

Exposure-Based Treatment for Anger Problems: Focus on the Feeling

Elizabeth Brondolo
St. John's University

Raymond DiGiuseppe
*St. John's University and Institute for
Rational Emotive Therapy*

Raymond Chip Tafrate
Hofstra University

Excessive anger can foster health problems and damage relationships. Traditional methods for treating individuals with anger-related problems have employed skills training and relaxation methods. This paper proposes that anger and anxiety share many clinical features, and that intervention models that have been effectively employed in the treatment of anxiety disorders can also be used safely in the treatment of anger-related difficulties. Specifically, exposure and response prevention can be effectively integrated with other cognitive behavioral approaches in the treatment of anger problems. Procedures for conducting these treatments are described. Examples are drawn from clinical work with New York City traffic agents, dysfunctional couples, aggressive children, and outpatients self-referred for anger problems.

Excessive anger can damage interpersonal relationships, impair the ability to work productively, and may lead to or exacerbate health problems (Averill, 1982; Friedman et al., 1984; Novaco, 1975; Scherwitz & Rugulies, 1992). Although there are no formal diagnoses for anger disorders in the American Psychiatric Association's (APA; 1994) *Diagnostic and Statistical Manual of Mental Disorders*

(*DSM-IV*), practitioners commonly encounter anger-related problems in clinical practice. The purpose of this paper is to describe a program for the treatment of anger problems that is modeled on the exposure-based treatments used for anxiety disorders.

Anxiety disorders and their treatments have been well studied, and this knowledge can provide a useful conceptual framework to apply to anger problems. The first section of this paper will outline the components of anger, and contrast these components to those associated with anxiety. The second section will describe a multifaceted exposure-based treatment program for anger problems. Clinical examples will be drawn from work with couples, employees working in high-conflict situations, aggressive children, and self-referred men with anger-related problems.

The Experience of Anger

As is the case for anxiety, the experience of anger has multiple components. Perceptual, cognitive, physiological, and behavioral dimensions are involved in each experience of anger.

Function

The emotions of anxiety and anger both function to prepare and protect individuals from harm (Selye, 1978). In the face of injustice, inequality, or danger, both anxiety and anger can be powerful motivating forces for personal or social change. The failure to experience either emotion in the face of threat might result in reduced coping resources. However, these emotions can become problematic if they are evoked too frequently or too intensely, or if they persist for a prolonged duration. They may also become problematic if they are associated with patterns of aggression or avoidance that interfere with work or interpersonal relations. Chronic or intense anger may be associated with excess physiological arousal, which can promote the development of cardiovascular and other diseases (Krantz & Manuck, 1984).

Perceptions and Cognitive Processes

Certain information processing styles or cognitive processes are characteristic of anxiety disorders. For example, in anxiety, individuals are more likely to perceive neutral stimuli as dangerous. They overestimate the likelihood of the occurrence of the feared stimuli, and underestimate their own ability to tolerate the experience of anxiety and distress (Barlow, Craske, Cernz, & Klosko, 1989).

Deffenbacher (1994) and Ellis (1977) have proposed several cognitive processes that contribute to anger. These include overestimating rejection by others, catastrophizing, overgeneralization, dichotomous thinking, and mind reading. These information processing styles may make it more likely that individuals

will perceive a stimulus as provocative. If these cognitive processes are evoked automatically following a provocation, effective resolution of the conflict may be more difficult.

Dodge (1985) provides some evidence that aggressive children make estimation errors, misperceiving other people's intentions or the degree of personal threat. Estimation errors may emerge when individuals are hypervigilant in their search for potential threats. If angry individuals focus on a perceived threat to the exclusion of other information, they may miss information that could help them to reinterpret the threatening stimuli in a more neutral manner. This style of information processing can heighten the sense of emergency and limit the ability to view situations from several perspectives.

In catastrophic thinking or overgeneralization, the individual draws faulty conclusions about the causes of a provocative event. The angry person may bypass a detailed, more step-by-step analysis of the problem and jump to a catastrophic conclusion. For example, given a disturbing event (e.g., the boss criticizes a piece of work), the angry individual immediately jumps to the "worst-case scenario" (e.g., "My boss doesn't respect me at all!"). In dichotomous, or "black-and-white," thinking, individuals process only a limited amount of information at any given time, making it difficult to perceive complex situations. For example, a person engaged in dichotomous thinking may say to him or herself, "I'm either a winner or a loser in this situation. I can't tolerate being a loser, so I'd better fight back." He or she has difficulty thinking about cases in which some aspects of a situation might be won and others forfeited.

These cognitive processes may emerge from the heightened arousal characteristic of anger (Berkowitz, 1990). When preparing for "fight or flight," individuals focus their attention on the perceived threat, ignoring distracting stimuli from the periphery. In the heat of the moment, they may make rapid global assessments of incoming information. These judgments have the advantage of speed, but are often rigid or limited. Unfortunately, when judgments are made in the presence of strong emotion or heightened physical arousal, individuals may view the conclusions as being especially truthful.

Cognitions

Anxious individuals hold a variety of faulty beliefs concerning the relationship between feelings of anxiety and their own morbidity and mortality (e.g., "I feel anxious, therefore I might die or go crazy"), and the relationship between certain random events and negative outcomes (e.g., "My husband is a half hour late, he must have been in a car accident").

