Updated 2019

ANGER MANAGEMENT

for Substance Use Disorder and Mental Health Clients

A Cognitive–Behavioral Therapy Manual

SAMHSA
Substance Abuse and Mental Health Services Administration

Anger Management

for Substance Use Disorder and Mental Health Clients

A Cognitive–Behavioral Therapy Manual

UPDATED 2019

Patrick M. Reilly, Ph.D.
Michael S. Shopshire, Ph.D.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

5600 Fishers Lane
Rockville, MD 20857

Acknowledgments

Numerous people contributed to the development of this manual (see appendix). The publication was written by Patrick M. Reilly, Ph.D., and Michael S. Shopshire, Ph.D., of the San Francisco Treatment Research Center. Sharon Hall, Ph.D., was the Treatment Research Center's Principal Investigator.

This publication is, in part, a product of research conducted with support from the National Institute on Drug Abuse, Grant DA 09253, awarded to the University of California–San Francisco. The research for this publication was also supported by funding from the Department of Veterans Affairs to the San Francisco Veterans Affairs Medical Center. This publication was updated under contract number 270-14-0445 by the Knowledge Application Program (KAP) for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Suzanne Wise served as the Contracting Officer's Representative, and Candi Byrne served as Alternate Contracting Officer's Representative. Darrick D. Cunningham, LCSW, BCD, and Arlin Hatch, CDR, USPHS, Ph.D., served as the Product Champions.

Disclaimer

The views, opinions, and content expressed herein are the views of the authors and do not necessarily reflect the official position of SAMHSA. No official support of or endorsement by SAMHSA for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

Public Domain Notice

All materials appearing in this volume except those taken directly from copyrighted sources are in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA.

Electronic Access and Copies of Publication

This publication may be downloaded or ordered at https://store.samhsa.gov or by calling SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Recommended Citation

Reilly, P.M., & Shopshire, M.S. *Anger Management for Substance Use Disorder and Mental Health Clients: A Cognitive–Behavioral Therapy Manual.* SAMHSA Publication No. PEP19-02-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

Originating Office

Quality Improvement and Workforce Development Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA Publication No. PEP19-02-01-001.

Nondiscrimination Notice

SAMHSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad, o sexo.

SAMHSA Publication No. PEP19-02-01-001
First Printed 2002
Updated 2019

FOREWORD

Anger and substance use disorders often co-occur, increasing the risk for negative consequences such as physical aggression, self-harm, distressed relationships, loss of a job, or criminal justice involvement. According to a 2014 meta-analysis of 23 studies, nearly half of people who committed homicides were under the influence of alcohol and 37 percent were intoxicated (Kuhns, Exum, Clodfelter, & Bottia, 2014). Anger, violence, and associated traumatic stress can often correlate with the initiation of drug and alcohol use and can be a consequence of substance use. Individuals who experience traumatic events, for example, may experience anger and act violently, as well as misuse drugs or alcohol.

Clinicians often see how anger and violence and substance use are linked (Shopshire & Reilly, 2013). Many clients with substance use and mental health issues experience traumatic life events, which, in turn, lead to substance use, anger, and increased risk for violence. Meta-analyses have reliably demonstrated the efficacy of cognitive–behavioral therapy in the treatment of addictions and other mental health issues, such as depression, traumatic stress, and anxiety.

To provide clinicians with tools to help deal with this important issue, the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration is pleased to present revised and updated versions of *Anger Management for Substance Use Disorder and Mental Health Clients: A Cognitive–Behavioral Therapy Manual* and its companion book *Anger Management for Substance Use Disorder and Mental Health Clients: Participant Workbook,* which were originally published in 2002.

The anger management treatment design in this manual, which has been delivered to thousands of clients over the past three decades, has been popular with both clinicians and clients. This format of the manual lends itself to use in a variety of clinical settings; can be adapted to accommodate different racial-ethnic minority groups and genders, and diverse treatment settings; and will be a helpful tool for the field.

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration

CONTENTS

Foreword iii

Introduction 1

How To Use This Manual 5

Session 1 Overview of Group Anger Management Treatment 7

Session 2 Events and Cues: A Conceptual Framework for Understanding Anger 15

Session 3 Anger Control Plans: Helping Group Members Develop a Plan for Controlling Anger 21

Session 4 The Aggression Cycle: How To Change the Cycle 27

Session 5 Cognitive Restructuring: The A-B-C-D Model and Thought Stopping 33

Session 6 Practice Session #1: Reinforcing Learned Concepts 37

Sessions 7 & 8 Assertiveness Training and the Conflict Resolution Model: Alternatives for Expressing Anger 39

Sessions 9 & 10 Anger and the Family: How Past Learning Can Influence Present Behavior 45

Session 11 Practice Session #2: Reinforcing Learned Concepts 49

Session 12 Closing and Graduation: Closing Exercise and Awarding of Certificates 51

References 53

Appendix Authors' Acknowledgments 57

INTRODUCTION

This manual, which was originally published in 2002 and has been revised and updated for the current edition, was designed for use by clinicians who work with clients who have substance use and mental health problems co-occurring with anger management problems. In addition, it has been used by individuals for self-paced study outside of a group counseling setting (e.g., by individuals who are incarcerated). The manual describes a 12-week cognitive–behavioral anger management group treatment model. Each of the 12, 90-minute weekly sessions is described in detail with specific instructions for group leaders, tables and exhibits that illustrate the key conceptual components of the treatment, and between-session challenges for group members. The accompanying participant workbook (see *Anger Management for Substance Use Disorder and Mental Health Clients: Participant Workbook*; Reilly, Shopshire, Durazzo, & Campbell, 2019) has been updated to correspond with the updated manual. It should be used in conjunction with this manual to enable group members to better learn, practice, and integrate the treatment strategies presented in the manual. This intervention was developed for studies at the San Francisco Veterans Affairs (SFVA) Medical Center and San Francisco General Hospital (now known as the Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center [Zuckerberg San Francisco General Hospital]).

Cognitive–behavioral therapy (CBT) has been found to be an effective, time-limited treatment for anger problems (Fernandez, Malvaso, Day, & Guharajan, 2018; Henwood, Chou, & Browne, 2015). Four types of CBT interventions, theoretically unified by principles of social learning theory, are most often used when treating anger management problems:

- ***Relaxation training*** targets emotional and physiological components of anger.
- ***Cognitive interventions*** target cognitive processes such as building awareness of cues and triggers, hostile appraisals and attributions, maladaptive beliefs, and inflammatory thinking. (The manual uses the term "trigger" because it will be a familiar concept to group members who have gone through substance use disorder treatment. The term "trigger" is *not* meant to convey that anger is an automatic response that cannot be controlled.)
- ***Communication skills interventions*** target strengthening assertiveness and conflict resolution skills.
- ***Combined interventions*** integrate two or more CBT interventions and target multiple response domains.

Meta-analyses and reviews of the literature (Fernandez et al., 2018; Henwood et al., 2015), including studies of prison populations, conclude that there are clinically significant anger reduction effects as a result of CBT interventions. The treatment model described in this manual is a combined CBT approach that employs relaxation, cognitive, and communication skills interventions.

This combined approach presents group members with options that draw on these different interventions and then encourages them to develop an individualized anger control plan using as many techniques as possible. Not all group members will use all the techniques and interventions

presented in the treatment (e.g., cognitive restructuring), but almost all will finish the treatment with more than one technique or intervention in their anger control plans.

Theoretically, the more techniques and interventions an individual has in his or her anger control plan, the better equipped he or she will be to manage anger in response to anger-provoking events.

In studies at the SFVA Medical Center and the Zuckerberg San Francisco General Hospital using this treatment model, significant reductions in self-reported anger and violence have consistently been found, as well as decreased substance use (Reilly, Clark, Shopshire, & Delucchi, 1995; Reilly & Shopshire, 2000). Most participants in these studies met *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV) (American Psychiatric Association [APA], 1994), criteria for substance dependence and would meet the criteria for substance use disorder as updated in DSM-5 (APA, 2013).

The overall treatment model is flexible; can accommodate racial, cultural, and gender issues; and was found to be effective with different racial-ethnic minority groups and with both men and women (Reilly & Shopshire, 2000). In the anger management studies using this manual, the majority of patients were from racial-ethnic minority groups. The events or situations associated with someone's anger may vary somewhat depending on his or her culture or gender. The cues or warning signs of anger may vary in this regard as well. A person still has to identify the event that led to anger, recognize the cues to anger, and develop anger management (cognitive–behavioral) strategies in response to the event and cues, regardless of whether these events and cues are different for other men and women or for people in other cultural groups.

In addition to the studies in San Francisco, Morland et al. (2010) studied 125 veterans with post-traumatic stress disorder (PTSD) and anger control problems from three Veterans Health Administration clinical sites and three Vet Centers in Hawaii. Participants were randomly assigned to receive the anger management treatment either in face-to-face sessions or over videoconference equipment. Regardless of mode of presentation, participants reduced their levels of anger significantly, suggesting that people can achieve significant reductions in anger levels using many different modes of presentation. Ninety percent of participants completed anger management treatment. Similar to findings from studies at the SFVA Medical Center (Reilly et al., 1995), greater PTSD symptom severity had higher anger levels at baseline, but higher levels of PTSD symptoms did not predict greater anger symptom reductions. Mackintosh et al. (2014) attempted to identify participants who achieved the greatest decrease in anger levels, but patients showed similarly lower levels of anger across a range of psychosocial, racial-ethnic, and psychiatric variables.

A study by Zarshenas, Baneshi, Sharif, and Sarani (2017) suggests the anger management treatment described in this manual may produce clinically significant reductions in levels of anger with participants in other countries. Zarshenas et al. used a quasi-experimental design with a sample of 36 patients at Ebnesina Hospital, in Shiraz, Iran. The group receiving the anger management treatment did not differ from the comparison condition with regard to age, marital status, education level, or substance of choice. Anger and aggression were measured with a questionnaire developed by Buss and Perry (1992). Anger and aggression decreased significantly for participants who received the anger management treatment but increased for the comparison group.

A study by Walitzer, Deffenbacher, and Shyhalla (2015) further illustrates the usefulness of anger management treatments for individuals with substance use disorders. They conducted a randomized controlled trial comparing a 12-session alcohol-adapted anger management treatment similar to the one in this treatment manual with a 12-Step facilitation treatment. The anger management treatment focused on monitoring cues to anger arousal, relaxation training, and cognitive restructuring. Participants were encouraged to use these anger management strategies to cope with anger-related events that could increase the risk of alcohol use or relapse. Participants in both conditions decreased their levels of anger, but in the anger management treatment condition, people who lowered their levels of anger were less likely to experience negative alcohol-related consequences, such as taking foolish risks or damaging a friendship or close relationship.

The intervention involves developing individualized anger control plans. For example, some women identified their relationships with their partners or parenting concerns as events that led to their anger, but men rarely identified these issues. Effective individual strategies could be developed to address these issues, provided the women accept the concepts of monitoring anger (using the anger meter and the anger awareness record) and having (and using) an anger control plan.

This treatment model was also used successfully with clients who were not abusing substances seen in the outpatient SFVA Mental Health Clinic. These clients were diagnosed with a variety of problems, including mood, anxiety, and thought disorders. The treatment components described in this manual served as the core treatment in these studies.

The anger management treatment was designed to be delivered in a group setting. The ideal number of participants in a group is 8, but groups can range from 5 to 10 members. There are several reasons for this recommendation. First, solid empirical support exists for group cognitive–behavioral interventions (Cuijpers, Cristea, Karyotaki, Reijnders, & Huibers, 2016; Owen, Sellwood, Kan, Murray, & Sarsam, 2015); second, group treatment is efficient and cost-effective (Hoyt, 1993; Piper & Joyce, 1996); and third, it provides a greater range of possibilities and flexibility in roleplays (Yalom, 1995) and behavioral rehearsal activities (Heimberg & Juster, 1994; Juster & Heimberg, 1995). Counselors and social workers should have training in CBT, group therapy, and substance use disorder treatment.

