

The Development of CBT Programmes for Anger: The Role of Interventions to Promote Perspective-Taking Skills

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Abstract. Although the emotion of anger has, in recent years, been the subject of increasing theoretical analysis, there are relatively few accounts of how interventions designed to reduce problematic anger might be related to cognitively oriented theories of emotion. In this review of the literature we describe how a cognitive-behavioural approach to the treatment of those with anger-related problems might be understood in relation to conceptualizations of anger from a cognitive perspective. Three additional interventions (visual feedback, chair-work, forgiveness therapy) are identified that aim to improve the perspective-taking skills of angry clients. It is concluded that such interventions might be considered for use within the context of cognitive-behavioural treatment.

Keywords: Anger, perspective taking, empathy, anger management, cognitive-behavioural therapy.

Introduction

Individuals who have a low threshold for anger arousal and who stay in a state of near constant turmoil create significant problems for themselves and those around them (Edmondson and Conger, 1996). Anger is widely believed to act as an important precursor to aggressive and violent behaviour (Berkowitz, 1986; Novaco, 1997) and so interventions designed to help individuals control aggressive behaviour have great potential value. Of course not all violent acts are committed in a state of high anger arousal, but it seems likely that many are. Howells (2008), for example, has recently suggested that at least two-thirds of all homicides may

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be anger-induced. Thus, although anger is neither a necessary nor a sufficient condition for aggression, and the vast majority of episodes of anger do not culminate in violence (Averill, 1982), for many perpetrators of violence, anger is considered to be a particularly important antecedent (Howells *et al.*, 2005).

It is probably true to say that whilst the stated aim of treatment for anger related problems is to reduce the intensity of anger experience, particularly given the negative intrapersonal and interpersonal costs of such anger, an extremely important outcome – at least from an offender rehabilitative perspective – is behavioural change in terms of reducing the incidence of aggressive episodes (Tafrate, Kassonov and Dundin, 2002). It is here that the cognitive-behavioural treatment of anger differs from other interventions in mental health, where the goals of treatment are primarily to reduce personal distress and improve well-being. Of course, anger management is also used to ameliorate difficulties with close interpersonal relationships, job performance and satisfaction in a range of other interpersonal settings. Anger management also serves a protective function, for example as a means to cope with feelings of shame (Gilbert, 1998), and as such anger management programmes may have utility with a wide range of clients accessing health care, vocational, and criminal justice services.

Our primary interest in this paper is to explore interventions that promote change in the way in which provocations are perceived. This involves the processing of aspects of anger arousal (such as cognitive appraisals of current and past situations) that determine how an external event is understood (Novaco, 1978; Watt and Howells, 1999). In this way, individuals who have a tendency to experience intense anger in response to provocation can be understood as having maladaptive appraisal styles. Novaco, Ramm and Black (2001), for example, suggest that often anger prompts the harm-doing behaviour of violent criminals by locking in schemas and scripts associated with threat and retaliation. Eckhardt and colleagues (Eckhardt, Barbour and Davison, 1998; Eckhardt and Kassonov, 1998) reported greater cognitive distortions (irrational beliefs and cognitive biases), as well as greater levels of cognitive deficiency (impaired ability to reduce anger experience through cognitive examination of the situation) in maritally-violent males in comparison to a group of non-violent participants.

In this paper we explore the ideas raised by Day, Gerace, Wilson and Howells (*in press*) that exercises that improve an individual's ability to take the perspective of another, even though not typically used in anger management programmes, have a potential role to play within the cognitive-behavioural treatment of anger. We suggest that whilst these exercises may not typically be regarded as cognitive-behavioural in nature, they potentially work in ways that are consistent with cognitive theories of anger and can thus provide useful adjuncts to current interventions that are offered to a range of different people who are referred for anger management.

The cognitive-behavioural approach to anger management

Spielberger (1999) defines the construct of anger as “a psychobiological emotional state or condition that consists of feelings that vary in intensity from mild irritation or annoyance to intense fury and rage, accompanied by activation of the autonomic nervous system” (p. 19). For Spielberger, anger and hostility are separated into independent constructs, with the emotion of anger as a necessary but not a sufficient condition for the development of hostile attitudes and the manifestation of vindictive behaviour. Novaco (1978, 1997) and Howells (1998) consider the construct of anger in somewhat more holistic and interactional terms than

Spielberger. For these theorists, anger is regarded as a multi-dimensional construct consisting of *physiological* (general sympathetic arousal), *cognitive* (automatic thoughts, beliefs, images), *phenomenological* (subjective awareness and labelling of angry feelings), and *behavioural* (body language, facial expressions) domains. Each of these dimensions are thought to interact with each other, and influence the individual's experience (or their lack of an experience) of anger.

