Anger Management
(3 Hours/Units)

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Course Objectives: This course is designed to help you:

1. Become familiar with cultural influences on anger management
2. Become familiar with historical influences on anger management
3. Identify poor anger management symptomology
4. Utilize fundamental anger management techniques
5. Access vital anger management mental healthcare resources

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1. Definitions, History, and Culture

The term anger management typically refers to a system of psychological therapeutic techniques and exercises by which someone with excessive or uncontrollable anger can control or reduce the triggers, degrees, and effects of an angered emotional state.

Most civilized societies consider anger as an immature or uncivilized response to frustration, threat, violation, or loss. Instead, remaining calm, levelheaded, or “turning the other cheek” is considered more socially acceptable. This conditioning can cause inappropriate expressions of anger such as uncontrolled violent outbursts, misdirected anger or repressing all feelings of anger when it would be an appropriate response to the situation. Also, anger that is constantly “bottled up” can lead to persistent violent thoughts or actions, nightmares and even physical symptoms. Anger can also aggravate an already present mental health problem such as clinical depression (Lehrer, Paul M.; David H., Barlow, Robert L. Woolfolk, Wesley E. Sime, 2007. Principles and Practice of Stress Management, Third Edition).

A large school of thought asserts that depression is essentially anger internalized. Perhaps this is due to the fact that many depressed persons react to stress by internalizing their anger in response to physical or mental abuse or neglect from parents or others. Another impact of the depression sufferer's denial of anger is that their interpersonal relationships are often unfulfilling. Anger can fuel obsessions, phobias, addictions and manic tendencies. Many people unable to express their anger appropriately will externalize it in furious activity which can result in clinical depression or even bipolar disorder. Anger can also intensify paranoia and prejudice, even in normal, everyday situations. People tend to express their anger either passively or aggressively through the fight-or-flight response (Lehrer, Paul M.; David H. Barlow, Robert L. Woolfolk, Wesley E. Sime, 2007. Principles and Practice of Stress Management, Third Edition). The flight response is often manifested through repression and denial of anger for safety. Aggressive behavior is associated with the fight response and the use of the verbal and physical power of anger.
Anger and rage are often conceptualized to be at opposite ends of an emotional continuum, mild irritation and annoyance at one end and fury or murderous rage at the other. Recently, Sue Parker Hall (2008) has challenged this idea; she conceptualizes anger as a positive, pure and constructive emotion, which is always respectful of others; only ever utilized to protect the self on physical, emotional, intellectual and spiritual dimensions in relationships. She argues that anger originates at age 18 months to 3 years in order to provide the motivation and energy for the individuation developmental stage whereby a child begins to separate from their careers and assert their differences. Anger emerges at the same time as thinking is developing therefore it is always possible to access cognitive abilities and feel anger at the same time (Parker Hall, 2008, *Anger, Rage and Relationship: An Empathic Approach to Anger Management*, Routledge, London).

*Parker Hall (2008)* proposes that it is not anger that is problematic but rage, a different phenomenon entirely; rage is conceptualized as a pre-verbal, pre-cognition, psychological defiance mechanism which originates in earliest infancy as a response to the trauma experienced when the infant's environment fails to meet their needs. Rage is construed as an attempt to summon help by an infant who experiences terror and whose very survival feels under threat. The infant cannot manage the overwhelming emotions that are activated and need a caring other to attune to them, to accurately assess what their needs are, to comfort and soothe them. If they receive sufficient support in this way, infants eventually learn to process their own emotions. Rage problems are conceptualized as the inability to process emotions or life's experiences either because the capacity to regulate emotion has never been sufficiently developed or because it has been lost due to more recent trauma (*Schore, 1994*). Rage is understood as 'a whole load of different feelings trying to get out at once' (*Harvey, 2004*) or as raw, undifferentiated emotions, which spill out when one more life event that cannot be processed, no matter how trivial, puts more stress on the organism than they can bear. Framing rage in this way has implications for working therapeutically with individuals with such difficulties. If rage is accepted as a pre-verbal, pre-cognitive phenomenon (and most sufferers describe it colloquially as 'losing the plot') then it follows that cognitive strategies, eliciting commitments to behave differently or educational programs are contra-indicated. Parker Hall proposes an empathic therapeutic relationship to support clients to develop or recover their organismic capacity (*Rogers, 1951*) to process their often multitude of traumas. This approach is a critique
of the dominant anger and rage interventions including probation, prison and psychology models, which she argues does not address rage at a deep enough level (Parker Hall, 2008, Anger, Rage and Relationship: An Empathic Approach to Anger Management, Routledge, London).

Historically, therapists thought that venting angry feelings was healthy and appropriate based on Freud’s “Hydraulic Model” of energy. He believed that energy could build up to the point that it would overflow and flood the system. The release was called catharsis which was an emptying of emotional reservoirs. However, contemporary research does not support this theory. Carol Tavris (1982) concluded that people who vent their anger tend to become more rather than less angry. The research consistently demonstrates that free expression of anger and hostility resulted in measurably increased angry and negative feelings.

2. Anger Symptoms

The experience of anger can include a sense of pressure to do something. The pressure persists until an action occurs to relieve it. Hostility may bring feelings of relief from mounting tension. Angry emotions often consist of discomfort and tension. Anger appears to be designed to disturb one’s state of equilibrium in order to provide warning (Parker Hall, 2008, Anger, Rage and Relationship: An Empathic Approach to Anger Management, Routledge, London).

There are essentially two types of anger: Passive anger and Aggressive anger. These two types of anger have some characteristic symptoms:

**Passive anger**

Passive anger can be expressed in the following ways:

- Secretive behavior, such as internalized mounting resentments the silent treatment or under the breath mutterings, avoiding eye contact, putting others down, gossiping, anonymous complaints, and stealing.

- Manipulation, such as provoking others followed by patronizing them, emotional blackmail, false tearfulness, feigning illness, sabotaging relationships, using sexual provocation, using a third party to convey negative feelings, withholding money or resources.
• Self-blame, such as apologizing too often, being overly critical, inviting criticism.

• Self-sacrifice, such as being overly helpful, making do with second best, quietly making long suffering signs but refusing help, or lapping up gratefulness.

• Ineffectualness, such as setting yourself and others up for failure, choosing unreliable people to depend on, being accident prone, underachieving, sexual impotence, expressing frustration at insignificant things but ignoring serious ones.

• Dispassion, such as giving the cold shoulder or phony smiles, sitting on the fence while others sort things out, dampening feelings with substance abuse, overeating, oversleeping, not responding to another’s anger, and frigidity.

• Obsessive behavior, such as an excessive need for cleanliness, ritualistically checking things, over-dieting or overeating, and demanding perfection in others.

• Evasiveness, such as turning your back in a crisis, avoiding conflict, not arguing back, becoming phobic.


Aggressive anger

The symptoms of aggressive anger include:

• Threats, such as frightening people by saying how you could harm them, their property or their prospects, finger pointing, fist shaking, wearing clothes or symbols associated with violent behavior, tailgating, excessively blowing a car horn, slamming doors.

• Hurtfulness, such as physical violence, verbal abuse, biased or vulgar jokes, breaking a confidence, using foul language, ignoring people’s feelings, willfully discriminating, blaming, punishing people for unwarranted deeds, labeling others.
Destructiveness, such as destroying objects, harming animals, destroying a relationship between two people, reckless driving, substance abuse.

Bullying, such as threatening others directly, persecuting, pushing or shoving, using power to oppress, shouting, exploiting the weaknesses of others.

Unjust blaming, such as accusing others for your mistakes, blaming people for your feelings, making general accusations.

Manic behavior, such as speaking too fast, walking too fast, working too much and expecting others to fit in, driving too fast, reckless spending.

