

**TREATMENT PRINCIPLES
FOR DVA FUNDED
ANGER MANAGEMENT
PROGRAMS**

**Australian Centre for Posttraumatic
Mental Health**

&

Vietnam Veterans Counselling Service

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1. INTRODUCTION AND TARGET POPULATION

The following principles were developed at the request of VVCS to support the delivery of high quality group based treatments for VVCS eligible clients (veterans, their partners and sons and daughters) with clinically significant anger problems with or without aggressive and violent behaviour. The principles were developed through an examination of the evidence-based literature and with input from a panel of experts. It is anticipated that these principles may inform the development of service and tender specifications mandated by VVCS for the purposes of contracting service providers.

1.1 Utility and limitations of these principles

- The main use of these principles is to support the high quality of and clarity in expectations of DVA funded anger treatment programs
- The interventions described in these principles go beyond psychoeducation and therefore expect that professionally qualified and competent practitioners skilled in psychosocial interventions are conducting these treatments
- The principles are not designed to substitute for the knowledge and skill of competent individual practitioners which are best assessed against the professional standards prevailing at the time
- The principles are not designed to be used as a prescription concerning the content or structure of treatment
- The principles are not designed to limit treatment innovation and development based upon scientific evidence, expert consensus and practitioner judgment for the needs of the client group concerned.

1.2 Definitions

This document defines anger as a subjective emotional state comprising increased physiological arousal and cognitions of antagonism. The anger state is identified as an impulse to be aggressive and may be a causal determinant of aggressive or violent behaviour. While it is recognised that anger is a natural and often adaptive emotional state, for the purposes of these principles, anger is defined as problematic and clinically significant when it is assessed to be of excessive frequency, intensity or duration and/or associated with maladaptive behaviour including aggression and violence. Aggressive and or violent behaviours can be categorised in four dimensions that include physical violence, verbal aggression, indirect expression of anger and impulsive aggressive acts (Novaco, 1994). It is noted that definitions of aggression and violence vary across clinical settings. The Institute for Clinical Systems Improvement Health Care Guidelines on Domestic Violence (2001) supported by the US National Institute of Health (NIH) identify four categories of abuse and violence in relationships. These include physical, emotional / psychological (controlling through fear and degradation), sexual (any form of forced sex or sexual degradation) and social (behaviours that control the victims' activities with other people). The broadening of the definition of violence to include all behaviours, criminal or non criminal, oriented toward

control of others, or denial of others' equality or autonomy is also supported by the Victorian network for the prevention of male family violence (No To Violence, previously known as V-Net, 1995).

1.3 The principles

- The principles are for practitioners working with clients with clinically significant anger problems with or without aggression and violence, eligible for DVA funded treatment through VVCS
- The treatment is cognitive-behavioural in orientation
- The treatment targets both problematic anger and maladaptive behaviours including aggression and violence. As such, it may also be considered a behaviour change program.
- Treatment should be provided by suitably qualified and competent mental health professionals
- Safety of clientele and their families and practitioners needs to be of paramount importance throughout the program
- The intervention should be appropriately evaluated and outcomes monitored

2. CLIENT INCLUSION AND EXCLUSION CRITERIA

2.1 Inclusion criteria

- Entitlement to treatment through VVCS (veteran, partner, son or daughter)
- Currently reporting clinically significant anger problems and expresses genuine concern about their anger and a desire to reduce anger and address aggressive and violent behaviour where present.
- Awareness of the commitments required from the therapy program
- Ability to tolerate and benefit from group based treatment
- Detoxified from the acute effects of alcohol and other drugs of addiction. In general, admission to a treatment program immediately following detoxification is not recommended. A period of sobriety, however short, with specific treatment if indicated, is considered highly desirable.
- Commitment and ability to attend
- Informed consent is carefully obtained considering the range of external pressures upon the person, the intensity and duration of treatment and a realistic appraisal of its likely benefits.
- Past or recent legal sanctions for violence /aggression should not in themselves be a barrier to treatment
- Client agreement for partners and immediate family members to be contacted and for limited confidentiality to apply
- Client agreement to abide by requirements of any legal orders

