The Humanistic Psychologist
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t775653705

The Resolution of Anger in Psychotherapy: A Task Analysis

Divya Kannan[a]; Jennifer R. Henretty[a]; Elizabeth Piazza-Bonin[a]; Heidi M. Levitt[b]; Rachel A. Coleman[a]; Manda Bickerest-Townsend[a]; Susan S. Mathews[c]
[a] The University of Memphis, [b] The University of Massachusetts Boston, [c] University of Kentucky,

Online publication date: 09 May 2011

To cite this Article Kannan, Divya , Henretty, Jennifer R. , Piazza-Bonin, Elizabeth , Levitt, Heidi M. , Coleman, Rachel A. , Bickerest-Townsend, Manda and Mathews, Susan S.(2011) 'The Resolution of Anger in Psychotherapy: A Task Analysis', The Humanistic Psychologist, 39: 2, 169 — 181
To link to this Article: DOI: 10.1080/08873267.2011.563724
URL: http://dx.doi.org/10.1080/08873267.2011.563724

The Humanistic Psychologist, 39: 169–181, 2011

ISSN: 0887-3267 print/1547-3333 online
DOI: 10.1080/08873267.2011.563724

Routledge
Taylor & Francis Group

The Resolution of Anger in Psychotherapy
A Task Analysis

Divya Kannan, Jennifer R. Henretty, and Elizabeth Piazza-Bonin
The University of Memphis

Heidi M. Levitt
The University of Massachusetts Boston

Rachel A. Coleman and Manda Bickerest-Townsend
The University of Memphis

Susan S. Mathews
University of Kentucky

Anger often is conceptualized as a disruptive emotional force, but it may be seen as an adaptive internal signal that cues self-protective action. In this study, an adaptation of task analysis was used to develop a model of how anger is resolved in psychotherapy. Episodes with markers of client anger ($N = 10$) were identified in audio-taped psychotherapy sessions by using clients' feedback. From this analysis, two distinct types of processes leading to the resolution of anger were identified in Paths I and II. Across these paths, clients engaged in interventions such as planning action for the future, meta-communicating about the use of emotions, and differentiating and exploring aspects of emotional experience.

THE TASK OF RESOLVING ANGER IN PSYCHOTHERAPY

Psychological Conceptualizations of Anger

As a basic human emotion, anger is experientially commonplace but theoretically complex. Current theories articulate multiple interrelated components, including cognitive, physiological, behavioral, and social aspects of anger (Kassinove & Tafrate, 2006). Although a review of all the dimensions of anger is outside the purview of this article (for a detailed review on this literature, see Mayne & Ambrose, 1999), when considered in relation to psychotherapy, there appears to be a recurring tension between views of anger as a healthy or a maladaptive psychotherapy experience.

Correspondence should be addressed to Divya Kannan, Department of Psychology, University of Memphis, 202 Psychology Building., Memphis, TN 38152. E-mail: dkannan1@memphis.edu

In the latter approach, anger tends to be considered as a psychopathological process. According to the American Psychological Association's (2000) *Diagnostic and Statistical Manual* nosology, clients presenting with anger and feelings associated with anger (e.g., irritability), meet a diagnostic criterion that is associated with a vast range of mental health disorders. These include bipolar I and II disorders, substance related disorders, adjustment disorder, posttraumatic stress disorder, intermittent explosive disorder, personality disorders, and schizophrenia or other psychotic disorders. Anger tends to be conceptualized as a disruptive emotional force to be mitigated (Kassinove & Tafrate, 2002) or as a maladaptive attempt at coping with stressful environments resulting in greater conflict and personal discomfort (Cox, Stabb, & Bruckner, 1999; Novaco, 1975).