Grandiosity, such as showing off, expressing mistrust, not delegating, being a sore loser, wanting center stage all the time, not listening, talking over people’s heads, expecting kiss and make-up sessions to solve problems.

Selfishness, such as ignoring other’s needs, not responding to requests for help, queue jumping.

Vengeance, such as being over-punitive, refusing to forgive and forget, bringing up hurtful memories from the past.

Unpredictability, such as explosive rages over minor frustrations, attacking indiscriminately, dispensing unjust punishment, inflicting harm on others for the sake of it, using alcohol and drugs, illogical arguments.


3. Anger Management Techniques

Psychologists recommend a balanced approach to anger, which both controls the emotion and allows the emotion to express itself in a healthy way. Some descriptions of actions of anger management are:
• Direct, such as not beating around the bush, making behavior visible and conspicuous, using body language to indicate feelings clearly and honestly, anger directed at persons concerned.

• Honorable, such as making it apparent that there is some clear moral basis for the anger, being prepared to argue your case, never using manipulation or emotional blackmail, never abusing another person’s basic human rights, never unfairly hurting the weak or defenseless, taking responsibility for actions.

• Focused, such as sticking to the issue of concern, not bringing up irrelevant material.

• Persistent, such as repeating the expression of feeling in the argument over and over again, standing your ground, self defense.

• Courageous, such as taking calculated risks, enduring short term discomfort for long term gain, risking displeasure of some people some of the time, taking the lead, not showing fear of other’s anger, standing outside the crowd and owning up to differences, using self-protective skills.

• Passionate, such as using full power of the body to show intensity of feeling, being excited and motivated, acting dynamically and energetically, initiating change, showing fervent caring, being fiercely protective, enthusing others.

• Creative, such as thinking quickly, using more wit, spontaneously coming up with new ideas and new views on subject

• Forgive, such as demonstrating a willingness to hear other people’s anger and grievances, showing an ability to wipe the slate clean once anger has been expressed.

• Listen to what is being said to you. Anger creates a hostility filter, and often all you can hear is negatively toned.

A common skill used in most anger management programs is learning assertive communication techniques. Assertive communication is the appropriate use of expressing feelings and needs without offending or taking away the rights of others. It is typically started with the use of “I” statements followed by a need statement. For example, “I feel upset when you don't take my feelings into consideration when you talk about your past relationships. I hope you can be more thoughtful and know what you should and should not say the next time.” (Bower, S. A. & Bower, G. H., 1991. Asserting Yourself: A Practical Guide for Positive Change. 2nd ed. Reading, MA: Addison Wesley).

Assertiveness is a trait taught by many personal development experts and psychotherapists and the subject of many popular self-help books. It is linked to self-esteem and considered an important communication skill. As a communication style and strategy, assertiveness is distinguished from aggression and passivity. How people deal with personal boundaries; their own and those of other people, helps to distinguish between these three concepts. Passive communicators do not defend their own personal boundaries and thus allow aggressive people to harm or otherwise unduly influence them. They are also typically not likely to risk trying to influence anyone else. Aggressive people do not respect the personal boundaries of others and thus are liable to harm others while trying to influence them. A person communicates assertively by not being afraid to speak his or her mind or trying to influence others, but doing so in a way that respects the personal boundaries of others. They are also willing to defend themselves against aggressive incursions (Bower, S. A. & Bower, G. H., 1991. Asserting Yourself: A Practical Guide for Positive Change. 2nd ed. Reading, MA: Addison Wesley).

Assertive people have the following characteristics:

- They feel free to express their feelings, thoughts, and desires.
- They know their rights.
- They have control over their anger. It does not mean that they repress this feeling. It means that they control it for a moment and then talk about it later in a reasoning manner.

**Assertiveness Techniques**

*Broken record*

A widely recognized technique advocated by assertiveness experts is the *Broken Record Technique*. This consists of simply repeating your requests every time you are met with illegitimate resistance. The term comes from vinyl records, the surface of which when scratched would lead the needle of a record player to loop over the same few seconds of the recording indefinitely. However, a disadvantage with this technique is that when resistance continues, your requests lose power every time you have to repeat them. If the requests are repeated too often it can backfire on the authority of your words. In these cases it is necessary to have some sanctions on hand (Bower, S. A. & Bower, G. H., 1991. Asserting Yourself: A Practical Guide for Positive Change. 2nd ed. Reading, MA: Addison Wesley)

*Fogging*

Another technique is called Fogging, which consists of finding some limited truth to agree with in what an antagonist is saying. More specifically, one can agree in part or agree in principle.

*Negative inquiry*

Negative inquiry consists of requesting further, more specific criticism. Negative assertion however, is agreement with criticism without letting up demand.

*I statements*

I statements can be used to voice one's feelings and wishes from a personal position without expressing a judgment about the other person or blaming one's feelings on them.

Dr. Eva L. Feindler recommends that people try, in the heat of an angry moment, to see if they can understand where the alleged perpetrator is coming from. Empathy is very difficult when one is angry but it can make all the difference in the world. Taking the other person's point of view can be excruciating when in the throes of anger, but with practice it can become second nature. Of course, once the angry person is in conditions of considering the opposite position, then the anger based on righteous

**Stress Management**

Many techniques are available to cope with stress. Time management techniques may help a person better control stress. In response to high demands, effective stress management may include learning to set limits and to say "No" to some demands that others make. The following techniques have been recently dubbed “Destressitizers” by The *Journal of the Canadian Medical Association*. A destressitizer is “any process by which an individual can relieve stress”. Techniques of stress management will vary according to the theoretical paradigm adhered to, but may include:

- Autogenic training
- Cognitive therapy
- Conflict resolution
- Exercise
- Getting a hobby
- Meditation
- Deep breathing
- Nootropics
- Relaxation techniques
- Artistic Expression
- Fractional relaxation
- Progressive relaxation
- Spas
- Stress balls
- Natural medicine
- Clinically validated alternative treatments
- Time management
- Listening to certain types of relaxing music

Stress may be measured with the *Holmes and Rahe Stress Scale* to rate stressful life events. Changes in blood pressure and galvanic skin response can also be measured to test stress levels as well as changes in stress levels. A digital thermometer can be used to evaluate changes in skin temperature, which can indicate activation of the fight or flight response drawing blood away from the extremities. Stress management has physiological and

**Deep Breathing**

Diaphragmatic breathing, abdominal breathing, belly breathing or deep breathing is the act of breathing deep into your lungs by flexing your diaphragm rather than breathing shallowly by flexing your rib cage. This deep breathing is marked by expansion of the stomach (abdomen) rather than the chest when breathing. It is generally considered a healthier and fuller way to ingest oxygen and is often used as a therapy for hyperventilation and anxiety disorders (Doug Keller. "Diaphragmatic Breath" excerpt from Refining the Breath).

Some yoga and meditation traditions distinguish between diaphragmatic breathing and abdominal breathing or belly breathing. The more specific technique of diaphragmatic breathing is considered to be more beneficial. Although the diaphragm is the primary breathing muscle, many people have a low sensory awareness of their diaphragm and almost no idea of how to engage it more fully or how it works. Some breath therapists and breathing teachers believe that due to increasing stress of modern life and the resulting over-stimulation of the sympathetic nervous system, as well as of the ideal of the hard, flat belly, that many people carry excessive tension in the belly, chest, and back, and this tension makes it difficult for the diaphragm to move freely through its full range of motion (Doug Keller. "Diaphragmatic Breath". Excerpt from Refining the Breath).

To breathe with the diaphragm, air must be drawn into the lungs in a way which will expand the stomach without expanding the chest. It is most effective to perform these breaths as long, slow intakes of air while allowing the body to absorb all of the inhaled oxygen while simultaneously relaxing the person breathing (Doug Keller. "Diaphragmatic Breath". Excerpt from Refining the Breath).

