a fear provoking event and attempt to escape the social conflict as soon as possible. According to both theories, emotional experiences result from socially learned expectations of what is an appropriate reaction to specific stimuli. The person holds a scheme which includes the appropriate or culturally sanctioned emotions, evaluations and beliefs, and the social expression and behavioral reaction to a class of activating events. To the extent that anger occurs because of an absence of awareness of alternative forms of responding, one hypothesis would suggest that angry persons lack a script for an adaptive form of anger.

Discussions of the alternative script to anger provoking events with angry

clients usually results in surprise. First, clients usually defend the script that currently guides their behavior. For example, one adolescent reported that he believed it was necessary to attack all transgressors or else he would be overwhelmed by them, and disgraced in the eyes of his peers. In addition, angry clients often insist that it is important to express anger to avoid the negative health consequences that accompany anger suppression. American cultural scripts usually incorporates the expectation of an automatic reflex of aggression to experiencing anger. It seems to us that our culture has a limited number of alternative scripts for anger in comparison to other cultures. Clients often emphasize the importance of cathartic release of anger. Anger and its treatment will be better understood if clinicians and researchers investigate the common scripts people hold concerning anger, and how these scripts relate to adjustment.

Culture, Families, and Emotional Scripts

Cultural considerations could be an important issue in helping clients reach an agreement on the goal to change their anger. The development of nondisturbed, functional alternative emotional scripts, such as annoyance, may depend on the availability of such scripts in their culture and family. Over the years, one of the authors has had considerable experience training therapists in REBT throughout the world. From this experience, it has become clear that therapists from different cultural groups have varying degrees of difficulty accepting Ellis' (1977) notion of both disturbed and non-disturbed versions of anger. Those from English speaking countries have some difficulty understanding the difference between disturbed anger and non-disturbed annoyance. It is not that the English language does not have alternative words for anger type emotions. Rather, it appears the term anger is used very indiscriminantly. One can use the word anger to reflect a range of emotions from the mildest irritation to homicidal rage. Therapists from Spanish speaking countries, on the other hand, seem to grasp the distinction easily. They report that their language has words similar to English to express disturbed variations of anger such as "rabio" and "furioso," these words are used much more precisely in Spanish. Israeli therapists seemed to have the greatest difficulty attempting to apply Ellis' distinction in their language. They claimed that there was one commonly used word for what we call anger which was translated literally as, "I am nervous at you." Not surprisingly, they reported difficulty helping clients to accept the goal of changing their anger and had few culturally accepted alternative scripts available to replace clinically dysfunctional anger.

Thus, the existence of vocabulary words in the client's language that make distinctions between emotional scripts may not actually influence the availability of the scripts to the clients. Instead, the frequency with which such distinctions are made in the language affect the availability of alternative emotional scripts. The more different words that are used to describe alternative scripts to similar events, the more these alternative scripts will be accessed in the culture. It follows

that cultures, subcultures, or linguistic groups whose language does not have many commonly used words to represent alternative emotions to the same situation will have fewer emotional scripts. The fewer alternative emotional scripts that can be accessed by common words, the more difficulty people in that group will have with that emotion. Simply stated, the lack of acceptable, socially sanctioned emotional scripts leads to inflexibility of emotional reactions to troublesome situations. This hypothesis can be tested by cross cultural research which attends to the emotional scripts and the vocabulary used to express them in various cultures.

Cultural scripts for anger are likely to differ by gender. Many researchers propose gender specific patterns of anger expression and inhibition (Tavris, 1989; 1992). Biological arguments suggested that because infrahuman males tend to be more aggressive, so too are human males (Lorenz, 1966). Another view suggests that men and women are equally capable of anger expression, but our male-dominated society inhibits female anger expression. Averill's (1983) data showed that men and women experience and express anger at a similar frequency, with similar intensity, and for similar reasons. One gender difference did emerge. When angry, women reported crying significantly more often than did men.