Although a group format is recommended for the anger management treatment, it is possible for qualified clinicians to use this manual in individual sessions with their clients (Awalt, Reilly, & Shopshire, 1997). In this case, the same treatment format and sequence can be used. Individual sessions provide more time for indepth instruction and individualized behavioral rehearsal. Reports from practitioners have also established that the manual and workbook have been used for self-study, without the support of a clinician or a group. Although there has been no research into the validity of this use of the manual, anecdotal reports indicate that individuals have had success with it.

The anger management treatment manual is designed for adults (ages 18 and older) who have substance use and mental health conditions. The groups studied at SFVA Medical Center and the Zuckerberg San Francisco General Hospital have included patients who have used many substances (e.g., cocaine, alcohol, heroin, methamphetamine). These patients used the anger management materials and benefited from the group treatment, despite differences in their primary drug of choice.

It is recommended that group members be abstinent from drugs (except for properly used prescription medications) and alcohol for at least 2 weeks before joining the anger management group. If a participant in the San Francisco treatment groups had a "slip" during his or her enrollment in the group, he or she was not discharged from the group. However, if he or she had repeated slips or a relapse, the individual was referred to a more intensive treatment setting and asked to start the anger management treatment again. Group leaders may consider the possible risk-reduction benefits of people participating in this treatment who are not abstinent, as clinically indicated.

Many group members were diagnosed with co-occurring disorders (e.g., PTSD, mood disorder, psychosis) and still benefited from the anger management group treatment. Patients were compliant with their psychiatric medication regimen and were monitored by interdisciplinary treatment teams. The San Francisco group found that, if patients were compliant with their medication regimen and abstinent from drugs and alcohol, they could comprehend the treatment material and effectively use concepts such as timeouts and thought stopping to manage anger. However, if a group member had a history of severe mental illness, did not comply with instructions on his or her psychiatric medication regimen, and had difficulty processing the material or accepting group feedback, he or she was referred to his or her psychiatrist for better medication management.

Because of the many problems often experienced by clients with substance use and mental health conditions, this intervention should be used as an adjunct to treatment for substance use and mental disorders. Certain issues, such as anger related to clients' family of origin and past learning, may best be explored in individual and group therapy outside the anger management group.

Finally, the authors stress the importance of providing ongoing anger management aftercare groups. Participants at the SFVA Medical Center repeatedly asked to attend aftercare groups where they could continue to practice and integrate the anger management strategies they learned in this treatment. At the SFVA Medical Center, both an ongoing drop-in group and a more structured 12-week phase-two group were provided as aftercare components. These groups helped participants maintain (and further reduce) the decreased level of anger and aggression they achieved during the initial 12-week anger management group treatment. Participants can also be referred to anger management groups in the community.

It is hoped that this anger management manual will help clinicians who treat substance use and mental disorders provide effective anger management treatment to clients who experience anger problems. Reductions in frequent and intense anger and its destructive consequences can lead to improved physical and mental health of individuals and families.

HOW TO USE THIS MANUAL

The information presented in this manual is intended to allow professionals who treat clients with mental and substance use disorders to deliver group cognitive–behavioral anger management treatment. With the exception of session 12 (which is a graduation and award ceremony), the chapter for each 90-minute weekly session is divided into four sections:

- Instructions to Group Leaders
- Check-In Procedure (beginning in the second session)
- Suggested Remarks
- Between-Session Challenge

The Instructions to Group Leaders section summarizes the information to be presented in the session and outlines the key conceptual components. The Check-In Procedure section provides a structured process by which group members report on the progress of their between-session challenges from the previous week. The Suggested Remarks section provides narrative scripts for the group leader presenting the material in the session. ***Although the group leader is not required to read the scripts verbatim, the group leader should deliver the information as closely as possible to the way it is in the script.*** The Between-Session Challenge section provides instructions for group members on what tasks to review and practice for the next meeting. Session 1 also includes a special section that provides an overview of the anger management treatment and outlines the group rules.

This manual should be used in conjunction with the *Anger Management for Substance Use Disorder and Mental Health Clients: Participant Workbook* (Reilly et al., 2019). The workbook provides group members with a summary of the information presented in each session, worksheets for completing between-session challenges, and space to take notes during each session. The workbook facilitates the completion of between-session challenges and reinforces the concepts presented over the course of the anger management treatment program.

Although group members are kept busy in each session, 90 minutes should be enough time to complete the tasks at hand. Most sessions include prompts to engage members, but group leaders should feel free to elicit input from the group more frequently. The group leader needs to monitor and may, at times, need to limit the responses of members, however. This can be done by redirecting them to the question or activity.

In practice, some individuals have opted to use this manual for self-directed learning: clarifying their needs, setting goals, learning new information, and choosing and implementing strategies. While a person's motivation and willingness to undertake self-improvement are encouraging, little research has been done on how self-directed learning relates to actual behavior change in anger management.

OVERVIEW OF GROUP ANGER MANAGEMENT TREATMENT

Session 1

Instructions to Group Leaders

In the first session, the leader presents the purpose and overview of the 12 sessions, the group rules, and the conceptual framework and rationale for anger management treatment. Most of this session is spent presenting conceptual information. Because there is a lot of information to communicate, the leader should pause periodically to engage group members in conversation and verify that they understand the concepts. The session concludes with a group exercise in awareness building and a presentation of the anger meter (see Exhibit 1, page 13).

The leader starts the first session by introducing himself or herself and asking group members to share their name, the reasons they are interested in participating in the anger management group, and what they hope to achieve in the group. After a member introduces himself or herself, the leader offers a supportive comment that validates the member's decision to participate in the group. Experience shows that this helps members feel the group will meet their needs and reduces the anxiety associated with the introductions and the first group session in general.

Outline of Session 1

- Instructions to Group Leaders
- Suggested Remarks
  - Purpose and Overview
  - Group Rules
  - The Problem of Anger: Some Operational Definitions
  - When Does Anger Become a Problem?
  - Payoffs and Consequences
  - Myths About Anger
  - Anger as a Habitual Response
  - Changing the Anger Habit
  - Participant Discussion
  - Anger Meter
- Between-Session Challenge

Suggested Remarks

(Use the following script or put it in your own words.)

Purpose and Overview

The purpose of the anger management group is to:

- Learn to manage anger.
- Stop violence or the threat of violence.
- Develop and strengthen skills for self-control over thoughts and actions.
- Receive support and feedback from others.

Group Rules

1. ***Group Safety.*** No violence or threats toward staff and other group members are allowed. It is important that you perceive the group as a safe place to share your experiences and feelings without threats or possible physical harm.

2. *Confidentiality.* You should not discuss outside the group what other group members say during group sessions. There are limits to confidentiality, however. In every state, health laws govern how and when professionals must report certain actions to the proper authorities. These actions may include any physical or sexual abuse inflicted on a child or adolescent younger than age 18, a person age 65 or older, or a dependent adult. A dependent adult is someone between ages 18 and 64 who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights. Reporting abuse of these persons supersedes confidentiality laws involving clients and health professionals. Similarly, if a group member makes credible threats to physically harm or kill another person, the group leader is required, under the *Tarasoff* ruling, to warn the intended victim and notify the police.

3. *Between-Session Challenges.* Brief assignments will be given each week. Doing the between-session challenges will improve your anger management skills and allow you to get the most from the group experience. Like any type of skill acquisition, anger management requires time and practice. These assignments provide the opportunity for skill development and refinement.

4. *Absences and Cancellations.* You should call or notify the group leader in advance when you cannot attend a session. Because of the considerable 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 would not be able to adequately learn, practice, and apply the concepts and skills that are necessary for effective anger management. You can continue to attend the group sessions, but you will not receive a certificate of completion. You can join another session as space becomes available.

5. *Timeout.* The group leader reserves the right to call for a timeout. You may be familiar with the term timeout from sporting events. For example, when a football team feels it is not making progress, the team takes a timeout and regroup. We use this term in a similar way. If a group member's anger begins to escalate out of control during a session, the leader will ask that member to take a timeout from the topic and the discussion. This means that the member, along with the rest of the group, *will immediately stop talking about the issue* that is causing the member's anger to escalate. If the member's anger has escalated to the point that he or she cannot tolerate sitting in the group, the leader may ask the person to leave the group for 5 or 10 minutes or until he or she can cool down. The member is then welcomed back, provided he or she can tolerate continued discussion in the group.

A timeout is an effective anger management strategy and will be discussed in more detail later in this session and in session 3. Eventually, you will learn to call a timeout yourself when you feel you may be losing control as the result of escalation of your anger. For these sessions, however, it is essential that the leader calls for a timeout and that you comply with the rule. This rule ensures that the group will be a safe place to discuss and share experiences and feelings. Failure to comply with the timeout rule may lead to termination from the group.

6. *Relapses.* If a group member has a relapse during enrollment in the group, he or she is not discharged. However, if the group member has repeated relapses, he or she will be asked to start the treatment again and will be referred to a more intensive treatment setting.

(Ask group members if they have questions about the group rules. Use time for discussion if needed.)

The Problem of Anger: Some Operational Definitions

In the most general sense, anger is a feeling or emotion that ranges from mild irritation to intense fury and rage. Anger is a natural response to those situations where we feel threatened, we believe harm will come to us, or we believe that another person has unnecessarily wronged us. We may also become angry when we feel another person, like a child or someone close to us, is being threatened or harmed. Anger can be a positive emotion—a moral response to injustice or a rational response to a threat—and it can be expressed in assertive and productive ways. In addition, anger may result from frustration when our needs, desires, and goals are not being met. When we become angry, we may lose our patience and act impulsively, aggressively, or violently.

People often confuse anger with aggression. Aggression is *behavior* that is intended to cause harm to another person or damage property. This behavior can include verbal abuse, threats, or violent acts. Anger, on the other hand, is an *emotion* and does not necessarily lead to aggression. Therefore, a person can become angry without acting aggressively.

A term related to anger and aggression is hostility. Hostility refers to a complex set of attitudes and judgments that motivate aggressive behaviors. Whereas anger is an emotion and aggression is a behavior, hostility is an *attitude* that involves disliking others and evaluating them negatively.

In this group, you will learn helpful strategies and skills to manage anger, express anger in constructive ways, solve problems, change hostile attitudes, and prevent aggressive acts, such as verbal abuse and violence.

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. During prolonged and frequent episodes of anger, certain parts of the nervous system become highly activated. Consequently, blood pressure and heart rate increase and stay elevated for long periods. This stress on the body may produce many different health problems, such as hypertension, heart disease, and diminished immune system efficiency. Thus, from a health standpoint, avoiding physical illness is a motivation for controlling anger.

Another compelling reason to control anger concerns the negative consequences that result from expressing anger inappropriately. In the extreme, anger may lead to violence or physical aggression, which can result in numerous negative consequences, such as being arrested or jailed, losing your job, being physically injured, being retaliated against, alienating loved ones, being terminated from a substance use disorder treatment or social service program, or feeling guilt, shame, or regret.

Even when anger does not lead to violence, the inappropriate expression of anger, such as verbal abuse or intimidating or threatening behavior, often results in negative consequences. For example, it is likely that others will develop fear, resentment, and lack of trust toward those who subject them to angry outbursts, which may cause alienation from individuals, such as family members, friends, and coworkers.

Payoffs and Consequences

The inappropriate expression of anger initially has many apparent payoffs. One payoff is being able to manipulate and control others through aggressive and intimidating behavior; others may comply with someone's demands because they fear verbal threats or violence. Another payoff is the release of tension that occurs when you lose your temper and act aggressively. You may feel better after an angry outburst, but everyone else may feel worse.

In the long term, however, these initial payoffs lead to negative consequences. For this reason they are called "apparent" payoffs because the long-term negative consequences far outweigh the short-term gains. For example, consider a father who persuades his children to comply with his demands by using an angry tone of voice and threatening gestures. These behaviors imply to the children that they will receive physical harm if they are not obedient. The immediate payoff for the father is that the children obey his commands. The long-term consequence, however, may be that the children learn to fear or dislike him and become emotionally detached from him. As they grow older, they may avoid contact with him or refuse to see him altogether.

