Cognitive-Behavioral Conceptualization and Treatment of Anger

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This article outlines several therapeutic issues in working with angry clients and provides a conceptual framework for understanding, assessing, and treating them. Cognitive-behavioral interventions addressing different elements of the problematic anger are then described. However, it was emphasized that careful attention must be paid to unique client characteristics, to their stage of readiness for change, and to the therapeutic relationship and alliance if therapeutic impasses are to be minimized and successful application of cognitive-behavioral strategies is to be maximized. These issues and strategies are clarified in the specifics of two difficult cases. © 1999 John Wiley & Sons, Inc. J Clin Psychol 55: 295–309, 1999.

This article begins with a clinical model of anger consistent with cognitive-behavior therapy, one that provides a useful way of thinking about anger, parameters for assessment, and goals for intervention. This is followed by a discussion of clinical issues affecting two cases involving anger. The remainder of the article explores these issues and the cognitive-behavioral interventions in the two cases.

CONTRIBUTORS TO ANGER

Neurological, temperament, endocrine, and other physiological processes influence the development, experience, and expression of anger. However, at a given point in time, anger can be viewed as arising from interactions among (i) one or more eliciting events, (ii) the individual's pre-anger state, including both momentary and enduring characteristics, and (iii) the person's appraisals, not only of the eliciting events, but also of his or her coping resources (primary and secondary appraisals, respectively) (Deffenbacher, 1994,

1995). Anger is an experiential state consisting of emotional, cognitive and physiological components that co-occur, rapidly interacting with and influencing each other in such a way that they tend to be experienced as a singular phenomenon. The individual also behaves in reaction to precipitating events and to experienced anger.

Eliciting Events

Anger is aroused by three classes of stimuli that are not mutually exclusive. Anger some-times is elicited by specific *external events*. These include identifiable circumstances (for instance, waiting in slow lines or being cut off in traffic), behavior of others (for example, criticism), objects (for instance, a computer or car that does not work), and one's own behavior and characteristics (for example, oversleeping and missing a meeting or being overweight).

In other cases, anger appears is evoked by *a combination of external events and anger-related memories and images elicited* by them. Some of the strongest reactions of this type are seen in posttraumatic stress victims. For example, a driver became furious with truckers, even when driving appropriately, because of memories of an accident in which a trucker killed a sibling. Other less dramatic but clinically relevant examples are often encountered. For example, a woman became intensely jealous and angry when her husband talked with other women. This triggered memories of her father's philandering, of her mother's anguish and depression in their divorce, and fantasies of her suffering the same fate.

In still other cases, anger is triggered by *internal stimuli, usually thoughts or emo-tions*. For example, an individual becomes very angry while brooding or ruminating about an ex-spouse or a poor performance review. Anger may also be triggered by other emotions, such as feelings of anxiety, hurt, rejection, or loss (for example, a person reacts angrily and defensively because he or she is afraid of another's criticism and rejection).

Pre-anger state. The pre-anger state consists of three elements, one immediate or momen-tary and two more enduring or lasting. The individual's immediate state at the time can significantly influence the probability, intensity, and course of anger expression. Prior anger may exacerbate subsequent anger. Excitation from the prior state of anger transfers and increases the probability of anger in subsequent situations, even when these situa-tions are dissimilar to prior provocation (Zillman, 1971). This facilitation effect or low-ering of anger threshold is not limited to anger alone. Berkowitz's (1990) research suggests that nearly any aversive emotional or physical state such as being stressed, ill, hungry, or tired raises the probability of anger by increasing the presence and salience of aversive feelings and images. Clients often report that their anger was exacerbated by such conditions.

Anger is also related to the individual's enduring cognitive characteristics. Anger is often aroused by challenges to important self schema, a blameful attack on one's ego identity (Lazarus, 1991), a trespass on one's personal domain (Beck, 1976), violations of personal rules for living and codes of conduct (Dryden, 1990, Ellis, 1977), and/or frus-tration of goal-directed behavior. Intense and dysfunctional anger eventuates when these processes become rigid, arbitrary, and overinclusive. Values cease to be preferences, but become sanctified dogma imposed on others. Personal desires take the form of command-ments. Expectations and promises become absolute, never to be unfulfilled. Goal-directed behavior is no longer a desired outcome, but an imperative. That is, the nature and structure of cognitive schema, personal domains, ego identities, and attitudes about

goal-directed behavior significantly influence the presence, intensity, expression, and targets of anger, both mild and appropriate and strong and dysfunctional.

The second enduring element of the pre-anger state is the residue of one's culture. Anger is a common, if not universal emotion. However, cultures around the world include many norms for the experience, expression, and targets of anger expression. Anger is to be experienced and expressed in only certain ways toward certain individuals, and only under certain circumstances. One's internalized cultural rules for the experience, expression, and targets of anger and aggression thus play a guiding role. Understanding clinical anger means putting it in a cultural context. Some dysfunctional anger stems from not learning appropriate norms for anger and its expression. Other cases involve internalization of conflicting norms. Still others result from a kind of cultural clash in which the norms for one culture violate those of another (for example, one culture condones loud, noisy verbal exchanges, whereas another considers such behavior rude, impolite, and aggressive).