Cultures and their languages may vary greatly in the distinctions they make between affective states. Therapists need to be aware of how the emotional script for anger (or any other emotional state) is valued in a patient's culture or subculture and what alternative scripts are available from that culture. If the patient's cultural, subcultural, or family group has no alternative script for a functional emotional response, the therapists will have to attempt to build a scheme for them.

It is also our experience that families may have idiosyncratic scripts that may differ from their culture. Most often we find that families with anger problems have too few emotional scripts. Family members fail to make distinctions between various reactions they can have to events. Perhaps because only one emotional script has been modeled, clients will behave rigidly with the same emotional reaction. This lack of flexibility will result in dysfunctional family interactions.

Failure to have an emotional script for an adaptive, nondisturbed anger will most likely lead to a failure to want to change one's anger. This will translate into a failure to agree changing one's anger as the goal of therapy.

Building An Alliance

To establish a therapeutic alliance with angry clients, the following strategies are suggested:

(1) *Assess the client's goals.* The therapists needs to clearly assess whether angry clients have a change in their anger as their goal. Failure to closely attend to the issue of agreement on the therapeutic goals will clearly lead to a problem in forming an alliance.

(2) *Acknowledging the transgression to the client.* Because the client's anger may be out of proportion to the transgression, it is easy for therapists to avoid acknowledging the negative events that evoked the client's anger. Therapists' attempts to change the patient's anger are often perceived by the patient to mean that the therapist does not believe that the transgressor is responsible for the problem, or does not agree that the patient was aggrieved, or does not believe the transgressor was wrong (Walen, DiGiuseppe, & Dryden, 1992). Patients often experience therapeutic attempts to change their anger as invalidating their moral outrage against the offender, or that the therapist disagrees with their moral standard.

To help clients focus on the goal of changing their destructive anger, it may be necessary to first acknowledge and validate their frustration and disappointment at the hands of their enemy. Clinically, we have found many clients respond to our attempts to discuss changing their anger with the accusation that we have taken the side of the significant other at whom the client is angry. Validation that a negative event or transgression has occurred to the client helps them move on to evaluate the adaptiveness of their anger.

This point was made by a couple who sought help for their arguments over the husband's 21-year-old daughter, by a previous marriage, who lived with them. The daughter had dated a drug user who stole from the couple's house to support his habit. The father felt hurt but forgave the daughter. The wife felt angry at the daughter for allowing the family home to be violated. She was angry at the father for forgiving the daughter. The therapist's first intervention was to help the wife evaluate the dysfunctional nature of her anger. This resulted in more anger. The wife believed that attempts to change her anger meant that the therapist and the husband believed that the daughter had done no wrong, and that the wife had not been harmed. First, acknowledging the wife's hurt and validating her sense of vulnerability and betrayal by the daughter before implementing other interventions, helped the alliance. Agreeing that one goal of therapy would be to discuss how to prevent the daughter from putting the family at risk allowed the client to move on and examine if her anger at her husband actually accomplished her goal.

(3) *Agree on the goal to explore.* If clients do not wish to change their anger but the therapist believes that anger is a problem, the therapist may suggest that they spend some time reviewing the functionality and adaptiveness of the clients' anger. The goal is exploration first, not change.

(4) *Explore the consequences of the anger.* The therapist can lead the clients through an analysis of the consequences of their anger by Socratic questioning. Clients are likely to focus on the immediate consequences of their anger rather than the longer term social consequences. Thus, clients might focus on the consequence of venting their anger or their success in getting someone to comply with their demands, but avoid the fact that they seriously damaged the relationship. Frequently, clients lack empathy concerning how their anger affects others.

It is helpful for them to recall how they feel when others are angry at them and then to imagine how significant others feel when the client gets angry. Accomplishing this task may take longer than other stages of therapy. It is best to continue this phase until clients appear to have awareness of the negative consequences of their anger.