2.2 Exclusion Criteria

- Where the client is assessed as not experiencing a clinically significant anger problem
- History of violence that is not predominantly anger-related; e.g., history of instrumental violence, violence that is “calculated” with no remorse after the fact, or evidence of anti-social personality disorder as indicated by socially violent behaviour as a child or teenager including family violence, cruelty to animals, and violence in intimate relationships.
- Current inability to make a commitment to desist from physical violence or make his/her family safe. Violence issues should be followed up in the interview assessment.
- Currently psychotic or with a history of an organic brain syndrome that would preclude the client benefiting from this mode of intervention
- A major suicide risk. Participants should be screened for recent admissions for suicide attempts.
- Potential participants should not commence a program if a major change in their living arrangements is imminent (e.g., relocating interstate, impending separation from partner).

3. ASSESSMENT

It is assumed that the principles of assessment described in this section concerning anger and aggression will form part of a more comprehensive health and psychosocial assessment. The aim of the assessment described in this section is to obtain an understanding of the client in terms of their suitability for the program and the nature of their anger condition and aggressive and violent behaviour where present. The assessment also serves as a baseline against which treatment gains can be assessed. Phone screening may offer an initial opportunity to assess suitability according to the more obvious inclusion and exclusion criteria. Subsequent face-to-face assessment is likely to require 2-3 sessions and needs to address the following areas.

3.1 Assessment of anger, aggression and violence

A preliminary assessment should be conducted to identify key triggers and cues to anger and the extent of the person's anger responses. The chronicity of the pattern of anger should also be established and key people related to anger identified.

The person's social network should be assessed to help identify people who are likely to play an important role in treatment. Particular individuals to be included are the person's partner and/or children living at home.

It is required that a history be taken of all forms of violence, including injuries to others and an appraisal made of the client's potential to engage in violence. It should also be established whether or not the client is in the possession of weapons. The client's legal position including orders existing and charges pending should be explored.

An assessment needs to be made of the client's ability to keep his partner and family safe from physical violence and agree to ongoing monitoring of progress and for the clinicians to have contact with family members.

An assessment is also needed of the client's willingness to accept that group facilitators can contact partners throughout the program. Clients with high levels of risk of violence are unlikely to gain from group treatment until their violence is contained. Assessment of level of risk should include the administration of a risk assessment scale.

Clients engaging in violence where anger is not a significant feature of the presentation would not be included in the group interventions outlined in this document but could be managed according to the current principles of the Victorian network for the prevention of male family violence (www.ntv.net.au).

3.2 Assessment of Mental Health status

It is essential that clients be assessed for existing mental health conditions by a suitably qualified and experienced mental health professional prior to their commencement in the program. Such an assessment should identify case management needs of the client during treatment and act as a triage to appropriate treatment if the client is unsuitable for the program at the time of assessment. This assessment should be thorough and structured in order to identify potential factors that will influence the outcomes of this anger management program. Liaison with any other health professional dealing with the person is recommended.

The aim of this assessment is to identify any untreated mental health disorder (e.g., depression, PTSD, panic disorder, alcohol dependence). Such conditions would not preclude participation in the anger treatment program, but it is important they are managed so they do not interfere with treatment. In particular, evidence of a reasonably stable treatment history over the last few weeks prior to assessment needs to be established, including no major changes in psychotherapy or medication. Clients with histories of physical or sexual abuse should also be evaluated in terms of their capacity to benefit from the program and may need referral to other services specifically addressing the sequelae of their abuse prior to their involvement in the program.

Potential clients presenting with diagnoses of Antisocial Personality Disorder, Narcissistic Personality Disorder or Paranoid Personality Disorder should be referred to other services as they are unlikely to gain from treatment and are likely to cause problems for the effective delivery of interventions to other clients.

3.3 Assessment of motivation and readiness

It is recognised the majority of clients presenting for anger management are likely to be presenting due to pressures from others. Therefore, it is important to assess the person's level of expressed concern about their current level of anger and their desire for anger reduction and behaviour change. To stay engaged and to profit most from treatment the client needs to demonstrate a sufficiently high level of intrinsic motivation rather than simply extrinsic motivation. The process of assessment may be used to enhance such intrinsic motivation through the use of motivational interviewing techniques.