Although it may not initially feel comfortable not expanding the chest during breathing, diaphragmatic breathing actually fills up the majority of the lungs with oxygen, much more than chest-breathing or shallow breathing.

Many yoga and pranayama teachers believe that the most complete and fullest way of breathing is the "three-part breath," also called in yoga "The Complete Breath," which includes diaphragmatic breathing as the first step,
followed by thorax expansion and then chest expansion. This way of breathing is known in Tantric yoga as that which facilitates the greatest flow of life force through the body. There are several variations of the "three-part breath," but many breath therapists and breathing teachers maintain that this approach can create breathing imbalances and other problems (Doug Keller "Diaphragmatic Breath". Excerpt from Refining the Breath).

A common diaphragmatic breathing exercise is as follows:

1. Sit or lie comfortably, with loose garments.
2. Put one hand on your chest and one on your stomach.
3. Slowly inhale through your nose or through pursed lips (to slow down the intake of breath).
4. As you inhale, feel your stomach expand with your hand. If your chest expands, focus on breathing with your diaphragm.
5. Slowly exhale through pursed lips to regulate the release of air.
6. Rest and repeat.

(Doug Keller. "Diaphragmatic Breath". Excerpt from Refining the Breath).

**Stress Management**

Stress Inoculation Training (SIT), one of the most researched and comprehensive anxiety management programs (Meadows & Foa, 1998). SIT is helpful in imparting coping skills thereby reducing anxiety, hypervigilance, hyperarousal, sleep disturbances, and difficulty in concentration (Foa et al., 1999). These coping skills include muscle relaxation training, controlled breathing exercises, role playing, covert modeling, positive thinking, self-talk, assertiveness training, guided self imagery and dialogue, and thought stopping (Foa et al., 1999). Effective stress management increases the likelihood that anger management techniques will be successful.

**Analyze Trigger Thoughts**

The precursor to inappropriate expressions of anger is the trigger thought. Trigger thoughts often contain gross overgeneralizations about others and the world. Accuracy and nonexaggeration can be effective in changing the anger response. Avoiding words/concepts such as “always” and/or “never”
decrease exaggerated responses. Identification of one’s triggers and trigger thoughts is an important component of anger management.

**Personal Responsibility**

There are many methods designed to help someone who feels angry and helpless about another’s behavior. The following will assist an individual in developing personal responsibility thereby decreasing inappropriate expressions of anger:

1. Develop more effective strategies for reinforcement of the other person. Develop strategies for rewarding the other person for doing the things that you want.

2. Meet the need yourself. Sometimes you are able to meet your own needs that others are unable to.

3. Develop new sources of support, nourishment, and appreciation. There are some things within relationships that the other person may never be able to give you. Instead of feeling helpless, you can go to an alternative source for what you need

4. Set limits. Many people feel pressured by others to do things that they do not want to do. When you do not say no to these pressures, you may become angry. Setting limits by saying no is an important way of taking responsibility for situations you dislike.

5. Negotiate assertively. This involves clearly, directly, and calmly asking for what you want.

6. Let Go. When appropriate, develop an acceptance that the situation cannot change and that you will have to live with it. This type of taking responsibility also means letting go of the expectation that things will be different and that you will have what you want.


**Cognitive Behavioral Therapy**
By teaching clients to recognize the early onset of anger and responding promptly to manage it, there is an increased chance to perform an “instant replay”, focusing on the automatic thoughts, cognitive distortions, and basic beliefs that underlie anger. By identifying and correcting these distortions immediately, clients can reduce hostility and inappropriate expressions of anger. Using cognitive behavioral therapeutic techniques to evaluate the accuracy of trigger thoughts may serve as a preventative measure in decreasing hostility (Beck, A, Cognitive Therapy and the Emotional Disorders).

4. Anger Management for Substance Abuse and Mental Health Clients Participant Workbook

Introduction
This workbook is designed to be used by participants in an anger management group treatment curriculum for substance abuse and mental health clients. It provides individuals participating in the 12-week anger management group treatment with a summary of core concepts, worksheets to complete homework assignments, and space to take notes for each of the sessions. The concepts and skills presented in the anger management treatment are best learned by practice and review and by completing the homework assignments given in this workbook. Using this workbook as an adjunct to your participation in the 12-week anger management group treatment will help you develop the skills that are necessary to successfully manage anger.

Session 1:
Overview of Anger Management Treatment
In this first session, you will get a general overview of the anger management treatment. This includes the purpose of the group, group rules, definitions of anger and aggression, myths about anger, anger as a habitual response, and the introduction of the anger meter used to monitor anger.
I. Purpose of the Group
1) Learn to manage anger effectively.
2) Stop violence or the threat of violence.
3) Develop self-control over thoughts and actions.
4) Receive support from others.
II. Group Rules
1) **Group Safety:** No violence or threats of violence toward staff or other group members are permitted. It is very important that you view the group as a safe place to share your experiences and feelings without threats or fear of physical harm.
2) **Confidentiality:** Group members should not discuss outside of the group what other members say. (The group leader should determine the limits of the laws or rules pertaining to confidentiality in his or her State.)
3) **Homework Assignments:** Brief homework assignments will be given each week. Doing the homework assignments will improve your anger management skills and allow you to get the most from the group experience.
4) **Absences and Cancellations:** You should call or notify the group leader in advance if you cannot attend a group session. Because of the amount of material presented in each session, you may not miss more than 3 of the 12 sessions. If you miss more than three sessions, you may continue attending the weekly sessions, but you will not receive a certificate of completion.
5) **Timeouts:** The group leader reserves the right to call a timeout at any time. Eventually, you will learn to call a timeout yourself if you feel that you may be losing control because your anger is escalating.

III. Definitions
In the most general sense, anger is a feeling or emotion that ranges from mild irritation to intense fury and rage. Many people often confuse anger with aggression. Aggression is behavior that is intended to cause harm or injury to another person or damage to property. Hostility, on the other hand, refers to a set of attitudes and judgments that motivate aggressive behaviors.

• Before you learned these definitions, did you ever confuse anger with aggression?
Please explain how.

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IV. 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.
• List some ways anger may be affecting you physically.
V. Payoffs and Consequences
The inappropriate expression of anger initially has apparent payoffs (e.g., releasing tension, controlling people). In the long-term, however, these payoffs lead to negative consequences. That is why they are called “apparent” payoffs; the long-term negative consequences far outweigh the short-term gains.
• List some payoffs to using anger that you are familiar with.

VI. Myths About Anger
Myth #1: Anger Is Inherited. One misconception or myth about anger is that the way people express anger is inherited and cannot be changed. Evidence from research studies, however, indicates that people are not born with set
and specific ways of expressing anger. Rather, these studies show that the expression of anger is learned behavior and that more appropriate ways of expressing anger can also be learned.

Myth #2: Anger Automatically Leads to Aggression. A related myth involves the misconception that the only effective way to express anger is through aggression. There are other more constructive and assertive ways, however, to express anger. 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: You Must Be Aggressive To Get What You 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. Expressing yourself in an assertive manner does not blame or threaten other people and minimizes the chance of emotional harm. You will learn about the topic of assertiveness skills in more detail in sessions 7 and 8.

Myth #4: Venting Anger Is Always Desirable. For many years, there was a popular belief that the aggressive expression of anger, such as screaming or beating on pillows, was therapeutic and healthy. Research studies have found, however, that people who vent their anger aggressively simply get better at being angry. In other words, venting anger in an aggressive manner reinforces aggressive behavior.

• Before our discussion, did you believe any of these myths about anger to be true?

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Participant Workbook
VII. Anger Is a Habit
Anger 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. A habit, by definition, means performing behaviors automatically, over and over again, without thinking. The frequent and aggressive expression of anger can be viewed as a maladaptive habit because it results in negative consequences.