(5) *Explore alternative scripts.* Once clients agree that it is in their best interest to change their anger, they still can be thwarted because they may not possess alternative scripts. Helping clients generate alternative scripts is similar to generating alternative solutions in the social problem solving model (Spivack, Platt, & Shure, 1976). This can be achieved by having the client recall how a model successfully reacted to a similar situation. The model can be a significant other, a respected member of the community, or even a fictional character. The therapist may have to suggest models from the general culture or from the literature, folklore, or film of the client's culture.

For example, we recently treated a male adolescent who was angry and fought with peers at least once a day. He was very proud of his anger and believed it was functional, despite several fights which he lost and being expelled from four parochial high schools. He could not conceptualize any alternative reaction that he considered socially acceptable. This client was enamored with the "Godfather" movies. The therapist pointed out that his behavior was like the behavior of Sonny Corleone. Like the character in the film, our client got intensely angry, expressed his anger in a highly histrionic manner, and impulsively attacked the instigators who angered him. The therapist asked, "What happened to Sonny?" The client reported how Sonny's enemies know how he acts, provoked his anger, ambushed, and killed him! "Well, you're just like Sonny!" the therapist responded. After examining how the client's and film character's behavior were similar, the therapist suggested that other models were available. Could the client imagine himself reacting like the other son, Michael Corleone, who eventually became the new "Don?" This character rarely reacted impulsively, but thought through his reactions and never let others know his emotions. This client identified with the character and was now able to conceptualize an alternative reaction. Therapy was highly successful after this intervention. One may question the value of using a gangster as a model for an adolescent boy. However, it is important that the model is respected by the client. We focused on prosocial aspects of the model's behavior and downplayed the negative aspects of the model's behavior.

After a model is chosen for an alternative script, it is important to review the consequences of the model's behavior following the script. Next, clients are asked to imagine that they react according to the script and consider what consequences will follow. In this way, clients provide information concerning whether they view the script as socially or personally acceptable to them. In the case discussed above, we asked the boy how the character Michael would respond to a situation the boy was angry about. Then we asked if he could react the same way, or if he thought the character's reaction was appropriate. Once the

client agreed that he could accept the new model, we had established an alternative script. With some clients, the behavior of three or four persons will have to be reviewed before an acceptable model is found.

Once the therapist and client have successfully accomplished these steps, the therapist can continue with the treatment of the client's anger. Therapists are free to implement any strategy they and the client mutually agree upon. The strategy suggested above helps motivate the client to continue with therapy. We often find it helpful to quickly review the steps at the beginning of each session or the initiation of a discussion on a new anger arousing event. After a client reports a new situation that he felt angry about, the therapist might respond:

> "OK, Jack you said that your typical angry reaction usu-
> ally backfires on you and causes more problems in the long
> run. Do you think you can respond with the new alterna-
> tive emotional response you thought would be more helpful
> in this situation?"

By reviewing consequences of clients' emotions, considering alternative scripts, and considering the consequences of the alternative scripts, therapists can motivate clients to keep working at controlling their anger. Reviewing this information can also be considered a restatement of the therapeutic alliance.

We have found the early stages of involvement with angry clients to be crucial for successful intervention. The early steps of treatment involve a thorough assessment of the anger to help the client become aware of the extent of the problem, identification of the cognitions that interfere with the goal of changing the anger, reviewing the short and long term consequences of anger, and exploring alternative emotional scripts and their potential consequences.

Interventions With Anger

There is much less research on the treatment of anger to drive clinical practice than exists for other emotional and behavioral disorders. In reviewing the experimental outcome studies on anger (Tafrate, 1993; Tafrate, DiGiuseppe, & Eckhardt, 1994), we uncovered only 14 studies comparing an anger treatment to a control condition with adults. Our search also revealed that only a small number of psychotherapeutic strategies for dealing with anger were experimentally tested. What is most notable in the anger treatment outcome literature, besides the small number of studies, was the lack of representation of many popular psychotherapeutic orientations. There were no studies assessing the efficacy of cognitive therapy, family therapy, psychoanalytic therapy, experiential therapy, or client centered therapy for treating clients with anger problems. One case study exists on the use of rational emotive therapy with anger (Haaga & Davison, 1989).