Appraisal Processes

Precipitating events are appraised in light of the momentary and enduring elements of the pre-anger state and the situational context. Employing Lazarus' (1991) conceptualization, primary appraisal involves the individual's initial assessment of the precipitating events. Anger results when events are judged to involve a trespass upon the personal domain, an insult to or an assault upon ego identity, a violation of values and expectations, and/or unwarranted interference with goal-directed behavior. In essence, something has happened or could happen that "should not." Moreover, the probability and intensity of anger increase if the event is judged as (i) unwarranted or unjustified (that is, unfair or undeserved), (ii) intentional (that is, someone purposefully and willfully inflicted the event upon the person), (iii) preventable (that is, the event could have been controlled or prevented and, by implication, it "should" have been prevented), and/or (iv) blameworthy (that is, provocateurs are responsible and should be punished or suffer).

There is also a secondary appraisal whereby individuals evaluate their coping resources for dealing with these events. The individual may feel overwhelmed and unable to cope with anger ensuing if primary appraisals channel him or her toward anger as outlined above. Other appraisal processes heavily involved in anger are the individuals' sense that they "should not" have to experience, put up with, or cope with negative experiences, an appraisal process described by rational-emotive therapists as low frustration tolerance (Dryden, 1990). Such individuals externalize all responsibility for events and invoke a narcissistic rule exempting themselves from inconvenience, frustration, disappointment, hurt, loss, and the like. Such appraisals legitimize, often sanctify anger and aggression, and insulate them from any responsibility for feelings and behavior engaged in while angry. Finally, the inclination toward anger increases when an individual holds positive outcome expectancies for aggression and sees aggression as an acceptable form of coping (Lazarus, 1991).

In summary, anger is likely when individuals assess themselves experiencing something they should not have experienced and with which they are unable to cope or should not have to cope, and/or for which they believe attack and aggression are appropriate.

CHARACTERISTICS OF ANGER AND ANGER-RELATED BEHAVIOR

Such appraisals activate cognitive, emotional, physiological, and behavioral response systems that co-occur, often rapidly interacting with and reinforcing each other. Within the present model, anger is viewed as an internal, experiential state consisting of the

cognitive, emotional and physiological components. This state and its components are very related to, but clinically separable from, how the person behaves or expresses anger. Emotionally, anger is experienced as a feeling state, varying in intensity from mild annoyance and irritation through frustration and anger, to fury and rage. Physiologically, anger consists of sympathetic arousal, increased muscle tension, release of adrenal hormones, and other elements of the "flight or fight" response. Cognitively, clinical anger involves biased information processing, including thoughts, images, and attributions involving (i) an exaggerated sense of violation and being wronged; (ii) attack, revenge, and retribution; (iii) blame; (iv) externalization; (v) denigration and minimization of the source of anger; (vi) overgeneralized, often inflammatory labeling, and the like. The presence, salience, and consequences in each domain are very important in selecting and targeting assessment and intervention strategies.

Anger is not synonymous with aggression. Certainly, when angry, some individuals respond with physical and/or verbal assault. Others may engage in passive, indirect aggression. Aggression is common, but other possibilities abound. Some individuals, especially when anger is moderate, engage in adaptive behavior such as assertiveness, conflict management, problem-solving, limit setting, and appropriate disengagement such as the taking of a time out. Still others behave dysfunctionally, but not aggressively (for example, drive recklessly or become intoxicated). How one behaves when angry varies with many things, such as the situational context, cultural norms, intensity of anger, prior history in such situations, pre-anger state, and the like. How the person behaves, the consequences of behavior, and the variability of adaptive and maladaptive behavior across anger episodes should be assessed and integrated into treatment planning.

COGNITIVE-BEHAVIORAL INTERVENTIONS FOR ANGER REDUCTION

Cognitive-behavioral interventions target different elements in this working model. For instance, strategies that enhance self-awareness of anger can target the whole sequence-(for example, keeping records of one's reactions, role plays, and behavioral experiments in which the individual attends to experiential and behavioral elements). Clients may experience increased efficacy in lowering anger as they become able to initiate other coping strategies when they are aware of themselves and the triggers of their anger.

Other strategies intervene between anger engendering events and responses to them. For example, an individual might appropriately (i) avoid anger-provoking events (for example, a couple agrees not to discuss difficult family issues after 9:00 p.m. when both are tired); (ii) distance one's self in time from provocative cues (for example, an angry business man learned to say things such as, "I need a little time to think that through and get back to you," and abort impulsive, aggressive remarks); and (iii) take a time out.

Relaxation interventions focus on emotional and physiological arousal, thus training clients to lower arousal and increase a sense of calmness and control, thereby increasing overall coping capacity.

Cognitive therapy focuses on dysfunctional cognitive and cultural components of the pre-anger state, biased appraisal processes, and the cognitive component of experienced anger, and helps the individual identify and alter anger-engendering cognitive and schema themes. Self-instructional training and problem-solving address cognitive elements of anger, providing assistance in changing angry self-dialogue and guiding one's self through angry events in a calmer, more task-focused manner.

Silly humor has also been suggested (Deffenbacher, 1994, 1995) for angry emotionality and cognitions. For example, if clients labeled others as a "dumb ass," they might be asked to define their terms concretely. Usually this leads to the notions of retarded burros

or buttocks, silly nonangry notions. They could then be asked to draw a picture of a "dumb ass," which might lead to sketch of a burro or buttocks with a dunce's hat. These images could be rehearsed whenever the individual engaged in such labeling.