• Has anger become a habit for you? How?

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• In what ways has it been maladaptive?

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VIII. Breaking the Anger Habit
You can break the anger habit by becoming aware of the events and circumstances that trigger your anger and the negative consequences that result from it. In addition, you need to develop a set of strategies to effectively manage your anger. You will learn more about strategies to manage anger in session 3.

• List some anger control strategies that you might know or that you may have used in the past.

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Anger Management for Substance Abuse and Mental Health Clients

IX. Anger Meter
A simple way to monitor your anger is to use a 1 to 10 scale called the anger meter. A score of 1 on the anger meter represents a complete lack of anger or a total state of calm, whereas 10 represents an angry and explosive loss of control that leads to negative consequences.

• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

_____ M _____ T _____ W _____ Th _____ F _____ Sat _____ Sun

• Be prepared to report the highest level of anger you reached during the week in next week’s group.

Participant Workbook
Anger Meter
• Explosion
• Violence
• Loss of Control
• Negative Consequences
• You Lose!
• You have a choice!
• Use your anger control plan to avoid reaching 10!

Notes
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In this session, you begin to learn how to analyze an episode of anger. This involves learning how to identify events and cues that indicate an escalation of anger.

I. Events That Trigger Anger
When you get angry, it is because you have encountered an event in your life that has provoked your anger. Many times, specific events touch on sensitive areas. These sensitive areas or “red flags” usually refer to long-standing issues that can easily lead to anger. In addition to events that you experience in the here and now, you may also recall an event from your past that made you angry. Just thinking about these past events may make you angry now. 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.

- What are some of the general events and situations that trigger anger for you?
II. Cues to Anger: Four Cue Categories
A second important way to monitor anger 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 escalating. Cues can be broken down into four cue categories: physical, behavioral, emotional, and cognitive (or thought) cues. After each category, list the cues that you have noticed when you get angry.

1) Physical Cues (how your body responds; e.g., with an increased heart rate, tightness in the chest, feeling hot or flushed)

2) Behavioral Cues (what you do; e.g., clench your fists, raise your voice, stare at others)
3) *Emotional Cues* (other feelings that may occur along with anger; e.g., fear, hurt, jealousy, disrespect)

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4) *Cognitive Cues* (what you think about in response to the event; e.g., hostile self-talk, images of aggression and revenge)

III. Check-In Procedure: Monitoring Anger for the Week
In this session, you began to learn to monitor your anger and to 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 past week. You will also be asked to identify the event that triggered your anger, the cues that were associated with your anger, and the strategies you used to manage your anger in response to the event. You will be using the following format 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?

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3) What cues were associated with the anger-provoking event?
Physical cues
________________________________________________________________________

Behavioral cues
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Emotional cues
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Cognitive cues
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4) What strategies did you use to avoid reaching 10 on the anger meter?
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- For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

   M   T   W   Th   F   Sat   Sun

Events, Cues, and Strategies Identified During the Check-In Procedure
Anger Management for Substance Abuse and Mental Health Clients
Event Cues Strategies
In this session, you will begin learning about specific strategies to manage your anger. The anger control plan refers to the list of strategies you will identify to manage and control your anger.

I. Anger Control Plans
Up to now the group has been focusing on how to monitor anger. In the first session, you learned how to use the anger meter to rate your anger. Last week, you learned how to identify the events that trigger your anger, as well as the physical, behavioral, emotional, and cognitive cues associated with each event. In this session, you will begin to develop your own anger control plans and learn how you can use specific strategies, such as timeouts and relaxation, to control anger. Some people refer to their anger control plans as their toolbox and the specific strategies they use to control their anger as the tools in their toolbox. An effective set of strategies for controlling anger should include both immediate and preventive strategies. Examples of immediate strategies include timeouts, deep-breathing exercises, and thought stopping. Examples of preventive strategies include developing an exercise program and changing irrational beliefs. These strategies will be discussed in later sessions.

Timeouts
The timeout is a basic anger management strategy that should be in everyone’s anger control plan. A timeout can be used formally or informally.
In its simplest form, it means taking a few deep breaths and thinking instead of reacting. It may also mean leaving the situation that is causing the escalation or simply stopping the discussion that is provoking your anger. The formal use of a timeout involves our relationships with other people. These relationships may involve family members, friends, and coworkers. The formal use of a timeout involves having an agreement, or a prearranged plan, by which any of the parties involved can call a timeout and to which all parties have agreed in advance. The person calling the timeout can leave the situation, if necessary. It is agreed, however, that he or she will return to either finish the discussion or postpone it, depending on whether the parties involved feel they can successfully resolve the issue. A timeout is important because it can be used effectively in the heat of the moment. Even if a person’s anger is escalating quickly as measured on the anger meter, he or she can prevent reaching 10 by taking a timeout and leaving the situation. A timeout is also effective when used with other strategies. For example, you can take a timeout and go for a walk. You can also take a timeout and call a trusted friend or family member or write in your journal. These other strategies help you calm down during your timeout period.

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• Can you think of situations where you would use the timeout strategy? Please describe them.

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• Can you think of specific strategies that you might use to control your anger? Please describe them.

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Sample of an Anger Control Plan

Anger Management for Substance Abuse and Mental Health Clients

Anger Control Plan
1. Take a timeout (formal or informal)
2. Talk to a friend (someone you trust)
3. Use the Conflict Resolution Model to express anger
4. Exercise (take a walk, go to the gym, etc.)
5. Attend 12-Step meetings
6. Explore primary feelings beneath the anger

II. Relaxation Through Breathing

End this session by practicing a deep-breathing exercise as a relaxation technique. You can practice this exercise on your own by focusing on your breathing, taking several deep breaths, and trying to release any tension you might have in your body. You should practice this exercise as often as possible. Here are the directions. Find a comfortable position in your chair. If you would like, close your eyes; if not, just gaze down at the floor. Take a few moments to settle yourself. Now become aware of your body. Check for any tension, beginning with your feet, moving upward to your head. Notice any tension you might have in your legs, stomach, hands and arms, shoulders, neck, and face. Try to let go of any tension.

Now, become aware of your breathing. Pay attention to your breath as it enters and leaves your body. This can be very relaxing.

Take a deep breath. Notice your lungs and chest expanding. Now slowly exhale through your nose. Again, take a deep breath. Fill your lungs and your chest. Notice how much air you can take in.

Hold it for a second. Now release it and exhale slowly. Inhale slowly and fully one more time. Hold it for a second, and release.

Continue breathing in this way for another couple of minutes.

Continue to focus on your breath. With each inhalation and exhalation, feel your body becoming more and more relaxed. Use your breathing to wash away any remaining tension. Now take another deep breath. Inhale fully, hold it for a second, and release. Inhale again, hold, and release. Continue to be aware of your breath as it fills your lungs. Once more, inhale fully, hold it for a second, and release.

When you feel that you are ready, open your eyes. How was that?

Did you notice any new sensations while you were breathing? How do you feel now? This breathing exercise can be shortened to just three deep inhalations and exhalations. Even that can be effective in helping
you relax when your anger is escalating. You can practice this at home, at work, on the bus, while waiting for an appointment, or even while walking. The key to using deep-breathing as an effective relaxation technique is to practice it frequently and to apply it in a variety of situations.

Participant Workbook

III. Monitoring Anger for the Week

1) What was the highest number you reached on the anger meter during the past week?

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2) What was the event that triggered your anger?

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3) What cues were associated with the anger-provoking event?

Physical cues

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Behavioral cues

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Emotional cues

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Cognitive cues

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4) What strategies did you use to avoid reaching 10 on the anger meter?

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• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

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Anger Management for Substance Abuse and Mental Health Clients Notes
Participant Workbook

Session 4:
The Aggression Cycle
In this session, you will learn about the aggression cycle and practice progressive muscle relaxation.