Although the available research can provide some guidance in the treatment of anger, substantial limitations exist in the literature. The subjects in almost all studies were volunteer undergraduates or some other non-clinical sample. Our research suggests that volunteers may not be representative of the typical angry client. While advertising in the community for adult males who have anger problems, we found that about half of the requests were made by wives and girlfriends who desired treatment for their partners. Many clinicians treat angry clients who are referred by courts, employee assistance programs, or are coerced into treatment by family members. Undergraduate volunteers seeking treatment for anger may represent a substantially different population than angry persons presenting for treatment.

Cognitive Interventions

The cognitive intervention that has received the most research support is self-instructional training (Meichenbaum, 1977). Self-instructional training is an important component of Novaco's (1975) stress inoculation treatment. The outcome research indicates that both stress inoculation and self-instructional training alone are effective in helping clients control their anger (Tafrate, DiGiuseppe, & Eckhardt, 1994).

There is little research evidence on the role of cognitions in mediating anger. Most anger treatments appear to have been designed with little theory concerning which types of cognitions mediate anger. Novaco's (1975) popular anger treatment package appears based on the assumption that angry persons have a deficit in the verbal mediation of behavior. Dryden (1990) and Ellis (1977) posit that irrational beliefs mediate disturbed anger. However, little empirical evidence exists to support the premise that the cognitive constructs targeted by the therapies contribute to anger.

Dodge's (1985) research with aggressive children and adolescents suggests that anger may be mediated by both cognitive excesses and cognitive deficits. Automatic thoughts about rejection and criticism by others are endorsed more by aggressive boys than by normal children. Dodge's research also indicates that aggressive individuals lack social problem solving skills and fail to display verbal mediation of adaptive behaviors. Our clinical experience suggests that angry clients may have some cognitive deficits leading to impulsive behaviors and sudden flares of emotion. In addition, angry clients display numerous distorted automatic thoughts and irrational beliefs. We propose that anger may be mediated by both the presence of distorted automatic thoughts, irrational beliefs, and deficits in problem solving and the verbal mediation of behavior.

Given the lack of research on the cognitive mediation of anger and treatment outcome, it seems prudent for clinicians to use multiple component treatment programs until empirical evidence emerges concerning which type of cognitive variables mediate anger and which treatments have empirical support. Rather

than focus on one cognitive variable, we recommended that clinicians assess angry clients for the presence or absence of verbal mediating self statements, the presence of negative, positive, or vengeful automatic thoughts, and irrational beliefs, as well as the client's social problem solving skills.

Automatic thoughts in anger. Angry clients do appear to over-estimate the degree of rejection and disapproval by others (Dodge, 1985). Other automatic thoughts are quite common. One is the belief that a transgressor acted purposely to insult or frustrate the client. Angry clients seem to believe that another's behavior was performed only with the intent of harming them. This belief may reflect a more pervasive problem of egocentricity and a lack of role taking ability. These automatic thoughts appear to improve in response to the technique of cognitive restructuring through collaborative empiricism recommended by Beck (Beck, Rush, & Emery, 1979).