In general, individuals respond with anger to situations regarded as unfair, unjust, dangerous, or frustrating, and in which the offense is judged to be intentional (Deffenbacher, 1994). Angry individuals may hold a variety of faulty beliefs about the intentionality of the violation or the degree to which they can tolerate the offense. Anger-prone individuals may feel that other people must

be nice, behave fairly, or show proper respect (e.g., "If people aren't polite, it means they don't respect me; I can't tolerate any message in which I am not respected"). The degree to which people hold irrational beliefs about fairness and other issues is associated with their propensity to feel angry (Lohr, Hamberger, & Bonge, 1988). Data on the relationship between hostile attitudes and angry responses to different situations suggest that cynical and suspicious attitudes (i.e., beliefs about trust and fairness) are associated with the propensity to feel angry more often and more intensely (Smith, 1992).

Attitudes toward the effectiveness of aggression may influence the choice of anger expression style (Lazarus, 1991). Examples of irrational beliefs that may lead to the aggressive expression of anger include ideas about the relationship between suppressed anger and illness (e.g., "If I don't express my anger I will get sick or go crazy"); incorrect beliefs about the relationship between the expression of anger and the communication of personal values (e.g., "If I don't express my anger, I am giving permission for the person to do this bad or immoral or provocative thing"); and faith in the effectiveness of aggression (e.g., "If I threaten them, they will listen to what I say").

Cognitions associated with the anxious or resentful suppression of anger may include ideas about the dangers of retaliation if they express anger (e.g., "If I express myself, the other guy will blast me"); concerns about losing control (e.g., "If I let my feelings out, I'll never stop hitting or yelling and I'll destroy the other person or go crazy"); or cynical beliefs about the effectiveness of the effort (e.g., "It doesn't matter what I say or do, nothing will ever change. I have no personal power").

Physical Sensations

Both anxiety and anger are associated with an increase in perceived arousal, although the physiological systems involved in the response may differ between emotions and among individuals (Henry, 1986; Levenson, 1992; Seyle, 1978). In acute states of anger and anxiety, people can report feeling a dry mouth, racing heart rate, rapid breathing, and muscle tension. There is also evidence that hostile or habitually angry individuals display greater cardiovascular reactivity (i.e., greater blood pressure responses) in response to interpersonal provocations (Suls & Wan, 1993). In turn, the unpleasant sensations associated with physical arousal can foster more aggressive behavior and hostile attitudes (Berkowitz, 1990).

Behaviors

On a behavioral level, anxiety is associated with both avoidance (e.g., distraction, escape maneuvers) and compulsive behavior (e.g., checking, hair pulling). Anger is associated with a different set of behaviors, and there is less agreement on methods for organizing these behaviors. Harburg and colleagues (Harburg, Blakelock, & Roeper, 1979; Harburg, Gleiberman, Russell,

& Cooper, 1991) draw the distinction between reflective and impulsive expressions of anger. In reflective responses, individuals can modulate the experience of emotion, and develop a reasoned response to provocation. In impulsive responses, the reaction is automatic, triggered by the experience of the anger. Impulsive responses can include both aggressive behavior, characterized by yelling, hitting, or the immediate, but resentful, suppression of anger, seen in sulking, pouting, or withdrawal. This contrast among calm reflection, aggressive expression, and resentful suppression reflects a common distinction drawn by researchers (Spielberger et al., 1985). These dimensions can also be conceptualized as calm assertion, aggression, and resentful passivity.

Models of Anger

There are a number of models of the interrelationships among the different facets of anger (Averill, 1982; Berkowitz, 1993; Kassinove & Eckhardt, 1995; Novaco, 1975; Spielberger et al., 1985). For the purposes of this article, we can summarize the relations among the components of anger by describing one possible model of the relations among mood, cognitions, and behavior. The chain of events leading to an aggressive or suppressed response to anger starts with a trigger or provocation. The link between a particular trigger and an angry response may depend on an individual's learning history. Classical conditioning can account for relations between some triggers, such as tone of voice and anger (Salzinger, 1995). Cognitive processes, such as estimation errors, may increase the likelihood of detecting or perceiving a provocation (Lazarus, 1991). A negative mood or physical discomfort can make a previously neutral stimulus more likely to evoke anger (Berkowitz, 1990). Certain situations, which are unjust or dangerous, also make it more likely that individual will experience anger (Harburg et al., 1979).

An Anger-Evoking Chain

The triggers may set in motion a chain of events characterized by heightened arousal, fueling the tendency to focus on the threat and make more negative judgments about it (Berkowitz, 1990; Novaco, 1975). The ability to make reasoned or analytic judgments about the situation may diminish, as the angry person favors a more impulsive style of information processing (Ellis, 1994). Heightened arousal and rapid automatic information processing may propel the angry individual toward impulsive behavior. Depending on the circumstances, this may result in a resentful suppression of anger or an aggressive outburst (Harburg et al., 1991; Novaco).

The process may be interactive. For example, muscle tension and discomfort increases the likelihood that a situation will be viewed as provocative. In turn, the experience of being provoked and the resulting anger can increase muscle tension. The tendency to use a dichotomous thinking process both increases

the likelihood that a stimulus will be perceived as provocative and then engenders difficulties in resolving conflict situations.

This model directs our clinical interventions by highlighting facets of the experience and expression of anger that might benefit from intervention. All models of anger emphasize the importance of analyzing the triggers of anger. By bringing trigger stimuli to conscious awareness, therapists try to "break the chain" that links these triggers to automatic and destructive thoughts and actions. By exposing the person to the experience of anger, without permitting any retaliatory action, the automatic emotional response to the trigger stimulus can be extinguished. Breaking the link between the trigger and arousal may permit the development of a more reasoned approach to conflict.