Myths About Anger

Myth #1: The Behavioral Expression of Anger Is Fixed and Cannot Be Changed. One misconception or myth about anger is that the way we behaviorally express anger is inherited and cannot be changed. Our facial expressions and our nervous system's response when we become angry are inherited, but what we do next, our behavior, is learned. Sometimes, we may hear someone say, "I inherited my anger from my father; that's just the way I am." This statement implies that the behavioral expression of anger is fixed and cannot be changed. Although to some extent a person's proneness toward anger has a genetic basis, psychological traits, like proneness toward anger, are not fixed. A person's childhood environment plays a major role in determining how a person expresses anger (Buades-Rotger & Gallardo, 2014). Because people are not born with set, specific ways of expressing anger it is possible to learn more appropriate ways of expressing anger. Similarly, it is possible to change the way your nervous system reacts after you get angry. You can learn to calm down more quickly with practice.

The approach to anger management used in this treatment manual was influenced by Bandura's (2018) social cognitive theory, in particular, the assumption that behavior is socially learned. Many studies have established that the way people learn to express anger and violence is by observing others, particularly influential people (Brook, Balka, Zhang, & Brook, 2015; Conger, Neppl, Kim, & Scaramella, 2003). These people include parents, family members, and friends. If children observe parents expressing anger through aggressive acts, such as verbal abuse and violence, it is very likely that they will learn to express anger in similar ways. Fortunately, this behavior can be changed by learning new and appropriate ways of expressing anger. It is not necessary to continue to express anger by aggressive and violent means.

Myth #2: Anger Automatically Leads to Aggression. A related myth involves the misconception that the only effective way to express anger is through aggression. It is commonly thought that anger is something that builds and escalates to the point of an aggressive outburst. As we saw earlier, however, anger does not necessarily lead to aggression. In fact, effective anger management involves controlling the escalation of anger by learning assertiveness skills, changing negative and hostile thoughts or "self-talk," challenging maladaptive beliefs, and

employing a variety of behavioral strategies. These skills, techniques, and strategies will be discussed in later sessions.

Myth #3: People Must Be Aggressive To Get What They 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. For example, if you were upset because a friend was repeatedly late for meetings, you could respond by shouting obscenities and name-calling. This approach is an attack on the other person rather than an attempt to address the behavior that you find frustrating or anger provoking.

An assertive way of handling this situation might be to say, "When you are late for a meeting with me, I get pretty frustrated. I wish that you would be on time more often." This statement expresses your feelings of frustration and dissatisfaction and communicates how you would like the situation changed. This expression does not blame or threaten the other person and minimizes the chance of causing emotional harm. We will discuss assertiveness skills in more detail in sessions 7 and 8.

Myth #4: Venting Anger Is Always Desirable. For many years, the popular belief among numerous mental health professionals and laypeople was that the aggressive expression of anger, such as screaming or beating on pillows, was healthy and therapeutic. Research studies have found, however, that people who express their anger aggressively simply get better at being angry (Lilienfeld, Lynn, Ruscio, & Beverstein, 2010; Olatunji, Lohr, & Bushman, 2007). In other words, expressing anger in an aggressive manner reinforces aggressive behavior.

(Ask group members if they have any questions about anger myths or the problems and consequences of anger. Use time for discussion if needed.)

Anger as a Habitual Response

Not only is the behavioral expression of anger learned, but it can become a routine, familiar, and predictable response to a variety of situations. In the short term, people expressing anger often get their way, so they may keep using anger. When anger is displayed frequently and aggressively, it can become a maladaptive habit because it results in negative consequences. Habits, by definition, are performed over and over again, without thinking. People with anger management problems often resort to aggressive displays of anger to solve their problems, without thinking about the negative consequences they may suffer or the effects it may have on the people around them.

Breaking the Anger Habit

Becoming Aware of Anger. To change the anger habit, you must develop an awareness of the circumstances and behaviors of others that trigger your anger. It's also important to be aware of events or situations that can result in anger, even when others aren't involved—when your car won't start or when your computer malfunctions. This awareness also involves understanding the negative consequences that result from anger. For example, you may be in line at the supermarket and become impatient because the lines are too long. In this case, perhaps your anger is triggered by having your time wasted or by being made late for an appointment. You could become angry and then demand that the checkout clerk call for more help. As your anger escalates, you may become involved in a heated exchange with the clerk or another customer.

The store manager may respond by having a security officer remove you from the store. The negative consequences that result from this event are not getting the groceries that you wanted and the embarrassment and humiliation you suffer from being removed from the store. In session 2, we will introduce the anger meter and the anger awareness record, tools that will help you gain deeper awareness of your anger by helping you track what led to the anger and the consequences of anger episodes.

Strategies for Controlling Anger. In addition to becoming aware of anger, you need to develop skills and strategies to effectively manage it. These strategies can be used to stop the escalation of anger before you experience negative consequences. An effective set of strategies for controlling anger should include immediate, interpersonal, and preventive strategies. Immediate strategies include taking a timeout, deep-breathing exercises, and thought stopping. Interpersonal strategies include strengthening assertive communication and problem solving. Preventive strategies include developing an exercise program and changing your maladaptive beliefs. These strategies will be discussed in more detail in later sessions.

One example of an anger management strategy you can use right now is the timeout. A timeout involves leaving a situation if you feel your anger is escalating out of control. For example, you may be a passenger on a crowded bus and become angry because you perceive that people are deliberately bumping into you. In this situation, you can simply get off the bus and wait for a less crowded bus.

The informal use of a timeout may involve stopping yourself from engaging in a discussion or argument if you feel that you are becoming too angry. In this group, you should call a timeout if you feel that your anger is escalating out of control. This can mean that you stop taking part in a difficult conversation or that you leave the room for a short period if you feel that you need to do so. However, please come back for the remainder of the group session after you have calmed down.

Participant Discussion

(At this point, check back in with group members, perhaps asking them to reintroduce themselves. Ask if anyone has any questions and inquire about their impressions of the information presented thus far. As time allows, engage the group in discussion.)

Anger Meter

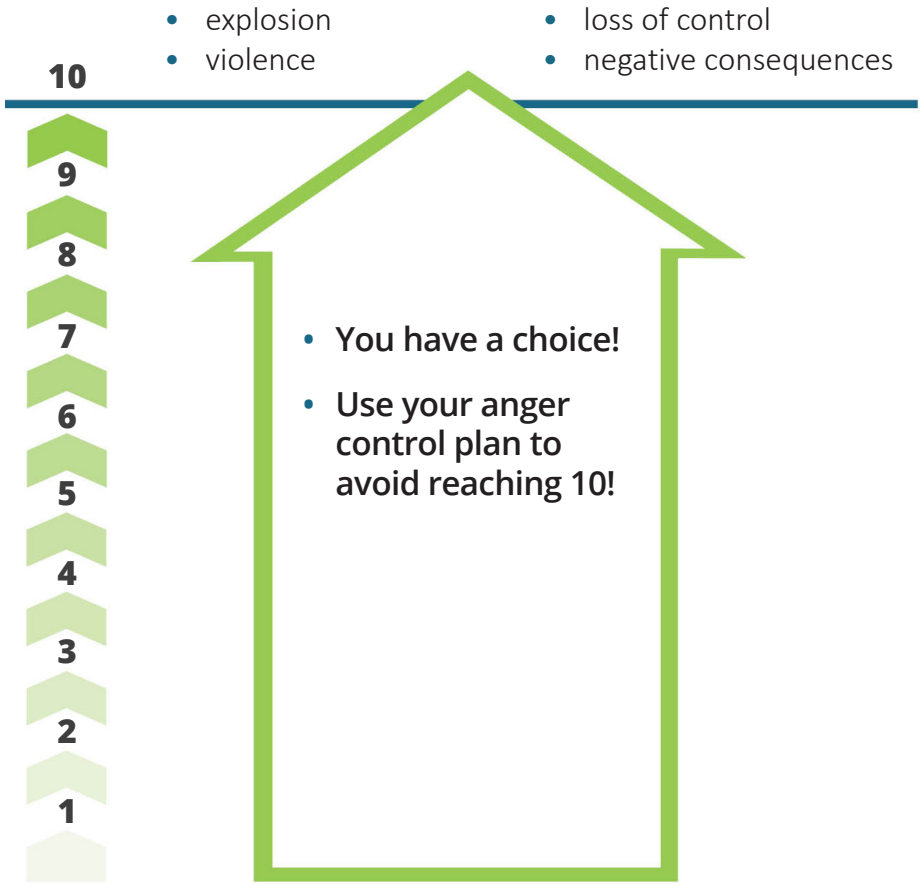
One technique that is helpful in increasing the awareness of anger is learning to monitor it. A simple way to monitor anger is to use what is called the "anger meter." A 1 on the anger meter represents a complete lack of anger or a total state of calm, whereas a 10 represents intense anger, along with the feeling that you may lose control, that leads to negative consequences. Points between 1 and 10 represent feelings of anger between these extremes. The purpose of the anger meter is to monitor the escalation of anger as it moves up the scale. For example, when a person encounters an anger-provoking event, he or she does not reach a 10 immediately, although it may sometimes feel that way. In reality, the individual's anger starts at a low number and rapidly moves up the scale. There is always time, provided one has learned effective coping skills, to stop anger from escalating to a 10.

It's important for you to understand that a 10 is reserved for instances when you begin to lose control and suffers (or could suffer) negative consequences. Examples are when a person angrily

threatens an intimate partner and the partner moves out or when an individual assaults another person and is arrested by the police.

A second point to make about the anger meter is that people may interpret the numbers on the scale differently. What may be a 5 for one person may be a 7 for someone else. It is much more important to personalize the anger meter and become comfortable and familiar with your individual readings of the numbers on the scale. For this group, however, a 10 is reserved for instances when someone begins to lose control and suffers (or could suffer) negative consequences.

Exhibit 1. The Anger Meter



Between-Session Challenge

Have group members refer to the participant workbook. Ask them to review the group's purpose and rules, the definitions of anger and aggression, the myths about anger, anger as a habitual response, and the anger meter. Ask group members to monitor their levels of anger on the anger meter during the upcoming week and be prepared to report their highest level of anger during the check-in procedure of next week's session.

EVENTS AND CUES

A Conceptual Framework for Understanding Anger

Session 2

Outline of Session 2

- Instructions to Group Leaders
- Suggested Remarks
  - Events Associated With Anger
  - Cues to Anger
- Explaining the Check-In Procedure
- Between-Session Challenge

Instructions to Group Leaders

In this session, the leader teaches group members how to analyze an anger episode and to identify the events and cues that indicate an escalation of anger. The session begins by following up on the between-session challenge from last week. Group members report on the highest level of anger they reached on the anger meter during the past week. The leader then explains events and cues. A more complete check-in procedure will be used in session 3 after members have been taught to identify specific anger-related events and the cues that indicate an escalation of anger.

After the check-in procedure, the leader presents the four different types of anger cues (i.e., physical, emotional, behavioral, and cognitive; see Exhibit 2, page 18). After each category is described, group members provide examples and the leader emphasizes that cues may be different for each individual. Members should identify cues that indicate an escalation of their anger.

Finally, the leader introduces group members to the anger awareness record (see Exhibit 3, page 19), which they will use in concert with the anger meter. Group members use this tool to list specific events associated with their anger, how intense the anger was, how the anger vested itself, and the consequences of their anger. The leader pays special attention to helping them distinguish between the events and their interpretation of these events. Events refer to facts; interpretations refer to opinions, value judgments, or perceptions of the events. For example, a group member might say, "My boss criticized me because she doesn't like me." The leader points out that the specific event was that the boss criticized the group member and that the belief that his boss doesn't like him is an interpretation that may or may not be accurate.

Suggested Remarks

(Use the following script or put it in your own words.)