By far, the most common automatic thoughts in angry clients are concerned with deservingness or unfairness. Almost all angry clients we have seen report being treated unfairly. They believe they have not received fair treatment from others, or have not gotten their fair share of some reward or wealth. Another variation on this theme concerns not receiving sufficient respect or deference from others. These fairness thoughts are the most difficult to challenge. Beliefs about fairness involve moral rules. In our experience, angry clients have responded poorly to attempts to tell them that their moral reasoning and judgement is incorrect. Also, because judgements about what is fair are definitional and not factual, these thoughts do not respond well to the collaborative empiricism model of cognitive restructuring (Beck & Emery, 1985; Beck, Rush, & Emery, 1979). In challenging a belief concerning empirical reality, one can agree on what would constitute evidence to support or reject the clients' automatic thoughts. However, ideas about fairness are moral or definitional. Clients may have a reason to conclude that the behavior of others is unfair based on some moral principle; or they may simply label it unfair because they arbitrarily define any behavior of others that they dislike as "unfair." We have found it more helpful to follow the rational emotive strategy (Dryden, 1990; Ellis, 1977; Ellis & Dryden, 1988; Walen, DiGiuseppe, & Dryden, 1992), which is to concede to the clients' that their automatic thoughts concerning fairness are hypothetically correct and ask what that means to the clients if they are true. For example one client reported thinking, "My wife treated me unfairly when she criticized me." The therapist then asked, "Well, what if your wife did in the past, and continues in the future to criticize you unfairly, what does that mean to you?" The client responded, "She has no right to act that way and I can't let her do that." Many angry clients reveal dogmatic demanding thoughts that they must be treated fairly and receive all that they deserve. In this case we proceeded to challenge the belief that the wife had no right to act unfairly. We pointed out that all human beings have the potential to act unfairly or wrongly. Although he may choose to try to influence her behavior, he could not control her. Further research is needed to

test our hypotheses that fairness beliefs are unresponsive to empirical challenge and therapists are better off dealing with such cognitions with more philosophical strategies of cognitive restructuring.

Exposure and Skills Training Therapies

Most therapy packages for anxiety and depression include behavioral exposure or rehearsal components. We propose the same should be true with anger. Reliance solely on cognitive restructuring with no practice of behavior change would not be effective. One class of treatments that may be effective for anger and has received little research attention are exposure based therapies. Historically, exposure procedures have been used to treat anxiety disorders (Wolpe, 1990). There is some research demonstrating the effectiveness of imaginal exposure treatments for anger. Following Suinn's development of anxiety management training (Suinn & Deffenbacher, 1988), which is a variation of systematic desensitization (SD), Deffenbacher and colleagues modified this procedure into anger management training (AMT). In this approach, clients are asked to develop a relaxation scene based on a real event. In addition, several anger scenes are developed also based upon real events. Once the client is proficient in relaxation and in imagining the relaxation scene, the first anger scene is presented. Once the client experiences anger, the therapist guides the client back to the imagined relaxation scene. The anger scenes are repeatedly presented to the client and are alternated with the relaxation scene. In our meta-analysis review of anger outcome studies, treatments using both SD and AMT were very effective. However, there seemed to be a large difference between the studies using relaxation training and AMT, and those using traditional systematic desensitization. The studies using AMT had a strong effect size. However, the studies that adhered to a strict SD model yielded an average effect size almost double that of any other treatments we examined. SD clearly emerged as the most promising treatment. Given these results, it is interesting that the research on SD and anger stopped in the 1970's. Although one can not conclude that SD is the most effective treatment for anger because too few studies exist, SD is a promising treatment for anger.

Although some research exists for imaginal exposure, there is no research studying the effect of in vivo exposure or anger induction exposure. Anger induction would involve a model role playing the anger provoking behavior of others. One case study (Kaufman & Wagner, 1972) used exposure principles for anger which they called the barb technique. This treatment involved the systematic presentation of anger provoking statements role played by the therapist to an inpatient adolescent male. The therapist began first in individual sessions. Later, other staff members delivered the barbs to the patient. They report substantial improvement in this case.

There are several reasons why we believe imaginal exposure, anger induc-

tion, and in vivo exposure procedures may hold promise for the treatment for anger. First, anxiety and anger are somewhat similar both physiologically and functionally. Both are associated with high levels of autonomic nervous system arousal such as increased heart rate, blood pressure, and respiration. Both emotions seem to energize an individual for action against a potential threat. Treatment packages for anxiety that include an exposure component have been shown to be quite effective. For example, Barlow, Craske, Cerny, and Klosko (1989) report an 85% success rate in the treatment of panic disorder. Their treatment includes exposure both to bodily sensations and to feared situations. Because there are some similarities between anxiety and anger, exposure techniques for anger may be as effective as they are for anxiety.