Treatment Models

Most recommended treatments for anxiety disorders (e.g., specific phobias, generalized anxiety disorder, panic disorder, and obsessive-compulsive disorder [OCD]) focus primarily on teaching patients to tolerate feelings of anxiety (Barlow, 1988; Foa, Steketee, & Ozarow, 1985; Josephson & Brondolo, 1993). In these exposure-based methods, clinicians rapidly expose the patient to feared stimuli, and prevent the patient from using avoidant or ritualistic behavior as a means of lessening the anxiety. Although therapists will often teach patients new methods for coping with anxiety-evoking situations, these skills-training interventions serve as secondary treatments following exposure.

Despite the lack of an official *DSM-IV* diagnosis for anger disorders, researchers and clinicians have developed a variety of effective treatments to reduce difficulties commonly viewed as the problematic behavioral expression of anger. These difficulties can include aggressive behavior (Feindler, 1994; Patterson, Reid, & Dishion, 1992), heart disease (Friedman et al., 1984), and spouse abuse (O'Leary, 1993), among others. These programs emphasize a skills-building approach, employing assertiveness training or social skills training plus relaxation and self-control among other techniques (Deffenbacher, 1988; Friedman et al.; Novaco, 1975; Schneider & Byrne, 1985).

However, because there are many similarities between anger and anxiety (Deffenbacher, 1994), it may be helpful to view the treatment of anger from the perspective of the models proposed by Barlow (1988) and others for the treatment of anxiety disorders (Foa et al., 1985). Treatment programs based on these models may be worth adding to the repertoire of interventions available for these anger-related problems.

Skills Building

Skills training approaches focus largely on behavior. They are based on operant conditioning principles, focusing on the anticipation of potential rewards for newly acquired prosocial skills. It is assumed that the positive con-

tingencies that follow effective problem solving will reinforce the use of new strategies rather than the previous ineffective strategies. In contrast, exposure and response prevention methods focus on both the affective and behavioral response to provocation. These methods draw on principles from classical conditioning and work to separate affective responses from overlearned but ineffective behavioral responses (Wilson, 1990). The goal is to present the anger-eliciting stimulus for a sufficient length of time that the emotional response to the stimulus will extinguish. Although no direct comparison between these two contrasting approaches (exposure versus skills training) has yet appeared, we propose that exposure-based methods can be used safely and can be integrated with more standard treatment approaches to improve the overall efficiency of the intervention.

Multifaceted Approaches

It is important to recognize that anger-related behavioral difficulties, such as aggressive behavior, heart disease, or spousal abuse, are likely to be multi-determined and influenced as much by systemic forces (e.g., legal consequences for aggression, access to health care) as they are by intra-individual forces. Multifaceted treatment is often needed (Brondolo, Baruch, Conway & Marsh, 1994). The individually oriented exposure and response prevention techniques outlined here can be useful to treat the component of these problems (i.e., aggressive behavior, heart disease, or spousal abuse, etc.) resulting from excessive anger.

Injustice and Anger

In addition, extreme anger can be an appropriate and necessary response to unjust or dangerous conditions (e.g., unequal distributions of rewards, access to resources, or exposure to risks). In these cases, identifying and, when possible, addressing the systemic factors responsible for these conditions is a critical step. Modifying individual pathology, without regard for the systemic factors contributing to the anger, can be seen as blaming the victim and further undermining the patient's dignity and rights.

For example, this conflict reduction program was delivered to New York City Department of Transportation Traffic Enforcement Agents. Traffic agents issue summonses for vehicular and parking violations. They are frequently harassed by motorists who are angry about receiving these summonses. Managing anger during and after these conflicts is a crucial component of the traffic agent's job. This treatment program was part of a package of interventions delivered to the entire agency. Part of the process of recruiting agent participants was to openly acknowledge that the agents receive serious, humiliating, and potentially dangerous provocations from members of the public. This permitted us to treat anger-related problems, but within a context in which the validity of the anger was acknowledged.

Treatment Protocols

Overview

The treatment package described here has five critical components: inspiring hope, analyzing triggers, reducing arousal, exposure and response prevention, and consolidating support. These components employ a series of cognitive, affective, and behavioral exercises. In the next section the components of treatment are presented in the order in which they were administered during an ongoing clinical trial of exposure-based treatments for conflict management with New York City traffic agents. These programs form the core of a 9-week program in conflict management, which has been conducted with over 79 traffic agents to date. The agents are not a clinical sample; however, they are exposed to a high level of provocation as a function of their job and report that conflicts with the public elicit high levels of anger and contribute to job stress (Brondolo, Jellife, Quinn, Tunick, & Melhado, 1996). Additional examples are drawn from experiences each of us has had working with different clinical samples, including conduct disordered and aggressive children, couples with severe marital problems, and self-referred angry men.

Introducing the Techniques

The first few sessions serve to build alliance and trust, to gain information about provocative situations, and to teach methods for physiological control of arousal (DiGiuseppe, Tafate, & Eckhardt, 1994). The first step is a cognitive exercise designed to inspire hope by "accentuating the positive." The therapist works with each client to identify existing strengths in anger management and conflict resolution. The discussion also focuses on the benefits of effective anger management. By starting with an emphasis on success, the task of effectively managing anger does not seem so daunting.

For example, in the agent groups, we begin each session by "Starting with something good." This is a technique we have previously used with patients with OCD to encourage a continued focus on the ability to tolerate anxiety (Brondolo, 1994). In the anger management groups, agents begin the group by identifying some moment in the past week in which they felt happy, proud, interested, or satisfied. In marital therapy and in groups for aggressive children, participants start the session by identifying a specific example in which anger was managed in a reasonable way (e.g., "Tell me something good that happened this week. Tell me a time when you felt angry or mad, but handled the anger in an effective and reasonable way").