Alternately, when viewed as an adaptive mechanism, anger has been seen as providing information (Greenberg, 2002), cueing self-protective action (e.g., Greenberg, Rice, & Elliott, 1993), and aiding in overcoming obstructed goals and perceived threats (Cox et al., 1999; Stein & Levine, 1989). It has been theorized that anger is an aroused and often heated state, in which are combined a sense of being wronged or frustrated and an opposing, potentially energizing feeling of power (Masters, 1999). According to Ramirez, Santisteban, Fujihara, and Van Goozen (2002), this energizing power or action readiness can be the means of responding to injury, either in a constructive way through assertion or in a destructive way through aggression. This tension in the conceptualization of anger can be seen as leading to different methods of empirical investigation within a psychotherapeutic context—with more adaptive understandings tending to be associated with process research, and more pathological understandings of anger tending to be associated with outcome research.

The Role of Anger in Psychotherapy

In this psychotherapy outcome literature, researchers have found that anger expressed by clients tends to be associated with negative therapy outcomes (Henry, Schacht, & Strupp, 1990). Anger has been negatively related to problem-focused coping across time and associated with aggressive and antisocial action (Whatley, Foreman, & Richards, 1998). In a qualitative research review on anger in psychotherapy, Mayne and Ambrose (1999) found empirical studies have actually demonstrated that catharsis does not necessarily result in a reduction of anger. In fact, venting can increase anger intensity and expression, perhaps by amplifying signals in the internal neural feedback loop. Conversely, the underexpression or overcontrol of anger also may be associated with negative effects including poorer social support, and increased risk of cardiovascular disease (Mayne & Ambrose, 1999). The relationship between these variables may be more complex, however. Spielberger, Reheiser, and Sydeman (1995) differentiated the outward expression of anger from the inward experience of anger. Examining this differentiation, Siegman and Snow (1997) found that soft and slow inward-focused explorations of anger attenuated the experience of anger and did not lead to cardiovascular stress in contrast with outward expressions of anger, which were viewed as pathogenic. This body of research tends to examine whether anger is harmful globally, rather than how the anger functions within the psychotherapy context.

In contrast, process research on emotional expression in psychotherapy suggests that anger can have an adaptive function. Task analytic research has indicated that facilitating the experience and expression of anger within this theoretical framework leads to productive psychotherapy outcome within different emotion focused therapy (EFT) interventions (e.g., self-critical two-chairing dialogues, Greenberg & Foerster, 1996; unfinished interpersonal business in empty-chairing dialogues, Paivio & Greenberg, 1995). For instance, a task analysis, which empirically examined the mechanism behind an EFT intervention—unfinished business chairing—found support for the experience of anger as productive in therapy: ''Once these effects [of heightening client experiential awareness of anger and its effects] are *fully* experienced and verbalized, a shift occurs in which associated and alternate healthy internal resources emerge spontaneously'' (Paivio, 1999, p. 317; italics added). Also, Beutler and colleagues (Beutler, Daldrup, Engle, Guest, & Corbishley, 1988; Beutler et al., 1991) have found that these latter dialogues are effective, especially when working with clients with over controlled anger.

In this branch of humanistic therapy (e.g., Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg et al., 1993), EFT therapists view anger not as a problem to alleviate, but as an opportunity to identify unexamined meanings and to discover adaptive ways of meeting unmet needs. Specifically, anger is viewed as an emotion that could signal the wish and the energy to overcome obstacles, redress a violation, or reestablish appropriate boundaries. Although there has been a concentration of research on emotional expression within the EFT approach, these findings may not be particular to this therapy. In their review of research on anger in psychotherapy, Mayne and Ambrose (1999) commented, ''One important aspect of [most therapies for anger] is that the techniques are applied and learning takes place while anger is actually occurring'' (p. 358). For instance, research on the treatment of anxiety disorders similarly indicates that emotional activation during treatment is a necessary condition for change to occur. In the face of the different perspectives on anger as pathological or adaptive, however, it is uncertain how non-EFT therapists tend to deal with anger in therapy. A model of the different pathways by which anger is resolved in therapy can be a useful contribution.

Study Objectives

This study was conducted to develop an exploratory model of the processes of anger resolution that cut across diagnoses, disorders, and client concerns, as well as therapist theoretical orientation. The method of task analysis (Greenberg, 2007) was adapted to suit this purpose, as described in the following section.

