

# ANGER CONTROL PROBLEMS

## BEHAVIORAL DEFINITIONS

1. Shows a pattern of episodic excessive anger in response to specific situations or situational themes.
2. Shows a pattern of general excessive anger across many situations.
3. Shows cognitive biases associated with anger (e.g., demanding expectations of others, overly generalized labeling of the targets of anger, anger in response to perceived “slights”).
4. Shows direct or indirect evidence of physiological arousal related to anger.
5. Reports a history of explosive, aggressive outbursts out of proportion with any precipitating stressors, leading to verbal attacks, assaultive acts, or destruction of property.
6. Displays overreactive verbal hostility to insignificant irritants.
7. Engages in physical and/or emotional abuse against significant other.
8. Makes swift and harsh judgmental statements to or about others.
9. Displays body language suggesting anger, including tense muscles (e.g., clenched fist or jaw), glaring looks, or refusal to make eye contact.
10. Shows passive-aggressive patterns (e.g., social withdrawal, lack of complete or timely compliance in following directions or rules, complaining about authority figures behind their backs, uncooperative in meeting expected behavioral norms) due to anger.
11. Passively withholds feelings and then explodes in a rage.
12. Demonstrates an angry overreaction to perceived disapproval, rejection, or criticism.
13. Uses abusive language meant to intimidate others.
14. Rationalizes and blames others for aggressive and abusive behavior.
15. Uses aggression as a means of achieving power and control.

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## LONG-TERM GOALS

1. Learn and implement anger management skills to reduce the level of anger and irritability that accompanies it.
2. Increase respectful communication through the use of assertiveness and conflict resolution skills.
3. Develop an awareness of angry thoughts, feelings, and actions, clarifying origins of, and learning alternatives to aggressive anger.
4. Decrease the frequency, intensity, and duration of angry thoughts, feelings, and actions and increase the ability to recognize and respectfully express frustration and resolve conflict.
5. Implement cognitive behavioral skills necessary to solve problems in a more constructive manner.
6. Come to an awareness and acceptance of angry feelings while developing better control and more serenity.
7. Become capable of handling angry feelings in constructive ways that enhance daily functioning.
8. Demonstrate respect for others and their feelings.

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## SHORT-TERM OBJECTIVES

1. Work cooperatively with the therapist to identify situations, thoughts, and feelings associated with anger, angry verbal and/or behavioral actions, and the targets of those actions. (1, 2)

## THERAPEUTIC INTERVENTIONS

1. Develop a level of trust with the client; provide support and empathy to encourage the client to feel safe in expressing his/her angry emotions as well as the impact anger expression has had

on his/her life as the interview focuses on the impact of anger on the client's life.

2. As the client describes his/her history and nature of anger issues in his/her own words, thoroughly assess the various stimuli (e.g., situations, people, thoughts) that have triggered the client's anger and the thoughts, feelings, and actions that have characterized his/her anger responses.
2. Complete psychological testing or objective questionnaires for assessing anger expression. (3)
3. Administer to the client psychometric instruments designed to objectively assess anger expression (e.g., *Anger, Irritability, and Assault Questionnaire*; *Buss-Durkee Hostility Inventory*; *State-Trait Anger Expression Inventory*); give the client feedback regarding the results of the assessment; re-administer as indicated to assess treatment response.
3. Cooperate with a medical evaluation to assess possible medical conditions contributing to anger control problems. (4)
4. Refer the client to a physician for a complete medical evaluation to rule out medical conditions or substances possibly causing or contributing to the anger control problems (e.g., brain damage, tumor, elevated testosterone levels, stimulant use).
4. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (5, 6, 7, 8)
5. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change;

demonstrates ambivalence regarding the “problem described” and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the “problem described,” is not concerned, and has no motivation to change).

6. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).
7. Assess for any issues of age, gender, or culture that could help explain the client’s currently defined “problem behavior” and factors that could offer a better understanding of the client’s behavior.
8. Assess for the severity of the level of impairment to the client’s functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
- ▼ 5. Cooperate with a medication evaluation for possible treatment
9. Assess the client for the need and willingness to take psychotropic

with psychotropic medications to assist in anger control; take medications consistently, if prescribed. (9, 10)

medication to assist in control of anger; refer him/her to a physician for an evaluation and prescription of medication, if needed. ▽

- ▽ 6. Keep a daily journal of persons, situations, and other triggers of anger; record thoughts, feelings, and actions taken. (11, 12)
- ▽ 7. Verbalize increased awareness of anger expression patterns, their causes, and their consequences. (13, 14, 15, 16)
10. Monitor the client for prescription compliance, effectiveness, and side effects; provide feedback to the prescribing physician. ▽
11. Ask the client to self-monitor, keeping a daily journal in which he/she documents persons, situations, thoughts, feelings, and actions associated with moments of anger, irritation, or disappointment (or assign “Anger Journal” in the *Adult Psychotherapy Homework Planner* by Jongsma); routinely process the journal toward helping the client understand his/her contributions to generating his/her anger. ▽
12. Assist the client in generating a list of anger triggers; process the list toward helping the client understand the causes and expressions of his/her anger. ▽
13. Assist the client in re-conceptualizing anger as involving different dimensions (cognitive, physiological, affective, and behavioral) that interact predictably (e.g., demanding expectations not being met leading to increased arousal and anger leading to acting out) and that can be understood, challenged, and changed. ▽
14. Process the client’s list of anger triggers and other relevant

journal information toward helping the client understand how cognitive, physiological, and affective factors interplay to produce anger. ▽