Since the 1980s cognitive-behavioural therapy has emerged as by far the most widely accepted approach to anger management, with most treatments based on Novaco's (1978) adaptation of Meichenbaum's (1975) Stress Inoculation Training. The cognitive-behavioural method is based upon a careful and collaborative assessment of the problem behaviour, and the associated antecedents, and consequences, be they environmental, cognitive, physiological or behavioural (Daffern and Howells, 2002). The approach to intervention typically centres on teaching the client to both recognize and dispute those beliefs and interpretations that lead to problematic behaviour.

Whilst there are many different approaches to cognitive-behavioural therapy, most adopt a Socratic method, involving the use of both open and closed questions to challenge or dispute unhelpful inferences and evaluations. The client's beliefs concerning the intentions and motives (attributions and appraisals) of other people involved would become the focus of intervention, especially when these beliefs appear unrealistic or unhelpful. The client is then encouraged to examine these beliefs carefully and conduct experiments to establish the extent to which they are justified. Typically, clients will be set homework tasks in which they are asked to practise disputation across a range of different situations. The final part of therapy typically involves generating alternative beliefs, and practising using these in the situations in which provocations are perceived, often in conjunction with methods such as relaxation training to help control physiological arousal (see DiGiuseppe and Tafrate, 2003). Anger management is typically delivered in group settings, so that participants can identify dysfunctional beliefs or inferences in their peers, assist therapists in challenging those attributions that appear to be self-serving, and reflect on what this means for their own problems.

Efficacy of anger management

Cognitive-behavioural methods represent the treatment of choice in relation to the treatment of anger related problems, although it is important to note here that many other interventions, including those described later in this paper, have not been subject to systematic evaluation. Meta-analytic reviews of treatment outcomes suggest that the cognitive-behavioural approach is generally effective, and associated with moderate effect sizes (Beck and Fernandez, 1998; Del Vecchio and O'Leary, 2004; DiGiuseppe and Tafrate, 2003; Edmondson and Conger, 1996; Sukhodolsky, Kassinove and Gorman, 2004). In their meta-analysis of the outcomes of cognitive-behavioural therapy interventions for anger, Beck and Fernandez (1998) examined 50 studies involving a total of 1640 participants, including prison inmates, abusive parents and spouses, juvenile delinquents, people with intellectual disabilities, as well as university students with anger problems. The majority of these studies examined interventions that combined cognitive restructuring and some technique promoting physical relaxation. The weighted mean effect size of the 50 studies was $d = 0.70$, which suggests moderate treatment gains.

The evidence to support the effectiveness of anger management to people who have been convicted of violent offences is, however, less convincing.¹ Violent offenders are a particularly important client group for those who deliver anger management programmes given that a central aim of treatment is to reduce the incidence of aggression. Of those studies reviewed by Beck and Fernandez (1998), only six involved participants who were known offenders, and it has been suggested that brief anger management programmes (20 hours) have a minimal therapeutic impact upon violent offenders (Howells et al., 2005). This may be because violent offenders as a group have multiple needs that cannot be adequately addressed within a relatively brief programme, or that external pressures related to their legal status make offenders less able or less willing than other groups to engage with some of cognitive-behavioural tasks suggested in anger management (Howells and Day, 2003). It is also possible that violent offenders with anger problems have even more limited insight into their problems than offenders who have not been convicted for violent offences, and as a consequence may be more likely to focus on changing the source of frustration, irritation or annoyance than on changing themselves (DiGiuseppe, 1999). Given that the cognitive-behavioural approach requires at least some acceptance of personal responsibility for the problematic behaviour, these clients may not engage as well with treatment as other clients. Furthermore, therapists who work with angry clients may encounter resistance to their requests for clients to undertake the self-monitoring exercises and experiments that are embodied in the cognitive-behavioural approach (Novaco et al., 2001). An important focus of current research relates not so much to the absolute efficacy of anger management (i.e. the extent to which it is more effective than no intervention), but to the efficacy of different components, or relative efficacy in relation to others approaches to intervention (DiGiuseppe and Tafrate, 2003).

