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Cognitive-Behavioral Treatment of Men and Anger: Three Single Case Studies

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The treatment of men with anger problems presents significant challenges for practitioners. This article discusses a cognitive-behavioral, individual therapy, approach within the framework of three single case studies involving men. Treatment challenges and methodology are presented. Key treatment issues included: establishing a therapeutic relationship; facilitating understanding of the cognitive basis of anger; and addressing male-role socialization messages and male-identity schema that contributed to the experience and expression of anger in these men. Limitations relative to the small sample (n = 3) and the lack of a randomized control group preclude any definitive statements regarding the effectiveness or generalizability of the intervention. Nevertheless, the study highlights important theoretical and practical concerns for practitioners and future researchers to consider when working with men and anger.

According to the National Institute of Justice Centers for Disease Control and Prevention (1998), men are the primary perpetrators of interpersonal violence. Other studies have indicated that men are also the primary perpetrators of workplace aggression (Anfuso, 1994; Paul & Townsend, 1998) and road rage (AAA Foundation, 1997), which has been characterized as the expression of anger and frustration at other drivers (Smart, Mann, Zhao, & Stoduto, 2005). Even though not all violence or aggression is necessarily rooted in anger, one could argue that anger plays a significant role in many instances of violent or aggressive behaviors. Norlander and Eckhardt (2005) have suggested that despite differing opinions about the role of anger in interpersonal violence, it is hard to ignore mounting evidence indicating that anger is not only a risk factor for interpersonal violence, but that anger is a characteristic of interpersonal violence perpetrators. Such expression of anger through aggression often has dire consequences for the angry person, for those around him or her, and for society at large. Therefore, it would seem logical that efforts to reduce acts of violence and aggression by men should include helping men cope with anger more effectively.

Review of Anger Treatments

DiGiuseppe and Tafrate (2003), in a meta-analytic review of anger treatments, suggested that the literature on anger has been hampered by a reliance on "under-graduate subjects, short treatment lengths, and a dearth of studies using individual sessions" (p. 71). In another meta-analytic review of the literature on cognitive behavior therapies (CBT) and anger, Beck and Fernandez (1998) reviewed 50 studies and found that only 1 relied on adult volunteers as subjects. The rest of the studies fell into categories such as college students, school children, juvenile delinquents, clinical adolescents, abusive spouses/parents, and inmates. Furthermore, a review of 23 anger treatment outcome studies by DelVecchio and O'Leary (2004) revealed that 17 of those studies (74%) relied on undergraduate college students, 3 studies focused on male veterans, and 3 other studies focused on adults that did not fall into any of these two categories; only 1 study (Tafrate & Kassinove, 1998) had been published in the recent literature.

A review of recently published outcome studies using CBT to treat anger reveals that, with the exception of Tafrate and Kassinove (1998) and Grodnitzky and Tafrate (2000), the majority of published anger treatment studies can be classified as relying either on college students (Deffenbacher, Dahlen, Lynch, Morris, & Gowensmith, 2000) or special populations. A sample of these special populations includes, among others, prisoners convicted of violent offenses (Echeburua, Fernández-Montalvo, & Amor, 2006; Howells et al., 2005; Ireland, 2004), offenders with intellectual disabilities (Taylor, Novaco, Gillmer, & Thorne, 2002, Taylor, Novaco, Gillmer, & Thorne, 2005), aggressive drivers (Galovski & Blanchard, 2002), cocaine-dependent individuals (Reilly & Shopshire, 2000), or anger related to other disorders such as Asperger's syndrome (Attwood, 2004). The studies that did not rely on either of the above-mentioned groups (Tafrate and Kassinove and Grodnitzky and Tafrate) primarily used a

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repeated imaginal or in-vivo exposure as the main strategy for anger reduction.

One could argue that the overreliance on college populations, mandated clients, or special groups highlights the gap that exists in the current research regarding the focus on adult, self-referred men, and raises questions around the generalization of such findings to self-referred individuals. This article begins to address such issues by focusing on adult men who initiated treatment.

