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CORE TASKS OF PSYCHOTHERAPY

1. Develop **therapeutic alliance** and help the patient "tell" his/her story. (After hearing the "pain," help the patient to identify "strengths" and signs of resilience. "What did he/she accomplish in spite of ...?" "How was this achieved?"

2. **"Educate"** the patient about his/her problem and possible solutions
   i. Convey information, use simple handouts
   ii. Have patient engage in self-monitoring and conduct situational analysis
   iii. Use videotape modeling films and other educational materials
   iv. Ongoing process

goal directed thinking

3. Help the patient **reconceptualize** his/her "problem" in a more **hopeful** fashion.
   i. Do life-review (time-lines). Identify "strengths."
   ii. Use videotapes
   iii. Use letter-writing, journaling
   iv. Use group processes

4. Ensure the patient has **coping skills**
   i. Train specific skills to the point of mastery
   ii. Nurture generalization

5. Encourage the patient to **perform "personal experiments"**
   i. Solicit commitment statements and self-explanations
   ii. Involve significant others
   iii. Take "data" from personal experiments as "evidence" to unfreeze beliefs

6. Ensure the patient **"takes credit"** for change
   i. Use attribution training – use metacognitive statements (**"notice,"** "catch," "interrupt," "game plan")
   ii. Nurture a sense of mastery

7. Conduct **relapse prevention**
   i. Be sensitive to beliefs that may block recovery
   ii. Consider the episodic nature and anniversary effects
   iii. Identify high risk situations and develop coping strategies

Additional Psychotherapeutic Tasks for Treating Patients With a History of Victimization

8. Address basic needs and safety and help develop symptom regulation including treating symptoms of comorbidity
   i. Consider sequential, parallel and integrated models of treatment

9. Address "memory work" and help after belief systems
   i. Consider various forms of "retelling" trauma story
   ii. Consider what implications (beliefs) the patient has drawn as a result of victimization experience
   iii. Consider impact on "shattered assumptions" and how to rescript narrative / life

10. Help the patient find "meaning"
   i. Consider what did to "survive"
   ii. What "lessons" learned
   iii. What evidence of strengths in self and in others
   iv. What role of religion (spirituality)

11. Help the patient "reconnect" with others: Address the impact on family members and on significant others
   i. How move beyond "victim" role
   ii. How move from "victim" to "survivor" to "thriver"
   iii. How engage in proactive "helper" role

12. Address issues of possible "revictimization"
   i. Issue of trust and nature of lessons learned

COGNITIVE-BEHAVIORAL TREATMENT PROGRAM: AN OVERVIEW

(Note, these treatments can be conducted on an individual, couples, family and group basis.)

Phase I: Initial Education and Conceptualization

Establish a therapeutic alliance, build rapport and trust (see DiGiuseppe, 1995; DiGiuseppe et al., 1994; Meichenbaum, 1994)

Conduct assessment procedures (Interview, self-report measures, self-monitoring) *Assessment strategy and measures.)*

Enhance client's personal awareness (Consider developmental and family of origin patterns; use imagery reconstruction, role playing.) Explore and understand anger and increase motivation for anger reduction.

Collaboratively develop treatment rationale and conceptualization and mutual goal setting.

Educate patients about the components and functions of anger and relationship to stress and aggression. Agree on acceptable means and goals of treatment.

Nature and functions of anger (Highlight that anger is a normal human reaction to a variety of perceived insults and that angry feelings have both positive and negative consequences.) **Negative** in the form of social, personal and physiological consequences (e.g., individuals with high levels of anger and hostility are at high risk for coronary heart disease). **Positive consequences** in terms of warning someone that something is wrong and that some form of self-protective action is called for or that there is a need to correct an injustice.