One important indicator is the location of anger and /or the aggressive and violent behaviour within the goal structure of the individual (Howells, 1999). Participants are more likely to benefit from treatment if it is established that their experience and expression of anger and aggression is incongruent with their short term or long-term goals. For example, the person shows genuine regret at times when getting angry with themselves or losing their temper with others and dislikes the long-term impact of their anger on relationships, work or personal wellbeing. Such participants are likely to show high levels of motivation for change. Other potential participants may recognise that *aggression* works for them in getting compliance, but are concerned about being unpopular because of their aggression. Such clients demonstrate *aggression* that is instrumental for short-term goals but conflicts with long-term goals. The conflict with long-term goals is likely to provide motivation for change.

If following discussion of the assessment findings, including the costs and benefits of anger and related behaviours summarised by the practitioner, a client shows no evidence of perceiving that anger produces problems for them in the short-term or long-term even though others may perceive such problems, then they are unlikely to gain from treatment.

The client should also demonstrate a commitment and willingness to attend all sessions of the program.

In some cases, the person may be assessed as likely to profit from the group treatment program but currently unable to meet the participation requirements. For example, the client may have drug and alcohol problems or have comorbid psychiatric conditions that need to be stabilised before entry to the group program. Such clients could be maintained on an individual basis until they are ready to participate in the program. However, if the issues preventing the client from participating in the group program are likely to be long-term, the client might be referred to an appropriate alternative treatment service.

3.4 Inclusion of partners in assessment

Following assessments of anger, violence, and mental health status (including alcohol and drug status), the assessment process should include a session

with the partner and, where appropriate, other family members. *This session should not be conducted in the presence of the identified client.* This assessment may act as another source of information about the client's current and past levels of violence, readiness to change and violence potential. Sessions with the family can only be conducted where the partner and children feel safe in the counselling session and also feel safe at home after the session.

There are considerable advantages to combining the identified client and their partners together in a number of the psychoeducational and skill-based group treatment sessions. In particular, from a systemic perspective, the more informed the partner is of the treatment issues and changes to anger-related behaviour, the more likely that these changes will be understood and supported. However, as stated above, an important caveat is that given the potential for aggression and violence within relationships, the safety of the partner must be of paramount concern. Where such behaviour is insufficiently contained, the participation of partners in sessions has the potential to increase the risk of violence outside these sessions. As such, sound clinical judgment about risk must be exercised prior to inclusion of partners in joint sessions with the identified client in the assessment / treatment phases, or indeed of the suitability of the identified client for the group process.

Recommended criteria for consideration of the inclusion of partners in the treatment process (following separate assessments) include where:

1. the couple is choosing to remain intact
2. partners express a wish to participate
3. there is no history of severe violence
4. violence is not severe enough to elicit substantial fear in the partner
5. both members of the couple acknowledge aggression or violence is a problem (where aggression or violence is present)
6. partners' mental or emotional state is sufficiently stable
7. partners possess adequate support resources
8. a safety plan for partners and family has been established

(Campbell, 2001; O'Leary, 2001)

It is recommended that all of the above criteria be met prior to inclusion of partners in combined sessions with the clients.

3.5 Standardized Assessment Measures

Interview assessment should be supplemented by standardised assessment measures. These measures need to provide information that can be used to assess treatment gains and personality factors relevant to treatment responsiveness.

Suitable measures of anger may include:

- The MMPI-2. Although a long inventory and restricted in use, the MMPI-2 provides scales directly relevant to selection. In particular, the Hostility and Over-controlled hostility scales provide useful information. In addition, the MMPI-2 Personality Psychopathology Five (Psy-5) dimensions of Aggressiveness and Constraint provide information about the person's capacity to control violent behaviour. The Anger content scale provides information about the frequency of anger responses.