Cognitive theories of emotion

The need for any treatment that aims to change behaviour to be based on a coherent and empirically supported theory of the causation of the behaviour under consideration has been stressed by a number of people (e.g. Andrews and Bonta, 2006; Cooley-Quille and Lorion, 1999). Izzo and Ross (1990) in their review of offender rehabilitation programmes found that, on average, treatment approaches based on *any* theoretical principle were five times more effective than approaches that had no particular theoretical basis. One theory that has clear relevance to cognitive-behavioural approaches to the treatment of anger is appraisal theory (Frijda, 1993). Appraisal theory suggests that emotional arousal follows a two-stage process – a primary appraisal of the significance of an event or situation, and a secondary appraisal of the meaning of the event (Frijda, 1993). Anger arousal is understood as occurring in situations that are seen as personally significant, as interfering with personal goals, and for which others are responsible (Smith and Lazarus, 1993; Smith, Haynes, Lazarus and Pope, 1993). The central defining construct of anger (or core relational theme) is thus commonly understood as “other-blame”, although more recent work by Kuppens and Van Mechelen (2007) has pointed to the central role of appraisals of frustration in anger arousal.

¹In addition, concerns have been raised about the extent to which the findings of research conducted with student populations can be generalized to applied settings (Novaco, 2007).

Baumeister, Stillwell and Wortman (1990), in their examination of narratives about anger, proposed that discrepancies between victim and perpetrator accounts of the situations in which anger arose may be central to the genesis of interpersonal anger, particularly when perpetrators fail to recognize and understand how their actions are perceived by their “victims”. Their analysis is reminiscent of attributional accounts of interpersonal behaviour, and in particular of the correspondent inference theory (Jones and Davis, 1965; Jones and Harris, 1967) and the fundamental attribution error (Ross, 1977), which suggests that when we attempt to explain someone else’s behaviour, we underestimate situational factors and overestimate the extent to which the behaviour reflects stable attitudes and traits. Ferguson and Rule (1983) have similarly argued that in interpersonal interactions in which an individual has in some way been harmed, he/she undertakes attributional work to understand whether what occurred was the result of behaviour from the other person that was accidental or deliberate, foreseeable or unforeseeable, and malevolently or non-malevolently intended. In addition, the individual makes a further assessment about the avoidable or unavoidable nature of what has occurred, as well as whether the other’s actions in the situation were justified.

These theories of anger are supported by a body of empirical studies suggesting that those with a propensity to anger arousal and aggression indeed tend to make more negative and hostile attributions than non-violent individuals (e.g. Dodge, Coie and Lynam, 2006; James and Seager, 2006; Moore, Eisler and Franchina, 2000; Witte, Schroeder and Lohr, 2006). Thus, theoretically, one of the most important ways in which anger management programmes bring about change is through influencing the ways in which participants perceive interpersonal provocation, such that they are able to take the perspective of the perceived protagonist in ways that do not give rise to hostility or blame. The term “perspective taking” is commonly used to denote the tendency or ability of an individual to consider a situation from another’s point of view, is considered the main cognitive process involved in empathy, and has been distinguished both theoretically and empirically from the affective or emotional components of the empathic experience (see Davis, 1994). Perspective-taking deficits have been identified as an important treatment target for those who commit acts of violence (e.g. Jolliffe and Farrington, 2004; Zechmeister and Romero, 2002), with Mohr, Howells, Gerace, Day and Wharton (2007) recently reporting that dispositional perspective taking is related to individuals’ appraisals of and self-reported probable anger in response to scenarios depicting interpersonal provocations. Moreover, in this study perspective taking was found to predict both trait anger and the manner of anger expression and control, with those higher in perspective taking reporting less outward expression and inward suppression of anger and greater use of adaptive strategies of control. These findings are particularly important, as not all individuals who experience high levels of anger tend to express it behaviourally, but may actually overcontrol the emotion (see Davey, Day and Howells, 2005). As such, perspective taking seems to be related to not only less expression of the emotion of anger and a decreased tendency to negatively suppress anger, but also more adaptive responses to its resolution. Despite this, it would appear that relatively little attention has been devoted to how the ability to take the perspective of another might be learned through intervention.