Individual profile – help the patient identify the chain of angry emotions, thoughts, and behaviors and obtain information about specific anger-evoking triggers. For example, have the patient tell or act out a "story" of the provocation-anger response. Along the way, ask the patient to identify and rate his/her feelings. At various points the therapist can ask, *"At that point how did you feel?"; "How much did you feel that way?"; "What were you thinking?"* Construct a **Personal Anger Provocation Hierarchy** that includes information about:

Triggers – physical, emotional, cognitive, behavioral (sources of anger and accompanying beliefs) ***"What lights the patient's fuse?"***

Early warning signs -- intra and interpersonal cues that indicate he/she is becoming angry and that his/her behavior is escalating toward violence

Setting events – identify high risk situations (where, when, with whom)

Role of exacerbating factors – alcohol, drugs, presence of peers

Role of coping responses -- ways to help the patient identify existing "strengths" or abilities in anger management and conflict resolution. Ask the patient about a time he/she felt angry or mad, but handled the anger in an "effective" and "reasonable" way. This discussion should start with "something positive".

Move to a problem-solving mode. Highlight that the patient has options in order to increase his/her sense of personal control.

a) **Intrapersonal** (e.g., what coping techniques used)
b) **Interpersonal** (e.g., discuss the value of sharing feelings about troubling events such as quarrels, relationship conflicts, or more serious incidents with a supportive listener -- see Pennebaker, 1992; Thomas, 1997

Engage in collaborative mutual goal setting (short-term, intermediate and long-term goal setting -- ***see questions below***).

Use bibliotherapy (see Clancy, 1990; Gottman et al., 1976; Mataskis, 1992; McKay et al., 1989; Sonkin & Durphy, 1984; Tavris, 1989; Thomas & Jefferson, 1996; Williams & Williams, 1993)

Phase II: Skills Training and Stress Inoculation Training

Teach patients how to:

1) develop **self-control skills** (identify provocation situations to which they are vulnerable, self-management relaxation training, taking time out, self-instructional training by means of behavioral and imaginal rehearsal, cognitive-restructuring, role playing, and in clinic and in vivo practice);

2) take **constructive action** on precipitants of anger whenever possible (problem solving, communication, bargaining, assertive, parenting, supervisory skills training, and the like);

3) employ **distraction and emotional-palliative** coping techniques when no constructive action is possible (e.g., use vigorous physical exercise, talk about angry incidents with a confidant).

Arousal reduction techniques including applied relaxation training – use slow deep breathing, cue-controlled relaxation which includes the use of calming imagery and slowly repeating the word "relax" and relaxing more with each repetition. Help the patient learn how to switch off anger images and anger-engendering self-dialogue and learn to visualize relaxation images. (See Suinn & Deffenbacher, 1988) (Note, relaxation training usually precedes cognitive-based intervention by 2 or 3 sessions)

Build in homework (address concerns about adherence - practice initially in nonstressful situations and then with a hierarchy of imaginal coping scenes) Eventually, **practice in vivo**.

Use taking time out procedures

Use self-instructional training patients are encouraged to generate their own self-statement package and self-control scripts

Use guided coping guided imagery training - use hierarchical scenarios from mildest to most anger arousing

Use role playing ("barb" or challenge techniques)

Use stress inoculation training (see Meichenbaum, 1985; Novaco, 1977; Awalt et al., 1997)

Phase III: Cognitive Restructuring and Problem-solving

Use **cognitive restructuring or "rethinking" procedures** – focus on reappraisal and reframing evidence-based, alternatives, and implication questions; use Socratic questioning and a **two chair dialogue** to help the patient differentiate the two sides of conflict.

Address the patients' beliefs about trust, fairness, injustice, entitlement (i.e., what they see as their "issues," values, convictions). View world as less conflict-oriented.

Use **coping modeling procedures** – initially show videotapes of individuals losing control. Have patients analyze these scenes and then generate alternatives. Then show coping models. Analyze and rehearse coping responses. Therapist can use think aloud and ask patients how angry they would feel if they were thinking in this manner. Consider alternative ways of thinking and behaving and possible benefits. Therapist can demonstrate and model anger coping responses in provocation situations that arise in therapy.

Problem-solving intervention (Goal, plan, do, check)

Social skills enhancement (listening, communicating, conflict resolution, assertiveness, bargaining to resolve a problem, parenting, supervisory skills.) Discuss what strategies to use at what phase of the de-escalation cycle (e.g., communication skills training – *see below*).

Discuss the **"wisdom" of postponing discussion of conflictual issues** until a more opportune time

Use **humor as a way to vent anger**, but discuss when and how to use it appropriately.