Other, more specific anger measures that are available to all clinicians and have been found in past research to be sensitive to treatment change are as follows:

- Spielberger State-Trait Anger Expression Inventory (STAXI Spielberger, 1986). Measures state and trait anger, anger control and inward expression of anger (anger-In) and outward expression of anger (anger-out)
- Buss-Perry scale (1991; formerly Buss-Durkee Scale). Measures physical and verbal aggression, anger and hostility.
- Dimensions of Anger Reactions Scale (DAR; Novaco, 1975)
- Novaco Anger Scale (NAS; Novaco 1994)
- Novaco Provocation Inventory (NPI; Novaco, 1994).

The three Novaco scales have been found to be relevant to veteran populations and are also integral to a cognitive-behavioural model of treatment (discussed below).

Measures of readiness for treatment may include:

- Anger Readiness to Change Questionnaire (Williamson, Day, Howells, Bubner & Jauncey, 2002)
- Three Types of Controlling or Violent Behaviour (Moyer, 1996). This test measures the incidence of physical verbal and emotional abuse

Measures of social and conflict resolution skill may include:

- Revised Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

At a minimum, an assessment should include the administration of either the STAXI or the NAS to identify the prominent components of anger for each client.

3.6 Feedback of the assessment to the client

The assessment phase should also include a component where the outcomes of the assessment process are fed back to the client. This should include discussion of program suitability and information identified from the preliminary functional analysis of the client's anger problems. This feedback, including the functional assessment, may then be used as a solid foundation for the group-based intervention. Where clients are deemed inappropriate for the program following assessment, clinical duty of care requires referral of the client to appropriate services. In the context of VVCS, this would include active case management to ensure engagement with appropriate services.

A flow chart outlining the assessment pathway can be seen in appendix 1.

4. CONTENT OF TREATMENT

Research is currently insufficient to identify which components of anger treatment programs are the most effective and therefore essential components of interventions. Howells (1999) has proposed that until extensive evidence based research is available, one solution is to make interventions comprehensive in their content and not to focus on a single component of treatment. It is also essential to have treatment follow principles found to be effective in general.

To date, the clearest evidence of effectiveness comes from research on cognitive behavioural programs for anger management. There is evidence that anger interventions based on cognitive-behavioural principles are effective in general outpatient community groups (Deffenbacher, 1999; Grodnitzky & Tafrate, 2000): forensic populations (Hollenhorst, 1998; Novaco, 1997; Renwick, Black, Ramm & Novaco, 1997; Swaffer & Holland, 2001) and with children (Frey, Hirschen & Guzzo, 2000). A recent meta-analysis of 50 studies investigating the impact of cognitive-behaviour therapy in the treatment of anger supported the efficacy of such approaches citing an overall effect size of .70 which is representative of a moderate treatment effect (Beck & Fernandez (1998). Importantly meta-analytic studies also support the maintenance of clinical gains from cognitive-behavioural anger treatments from termination of treatment to follow-up (Di Giuseppe & Tafrate, 2001).

Most relevant to the current principles are the findings of Chemtob, Novaco, Hamada and Gross (1997) who found that a manual based treatment program developed by Novaco (1994) was effective in bringing about therapeutic change in traumatised Vietnam veterans with severe anger problems.

A review of the literature indicates that CBT approaches have a number of components which have a differential effect on different aspects of problem anger. The following dimensions are considered to be essential components of anger interventions from within the CBT framework.

4.1 Education Phase of Treatment

In working with angry clients it is important to adopt a collaborative approach based on mutual respect. Thus, the model of treatment should be shared with the client. Novaco (1999) provides a client manual explaining anger in terms of its cognitive, physiological and behavioural components. It is recommended that the manual is given to the client and a discussion of the functional analysis of the client's own pattern of anger response and responses on the NAS is used to help the client understand the basis of his or her anger and as a rationale for treatment interventions. The education phase also acts as a means of enhancing motivation for change.

Essential components of the education phase include: monitoring of anger frequency, intensity or duration preferably recorded in a diary, identification of anger cues and triggers, identification of contextual factors that influence anger, and discussion of the individual's anger response in terms of

physiological arousal, cognitive and behavioural components. The client is encouraged to undergo a detailed examination of instances of anger in terms of the circumstances in which the dysfunctional anger occurred, the exact nature of the anger response and the person's internal perceptions, thoughts, attributions, expectations and images associated with the anger response. This understanding is used as a basis to explore the alternative strategies which can be chosen and the effective management techniques available to the client. It is also important to explore whether anger is a manifested expression of underlying feelings of sadness, fear, hurt or vulnerability.