Events Associated With Anger

When you get angry, it is because your interpretation of an event has provoked your anger. For example, you may get angry when the bus is late, when you have to wait in line at the grocery store, or when a neighbor plays his music too loud. Everyday events such as these can provoke your anger.

Many times, specific events touch on sensitive areas in your life. These sensitive areas, sometimes called "red flags," usually refer to longstanding issues that can easily lead to anger.

For example, some of us may have been slow readers as children and may have been sensitive about our reading ability. Although we may read well now as adults, we may continue to be sensitive about this issue. This sensitivity may be revealed when someone rushes us while we are completing an application or reviewing a memo and may trigger anger because we may feel that we are being criticized or judged as we were when we were children. This sensitivity may also show itself in a more direct way, such as when someone calls us "slow" or "stupid."

A new trigger to anger that has emerged over the last decade is bad online behavior. This can take many forms. It's easy to get drawn into a debate and become angry when you cannot change someone's mind about something you care passionately about. Some people, commonly called "trolls," enjoy teasing, bullying, or belittling people in social media forums. People can defame or post unflattering or damaging pictures of those they feel have wronged them. In extreme cases, people can steal your identity or post your private information on social media (commonly called "doxing").

Usually, anger-related events involve other people who get in the way of achieving our goals, but sometimes we may treat inanimate objects as if they were people who were trying to interfere with our plans and goals, such as cars that break down or cell phones and computers that malfunction. Sometime people get angry and take it out on inanimate objects, such as smashing a computer or throwing a cell phone out the window when a signal is lost during an important conversation.

In addition to events experienced in the here and now, you may also recall an event from your past that made you angry. You might remember, for example, how the bus always seemed to be late before you left home for an important appointment. Just thinking about how late the bus was in the past can make you angry in the present. Another example may be when you recall a situation involving a family member who betrayed or hurt you in some way. Remembering this situation, or this family member, can raise your number on the anger meter. Here are examples of things in daily life that can trigger anger:

- Having to wait a long time (on the phone or in an office)
- Being stuck in traffic or on a crowded bus
- A friend or coworker saying hurtful or untrue things
- A friend not paying back money owed to you
- Having to clean up someone else's mess
- Neighbors who are inconsiderate
- Dealing with a frustrating person or situation on the Internet

Cues to Anger

A second important aspect of anger monitoring is to increase awareness of the cues that occur in response to the anger-related event. These cues serve as warning signs that you have become angry and that your anger is continuing to escalate. They can be broken down into four cue categories: physical, behavioral, emotional, and cognitive (or thought) cues.

Physical Cues. Physical cues involve the way our bodies respond when we become angry. For example, our heart rates may increase, we may feel tightness in our chests, or we may feel hot and flushed. These physical cues can also warn us that our anger is escalating out of control or

approaching a 10 on the anger meter. We can learn to identify these cues when they occur in response to an anger-related event.

Can you identify some physical cues that you have experienced when you have become angry?

Behavioral Cues. Behavioral cues involve the behaviors we display when we get angry, which are observed by other people around us. For example, we may clench our fists, pace back and forth, slam a door, or raise our voices. These behavioral responses are the second cue of our anger. As with physical cues, they are warning signs that we may be approaching a 10 on the anger meter.

What behavioral cues have you experienced when you have become angry?

Emotional Cues. Emotional cues involve other feelings that may occur along with our anger. For example, we may become angry when we feel abandoned, afraid, discounted, disrespected, guilty, humiliated, impatient, insecure, jealous, or rejected. These kinds of feelings are the core or primary feelings that underlie our anger. It is easy to discount these primary feelings because they often make us feel vulnerable. An important component of anger management is to become aware of, and to recognize, the primary feelings that underlie our anger. In this group, we will view anger as a secondary emotion to these more primary feelings.

Can you identify some primary feelings that you have experienced during an episode of anger?

Cognitive Cues. Cognitive cues refer to the thoughts that occur in response to the anger-related event. When people become angry, they may interpret events in certain ways. For example, we may interpret a friend's comments as criticism, or we may interpret the actions of others as demeaning, humiliating, or controlling. Some people call these thoughts "self-talk" because they resemble a conversation we are having with ourselves. For people with anger problems, this self-talk is usually very critical and hostile in tone and content. It reflects beliefs about the way they think the world should be—beliefs about people, places, and things. As the self-talk continues to spiral, the person can become more and more angry.

Closely related to thoughts and self-talk are fantasies and images. Fantasies and images are other types of cognitive cues that can indicate an escalation of anger. For example, we might fantasize about seeking revenge on a perceived enemy or imagine or visualize our spouse having an affair. When we have these fantasies and images, our anger can escalate even more rapidly.

Can you think of other examples of cognitive or thought cues?

Explaining the Check-In Procedure

(In this session, group members are instructed to begin to monitor their anger and identify anger-related events and situations using the anger meter that was introduced in session 1 and the anger awareness record. Use the following script or put it in your own words.)

In each weekly session, we will use a check-in procedure to follow up on the between-session challenge from the previous week to report on anger you may have experienced during the week. The weekly check-in procedure helps increase awareness about your patterns of anger and identifies the kinds of situations, thoughts, feelings, and consequences that are associated with anger. At each check-in, we will provide encouraging and supportive comments for any efforts made, briefly discuss ways you solved problems or removed barriers that you encountered with the between-session challenge, and encourage your efforts moving forward.

Use the anger meter to determine your highest level of anger and the columns in the anger awareness record to identify the event that led to your anger, the cues that were associated with this anger, the number rating on the anger meter, the behavior that resulted, negative consequences from the anger, and the strategies you used to manage the anger in response to the event. We will be sure to discuss any positive outcomes. Did you head off your anger? If so, what strategies did you use? We will use the following questions to check in at the beginning of each session:

1. What was the event that led to your anger?
2. What cues were associated with the anger-related event? For example, what were the physical, behavioral, emotional, or cognitive cues?
3. Were there negative consequences from your anger?
4. What strategies did you use and how did they help you manage your anger?

Exhibit 2. Cues to Anger: Four Cue Categories

1. **Physical** (examples: rapid heartbeat, tightness in chest, feeling hot or flushed)
2. **Behavioral** (examples: pacing, clenching fists, raising voice, staring)
3. **Emotional** (examples: fear, hurt, jealousy, guilt)
4. **Cognitive/Thoughts** (examples: hostile self-talk, images of aggression and revenge)

Exhibit 3. Anger Awareness Record

Situation	Anger Cues	Anger Meter Rating	Behavior	Consequences (positive or negative)	Strategies Used
What sets me up to become angry?	What was I thinking? What was I feeling? What did I tell myself?	1=Low 10=High	What did I do then?	What good or bad things happened?	What tools did I use to respond?

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Group members will learn more anger management strategies starting in session 3, but encourage them to use those already discussed—or those that have worked for them in the past—and record them in the anger awareness record. Tell group members they should be prepared to report on this assignment during the check-in procedure in next week's session.

ANGER CONTROL PLANS

Helping Group Members Develop a Plan for Controlling Anger

Session 3

Outline of Session 3

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
  - Why Cognitive–Behavioral Therapy?
  - Anger Control Plans
  - Social Support
  - Relaxation Through Breathing
- Between-Session Challenge

Instructions to Group Leaders

In this session, the leader begins by discussing with group members the reasoning behind cognitive–behavioral strategies for managing their anger. By now, group members have begun to learn how to monitor their anger and identify anger-related events and situations. At this point, it is important to help them develop a collection of anger management strategies. This repertoire of strategies includes an anger control plan (see Exhibit 4, page 23) and a social support plan (see Exhibit 5, page 25). The anger control plan should consist of *immediate* strategies, those that can be used in the heat of the moment when anger is rapidly escalating, and *preventive* strategies, those that can be used to prevent escalation of anger before it begins. It is important to encourage members to use strategies that work best for them. Some find cognitive restructuring (e.g., challenging hostile self-talk or maladaptive beliefs) very effective. Others prefer using strategies such as a timeout, thought stopping, assertive communication, and problem solving (discussed later). The main point is to help group members individualize their anger control plans and develop strategies that they are comfortable with and that they will readily use. A good starting place is for members to build on strategies they are already using to manage their anger. This session concludes by helping group members develop effective strategies for controlling their anger and clarifying and reinforcing these strategies during the check-in procedure.

This session starts with the check-in procedure and ends with a breathing exercise as a form of relaxation training. Before leading members in the breathing exercise, the leader asks whether anyone has had experience with different forms of relaxation. Then the leader describes the continuum of relaxation techniques, which can range from simple breathing exercises to elaborate, guided imagery. Group members practice two short and simple relaxation exercises, deep breathing and progressive muscle relaxation. Experience shows that they are more likely to use these simple forms of relaxation if they practice them with the group first.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event, classify these cues into the four cue categories, and identify successes and challenges

in managing their anger in the previous week. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems or removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put it in your own words.)

Why Cognitive–Behavioral Therapy?

One goal of cognitive–behavioral therapy is to reframe the way you think about a problem (the cognitive part) so that you can change your approach to it (the behavioral part). When you use cognitive–behavioral techniques, you train your brain to respond in a different way to a problem. As our sessions progress, we will pay attention to feelings and sensations that let us know when we're getting angry and practice techniques we can use to stop anger from escalating. The more we pay attention to anger cues and triggers and the more we practice different techniques to stop anger, the better you will get at managing your anger.

Up to this point, you have focused on how to monitor your 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 associated with your anger, as well as the physical, behavioral, emotional, and cognitive cues associated with each event, and how to track them with the anger awareness record. Today, we will discuss how to develop an anger control plan and a social support plan and how you can use specific strategies, such as timeouts and relaxation, to control your anger. In later sessions, we will cover other strategies, such as learning to change negative or hostile self-talk and using the Conflict Resolution Model (see sessions 7 and 8). These more advanced strategies can be used along with timeouts and relaxation.

Anger Control Plans

The basic idea in developing an anger control plan is to try many different strategies and find the anger control techniques that work best for you. Once you identify these strategies, you can add them to your anger control plans and use them when you start to get angry. Some people refer to their anger control plans as their toolbox and the specific strategies they use to control their anger as their tools. This analogy may be very helpful. Again, it is important to identify the specific anger control strategies that work best for you. These strategies should be written down in a formal anger control plan that you can refer to when you encounter an anger-related event.

An effective strategy that many people use, for example, is to talk about their feelings with a supportive friend who was not involved with the event that led to their anger. By discussing anger, you can begin to identify the primary emotions that underlie it and determine whether your thinking and expectations in response to the anger-related event are rational. Often, a friend whom you trust can provide a different perspective on what is going on in your life. Even if your friend just listens, expressing your feelings can make you feel better. It is a good idea to make a plan ahead of time for social support. Whom will you talk to when you need some perspective on your anger?

The long-term objective of anger management treatment is to develop a set of strategies that you can use appropriately for specific anger-related events. Later sessions will introduce more strategies and techniques that are helpful in managing anger. Once you have selected the

strategies that work best, you should refine them by applying them in real-life situations. To use the toolbox analogy, different tools may be needed for different situations. We will return to this concept in later sessions and highlight the importance of developing an anger control plan that helps you manage anger effectively in a variety of situations.

Timeout. As mentioned in session 1, the concept of a timeout is especially important to anger management. It is the basic anger management strategy recommended for inclusion in everyone's anger control plan. As we said earlier, it's similar to how football teams take a timeout to regroup. A timeout means leaving the situation that is causing the escalation of anger or putting a stop to the discussion that is provoking it.

It's possible to also develop a formal timeout policy with family and friends. A formal timeout involves relationships with other people; it requires an agreement or a plan that has been drawn up in advance. These relationships may involve family members, friends, and coworkers. Any of the parties involved may call a timeout based on rules that have been agreed on by everyone. 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 all those involved feel they can successfully resolve the issue.

Whether you use a timeout or a formal timeout, these strategies are important because they can be effective in the heat of the moment. Even if your anger is escalating quickly on the anger meter, you can avoid reaching 10 by taking a timeout and leaving the situation.

Timeouts are also effective when they are 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 should help you calm down during the timeout period.