It may also be helpful to "accentuate the negative" by highlighting the costs of excessive anger. Some of these costs can include impaired concentration, marital disruption, violence, etc. By focusing on the costs of the inappropriate behavior, we hope to generate motivation for the effort to change (Azrin & Nunn, 1973).

Analyzing Triggers

The thorough behavioral assessment of the anger-evoking stimuli is the goal of this component. The key to the success of the entire treatment package is the careful analysis of those aspects of a situation (i.e., the tone, the gestures, the verbal content, or the environment) that started the chain of angry emotion. Teaching skills in behavioral analysis is the first step.

One way we obtain information about the specific anger-evoking trigger is to ask people to tell us or act out the story of the provocation. The first time, if they wish, they can tell the whole story without stopping. The next round, we stop them at each step along the way and ask them to identify and rate the intensity of their feelings.

For example, in an agent group, one agent told a story about a well-dressed man who came running up to her traffic enforcement car as she was stopped at a stop light. The man screamed, "Are you gonna write a ticket to my car? Don't you write a ticket to my car!" This situation later erupted into a serious argument that was halted by the presence of a supervisor.

Initially the agent simply told the group the entire story. To understand why this situation was so provocative for the agent, we asked her to begin to role play the situation from a period about 10 or 15 minutes before she encountered this motorist. To help her identify the feelings and thoughts she experienced during this exchange, she was frequently reminded to use the "Feeling Board." This is a large board containing a list of about 30 feelings (angry, embarrassed, relaxed, etc.). At the bottom of the board is a line extending from one side of the board to the other, with one end marked 1 (*not at all*) and the other end marked 100 (*as much as possible*). At each step in the story, the agent picked out a word to describe how she was feeling. We prompt this analysis by interrupting and asking: "You were driving down Broadway at about 5:00 P.M. and you were on your way back to the office. How did you feel? How much did you feel that way?" As the agent continues, the prompting persists: For example, "Now you are stopped at the light and you see a guy running toward you. How did you feel? How much did you feel that way? What were you thinking?"

If the participant strings many steps together in a rush of emotion (i.e., "*He came running down the steps and started shouting and then he hit my car and I got out and then I started shouting and you can't believe how angry I was and what a jerk that guy was . . .*"), it is helpful to return to the first step in this chain, and ask questions about each event. It is often easier to get people talking if they are standing up, out of their seats, acting out the scenario, and if their evaluations are guided by structured reminders to identify feelings and associated cognitions.

In this case, the trigger for the agent's anger was the motorist's tone of voice, combined with his fancy appearance. The agent interpreted his comments to mean that he thought she was not as "good" or deserving or competent as he was. This agent is very sensitive to the notion of inequality, and because of her personal history, is likely to be easily angered by a man in authority imply-

ing she is not valuable or important. After she described the story of the motorist, and identified the provocative component, she was easily able to tell the group which events in her past and current life were responsible for sensitizing her to these types of occurrences.

This type of detailed analysis may feel unnatural to the participant and may require a great deal of persistence on the part of the therapist. Sometimes clients are reluctant to reveal the details of the provocations. They may be embarrassed to reveal the obscene language spoken to them or the nature of the insult. However, with gentle encouragement, most people will reveal the exact details of the interaction. This detailed analysis permits the therapist and patients to gain much valuable information. For example, one traffic agent hated it when motorists called her a "bitch." During the behavioral analysis, she disclosed that her ex-husband called her a bitch as he was getting ready to beat her. In group situations, individuals learn the technique by watching other people, and the third or fourth participant completes the analysis more quickly than the first.

Inspiring Hope: Focus on the Values

Cognitive restructuring can be an important component of treatments for both anger and anxiety. Salkovskis & Warwick (1986) highlight the importance of including a cognitive component with exposure sessions in the treatment of OCD, and the same approach is useful in the treatment of anger. A number of theorists have suggested that cognitive schemas organize responses to the world, and that certain schemas make us more or less likely to respond to a given provocation (Beck, Freeman, & Associates, 1990; Lazarus, 1991).

We use the concept of core values to identify the cognitive schemas that organize people's response to anger-evoking triggers. Values (i.e., caring, equality, trust, brotherhood, community, integrity, accomplishment, etc.) are a positive and easily accessible way of labeling a set of internal beliefs and ideas each person possesses.

An analysis of cognitions can elucidate the person's values. One common cognition held by angry people is that the failure to express anger in the face of a provocation is tantamount to giving permission to the other person to continue to behave in the provocative way. In this case, the expression of anger is used to control other people's behavior. The patients may fear that without the anger expression ritual, the situation will become hopelessly out of control. One client thought, "If I don't yell at my husband when I see him looking at other women, he will think it is okay to do it. The situation will get out of control, and he will cheat on me." This is not very different from a person with OCD thinking: "If I don't check the stove one more time, the house will burn down."

To tackle these objections, the therapist can highlight the integrity of people's values. For example, in the situation described above, the woman values marital fidelity and loyalty. It is helpful to explicitly identify these values as good and beneficial. If we are in a group, we will ask the group members for confirmation

that she holds these values, and we will also ask for confirmation that they are important values.

The therapy is aimed at helping her change the way she upholds the values — not the values themselves. The therapist needs to distinguish between the value (i.e., marital fidelity and loyalty) and the methods for coping with violations of this value (i.e., screaming and attacking when a husband looks at other women). The failure to display rage when a violation has occurred does not mean that the client is accepting the violation. Clients can be encouraged to remember that this restraint is necessary to permit a search for a more effective method for achieving the goals.