We believe that perspective taking is an important focus for intervention for a number of reasons. The construct has considerable influence on the development of empathic and prosocial emotions such as sympathy and compassion, as well as altruism (e.g. Coke, Batson and McDavis, 1978). Indeed, the construct has a long history of examination in terms of its influence on moral behaviour (Hogan, 1973), and has more recently been identified as a

fundamental part of emotional intelligence (Schutte et al., 2001). In addition, perspective taking is considered important to cognitive processes such as attribution that are central to the anger experience. Finally, perspective taking is likely to be relevant to many processes involving higher cognitive effort or emotional complexity (Beitel, Ferrer and Cecero, 2005; Kang and Shaver, 2004), given that individuals who are able to take the perspective of others have been shown to maintain higher cognitive functioning under conditions of arousal (Richardson, Green and Lago, 1998). In other words, the ability to perspective take provides valuable information that can be used to appraise one's own beliefs about the actions of others. In this way, both inferential and evaluative cognitions may be altered through taking the perspectives of others.

Interventions to increase perspective-taking skills

In the rest of this paper we outline three interventions (visual feedback, chair-work, and forgiveness therapy) that have been used to improve the ability of participants to take the perspective of others. These interventions, although not typically used in anger management,² appear to be theoretically compatible with the cognitive-behavioural model and are broadly consistent with cognitive theories of anger. They differ from mainstream approaches to anger management in that their focus is more on improving problem awareness or what Benjamin (2003) calls "self-discovery" than on self-management.

Visual feedback

One method that has been used to improve perspective taking is allowing participants to watch themselves on film. In one of the earliest studies in this area, Storms (1973) showed research participants videotapes of themselves in conversation with another person. He found that reversing participants' usual orientation by exposing them to videotapes that focused on themselves instead of on the other actor tended to produce a shift in attributions. Consistent with the actor-observer effect (Jones and Nisbett, 1971), actors made more dispositional and less situational attributions for their own behaviour when taking the perspective of observers of that behaviour. Similarly, when the observers of a dyadic conversation had their perspective shifted from one actor to the other, their attributions for the latter's behaviour tended to become more situational and less dispositional. Hypothetically, situational attributions for one's own behaviour seem likely to be related to cognitive processing styles that may facilitate or justify anti-social behaviour or escape self-censure, whereas dispositional attributions would encourage more personal responsibility for behaviour. Complementary shifts in attributions for another's behaviour suggest a lesser tendency to blame and a lesser justification for affront or retribution. While research on visual feedback has decreased somewhat since the work of Storms, there has been some renewed interest in the area. A recent study by Önder and Öner-Özkan (2003), for example, presented participants with videos shot either from an objective point-of-view or where the camera acted as the eyes of the protagonist (subjective point-of-view). While there were no significant differences exhibited between participants who saw

²Although Kassonov and Tafrate (2002) have described the clinical application of forgiveness in anger management programmes.

either video on attributions (internal or external), participants in the subjective point-of-view group reported that they empathized more with the protagonist.

In another study, Chandler (1973) paid participants to attend a series of 10 workshops to develop and record films about young people in real-life situations. Each participant was required to play every role in the plot and review each film at the end of each workshop. By the end of the project participants showed a significant improvement in their perspective-taking abilities (and reduced rates of delinquency) at 18-month follow-up, when compared to a “placebo” comparison group of young offenders that made films unrelated to perspective taking, and a no-intervention control group.

Visual feedback through the use of video has also been used extensively to improve skill acquisition in a number of different settings (Shinar, 1983) and has been shown to improve both behavioural performance and cognitive reasoning skills (Solomon, 1997). It has also been used as an intervention in its own right to change inappropriate social behaviour in young people with learning disabilities (Embregts, 2000) and on classroom behaviour (Boyle, 1998). Day et al. (2006) used visual feedback as a research methodology to understand the experience of anger in prisoners from minority cultural backgrounds. The methodology involved filming individual accounts of anger before watching as a group and discussing the cultural meaning of the anger. Anecdotally, participants found this to be a useful therapeutic process, leading to a recommendation for the method to be evaluated for use in prison-based anger management programmes.

Chair-work

A second method that seeks to directly influence perspective taking is “chair-work”. This term is used to describe a technique most commonly used by Gestalt therapists to increase self-awareness (although it has also been recognized as an important component of schema therapy, Seager, 2005). Although the technique may appear simple, it requires a high level of skill and sensitivity, and may not be appropriate for those in crisis, those with personality problems, or with those whose thoughts may be disorganized or disordered (see also Wagner-Moore, 2004). Chair-work itself involves an experiential exercise, in the form of an experiment, in which the individual is asked to develop a dialogue between conflicting aspects of the self. Whilst this technique may be used in relation to different types of conflict, it is commonly used to improve awareness of subject-object splits and thus appears particularly useful in identifying the ways in which clients attribute the causes of behaviour that they experience as provocative. The technique explicitly encourages the client to use an alternative perspective to reflect on their own attributions for events.