Communication, assertion, and conflict management skills are linked to changing the individuals' appraisals of their ability to cope and dysfunctional ways of responding to inevitable interpersonal conflict.

Finally, interventions combining various treatments target multiple sites in anger arousal. For example, cognitive, relaxation, assertion, and communication skills have been put together in effective combinations.

Although these are but a few of the strategies that might be employed, they suggest how cognitive-behavior therapy can be adapted to anger reduction and target different elements thereof.

Interventions such as those described above are action- or change-oriented interventions. They assume that the client recognizes and accepts anger as a personal problem and is actively invested in anger reduction. This, however, is often not the case with angry clients, necessitating that cognitive-behavior therapy address two other important issue—stage of readiness and the therapeutic alliance.

Many individuals with anger problems are often at a precontemplative stage of change (Prochaska, Norcross, & DiClemente, 1995), in that they neither "own" anger as a personal problem nor seek reduction of it, no matter how others may see their anger. There are many different reasons they do not see themselves as having a problem. For example, anger and sometimes aggression are identity or role congruent. Anger is part of who they are or is consistent with a role they occupy (for example, supervisor or adolescent). If anger is identity or role congruent, viewing anger as a problem is thus identity or role incongruent. Anger reduction therapy creates role or identity dissonance and is rejected. Other angry individuals are simply unaware of their anger or its consequences to others. That is, they are relatively insensitive to themselves and/or to their impact on others and thus do not see anger as a problem. Still others are deficient in flexible emotional-behavioral scripts with which to respond. They respond with a great deal of anger because they do not know how to think, feel, and behave differently.

Perhaps most frequent are individuals who perceive their anger as stemming entirely from external sources. They do not have a problem with anger, because their anger is a natural, justified response to an unjust world. From their perspective, they have no need for anger management because others are the problem. If others did not treat them in the ways they do, these individuals would not be angry. Such individuals may be brought or referred to therapy by others, but they are not candidates for action-oriented interventions. Instead, they often come to get others off their back, reduce the consequences of their anger and aggression, and convince the therapist that others need to change.

Individuals like those described above do not see anger reduction as relevant because they are not at that stage of change. Interventions, if they are to be successful at all, need to identify the individual's stage of readiness and be matched to it in order to move the individual to the next stage of change. This often requires exploration of the consequences of anger and whether anger is helping the person achieve all of his or her goals (for example, anger may achieve some short-term goals, but often reduces chances of long-term goals of friendship, cooperation, others liking them, and so forth). Interventions often focus on increasing the person's awareness of anger and its consequences, and of alternative roles, scripts, and behaviors. Such interventions may provide the motivation for and movement toward more change-oriented strategies.

Achieving these goals and moving individuals toward a greater acceptance of anger as a problem often requires careful attention to the therapeutic alliance. First, rapport and

the relationship are often compromised if the therapist does not empathize with and actively communicate an understanding of the client's sense of being the aggrieved party. Therapists need not agree with the client's sense of things and behavior; however, as they would with any other client, the therapists need to understand things from the angry client's perspective. Second, agreement on the therapeutic goals is very important. If clients do not see anger reduction as the goal of therapy, it is unlikely they will participate actively in anger reduction. Anger reduction makes no sense to certain clients, and therapists cannot readily assume their clients have anger reduction as a goal. Initial goals of therapy may necessarily be those of building rapport and trust, exploring and understanding anger, and increasing the motivation for anger reduction. Third, the therapist and client need to agree upon the acceptable means of therapy. If they are not together on this, an angry impasse is likely to ensue.

Putting all of this another way, many angry individuals are not candidates for anger reduction because they are still at the precontemplative stage of change. If therapeutic impasses, angry and frustrating exchanges, and premature termination are to be minimized, therapists must accurately assess the stage of readiness and adjust the working alliance and therapeutic contract to the stage at which the client exists.

THE CASE OF CELESTE

Celeste's anger is marked by strong emotional arousal and retaliation that is both verbal and physical. Cognitive elements are less clear, but appear to involve several themes. She sees herself as blameless and justified in her anger and behavior, expresses no guilt or remorse, and possesses little self-understanding of her contributions to anger and negative interpersonal interactions. She appears to hold perfectionistic demands of self and others and justifies doing whatever she needs to do to get ahead. Very likely, she overgeneralizes, equating her performance with her sense of self and self-worth, such that negative evaluation of her work is perceived as a fundamental attack on her self and self-esteem, rather than as simply feedback about work. She is also characterized by low frustration tolerance and high blaming. These cognitive processes leave her vulnerable to rejection and criticism, particularly in work and achievement domains, and move her toward externalization, blame, and retaliation.

The influence of culture on Celeste's anger is unknown. It not clear what her cultural norms are for achievement and interpersonal behavior generally, or anger and anger expression specifically. Her family's culture of origin may sanction forms of emotional expression and achievement-oriented behavior not appropriate to the culture of her work place and other achievement environments. It is also unclear if and how idiosyncratic family attitudes and beliefs related to achievement may have been internalized in her role of an immigrant offspring or a "second" child. Elucidating these issues may not only increase self-understanding, but also provide targets of intervention for anger-engendering interpretations and schemas.