Can you think of specific strategies that you might use to control your anger?

Should these strategies be included in your anger control plan?

Exhibit 4. Sample of an Anger Control Plan

1. Take a timeout.
2. Talk to a friend (someone you trust).
3. Use the Conflict Resolution Model to solve problems with expressing anger (discussed in more detail in sessions 7 and 8).
4. Exercise (examples: take a walk, go to the gym).
5. Attend 12-Step meetings.
6. Explore primary feelings beneath the anger.

Social Support

An important part of the anger control plan can be social support. You should seek support and feedback from people you trust to support your recovery, including anger management strategies that will deescalate, rather than escalate, the situation. You should seek advice from one another

and others who are in recovery and from members in support networks, including members of 12-Step groups, 12-Step sponsors, or other mutual-help group members. A social support action plan that you develop yourself may help you follow through with seeking social support.

We all need support at different times in our lives to help us reach our goals and deal successfully with challenges that come our way. Having a network of people who understand and support your efforts to change can be extremely helpful.

What types of support are out there?

- Self-help groups
- Professional help
- Spiritual or religious affiliations
- Personal relationships
- Coworkers
- Community service agencies

How to ask for support

- Be specific about what type of support you need.
- Show appreciation for the person's support if it was helpful.
- Give feedback to the person if he or she is giving support that was not helpful.
- Find a way to support the other person.

Exhibit 5. Plan for Seeking Support

Support	How This Support Will Help	Plan for Getting This Support
Support	**How This Support Will Help**	**Plan for Getting This Support**
Support	**How This Support Will Help**	**Plan for Getting This Support**

(The leader might consider having participants practice asking for help in this session or in a later review session.)

Relaxation Through Breathing

We have discussed the physical cues to anger, such as an increased heartbeat, feeling hot or flushed, or muscle tension. These types of physical cues are examples of what is commonly called the stress response. In the stress response, the nervous system is energized; in this agitated state, a person may have trouble returning to lower levels on the anger meter and additional anger-related situations and events can increase risk for a further escalation of anger.

An interesting aspect of the nervous system is that everyone has a relaxation response that counteracts the stress response. It is physically impossible to be both agitated and relaxed at the same time. If you can relax successfully, you can counteract the stress or anger response.

We will end this session by practicing a deep-breathing exercise as a relaxation technique. In session 4, we will practice progressive muscle relaxation as another relaxation technique.

Deep-Breathing Exercise

(Use this script or put it in your own words.)

Get comfortable in your chair. If you like, close your eyes; or just gaze at the floor.

Take a few moments to settle yourself. Now make yourself aware of your body. Check your body for tension, beginning with your feet, and scan upward to your head. Notice any tension you might have in your legs, your stomach, your hands and arms, your shoulders, your neck, and your face. Try to let go of the tension you are feeling.

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

Let's all take a deep breath together. Notice your lungs and chest expanding. Now slowly exhale. Again, take a deep breath. Fill your lungs and chest. Notice how much air you can take in. Hold it for a second. Now release it and slowly exhale. One more time, inhale slowly and fully. Hold it for a second, and release.

Now on your own, continue breathing in this way for another couple of minutes. Continue to focus on your breathing. With each inhalation and exhalation, feel your body becoming more and more relaxed. Use your breathing to wash away any remaining tension.

(Allow group members to practice breathing for 1 to 2 minutes in silence.)

Now let's 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 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 much 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 making deep breathing an effective relaxation technique is to practice it frequently and to apply it in a variety of situations.

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Ask them to practice the deep-breathing exercise once a day during the upcoming week and develop a preliminary version of their anger control plans, including a plan for social support. Tell group members they should be prepared to report on these assignments during the check-in procedure at the next week's session.

THE AGGRESSION CYCLE

How To Change the Cycle

Session 4

Outline of Session 4

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
  - The Aggression Cycle
  - Progressive Muscle Relaxation
- Between-Session Challenge

Instructions to Group Leaders

In this session, the leader presents the aggression cycle (see Exhibit 6, page 29) and introduces progressive muscle relaxation. As in the previous two sessions, the session begins with the check-in procedure, namely, group members reporting on their anger and reviewing entries in their anger awareness record. The leader then presents the three-phase aggression cycle, which consists of buildup, explosion, and aftermath. This cycle serves as a framework that incorporates the concepts of the anger meter, cues to anger, and the anger control plan.

The session ends with a presentation on a progressive muscle relaxation exercise. Progressive muscle relaxation is another technique that has been effective in reducing anger levels. An alternative to the deep-breathing exercise introduced in session 3, it is straightforward and easy to learn. Progressive muscle relaxation can also be done in combination with deep breathing.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event, classify these cues into the four cue categories, and identify successes and challenges in managing their anger in the previous week. As part of the check-in procedure, include a follow-up on the between-session challenge from the previous week's session. Ask group members to report on the specific anger management strategies listed thus far in their anger control plans. In addition, inquire whether they practiced the deep-breathing exercise that was introduced in session 3. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems or removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put it in your own words.)

The Aggression Cycle

In the last three sessions, we reviewed the anger meter, the anger awareness record, cues to anger, and the anger control plan, including social support. This session presents the framework for integrating these anger management concepts. This framework is the aggression cycle.

From an anger management perspective, an episode where anger leads to aggression can be viewed as consisting of three phases: *buildup, explosion,* and *aftermath*. Together, they make up the aggression cycle. In this process, the buildup phase is characterized by cues that indicate anger is escalating. As stated in session 2, these cues can be physical, behavioral, emotional, or cognitive (thoughts). As you may recall, cues are warning signs, or responses, to anger-related events. Events are situations that occur and may lead to escalations of anger if effective anger management strategies are not used. Red-flag events are types of situations that are unique to you and that you are especially sensitive to because of past events. These events can involve internal processes (e.g., thinking about situations that were anger provoking in the past) or external processes (e.g., experiencing real-life, anger-related situations in the here and now).

If the buildup phase is allowed to continue, the explosion phase can follow. The explosion phase is marked by a discharge of anger displayed as verbal or physical aggression. This discharge, in turn, leads to negative consequences; it is synonymous with the number 10 on the anger meter.

The final stage of the aggression cycle is the aftermath phase. It is characterized by negative consequences resulting 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 or discharged from a drug treatment or social service program, being alienated from family and loved ones, or feelings of guilt, shame, and regret.

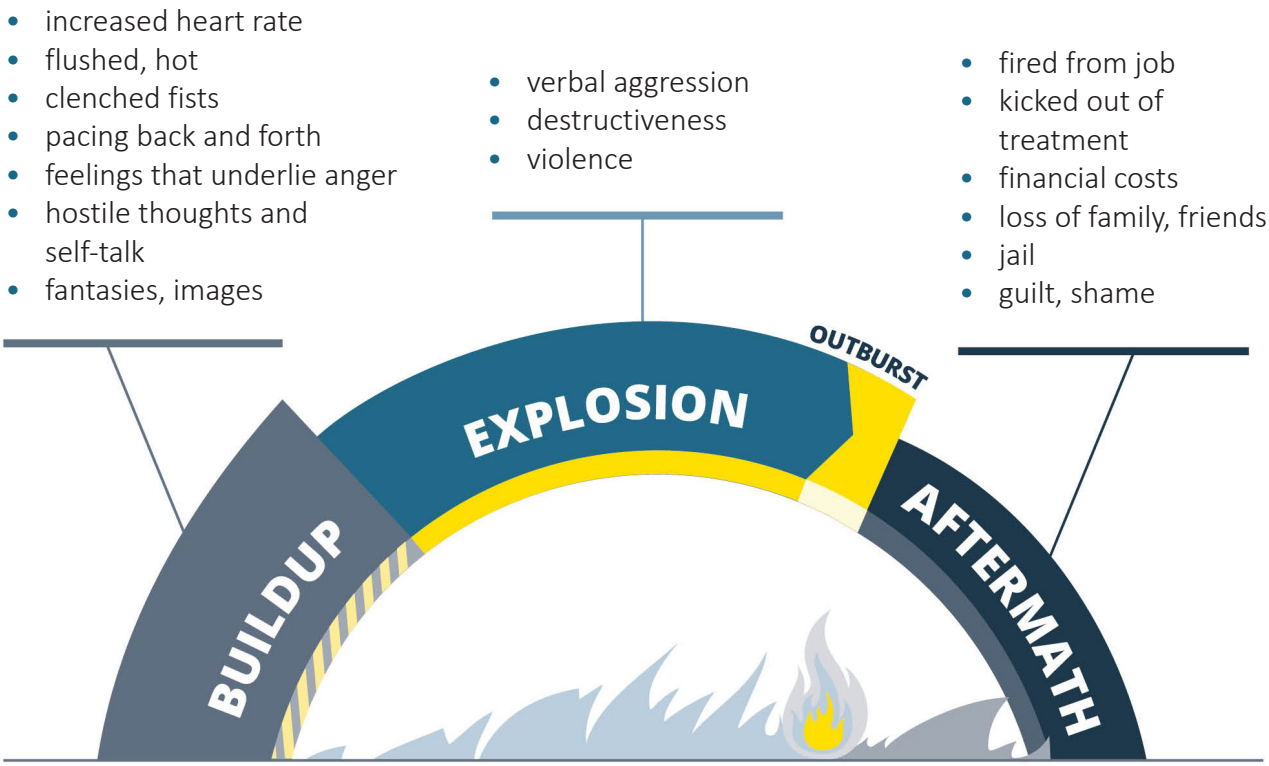
The intensity, frequency, and duration of anger in the aggression cycle vary among individuals. For example, one person's anger may build rapidly after a provocative event and, within just a few minutes, reach the explosion phase. Another person's anger may build slowly but steadily over several hours before reaching the explosion phase. Similarly, one person may experience more episodes of anger and progress through the aggression cycle more often than another person. However, both individuals, despite differences in how quickly their anger escalates and how frequently they experience anger, will undergo all three phases of the aggression cycle.

The intensity of these individuals' anger also may differ. One person may engage in more violent behavior than another person in the explosion phase. For example, an individual may use weapons or assault someone. Another person may express his or her anger during the explosion phase by shouting at or threatening other people. Regardless of these individual differences, the explosion phase is synonymous with becoming verbally or physically aggressive.

Notice that the buildup and explosion phases of the aggression cycle correspond to the levels on the anger meter. The points below 10 on the anger meter represent the buildup phase, the building up of anger. The explosion phase, on the other hand, corresponds to 10 on the anger meter. Again, 10 on the anger meter is the point at which one expresses anger through verbal or physical aggression that leads to negative consequences.

One of the primary objectives of anger management treatment is to keep from reaching the explosion phase. This is accomplished by using the anger meter to monitor changes in your anger, using the anger awareness record to help you pay attention to the cues or warning signs that indicate anger is building, and employing the appropriate strategies from your anger control plans to stop the buildup of anger. If you prevent the explosion phase from occurring, the aftermath phase will not occur, and the aggression cycle will be broken. If you use your anger control plans effectively, your anger should not progress to a 10 on the anger meter. This is a reasonable goal to aim for.

Exhibit 6. The Aggression Cycle



Progressive Muscle Relaxation

Last week you practiced deep breathing as a relaxation technique. Today I will introduce progressive muscle relaxation.

A Progressive Muscle Relaxation Exercise

(Use this script or put it in your own words.)

Start by getting comfortable in your chairs. Close your eyes if you like. Take a moment to really 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 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 the tension. Imagine all the tension being released from 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 it. Let the tension in your arms unfold and your hands float back to your thighs. Feel the tension drain out of your arms. 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 them up for a second. 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 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 final time, tense all the muscles in your neck and face, hold, and release. Be aware of your 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 we started?

(If anyone experiences pain during this exercise, encourage them to reduce their level of exertion or focus on relaxing their muscles without first tensing them.)

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Ask them to review the aggression cycle and practice progressive muscle relaxation, preferably once a day, during the coming week. Remind them to continue to develop their anger control plans.