Use **application training** (imaginal role playing and behavioral rehearsal of simulated graduated exposure responses); apply coping skills under conditions of increased anger arousal, ***"barb" techniques***)

Train coping skills in conjunction with **progressive exposure** to graduated doses of provocation in a therapeutic setting and eventually in vivo.

Incorporate external prompts and consequences into treatment program.

Enlist peers and family members as "allies" in the treatment process. Encourage the patient to spend time with people who support the changes they are making.

Phase IV: Review and Plan for the Future

Self-attribution procedures -- ensure that patients "**take credit**" for the changes they have implemented

Relapse prevention procedures -- identify high-risk situations, early warning signs, and collaboratively develop plans and back-up plans of action; point out times of vulnerability to excess anger

Include follow-through and booster sessions

The treatment should be applied in a **flexible manner,** not in a lock-step progression. **The length of treatment usually varies between 6 to 20 sessions.** The number and timing of the treatment sessions are individually tailored to the needs of the patient. In general, the sessions are:

(1) once a week and in more severe cases initially twice a week;

(2) and eventually thinned out (every other week, once a month, once every 6 weeks, once every 2 months);

(3) use booster sessions ***("Strengthen anger antibodies").*** Booster sessions can be conducted on an individual, group, couples, or family basis.

In some instances, the trainers were selected and trained from the participant groups (e.g., police officers, marine drill instructors, vets, adolescents) who have gone through the training.

We will now consider some of the training procedures in more detail, namely:

1) **Developing a Therapeutic Alliance and Goal Setting**

2) **Time -out Procedures**

3) **Self-instructional Training**

4) **Cognitive Restructuring and Problem-solving Interventions**

5) **Communication Skills Training**

PROCEDURAL CHECKLIST FOR CONDUCTING SELF-MONITORING AND OTHER EXTRA-THERAPY ACTIVITIES

1. Provide opportunity for patient to come up with suggestion.

2. Provide rationale.

3. Keep request simple (use behavioral tasks and "foot in door" approach).

4. Ensure patient has skills.

5. Give "choice."

6. Build in reminders. Provide written reminders.

7. Check comprehension (use role-reversal).

8. Anticipate possible barriers.

9. Elicit commitment statements and "reasons."

10. Inquire about self-monitoring (other "homework" activities).

11. Nurture patient self-attributions ("take credit" change).

12. Reinforce effort and not product.

13. View failures as "learning opportunities."

14. Keep record of patient's compliance.

ANGER LOG

"Listening to Yourself with a Third Ear."
(See Deffenbacher et al., 1996; Feindler & Ecton, 1986; Gerlock, 1996; Meichenbaum, 1994)

Have the patient keep an Anger Log or Diary for several weeks, recording brief accounts of anger episodes. Subsequently the patient and the therapist can analyze this data for recurrent patterns and themes. Such Anger Logs can focus on the prompt-appraisal-anger expression sequence and the role of anger, hostility, and the accompanying aggression cycle. The Anger Log or Diary are designed to help the patient collect data on the frequency of anger experiences, the degree of anger experienced, and the ability to demonstrate control and coping responses. Patients are encouraged to record the full range of provocations, from minor annoyance to infuriating events in order to improve their ability to monitor and control their angry outbursts. The overall goal is to help the patient understand the daily experience of anger in his/her world.

Trigger	Describe "what happened"
Anger Level	Use a 0 to 10 "anger meter"
Note various gradient feelings of anger	Help the patient draw a distinction between feelings such as being "bothered, upset, irritable, hassled, annoyed, frustrated" **versus** "very angry, burned up, pissed off, irate, furious, enraged, boiling over, fit to be tied"
Anger-up thoughts and feelings	Thoughts that dehumanize, externalize, convey jealousy, sense of entitlement
Anger-down thinking	De-escalating thoughts and feelings
Behavior	What did the patient do? (Take time out, use relaxation, problem-solving)
Note other feelings and accompanying thoughts	Experience of jealousy, hostility, loathing, disgust, anxiety, depression

Another form of self-monitoring that can be used is to ask the patient to **plot the intensity of anger** on a 10-point scale on the vertical axis (1 being annoyance, 5 being anger, and 10 being rage) and plot time of anger on the horizontal axis (Beck & Fernandez, 1998).

