ANGER MANAGEMENT
for Substance Abuse and Mental Health Clients

A Cognitive Behavioral Therapy Manual

Patrick M. Reilly, Ph.D.
Michael S. Shopshire, Ph.D.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

1 Choke Cherry Road
Rockville, MD 20857

Acknowledgments

Numerous people contributed to the development of this manual (see appendix). The publication was written by Patrick M. Reilly, Ph.D., and Michael S. Shopshire, Ph.D., of the San Francisco Treatment Research Center. Sharon Hall, Ph.D., was the Treatment Research Center's Principal Investigator.

This publication is, in part, a product of research conducted with support from the National Institute on Drug Abuse, Grant DA 09253, and the Department of Veterans Affairs to the San Francisco Veterans Affairs Medical Center, San Francisco Treatment Research Center, Department of Psychiatry, University of California, San Francisco. The publication was produced by JBS International, Inc., under Contract No. 270-99-7072 with the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Karl White, Ed.D., served as the Center for Substance Abuse Treatment (CSAT) Knowledge Application Program (KAP) Project Officer.

Disclaimer

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or HHS.

Public Domain Notice

All materials appearing in this publication except those taken from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

Electronic Access and Printed Copies

This publication may be ordered or downloaded from SAMHSA's Publications Ordering Web page at http://store.samhsa.gov. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Reilly PM and Shopshire MS. *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual*. HHS Pub. No. (SMA) 13-4213. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2002.

Originating Office

Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

HHS Publication No. (SMA) 13-4213
First printed 2002
Revised 2003, 2005, 2006, 2007, 2008, 2012, and 2013

FOREWORD

Substance use and abuse often coexist with anger and violence. Data from the Substance Abuse and Mental Health Services Administration's National Household Survey on Drug Abuse, for example, indicated that 40 percent of frequent cocaine users reported engaging in some form of violent behavior. Anger and violence often can have a causal role in the initiation of drug and alcohol use and can also be a consequence associated with substance abuse. Individuals who experience traumatic events, for example, often experience anger and act violently, as well as abuse drugs or alcohol.

Clinicians often see how anger and violence and substance use are linked.

Many substance abuse and mental health clients are victims of traumatic life events, which, in turn, lead to substance use, anger, and violence.

Despite the connection of anger and violence to substance abuse, few treatments have been developed to address anger and violence problems among people who abuse substances. Clinicians have found the dearth of treatment approaches for this important issue disheartening.

To provide clinicians with tools to help deal with this important issue, the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration is pleased to present *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual* and its companion book *Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook*.

The anger management treatment design in this manual, which has been delivered to hundreds of clients over the past 8 years, has been popular with both clinicians and clients. This treatment design can be used in a variety of clinical settings and will be beneficial to the field.

Pamela S. Hyde, J.D.
Administrator
Substance Abuse and Mental Health Services Administration

Dr. H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

CONTENTS

Foreword iii

Introduction 1

How To Use This Manual 5

Session 1 Overview of Group Anger Management Treatment 7

Session 2 Events and Cues: A Conceptual Framework for Understanding Anger 15

Session 3 Anger Control Plans: Helping Group Members Develop a Plan for Controlling Anger 21

Session 4 The Aggression Cycle: How To Change the Cycle 27

Session 5 Cognitive Restructuring: The A-B-C-D Model and Thought Stopping 33

Session 6 Review Session #1: Reinforcing Learned Concepts 37

Sessions 7 & 8 Assertiveness Training and the Conflict Resolution Model: Alternatives for Expressing Anger 39

Sessions 9 & 10 Anger and the Family: How Past Learning Can Influence Present Behavior 45

Session 11 Review Session #2: Reinforcing Learned Concepts 49

Session 12 Closing and Graduation: Closing Exercise and Awarding of Certificates 51

References 53

Appendix: Authors' Acknowledgments 57

INTRODUCTION

This manual was designed for use by qualified substance abuse and mental health clinicians who work with substance abuse and mental health clients with concurrent anger problems. The manual describes a 12-week cognitive behavioral anger management group treatment. Each of the 12 90-minute weekly sessions is described in detail with specific instructions for group leaders, tables and figures that illustrate the key conceptual components of the treatment, and homework assignments for the group participants. An accompanying Participant Workbook is available (see *Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook,* Reilly, Shopshire, Durazzo, & Campbell, 2002) and should be used in conjunction with this manual to enable the participants to better learn, practice, and integrate the treatment strategies presented in the group sessions. This intervention was developed for studies at the San Francisco Veterans Affairs (SFVA) Medical Center and San Francisco General Hospital.