15. Ask the client to list and discuss ways anger has negatively impacted his/her daily life (e.g., hurting others or self, legal conflicts, loss of respect from self and others, destruction of property); process this list. ▽
16. Assist the client in identifying the positive consequences of managing anger (e.g., respect from others and self, cooperation from others, improved physical health, etc.) (or assign “Alternatives to Destructive Anger” in the *Adult Psychotherapy Homework Planner* by Jongsma). ▽
- ▽ 8. Explore motivation and willingness to participate in therapy, and agree to participate to learn new ways to think about and manage anger. (17)
- ▽ 9. Verbalize an understanding of how the treatment is designed to decrease anger and improve the quality of life. (18)
- ▽ 10. Read a book or treatment manual that supplements the therapy by improving understanding of anger and anger control problems. (19)
17. Use motivational interviewing techniques to help the client clarify his/her motivational stage, moving the client to the action stage in which he/she agrees to learn new ways to conceptualize and manage anger. ▽
18. Discuss the rationale for treatment, emphasizing how functioning can be improved through change in the various dimensions of anger; revisit relevant themes throughout therapy to help the client consolidate his/her understanding. ▽
19. Assign the client reading material that educates him/her about anger and its management (e.g., *Overcoming Situational and General Anger: Client Manual* by

Deffenbacher and McKay; *Of Course You're Angry* by Rosselini and Worden; *The Anger Control Workbook* by McKay and Rogers; *Anger Management for Everyone* by Kassiove and Tafrate); process and revisit relevant themes throughout therapy to help the client consolidate his/her understanding of the treatment. ▽

- ▽ 11. Learn and implement calming and coping strategies as part of an overall approach to managing anger. (20)
- ▽ 12. Identify, challenge, and replace anger-inducing self-talk with self-talk that facilitates a less angry reaction. (21, 22, 23)
20. Teach the client calming techniques (e.g., progressive muscle relaxation, breathing induced relaxation, calming imagery, cue-controlled relaxation, applied relaxation, mindful breathing) as part of a tailored strategy for reducing chronic and acute physiological tension that accompanies the escalation of his/her angry feelings. ▽
21. Explore the client's self-talk that mediates his/her angry feelings and actions (e.g., demanding expectations reflected in *should*, *must*, or *have-to* statements); identify and challenge biases, assisting him/her in generating appraisals and self-talk that corrects for the biases and facilitates a more flexible and temperate response to frustration. Combine new self-talk with calming skills as part of a set of coping skills to manage anger. ▽
22. Assign the client a homework exercise in which he/she identifies angry self-talk and generates alternatives that help moderate angry reactions; review; reinforce success,

providing corrective feedback toward improvement. ▽

13. Learn and implement thought-stopping to manage intrusive unwanted thoughts that trigger anger. (24)
- ▽ 14. Verbalize an understanding of assertive communication and how it can be used to express thoughts and feelings of anger in a controlled, respectful way. (25)
- ▽ 15. Learn and implement problem-solving and/or conflict resolution skills to manage interpersonal problems. (26, 27, 28)
23. Role-play the use of relaxation and cognitive coping to visualized anger-provoking scenes, moving from low- to high-anger scenes. Assign the implementation of calming techniques in his/her daily life and when facing anger-triggering situations; process the results, reinforcing success and problem-solving obstacles. ▽
24. Assign the client to implement a “thought-stopping” technique in which he/she shouts STOP to himself/herself in his/her mind and then replaces the thought with an alternative that is calming (or assign “Making Use of the Thought-Stopping Technique” in the *Adult Psychotherapy Homework Planner* by Jongsma); review implantation, reinforcing success and providing corrective feedback for failure.
25. Use instruction, modeling, and/or role-playing to teach the client the distinctive elements as well as the pros and cons of assertive, unassertive (passive), and aggressive communication. ▽
26. Teach the client problem-solving skills (e.g., defining the problem clearly, brainstorming multiple solutions, listing the pros and cons of each solution, seeking input from others, selecting and implementing a plan of action, evaluating the outcome, and readjusting the plan as necessary). ▽