How Celeste conceptualizes anger is also very important. Currently, she does not identify anger as a personal problem in need of change. For her, anger stems naturally from the incompetence and mistreatment of others. It is not she, but *they* who need to change. If others, including the therapist, did not provoke her, she would be neither angry nor aggressive. The sources of problems lie outside her, and, therefore, psychotherapy is irrelevant or at least questionable. This interpretation is supported by her repeated ambivalence about therapy, her prior refusals to enter therapy, her immediate reaction to therapist attempts at having her "own" part of the anger, and her resentment at being labeled the problem.

Celeste is at a precontemplative stage in her readiness to change, as problems and consequences are attributed externally. At best, she is on the cusp of a contemplative level of readiness, because she took the referral for counseling and is still there in the third session. An action-oriented therapeutic contract to "work on understanding *and* managing Celeste's anger" appears premature, as she did not identify with the need for managing her anger. There is a fundamental disagreement between therapist and client goals of therapy, hence the angry interchange over the therapist's intervention. Retrospectively, the therapist may have wanted to strike a different therapeutic contract, one aimed at understanding Celeste and her anger. From the trust and rapport built in that therapeutic alliance, it *may* be possible to understand how she contributes to negative events. This *may* increase her readiness to see anger as a personal issue; however, for now, this is not the case.

Given the immediate interchange, cognitive-behavior therapists appear to have three general choices, each with its attendant risks. The first is to use the exchange to probe her underlying low frustration tolerance. After summarizing her anger at the therapist, the therapist could explore her demand that she not be frustrated or treated poorly. The therapist may be able to work this theme successfully, but given her sensitivity to thinking others mistreat her and label her the problem, she is likely to feel misunderstood, accused, and become more angry and attacking, perhaps dropping out of therapy in an angry snit.

A second strategy is to explore the angry interchange between therapist and client as an immediate sample of interpersonal behavior—exploring triggers and her reactions, and attempting to understand how the exchange unfolded. The therapist will be especially interested in the assumptions and interpretations Celeste made during the exchange, as well as able to empathize with her feelings. For example:

THERAPIST: [*She's really angry. Let's use this as a sample of the things she thinks, feels, and does. That should help her feel like I am on her side while increasing my understanding of "hot" processes because she is hot right now.*] Celeste, you're really angry with me right now, perhaps like you are with a lot of other people. Can we take a moment and go back to the point where you got angry with me and walk through it in slow motion so I can understand what you were reacting to and how you were feeling? [*Let me frame it as my issue so she does not feel more attacked.*]

CLIENT: I guess so. But, I am so damned tired of being told that I am some kind of raging loonie.

THERAPIST: [*She is likely to feel accused, so for now, I am not going to make a direct response to that. I'll start open ended, but focus quickly on the specific trigger, which was when I referred to her contribution.*] A few minutes ago you were not angry. Then you became angry with me. Describe for me what angered you and what went on inside you.

This approach should increase Celeste's sense that the therapist is aligned with her as well as the therapist's understanding of her anger. However, unless pursued very carefully, this course has two problems. First, given the client's activated sensitivity to interpersonal criticism and evaluation, she may interpret the therapist's trying to understand her as telling her that everything is the client's problem. The therapist may wish to explore the client's reactions with open-ended questions and reflective summaries to minimize this type of reaction. Second, it does *not* fundamentally change the therapeutic goal; the therapist is still working on understanding *and* change, but the client is not in agreement with this combined goal. Thus it is likely that future interactions will be marked by similar angry dynamics.

A third approach is to attempt to repair the breach in the therapeutic alliance and return to building the relationship and increasing Celeste's self-understanding of her thoughts, feelings, and behaviors. If this route is chosen, the initial focus would be exploring and communicating understanding of her sense of being misunderstood and mistreated. Celeste often feels misunderstood, once already by the therapist, and is unlikely to accept readily that the therapist now understands. The therapist should be ready to clarify many different examples and to communicate empathy and understanding for her position. The therapist need not agree with her interpretations, but should communicate understanding of the client's sense of being the aggrieved party. As rapport (which is likely to be tenuous, as Celeste may react to any misunderstanding with anger and, potentially, denigration and bullying) is strengthened, the therapist can gradually enhance readiness.

It is suggested that, in an inductive manner, the therapist begin to explore the consequences of her anger to her and others, but with a particular focus on her. As Celeste inventories the consequences, she may move more toward owning anger as a problem, because the costs otherwise are higher than she wishes. For example, the therapist might ask open-end questions such as, "What happened as a result of expressing anger in that way?" This could be followed with consequence summaries (for example, "So, you were able to get the anger off your chest and get back at her right then, but it ultimately left you angry, depressed, and missing out on a job that you really wanted and worked hard for. Some short-term gain, but a fair amount of long-term pain and loss."). Several concrete examples could be followed with more general questions, such as, "So, is your anger getting you all of what you want?" Alternative courses of action could be explored (for example, "What are some other ways of handling that situation?" followed by questions like, "How do you think things would turn out if you approached it in that manner?"). Contrasting examples in which she was angry but did not retaliate would be solicited (for example, "Celeste, can you remember a time when you were really angry and did not take it out on someone?" followed by questions like, "What did you do then?" "How did you feel about that?" "How did you feel about yourself?"). Contrasts from within her behavior can not only outline different consequences, but also provide a springboard from which to explore alternative ways of behaving.