The aggression cycle serves as an integrative framework that incorporates the concepts of the anger meter, cues to anger, and the anger control plan.

I. The Aggression Cycle
An episode of anger can be viewed as consisting of three phases: escalation, explosion, and postexplosion. Together, these three phases make up the aggression cycle. The escalation phase is characterized by cues that indicate anger is building. As you may recall, cues are warning signs, or responses, to anger-provoking events. If the escalation phase is allowed to continue, the explosion phase will follow. The explosion phase is marked by an uncontrollable discharge of anger that is displayed as verbal or physical
aggression. The postexplosion phase is characterized by the negative consequences that result from the verbal or physical aggression displayed during the explosion phase. These consequences may include going to jail, making restitution, being terminated from a job, being discharged from a drug treatment or social service program, losing family and loved ones, or feelings of guilt, shame, and regret.

II. The Aggression Cycle and the Anger Meter
Notice that the escalation and explosion phases of the aggression cycle correspond to levels or points on the anger meter. The points on the anger meter below 10 represent the escalation phase, the building up of anger. The explosion phase, on the other hand, corresponds to a 10 on the anger meter. A 10 on the anger meter represents when you lose control and express anger through verbal or physical aggression that leads to negative consequences. One of the primary objectives of anger management treatment is to prevent reaching the explosion phase. This is accomplished by using the anger meter to monitor changing levels of anger, attending to the cues or warning signs that indicate anger is building, and using the appropriate strategies from your anger control plans to stop the escalation of anger. If the explosion phase is prevented, the postexplosion phase will not occur and the aggression cycle will be broken.

• What phase of the aggression cycle are you in if you reach a 7 on the anger meter?

• What phase are you in if you reach 10 on the anger meter?


III. Relaxation Through Progressive Muscle Relaxation
Last week you practiced deep-breathing as a relaxation technique. This week you are introduced to progressive muscle relaxation. You should practice this exercise as often as possible.
Here are the directions.
Take a moment to settle in. Now, as you did last week, begin to focus on your breathing. Take a deep breath. Hold it for a second. Now exhale fully and completely. Again, take a deep breath. Fill your lungs and chest. Now release and exhale slowly. Again, one
more time, inhale slowly, hold, and release.
Now, while you continue to breathe deeply and fully, bring your awareness to your hands. Clench your fists very tightly. Hold that tension. Now relax your fists, letting your fingers unfold and letting your hands completely relax. Again, clench your fists tightly. Hold, and release. Imagine all the tension leaving your hands down to your fingertips. Notice the difference between the tension and complete relaxation.

Now bring your awareness to your arms. Curl your arms as if you are doing a bicep curl. Tense your fists, forearms, and biceps. Hold the tension, and release. Let your arms unfold and your hands float back to your thighs. Feel the tension drain out of your arms. 22 Anger Management for Substance Abuse and Mental Health Clients Again, curl your arms to tighten your biceps. Notice the tension, hold, and release. Let the tension flow out of your arms. Replace it with deep muscle relaxation.

Now raise your shoulders toward your ears. Really tense your shoulders. Hold the tension for a second. Now gently drop your shoulders and release all the tension. Again, lift your shoulders, hold the tension, and release. Let the tension flow from your shoulders all the way down your arms to your fingers. Notice how different your muscles feel when they are relaxed.

Now bring your awareness to your neck and your face. Tense all those muscles by making a face. Tense your neck, jaw, and forehead. Hold the tension, and release. Let the muscles of your neck and jaw relax. Relax all the lines in your forehead. One more time, tense all the muscles in your neck and face, hold, and release. Be aware of the muscles relaxing at the top of your head and around your eyes. Let your eyes relax in their sockets, almost as if they were sinking into the back of your head. Relax your jaw and your throat. Relax all the muscles around your ears. Feel all the tension in your neck muscles release.

Now just sit for a few moments. Scan your body for any tension and release it. Notice how your body feels when your muscles are completely relaxed.
When you are ready, open your eyes. How was that? Did you notice any new sensations? How does your body feel now? How about your state of mind? Do you notice any difference now from when you started?

IV. Monitoring Anger for the Week
1) What was the highest number you reached on the anger meter during the past week?

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2) What was the event that triggered your anger?

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Participant Workbook
3) What cues were associated with the anger-provoking event?
Physical cues

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Behavioral cues

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Emotional cues

_____________________________________________________________

Cognitive cues

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4) What strategies did you use to avoid reaching 10 on the anger meter?

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• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

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Anger Management for Substance Abuse and Mental Health Clients

Notes
In this session, you will learn about the A-B-C-D Model as a form of cognitive restructuring. You will also learn about thought stopping, an alternative to the A-B-C-D Model.

I. The A-B-C-D Model
The A-B-C-D Model (see next page) is consistent with the way some people conceptualize anger management treatment. In this model, “A” stands for an activating event. The activating event is the “event” or red-flag event. “B” represents our beliefs about the activating event. It is not the events themselves that produce feelings such as anger; it is our interpretations and beliefs about the events. “C” stands for the emotional consequences. These are the feelings experienced.
as a result of interpretations and beliefs concerning the event. “D” stands for dispute. This part of the model involves identifying any irrational beliefs and disputing them with more rational or realistic ways of looking at the activating event. The idea is to replace self-statements that lead to, or escalate, anger with ideas that allow you to have a more realistic and accurate interpretation of the event.

- What does each of the letters of the A-B-C-D Model stand for?
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- List some of your irrational beliefs.
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- How might you dispute these beliefs?
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II. Thought stopping
A second approach to controlling our anger is called “thought stopping.” Thought stopping is an alternative to the A-B-C-D Model. In this approach, you simply tell yourself through a series of self-commands to stop thinking the thoughts that are making you angry. For example, you might tell yourself, “I need to stop thinking these thoughts. I will only get into trouble if I keep thinking this way,” or “Don’t buy into this situation,” or “Don’t go there.” In other words, instead of trying to dispute your thoughts and beliefs as outlined in the A-B-C-D Model above, the goal is to stop your current pattern of angry thoughts before they lead to an escalation of anger and a loss of control.

- What are some other examples of thought-stopping statements you can use when you become angry?

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Anger Management for Substance Abuse and Mental Health Clients

A-B-C-D Model*

A = Activating Situation or Event
B = Belief System
What you tell yourself about the event (your self-talk)
Your beliefs and expectations of others
C = Consequence
How you feel about the event based on your self-talk
D = Dispute
Examine your beliefs and expectations
Are they unrealistic or irrational?

III. Monitoring Anger for the Week

1) What was the highest number you reached on the anger meter during the past week?

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2) What was the event that triggered your anger?

_____________________________________________________________
3) What cues were associated with the anger-provoking event?
   Physical cues
   __________________________
   __________________________

   Behavioral cues
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   Emotional cues
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   Cognitive cues
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4) What strategies did you use to avoid reaching 10 on the anger meter?
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• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.
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Anger Management for Substance Abuse and Mental Health Clients
Session 6:
Review Session
In this session, you will review and summarize the basic concepts of anger management presented thus far. If you have any questions or you are unclear about any of the concepts or strategies, ask the group leader to further review this material with you.

I. Monitoring Anger for the Week
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?
Physical cues

Behavioral cues

Emotional cues
Cognitive cues

4) What strategies did you use to avoid reaching 10 on the anger meter?

• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

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Sessions 7 & 8:
Assertiveness and the Conflict Resolution Model
In these two sessions, you will learn about assertiveness and the Conflict Resolution Model and how acting in an assertive manner can reduce conflicts you have with others.
I. Assertiveness Training
As you remember from session 1, aggression is behavior that is intended to cause harm to another person or damage to property. This behavior can include verbal abuse, threats, or violent acts. Often, the first reaction when another person has violated your rights is to fight back or retaliate. The basic message of aggression is that *my* feelings, thoughts, and beliefs are very important and *your* feelings, thoughts, and beliefs are unimportant and inconsequential. One alternative to aggressive behavior is to act passively or in a nonassertive manner. This behavior is undesirable because you allow your rights to be violated. You may resent the person who violated your rights, and you may also be angry with yourself for not standing up for your rights. The basic message of passivity is that *your* feelings, thoughts, and beliefs are very important but *my* feelings, thoughts, and beliefs are unimportant and inconsequential. From an anger management perspective, the best way to deal with a person who has violated your rights is to act assertively. Acting assertively involves standing up for your rights in such a way that is respectful of other people. The basic message of assertiveness is that *my* feelings, thoughts, and beliefs are important and *your* feelings, thoughts, and beliefs are equally important. By acting assertively, you can express your feelings, thoughts, and beliefs to the person who violated your rights without suffering the negative consequences associated with aggression or the devaluation of yourself associated with passivity or nonassertion. It is important to emphasize that assertive, aggressive, and passive responses are learned behaviors; they are not innate, unchangeable traits. By practicing the Conflict Resolution Model, you can learn to develop assertive responses that will allow you to manage interpersonal conflicts in a more effective way.

• What are some problems that you may experience if you act aggressively during conflicts with others?

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• What are some problems that you may experience if you respond passively during conflicts?
• What are some of the advantages of acting assertively when trying to resolve conflicts?

II. Conflict Resolution Model
The Conflict Resolution Model is one method you can use to act assertively. It involves five steps that can easily be memorized.
1) Identifying the Problem. This step involves identifying the specific problem that is causing the conflict (e.g., a friend’s not being on time when you come to pick him or her up).
2) Identifying the Feelings. In this step, you identify the feelings associated with the conflict (e.g., frustration, hurt, or annoyance).
3) Identifying the Specific Impact. This step involves identifying the specific impact or outcome of the problem that is causing the conflict (e.g., being late for the meeting that you and your friend plan to attend).
4) Deciding Whether To Resolve the Conflict. This step involves deciding whether to resolve the conflict or let it go. In other words, is the conflict important enough to bring up?
5) Addressing and Resolving the Conflict. In this step, you set up a time to address the conflict, describe how you perceive it, express your feelings about it, and discuss how it can be resolved.
• Identify the five steps of the Conflict Resolution Model, and apply it to an example of your own.

III. Monitoring Anger for the Week
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?
   Physical cues

   Behavioral cues

   Emotional cues
Cognitive cues

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Participant Workbook
4) What strategies did you use to avoid reaching 10 on the anger meter?

• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

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Anger Management for Substance Abuse and Mental Health Clients
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Sessions 9 & 10:

Anger and the Family
In these two sessions, you will learn how anger and other emotions were expressed in your family. This involves analyzing how past family interactions affect current thoughts, feelings, and behavior.
I. Anger and the Family

For many of us, the interactions we had with our parents have strongly influenced our behaviors, thoughts, feelings, and attitudes as adults. With regard to anger and its expression, these feelings and behaviors were usually modeled for us by our parents or parental figures. The following series of questions concerns the interactions you had with your parents and the families that you grew up in. Discussing family issues can sometimes bring up uncomfortable feelings. Be sure to discuss these feelings with the group leader or your counselor.

• Describe your family. Did you live with both parents? Did you have any brothers and sisters? Where did you grow up?

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• How was anger expressed in your family while you were growing up? How did your father express anger? How did your mother express anger? Were you ever threatened with physical violence? Was your father abusive to your mother or you?

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• How were other emotions, such as happiness and sadness, expressed in your family? Was emotional expression limited to feelings of anger and frustration, or were many different kinds of emotions expressed?

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• How were you disciplined and by whom? Was physical punishment involved (e.g., being hit with hands, belts, switches, or other objects)? How did you respond to this discipline?

• What role did you take in your family? For example, were you the hero, the rescuer, the victim, the clown, the scapegoat, etc.?

• What messages did you receive about your father and men in general? What messages did you receive about your mother and women in general?

• What feelings, thoughts, and behaviors carry over into your relationships today? What purpose
do these behaviors serve today? What would happen if you gave up these behaviors?

II. Monitoring Anger for the Week
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?
   Physical cues
   Behavioral cues
   Emotional cues
   Cognitive cues

4) What strategies did you use to avoid reaching 10 on the anger meter?
• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

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Anger Management for Substance Abuse and Mental Health Clients

Session 11:
Review Session

In this session, you will review and summarize the basic concepts of anger management that have been presented in the group. If you have any questions or are unclear about any of the concepts or strategies, ask the group leader to further review this material with you.

I. Monitoring Anger for the Week
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?
Physical cues

Behavioral cues

Emotional cues

Cognitive cues

4) What strategies did you use to avoid reaching 10 on the anger meter?

• For each day of the upcoming week, monitor and record the highest number you reach on the anger meter.

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Anger Management for Substance Abuse and Mental Health Clients
Session 12:

Closing and Graduation
In this final session, you will review your anger control plans and rate the treatment components for their usefulness and familiarity. You will also complete a closing exercise and be awarded a certificate of completion.

I. Closing Exercise
   • What have you learned about anger management?

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   • List the strategies on your anger control plan. How can you use these strategies to better manage your anger?

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   • In what ways can you continue to improve your anger management skills? Are there any specific areas that need improvement?

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Appendix:

Authors’ Acknowledgments

The authors would like to acknowledge the following clinicians and researchers for their various contributions to the development of *Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual*:

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5. Youth Violence Prevention Research and Resources

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MODEL PROGRAMS: VIOLENCE PREVENTION

- [Functional Family Therapy c](#)
- [Multidimensional Treatment Foster Care c](#)
- [Multisystemic Therapy (MST) c](#)
- [Prenatal and Infancy Home Visitation by Nurses c](#)
• Seattle Social Development Project c s

MODEL PROGRAMS: RISK PREVENTION

• Life Skills Training (LST) s
• Midwestern Prevention Project s

PROMISING PROGRAMS: VIOLENCE PREVENTION

• Intensive Protective Supervision Project c
• Montreal Longitudinal Study/Preventive Treatment Program s
• Perry Preschool Program s
• School Transitional Environmental Program (STEP) s
• Striving Together to Achieve Rewarding Tomorrows, CASASTART, formerly Children At Risk (CAR) Program c
• Syracuse Family Development Research Program c

PROMISING PROGRAMS: RISK PREVENTION

• Bullying Prevention Program s
• Families and Schools Together (FAST Track) c s
• Good Behavior Game s
• I Can Problem Solve c s
• The Incredible Years Series c s
• Iowa Strengthening Families Program s
• Linking the Interests of Families and Teachers (LIFT) s
• Parent Child Development Center Programs c
• Parent-child Interaction Training c
• Preparing for the Drug-free Years c
• Preventive Intervention s
• Promoting Alternative Thinking Strategies (PATHS) c s
• Quantum Opportunities Program s
• Yale Child Welfare Project c

Social scientists have made great progress in understanding the causes and correlates of youth violence. Brief descriptions of the 27 programs* that meet the U.S. Surgeon General's rigorous scientific standards are presented below. School-based programs are denoted by s. Community-based programs are denoted by c.

MODEL PROGRAMS: VIOLENCE PREVENTION
Functional Family Therapy

**Target:** Youth ages 11 to 18 at risk of or already demonstrating a broad range of acting-out behaviors.

**Description:** Multistep, phased intervention that provides customized direct services to youth and their families. Delivered in multiple settings by supervised paraprofessionals, trained probation officers, mental health technicians, and mental health professionals.