The second reason we think exposure based treatments may be effective for anger is our conclusions of a review of available treatment outcome studies on anger. Results of a meta-analysis indicated that the largest effect size occurred for treatments which included some form of exposure to anger provoking stimuli (Tafrate, 1993). Systematic desensitization and anger management training appear to be most effective in helping clients reduce their anger.

The third reason we recommend exposure treatments for anger is that we have found them to be quite successful. We have employed exposure based treatments with a diverse group of clients such as adolescents, adults, males, and females with anger associated with family violence and fights in school, and with gang members. We have used exposure techniques as part of a multicomponent treatment package that includes cognitive restructuring, self-statement generation and rehearsal, and social problem solving skills.

There are many ways to implement exposure techniques with clients who have anger problems. For example, we ask clients who have difficulty dealing with people, in either their home life or at work, to identify the situations and statements that are most likely to trigger their anger. These negative statements are then repeatedly presented to the client in the session by the therapist. Intensity of the exposure can be altered by the therapist's tone of voice, proximity to the client, and by using threatening posture and hand gestures. Surprisingly, many of our clients have told us that it is more helpful for the therapist to "act" very loud and aggressive when practicing exposure to the negative statements.

In one case, a client sought treatment because he had lost several jobs in the preceding year due to his angry outbursts. He had recently found work but was concerned that he might lose his temper with several co-workers he disliked and thereby lose the job. We identified things that the co-workers said that elicited his anger. The therapist repeatedly exposed the client to those statements in the sessions. In later sessions, coping statements based on rational emotive therapy (Ellis, 1977) were added. The client would rehearse the rational self-statements following the presentation of the negative anger provoking statements. After 12 sessions, the client reported good control over his anger at work and remained employed at follow-up several months later.

In supervision and training workshops, many therapists express reluctance to utilize exposure techniques with angry clients because of their fear of the angry clients' reactions. They believe that the client may become angry and yell or hit the therapist in the enactment of the anger eliciting situation. We have used exposure based treatments for anger many times and have yet to have a client mistake us for the real target of their wrath.

Most of the angry clients we have worked with have responded well to exposure techniques once a therapeutic alliance is established. Agreement on the goals of treatment establishes the motivation for change. Many clients do not understand how exposure works and think that it is sadistic to rehearse situations that elicit anger. A clear rationale of exposure techniques may be necessary to develop an agreement on the tasks of treatment.

Often in vivo exposure is not possible. In these cases the therapist can help the client construct anger provoking scenes that can be presented in the session in imagery. The imagery of the scenes and the rational coping statements can be practiced at home.

Although we believe that exposure based treatments are a crucial aspect of anger management, they may not be sufficient for successful therapy. A good example is the treatment of a patient with a long history of anger and aggressive behaviors. This client had completed a prison term for assault and battery. He was concerned about his ability to keep his anger in check at work. After a number of exposure sessions, the patient reported that he did not react in a hostile manner to his supervisor who frequently yelled at him. Although the client was pleased that he was still employed, he nonetheless expressed sadness and concern about how to respond to his supervisor. He revealed that after a difficult work day he found himself crying after work. After some questioning, it was clear that the client did not know a constructive way to respond to the supervisor's criticisms.

In this example, the exposure was successful in eliminating the client's angry responses toward his supervisor and he was able to keep his job. However, exposure did not increase his skills in dealing with a difficult situation. He had no prosocial response in his repertoire for conversing with the critical supervisor. Through problem solving, we generated alternative ways he could respond to the supervisor. These strategies were then role played with the therapist alternating between modeling the behavior and playing the role of the supervisor. Our experience suggests that it is not uncommon for angry clients to have a limited set of strategies for dealing with conflict. For this reason, social skills training, assertiveness training, and social problem solving strategies may be an important part of a comprehensive treatment program. The research on anger demonstrates that each of these strategies is an effective treatment for anger (Tafrate, 1993).