To illustrate the method, Goulding and Goulding (1997) describe a version of this technique in their work with people who have experienced sexual and physical abuse in which the client is first asked to describe an abuse scene from the perspective of an outside observer. After the client and the therapist have discussed the scene (to clarify the details), the client is to imagine him/herself as a child sitting in a different chair and asked to have a dialogue with the “child” about the abusive experience. The “child” is then asked to recount the abuse as s/he experienced it. The perpetrator is then put into the empty chair and is confronted. The method concludes with the client clearly stating how s/he will live life in defiance of what the abuser did (see Kellogg, 2004). An important feature of the exercise is that the abuser is not allowed to change in any way (e.g. s/he is not allowed to apologise, or promise to make reparation). This is because

the objective of the exercise is to bring about change in the client. It is easy to imagine variants of this exercise in situations where it is important, for example, to increase the perpetrator's awareness of the victim's perceptions following incidents of domestic violence, for those who experience intense anger following minor interpersonal transgressions, or for those who fail to offer assistance to another who is in danger or distress. Our clinical experience with this method suggests that it is particularly powerful for those clients who hold very fixed beliefs blaming another for the situation in which they experience anger; for example, clients who remain unhealthily angry over treatment they receive in their workplace, or in relation to infidelity in a relationship. The physical act of changing chairs seems to enable a shift away from this position and facilitate movement, whilst some clients find this an emotionally unsettling experience. It is, in our view, a powerful method for moving clients who appear "stuck".

Like other cognitive interventions with a focus on shifting perspectives, chair-work addresses perspective taking as both the ability to see the point-of-view of the other, as well as the ability to see oneself from the perspective of another. The notions inherent in chair-work also fit well with research on violent and sexual offending. Scully (1988), for example, reported problems in both synesis (attempting to adopt the view of the other) and reflexive (the evaluation of the self through monitoring others' reactions) role taking in a sample of rapists. Similarly, disorders that are often evident in offender populations such as alexithymia and psychopathy often involve fundamental problems in empathic response (cognitive and emotional), engagement in self-reflection, and self-insight (Haviland, Sonne and Kowert, 2004).

Forgiveness therapy

The process of developing perspective-taking skills can also be illustrated by reference to forgiveness therapies (Wade and Goldman, 2006). Forgiveness therapy can be understood as promoting the resolution of interpersonal conflict by facilitating perspective taking (see Day et al., in press). Forgiveness has been summarised as involving four major phases (Enright and the Human Development Study Group, 1996). These are: 1) an uncovering phase in which emotions are dealt with (i.e. examination of psychological defences, confrontation of anger, awareness of cognitive rehearsal); 2) a decision phase of considering old strategies (insight into an altered "just world" view, insight that the victim may be comparing self with the offender); 3) a work phase of learning a new process (awareness of compassion, empathy towards the offender, acceptance of pain); and 4) an outcome phase of consolidation (awareness of decrease in negative affect, increase in positive affect and of an internal emotional release (Denton and Martin, 1998). Forgiveness therapy based on this four-phase model has been delivered to a range of different populations, with evaluations suggesting that it typically produces beneficial therapeutic changes, although effects on anger are not always assessed (Al-Mabuk, Enright and Cardis, 1995; Coyle and Enright, 1997; Freedman and Enright, 1996; Hebl and Enright, 1993; Lin, Mack, Enright, Krahn and Baskin, 2004).

In our clinical experience this type of approach is most useful for those clients who have been victimized and for whom anger, although a legitimate response, has limited their capacity to experience positive relationships with those who are not responsible for the victimization.

Discussion

In this paper we have outlined the cognitive-behavioural approach to anger management, linking it to cognitive models of anger arousal. Three different therapeutic approaches or

exercises that might not normally be considered as having a place within current approaches to anger management are described. It is suggested that these interventions, given their explicit focus on addressing deficits in perspective taking, re-attribution, and modifying hostile appraisals, are theoretically compatible with a cognitive-behavioural approach to the treatment of anger. That is not to say that a conventional cognitive-behavioural approach with a focus on teaching clients to both recognize and dispute those beliefs and interpretations that lead to problematic behaviour is likely to be unsuccessful. Rather, it is to offer alternative approaches that may be useful when this approach encounters resistance. Therapists frequently encounter resistance when they ask anger management participants to complete the self-monitoring exercises and experiments embodied in the cognitive-behavioural approach (Novaco et al., 2001; Tafrate and Kassonov, 2003). Angry clients typically seek to attribute blame to others and minimize personal responsibility for their behaviour, making them difficult to treat. An advantage of these approaches is that each explicitly seeks to increase emotional arousal and insight into the nature of anger problems. For violent offenders, who do not appear to respond that well to anger management, such methods may prove to be particularly valuable (see also Day, Bryan, Davey and Casey, 2006), although the interventions outlined in this paper may be even more appropriate and successful with less aggressive clients who identify their anger as problematic and may have a greater capacity to benefit from interventions that are more reflective in nature. The approaches are also all empathic and non-confrontational, allowing clients to re-appraise their behaviour from within their existing value systems.