COGNITIVE RESTRUCTURING

The A-B-C-D Model and Thought Stopping

Session 5

Outline of Session 5

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
  - The A-B-C-D Model
  - Thought Stopping
- Between-Session Challenge

Instructions to Group Leaders

In this session, the leader presents the A-B-C-D Model—a form of cognitive restructuring (see Exhibit 7, page 35; Ellis, 1979; Ellis & Harper, 1975)—and the technique of thought stopping. Cognitive restructuring is an advanced anger management technique that requires group members to examine and change their thought processes. Some may be familiar with cognitive restructuring, whereas others may have little or no experience with this concept. In addition, some people may initially have difficulty understanding the concept or may not yet be ready to challenge or change their maladaptive beliefs. It is important to accept these group members, whatever their level of readiness and understanding, and help them identify how their maladaptive beliefs perpetuate anger and how modifying these beliefs can prevent further escalation of anger.

In addition to presenting the A-B-C-D Model, the session includes a discussion on thought stopping. Thought stopping is accepted and readily understood by most clients. Regardless of whether they view particular beliefs as maladaptive, most people recognize that these specific beliefs increase anger and lead to the explosion phase (10 on the anger meter). Thought stopping provides an immediate and direct strategy for helping people manage the beliefs that cause their anger to escalate.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event and help them classify these cues into the four cue categories. As part of the check-in procedure, include a follow-up of the between-session challenge from last week's session. Specifically, ask group members to report on the development of their anger control plans. In addition, inquire whether they practiced the progressive muscle relaxation exercise. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems or removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put it in your own words.)

The A-B-C-D Model

The A-B-C-D Model (or rational-emotive model) is consistent with the way we conceptualize anger management treatment. In this model, *"A" stands for an activating event*, what we have been calling the red-flag event. *"B" represents the beliefs people have about the activating event.* The model is based on the assumption that it is not the events themselves that produce feelings such as anger, but our interpretations of and beliefs about the events. *"C" stands for the emotional consequences of events.* In other words, these are the feelings people experience as a result of their interpretations of and beliefs concerning the event.

According to cognitive–behavioral theorists, as people become angry, they engage in an internal dialog, called "self-talk." For example, suppose you were waiting for a bus to arrive. As it approaches, several people push in front of you to board. In this situation, you may start to get angry. You may be thinking, "How can people be so inconsiderate! They just push me aside to get on the bus. They obviously don't care about me or other people." Examples of the maladaptive self-talk that can produce anger escalation are reflected in statements such as "People should always be more considerate of my feelings," "How dare they be so inconsiderate and disrespectful," and "They obviously don't care about anyone but themselves."

People do not have to get angry when they encounter such an event. The event itself does not get them upset and angry; rather, it is people's interpretations of and beliefs concerning the event that cause the anger. Beliefs underlying anger often take the form of "should" and "must." Most of us may agree, for example, that respecting others is an admirable quality. Our belief might be, "People should always respect others." In reality, however, people often do not respect each other in everyday encounters. You can choose to view the situation more realistically as an unfortunate defect of human beings, or you can let your anger escalate every time you witness, or are the recipient of, another person's disrespect. Unfortunately, your perceived disrespect can keep you angry and push you toward the explosion phase. Ironically, it may even lead you to show disrespect to others, which would violate your own fundamental belief about how people should be treated.

The A-B-C-D approach consists of identifying maladaptive beliefs and disputing them with more rational or realistic perspectives, so in this model, *"D" stands for dispute.* You may get angry, for example, when you start thinking, "I must always be in control. I must control every situation." It is not possible or appropriate, however, to control every situation. Rather than continue with these beliefs, you can try to dispute them. You might tell yourself, "I have no power over things I cannot control" or "I have to accept what I cannot change." These are examples of ways to dispute beliefs that you may have already encountered in 12-Step programs such as Alcoholics Anonymous or Narcotics Anonymous.

People may have many other maladaptive beliefs that can lead to anger. For example, suppose a friend disagrees with you. You may start to think, "I'm always very nice to him; he should like me and trust my opinion." If you hold such a belief, you are likely to get upset and angry when you perceive rejection. However, if you dispute this maladaptive belief by saying, "People won't always agree with me; some people will disagree with me," you will most likely start to calm down and be able to control your anger more easily.

Another common maladaptive belief is, "I must be respected and treated fairly by everyone." This also is likely to lead to frustration and anger. People will sometimes be rude to you and treat you unfairly—it's unavoidable. Perhaps those people are rude and inconsiderate to everyone; perhaps they are normally kind but are having a stressful day. This is unfortunate, but from an anger management perspective, it is better to accept the unfairness and lack of interpersonal connectedness that can happen in our day-to-day interactions. Thus, to dispute this belief, it is helpful to tell yourself, "I can't expect to be treated fairly by everyone."

Other beliefs that may lead to anger include "Everyone should follow the rules" or "Life should be fair" or "Good should prevail over evil" or "People should always do the right thing." These are beliefs that are not always followed by everyone in society, and usually there is little you can do to change that. How might you dispute these beliefs? In other words, what thoughts that are more adaptive and less apt to lead to anger can be substituted for such beliefs?

For people with anger control problems, these maladaptive beliefs can lead to the explosion phase (10 on the anger meter) and to the negative consequences of the aftermath phase. It is often better to change your outlook by disputing your beliefs and creating an internal dialog or self-talk that is more rational and adaptive.

Exhibit 7. The 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 maladaptive?

Based on the work of Ellis (1979) and Ellis and Harper (1975).

Thought Stopping

A second approach to controlling anger is called "thought stopping." It provides an immediate and direct 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 getting 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, the goal is to stop your current pattern of angry thoughts before they lead to an escalation of anger.

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Ask members to review the A-B-C-D Model and to record at least two maladaptive beliefs and how they would dispute these beliefs. In addition, instruct them to use the thought-stopping technique, preferably once a day during the coming week. Remind them to continue to develop their anger control plans.

PRACTICE SESSION #1

Reinforcing Learned Concepts

Session 6

Outline of Session 6

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
- Between-Session Challenge

Instructions to Group Leaders

In this session, the leader reviews and summarizes the basic concepts of anger management presented thus far, paying special attention to clarifying and reinforcing concepts (i.e., the anger meter, anger awareness record, cues to anger, anger control plans, the aggression cycle, and cognitive restructuring). The leader also encourages and supports efforts to develop anger control plans and to balance cognitive, behavioral, immediate, and preventive strategies. Group members practice the various techniques they have learned, including rehearsing their anger control and social support plans.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event and help them classify these cues into the four cue categories. As part of the check-in procedure, include a follow-up of the between-session challenge from last week's session. Ask what strategies they employed or might employ. Ask group members to report on their use of the A-B-C-D Model during the past week and to provide a brief update on the ongoing development of their anger control plans. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems and removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put it in your own words.)

In this session, we will review the anger management material we have covered thus far. We will review each concept and clarify any questions that you may have. Here are topics that we might want to cover:

- Anger myths (pages 10–11)
- Changing the anger habit (page 11)
- Anger meter (page 13)
- Triggers for anger (pages 15–16)
- The four kinds of anger cues (pages 16–17)
- Anger awareness record (page 19)
- Anger control plans (pages 22–23)
- Enhancing social support (pages 23–24)
- Deep breathing and muscle relaxation (page 26)
- The aggression cycle (pages 28–29)
- Progressive muscle relaxation (page 30)
- A-B-C-D Model (pages 34–35)
- Thought stopping (page 35)

Discussion is encouraged during this review, and you will be asked to describe your understanding of the anger management concepts.

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Remind them to continue to develop their anger control plans.

ASSERTIVENESS TRAINING AND THE CONFLICT RESOLUTION MODEL

Alternatives for Expressing Anger

Sessions 7 & 8

Outline of Sessions 7 & 8

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
- Between-Session Challenge

Instructions to Group Leaders

Sessions 7 and 8 are combined because it takes more than one session to adequately address assertiveness, aggression, passivity, and the Conflict Resolution Model (see Exhibit 8, page 43). Assertiveness is such a fundamental skill in interpersonal interactions and anger management that the group will spend 2 weeks developing and practicing this concept. These two 90-minute sessions present an introduction to assertiveness training. The majority of this week's session is spent reviewing the definitions of assertiveness, aggression, and passivity and presenting the Conflict Resolution Model. The Conflict Resolution Model is an assertive device for resolving conflicts with others. It consists of a series of problem-solving steps that, when followed closely, minimize the potential for anger escalation. Next week's session, in contrast, focuses on group members roleplaying real-life situations using the Conflict Resolution Model. It is important to emphasize that assertive, aggressive, passive, and passive-aggressive responses are learned behaviors and not innate, unchangeable traits. The goal of these two sessions is to teach members how to use the Conflict Resolution Model to develop assertive responses rather than aggressive, passive, or passive-aggressive responses.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event and help them classify these cues into the four cue categories. Ask members to report on the ongoing development of their anger control plans. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems and removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put it in your own words.)

Assertiveness Training

Sessions 7 and 8 provide an introduction to assertiveness training and the Conflict Resolution Model. Assertiveness involves a set of behaviors and skills that require time and practice to learn and master. In this group, we focus on one important aspect of assertiveness training, that is, conflict resolution. The Conflict Resolution Model can be particularly effective for helping individuals manage their anger.

Many interpersonal conflicts occur when you believe that your rights have been violated. Before entering anger management treatment, you may have tended to respond with aggressive behavior when you believed that another person showed you disrespect or treated you unfairly. In today's session, we will discuss several ways to resolve interpersonal conflicts without resorting to aggression.

As we discussed in session 1, aggression is *behavior* that is intended to control a person or situation or cause harm or injury to another person or damage property. This behavior can include verbal abuse, threats, or violent acts. Often, when another person has been rude or unfair to you, your first reaction may be to fight back or retaliate. The basic message of aggression is, "My feelings, thoughts, and beliefs are important and that your feelings, thoughts, and beliefs are unimportant and inconsequential."

One alternative to using aggressive behavior is to act passively or in a nonassertive manner. Acting in a passive or nonassertive way is undesirable because you allow your rights to be violated. You may resent the person who treated you unfairly, and you may be angry with yourself for not standing up to the other person. In addition, it is likely that you will become even more angry the next time you encounter this person. The basic message of passivity is, "*Your* feelings, thoughts, and beliefs are important, but *my* feelings, thoughts, and beliefs are unimportant and inconsequential." Acting in a passive or nonassertive way may help you avoid the negative consequences associated with aggression, but it may also ultimately lead to negative personal consequences, such as diminished self-esteem, and prevent you from having your needs satisfied.

Some people express hostility with *passive-aggressive* behavior. The term passive-aggressive was first used in the 1940s. But these days, the term broadly refers to any situation where demands are made on a person and the demands are seen as unfair or unreasonable or as interfering with one's life (Pretzer & Beck, 1996). Some people have problems following rules and dealing with authority figures, such as teachers, police officers, and physicians. People who are passive-aggressive may often feel that others are trying to control them or are on a "power trip." Rather than comply with others' demands or express their opinions and feelings directly, they may feel irritable and openly refuse to do what is expected of them. When given a task to perform, such as taking a friend to a doctor's appointment, the passive-aggressive person may arrive late or not show up at all, pretending that he or she forgot. In some cases, a passive-aggressive person may express hostility by screwing things up for people they resent (Hopwood & Wright, 2012).

Rather than behave in a passive-aggressive way, it may be useful to express your opinions and feelings to the people who are making demands of you. People who display passive-aggressive behavior tend to believe that the demands are unreasonable. If you express the opinion that you

see the demand as unreasonable in an assertive rather than a passive-aggressive way, others may understand your perspective, and you may be able to reach a compromise.

From an anger management perspective, the best way to deal with a person who has treated you unfairly is to act assertively. Acting assertively involves standing up for yourself in a way that is respectful of other people. The basic message of assertiveness is, "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 was unfair to you without suffering the negative consequences associated with aggression or the devaluation of your feelings, which is associated with passivity or nonassertion.