Cognitive behavioral therapy (CBT) treatments have been found to be effective, time-limited treatments for anger problems (Beck & Fernandez, 1998; Deffenbacher, 1996; Trafate, 1995). Four types of CBT interventions, theoretically unified by principles of social learning theory, are most often used when treating anger disorders:

- *Relaxation interventions,* which target emotional and physiological components of anger
- *Cognitive interventions,* which target cognitive processes such as hostile appraisals and attributions, irrational beliefs, and inflammatory thinking
- *Communication skills interventions,* which target deficits in assertiveness and conflict resolution skills
- *Combined interventions,* which integrate two or more CBT interventions and target multiple response domains (Deffenbacher, 1996, 1999).

Meta-analysis studies (Beck & Fernandez, 1998; Edmondson & Conger, 1996; Trafate, 1995) conclude that there are moderate anger reduction effects for CBT interventions, with average effect sizes ranging from 0.7 to 1.2 (Deffenbacher, 1999). From these studies, it can be inferred that the average participant under CBT conditions fared better than 76 percent of control participants. These results are consistent with other meta-analysis studies examining the effectiveness of CBT interventions in the treatment of depression (Dobson, 1989) and anxiety (Van Balkom et al., 1994).

The treatment model described in this manual is a combined CBT approach that employs relaxation, cognitive, and communication skills interventions.

This combined approach presents the participants with options that draw on these different interventions and then encourages them to develop individualized anger control plans using as many of the techniques as possible. Not all the participants use all the techniques and interventions presented in the treatment (e.g., cognitive restructuring), but almost all finish the treatment with more than one technique or intervention on their anger control plans.

Theoretically, the more techniques and interventions an individual has on his or her anger control plan, the better equipped he or she will be to manage anger in response to anger-provoking events.

In studies at the SFVA Medical Center and San Francisco General Hospital using this treatment model, significant reductions in self-reported anger and violence have consistently been found, as well as decreased substance use (Reilly, Clark, Shopshire, & Delucchi, 1995; Reilly, Shopshire, & Clark, 1999; Reilly & Shopshire, 2000; Shopshire, Reilly, & Ouaou, 1996). Most participants in these studies met *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) (American Psychiatric Association, 1994) criteria for substance dependence, and many also met DSM-IV criteria for posttraumatic stress disorder. A study comparing Caucasian and African-American patients found that patients from both groups reduced their anger significantly (Clark, Reilly, Shopshire, & Campbell, 1996). Another study showed that women also benefited from the intervention—that is, reported decreased levels of anger (Reilly et al., 1996).

In the anger management studies using this manual, the majority of patients were from ethnic minority groups. Consistent reductions in anger and aggressive behavior occurred in these groups, indicating that anger management group treatment is effective. The treatment model is flexible and can accommodate racial, cultural, and gender issues. The events or situations that trigger someone's anger may vary somewhat depending on his or her culture or gender. The cues or warning signs of anger may vary in this regard as well. Nevertheless, the overall treatment model still applies and was found effective with different ethnic groups and with both men and women. A person still has to identify the triggering event, recognize the cues to anger, and develop anger management (cognitive behavioral) strategies in response to the event and cues, regardless of whether these events and cues are different for other men and women or for people in other cultural groups.

The intervention involves developing individualized anger control plans. For example, some women identified their relationships with their boyfriends or partners or parenting concerns as events that triggered their anger but men rarely identified these issues. Effective individual strategies could be developed, however, to address these issues, provided the women accept the concepts of monitoring anger (using the anger meter) and having (and using) an anger control plan.

This treatment model was also used successfully with non–substance-abusing clients seen in the outpatient SFVA Mental Health Clinic. These clients were diagnosed with a variety of problems, including mood, anxiety, and thought disorders. The treatment components described in this manual served as the core treatment in these studies.

The anger management treatment should be delivered in a group setting. The ideal number of participants in a group is 8, but groups can range from 5 to 10 members. There are several reasons for this recommendation. First, solid empirical support exists for group cognitive behavioral interventions (Carroll, Rounsaville, & Gawin, 1991; Maude-Griffin et al., 1998; Smokowski & Wodarski, 1996); second, group treatment is efficient and cost-effective (Hoyt, 1993; Piper & Joyce, 1996); and third, it provides a greater range of possibilities and flexibility in roleplays (Yalom, 1995) and behavioral rehearsal activities (Heimberg & Juster, 1994; Juster & Heimberg, 1995). Counselors and social workers should have training in cognitive behavioral therapy, group therapy, and substance abuse treatment (preferably, at the master's level or higher; doctoral-level psychologists have delivered the anger management treatment as well).

Although a group format is recommended for the anger management treatment, it is possible for qualified clinicians to use this manual in individual sessions with their clients. In this case, the same treatment format and sequence can be used. Individual sessions provide more time for in-depth instruction and individualized behavioral rehearsal.