Between-session record keeping might be introduced with an initial focus on understanding the daily experiences of anger in her world. Over time this self-monitoring could be expanded to related activities and their consequences. Still later, self-monitoring could be extended by having Celeste suggest alternative ways of handling situations and list anticipated consequences.

The client might be encouraged, either through interviewing or visualization, to experience a situation in which she was the object of anger and behavior similar to hers. The consequences to her would be explored with questions like, "How did you feel she when treated you that way?" "Did you want to be her friend?" "Did you want to cooperate with her and help her with her work?" A Gestalt two-chair approach might be adapted to this task. In one chair, the client would be encouraged to experience and express her anger in ways typical of her. When she switched chairs, she would be encouraged to experience and express how she felt as the recipient of this anger. She might also be encouraged in day-to-day interactions to take the role of another and anticipate how that person thinks and feels about being the object of her behavior.

The goals of these repeated explorations are to build rapport and communicate empathy for her sense of being treated unfairly and, over time, to move her toward a more contemplative stage of change as she examines different consequence structures for experiencing and expressing anger.

Movement to more action-oriented goals is likely to be blocked or slowed due to her beliefs in low frustration tolerance, blame, and preventability. It is suggested that these issues be addressed in an inductive, explorative manner. Initial probes would inquire as to why she "should not" have to deal with frustration, disappointment, hurt, and the like. For example, the therapist might inquire, "I understand that is really frustrating and inconvenient, but why *shouldn't* you have to deal with it?" Celeste may become angry, rigid, and rhetorical, claiming that she shouldn't because it is simply wrong. The therapist should not accept that premise, but try to have her explore the assumption that she should not have to deal with difficulties. For example, when she is describing "incompetent idiots" at work, the following dialogue might take place:

THERAPIST: Sounds like people at work don't do things the way you would like.

CLIENT: Boy, have you got that right. Dumb shits all the way around!

THERAPIST: [*Gentle now. Maybe pick up on the humor in that later as she might laugh at the idea of retarded fecal material. Also, let me model a less catastrophic tone, even though we have not addressed the implied catastrophes yet. She may pick up on it naturally, but if not, it will be a place to start later, and she will have heard that kind of thinking from me repeatedly.*] Yeah, real frustrating people, but why *shouldn't* you have to put up with frustrating people?

CLIENT: Huh? What do you mean? They're idiots and shouldn't be allowed to get away with that.

THERAPIST: They are really frustrating, but why *shouldn't* you have to put up with your share of frustration?

CLIENT: They just a bunch of incompetents. Nobody should have to put up with their crap.

THERAPIST: [*Let me stay indirect here and see if I can get the job done. I will tighten the confrontation if needed. I think that she trusts me enough now to handle it.*] But it seems like you are being angry about things beyond your control like the weather?

CLIENT: What the hell are you talking about? You're sounding as crazy as they are.

THERAPIST: Well, if you were planning an outing to the beach on a summer's day and it turned cold and rainy, would you rant and rave at the weather?

CLIENT: No. I'd be mad, but I'd figure out something else to do. So, what's the point?

THERAPIST: You don't have to like the weather, but you don't become enraged and try to attack it either. Right?

CLIENT: Right.

THERAPIST: You accept it as unfortunate and go to plan B. Not fun, but you accept that weather sometimes doesn't go you way. But when it comes to people not going your way, you rail at them in ways you would never think to do with the weather. They just shouldn't be that way. I'm not suggesting that you like some of the things people do any more than you do the weather, but, just like the weather, people are often don't do what you want and are frustrating. So why *shouldn't* you have to put up with frustrating people, just like frustrating weather?

This interchange is not likely to turn things around in a flash of insight and understanding. In fact, it is likely that the therapist will have to continue in this manner for several cycles, perhaps introducing or using other examples or analogies. Pressure on the cognitive systems has been low to this point, and greater confrontation may be necessary. For example, the therapist might ask Celeste a more provocative question, such as: "And who appointed you God?" This would be followed by an exploration of the notion that gods can issue commandments, but mortals only get to want and prefer. Certainly she is

free to prefer others not treat her in certain ways and to take appropriate action to prevent frustrations by others, but demanding only leads to her godlike wrath.

In addressing this issue, the "paradox of freedom" might be introduced. The therapist asks a question such as, "Do you always do what others want?" The answer is usually an unequivocal no. Then the therapist asks, "Why not?" Usually the response includes the notion that the client is free to make her own choices. Then the paradox is clarified, namely that she insists on her right to make independent choices and not to conform to the wishes of others, but that she denies that right to others (that is, they must conform to her wishes and never frustrate her). The client and therapist then explore that others have the same rights, often the right to be wrong from the client's point of view. This naturally leads to differences, disagreement, and frustration. These are to be expected, but if the client accepts this, she is free to problem solve and cope with natural frustrations.