**Benefits:** Effective treatment of conduct disorder, oppositional defiant disorder, disruptive behavior disorder, and alcohol and other drug abuse disorders; reductions in need for more restrictive, costly services and other social services; reductions in incidence of original problem addressed; reductions in proportion of young people who eventually enter adult criminal justice system; fewer siblings with juvenile court records 2.5 to 3.5 years following the program.

**Contact:** James F. Alexander, Ph.D., University of Utah, 801-581-6538.

Multidimensional Treatment Foster Care

**Target:** Teenagers with histories of chronic and severe criminal behavior at risk of incarceration, group or residential treatment, or hospitalization.

**Description:** Multicontextual clinical intervention that involves community foster families plus treatment, intensive supervision, separation from delinquent peers, and biological parent training and other services.

**Benefits:** Reduced time of incarceration, overall arrest rates, drug use, and program dropout rates in treated young people during the first 12 months after participation; more speedy placement of youth in less restrictive, community settings. This community-based treatment is more successful than residential treatment.

**Contact:** Patricia Chamberlain, Ph.D., Oregon Social Learning Center, 541-485-2711.

Multisystemic Therapy (MST)

**Target:** Families with children in the juvenile justice system who are violent, or substance-abusing, or chronic offenders, ages 12 to 17, at high risk of out-of-home placement.

**Description:** Intensive family- and community-based treatment implemented within a network of interconnected systems that includes one or more contexts: individual, family, peer, school, and neighborhood. Home-
based model delivers strategic family therapy, structural family therapy, behavioral parent training, and cognitive-behavioral therapy.

**Benefits:** Reductions in long-term rates of re-arrest, reductions in out-of-home placements, improvements in family functioning, reductions in mental health problems among treated youth compared to controls.

**Contact:** Scott W. Henggeler, Ph.D., Family Services Research Center, Medical University of South Carolina, 843-876-1800.

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**Prenatal and Infancy Home Visitation by Nurses**

**Target:** At-risk, low-income pregnant young women bearing their first child.

**Description:** The sole home visitation program that meets the criteria for model youth violence prevention program. Intensive, comprehensive home visitation by nurses during pregnancy and first 2 years after birth of child; aims to improve pregnancy outcomes and child care, health, and development; build social support network around family; and enhance mothers’ personal development.

**Benefits:** Positive long-term effects on youth violence and related outcomes, including fewer arrests and less alcohol use by young people at age 15, and 79 percent lower rates of child abuse and neglect by youthful mothers.

**Contact:** David L. Olds, Ph.D., Prevention Research Center for Family and Child Health, Denver, CO, 303-864-5200.

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**Seattle Social Development Project**

**Target:** General populations and high-risk children in elementary and middle school, and their parents and teachers.

**Description:** Classroom behavior management, child skills training, and parent training program to enhance elementary school students’ bonds with school and families while decreasing several early risk factors for violence; promotes prosocial behavior, interpersonal problem solving, academic success, and avoidance of drugs.

**Benefits:** Reduces initiation of alcohol, marijuana, and tobacco use by grade 6, and improves attachment and commitment to school. At age 18, young people who participated in the full 5-year version had lower rates of violence, heavy drinking, and sexual activity (including multiple sexual partners and pregnancy), and better academic performance than controls.

**Contact:** J. David Hawkins, Ph.D., Social Development Research Group, University of Washington, 206-286-1805.
MODEL PROGRAMS: RISK PREVENTION

Life Skills Training (LST)

**Target:** Students in middle or junior high school, with initial implementation in grades 6 and 7 and booster sessions for the next 2 years.

**Description:** School-based skill- and competency-building program to prevent or reduce gateway drug use, promote self-management and social skills, and provide information related to drug use.

**Benefits:** Can cut tobacco, marijuana, and alcohol use. Long-term effects include reducing risk of polydrug use, pack-a-day smoking, and use of inhalants, narcotics, and hallucinogens.

**Contact:** Gilbert Botvin, Ph.D., Institute for Prevention Research, Cornell University Medical College, 212-746-1270.

Midwestern Prevention Project

**Target:** Middle-school students (grades 6 or 7).

**Description:** School-based skill- and competency-building program to reduce risk of gateway drug use associated with transition from early adolescence to middle through late adolescence; trains young people to avoid drug use and situations in which drugs are likely to be used. Implements five major components in steps over 4 years: a mass media program, a school program, parent education and organization, community organization, and local health policy.

**Benefits:** Reduces daily smoking and marijuana use; lessens marijuana and hard drug use, and smoking through age 23; facilitates improvements in parent-child communication about drug use and in development of prevention programs, activities, and services within communities.

**Contact:** Mary Ann Pentz, Ph.D., and Sadina Rothspan, Ph.D., University of Southern California School of Medicine, 213-764-0325.

PROMISING PROGRAMS: VIOLENCE PREVENTION

Intensive Protective Supervision Project

**Target:** Delinquent youth under age 16 (status offenders).

**Description:** Removes delinquent youth from criminal justice institutions; provides them with proactive and extensive community supervision, home visitations, and individualized service plans based on external evaluations.

**Benefits:** Greater deterrent effects on referrals to juvenile court than
standard protective supervision.

Contact: Kathy Dudley, Juvenile Services Division, Administrative Office of the Courts, Raleigh, NC, 919-662-4738.

Montreal Longitudinal Study/Preventive Treatment Program s

Target: Boys ages 7 to 9 identified as disruptive, in families with low socioeconomic status, and their parents.

Description: Delinquency prevention program that provides school-based social skills training and parent training; parents are trained to read with their children, monitor and reinforce their children’s behavior, use effective discipline, and manage family crises.

Benefits: Long-term positive effects for Canadian boys in academic achievement and avoidance of gang involvement, drug and alcohol use, and delinquency up to age 15.

Contact: Richard E. Tremblay, Université de Montréal, Canada, 514-343-6963.

Perry Preschool Program s

Target: Children ages 3 and 4 in families with low socioeconomic status.

Description: High-quality early childhood education that promotes young children’s intellectual, social, and physical development; weekly home visits by teachers, and referrals for social services, when needed.

Benefits: Long-term effects (up to age 19) on academic achievement and other school-related outcomes; significant reductions in antisocial behavior, serious fights, police contacts, and school dropout rates.


School Transitional Environmental Program (STEP) s

Target: Students at large, urban junior high and high schools with multiple feeders.

Description: A program to reduce the stress and disorganization often associated with changing schools by redefining the role of homeroom teachers; it uses behavior management to create an environment that promotes academic achievement and reduces school behavior problems and absenteeism.

Benefits: Reduces substance use and delinquency, and improves academic
achievement and school dropout rates. Most successful with students entering junior and senior high schools in urban, predominantly nonwhite communities. Also effective with students at high risk of behavioral problems.

Contact: Robert D. Felner, Ph.D., University of Rhode Island, 401-277-5045.

**Striving Together to Achieve Rewarding Tomorrows, CASASTART, formerly Children At Risk (CAR) Program**

**Target:** At-risk young people ages 11 to 13 who live in severely distressed neighborhoods.

**Description:** Each core component targets a different context that affects risk of violence: community-enhanced policing and enhanced enforcement; case management for youth and families; criminal/juvenile justice intervention; family services; after-school and summer activities; educational services, mentoring, and incentives for participation.

**Benefits:** Positive effects on gateway drug use, violent crime, and drug sales, up to 1 year after participation.

Contact: Adele Harrell, The Urban Institute, Washington, DC, 202-261-5709.

**Syracuse Family Development Research Program**

**Target:** Parents and children in impoverished families.

**Description:** Weekly home visitation with parent training by paraprofessional child development trainers and 5-year individualized day care that includes child training on social and cognitive skills and behavior management.

**Benefits:** Reduced juvenile delinquency and improved school functioning.

Contact: J. Ronald Lally and Peter L. Mangione, Center for Child and Family Studies, Far West Laboratory for Educational Research and Development; Alice S. Honig, Syracuse University, 315-443-4296. (No technical assistance available for program implementation.)