METHOD

Participants

Clients. Eight female clients ($N = 8$) participated in this study. Each was receiving individual psychotherapy at a university counseling center that serves the student population at the University of Memphis. Participants' ages ranged from 21 to 33 years of age and their ethnicity was Caucasian ($N = 7$) and African American ($N = 1$). On average, these clients engaged in a

total number of 8.75 sessions ($SD = 2.94$). The sessions selected for examination ranged from sessions number 2 to 12 ($M = 4.5$, $SD = 2.94$).

Therapists. Therapists ($N = 7$) included doctoral counseling psychology trainees ($N = 2$), interns ($N = 4$), and staff ($N = 1$). Six of the therapists were women, and one was a man. Therapist ethnicities were Caucasian ($N = 5$), Asian ($N = 1$), and African American ($N = 1$). Their main theoretical orientations were cognitive behavioral ($N = 3$), humanistic ($N = 2$), feminist ($N = 1$), and eclectic ($N = 1$). Therapists had completed a master's degree ($N = 6$) or a doctoral degree ($N = 1$) level of training.

Research team. The research team was composed of four graduate students in clinical psychology, two psychologists, and one undergraduate student assistant. Our preliminary understanding of anger was influenced by constructivist approaches to change and, in particular, EFT (e.g., Greenberg et al., 1993). As a result, we approached the analysis holding our preconceptions at a distance and were interested in identifying commonalities in the ways therapists worked with anger within their respective psychotherapy orientations.

Recruitment

As part of a larger psychotherapy effectiveness research project at the University of Memphis Career and Psychological Counseling Center, under the supervision of the fifth and final authors, clients gave consent to complete a short questionnaire after every third session and to have their sessions audiotaped for research purposes. As part of their postsession questionnaire, clients completed an Emotional Arousal Session Report Measure (EASR; Warwar & Greenberg, 2002) on which they indicated the intensity of their experience of anger in their previous session, using a Likert scale of 1–7 (where 1 = *not at all* and 7 = *very much*). Sessions with ratings of 3 or higher, where 3 indicated that clients experienced at least some anger, met inclusion criteria for the current analysis.

Our Adaptation of Task Analysis

Task analysis (Greenberg, 2007) is an inductive approach in which patterns of change are identified within a psychotherapy context. Typically, a task analysis focuses on a task defined within a particular form of therapy and examines good and poor resolution outcome patterns in that approach. This study focused upon the discovery phase of task analysis. Because our aim was to examine ways in which therapists worked with anger, we used a modified form of task analysis that included the following stages.

(1) Specifying the task and hypothetical rational model. After identifying 29 sessions that showed evidence of anger via ratings on the EASR, six moments were identified by clear markers of anger (i.e., an explicit statement of anger, agreement with the therapists' labeling of anger, or an angry and/or loud tone) and by progression towards resolution (i.e., the anger or angry event initially became the focus of the discussion and then the anger appeared to reduce and/or shift in its meaning), as judged by group consensus between the first four and the sixth authors. We formed an initial hypothetical model via studying these first six events together.

In this model, a shift toward resolution could include a new meaning or emotional state being linked to the experience of anger, a change in methods of coping with anger, or a reduction of anger as judged by vocal tone and/or statements to that effect.

(2) The inductive process. After identifying the anger moments in the manner described, the analysts individually studied the microprocesses used in anger resolution. Then, the first four authors met together to discuss and map out the microprocesses for each separate anger sequence using a process of consensus. Finally, the first five authors met and reviewed the jointly-generated maps of the sequences and also, using a process of consensus, formed an omnibus model of anger resolution. Two patterns leading to resolution were identified, which emphasized the commonalities across the individual processes of resolving anger.

This method is an adaptation of the traditional task analytic method. A traditional task analysis examines a smaller set of episodes (e.g., three episodes) and builds an initial model and then engages in a comparative analysis with a second similarly sized set of episodes, and includes resolved and unresolved cases together. Because we were examining events from across psychotherapy orientations and were unsure how much commonality we might find, we studied a larger initial set of episodes (six) that entailed evidence of resolution—to develop an awareness of the different productive processes used across psychotherapy orientations before examining unresolved cases.