The anger management treatment manual is designed for adult male and female substance abuse and mental health clients (age 18 years and above). The groups studied at SFVA Medical Center and San Francisco General Hospital have included patients who have used many substances (e.g., cocaine, alcohol, heroin, methamphetamine). These patients have been able to use the anger management materials and benefit from the group treatment despite differences in their primary drug of abuse.

It is recommended that participants be abstinent from drugs and alcohol for at least 2 weeks prior to joining the anger management group. If a participant had a "slip" during his or her enrollment in the group, he or she was not discharged from the group. However, if he or she had repeated slips or a full-blown relapse, the individual was referred to a more intensified treatment setting and asked to start the anger management treatment again.

Many group participants were diagnosed with co-occurring disorders (e.g., posttraumatic stress disorder [PTSD], mood disorder, psychosis) but benefited from the anger management group treatment. Patients were compliant with their psychiatric medication regimen and were monitored by interdisciplinary treatment teams. The San Francisco group found that, if patients were compliant with their medication regimen and abstinent from drugs and alcohol, they could comprehend the treatment material and effectively use concepts such as timeouts and thought stopping to manage anger. However, if a participant had a history of severe mental illness, did not comply with instructions on his or her psychiatric medication regimen, and had difficulty processing the material or accepting group feedback, he or she was referred to his or her psychiatrist for better medication management.

Several practitioners have requested the manual to work with adolescent clients in substance abuse treatment, but no preliminary data from these treatment encounters are available.

Because of the many problems often experienced by substance abuse and mental health clients, this intervention should be used as an adjunctive treatment to substance abuse and

mental health treatment. Certain issues, such as anger related to clients' family of origin and past learning, for example, may best be explored in individual and group therapy outside the anger management group.

Finally, the authors stress the importance of providing ongoing anger management aftercare groups. Participants at the SFVA Medical Center repeatedly asked to attend aftercare groups where they could continue to practice and integrate the anger management strategies they learned in this treatment. At the SFVA Medical Center, both an ongoing drop-in group and a more structured 12-week phase-two group were provided as aftercare components. These groups help participants maintain (and further reduce) the decreased level of anger and aggression they achieved during the initial 12-week anger management group treatment. Participants can also be referred to anger management groups in the community.

It is hoped that this anger management manual will help substance abuse and mental health clinicians provide effective anger management treatment to clients who experience anger problems. Reductions in frequent and intense anger and its destructive consequences can lead to improved physical and mental health of individuals and families.

HOW TO USE THIS MANUAL

The information presented in this manual is intended to allow qualified mental health and substance abuse professionals to deliver group cognitive behavioral anger management treatment to clients with substance abuse and mental health disorders. Each of the 12 90-minute weekly sessions is divided into four sections:

- Instructions to Group Leaders
- Check-In Procedure (beginning in the second session)
- Suggested Remarks
- Homework Assignments.

The Instructions to Group Leaders section summarizes the information to be presented in the session and outlines the key conceptual components. The Check-In Procedure section provides a structured process by which group members check in at each session and report on the progress of their homework assignments from the previous week. The Suggested Remarks section provides narrative scripts for the group leader presenting the material in the session. *Although the group leader is not required to read the scripts verbatim, the group leader should deliver the information as closely as possible to the way it is in the script.* The Homework Assignment section provides instructions for group members on what tasks to review and practice for the next meeting. Session 1 also includes a special section that provides an overview of the anger management treatment and outlines the group rules.

This manual should be used in conjunction with the *Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook* (Reilly, Shopshire, Durazzo, & Campbell, 2002). The workbook provides group members with a summary of the information presented in each session, worksheets for completing homework assignments, and space to take notes during each session. The workbook will facilitate the completion of homework assignments and help reinforce the concepts presented over the course of the anger management treatment program.

Although participants are kept busy in each session, 90 minutes should be enough time to complete the tasks at hand. The group leader needs to monitor and, at times, limit the responses of participants, however. This can be done by redirecting them to the question or activity.

OVERVIEW OF GROUP ANGER MANAGEMENT TREATMENT

Session 1

Instructions to Group Leaders

In the first session, the purpose, overview, group rules, conceptual framework, and rationale for the anger management treatment are presented. Most of this session is spent presenting conceptual information and verifying that the group members understand it. Then the leader takes the group members through an introductory exercise and a presentation of the anger meter.

Suggested Remarks

(Present the following script or put this in your own words.)

Purpose and Overview

The purpose of the anger management group is to:

1. Learn to manage anger
2. Stop violence or the threat of violence
3. Develop self-control over thoughts and actions
4. Receive support and feedback from others.