Regardless of strategies employed, the goals are to maintain high rapport and explore issues that will increase her self-awareness and motivation for change, at the same time addressing issues that interfere with her moving in that direction. Celeste is an example of many angry clients who do not see anger as a personal problem. Initial contracts to manage or reduce their anger often lead to angry exchanges, therapeutic impasses, and premature termination. It is not being suggested that every angry client will move to reduce externalization and blame and own anger as a personal problem. However, if therapists do not recognize and accept the stage of change at which the client is and adjust accordingly, therapeutic difficulties are highly likely. Efforts such as those outlined above minimize therapeutic difficulties and, where unsuccessful, allow therapy to be terminated ethically as unworkable at that time. Such an approach also increases the chances that the client may see therapy as useful in the future.

THE CASE OF DAVID

David's anger is marked most by emotional and physiological arousal, including reactive blood pressure. Although information on the cognitive element of anger is scant, there are references to aggressive fantasies and his awareness he is upsetting himself. These likely refer to periods of ruminative imagery and self-dialogue regarding his wife's affair, being unfairly treated, humiliation, and images of his revenge and retaliation. David does not act on these fantasies with much physical or verbal aggression, but rather behaves more passively and indirectly (for example, "silent anger," sarcasm, and multiple calls to his wife's pager). His preferred style of handling conflict appears to be suppression of anger and withdrawal into isolated activities, a well-established pattern dating back to childhood. It appears that this pervasive withdrawal in the face of stress and conflict has been with him throughout his adult life, including his current marriage.

Motivation and readiness for action-oriented therapy appear moderately high as reflected in the client' request to do something useful and lower his blood pressure. The initial goals of therapy can and should center on lowering emotional and physiological arousal. However, the therapist would be wise to acknowledge that, for the present, the client finds only a certain subset of means of therapy as acceptable (that is, those that do not involve verbal introspection and "talk" therapy). Perhaps this is because these activities draw on affective reflection and communication skills absent or difficult since childhood, and which were not an effective approach in earlier marital therapy. Therapy, if it is to be successful and build the base for other interventions, should focus on the direct reduction of emotional and physiological arousal (goal of therapy) and do so in a manner that does not call for a great deal of verbal exploration (means of therapy).

An applied relaxation approach is suggested, first as a collaborative extension of discussion with David and, failing that, as a direct therapist suggestion. This approach is chosen for three reasons. First, it is empirically validated for reducing anger, anxiety, stress, and psychophysiological reactions. Second, the therapeutic tasks are highly structured, involving, especially in the beginning, a great deal of therapist-directed activities (for example, relaxation exercises, relaxation and anger imagery construction, practice of relaxation to lower anger). These are consistent with his preferences for "doing something" but "not talking about it." That is, therapeutic tasks are reasonably well matched to client's definition of acceptable therapy. Moreover, if the client becomes sarcastic or skeptical, as he might, he could be given the task of reading the empirical literature, consistent with intellectual style and his nondiscussion predilections. Third, this approach reduces initial resistance to cognitive interventions (Deffenbacher & Lynch, 1998). Many angry clients fight cognitive interventions for a few sessions, a time during which David might drop out. However, these problems are minimized when cognitive interventions are preceded by applied relaxation.

Applied relaxation might be introduced in the following manner. The therapist would first attempt to invest the client in suggesting relaxation-like interventions, but would be ready to switch to a direct therapist suggestion to match the client's preference for the means of therapy and to avoid "expensive talk."

THERAPIST: [*Agree with him and move toward relaxation, so we agree on therapeutic tasks. Ignore the sarcasm and follow his focus on blood pressure and anger.*] I too have been thinking a lot about that since our last session and have some ideas to share, but I was wondering what has worked best for you in the past to lower tension and stress?

CLIENT: What do you mean?

THERAPIST: Well, you have a lot of experience coping with stress over the years. What have you done that has helped to calm down and "obtain some peace" [*a phrase the client used in describing the benefits of smoking and drinking, both physically oriented events*]?

CLIENT: I'm not sure what you mean, but it used to help to go for long walks with the dog or to read, especially sitting by the fire. That helped me unwind.

THERAPIST: So, when you do things like long walks and read by the fire, they clear your mind and calm you. Any other things calm you down?

CLIENT: That's about it, and they don't even work now. Too often when I'm reading or walking, I find myself thinking about my wife and become upset all over again.

THERAPIST: [*Normally, I might try to explore his thoughts here, but let's shift to relaxation interventions, because he is still with me.*] So right now, even the old stand-bys aren't working. You encounter thoughts and events related to your wife and up goes your anger and blood pressure, and you have no reliable ways of calming down, of relaxing and lowering your anger and blood pressure. David, there are some specific things that we can do that will help you develop those ways of calming down so things don't spiral out of control. I am not suggesting that you don't have a right to feel hurt and upset about what happened, for you certainly do. [*I don't want him to think I am blaming him, only that we can help him address his heightened reactivity.*] I am only suggesting we can help you learn ways to relax and keep your anger and blood pressure down. [*This reference is specific to physical and emotional arousal here, but will hopefully also serve as an analogy for more cognitive and behavioral interventions later if they become relevant. He seems interested and is not objecting,*

*so I will continue with the level of direction and see if we can strike a contract
consistent with the content and form of his comments without giving him too much
time to discount therapy or avoid in some other way. Steps of an applied relaxation
intervention would be described at this point.*]

If the client agreed to a relaxation intervention, the remainder of this session would
involve progressive relaxation training. Homework involves daily practice and recording
of relaxation and the identification of a specific time when he was relaxed and at peace.
The latter would be used in the next session for the development of a relaxation image.