As part of this process a cost-benefit analysis of the client's anger-related behaviour should be conducted to help the client recognise the problems caused by dysfunctional anger and the likely benefits of anger management. In looking at the costs and benefits of anger the client should be encouraged to separate out immediate, short-term outcomes from longer-term outcomes. The results of the cost-benefit analysis can be used to motivate the client toward alternative outcomes. A written record of the cost-benefit analysis should be created.

Depending on the particular composition of the client group, a number of specific components may be included in the education section of treatment. For veteran groups, it is recommended that material be included that addresses the potential impact of military training on the development of the anger response. Useful material on this topic can be found in the video produced by VVCS titled "You're not in the forces now". For veteran groups where PTSD or other posttraumatic presentations are a prominent feature, the introduction of concepts such as the "survivor mode" of functioning is recommended. This model canvasses a view of anger in posttraumatic presentations being intrinsically linked to the perception of threat and to survival needs, and that threat perception and anger schemas are reciprocally influenced (Novaco & Chemtob, 2002). In addition, where the client group is primarily Vietnam veterans, material addressing the potential impact of the homecoming experience may be particularly useful in identifying key themes and triggers as part of the continued functional analysis of the anger response.

4.1.1 Therapeutic alliance

There is now a mounting body of literature that identifies the therapeutic alliance, which is the collaborative aspect of the relationship between therapist and client, as a significant factor contributing to treatment outcome (Hatcher & Barends, 1996). This is pertinent as clients with anger problems often have difficulty forming this alliance with therapists. Reasons for this may include therapists and clients failing to agree on the goals of therapy, with therapists wanting to address clients' anger and clients wanting to work on changing the behaviour of the targets of their anger or getting revenge (DiGiusseppe, 1999). In addition, in the context of posttraumatic presentations, the schematic bias toward threat-detection may result in the therapist being perceived as a threat and clients attendance at treatment prematurely terminated (Stevenson & Chemtob, 2000). Failure to establish or disruptions to the therapeutic

alliance therefore have the potential to reduce treatment efficacy and may result in premature treatment termination. As such, the education phase of the treatment is critical for establishing the therapeutic alliance through personal validation (validating clients' perceptions of transgression), empathy and addressing motivation for change. For posttraumatic populations, presentation of the "survivor mode" model of bias toward threat detection (Chemtob & Novaco, 2002) may be helpful in preempting threats to the alliance.

4.2 Improving Control of Physiological Arousal

Anger is nearly always accompanied by physiological arousal. However, individuals differ in their patterns of arousal in terms of the intensity and duration of the arousal and the person's resting levels of somatic activity. Individuals also differ in their capacity to be aware of their arousal and its impact on their behaviour. Treatment therefore needs to contain training in a series of arousal management techniques. Specific strategies found to be effective include breathing techniques, relaxation (especially deep muscle relaxation) and distraction techniques.

Cognitively based interventions such as self-instruction training are also effective in assisting the client to prepare and manage particularly stressful events. In self-instruction training the client is assisted to identify the stages of their anger reaction. Standard stages include preparation prior to entering the anger provoking situation, coping with encountering the situation and evaluating the aftermath of the situation. The client learns a series of statements which act to control the negative affect in the situation and which can be rehearsed to prepare for the event and in managing reactions after the event..

4.3 Imaginal exposure to anger triggering events and identification of contextual stressors.

An important component of anger management is the use of graded imaginal exposure to anger provoking scenarios identified during the assessment phase. *This component of treatment is best conducted in the individual therapy sessions attached to the group program.* The client is assisted in developing short evocative descriptions of anger triggering situations. These situations are developed from the client's diary of anger experiences and capture events that are likely to recur. The events are arranged in a hierarchy from least to most anger provoking. In treatment, the client is assisted to imagine the scene and then to practice skills of anger management in response. Thus the client imagines the scene and as the anger reaction emerges, techniques of relaxation and breathing control are used along with self-instructions generated by the client that act to defuse the anger. Situations are re-evoked until the client is able to manage each situation effectively. People or aspects of each situation that influence the level of anger experienced are also identified to assist the person to manage the imaginal exposure. This intervention is therefore based on the model of exposure combined with skill rehearsal to promote coping and mastery.

