COMMON LANGUAGE for PSYCHOTHERAPY (clp) PROCEDURES
www.commonlanguagepsychotherapy.org

ANGER MANAGEMENT

Raymond W NOVACO & Stanley J RENWICK, Department of Psychology & Social Behavior, University of California, Irvine, CA 92697-7085; ph 001-949-824-7206

Definition: A structured treatment to foster self-regulation of anger and aggressive behaviour.

Elements: Clients are taught to become alert to triggers and signs of their anger. Anger management tries to reduce anger frequency, intensity, duration, and mode of expression in three key areas:

1. Cognitive restructuring of clients' attentional focus, thinking styles, fixed ways of perceiving aversive events, and rumination.
2. Reducing general tension, arousal to provocation, and impulsive reactions by training controlled breathing, deep muscle relaxation, and use of tranquil imagery.
3. Training behavioural coping (e.g. diplomacy, strategic withdrawal, and respectful assertiveness) to handle provoking situations constructively and promote problem solving.

Cognitive, arousal reduction, and behavioural skills are fostered through therapist-guided progressive exposure to simulated anger-provocations in imagined and role-play scenarios. People with angry dispositions, particularly in forensic settings, often require preliminary raising of readiness for anger management by fostering recognition of the costs of recurrent anger, by learning and practising self-monitoring and relaxation skills, and by making it safe to talk about anger.

Related Procedures: Cognitive restructuring, exposure, mindfulness, motivational interviewing, problem-solving, relaxation training, role play, schema-focused therapy, social skills training, stress immunization (inoculation).

Application: Individually and in groups, for adolescents and adults, in community and institutional settings. Depth and length of sessions vary with client needs.

1st use: Novaco (1975)

References:

1. Cavell TA, Malcolm KT (2007) *Anger, aggression, and interventions for interpersonal violence*. Mahwah, NJ: Erlbaum.
2. Novaco RW (1975) *Anger control: The development and evaluation of an experimental treatment*. Lexington, MA: DC Heath.
3. Novaco RW, Chemtob CM (2002) Anger and combat-related posttraumatic stress disorder. *Journal of Traumatic Stress, 15:* 123-132.
4. Renwick S, Black L, Ramm M, Novaco RW (1997) Anger treatment with forensic hospital patients. *Legal and Criminological Psychology, 2:* 103-116.

Case Illustration (Novaco & Renwick, unpublished)

Sandy, a soldier aged 26, was admitted to hospital after attempting suicide by overdose. He was angry, irritable, slept poorly, and drank excessive alcohol. Outbursts caused social isolation and frightened his family. Anger had been lifelong, and alternated with depression. He blamed recurrent "road rages" on `bad driving by

miscreants', whom he pursued and confronted. Those "road rage" episodes had begun three years earlier, after two driving accidents in a combat zone where he'd been the commanding officer but not the driver. The accidents left him disabled with pain and discomfort. He was judged unfit for service. Social withdrawal led to self-styled "paranoid" rumination with high arousal and sensitivity. There was no post-traumatic stress disorder. He'd been physically abused as a child.

Sandy had anger management in individual one-hour sessions twice-weekly over six months. Keeping an anger diary helped him detect thinking, feeling, and action aspects of his anger reactions. He was helped to spot and replace antagonistic thinking with more constructive thoughts. For example, he believed that his trouble in getting medical care and military-unit support was because they felt embarrassed by and wanted to discharge him. On uncovering this belief, the therapist encouraged Sandy to question its validity and see realistic alternatives, such as errors in administration and care pathways -- i.e., a flawed system rather than a conspiracy. His "paranoid" world view was challenged supportively and changed from seeing "conspiracy" to seeing "fallibility" or "incompetence". In parallel, the therapist helped Sandy to detect anger at its onset (e.g. when provoked by an official letter or pain from his injuries). Early detection of anger signs prevented anger intensifying and escalating into conflict with others. Slow breathing, calming self-instructions, and shifting attention to something benign served to reduce angry feelings on the spot. Arousal-reduction skills were enhanced by training in muscle relaxation and using tranquil imagery. Recurrent critical problems were reviewed to help him adopt alternative constructive ways to deal with them. In a stress-inoculation procedure the therapist reviewed with Sandy past anger-evoking situations and re-exposed him to them, progressing gradually from low-anger to high-anger ones. Sandy did the re-exposures in imagined and role-play scenarios, such as difficult contacts with administrators about his continuing medical-care needs. The therapist showed and rehearsed with Sandy how to elicit the help he needed and to set aside his hostile manner that alienated people.

During anger management work, Sandy's anger outbursts became less frequent and intense. This, in turn, helped him to sleep better, drink less alcohol, and improve his family life. Despite continuing pain and disability, he became more positive and self-confident.