

## Cognitive-Behavior Therapy for Reduction of Persistent Anger

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*Although persistent anger is not represented in DSM-IV as a psychiatric disorder, it is nevertheless a significant clinical problem. Based on our experience with both research and clinic patients from a diverse urban population, and drawing on methods utilized by others, we have refined and elaborated several treatment strategies that appear useful for anger reduction. The strategies derive from a counterconditioning treatment model: patients are exposed (either naturally or by design) to situations that may evoke anger; while they apply physiological, cognitive, and/or behavioral methods that can dampen the habitually angry response. The specific anger-reduction methods include: applied muscle relaxation, cognitive reappraisal, inhibition of overresponding, and reversal of underresponding (through acquisition of effective communication and problem-solving skills). Preliminary evidence is presented indicating that anger patients experience significant reduction in the intensity, duration, and frequency of anger reactions after completing 12 sessions of therapy utilizing these anger-reduction methods.*

ANGER is the neglected stepchild of the mental health field. Although widely recognized as a significant mental health problem, persistent anger still is not represented by a diagnostic category in the official psychiatric nomenclature (*DSM-IV*; American Psychiatric Association, 1994). In contrast, anxiety and depression—the other two principal negative emotions—have numerous categories and distinctions specified in *DSM-IV*.

Yet, persistent anger has significant psychological, behavioral, and even medical ramifications. Persistent anger causes major emotional suffering for both the person who experiences the anger as well as for those involved with him or her. Persistent anger is associated with risk for cardiac illness (Smith, 1992). Persistent anger also presents dangers from a public safety standpoint, as it can lead to domestic or other forms of violence (Eckhardt, Jamison, & Watts, 2002; Lundeberg, Stith, Penn, & Ward, 2004; Norlander & Eckhardt, 2005). Finally, anger is often a component of other psychological illnesses, such as anxiety and mood disorders, and successful treatment of these conditions may depend on alleviation of persistent anger (Suls & Bunde, 2005).

Unfortunately, as a clinical phenomenon, persistent anger is not as well understood as many other psychiatric constructs. The lack of an official Axis I diagnostic category for an “anger disorder” *per se* has undoubtedly

hampered progress in this area, making it difficult to arrive at empirically based prevalence estimates. The limited evidence available suggests that a legitimate anger disorder can exist on its own, without other psychiatric diagnoses present, and that anger problems are often correlated with other behavioral or social problems such as school or work difficulties, alcohol and drug use, financial difficulties, legal difficulties, and low self-esteem (e.g., Deffenbacher, Demm, & Brandon, 1986; Deffenbacher & McKay, 2000; Deffenbacher et al., 1996). At the same time, evidence indicates that anger can also be associated with specific psychiatric disorders (Suls & Bunde, 2005). Psychiatric comorbidity studies find overlap among anxiety disorders, depressive disorders, and anger problems: a patient experiencing any one of these disturbances is at increased risk for experiencing the others (Fava & Rosenbaum, 1999; Koh, Kim, & Park, 2002; Stavrakaki & Vargo, 1986; Swan, Carmelli, & Rosenman, 1989).

Treatment studies provide further evidence for the clinical connections among anxiety, depression, and anger, as research indicates that pharmacological and psychosocial treatments directed at one symptom area can improve the other two (Suls & Bunde, 2005). For example, selective serotonin reuptake inhibitors (SSRIs), which are effective in treating both anxiety disorders and depression (Dunner, 2001), have been found helpful in the treatment of aggressive behavior in substance abusers (Lavine, 1997) and anger attacks in depressed patients (Fava et al., 1993). In addition, psychosocial treatments directed at one symptom area (anxiety, depression or anger) have been

shown to improve the others (Barrowclough et al., 2001; Borkovec & Ruscio, 2001; Brown, Antony, & Barlow, 1995; Dahlen & Deffenbacher, 2000; Deffenbacher, Dahlen, Lynch, Morris, & Gowensmith, 2000; Kolko, Brent, Baugher, Bridge, & Birmaher, 2000; March, Amaya-Jackson, Murray, & Schulte, 1998).