Outline of Session 1

- Instructions to Group Leaders
- Suggested Remarks
  - Purpose and Overview
  - Group Rules
  - The Problem of Anger: Some Operational Definitions
  - Myths About Anger
  - Anger as a Habitual Response
  - Breaking the Anger Habit
  - Participant Introductions
  - Anger Meter
- Homework Assignment

Group Rules

1. Group Safety: No violence or threats toward staff and other group members is allowed. It is important that members perceive the group as a safe place to share their experiences and feelings without threats or possible physical harm.
2. Confidentiality: Group members should not discuss outside the group what group members say during group sessions. There are limits to confidentiality, however. In every State, health laws govern how and when professionals must report certain actions to the proper authorities. These actions may include any physical or sexual abuse inflicted on a child younger

than age 18, a person older than age 65, or a dependent adult. A dependent adult is someone between 18 and 64 years who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. Reporting abuse of these persons supersedes confidentiality laws involving clients and health professionals. Similarly, if a group member makes threats to physically harm or kill another person, the group leader is required, under the Tarasoff Ruling (*Tarasoff* v. *Regents of the University of California,* 529 P.2d 553 (Cal. 1974), vacated, reheard en bank, and affirmed, 131 Cal. Rptr. 14, 551 P.2d 334 (1976)), to warn the intended victim and notify the police.

3. Homework Assignments: Brief homework assignments will be given each week. Doing the homework assignments will improve group members' anger management skills and allow them to get the most from the group experience. Like any type of skill acquisition, anger management requires time and practice. Homework assignments provide the opportunity for skill development and refinement.

4. Absences and Cancellations: Members should call or otherwise notify the group leader in advance when they cannot attend a session. Because of the amount of material presented in each session, members may not miss more than 3 of the 12 sessions. If a group member misses more than three sessions, he or she would not be able to adequately learn, practice, and apply the concepts and skills that are necessary for effective anger management. He or she can continue to attend the group sessions, but the group member will not receive a certificate of completion. He or she can join another session as space becomes available.

5. Timeout: The group leader reserves the right to call for a timeout. If a group member's anger begins to escalate out of control during a session, the leader will ask that member to take a timeout from the topic and the discussion. This means that the member, along with the rest of the members of the group, *will immediately stop talking about the issue* that is causing the member's anger to escalate. If the participant's anger has escalated to the point that he or she cannot tolerate sitting in the group, the leader may ask the person to leave the group for 5 or 10 minutes or until he or she can cool down. The participant is then welcomed back to the group, provided he or she can tolerate continued discussion in the group.

   A timeout is an effective anger management strategy and will be discussed in more detail later in this session and in session 3. Eventually, group members will learn to call a timeout themselves when they feel they may be losing control as the result of escalation of their anger. For this session, however, it is essential that the leader calls for a timeout and that members comply with the rule. This rule helps ensure that the group will be a safe place to discuss and share experiences and feelings. Therefore, failure to comply with the timeout rule may lead to termination from the group.

6. Relapses: If a participant has a relapse during his or her enrollment in the group, he or she is not discharged. However, if the participant has repeated relapses, he or she will be asked to start the treatment again and will be referred to a more intense treatment setting.

The Problem of Anger: Some Operational Definitions

In the most general sense, anger is a feeling or emotion that ranges from mild irritation to intense fury and rage. Anger is a natural response to those situations where we feel threatened, we believe harm will come to us, or we believe that another person has unnecessarily wronged us. We may also become angry when we feel another person, like a child or someone close to us, is being threatened or harmed. In addition, anger may result from frustration when our needs, desires, and goals are not being met. When we become angry, we may lose our patience and act impulsively, aggressively, or violently.

People often confuse anger with aggression. Aggression is *behavior* that is intended to cause harm to another person or damage property. This behavior can include verbal abuse, threats, or violent acts. Anger, on the other hand, is an *emotion* and does not necessarily lead to aggression. Therefore, a person can become angry without acting aggressively.

A term related to anger and aggression is hostility. Hostility refers to a complex set of attitudes and judgments that motivate aggressive behaviors. Whereas anger is an emotion and aggression is a behavior, hostility is an *attitude* that involves disliking others and evaluating them negatively.

In this group, clients will learn helpful strategies and techniques to manage anger, express anger in alternative ways, change hostile attitudes, and prevent aggressive acts, such as verbal abuse and violence.

When Does Anger Become a Problem?

Anger becomes a problem when it is felt too intensely, is felt too frequently, or is expressed inappropriately. Feeling anger too intensely or frequently places extreme physical strain on the body. During prolonged and frequent episodes of anger, certain divisions of the nervous system become highly activated. Consequently, blood pressure and heart rate increase and stay elevated for long periods. This stress on the body may produce many different health problems, such as hypertension, heart disease, and diminished immune system efficiency. Thus, from a health standpoint, avoiding physical illness is a motivation for controlling anger.

Another compelling reason to control anger concerns the negative consequences that result from expressing anger inappropriately. In the extreme, anger may lead to violence or physical aggression, which can result in numerous negative consequences, such as being arrested or jailed, being physically injured, being retaliated against, losing loved ones, being terminated from a substance abuse treatment or social service program, or feeling guilt, shame, or regret.