4.4 Changing dysfunctional cognitive schemata and distorted inferences

People with problems with anger are often poor processors of information and are likely to appraise situations as threatening in the absence of clear evidence. Thus treatment needs to address faulty attributions and appraisal and evaluation styles. Standard cognitive interventions (e.g., Cognitive therapy or REBT) designed to identify maladaptive thoughts and beliefs and to assist the client in developing ways of challenging those beliefs should be incorporated into treatment to feed into techniques such as self-instruction training. In this way the client is assisted to identify their assumptions that guide their behaviour and the distorted evaluations they make of events that underlie the anger reaction. By making such assumptions conscious the client can be assisted to alter those evaluations and thereby ameliorate the negative affectivity associated with their anger reaction.

There is considerable literature detailing a range of anger related disturbances in the appraisal processes. These disturbances may occur at a primary or secondary level (Deffenbacher, 1999). Primary appraisal disturbances refer to the individual's assessment of the precipitating event, which usually involves judgments of trespassing on personal domain, insults to or assaults upon ego identity, violation of values and expectations, and / or unwarranted interference with goal directed behaviour. Disturbances in secondary appraisal refer to the client's negative evaluations of their coping capacities for dealing with these events and that they "should not" have to experience or tolerate such negative experiences. Clinicians are also referred to the work of Novaco and Welsh (1989) who identified biases in information processing predisposing individuals toward anger.

4.5 Addressing core schemas about gender

The program should also include a component that addresses core schemas about gender and their relationship to patterns of interpersonal interaction and behaviour. The presentation of this topic should be one of challenging beliefs, assumptions and prescriptions about gender and how these influence behaviour and relationship patterns. This issue is a complex one and difficult to condense for the purposes of inclusion in these programs. It is an area of intense debate as the politics of gender are strongly upheld within many ideologies. Reference should therefore be made to a spectrum of positions (Rhode 1990). These may include:

- Social Learning theory (ref: Bandura 1977 and Bland 1998);
- Psychoanalytic theory (ref: Chodorow NW 1989, 1994 and 1999);
- Feminist theory (ref: Walters et al 1988);
- the Men's Movement (ref: Pease 1997, Biddulph 1994);
- Post-modern theory (ref: Pease 1999, Hare-Mustin and Maracek 1990)and
- the Co-dependency Movement (ref: Irvine1995 Hands &Dear 1994).

4.6 Broadening the repertoire of coping responses and enhancing social skills and problem solving skills

People with problems with anger are usually deficient in alternative strategies for solving problems, especially interpersonal problems, without resorting to aggressive behaviour (Novaco, 1997). The effectiveness of aggression in achieving immediate needs also means that they have had little practice in assertion or in general communication skills. Therefore, specific skills training in problem solving, social skills training, communication skills, assertion techniques, and negotiation and conflict resolution are incorporated. Short circuit techniques such as time out and time management are also discussed. These interventions are introduced later in the treatment program after the client has developed more efficient anger management skills. Programs targeted at children or adolescents are advised to increase the emphasis on interpersonal and social (communication) skills and problem solving skill training, including the use of role play, as these strategies are most indicated for these client groups (Frey, Hirschstein & Guzzo, 2000).

5. STRUCTURE OF TREATMENT

To date, nearly all CBT-based treatment models for anger are based on a one-to-one model of treatment. One-to-one work has the advantage of being tailored to the individual client's needs. However, such individualised treatments are more time consuming and costly. An alternative is group treatment that is commonly used in interventions with veterans and which is more economical in terms of time and cost. Group interventions also offer a number of advantages for treatment of people with anger problems. Some benefits of working in groups include:

- Vicarious learning about anger from hearing the stories of other people in the group;
- The opportunity to see other people going through the change process can help the person to make their own changes;
- The group creates a support network; &
- The group enables more effective anger management to be modelled and for the exploration of feelings of vulnerability, respect and assertion rather than aggression.
- The group can be used to role play/practice new skills and receive positive feedback

For group treatment to be viable in working with anger, the intervention needs to be sufficiently intensive and extended to allow for individualised treatment needs (Howells, 1999). For the purposes of these principles, a combination of individual and group treatment sessions is proposed. Where treatment programs for sons and daughters are conducted it is recommended that groups be run separately from the veteran or partner groups. In selecting individuals for groups it is important that consideration be given to the

composition of the group. Cohort profiles that isolate individuals should be avoided (e.g. marital status, gender, etc).