Meichenbaum

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MY GOAL SHEET

A Goal is something I want to get or something I want to have happen and I am willing to work for it.

My goal is:

The change(s) I want to make are:

The most important reasons for changing are:

The steps I plan to take in changing are / or the advice I would give someone else to achieve this goal is:

How can I get started? What small changes can I make to begin with?

The ways other people can help me are:

Person:	Possible ways they can help:

I will know if my plan is working if:

Who else would notice the change? What would he/she observe?

Some things that would interfere with my plan are:

If my plan does not work, I will: ***("I will be on the lookout for ..."; "Whenever I see .. I will do ...": "I will tell myself ...")***

What else do I have to do to increase the likelihood of achieving my goals?

a) Include reminders ("if ... then" statements; "Whenever" statements)
b) Conduct a cost-benefit analysis (pros-cons, short-term, long-term benefits)
c) Share my plans with supporting others
d) Make commitments statements
e) Take credit for my efforts
f) Reinforce myself

DIFFERENT WAYS TO CONDUCT EDUCATION

The therapist can educate patients about the nature of anger and coping processes using a variety of procedure, including:

1. **Interviewing** the patients about current and developmental difficulties and strengths, using time lines to identify risk and protective factors;

2. **Assessing** the patients and providing feedback;

3. **Sharing a Case Conceptualization Model;**

4. Having the patient engage in **self-monitoring;**

5. **Discussing** with the patient the adaptive and maladaptive functions of anger, warning signs, conflict cycle, nature of provocations, cognitive distortions, relapse prevention, and defensive responses such as denial, minimization of severity, rationalization about how one is provoked (A, B, C analysis) and the tendency to blame others;

6. **Considering myths** concerning anger and aggression

7. Considering **cultural influences** - code of honor, street code, gender influences;

8. Incorporating within the education discourse **metaphors, analogies, journaling, letter-writing** (e.g., See Wexler, 2000, House of Abuse and House of Self-worth and Empowerment);

9. **Therapist modeling, using coping-oriented self-disclosure, story-telling;**

10. **Providing written materials**, handouts for the patient and spouse, refer to books and Websites on anger control;

11. Engaging the patient in **skills-training** procedures (e.g., relaxation, self-instructional training, communication skills) and providing individual and /or group with feedback;

12. Using **videotape modeling films, relaxation tapes**, etc.;

13. Having the patient engage in **graded experiments** (in therapy -- imagery-based, behavioral rehearsal and outside of therapy);

14. Putting the patient in a **consultative mode** (patients are asked to explain what to do and examine why and how they brought about change). Engage patients in **self-attributions** (have them "take credit" for change).

Table 21
WHAT KIND OF SITUATIONS MAKE PEOPLE ANGRY:
***CODING* PROVOCATIONS**

I I	C E	HOPE

Interruption of planned activities and obstacles to goal-directed behaviors – the closer someone is to the achievement of his/her goal, the greater is the frustration and anger when interrupted

Implications of noncompliance (possible short and long-term consequences of the significant other not complying) – e.g., not only what others do, but the implications for the future as in the case of significant others engaging in unhealthy behavior

Concern about possible injury to others or to self and possible concern of what might have happened – e.g., other engaging in high-risk behaviors

Expectations violated – disruption of the flow of interpersonal interactions by breaking implicit shared rules. Something that significant other "should" or "should not" be doing that elicits anger

History repeats itself (over and over again) – pattern of annoying behaviors that can accumulate over time

Overload of the individual – fatigue or stress can lessen the tolerance level of the individual (i.e., it takes less to get someone angry – "straw that breaks the camel's back")

Personal peeve (violation of personal rules and values) – e.g., being "dissed" or disrespected in front of others

Embarrassment (noncompliant behavior occurs in public places in front of others)