Even when anger does not lead to violence, the inappropriate expression of anger, such as verbal abuse or intimidating or threatening behavior, often results in negative consequences. For example, it is likely that others will develop fear, resentment, and lack of trust toward those who subject them to angry outbursts, which may cause alienation from individuals, such as family members, friends, and coworkers.

Payoffs and Consequences

The inappropriate expression of anger initially has many apparent payoffs. One payoff is being able to manipulate and control others through aggressive and intimidating behavior; others may comply with someone's demands because they fear verbal threats or violence. Another payoff is the release of tension that occurs when one loses his or her temper and acts aggressively. The individual may feel better after an angry outburst, but everyone else may feel worse.

In the long term, however, these initial payoffs lead to negative consequences. For this reason they are called "apparent" payoffs because the long-term negative consequences far outweigh the short-term gains. For example, consider a father who persuades his children to comply with his demands by using an angry tone of voice and threatening gestures. These behaviors imply to the children that they will receive physical harm if they are not obedient. The immediate payoff for the father is that the children obey his commands. The long-term consequence, however, may be that the children learn to fear or dislike him and become emotionally detached from him. As they grow older, they may avoid contact with him or refuse to see him altogether.

Myths About Anger

Myth #1: Anger Is Inherited. One misconception or myth about anger is that the way we express anger is inherited and cannot be changed. Sometimes, we may hear someone say, "I inherited my anger from my father; that's just the way I am." This statement implies that the expression of anger is a fixed and unalterable set of behaviors. Evidence from research studies, however, indicates that people are not born with set, specific ways of expressing anger. These studies show, rather, that because the expression of anger is learned behavior, more appropriate ways of expressing anger also can be learned.

It is well established that much of people's behavior is learned by observing others, particularly influential people. These people include parents, family members, and friends. If children observe parents expressing anger through aggressive acts, such as verbal abuse and violence, it is very likely that they will learn to express anger in similar ways. Fortunately, this behavior can be changed by learning new and appropriate ways of anger expression. It is not necessary to continue to express anger by aggressive and violent means.

Myth #2: Anger Automatically Leads to Aggression. A related myth involves the misconception that the only effective way to express anger is through aggression. It is commonly thought that anger is something that builds and escalates to the point of an aggressive outburst. As has been said, however, anger does not necessarily lead to aggression. In fact, effective anger management involves controlling the escalation of anger by learning assertiveness skills, changing negative and hostile "self-talk," challenging irrational beliefs, and employing a variety of behavioral strategies. These skills, techniques, and strategies will be discussed in later sessions.

Myth #3: People Must Be Aggressive To Get What They Want. Many people confuse assertiveness with aggression. The goal of aggression is to dominate, intimidate, harm, or injure another person—to win at any cost. Conversely, the goal of assertiveness is to express feelings of anger

in a way that is respectful of other people. For example, if you were upset because a friend was repeatedly late for meetings, you could respond by shouting obscenities and name-calling. This approach is an attack on the other person rather than an attempt to address the behavior that you find frustrating or anger provoking.

An assertive way of handling this situation might be to say, “When you are late for a meeting with me, I get pretty frustrated. I wish that you would be on time more often.” This statement expresses your feelings of frustration and dissatisfaction and communicates how you would like the situation changed. This expression does not blame or threaten the other person and minimizes the chance of causing emotional harm. We will discuss assertiveness skills in more detail in sessions 7 and 8.

Myth #4: Venting Anger Is Always Desirable. For many years, the popular belief among numerous mental health professionals and laymen was that the aggressive expression of anger, such as screaming or beating on pillows, was healthy and therapeutic. Research studies have found, however, that people who vent their anger aggressively simply get better at being angry (Berkowitz, 1970; Murray, 1985; Straus, Gelles, & Steinmetz, 1980). In other words, venting anger in an aggressive manner reinforces aggressive behavior.

Anger as a Habitual Response

Not only is the expression of anger learned, but it can become a routine, familiar, and predictable response to a variety of situations. When anger is displayed frequently and aggressively, it can become a maladaptive habit because it results in negative consequences. Habits, by definition, are performed over and over again, without thinking. People with anger management problems often resort to aggressive displays of anger to solve their problems, without thinking about the negative consequences they may suffer or the debilitating effects it may have on the people around them.

Breaking the Anger Habit

Becoming Aware of Anger. To break the anger habit, you must develop an awareness of the events, circumstances, and behaviors of others that “trigger” your anger. This awareness also involves understanding the negative consequences that result from anger. For example, you may be in line at the supermarket and become impatient because the lines are too long. You could become angry, then boisterously demand that the checkout clerk call for more help. As your anger escalates, you may become involved in a heated exchange with the clerk or another customer. The store manager may respond by having a security officer remove you from the store. The negative consequences that result from this event are not getting the groceries that you wanted and the embarrassment and humiliation you suffer from being removed from the store.