(3) Identifying essential aspects of the change process. After we generated a provisional model of anger resolution, we looked for unresolved cases and studied which of the stages in the model tended to be omitted when resolution was not reached. At this point, the authors added four unresolved outcome moments of anger from clients' therapy sessions through the same process of identification described previously. Although most of the anger moments were identified from separate clients, two clients had two moments examined from different sessions (from each of the two clients we had one resolved and one unresolved moment, i.e., for client #1 we identified anger moments in sessions 4 and 12, and for client #7, we identified anger moments in sessions 2 and 6). Unresolved outcome moments were determined via consensus of the first three authors to have not undergone any shift in meaning or de-escalation of anger from when they were introduced into the session dialogue. Patterns for these outcome instances were compared with the productive pattern model to help identify which stages appeared to be critical in leading toward a positive outcome. Also, this last analysis was used to see if these added episodes brought to light any new stages or if the model appeared to be saturated (Glaser & Strauss, 1967), meaning that additional data did not produce new information. The model met criterion for saturation as the new data examined did not contribute any novel processes to those already in the model beforehand.

RESULTS

Analysis of the 10 anger moments in this study yielded an empirical model with two main paths toward resolution—anger explored as a fear of being overwhelmed and anger explored as a fear of being hurt. From these sessions, six moments of anger were identified as yielding examples of resolved processes, although four moments were coded as incompletely resolved. The anger

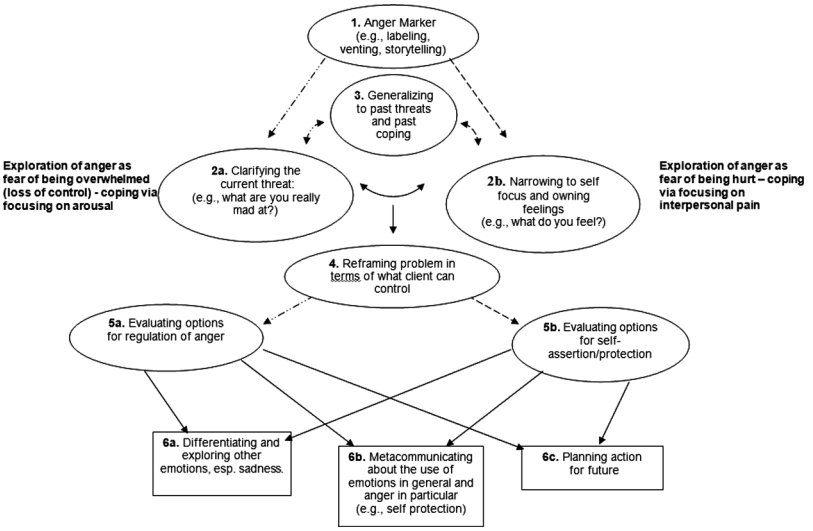

FIGURE 1 A task analysis of anger resolution in psychotherapy.

model is diagrammed in Figure 1, and is comprised of six stages with the initial four stages being common to both paths.

Stage 1: Exploration of the Anger Marker

The unfolding of the initial anger marker (Stage 1) appeared to be similar in both paths. This process involved a verbal elaboration of the anger event. In this process, a story was relayed that communicated the context of the anger and justified this reaction. During this storytelling, the anger emotion typically was labeled by the client and/or therapist. In one exchange, the client (#4) told her therapist, ''I'm 23 frickin' years old and he thinks somebody needs to keep an eye on me!'' to which the therapist responded, ''Were you pissed?'' and the client assented enthusiastically.

In this stage, clients explored the meanings of their emotion. Often the anger related to a sense of injustice. For instance, client #2 described, ''I've done with being treated like I'm disposable. I'm done with it . . . pouring so much time and effort and energy into something and have it in no way to be reciprocated.'' The exploration of the anger episode appeared to heighten a sense of being wronged.