Staying in Control, Not Accepting Abuse

It is important to teach the client to differentiate between taking abuse and being in control. Clients may stop treatment if they misconstrue the therapy as requiring them to tolerate the abuse. Instead, we emphasize that emotional control is a prerequisite for devising an effective response to injustice. The fact that all good martial arts training begins with training in emotional control is a good metaphor for angry clients. Sometimes a loud voice or a sharp remark is an effective and appropriate response to a provocation. However, these responses need to be employed in a deliberate, planned manner, when it seems like the most effective strategy. For example, in treating traffic agents, the therapists continuously agree with them that angry, offensive motorists are very inappropriate, uncivilized, wrong, and offensive. However, the therapists also review the negative consequences of expressing too much emotion to these motorists. Excess anger displayed in a confrontation may provoke the motorist and make the situation more dangerous.

Reducing Arousal

Participants need some reasonable and reliable methods for controlling their internal agitation. It is helpful to make explicit the connection between excess arousal and certain styles of information processing (i.e., hypervigilance to threats). One way to teach relaxation skills is to begin with a very simple abdominal breathing exercise, and then adapt many of the exercises provided in *Progressive Relaxation* (Jacobson, 1974). Simple but detailed instructions for conducting these sessions is provided in Davis, Eshelman, and McKay (1980).

These skills are taught in one session, and additional practice is provided in each subsequent session. Participants are asked to practice these skills at home. During the in-session, practice feedback is provided until participants are reliably able to decrease their tension level by about half. Examples of feedback include praise and specific instructions about places to relax (e.g., “try to relax your jaw,” “you’re breathing beautifully”). Cognitive coping statements or rational beliefs can also be used (e.g., “I can calm myself down”; “I can stand this stuff and I do not need to make myself angry”).

We have found that most people do not practice their relaxation homework on their own. For individuals who can reliably relax in response to a trainer's instructions during a session, this is not a critical problem. For individuals who have difficulty calming down quickly when guided by a trainer, it may be necessary to be more insistent on home practice. Participants can begin with brief practice sessions, 2 to 3 minutes of slow abdominal breathing 3 or 4 times a day, in the car or before they sleep. As they build in time for relaxation, they can progress to more structured and focused practice on muscle relaxation and meditation. It may be helpful to make tapes of individualized relaxation exercises. It is important for participants to be able to achieve about a 50% reduction in body tension in the session before starting the exposure exercises. Some individuals can accomplish this right away; others need more practice.

Exposure

The majority of sessions are spent on exposure techniques. Repeated and prolonged exposure to an anger-evoking stimulus is designed to extinguish the frequency and intensity of the emotional response to the trigger stimulus. Prolonged exposure to the emotion itself—the anger experienced during the provocation—reduces some of the fear and resentment associated with the experience of anger, independent of the actual provocation. As individuals learn to tolerate the experience of anger, they may become more flexible in their responses to provocation. Response prevention acts to break the association between affect (anger) and automatic, ineffective behaviors (aggression or resentful passivity).

All exposure sessions begin with a brief period of relaxation. It is helpful for people to start from a low level of tension or they may escalate their emotional response too quickly and fail to learn they can control their feelings. In group sessions, there is a 5-minute relaxation period prior to beginning and ending the exposure sessions with each group member.

During the exposure, we use the worst, most awful, most ego-damaging comments or threats first. This is the most straightforward way of demonstrating that there is nothing to fear. In the exposure sessions, the client is presented with the provocations for a prolonged period, and asked to try to calm down while being exposed to the provocation. This prolonged exposure is designed to allow the emotional response to the presentation to extinguish.

For example, in his work with self-referred angry men, Tafrate (Tafrate, 1995; Tafrate & Kassonov, 1997) used verbal barbs for the exposure, including: "You look so fucking sloppy, like you don't care about yourself"; "Your low intelligence seems obvious to anyone who meets you"; "I'm sure you don't have any friends because you are so goddamn irritating"; "You're so physically unfit, that anybody in this building could beat the crap out of you."

If necessary, the client can be exposed to the most upsetting insult in a graded way. We accomplish this by removing the emotional inflections from the words.

Therefore, if being called a “low-life bitch” in an angry insulting way really upsets the client, we may start with “low-life bitch” repeated with no emotional tone at all. The word is said with the same inflection as you might say “hamburger” or “fork.” Clients often experience this as funny, and the humor helps them put the comments in better perspective.

A flat tone helps people quickly figure out what bothers them about the comment. They are not distracted by the emotional intensity, and can often relax through exposure to this stimulus without any help. This initial success increases their sense of efficacy and encourages them to continue. If the trigger is a non-verbal expression (e.g., a waving fist, a facial expression), the therapist simply makes the gesture without any other verbalizations. If necessary, the therapist can make the gesture more slowly, decreasing the appearance of threat.

As quickly as possible, we add emotional intensity to the stimuli by increasing the volume with which the barbs are delivered or adding facial expressions and gestures that make the trigger comments really sting. The exposure is continued until the client can remain calm while listening to the insults. Clients are encouraged to look directly at the provoking person (i.e., the person taunting them), without making any comments or taking any action.

In the traffic agent groups, one agent sits in the center of the group with the therapist next to him or her ready to whisper instructions and support. Another client plays an angry motorist. The “motorist” harasses the agent using the kinds of obscene, aggressive remarks that the agent has indicated are most upsetting. The agent’s job is to continue to breathe and relax throughout this exposure. No response to the provocation is permitted. The therapist provides encouragement and support to the agent, including cues to relax. The therapist might whisper, “Keep breathing, you’re doing fine! Remind yourself not to take it personally.” The “motorist” continues harassing the client until it is clear that the client can remain relaxed while being harassed by the “motorist.” Members of the group provide feedback about any signs of tension they might see. For example, they might say, “Oh, I see she tightened her jaw when the motorist started yelling. Try relaxing the jaw.” At the end of the exposure session, the agent receives support and praise from others for maintaining control throughout the exposure.