Strategies for Controlling Anger. In addition to becoming aware of anger, you need to develop strategies to effectively manage it. These strategies can be used to stop the escalation of anger before you lose control and experience negative consequences. An effective set of strategies for controlling anger should include both immediate and preventive strategies.

Immediate strategies include taking a timeout, deep-breathing exercises, and thought stopping. Preventive strategies include developing an exercise program and changing your irrational beliefs. These strategies will be discussed in more detail in later sessions.

One example of an immediate anger management strategy worth exploring at this point is the timeout. The timeout can be used formally or informally. For now, we will only describe the informal use of a timeout. This use involves leaving a situation if you feel your anger is escalating out of control. For example, you may be a passenger on a crowded bus and become angry because you perceive that people are deliberately bumping into you. In this situation, you can simply get off the bus and wait for a less crowded bus.

The informal use of a timeout may also involve stopping yourself from engaging in a discussion or argument if you feel that you are becoming too angry. In these situations, it may be helpful to actually call a timeout or to give the timeout sign with your hands. This lets the other person know that you wish to immediately stop talking about the topic and are becoming frustrated, upset, or angry.

In this group, you should call a timeout if you feel that your anger is escalating out of control. You also are encouraged to leave the room for a short period of time if you feel that you need to do so. However, please come back for the remainder of the group session after you have calmed down.

Participant Introductions

At this point, ask group members to give their names, the reasons they are interested in participating in the anger management group, and what they hope to achieve in the group. After each member's introduction, offer a supportive comment that validates his or her decision to participate in the group. Experience shows that this helps members feel the group will meet their needs and helps reduce the anxiety associated with the introductions and the first group session in general.