27. Teach the client conflict resolution skills (e.g., empathy, active listening, “I messages,” respectful communication, assertiveness without aggression, compromise); use modeling, role-playing, and behavior rehearsal to work through several current conflicts. ▽
  28. Conduct conjoint sessions to help the client implement assertion, problem-solving, and/or conflict resolution skills in the presence of his/her significant other. ▽
  29. Assist the client in constructing a client-tailored strategy for managing anger that combines any of the somatic, cognitive, communication, problem-solving, and/or conflict resolution skills relevant to his/her needs. ▽
  30. Select situations in which the client will be increasingly challenged to apply his/her new strategies for managing anger. ▽
  31. Use any of several techniques, including relaxation, imagery, behavioral rehearsal, modeling, role-playing, or *in vivo* exposure/behavioral experiments to help the client consolidate the use of his/her new anger management skills. ▽
  32. Monitor the client’s reports of angry outbursts toward the goal of decreasing their frequency, intensity, and duration through the client’s use of new anger management skills (or assign “Alternatives to Destructive Anger” in the *Adult*
- ▽ 16. Practice using new anger management skills in session with the therapist and during homework exercises. (29, 30, 31)
- ▽ 17. Decrease the number, intensity, and duration of angry outbursts, while increasing the use of new skills for managing anger. (32)

*Psychotherapy Homework Planner* by Jongsma); review progress, reinforcing success and providing corrective feedback toward improvement. ▽

- ▽ 18. Verbalize an understanding of relapse prevention and the difference between a lapse and relapse. (33, 34)
- ▽ 19. Identify potential situations that could trigger a lapse and implement strategies to manage these situations. (35, 36, 37, 38)
33. Provide a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it. ▽
34. Discuss with the client the distinction between a lapse and relapse, associating a lapse with an initial and reversible angry outburst and relapse with the choice to return routinely to the old pattern of anger. ▽
35. Identify and rehearse with the client the management of future situations or circumstances in which lapses back to anger could occur. ▽
36. Instruct the client to routinely use the new anger management strategies learned in therapy (e.g., calming, adaptive self-talk, assertion, and/or conflict resolution) to respond to frustrations. ▽
37. Develop a “coping card” or other reminder on which new anger management skills and other important information (e.g., calm yourself, be flexible in your expectations of others, voice your opinion calmly, respect others’ point of view) are recorded for the client’s later use. ▽
38. Schedule periodic “maintenance” sessions to help the client maintain therapeutic gains. ▽

## 24 THE COMPLETE ADULT PSYCHOTHERAPY TREATMENT PLANNER

20. Identify the advantages and disadvantages of holding on to anger and of forgiveness; discuss with therapist. (39, 40)
21. Write a letter of forgiveness to the perpetrator of past or present pain and process this letter with the therapist. (41)
22. Participate in Acceptance and Commitment Therapy (ACT) for learning a new approach to anger and anger management. (42, 43, 44, 45)
39. Discuss with the client forgiveness of the perpetrators of pain as a process of letting go of his/her anger.
40. Assign the client to read *Forgive and Forget* by Smedes; process the content as to how it applies to the client's own life.
41. Ask the client to write a forgiving letter to the target of anger as a step toward letting go of anger; process this letter in session.
42. Use an ACT approach to help the client experience and accept the presence of worrisome thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy* by Hayes, Strosahl, and Wilson).
43. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing but not reacting to non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).
44. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

23. Gain insight into the origins of anger control problems by discussing past relationships with significant others. (46)
  24. Identify social supports that will help facilitate the implementation of anger management skills. (47)
  45. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy* by Hayes).
  46. Assist the client in identifying past relationship conflicts (e.g., with father, mother, others) that may have influenced the development of current anger control problems; discuss how these experiences have positively or negatively influenced the way he/she handles anger.
  47. Encourage the client to discuss his/her anger management goals with trusted persons who are likely to support his/her change.
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## DIAGNOSTIC SUGGESTIONS

Using *DSM-IV/ICD-9-CM*:

<b>Axis I:</b>	312.34	Intermittent Explosive Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder
	312.8	Conduct Disorder
	310.1	Personality Change Due to Axis III Disorder
	309.81	Posttraumatic Stress Disorder

	V61.12	Physical Abuse of Adult (by Partner)
	V61.83	Physical Abuse of Adult (by non-Partner)
<b>Axis II:</b>	301.83	Borderline Personality Disorder
	301.7	Antisocial Personality Disorder
	301.0	Paranoid Personality Disorder
	301.81	Narcissistic Personality Disorder
	301.9	Personality Disorder NOS

Using DSM-5/ICD-9-CM/ICD-10-CM:

<u>ICD-9-CM</u>	<u>ICD-10-CM</u>	<u>DSM-5 Disorder, Condition, or Problem</u>
312.34	F63.81	Intermittent Explosive Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
312.8	F91.x	Conduct Disorder
310.1	F07.0	Personality Change Due to Another Medical Condition
309.81	F43.10	Posttraumatic Stress Disorder
V61.12	Z69.12	Encounter for Mental Health Services for Perpetrator of Spouse or Partner Violence, Physical
V62.83	Z69.82	Encounter for Mental Health Services for Perpetrator of Nonspousal Adult Abuse
301.83	F60.3	Borderline Personality Disorder
301.7	F60.2	Antisocial Personality Disorder
301.0	F60.0	Paranoid Personality Disorder
301.81	F60.81	Narcissistic Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.