For example, one traffic agent hated it when motorists made comments like, “You people can’t get a better job than bothering us.” She felt extremely angry when she heard the phrase “You people” because it made her think that the motorist was making disparaging and racist comments about her ethnicity. She was concerned that the comment meant the equivalent of “All you African American people are dumb and have no future.” She resented being lumped into any class of person and wanted to be seen as an individual. Second, she felt put down about her educational accomplishments and professional goals. She was sensitive to this issue because, although she had completed many credits toward her college degree, she had not yet persevered to gain a degree. The

comment "You people" further exacerbated her concerns about her own future and her ability to accomplish her professional goals.

As the first step in the exposure treatment, the agent relaxed. Then another agent played the role of a harassing motorist, continually calling her "You people," and making negative and insulting remarks about the intelligence and education of African American people using a harsh, insistent tone of voice. For this agent, the exposure lasted about 10 minutes. As the "motorist" made the harassing comments, the trainer pointed out places where the agent experienced tension. For example, when she was called "dumb-ass nigger," her jaw noticeably tightened. The trainer sat next to the agent and whispered calming statements to encourage her to calm her self down. The "motorist" continued to repeat these comments until the agent had habituated to the exposure, and her emotional response had substantially diminished. She still correctly believed that the racist comments were vile, but the comments no longer had the power to involuntarily arouse anger in her. She no longer felt she was sharing a part of herself by involuntarily experiencing anger in response to these remarks. She was now free to make choices about how to respond to this type of abuse. If she uses less energy to respond to the motorist's negative comments, she can have more energy available for a systematic and focused response to racism (and to pursue her personal goals).

In group work, we repeat this procedure with every member, so that each member has some vicarious exposure to other barbs. This maximizes the effectiveness. In individual sessions, it may be necessary to repeat the exposure treatment several times to insure that the anger response has effectively extinguished.

A trigger that produces a strong anger response may require multiple sessions of exposure. If the person is re-sensitized to the trigger in between sessions (i.e., called "You people," and some other different but equally upsetting remark), then the original comment may re-acquire some of its anger-evoking capacity.

Applications of Exposure Treatment

With aggressive kids, we can also use exposure strategies. One child will role play an aggressive or taunting peer, while the target child is helped to tolerate the taunts. These strategies are similar to those employed by Feindler (1994; Feindler & Guttman, 1994) in the treatment of aggressive children. With very disruptive or impulsive children it may be necessary to work slowly, with few people and distractions in the room, and starting with the least offensive rather than the most offensive words or use imaginal rather than in-vivo provocations. It can take up to a year to establish rules of conduct during group sessions with very disruptive children. It may be necessary to use token economies to regulate behaviors such as staying in seat and participating in exercises before conducting the exposure treatment (Brondolo et al., 1994). When effective behavioral control has been obtained (i.e., when children can sit through a 20 to 30 minute

group without leaving the room or acting out aggressively), it can be efficient to move to an exposure-based model. Lower level barbs, administered slowly and with continuous reminders to calm down, reduce the risk that the children will become so agitated that physical restraint will be necessary. With low level or imaginal barbs it may be possible to have children remain in their seats by placing a hand on their shoulder or loosely across their chest. It is useful to tell children (and probably their parents as well) the details of the treatment procedure and the methods you will use to help the children remain in control.

It is important to note that these procedures are not intended for use with children who have attention deficit disorder, schizophrenia, or a serious mood disorder. These disorders may be associated with excessive displays of anger, and must be effectively treated first. When a mood disorder or attention deficit disorder is adequately controlled with medication and other treatments, then it may be reasonable to try these procedures. Our clinical experience suggests that this treatment is too stressful and counterproductive for patients with schizophrenia-spectrum disorders.

The same strategy can be employed in marital therapy. One spouse can re-enact the behaviors or words that trigger the other's anger. In battles between spouses, a particular facial expression, voice inflection or comment made by one spouse can trigger feelings of rage in the other spouse. These responses may seem innocuous to the therapist because they have private meaning within the dyad. Such brief comments and nonverbal gestures may be perceived as codes by the angry partner and often may elicit a range of disturbing automatic thoughts or irrational beliefs.

For example, in one case, a wife turned up the corner of her mouth in a small expression of disgust. This reaction, which was initially almost imperceptible to the therapist, triggered rage in the husband. He associated this expression with a host of automatic thoughts. His thoughts included, "You never take my feelings seriously. You think I am not smart or important, and think I'm beneath you." In this case, the therapist encouraged the wife to display this nonverbal behavior and worked with the husband to decrease his anger to the behavior. As the wife made the gesture, the therapist cued the husband to breathe deeply and slowly while rehearsing rational coping statements. With the arousal reduced, the couple could have a reasonable discussion about the nature of their disagreements.

Response Prevention

Angry clients often have a habitual, almost reflexive response to the eliciting stimuli. These responses are often incompatible with a controlled, reflective response. Therefore, it is important that the clients do not engage in any of their usual expressions of anger during the exposure sessions. During the exposures, the traffic agents do not speak back to the motorist, the angry child

is instructed not to fight or answer back to his peers, and the angry men do not react to their mates or employers.