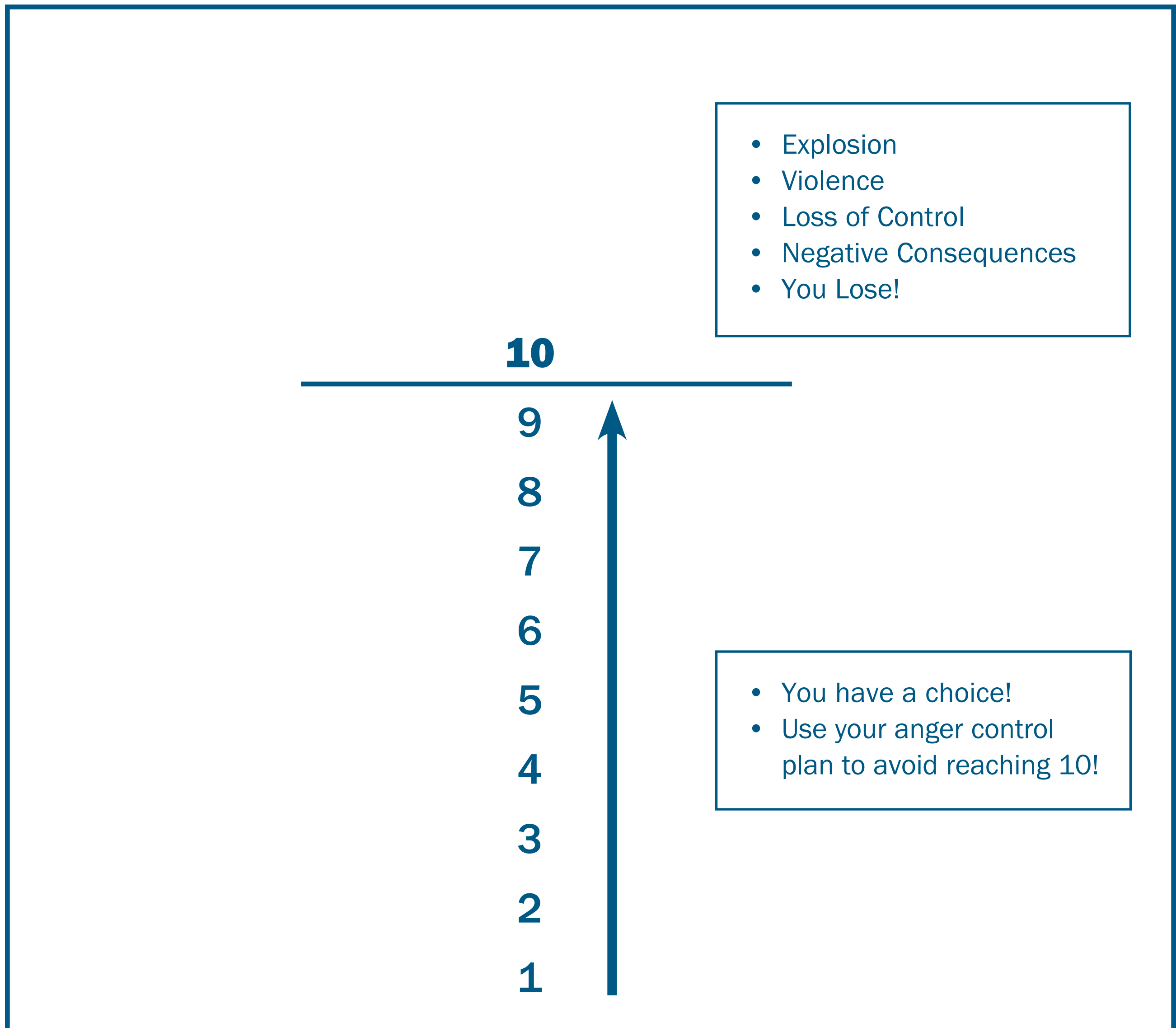
Anger Meter

One technique that is helpful in increasing the awareness of anger is learning to monitor it. A simple way to monitor anger is to use the "anger meter." A 1 on the anger meter represents a complete lack of anger or a total state of calm, whereas a 10 represents a very angry and explosive loss of control that leads to negative consequences. Points between 1 and 10 represent feelings of anger between these extremes. The purpose of the anger meter is to monitor the escalation of anger as it moves up the scale. For example, when a person encounters an anger-provoking event, he or she does not reach a 10 immediately, although it may sometimes feel that way. In reality, the individual's anger starts at a low number and rapidly moves up the scale. There is always time, provided one has learned effective coping skills, to stop anger from escalating to a 10.

One difficulty people have when learning to use the anger meter is misunderstanding the meaning of a 10. A 10 is reserved for instances when an individual suffers (or could suffer) negative consequences. An example is when an individual assaults another person and is arrested by the police.

A second point to make about the anger meter is that people may interpret the numbers on the scale differently. These differences are acceptable. What may be a 5 for one person may be a 7 for someone else. It is much more important to personalize the anger meter and become comfortable and familiar with your readings of the numbers on the scale. For the group, however, a 10 is reserved for instances when someone loses control and suffers (or could suffer) negative consequences.

Exhibit 1. The Anger Meter



Homework Assignment

Have group members refer to the participant workbook. Ask them to review the group's purpose, rules, definitions of anger and aggression, myths about anger, anger as a habitual response, and the anger meter. Ask them to monitor their levels of anger on the anger meter during the upcoming week and report their highest level of anger during the Check-In Procedure of next week's session.

EVENTS AND CUES
A Conceptual Framework for Understanding Anger

Session 2

Outline of Session 2

- **Instructions to Group Leaders**
- **Suggested Remarks**
  - **Events That Trigger Anger**
  - **Cues to Anger**
- **Explaining the Check-In Procedure**
- **Homework Assignment**

Instructions to Group Leaders

This session teaches group members how to analyze an anger episode and to identify the events and cues that indicate an escalation of anger. Begin the session with a check in (following up on the homework assignment from the last week, namely, have group members report on the highest level of anger they reached on the anger meter during the past week) and follow with a presentation and discussion of events and cues. A more complete Check-In Procedure will be used in session 3 after members have been taught to identify specific anger-provoking events and the cues that indicate an escalation of anger.

After the Check-In Procedure, ask group members to list specific events that trigger their anger. Pay special attention to helping them distinguish between the events and their interpretation of these events. Events refer to facts. Interpretations refer to opinions, value judgments, or perceptions of the events. For example, a group member might say, “My boss criticized me because he doesn’t like me.” Point out that the specific event was that the boss criticized the group member and that the belief that his boss doesn’t like him is an interpretation that may or may not be accurate.

Be aware of gender differences. Women participants often identify relationships with their boyfriend or partner or parenting concerns as events that trigger their anger. Men, however, may rarely identify these issues as triggers.

Finally, present the four cues to anger categories. After describing each category, ask group members to provide examples. It is important to emphasize that cues may be different for each individual. Members should identify cues that indicate an escalation of their anger.

Suggested Remarks

(Use the following script or put this in your own words.)

Events That Trigger Anger

When you get angry, it is because an event has provoked your anger. For example, you may get angry when the bus is late, when you have to wait in line at the grocery store, or when a neighbor plays his stereo too loud. Everyday events such as these can provoke your anger.

Many times, specific events touch on sensitive areas in your life. These sensitive areas or "red flags" usually refer to long-standing issues that can easily lead to anger. For example, some of us may have been slow readers as children and may have been sensitive about our reading ability. Although we may read well now as adults, we may continue to be sensitive about this issue. This sensitivity may be revealed when someone rushes us while we are completing an application or reviewing a memorandum and may trigger anger because we may feel that we are being criticized or judged as we were when we were children. This sensitivity may also show itself in a more direct way, such as when someone calls us "slow" or "stupid."