Clinicians are universally aware that anger is an important and difficult clinical problem in its own right and that, even if a diagnostic category for an anger disorder does not yet exist, an effective treatment is required. Fortunately, the problem has not been entirely neglected by cognitive-behavioral psychologists (Brodolo, DiGiuseppe, & Tafrate, 1997; Deffenbacher & McKay, 2000; DiGiuseppe, Tafrate, & Eckhardt, 1994; Novaco, 1975; Williams & Williams, 1994), and treatment methods have proven effective (Del Vecchio & O'Leary, 2004; DiGiuseppe & Tafrate, 2003). Among the methods that have been used and empirically supported are applied relaxation, cognitive therapy, social and communication skills training, as well as approaches that combine these different elements (Del Vecchio & O'Leary, 2004).

With applied relaxation (also called relaxation coping skills training; Deffenbacher, 1995) patients are taught a standard progressive muscle relaxation exercise, which is then refined and shortened through the use of imagery and/or breathing as relaxation cues. Patients next rehearse relaxation coping skills by combining the visualization of anger-provoking scenes with the application of the relaxation response. Patients then extend the application of the relaxation response to real-life anger situations. Studies finding empirical support for applied relaxation include those by Deffenbacher, Filetti, Lynch, Dahlen, and Oetting (2002), and Hazaleus and Deffenbacher (1986).

With cognitive therapy, patients are taught to be aware of how their thinking can either trigger or augment feelings of anger. For example, anger patients commonly misinterpret the motives of others, perceiving malevolent intentions where none exist. Cognitive therapy is designed to help patients identify such distortions and ultimately modify them. Studies finding empirical support for cognitive techniques include those by Dahlen and Deffenbacher (2000), Deffenbacher et al. (2000), and Hazaleus and Deffenbacher (1986).

With social and communication skills training, patients are taught listening skills, compromise strategies, and assertiveness (Deffenbacher, 1995). These skills are then rehearsed in therapy sessions and ultimately transferred to real-life situations. Studies finding empirical support for social/communication skills training include those by Deffenbacher, Thwaites, Wallace, and Oetting (1994), Moon and Eisler (1983), and Rimm, Hill, Brown, and Stuart (1974).

Despite the availability of cognitive-behavioral techniques for treating persistent anger, the methods are not as widely disseminated or taught as those for anxiety disorders or depression, so many clinicians remain unaware of these evidence-based treatments. Moreover, advances in clinical methodology are not readily shared, as regular forums devoted to anger treatment are lacking.

For the past several years, our Behavioral Medicine Program has been offering individual cognitive-behavior therapy for anger reduction both as a clinical service and as part of a randomized clinical trial to study the effects of anger reduction on physiology, specifically, heart period variability. Heart period variability is a noninvasive index of cardiac autonomic modulation linked in children and adults to differences in affect regulation. Anger or hostility is associated with reduction of heart period variability (Sloan et al., 2001), and both anger and reduced heart period variability are, in turn, predictors of cardiac disease (Liao et al., 1997; Smith, 1992; Tsuji et al., 1996). The research, in progress, is therefore designed to determine whether cognitive-behavioral anger-reduction therapy can have a salutary (i.e., heightening) effect on heart period variability.

At this point, we estimate that we have conducted individual therapy with over 200 adult anger patients from our diverse urban area—both research participants and clinic patients, all of whom had no other psychiatric diagnoses—and can share our treatment experiences as well as some preliminary findings. Our treatment approach integrates the empirically validated techniques described above—relaxation, cognitive therapy, and social skills training—but also incorporates certain refinements and elaborations that we have found advantageous. We believe that the resulting treatment package, which we present below in detail, will be useful to other clinicians who are encountering many of the same difficulties in their own patients.

### The Patients

The patients are varied, but they all report persistent anger in at least one of four areas: (a) domestic (i.e., interactions with their spouse, partner, or children), (b) interpersonal (i.e., interactions with boyfriend/girlfriend, friends or relatives), (c) occupational (interactions with boss, co-workers, subordinates), or (d) public (interactions with strangers, in stores, on public transportation, etc.). Patients in our clinical trial must have no other psychiatric diagnoses and must meet cutoff criteria involving scores of at least one standard deviation above the normative mean on both the Cook-Medley Hostility Scale (Cook & Medley, 1954) and the Trait Anger Scale of the State-Trait Anger Expression Inventory (Spielberger, Jacobs, Russell, & Crane, 1983).

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