Stages 2 and 3: A Cycle of Clarifying the Threat, Owning Emotions and Tying Anger to Past Events

Within all of the moments analyzed, the client–therapist dialogue then moved to Stage 2, which contained two main directions—both having to do with exploring anger in connection to a fear or worry. In Stage 2a (leading to the Path I example that follows), a fear of being

overwhelmed was the focus of the exploration. Here, the objective nature of the clients' concerns was assessed and clients reflected upon and evaluated the source of threat that was provoking their anger. For instance, client #4 said, ''It's just such a breach of trust that I just there is no way that I could ever forgive him for doing that.. . . Because it's just such a violation of everything I told him.'' Clients would explore their reactions to being overwhelmed, such as distancing others and shutting down emotionally. The main question driving this psychological exploration appeared to be: What is happening that you are really angry about? This exploration of being overwhelmed with anger often was joined with a fear of losing control.

In contrast, in Stage 2b (leading to the Path II example that follows), the fear of being hurt became the focus of the exploration. Here, therapists focused the clients' attention on their own feelings, thoughts, and needs (Stage 2b), narrowing their observations to the self. For instance, therapist one noted, ''I'm hearing a lot of you talking about how he needs to take care of himself during this period of time. . . . But not once, since you've told me this, have you said anything about what you need.'' The main question underlying these explorations appeared to be: What internal feeling or needs are leading to this anger? Although dyads might move between Stages 2a and 2b, typically the dyads adopted one of these two paths as a dominant route for exploration.

In the eight moments that reached Stage 3, the dyad explored links between the current and past threats and/or methods of coping with threat (Stage 3). For instance, one client (#6) began to view one event as indicative of a more general pattern of coping with anger that could be considered: ''He's the kind of guy where, he will kind of just—it's like, say a girl is like throwing a fit and [is] gonna cause all kinds of commotion and stuff, he will do, like whatever it takes to pacify them.'' Through this process, therapists led clients to notice that their anger is often a reaction to a threat (especially after 2a) or to their own feelings (especially after 2b).

Stages 4: Reframing the Problem

Now that the clients better understood a root of their anger, they could reframe their concern with this new conceptualization in mind. Typically, they moved on from this point to consider either how to cope with hurt or how to deal with the experience of being overwhelmed with anger within an interpersonal situation. For the clients in both of the paths described, the therapist helped them refocus on those features of the situation that the client could control. Although it might be hard to stop someone from doing something that made them feel angry, they could decide how to react when they felt overwhelmed or hurt.

Stages 5 and 6: Exploring Options & Integrating Change

In Stage 5, the dyads explored options that might provide answers for their newly framed problems. Once again, this exploration typically was manifested in one of two directions. In Stage 5a, clients examined how to regulate their angry reactions and in Stage 5b, they explored possibilities of self-assertion. In Stage 5a (leading to the Path I example that follows), clients were guided to evaluate options to respond to the increased arousal that resulted from the fear of losing control. These options included relaxation, time away from a situation, or monitoring their arousal.

In contrast, clients moving in the Stage 5b (leading toward the Path II example that follows) were guided to evaluate their options and respond to the hurt caused in the interpersonal

situation. Possible responses that were explored included empathizing with the other, self-soothing, or setting boundaries with the other. Clients sometimes explored more than one coping response with the therapist and would work to tailor options to fit their own needs. Often the recognition of the hurt underlying the anger would lead clients to become empowered and to consider ways to become more assertive about their needs.

Following this exploration, the two paths converged once again and clients would engage in one or more of three processes that could help them integrate these new responses: (Stage 6a) continuing on to explore other emotions and examining how they interact with the anger response, (Stage 6b) metacommunicating about the function of anger as a self-protective force, or (Stage 6c) planning for the future incidents when anger might occur. In Stage 6a, dyads might move on from the exploration of anger to explore a new emotional state—such as sadness. For instance, after an exploration of anger was concluded, client #5 responded to her therapist's inquiry about how she feels now by saying, ''Lost . . . I don't know where I am or where I'm going or who I am, or . . . what I'm supposed to be doing, or . . . I feel like I don't know anything. At all.'' The exploration of a new emotion might shed further light upon their new set of response options or might lead to the exploration of a new episode.