**PROMISING PROGRAMS: RISK PREVENTION**

**Bullying Prevention Program**

**Target:** Elementary, middle, and junior high school students.

**Description:** Using anonymous student questionnaires to assess bullying
problems in school, parents and teachers implement school, classroom, and individual-level interventions to address bullying problems. The program includes individual work with students identified as bullies and victims, and establishes and reinforces a set of rules about behavior and bullying, creating a positive, antibullying climate.

**Benefits:** Both individual change and environmental change objectives were achieved in programs in Norway, England, Germany, and the United States.

**Contact:** Dan Olweus, Ph.D., University of Bergen, Norway, phone 47-55-58-23-27.

### Families and Schools Together (FAST Track) c s

**Target:** Children in grades 1 to 6 that were identified as disruptive in kindergarten.

**Description:** Long-term, comprehensive program to prevent chronic, severe conduct problems by increasing communication and strengthening bonds among school, home, and child, thereby enhancing social, cognitive, and problem-solving skills and improving peer relationships; combines effective strategies of social skills training, parent training, home visitation, academic tutoring, and classroom behavior management techniques.

**Benefits:** Positive effects on several risk factors associated with youth violence, including academic achievement and parent-child relationships. Initial evaluations showed no effects on children’s antisocial behaviors, but ongoing long-term follow-up studies may determine FAST Track’s effect on this violence-related outcome.

**Contact:** Karen Bierman and Mark Greenberg, Pennsylvania State University, 814-863-0112; Kenneth Dodge, Duke University; Ellen Pinderhughes, Vanderbilt University; Robert McMahon, University of Washington; John Lochman, University of Alabama-Birmingham.

### Good Behavior Game s

**Target:** Elementary school students.

**Description:** A program to improve psychological well-being and decrease early aggressive or shy behavior, mainly through classroom behavior management.

**Benefits:** Reduces antisocial, aggressive behavior, but effects on violence and delinquency not yet measured.

**Contact:** Sheppard G. Kellam, M.D., American Institutes for Research, 202-944-5418.
I Can Problem Solve

**Target:** Students in preschool, kindergarten, and grades 5 and 6.

**Description:** School- and community-based program trains children to use problem-solving skills to find solutions to interpersonal problems.

**Benefits:** Improved classroom behavior and children’s problem-solving skills for up to 4 years after end of intervention; appropriate for all children, but most effective with children living in poor, urban areas.

**Contact:** Myrna B. Shure, Ph.D., M.C.P., Hahnemann University, 215-762-7205.

The Incredible Years Series

**Target:** At-risk children ages 3 to 8.

**Description:** Series of curricula for parents, teachers, and children aimed at promoting social competence and preventing, reducing, and treating conduct problems. Parent-training component focuses mainly on parent competence and school involvement; teacher-training component targets classroom behavior management; child-training component includes sessions on social skills, empathy, anger management, and conflict resolution.

**Benefits:** Positive effects on child conduct at home and cognitive problem solving with peers.


Iowa Strengthening Families Program

**Target:** Students in grade 6 and their families.

**Description:** Skills training program for students and parents designed to improve parenting skills and family communication.

**Benefits:** Reduced alcohol initiation 2 years after intervention; lower rates of tobacco, alcohol, and marijuana use and drunkenness after 4 years; short-term gains demonstrated in parenting practices, parent-child communication, and family bonding. Evaluated in rural, Midwestern schools with primarily white, middle-class students.

**Contact:** Richard Spoth, Iowa State University, 515-294-4518, www.exnet.iastate.edu.

Linking the Interests of Families and Teachers (LIFT)
**Target:** Students in grades 1 and 5 and their parents.

**Description:** School-based skills training and parent training on reducing children’s antisocial behaviors, involvement with delinquent peers, and drug and alcohol use.

**Benefits:** Less physical aggression on the playground, better social skills, and over the long term, less likelihood of associating with delinquent peers, using alcohol, or being arrested.

**Contact:** John B. Reid, Oregon Social Learning Center, 541-485-2711.

**Parent Child Development Center Programs c**

**Target:** Low-income families with children ages 2 months to 3 years.

**Description:** Broad range of family services; parent training component targets mothers as primary caregivers and focuses on infant and child development, home management, and family communication and interaction skills.

**Benefits:** Positive effects on a variety of risk factors for youth violence, including child antisocial behavior and fighting, and mother-child relationships.

**Contact:** Dale Johnson-Stone, University of Houston-University Park, 713-743-8612.

**Parent-Child Interaction Training c**

**Target:** Low-income parents with preschool children who have at least one behavioral or emotional problem.

**Description:** Training on a variety of parenting skills, such as child behavior management.

**Benefits:** Improved family management practices and reduced children’s antisocial behaviors, including aggression and anxiety.

**Contact:** Dr. Joseph Strayhorn, Early Childhood Behavior Disorders Clinic, Allegheny Square, Suite 414, Pittsburgh, PA 15212.

**Preparing for the Drug-free Years c**

**Target:** Middle school students and their families.

**Description:** Family competency training program that promotes healthy, protective parent-child interactions. Includes skills training about peer pressure for young people; parent component focuses on risk factors and family protective factors for adolescent substance use, effective parenting skills, managing anger and family conflict, and facilitating positive child
involvement in family activities.

**Benefits:** Positive effects on child-family relationships and avoidance of alcohol, tobacco, and marijuana use for up to 4 years after participation. Implemented successfully in the rural Midwest.

**Contact:** J. David Hawkins, Ph.D., Social Development Research Group, University of Washington, 206-685-1997.

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**Preventive Interventions**

**Target:** Students in grade 7 with low academic motivation, family problems, or disciplinary problems.

**Description:** Behavior monitoring and reinforcement in the classroom, plus enhanced communication (with regular classroom meetings and reports to parents) among teachers, students, and parents about school behavior and attendance.

**Benefits:** Positive effects on several aspects of academic achievement; reduced drug use and risk of having a county court record 5 years after participation.

**Contact:** Brenna H. Bry, Ph.D., Graduate School of Applied and Professional Psychology, Box 819, Rutgers University, Piscataway, NJ 08854.

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**Promoting Alternative Thinking Strategies (PATHS) Programs**

**Target:** Students entering school through grade 5.

**Description:** School- and community-based program targets emotional competence (expression, understanding, and regulation), self-control, social competence, positive peer relations, and interpersonal problem-solving skills.

**Benefits:** Positive effects on several risk factors associated with violence, including aggressive behavior, anxiety and depression, conduct problems, and lack of self-control; effective for both regular and special education students.

**Contact:** Mark T. Greenberg, Department of Human Development and Family Studies, Pennsylvania State University, University Park, 814-863-0112.

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**Quantum Opportunities Program(s)**

**Target:** Students, assigned to a peer group and a caring adult, receive educational services, activities to enhance personal development, life skills,
career planning, and service opportunities in the community.  
**Description:** Positive effects on several aspects of academic achievement.  
**Benefits:** Positive effects on several risk factors associated with violence, including aggressive behavior, anxiety and depression, conduct problems, and lack of self-control; effective for both regular and special education students.  
**Contact:** C. Benjamin Lattimore, Opportunities Industrialization Centers of America, Philadelphia, 215-236-4500 x251; Andrew Hahn, Brandeis University, 617-736-3851.

**Yale Child Welfare Project c**

**Target:** Healthy, first-born infants of mothers with incomes below poverty level who live in inner cities.  
**Description:** In-home visitation and day care program that delivers parent training and other family and child services, including medical care, psychological services, and early education.  
**Benefits:** Positive effects on parent involvement in children’s education, academic achievement, and antisocial behavior.  
**Contact:** No technical assistance available for program implementation.

**6. References**