Number of sessions will depend on issues of problem severity for the client group and program accessibility issues. Generally however it is recommended that the group program comprise 8-10 participants and include 12-20 sessions conducted on an outpatient basis of 2 hours duration. Three additional 1 hour sessions may also be conducted for clients with partners after every 4 sessions. The objective of the partner sessions would be to provide feedback to the client and to discuss the client's progress. The session would also operate as a single session intervention with the family. There may also be considerable benefit in including partners in 3-4 of the appropriate psycho-educational and skill based group sessions spread over the course of the program. As stated previously, obviously established criteria and sound clinical judgement needs to be exercised in regard to levels of risk when integrating clients and partners in group sessions. These sessions may be conducted separately where there are such concerns.

Three additional individual sessions would also be needed for clients to practice imaginal exposure to anger provoking scenes. This structure would apply equally to veteran, partner or sons and daughters programs. An **example** outline of a program structure can be seen in appendix 2.

The objectives of the group program would be

- (1) To introduce and consolidate the education phase of treatment;
- (2) To introduce each of the active treatment strategies;
- (3) To monitor client's progress in applying the new techniques;
- (4) To assess and foster the client's capacity to work on his anger problem.

It is recommended that regular and appropriate liaison occur between the deliverers of the anger management intervention and the clients' ongoing mental health care providers (with informed client consent) to ensure communication of pertinent clinical information.

6. STAFFING

The group program should be conducted by qualified mental health professionals (psychologists, social workers or other approved professional providers) with training and experience in cognitive behavioural therapy. Group leaders should have experience in groups directed at anger management. Familiarity with the client group of veterans and family violence programs would be an advantage.

The group program should be conducted by two clinicians/practitioners and groups kept to 8 to 10 participants. To maximise the quality of intervention, the program should be developed into a manual form with fidelity checks (such as supervision or audit) conducted on a regular basis.

7. REVIEW AND EVALUATION

In addition to the self report measures used at assessment, a minimum data set should be administered at intake, discharge and three and nine month follow up to allow for adequate monitoring and evaluation of program outcome. The minimum data set applied to a range of DVA funded mental health treatment programs includes brief measures of anxiety, depression, alcohol use, family functioning and quality of life. The brief anger measure, the DAR (7 items), should also be included as the anger specific measure in this data set. The lengthier anger specific measures used at assessment may also be re-administered at discharge and follow up.

Information pertaining to the minimum data set can be provided by Dr Des Perry (VVCS) or Associate Professor Graeme Hawthorne (Australian Centre for Posttraumatic Mental Health).

It is also recommended that semi-structured interviews be conducted with partners and family members to assess their perceived levels of safety.

8. DISSEMINATION OF INFORMATION ABOUT THE PROGRAM

Potential participants and their family/partners need to be fully informed about the commitment required to assist them in deciding whether to enter the treatment program. It is recommended that participants be given information about the length of treatment and about realistic expectations for treatment outcome (i.e., the program is not a quick fix/magical cure). Emphasis should also be placed on the program's expectations of participants and their responsibilities in the recovery process. This would include information about out-of-session assignments, participation in groups, and behavioural requirements during the treatment phase.

In addition, potential participants need to be informed that the objective of the treatment is not to eliminate all experiences and expressions of anger. Instead the program is directed at dealing with maladaptive and destructive experiences of anger in which anger is experienced too frequently, too intensely, or where anger is associated with aggression (Novaco, 1994).

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10. Appendix 1. Structure of assessment

11. Appendix 2. Structure of treatment