Men and Anger

As stated, a review of the literature on anger treatment underscores two significant issues: the lack of focus on self-referred, nonoffender men; and the lack of attention given in treatment to the effect of specific male-role socialization messages that shape men's masculine identity schemas, and how such beliefs contribute to the experience and expression of anger and other emotions. Some authors have theorized that men generally are not socialized to express vulnerability and nurturing, and instead receive and internalize familial and sociocultural-bound messages that reinforce a "take charge" stance (Levant, 1997; Mills & Rubin, 1992).

Such male-role socialization often creates a masculine identity that normalizes the expectation, in boys and men, of an independent and tough attitude, which in turn normalizes the expression of anger and aggression (Cox, Stabb, & Hulgus, 2000; Levant, 1997). Campbell (1993) suggested that, for men, anger may serve as an instrument to buffer against vulnerability, to establish control over situations, and to gain the respect of peers. Furthermore, Copenhaver, Lash, and Eisler (2000) studied a sample of 163 men and argued that men with high levels of adherence to such male role identity experience greater levels of what they described as masculine gender-role stress (MGRS). Copenhaver et al., define MGRS as "the tendency for such men to experience distress in the context of situations they appraise as a challenge or threat to their masculine identity" (p. 406). The authors suggest that men with high-MGRS experience higher levels of anger when compared with men with low-MGRS.

Purpose of the Study

This study outlines a therapeutic approach to treat anger in men that differs significantly from other anger treatments in the sense that it addresses the concerns expressed by DiGiuseppe and Tafrate (2003): the study focuses on self-referred adult men undergoing a fairly lengthy treatment approach, 16 sessions, delivered through individual therapy. Additionally, the treatment addresses specific challenges that practitioners may face when working with angry men, namely: the establishment of a therapeutic relationship; facilitating awareness of cognitive themes associated with anger; and the uncovering and restructuring of maladaptive male-identity schemas that relate to the experience and expression of anger.

The treatment described here includes traditional cognitive, behavioral, and psychoeducational strategies to help decrease levels of trait anger and improve overall functioning. The general components of treatment include the following: assessment of anger and general emotional symptoms in order to establish a therapeutic baseline; development of a therapeutic alliance; exploration of significant childhood experiences and the impact of such on the formation of relevant schemas; cognitive conceptualization of anger through the delineation of specific cognitive themes that underlie anger, with special focus on male-role socialization messages; challenging and reframing dysfunctional thinking; and the implementation of behavioral strategies to improve coping skills, including the assertive and socially responsible communication of anger and other emotions.

Healthy Anger Versus Toxic Anger

When treating anger one must make the distinction between the experience and expression of anger that is healthy and functional versus the anger that is dysfunctional, unhealthy, or "toxic." Anger in itself is a common human emotion that when experienced and expressed in a healthy and functional manner, with mild to moderate levels of arousal, helps the individual to communicate feelings clearly, directly, and assertively, and to implement socially appropriate corrective measures to resolve an unwanted situation (e.g., injustice or unfairness) (DiGiuseppe, 1995).

However, anger becomes maladaptive or toxic when it is experienced and/or expressed in ways that have a detrimental effect on the angry individual and others. This maladaptive expression of anger detracts from the individual's ability to identify and implement healthy measures to resolve unwanted situations. It is this maladaptive or toxic anger that becomes the target of treatment. The notion of "toxic anger" implies that anger has become a harmful, destructive, or deadly agent. Such anger may be expressed as aggression, verbal or physical, with high levels of internal or external arousal; "stuffing" the emotion and avoiding its healthy expression; passive-aggressively or indirectly; or by redirecting the anger toward other pathologies such as substance abuse (Gilbert, Gilbert, & Schultz, 1998; Larimer, Palmer, & Marlatt, 1999; DeMoja & Spielberger, 1997), self-cutting (AbuMadini & Rahim, 2001; Harris, 2000; Matsumoto et al., 2004), and bulimia (Meyer et al., 2005).

Three Angry Men

The three cases reviewed for this study—Paul, Vince, and Keith—had similar personal, demographic, and experiential characteristics. The three clients were adult,