It is slightly more difficult to insure that participants do not employ an impulsive suppression of anger to cope with the provocation. That is, they may be continuing to feel angry about the barbs or triggers, but choose to ruminate about their feelings and suppress the expression of anger. To avoid this difficulty, members of the group and the trainer carefully watch the participant's facial expressions and body language. People generally have a particular cast or set to their face when they are holding in angry feelings. In fact, the body language associated with the suppression of anger (i.e., pursed lips, a slight tightening of the jaw, narrowing of the eyes, or pulling down of the shoulders) can serve as a trigger for anger among spouses or between parents and children.

In real life, an angry response such as a sharp word or an angry tone may be an appropriate response to certain provocations. However, these expressions of anger are more effective if they are deliberate, and do not seem driven by rage or fear. Therefore, it is important for clients to have practice in experiencing anger without reflexively acting out. Once clients experience themselves as in control of their emotional response, their appropriate retaliatory measures may be more measured, but potentially more effective.

Providing Support

Our clinical experience suggests that it is important to provide more support to clients during exposures to anger versus anxiety-eliciting stimuli. This may be important because the beliefs held by the angry individuals about the necessity of impulsively responding to provocation sometimes have the force of overvalued ideas. There is some evidence that exposure works less effectively with anxious individuals who have overvalued ideas (Baer & Minichiello, 1986). Specifically, people can hold very strong convictions about the need to respond with aggression or withdrawal to perceived injustice or threat, and these beliefs can be difficult to challenge through discussion alone. Extra support and encouragement may be necessary for them to be willing to challenge these beliefs and to tolerate their anger without immediate retaliation.

One way we provide support is to tell the client exactly what will happen during the session. It is helpful to describe the whole procedure in detail and to indicate how support will be provided. For example, before treating a jealous girlfriend with imaginal exposure, we say, "Today we will expose you to some of the things that evoke your jealous rage. We will start by first relaxing you and helping you begin the session by being in a very calm and peaceful state. Then we will ask you to think about some of the things your boyfriend does that make you think he is fooling around. We will ask you to think about those behaviors and try to feel the anger and then relax through it. If you get too agitated, we will help you calm down by reminding you to breathe. You can stop at any time." In a role play situation (i.e., between agents or a husband

and wife) we tell people that we may touch them to help them remain seated or to point to areas of tension. We usually get their permission before we start the procedure to touch them: "I am going to sit right next to you like this and put my hand on your arm to remind you to stay relaxed. What do you think about that?"

Throughout the exposure, the therapist provides the client with positive feedback and soothing reminders or cues to relax. For example, it may be helpful to say, "Keep breathing, calm yourself, you don't need to respond to this attack." In some cases, a firm but gentle touch reminds the person to remain in control. This level of reassurance would probably be counterproductive in treating anxiety disorders. In anger responses, this level of reassurance seems to help the individual distance her or himself from the provocation, and to have the personal strength to tolerate the anger.

Reward Anger Control

During the exposure and desensitization procedures, the therapists keep up a constant murmur of praise and encouragement. We try never to miss an opportunity to identify a strength. Our general rule is to provide about 10 positive remarks for every single piece of corrective feedback we offer. Although they are initially suspicious, most people warm up to our positive feedback approach.

Therapists give specific targeted positive feedback as well as more global expressions of acceptance and caring. The goal is for angry clients to abandon their belief that aggression or impulsive suppression is the only necessary defense against insult. To do this they must be convinced that they can withstand an attack and do not need to be as defensive as they have been. Positive feedback instills courage and hope, and encourages people to reflect on the situation before responding impulsively.

Consolidating Support

The final step involves consolidating support for the participants. This is a skills component, composed of training in active listening and assertiveness. In group or couples training, effective listening skills are needed so that the members of the couple or group can provide effective support when someone has been provoked. In group sessions, agents are encouraged to provide effective support to each other each day to help reduce the stress and anger resulting from hostile confrontations with motorists. For example, participants are encouraged to "undo" the damaging effects of the conflict. For example, if an agent is called "stupid" by a motorist, the person providing support to the agent is asked to help the agent identify all the ways in which he/she is smart.

Assertiveness training is helpful to provide participants with effective but prosocial methods of handling anger-provoking situations. In agent groups, these skills are developed to permit participants to more actively seek support from co-workers and supervisors. Specifically, agents are encouraged to iden-

or imaginal exposure. Watch the nonverbal behavior of the clients and have them return to the relaxation exercises if they are too agitated.

If the individual has a significant history of uncontrolled physical aggression, these techniques may not be the best procedure to use when alone. Exposure and response prevention may still be a viable strategy, but it may be helpful to have an additional person available to help calm the client.

Harm to Patients

We are currently in the process of evaluating these programs, but initial responses from our subjects, clients, and their family members suggest that these procedures are well tolerated. For example, the adult men in the research sample were exposed to verbal barbs (insults) designed to create tension and arousal, providing a context for response prevention and the rehearsal of different cognitive coping statements. The level of anger was quite high on standardized measures. Many of the men who volunteered for the study had lost family or romantic relationships or jobs as a result of anger outbursts, or had histories of violence and prison sentences for various forms of assault and property destruction.

In this project, due to concerns about safety for participants and therapists, the barbs were presented cautiously and tentatively at first. Not only did the participants tolerate these procedures well, they provided many suggestions on how to make the exposure sessions more realistic and effective. All the authors have had clients and research participants say things such as, "If you really want this to work, you are going to have to be more angry with me and really get into it when you say these things." Others reported that it would be more helpful to present the barbs while standing up, by moving closer to them, or with more menacing facial gestures. In the sample of traffic agents, many agents became active participants in the scripting of the role-play exposures. Some of them reported the foulest insults they had received and encouraged the therapist or actor to use such profanity to make the situation realistic.