FIGURE 1
ANGER - AGGRESSION CYCLE

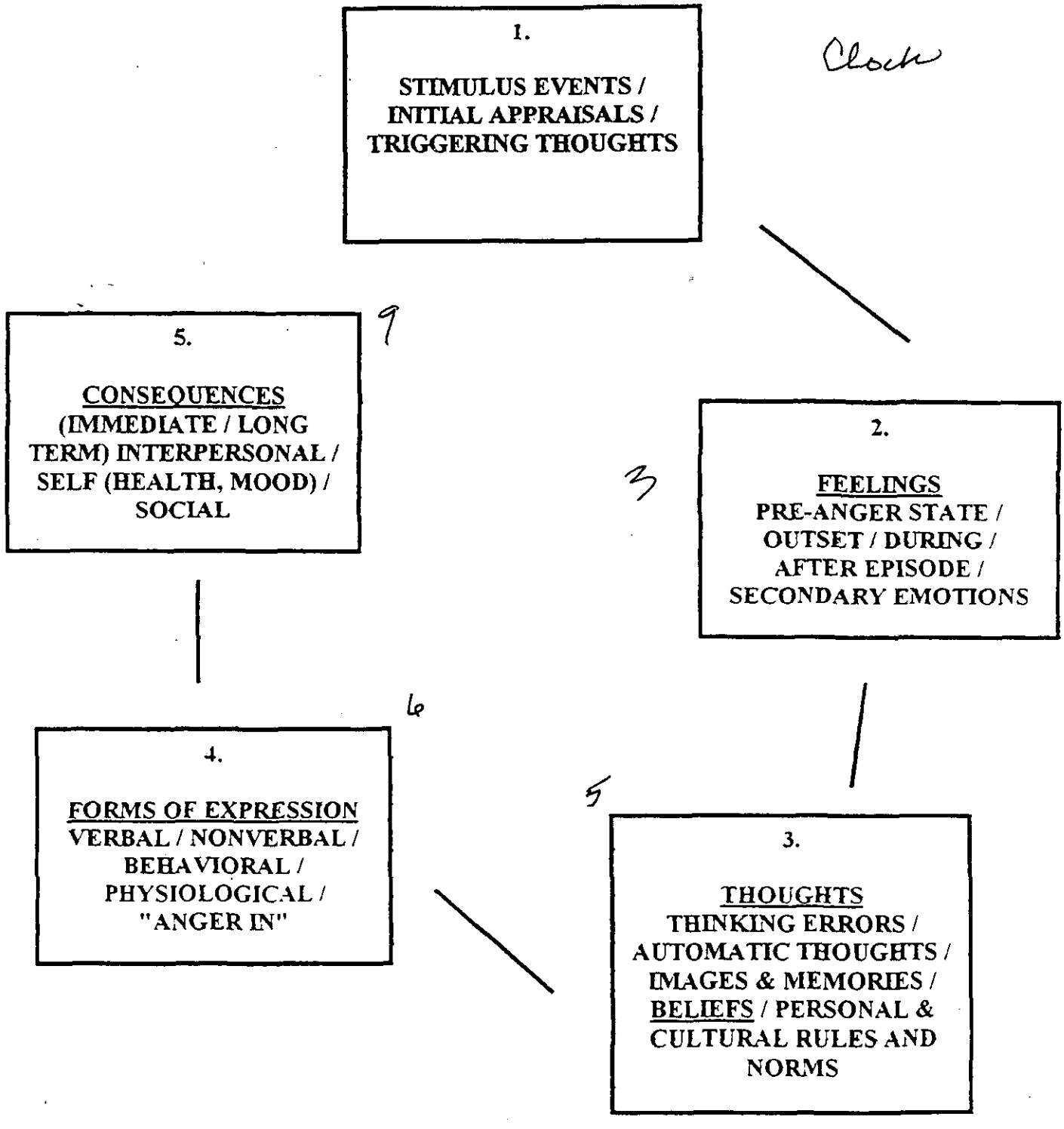

FIGURE 6
UNDERSTANDING "CORE HURTS"

I am feeling [**Name feelings**: Frustrated, Disappointed, Sad, Lonely, Ashamed, Afraid] **which means that I am** [Unlovable, Defective, Unimportant, Useless, Abandoned, Powerless, Helpless] **that leads to feelings of** [Shame, Guilt, Rage, Panic, Depression, Jealousy]

which leads to my behaving [**Overt**: Aggressively Toward Others, Property, Self — **Passive /**: Aggressively Towards Others, "Yes/ Buts", Avoidance] **with the result that** [**Elicit**: Negative reactions from others; Negative feelings; Counter-aggressive behaviors] **Thus, the "Cycle" Continues**

LEARNING TO USE TIME OUT (TO) PROCEDURES

One of the most effective self-control techniques that patients who have anger-control problems can use is **learning how to take a time out**. But, it turns out that taking time out is a **complex skill** involving the following multiple behavioral components.