In treatment packages for anxiety disorders, exposure techniques are often the last components to be implemented. Clients receive training in a variety of skills such as relaxation, and cognitive restructuring prior to exposure. In

treating anger, we also advocate a multi-component approach dependent on the client's presenting problems. However, there may be some advantage to implementing exposure techniques first, once an alliance is established, before implementing cognitive restructuring or skills training. Clients often bring negative, self destructive consequences upon themselves by their anger. Keeping their anger in check to avoid losing a job, or committing an aggressive criminal act may be an immediate concern. Exposure techniques help teach the client *not to react*. Not responding to an anger provoking stimuli may be a first step in treatment. This may be necessary to avoid the real social consequences of their anger that may have brought them into therapy. Cognitive restructuring and skills training usually take longer to work. By the time the skills are learned, the client may have already committed an impulsive self destructive behavior. Exposure techniques can teach subjects to rapidly inhibit angry responses and not respond. It does not appear necessary to first teach the client an alternative response, although that is the next goal of therapy. There are many behavioral techniques that may be beneficial to clients with anger problems. Both imaginal and in-vivo exposure techniques appear to hold great promise for effective treatment. In addition, social skills training, assertiveness training, and social problem solving techniques are important components which can be implemented after the client develops some control over the anger.

Summary

The treatment of anger has received much less attention than the treatment of other emotional problems. The model presented here includes a number of treatment components. The most important issue for the treatment of anger appears to be the development of a therapeutic alliance, specifically, securing agreement on the goal of therapy to be the treatment of anger. Angry clients may have difficulty reaching this goal. Important steps to reach this agreement include a review of the consequences of the client's anger and the creation of alternative emotional and behavioral scripts to guide future reactions to anger provoking situations.

Cognitive interventions with anger include challenging the automatic thoughts concerning the intent and rejection of others. In addition, therapy needs to focus on the definitional cognitions concerning demands for fair treatment by others. Finally, cognitive coping statements can be rehearsed while the client is exposed to anger eliciting stimuli in imagery or through role playing.

The model for the treatment of anger proposed here is based on the present state of knowledge that exists. The proposals put forth here are meant as working hypotheses to be researched. Hopefully, we will provoke more research on anger, our knowledge will increase, and anger will no longer be considered the forgotten emotion.

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Complexities and Lesser Known Aspects of Obsessive-Compulsive and Related Disorders

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Obsessive compulsive disorder (OCD) affects 1 out of 40 Americans (Robins et al., 1984). This means that approximately 5 million individuals will develop the disorder during their lifetime. Therefore, as a clinician, the likelihood of being asked to treat this disorder is very high. In addition, when one considers obsessive-compulsive related disorders, (e.g., body dysmorphic disorder, hypochondriasis, trichotillomania, Gilles de la Tourette syndrome) and obsessive compulsive behaviors observed in various conditions, the number of individuals affected is even greater. In approximately 27 years since the development of a behavioral treatment approach for obsessive-compulsive disorder (OCD), many advances have occurred. In this paper, the assessment and behavioral treatment of obsessive compulsive and related disorders will be discussed. In addition, some conditions where obsessive compulsive behavior is common will be explored. Prognostic indicators such as the severity of the initial depression or anxiety and the strength of the belief in the obsession and its role in treatment outcome will be presented. Ways to overcome these barriers will be discussed.

Differential Diagnosis and Assessment Tools

To date, there is no specific instrument to diagnose OCD. The Yale-Brown Obsessive-Compulsive Scale (YBOCS) (Goodman et al., 1989) is an interview based scale that primarily measures the severity of the symptoms. It does provide a checklist of obsessions and compulsions that the clinician uses to assess