Therapists may also be concerned that exposure may cause harm to the clients. We have never seen patients' mental status deteriorate as a function of these procedures. However, a careful evaluation of the patients' mental status may reveal issues that rule out exposure-based treatments. Individuals with other disorders, including attention deficit disorder, mood disorders, and some schizophrenia spectrum, disorders can also present with excessive anger. It is important to make sure clients have adequate and appropriate treatment for these underlying conditions before evaluating whether exposure-based methods will help their anger. Our research (DiGiuseppe, 1995b; Tafra, 1995) suggests a high comorbidity with substance abuse. We do not use exposure procedures with clients who are actively engaged in consuming alcohol or drugs. These exposure-based procedures are intended for individuals who are not psychotic

techniques may harm the client, and impair his or her mental status. The third concern is that these techniques will interfere with the development of the therapeutic relationship or alliance (DiGiuseppe, 1995a; DiGiuseppe, Tafrate, et al., 1994).

Harm to Therapists

We have used these procedures with over 70 traffic agents, a research sample of 45 angry men, and over 50 cases across a variety of psychotherapy clients, family therapy clients, and children. Some very strong emotional reactions have been produced by different exposure methods, such as noticeable increase in muscle tension in the arms and face, clutching the chair, clenching of their fists, crying, trembling, and reports of images of past violent outbursts. However, in Tafrate's (1995; Tafrate & Kassonov, 1997) study with over 45 men, and over 500 exposure sessions, not one single incident occurred where someone attempted to harm the therapist. Similarly, none of the traffic agents attempted to harm the therapist. In trials with aggressive youngsters, we found it took a longer period of time to establish group rules and we needed to slow down the pace of the procedures. With very impulsive children you may need to work more slowly and use very small groups. If a sufficient therapeutic alliance is established, and the goals and procedures are clearly defined, we believe there is no reason for concern about an anger outburst against therapists.

However, angry people can be dangerous. It is worth thinking about the worst-case scenario before you expose people to anger-evoking events. We make it clear that we expect that people will not hurt each other in our offices. Therapists should make sure that they provide sufficient support so that clients are having a successful experience during this exposure.

Arranging the physical space in the office is an important step. If there is a concern that individuals may become aggressive if provoked during an in-vivo exposure, it is recommended that the chairs for the participants be placed relatively far apart, with the therapist seated between the two participants. The therapist must feel comfortable touching the participants, and should keep each person in his or her seat if they start to rise up. It is also helpful to watch for nonverbal signs of agitation and intervene quickly to put people in their seats if they become agitated and stand up. Children have more difficulty maintaining control than adults, and they may need more assistance remaining in their seats. We provide consistent encouragement and support to help children maintain control, but sometimes we also need to provide them with a friendly hand on their shoulder to remain in their seats. Training in nonabusive physical intervention is helpful when working with aggressive children and adolescents.

If people become too angry and agitated during in-vivo exposures, it may be better to return to practicing separately with each individual. Have the clients resume the relaxation exercises, and then work individually, using role-play

In summary, our clinical and research experience suggests that exposure and response prevention methods can be used effectively and safely with clients with anger problems. We have applied these procedures in a variety of clinical situations, and integrated these procedures with other cognitive, relaxation, and skills-training methods. Clients have responded enthusiastically to this approach, and preliminary outcome data suggest that these approaches are effective in reducing conflict.

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and who are effectively treated for other existing Axis I conditions. For individuals with cardiac conditions, it may be useful to have a medical evaluation prior to treatment.

Interference With the Therapeutic Alliance

There also seems to be no reason for concern that these procedures will interfere with the therapeutic alliance. Tafrate (1995; Tafrate & Kassinove, 1997) administered the Working Alliance Inventory to 45 volunteer angry participants who received the barb exposure sessions (Horvath & Greenberg, 1989). The therapeutic alliance scores for participants in this sample were quite strong. This scale yields four scores, including an agreement on the goals subscale, an agreement on the tasks subscale, a therapeutic bond subscale, and a total alliance score. The items are answered on a 7-point Likert scale. In this sample, the average score per item was over 5.8. To put these numbers in perspective, a research project at the Beth Israel Medical Center in New York City found that when ratings drop to 4.5 or less on the scale, people start dropping out of therapy (Samstag, Batchelder, Muran, Safran, & Winston, 1997). With effective alliance building as a practical first step, exposure and response prevention can promote an effective therapeutic alliance (DiGiuseppe, Tafrate, et al., 1994).

Traffic agents completed consumer satisfaction questionnaires following the group training. Participants gave the group an average score of 5.5 out of 6 possible points on a measure of overall satisfaction. They gave the groups high marks on items that inquired about the utility of the exposure sessions. Most important, agents who received the treatment reported a significant decrease in the rate of conflict with the public when compared to a no-treatment control group.

When therapists are willing to conduct exposure sessions, they are communicating to the client that they are not afraid of angry feelings. This lack of fear is reassuring to the clients. Exposure treatment has strong face validity, and clients have the sense that they are being treated with a procedure that has a clear chance of being effective.

Conclusions

We believe that it is helpful to incorporate exposure-based exercises early in treatment with angry individuals. It seems easier for people to grasp their cognitive errors in the middle of an exposure versus in the middle of a discussion about their concerns. It is also easier for people to believe that being calm works (and does not involve loss of face) when they see it work during a session. Many agents told us they did not believe they could remain calm when exposed to insulting barbs. Using the response prevention techniques provided them with the opportunity to observe themselves tolerating their anger, without harm.

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Correspondence concerning this article should be addressed to Elizabeth Brondolo, Ph.D., Department of Psychology, St. John's University, 8000 Utopia Pkwy., Jamaica, NY 11439.

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