In addition to events experienced in the here-and-now, you may also recall an event from your past that made you angry. You might remember, for example, how the bus always seemed to be late before you left home for an important appointment. Just thinking about how late the bus was in the past can make you angry in the present. Another example may be when you recall a situation involving a family member who betrayed or hurt you in some way. Remembering this situation, or this family member, can raise your number on the anger meter. Here are examples of events or issues that can trigger anger:

- Long waits to see your doctor
- Traffic congestion
- Crowded buses
- A friend joking about a sensitive topic
- A friend not paying back money owed to you
- Being wrongly accused
- Having to clean up someone else's mess
- Having an untidy roommate
- Having a neighbor who plays the stereo too loud
- Being placed on hold for long periods of time while on the telephone
- Being given wrong directions

- Rumors being spread about your relapse that are not true
- Having money or property stolen from you.

Cues to Anger

A second important aspect of anger monitoring is to identify the cues that occur in response to the anger-provoking event. These cues serve as warning signs that you have become angry and that your anger is continuing to escalate. They can be broken down into four cue categories: physical, behavioral, emotional, and cognitive (or thought) cues.

Physical Cues. Physical cues involve the way our bodies respond when we become angry. For example, our heart rates may increase, we may feel tightness in our chests, or we may feel hot and flushed. These physical cues can also warn us that our anger is escalating out of control or approaching a 10 on the anger meter. We can learn to identify these cues when they occur in response to an anger-provoking event.

> Can you identify some of the physical cues that you have experienced when you have become angry?

Behavioral Cues. Behavioral cues involve the behaviors we display when we get angry, which are observed by other people around us. For example, we may clench our fists, pace back and forth, slam a door, or raise our voices. These behavioral responses are the second cue of our anger. As with physical cues, they are warning signs that we may be approaching a 10 on the anger meter.

> What are some of the behavioral cues that you have experienced when you have become angry?

Emotional Cues. Emotional cues involve other feelings that may occur concurrently with our anger. For example, we may become angry when we feel abandoned, afraid, discounted, disrespected, guilty, humiliated, impatient, insecure, jealous, or rejected. These kinds of feelings are the core or primary feelings that underlie our anger. It is easy to discount these primary feelings because they often make us feel vulnerable. An important component of anger management is to become aware of, and to recognize, the primary feelings that underlie our anger. In this group, we will view anger as a secondary emotion to these more primary feelings.

> Can you identify some of the primary feelings that you have experienced during an episode of anger?

Cognitive Cues. Cognitive cues refer to the thoughts that occur in response to the anger-provoking event. When people become angry, they may interpret events in certain ways. For example, we may interpret a friend's comments as criticism, or we may interpret the actions of others as demeaning, humiliating, or controlling. Some people call these thoughts "self-talk" because they resemble a conversation we are having with ourselves. For people with anger

problems, this self-talk is usually very critical and hostile in tone and content. It reflects beliefs about the way they think the world should be; beliefs about people, places, and things.

Closely related to thoughts and self-talk are fantasies and images. We view fantasies and images as other types of cognitive cues that can indicate an escalation of anger. For example, we might fantasize about seeking revenge on a perceived enemy or imagine or visualize our spouse having an affair. When we have these fantasies and images, our anger can escalate even more rapidly.

Can you think of other examples of cognitive or thought cues?

Explaining the Check-In Procedure

In this session, group members began to monitor their anger and identify anger-provoking events and situations. In each weekly session, there will be a Check-In Procedure to follow up on the homework assignment from the previous week and to report the highest level of anger reached on the anger meter during the week.

Have participants identify the event that triggered their anger, the cues that were associated with their anger, and the strategies they used to manage their anger in response to the event. They will be using the following questions to check in at the beginning of each session:

1. What was the highest number you reached on the anger meter during the past week?
2. What was the event that triggered your anger?
3. What cues were associated with the anger-provoking event? For example, what were the physical, behavioral, emotional, or cognitive cues?
4. What strategies did you use to avoid reaching 10 on the anger meter?

They will also be asked to monitor and record the highest number they reach on the anger meter for each day of the upcoming week after each session.

Exhibit 2. Cues to Anger: Four Cue Categories

Category	Examples
1. Physical	(examples: rapid heartbeat, tightness in chest, feeling hot or flushed)
2. Behavioral	(examples: pacing, clenching fists, raising voice, staring)
3. Emotional	(examples: fear, hurt, jealousy, guilt)
4. Cognitive/Thoughts	(examples: hostile self-talk, images of aggression and revenge)

Homework Assignment

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter during the upcoming week. In addition, ask them to identify the event that made them angry and list the cues that were associated with the anger-provoking event. Tell participants they should be prepared to report on these assignments during the Check-In Procedure in next week's session.