It is important to emphasize that assertive, aggressive, passive, and passive-aggressive responses are learned behaviors; they are not innate, unchangeable traits. Using the Conflict Resolution Model, you can learn to develop assertive responses that allow you to manage interpersonal conflicts in a more effective way.

In summary, aggression involves expressing feelings, thoughts, and beliefs in a harmful and disrespectful way. Passivity or nonassertiveness involves failing to express feelings, thoughts, and beliefs or expressing them in an apologetic manner that others can easily disregard. Assertiveness involves standing up for your rights and expressing feelings, thoughts, and beliefs in direct, honest, and appropriate ways that do not violate the rights of others or show disrespect.

It is helpful to think of real-life situations to help you understand what is meant by assertiveness. Suppose you have been attending an Alcoholics Anonymous meeting several times a week with a friend. Suppose you have been driving your friend to these meetings for several weeks. In the last few days, however, he has not been ready when you have come to pick him up. His tardiness has resulted in both of you being late for meetings. Because you value being on time, your friend's actions bother you a great deal. Consider the different ways you might act in this situation. You can behave in an aggressive manner by yelling at your friend for being late and refusing to pick him up in the future. The disadvantage of this response is that he may no longer want to continue the friendship. Another response would be to act passively, or in a nonassertive fashion, by ignoring the problem and not expressing how you feel. The disadvantage of this response is that the problem will most likely continue and that this will inevitably lead to feelings of resentment toward your friend. Again, from an anger management perspective, the best way to deal with this problem is to act assertively by expressing your feelings, thoughts, and beliefs in a direct and honest manner, while respecting the rights of your friend.

Let's consider a slightly different situation. Suppose your supervisor at work expects you to spend part of your lunch hour getting coffee and donuts for the office staff. You may feel that she is making an unreasonable demand. Passive-aggressive behavior would be not getting the coffee and donuts and, when confronted by your supervisor, pretending that you forgot. But passive-aggressive behavior has negative consequences. Your passivity (purposely not getting coffee and donuts) in this case is a form of aggression because your intention was to thwart your supervisor's demands. If it happens over and over again, she might note your inability to remember assignments on your performance review, which might keep you from getting a raise. It's better to openly discuss the matter. For example, if you were to tell your supervisor that the task cuts into your lunch hour and that you think it's unfair, she may let you leave for lunch early.

Conflict Resolution Model

One method of acting assertively is to use the Conflict Resolution Model, which involves five steps that can easily be memorized. This model gives you a structure for solving problems. The first step involves *identifying the problem* that is causing the conflict. It is important to be specific when identifying the problem. In the first example, the problem causing the conflict is that your friend is late. The second step involves *identifying the feelings* associated with the conflict. In this same example, you may feel annoyance or frustration or like you are being taken for granted. The third step involves *identifying the specific impact* of the problem that is causing the conflict. In this example, the impact or outcome is that you are late for the meeting. The fourth step involves *deciding whether to resolve the conflict* or let it go. This may best be phrased by the questions, "Is the conflict important enough to bring up? If I do not try to resolve this issue, will it lead to feelings of anger and resentment?" If you decide that the conflict is important enough, then the fifth step is necessary. The fifth step is *addressing and resolving the conflict*. This involves asking the friend to schedule time with you to discuss the problem. Agreeing to a time to discuss the problem is important because you might bring up the conflict when the other person does not have the time to address it or when he may be preoccupied with another issue. Once you have agreed on a time to talk with the person, you can describe the conflict, your feelings, and the impact of the conflict and ask for a resolution.

For example, the interaction may sound like this:

Joe: *Hey, Frank, sorry I'm late.*

Frank: *Hi, Joe. Can I talk to you about that?*

Joe: *Sure. Is something wrong?*

Frank: *Joe, I've noticed you've been late for the last few days when I've come to pick you up. Today, I realized that I was starting to feel frustrated and a bit taken for granted. When you are late, we are both late for the meeting, which makes me uncomfortable. I like to be on time. I'm wondering if you can make an effort to be on time in the future.*

Joe: *Frank, I didn't realize how bothered you were about that. I apologize for being late, and I will be on time in the future. I'm glad you brought this problem up to me.*

Of course, this is an idealized version of an outcome that may be achieved with the Conflict Resolution Model. Joe could have responded unfavorably or defensively, by accusing Frank of making a big deal out of nothing or by minimizing and discounting Frank's feelings, leaving the conflict unresolved.

The Conflict Resolution Model is useful even when conflicts are not resolved. Many times, you will feel better about trying to resolve a conflict in an assertive manner rather than acting passively or aggressively. Specifically, you may feel that you have done all that you could do to resolve the conflict. In this example, if Frank decided not to give Joe a ride in the future, or if Frank decided to end his friendship with Joe, he could do so knowing that he first tried to resolve the conflict in an assertive manner.

Exhibit 8. The Conflict Resolution Model

1. Identify the problem that is causing the conflict.

2. Identify the feelings that are associated with the conflict.

3. Identify the impact of the problem that is causing the conflict.

4. Decide whether to resolve the conflict.

5. Work for resolution of the conflict.

- How would you like the problem to be resolved?
- Is a compromise needed?

We are now going to practice using the Conflict Resolution Model by roleplaying. *(Be careful not to push group members into a roleplay situation if they are not comfortable about it or ready. Exercise your clinical judgment.)*

The following are some topics for roleplays:

- Dealing with a rude or unhelpful salesclerk
- Dealing with someone offering you alcohol or drugs
- Dealing with a physician who will not take the time to explain how a medication works
- Dealing with a supervisor who does not listen to you
- Dealing with a counselor who repeatedly cancels your therapy/counseling sessions
- Dealing with a friend who does not respect your privacy

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Ask them to review the definitions of assertiveness, aggression, and passivity. Instruct them to practice using the Conflict Resolution Model, preferably once a day during the coming week. Remind them to continue to develop their anger control plans.

ANGER AND THE FAMILY

How Past Learning Can Influence Present Behavior

Sessions 9 & 10

Outline of Sessions 9 & 10

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
  - Anger and the Family
- Between-Session Challenge

Instructions to Group Leaders

As with sessions 7 and 8, sessions 9 and 10 are combined because it takes more than one session to answer the questions beginning on page 46 and connect the responses to current behavior.

Sessions 9 and 10 (comprising two 90-minute sessions) help group members gain a better understanding of their anger with regard to the interactions they had with their parents and in the families that they grew up in (Reilly & Gruszynski, 1984). The leader helps them see how these past interactions have influenced their current behavior, thoughts, feelings, and attitudes, as well as the way they now interact with others as adults.

Many people are unaware of the connection between past learning and current behavior. The leader presents several questions to group members that help them understand how their learning histories relate to current patterns of behavior. Because of the nature and content of this exercise, with its focus on family interactions, the leader must monitor and structure the exercise carefully, while providing a warm and supportive environment. If some group members have unresolved traumatic past experiences, the leader may want to adjust the depth of these conversation and ensure that extra supports are available to help them deal with their trauma. Experience has shown there is a tendency for group members to elaborate on many detailed aspects of their family backgrounds that are beyond the scope of this exercise. Family issues may bring up difficult and painful memories that could potentially trigger anxiety, depression, or relapse to drug and alcohol use. Therefore, the leader must tell group members that they are not required to address any questions that they feel would be emotionally overwhelming to answer. If group members do become overwhelmed in the course of answering, the leader should give them a minute to compose themselves or just stop discussing the issue. The leader should encourage them to pursue these and other issues with their individual or group therapist.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event and help them classify these cues into the four cue categories. Ask them to report on their use of the Conflict Resolution Model and the ongoing development of their anger control plans. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems and removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put this in your own words.)

Anger and the Family

In sessions 9 and 10, you will explore how anger and other emotions were displayed by your parents and in the families in which you grew up. For many of us, the interactions we have 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 usually were modeled for us by our parents or parental figures. The purpose of these sessions is to examine the connection between what you have learned in the past, in the families in which you grew up, and your current behavior and interactions with others now as adults. You will be asked a series of questions concerning your parents and families. This is an involved and often emotionally charged topic, so you do not have to answer any questions that you make you uncomfortable. Also, because there is a natural tendency to want to elaborate on family issues because of their emotional content, please focus on answering the specific questions:

1. Describe your family. Did you live with both parents? Did you have any brothers and sisters? Where did you grow up?
2. How was anger expressed in your family while you were growing up? How did your father express anger? How did your mother express anger? How did your siblings express anger? *(Use open-ended questions to explore. Reflect what is being shared. Consider summarizing answers, thanking members for sharing, and identifying statements that reinforce motivation for behavior change.)*
3. How were other emotions such as happiness and sadness expressed in your family? Were warm emotions expressed frequently, or was emotional expression restricted to feelings of anger and frustration? Were pleasant emotions expressed at birthdays or holidays?
4. How were you disciplined and by whom? Did this discipline involve being spanked or hit with belts, switches, or paddles? *(An assumption of anger management treatment is that no form of physical discipline is beneficial to a child. Empirical studies have shown that nonphysical forms of discipline are very effective in shaping childhood behavior [Barkley, 1997; Ducharme, Atkinson, & Poulton, 2000; Webster-Stratton & Hammond, 1997]).*
5. What role did you take in your family? For example, were you the hero, the rescuer, the victim, or the scapegoat?
6. What did you learn from your father and siblings about how men should act in a family? What did you learn about how men are supposed to act in society? What did you learn from your mother about how women should act in a family? What did you learn about how women are supposed to act in society? *(Many of the messages group members have received differ from messages that are socially appropriate today. Point out the changing roles of men and women.)*
7. What behaviors, thoughts, feelings, and attitudes carry over into your relationships as adults today? Identify both positive and negative behaviors, thoughts, feelings, and attitudes. What purpose do these behaviors serve? What would happen if you gave up the negative behaviors? *(Help group members see the connection between past social learning and their current behavior.)*

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues associated with the anger-provoking event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Remind them to continue to develop their anger control plans.

PRACTICE SESSION #2

Reinforcing Learned Concepts

Session 11

Outline of Session 11

- Instructions to Group Leaders
- Check-In Procedure
- Suggested Remarks
- Between-Session Challenge

Instructions to Group Leaders

In this session, the leader reviews and summarizes the basic concepts of anger management that were presented, paying special attention to clarifying and reinforcing concepts (i.e., the anger meter, anger awareness record, cues to anger, anger control plans, the aggression cycle, cognitive restructuring, and conflict resolution). The leader encourages and supports efforts to develop anger control plans and to balance cognitive, behavioral, immediate, and preventive strategies. Group members practice the various techniques they have learned.

Check-In Procedure

Ask group members to report their highest level of anger on the anger meter and report on their use of the anger awareness record during the week to identify the events that led to their anger, the cues that were associated with the anger-related event, and positive outcomes or negative consequences. Help them identify the cues that occurred in response to the anger-related event and help them classify these cues into the four cue categories. Ask them to report on the ongoing development of their anger control plans, including the social support plan. Provide encouraging and supportive comments for any efforts made, briefly discuss ways group members solved problems and removed barriers encountered with the between-session challenge, and encourage efforts moving forward.

Suggested Remarks

(Use the following script or put it in your own words.)

This session involves a second review session for the anger management material we have covered thus far. We will review each concept and clarify any questions that you may have. Here are topics that we might want to cover:

- Anger myths (pages 10–11)
- Changing the anger habit (page 11)
- Anger meter (page 13)
- Triggers for anger (pages 15–16)
- The four kinds of anger cues (pages 16–17)
- Anger awareness record (page 19)
- Anger control plans (pages 22–23)
- Enhancing social support (pages 23–24)
- Deep breathing and muscle relaxation (page 26)
- The aggression cycle (pages 28–29)
- Progressive muscle relaxation (page 30)
- A-B-C-D Model (pages 34–35)
- Thought stopping (page 35)
- Assertiveness training (pages 40–41)
- Conflict Resolution Model (pages 42–43)
- Anger and the family (page 46)

Discussion is encouraged during this review, and you will be asked to describe your understanding of the anger management concepts.