The Transtheoretical Model of Change (Prochaska and DiClemente, 1992) identifies raising consciousness of the problem behaviour and increasing emotional arousal, social opportunities, and re-evaluation or insight into the problem as important therapeutic goals, particularly in the early stages of treatment. Increased insight is probably best regarded as a necessary, and possibly sufficient, condition for change in anger management programming. Further, given Clore and Centerbar's (2004) suggestion that attributions of agency, considered fundamental to anger arousal, are both perceptual and automatic in social situations, there would appear to be an argument to develop interventions that bring awareness of attributional and appraisal processes into consciousness. In this respect these interventions may be less likely to trigger resistance.

Perspective-taking deficits may exist at the level of traits (pervasive difficulties in inferring mental states, or deficits in inferring mental states only within specific situations), or as state-induced impairments, where an individual may have an adequate theory of mental states to make appropriate inferences about another's behaviour, but due to the influence of different factors (e.g. motivation, drugs, or dysphoric feelings), fails to use it (see Ward, Keenan and Hudson, 2000). Indeed, it is often an apparent lack of perspective taking in a specific situation that prompts concern and provides the impetus for treatment. It is our clinical experience that many angry and violent clients have the ability to take the perspective of others, but fail to do so when they start to feel angered or aroused. A further advantage of experiential exercises, such as those we have outlined above, is to allow state-dependent learning to take place, thereby increasing the likelihood of within-treatment learning generalizing to other settings.

Of course, we are not suggesting that anger management, even including such exercises, is likely to be sufficient to meet all of the needs of angry clients, particularly those who act violently. For example, as a group violent offenders have multiple needs that probably require a multi-modal approach (Polaschek and Collie, 2004), and some violent offenders are unlikely to be suitable candidates for anger management at all. Howells (1998) has pointed

out that, for some offenders, violence may not be anger mediated (for example a “cool” use of violence by a professional enforcer following a directive to harm a stranger), and as such anger management may not be appropriate. While violence committed by individuals defined as “psychopaths” (Hare, Strachan and Forth, 1993) may not be anger mediated, psychopaths as a group may show anger reactions to threats or provocation of an interpersonal kind, rather than by reactions that involve thwarting or frustrating. For this reason, while psychopathy is generally considered to be a contra-indication for anger management (Howells, 1998), for some psychopathic individuals anger management may hold promise for their socialization (Novaco et al., 2001).

The concern, of course, has been that teaching perspective-taking skills to those who commit antisocial behaviour may result in their use to further manipulate or hurt victims. This critique is particularly prevalent when discussing the psychopathic offender (Day, Mohr, Howells, Gerace and Lim, 2007) and raises a concern that is not specific to offenders (e.g. Dymond, 1950; Eisenberg, Zhou and Koller, 2001). There is also a danger that such interventions may be misinterpreted by clients as reducing their personal responsibility for a problematic situation. This is clearly something that therapists need to monitor closely throughout the course of any intervention. However, the large body of research on perspective taking would suggest that these skills are more likely to increase prosocial and more socially-sensitive responding. Additionally, there is some evidence for the effectiveness of programmes that attempt to build this empathic ability. Wells (2001), for example, reported reductions in convictions for violent and non-violent offending amongst a group of juvenile offenders following an intervention designed to increase social perspective taking (and related cognitive skills), as well as to increase the management of anger and aggression. As such, programmes operating within a cognitive-behavioural framework and addressing components of perspective taking seem to have promise.

The conclusion that might be drawn from this work is that there are a range of interventions, some of which might be considered to be evidence-based and are theoretically consistent with cognitive approaches to the treatment of anger, and can be usefully delivered as adjuncts to mainstream approaches to anger management. Such interventions may prove to be more engaging for participants, and thus potentially lead to improved outcomes for a broader range of people who are referred for anger management.

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