1) identify *early and interruptible* cues (i.e., personal profile of warning signs – physical and behavioral cues)

2) discuss taking TO – not view taking time out as "rolling over," "giving in," or "selling out;" view taking time out as an opportunity to exert self-control (use sports metaphor of taking an opportunity to create a game plan)

3) remove self for a period of time (length of time depends on the situation)

4) rehearse and use exit lines and exit behavior (no slamming doors)

"I'm beginning to feel like things are getting out of control and I don't want to do anything that will mess up our relationship. So I need to take a time out."
"I need some time to think it over." "I'll get back to you tomorrow."
"I am getting angry now and I will say things I do not mean or that I will regret."
"I need some time to calm down." (Provide an estimate of how long planning to be away.)
"We both just need a break right now until things calm down."
"I'm going out for a walk around the neighborhood. I'll be back in 15 minutes. Let's try talking about this when I get back. Okay?

5) handle others' possible negative reactions to taking a time out

"Call me what you will, but I am not going to get caught up in this."
"I need to get my act together."
"I'm going for a walk, and when I get back, we can talk about it."

6) give oneself permission to take time out

"I am getting pissed off. It is okay to take time out."
"Let my feet do the talking, not my hands."
"I am going to use my thought stopping and interrupt this cycle."

7) role play and imagery rehearse the use of time out procedures (e.g., review what to do if partner blocks path to leave)

8) discuss and practice what to do during time out (e.g., not brood, not think about retaliation, not curse, not use inflammatory language, not drive, not use drugs, but rather use anger reduction procedures). Include implementation intention statements such as "Whenever situation X arises, I will do Y."; "If ... then" statements, "When and where" statements." (See Gollwitzer, 1999, for discussion of goal statements.)

9) once "calmed down" return to the scene and call "time in" (not avoid the situation)

10) solicit commitment statements and the reasons for using time out procedures; teach others – put patient in a consultation mode where they can describe how to use time out and why doing so is important to them.

11) patient needs to inform partner in advance of purpose and steps involved in taking a TO. (See Wexler, 2000 pp. 55-56 for a partner handout sheet on TO.)

12) follow procedural guidelines for giving "homework." Check patent's comprehension, skills, commitment to use TO. Anticipate possible barriers ***("What problems do you think you will have in using the TO?")***

13) provide summary of time out procedure:

a) "stop-gap" measure - it does not resolve the issue, but puts it on hold
b) way to avoid conflict, control anger, and a sign of respect for the relationship
c) TO should not be used as a weapon or as a controlling device against others
d) learning to take TO is a "skill" that needs practice
e) learn to anticipate high-risk situations and recognize early warning signs. Develop a **Responsible Game Plan.**
f) learn to view "provocation" as a "problem" in search of a solution

14) In subsequent sessions review the patient's use of TO. Ask the patient:

"Did you use the TO procedure?"
"How did it work?"
"Could you feel the anger being worked off when you took a TO?"
"What problems do you anticipate in using the TO in the future?"

Another important self-control skill is learning how to **use self-talk**. In preparing patients to use **coping self-statements** the therapist should go through the following steps:

1) help patients appreciate that their anger sequence consists of <u>different phases</u>

   a) preparing for stressful encounters and getting worked up;
   b) having to deal with confrontations;
   c) dealing with anger at its most intense point;
   d) reflecting back on how they handled the situation;

2) reviewing what thoughts and feelings they had at each phase and their negative anger-inducing impact;

3) considering what different thoughts and feelings they might use instead at each phase;

4) collaborate with patients in generating a possible list of individualized coping self-statements;

5) sharing the list of what other patients who have had problems controlling their anger have come up with;

6) discuss where and how the patient can use their self-statements.