Therapists also might guide clients into a metacommunicative exchange about the use of emotions in general or anger specifically (Stage 6b). At the conclusion of one such exploration of anger, therapist #3 said,

> I just wanted to point out that you were able to identify some emotions today. . . . You are on a roll. The two [feelings] that I got that were I guess sort of across the board were scared and angry. But I also kind of get this underlying stuff too and I'm not sure if you are aware of that, but there is some stuff that's right here.

This exploration could help clients to realize how anger is linked to the implementation of self-protection or the desire for increased boundaries or assertion with others.

These realizations helped them plan to deal with recurring anger and plan for future action (Stage 6c). Clients would consider instances in which anger was anticipated to be a likely reaction. By developing responses to these instances as well, the clients prepared themselves to practice a new way of coping with anger across multiple situations.

Examples of Path I—Exploration of anger as fear of being overwhelmed: Coping via focusing on the arousal reaction. In this path, anger was associated with the fear of being overwhelmed or emotionally flooded when in a state of anger. Clients were guided to identify options for preventing an arousal reaction or calming themselves down when they were in this state. They explored how being overwhelmed by emotion led them to avoid unwanted feelings and thoughts and to distance themselves from other people. For example, a woman (#1) who is stressed by the demands of her job and graduate school expresses anger with a lack of understanding and support from friends and family members and is coached to develop ways to reduce her level of arousal. A client (#2), after being encouraged to calm herself in moments of anger, expresses to the therapist, ''I was going to do something really mean yesterday, and then I checked in with myself.'' This checking in process helped the client to become invested in identifying the self-evaluation strategies and relaxation options she could use to stay calm.

Example of Path II—Exploration of anger as fear of being hurt—coping via focus on interpersonal pain. In this path, anger was associated with an underlying fear of being hurt. Clients were guided to recognize the significance of the pain associated with their anger and how the anger was a reaction to protect themselves from an underlying feeling of hurt. This assessment allowed them to become empowered and claim their right to act on their own behalf. For example, one therapist (#4) asked her client (#3), ''Do you ever communicate your feelings to your boyfriend?'' These clients then examined the risks and benefits of strategies to protect themselves from being hurt in the future. For example, a woman who felt violated by her ex-boyfriend's emotionally violent and erratic behavior considered his propensity for physical violence and planned to take proactive defensive measures at the end of the exploration. The therapeutic dialogue helped the client focus on examining options for identifying and dealing with being hurt as the session continued.

Resolved Outcomes

Three types of resolution were identified in which expressed anger declined, as evidenced particularly by tone of voice. Clients all worked through at least five stages in the model (in Figure 1 from 1 to 2a or 2b, 4, 5a or 5b and then to 6a, 6b or 6c) to reach a level of successful resolution. In all of the fully resolved cases ($N = 6$), clients declared their intentions to adopt one or more strategies for asserting/defending themselves, self-soothing, or otherwise changing the way they handled anger in the future. Similarly, in all of the resolved moments, members of the dyad also engaged in meta-communication (#8) that established the value of attending to and/or expressing emotions (in general or anger specifically). Finally, four of the six resolved moments involved the identification and at least partial exploration of another strong emotion, typically sadness (#6).

Unresolved Outcomes

Four anger episodes ($N = 4$) were identified as being unresolved. In these moments, anger exploration was discontinued earlier in the model. In two unresolved moments that reached Stage 2a, the therapist directed the client away from anger to another emotion (sadness) without exploring the anger. In two other episodes, the therapist completed Stage 3 but then did not guide the client to reframing the problem in a way that could focus the client upon usefully exploring resolution options (instead shifting to focus aspects of a problem that were not related to anger, such as alcohol usage). It appeared that the completion of Stage 4 was the essential step in the path model as therapists who successfully reframed the anger problem continued on to lead their clients to resolution.