Between-Session Challenge

Have group members refer to the participant workbook. Ask them to monitor and record their highest level of anger on the anger meter. Ask them to use the anger awareness record to identify the event that led to their anger, the cues that were associated with the anger-related event, any positive outcomes or negative consequences, and the strategies that they used to manage their anger in response to the event. Remind them to update their anger control plans and to be prepared to present them in the final session next week.

CLOSING AND GRADUATION

Closing Exercise and Awarding of Certificates

Session 12

Outline of Session 12

- Instructions to Group Leaders
- Suggested Remarks

Instructions to Group Leaders

In the final session, group members review their anger control plans, rate the treatment components for their usefulness and familiarity, and complete a closing exercise. The leader reviews each anger control plan to balance cognitive, behavioral, immediate, and preventive strategies and gives corrective feedback if necessary. All group members should be congratulated for completing the anger management treatment, and each receives a certificate of completion (see sample on page 52).

Suggested Remarks

(Use the following script or put it in your own words.)

1. What have you learned about anger management?
2. List anger management strategies in your anger control plan. How can you use these strategies to better manage your anger?
3. In what ways can you continue to improve your anger management skills? Are there specific areas that need improvement?

CONGRATULATIONS

[NAME]

In Recognition of Completing the Anger Management Group in the Substance Abuse Outpatient Clinic

[ADD NAME OF CLINIC]

[DATE]

[NAME], Chief, Substance Abuse Clinic

[NAME OF COUNSELOR]

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Arlington, VA: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Awalt, R.M., Reilly, P.M., & Shopshire, M.S. (1997). The angry patient: An intervention for managing anger in substance abuse treatment. *Journal of Psychoactive Drugs, 29,* 353–358.

Bandura, A. (2018). Toward a psychology of human agency: Pathways and reflections. *Perspectives on Psychological Science, 13,* 130–136.

Barkley, R.A. (1997). *Defiant children: A clinician's manual for assessment and parent training* (2nd ed.). New York, NY: Guilford Press.

Brook, J.S., Balka, E.B., Zhang, C., & Brook, D.W. (2015). Intergenerational transmission of externalizing behavior. *Journal of Child and Family Studies, 24,* 2957–2965.

Brunner, T.M., Toale, S. J., Geffken, G., & Reid, A. (2014). Anger management in adolescents. In L. Rossman & L. Walfish (Eds.), *Translating psychological research into practice* (pp. 9–15). New York, NY: Springer.

Buades-Rotger, M., & Gallardo-Pujol, D. (2014). The role of the monoamine oxidase A gene in moderating the response to adversity and associated antisocial behavior: A review. *Psychology Research and Behavior, 7,* 185–200.

Buss, A.H., & Perry, M. (1992). The aggression questionnaire. *Journal of Personal and Social Psychology, 63*(3), 452–459.

Clark, H.W., Reilly, P.M., Shopshire, M.S., & Campbell, T.A. (1996). Anger management treatment in culturally diverse substance abuse patients. In *NIDA Research Monograph: Problems of Drug Dependence, Proceedings of the 58th Annual Scientific Meeting, College on Problems of Drug Dependence.* Rockville, MD: National Institute on Drug Abuse.

Coccaro, E.F., Berman, M.E., & McCloskey, M. (2017). Development of a screening questionnaire for DSM-5 intermittent explosive disorder (IED-SQ). *Comprehensive Psychiatry, 74,* 21–26.

Conger, R.D., Neppl, T., Kim, K.J., & Scaramella, L. (2003). Angry and aggressive behavior across three generations: A prospective, longitudinal study of parents and children. *Journal of Abnormal Child Psychology, 31,* 143–160.

Cuijpers, P., Cristea, I.A., Karyotaki, E., Reijnders, M., & Huibers, M.J.H. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. *World Psychiatry, 15,* 245–258.

Ducharme, J.M., Atkinson, L., & Poulton, L. (2000). Success-based, noncoercive treatment of oppositional behavior in children from violent homes. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(8), 995–1004.

Edmondson, C.B., & Conger, J.C. (1996). A review of treatment efficacy for individuals with anger problems: Conceptual, assessment, and methodological issues. *Clinical Psychology Review, 10,* 251–275.

Ellis, A. (1979). Rational-emotive therapy. In R. Corsini (Ed.), *Current psychotherapies* (pp. 185–229). Itasca, Il: Peacock Publishers.

Ellis, A., & Harper, R.A. (1975). *A new guide to rational living.* North Hollywood, CA: Wilshire Books.

Fernandez, E., Malvaso, C., Day, A., & Guharajan, D. (2018). 21st century cognitive behavioural therapy for anger: A systematic review of research design, methodology and outcome. *Behavioural and Cognitive Psychotherapy, 46*(4), 385–404.

Gilchrist, G., Munoz, J.T., & Easton, C.J. (2015). Should we reconsider anger management when addressing physical intimate partner violence perpetration by alcohol abusing males? A systematic review. *Aggression and Violent Behavior, 25,* 124–132.

Hall, G.C.N., & Ibaraki, H.Y. (2016). Multicultural issues in cognitive-behavioral therapy: Cultural adaptations and goodness of fit. In C.M. Nezu & A.M. Nezu (Eds.), *The Oxford handbook of cognitive and behavioral therapies* (pp. 465–477). New York, NY: Oxford University Press.

Heimberg, R.G., & Juster, H.R. (1994). Treatment of social phobia in cognitive behavioral groups. *Journal of Clinical Psychology, 55,* 38–46.

Henwood, K.S., Chou, S., & Browne, K.D. (2015). A systematic review and meta-analysis on the effectiveness of CBT informed anger management. *Aggression and Violent Behavior, 25*(Part B), 280–292.

Hopwood, C.J., & Wright, A.G.C. (2012). A comparison of passive-aggressive and negativistic personality disorders. *Journal of Personality Assessment, 94,* 296–303.

Hoyt, M.F. (1993). Group therapy in an HMO. *HMO Practice, 7,* 127–132.

Juster, H.R., & Heimberg, R.G. (1995). Social phobia: Longitudinal course and long-term outcome of cognitive behavioral treatment. *Psychiatric Clinics of North America, 18*, 821–842.

Kassinove, H., & Toohey, M.J. (2014). Anger management for offenders: A flexible CBT approach. In R.C. Tafrate & D. Mitchell (Eds.), *Forensic CBT: A handbook for clinical practice* (pp. 141–160). Malden, MA: Wiley-Blackwell.

Kuhns, J.B., Exum, M.L., Clodfelter, T.A., & Bottia, M.C. (2014). The prevalence of alcohol-involved homicide offending: A meta-analytic review. *Homicide Studies: An Interdisciplinary and International Journal, 18*(3), 251–270.

Lilienfeld, S.O., Lynn, S.J., Ruscio, J., & Beyerstein, B.J. (2010). *50 great myths of popular psychology: Shattering widespread misconceptions about human behavior.* New York, NY: Wiley-Blackwell.

Mackintosh, M.A., Morland, L.A., Kloezeman, K., Greene, C.J., Rosen, C.S., Elhai, J.D., & Frueh, B.C. (2014). Predictors of anger treatment outcomes. *Journal of Clinical Psychology, 70*(10), 905–913.

Morland, L.A., Greene, C.J., Rosen, C., Foy, D., Reilly, P., Shore, J., … Frueh, B.C. (2010). Telemedicine for anger management therapy in a rural population of combat veterans with posttraumatic stress disorder: A randomized noninferiority trial. *Journal of Clinical Psychiatry, 71,* 855–863.

Olatunji, B.O., Lohr, J.M., & Bushman, B.J. (2007). The pseudopsychology of venting in the treatment of anger: Implications and alternatives for mental health practice. In T.A. Cavell & K.T. Malcolm (Eds.), *Anger, aggression and interventions for interpersonal violence* (pp. 119–141). Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Owen, M., Sellwood, W., Kan, S., Murray, J., & Sarsam, M. (2015). Group CBT for psychosis: A longitudinal, controlled trial with inpatients. *Behaviour Research and Therapy, 65,* 76–85.

Piper, W.E., & Joyce, A.S. (1996). A consideration of factors influencing the utilization of time-limited, short-term group therapy. *International Journal of Group Psychotherapy, 46,* 311–328.

Pretzer, J.L., & Beck, A.T. (1996). A cognitive theory of personality disorders. In J.F. Clarkin & M.F. Lenzenweger (Eds.), *Major theories of personality disorder* (pp. 36–105). New York, NY: Guilford Press.

Reilly, P.M., Clark, H.W., Shopshire, M.S., & Delucchi, K.L. (1995). Anger management, post-traumatic stress disorder, and substance abuse. In *NIDA Research Monograph: Problems of Drug Dependence, Proceedings of the 57th Annual Scientific Meeting, College on Problems of Drug Dependence* (p. 322). Rockville, MD: National Institute on Drug Abuse.

Reilly, P.M., & Gruszynski, R. (1984). A structured didactic model for men for controlling family violence. *International Journal of Offender Therapy and Comparative Criminology, 28,* 223–235.

Reilly, P.M., & Shopshire, M.S. (2000). Anger management group treatment for cocaine dependence: Preliminary outcomes. *American Journal of Drug and Alcohol Abuse, 26*(2), 161–177.

Reilly, P.M., Shopshire, M.S., Durazzo, T.C., & Campbell, T.A. (2019). *Anger management for substance use disorder and mental health clients: Participant workboo*k. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Shopshire, M.S., & Reilly, P.M. (2013). Anger management treatment and substance use disorders. In E. Fernandez (Ed.), *Treatments for anger in specific populations: Theory, application, and outcome* (pp. 74–91). New York, NY: Oxford University Press.

Takebe, M., Takahashi, F., & Sato, H. (2017). The effects of anger rumination and cognitive reappraisal on anger-in and anger-control. *Cognitive Therapy and Research, 41*(4), 654–661.

Walitzer, K.S., Deffenbacher, J.L., & Shyhalla, K. (2015). Alcohol-adapted anger management treatment: A randomized controlled trial of an innovative therapy for alcohol dependence. *Journal of Substance Abuse Treatment, 59,* 83–93.

Webster-Stratton, C., & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology, 65*(1), 93–109.

Wydo, M.R., & Martin, R.C. (2015). An assessment instrument for anger management in correctional settings: The angry Cognitions Scale-Prison Form. *Journal of Rational-Emotive Cognitive Behavioral Therapy, 33,* 374–386.

Yalom, I.D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York, NY: Basic Books, Inc.

Zarshenas, L., Baneshi, M., Sharif, F., & Sarani, E.M. (2017). Anger management in substance abuse based on cognitive behavioral therapy: An interventional study. *BMC Psychiatry, 17*(1), 375.

APPENDIX

Authors' Acknowledgments

The authors would like to acknowledge the following original clinicians and researchers for their various contributions to the development of this manual and workbook:

Robert Awalt, Psy.D., Peter Banys, M.D., Torri Campell, Ph.D., H. Westley Clark, M.D., J.D., M.P.H., Darcy Cox, Ph.D., John Coyne, M.A., Timothy Durazzo, Ph.D., Sharon Hall, Ph.D., Anthony Jannetti, Ph.D., Monika Koch, M.D., Peg Maude-Griffin, Ph.D., Robert Ouaou, Ph.D., Teron Park, Ph.D., Amy Rosen, Psy.D., Sheila Shives, M.A., James Sorensen, Ph.D., David Thomson, LCSW, Donald Tusel, M.D., David Wasserman, Ph.D., and Lisa Wasserman, M.A. Dr. Durazzo assisted in editing the original manual.

In addition, the authors acknowledge SAMHSA staff, Darrick D. Cunningham, LCSW, BCD, and Arlin Hatch, CDR, USPHS, Ph.D., for their contributions in updating this manual as the Product Champions.

SAMHSA Publication No. PEP19-02-01-001
Substance Abuse and Mental Health Services Administration
First printed 2002
Updated 2019

SAMHSA
Substance Abuse and Mental Health
Services Administration