The next session would begin with a brief review and support of relaxation practice.
Self-monitoring would be introduced and described as the means for knowing when to
apply the relaxation (that is, he must know what things set him off in order to apply
relaxation and reduce anger and blood pressure). Self-monitoring may also provide access
to cognitive and behavioral information needed to address these issues later in therapy,
but do so in a nonthreatening way consistent with his preferences for not talking about them.
This material provides the basis for gentle therapeutic probes of readiness for addressing
other forms of needed change. Self-monitoring would be introduced in an open-ended,
collaborative way with a question like, "How might we keep track of the things that
trigger your anger and how you respond to them?" The therapist and client might agree
that he keep a journal of the events that elicited anger and his reactions to them. Self-
monitoring would be added to homework, and David would drop off his journal the day
before his sessions so that the therapist could review it, thereby initially reducing the time
needed to discuss its contents. Next, a relaxation scene is constructed, developed as a
concrete moment in time with as many situational and experiential details as possible to
make the experience as real and vivid when described by the therapist. The scene might
involve something like a time on a fall afternoon sitting quietly in the warm sun with his
dog in a local park. The remainder of the session would repeat relaxation, including the
relaxation image with homework involving self-monitoring and relaxation practice.

The next session would begin with a review of the self-monitoring homework. In
order to decrease resistance and to build rapport, the triggers and responses are noted
without much elaboration or discussion. Review of relaxation practice is approached in a
similar style, with the client's diligence and success supported. Assuming success with
relaxation, tension of the muscles would be dropped, and four relaxation coping skills
would be added: (i) relaxation without tension (focusing on muscle areas and relaxing
away the tension); (ii) relaxation imagery (visualization of the relaxation image from the
prior session); (iii) breathing-cued relaxation (taking 3 to 5 slow deep breaths, relaxing
more on each exhalation); and (iv) slowly repeating the word "relax," relaxing more on
each repetition. Homework would involve (i) continued self-monitoring; (ii) daily rehearsal
of relaxation skills; (iii) application of relaxation coping skills in nonstressful situations
to begin in vivo transfer of coping skills (for example, watching television or riding on a
bus); and (iv) specification of a situation which was moderately angering (that is, 50 or so
on 100-point scale of intensity).

At the beginning of the next session, we can hypothetically assume that he discloses
two episodes in which he was very angry with his wife and had again called in her lover's
phone number on her beeper. He would have felt out of control and have known this
would hurt her, but would justify it because of all the hurt she had brought upon him.
Under such circumstances, the therapist would acknowledge his feelings and how hard it
must have been to share them. The therapist would resist the desire to explore David's
thoughts and feelings in greater detail, for to do so could lead to avoidance by the client.
Instead, the revelations would be used as an opportunity to introduce a form of time out,

both as a response disruption and an extended assessment strategy in which "hot" cognitions of the moment could be assessed, rather than the "cold" intellectualized ones reported in therapy. The therapist might give David a small tape recorder and instruct him that any time he felt the urge to call his wife's beeper, he was to treat the tape recorder like the beeper, turning it on and expressing thoughts, feelings, urges, and images going through his mind. One of the incidents from the prior week would be practiced on the spot to ensure compliance. After this, an anger scene, such as one in which his wife was asking about weekend plans, might be developed in full situational and experiential detail. Behavioral elements involving sarcasm and withdrawal would be excluded, because their inclusion would involve the rehearsal of negative behaviors. Instead, these elements could be addressed by terminating the scene at the point at which David was angry and had the urge to make sarcastic comments to his wife. At this point in the session, the therapist would initiate relaxation without tension and begin coping skill rehearsal. The therapist would instruct the client to visualize the anger scene and to signal by raising an index finger when anger was experienced. The client is instructed to pay attention to the anger arousal and to let it build. After 20 to 30 seconds of arousal, the therapist instructs the client to switch the scene off and visualize the relaxation image. The relaxation image is used initially, as it tends to most effectively clear anger imagery early on in the practice of coping. The therapist would then instruct David to initiate another relaxation skill and signal when he was relaxed. This procedure would be repeated three or more times, alternating different combinations of coping skills. Homework continues as before, with the addition of the tape recorder as specified above.

The next five sessions would be devoted primarily to coping rehearsal. Over sessions, the level of anger in the arousing imagery is increased, and the format shifts from the high therapist control of the last session to an intermediate position in which the therapist initiates scene visualization and termination. David then relaxes by whatever method(s) work best for him, signaling when once again relaxed. In the last stage, David's self-control is increased as the therapist initiates visualization of scenes, but David self-initiates relaxation while he continues to visualize the anger-arousing scene. Between sessions, David begins applying relaxation any time he feels angry or tense for any reason. External application is framed as "tryouts," giving the client permission to fail at any specific application. "Tryouts" also set up the idea of cognitive and behavioral "tryouts," should they prove feasible in the future. Efforts at application are recorded in the client's journal and discussed briefly at the beginning of each session, gradually extending the amount of time and depth of emotional issues discussed. Self-monitoring would hopefully reveal considerable capacity in lowering anger and tension in the external environment.