The patient is taught how to **rescript angry dialogues** and **images**. Such "**rethinking**" exercises are **like writing scripts of internal plays in one's head**. In the rescripted version the patient alters the images and self-dialogue so the central character in the **internal play** they have in mind is calm and controlled, but <u>not</u> emotionally detached, nor withdrawn (Deffenbacher, 1999). For example, consider the following **anger control scripts** developed by one patient:

> ***This is going to upset me, but I know how to deal with it. ... Try not to take this too seriously. ... Time for a few deep breaths of relaxation. ... Remember to keep my sense of humor. ... Just roll with the punches; don't get bent out of shape. ... There is no point in getting mad. ... I'm not going to let him get to me. ... Look for the positives. Don't assume the worst or jump to conclusions. ... There is no need to doubt myself. What he says doesn't matter. ... I'll let him make a fool of himself. ... Let's take the issues point by point. ... My anger is a signal of what I need to do. ... Try to reason it out. ... I can't expect people to act the way I want them to. ... Try to shake it off. Don't let it interfere with my job. ... Don't take it personally.***

Procedural Steps in Using Provocation Scenes

1. Engage patients in a **collaborative process** in understanding the purpose and importance of practicing their coping skills in arousing and tension-producing situations. Have the patients contribute specific examples of provocation situations. Use the patient's Anger Logs and the conceptualization of provocation situations (*II CE HOPE*) to generate examples.

   a) Highlight that it is important to learn how to experience anger without reflexively acting out.

   b) How to tolerate anger without immediate retaliation.

   c) How to learn not to be afraid of angry feelings.

2. **Involve the patients** in generating specific verbal and nonverbal provocations that elicit anger and aggressive behavior. Ask them to consider the full range of emotions. What would it take to make them feel only annoyed, irritated, bothered, frustrated versus really angry to the point of acting out? Help them identify the key words and behaviors that trigger anger (e.g., when someone refers to the patient as, "You people!").

3. **Coping imagery procedures** can also be used as a form of cognitive rehearsal. The patient can be asked to visualize an anger-provoking scene and signal (raise finger) when anger is being experienced. The patient is told to pay attention to the anger and let it build. After 20 to 30 seconds of arousal, the patient is encouraged to generate a coping image (seeing themselves using their coping repertoire).

4. Use group members to **provide "barbs" (challenges).** Have the targeted patient and the therapist sit in the middle of a circle and practice coping with these provocations. The therapist can coach the patient by whispering suggestions:

   "Keep calm. Use your breathing control procedures. Remind yourself not to take it personally. You have choices! See it as a problem-to-be-solved and not a personal threat."

5. Afterwards ask the group members for **constructive feedback** on how the patient handled the challenges. Note that learning to handle anger is a skill that takes time and practice. (Ask for example of skills training.) As part of the feedback, the patient or the group of patients can be asked"

   "What did the patient do well? What were the first signs of tension that they saw? What were the emotional messages sent by the different kinds of body language? What else could the patient have done to improve how he/she coped?"

6. When using the barb technique, **graduate the exposure** from low to higher provocation situations. Slow down and pace the challenges to meet and extend the patient's coping skills. Such exposure trials usually **lasts about 10 minutes**.

7. Review with patients how they can use their coping responses in **real-life situations**. What might get in the way of their using their coping skills?

8. As patients develop anger management skills, they can be encouraged to practice them **in vivo, in a graduated fashion**, beginning with the least challenging situation. The patient can rate situations along a dimension of Subjective Units of Distress (SUDS). The patient can begin with situations that fall at the 50 SUDS level on 100 SUDS scale. The therapist should build in **back-up plans** and **relapse prevention procedures**, in case the coping procedures (e.g., assertive skills) do not work.

9. Such barb procedures should not be used when patients evidence alcohol or drug influence and may be under their influence during treatment or when they evidence schizophrenia, especially when there is evidence of intrusive ideation of personal threat of harm from others. (See Hiday, 1997, for a discussion of the relation between mental illness and violence).