After the third or fourth session, David might be asked to purchase a small blood pressure machine and take his blood pressure three times per day. Before taking it, he is to "scan his body and mood" and make a prediction about his blood pressure reading. This would be done to increase his sensitivity to the internal cues of elevated blood pressure, which otherwise tends to be "silent." Anytime his diastolic blood pressure was 90 or above, he would be instructed to immediately apply relaxation. With his permission, arrangements would be made for blood pressure readings in his physician's office. These efforts would be undertaken to make sure that relaxation is transferring to blood pressure, as his history of anger suppression and withdrawal may predispose him to continued blood pressure elevation.

At this point, the initial therapeutic contract may be complete. Other issues would likely remain (for example, David's cognitive involvement in anger arousal, dysfunctional ways of responding to conflict, and potential decisions about the marriage). However, it is hoped that selection of the applied relaxation intervention and acceptance of

David's initial preference for the means of therapy would have provided the rapport, trust, and therapeutic bond sufficient to contract for and address these issues. For example, cognitive themes might be outlined as one set of triggers for anger, but to this point would have been addressed by using relaxation to lower physiological and emotional reactivity. Because cognitions emerged naturally, it could be suggested that David might learn to change is mental overreactivity much as he has learned to change his emotional and physiological reactivity. One of the least threatening ways to bridge this is to look for naturally occurring contrasts in which he reacted differently to similar situations. A brief exploration of the basis of the difference may provide the basis for moving more toward cognitive restructuring. Behavioral change would be approached in much the same way, noting that some his behaviors lowered anger, whereas others exacerbated it. This brings up the possibility of changing anger-engendering behaviors. It may be important to help David see the difference between short- and long-term lowering of anger (that is, some behaviors such as avoidance and sarcasm may lower anger for the moment, but set up conditions for greater arousal over time because root causes remain).

In addressing cognitive and behavioral change, it is important to remember the client's characteristics. David has a long history of avoidance of emotions, is engaged in intellectual pursuits, and tends to intellectualize his problems, and does not like to spend time being emotionally vulnerable in "talk" therapy. In working with clients like David, the following general suggestions are made in addressing cognitive and behavioral change.

First, resist long, explorative verbal exchanges. During earlier portions of therapy devoted to relaxation interventions, gently and in small doses explore these issues, but do not make them the focus of therapy. Switch back relatively quickly to relaxation interventions.

Second, encourage the client to develop on his or her own large portions of what needs to be rehearsed. This avoids prolonged verbal discussions and plays to the client's strengths of solitary, intellectual pursuits. For example, a client might be encouraged to think of cognitive restructuring—like writing scripts for the internal plays in one's head. The client's job is to rescript angry dialogue and images so that the central character in the play is calm and rational, but not emotionally devoid or detached. In this endeavor, clients might identify a historical figure with whom they can identify or another person who embodies these characteristics and then script the new dialogue as that person would think it. Once cognitive restructuring is well under way, behavioral change might be approached similarly (that is, the client independently spends time defining effective behavioral scripts for handling provocative situations).

Third, rehearse new cognitive and behavioral changes in the imagery procedures employed with relaxation. These are familiar and less likely to be threatening than are behavioral enactment, role play procedures. When overt behavioral rehearsal is introduced within or between sessions, it can be framed in the "tryout" language employed earlier during relaxation procedures.

Fourth, approach the topic of marital therapy last. Feelings about the client's marriage are likely to emerge from applying relaxation. Let them emerge as rapport, and trust build. Marital therapy may prove irrelevant if the client decides to terminate the marriage. If the client continues in the marriage, and if behavioral change has already begun, then making changes in the marital relationship is an extension of behavioral change. However, given negative history with marital therapy, waiting until late in therapy when the positive working alliance is strongest may provide the greatest chance of success in this endeavor.

Finally, there is the issue of maintenance and relapse prevention. Given a long history of avoidance, withdrawal, and indirect means of addressing anger and conflict, clients like David are likely to drift into old avoidant patterns. It is suggested that this be

addressed directly as termination approaches. Strategies might include increased spacing between sessions (for example, going to sessions every other week, then once a month, then once every two months). The client might contract for regular follow-up sessions (say every six weeks for a certain period of time) or for periodic phone or written contact with the therapist between follow-up sessions. The client may continue self-monitoring, recording efforts to maintain change, and drop this material off periodically for therapist review. Several of these interventions could be framed in positive health terms as "booster shots" that help keep the patient healthy over time because they keep strengthening anger antibodies. Regardless of format, all of these strategies represent the attempt to keep the client's attention on continued change and maintenance—when he may have a tendency to revert to old patterns.

CONCLUSION

When individuals own anger as a personal problem and seek help, cognitive-behavioral interventions can prove beneficial. However, many angry individuals, like the cases in this article, are not ready for anger reduction, and their characteristics make therapy interesting and challenging, to say the least. Strategies must be shifted to fit client stage of readiness, and careful attention must be made to adjusting the therapeutic alliance such that clients low in initial readiness for anger reduction can be meaningfully moved toward more action- or change-oriented goals. Even when clients own anger as a personal problem, cognitive-behavioral interventions should not be applied reflexively in a "manualized" format. To the contrary, the therapist and client should work collaboratively, taking into account the client's history and characteristics (as in the case of David), and develop a set of interventions uniquely tailored to the sources and nature of the client's anger problems (Deffenbacher, 1995). This, the author believes, is the art and science of working with a difficult group of clients, those with recognized and unrecognized anger problems.

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