DISCUSSION

In this study, therapists dealt with their clients' anger from an empathic and facilitative stance, regardless of whether anger was explored as either a reaction to (1) feeling overwhelmed and out of control or (2) a relational threat in which they were being hurt by another. In the resolved cases, therapists encouraged their clients to understand their anger and its implications for their personal relationships.

Therapists whose theoretical orientations were cognitive behavioral ($N = 3$) tended to stay with a Path I focus. Both therapists in the humanistic ($N = 2$) and the one using a feminist orientation

($N = 1$) tended to emphasize Path II, but they also coached clients on strategies for coping with states of high arousal. The humanistic therapists guided their clients' understanding of anger with directives such as, ''Just slow down'' or ''What does it mean to feel awful?'' (Client #2). Staying with the experience of anger appeared to lead to clarity about the threat signaled by the anger. In the first path, clients were directed toward managing their anger, and exploring ways in which they could calm themselves in these states. Clients were able to identify that they were feeling overwhelmed by anger, and the emphasis in these moments tended to be placed upon strategies for quelling their anger, rather than exploration of related fears of loss of control or increasing their acceptance of strong anger. The movement in therapy to regulate their emotion could convey that anger is a problematic emotional response that should best be controlled (Kassinove & Tafrate, 2002).

In contrast, it appeared that in the second path, anger was not construed as an unhealthy or pathological emotion (c.f. Kassinove & Tafrate, 2002), but rather as a useful portal to understanding underlying emotional experiences. This path toward change can be conceptualized within a humanistic framework (e.g., Rogers, 1961), where therapists encouraged self-discovery and a free expression of emotion, rather than blocking of or distancing from difficult emotion, in order to produce a therapeutic anger experience.

When this exploration ended prematurely, however, then these underlying emotions and associated needs (e.g., the need for self-soothing or communication of the fear of hurt) remained inaccessible to the client and the anger continued to grate upon the client.

Common Processes in Therapy: Reflexive Exploration and Meaning Making

Despite the process and content differences between the paths, initial exploratory processes following anger markers appeared to be similar in this data set, and the two paths reconverged into similar processes as they approached resolution. Therapists generally responded to expressions of anger from a supportive and empowering stance and maintained a strong alliance in spite of the charged emotion.

In both paths, they tended to focus clients on the legitimacy of the need for self-protection and/or self-care. In addition, the therapists prompted the clients to redefine their problems in terms of psychological reactions that they could control—either as a fear of being overwhelmed or a fear of hurt. This collaborative intervention can be understood as an attempt to elicit an expression of clients' self-awareness and agency within the therapeutic relationship (see Levitt, Butler, & Hill, 2006; Rennie, 2004). In both pathways, clients left the session with a new understanding of their experience of anger and a heightened sense of its relationship to themselves.

Additionally, therapists often emphasized one path but also acknowledged the emotions and meaning in the other path as well at some point during the therapy session. For instance, therapists used self-soothing, an ''affective-meaning state that is characterized by fulfilling certain expressed needs oneself'' (Pascual-Leone & Greenberg, 2007, p. 879), in both paths to help clients to learn to relax their anger response, to develop responses to alleviate their hurt, and to become more comfortable with emotional experiences broadly. Notably, one of the final points of resolution in both paths was the exploration of additional, related emotions, and so it might be that beginning with either path could lead into an understanding of multiple emotional reactions and complexities. This self-examination harkens to Rennie's (1992) grounded theory analysis that found reflexive self-examination to be the core function of psychotherapy and Elliott's (1985) cluster analysis that found forming *new perspective* to be a major therapeutic task.

Study Limitations and Future Directions

Our sample consisted of mostly female student therapists and only female university student clients. It is unknown to what extent the anger resolution processes reflected in this study would generalize to sessions with male therapists and male clients, as well as more experienced therapists. In addition, the data were collected at a university counseling center and therapists had counseling psychology backgrounds, so caution should be taken when generalizing the results to other settings or therapists who have had different training experiences. Clients' narratives of their anger all related to their relationships with significant others. Although relationships may be typical contexts for anger in therapy, the analysis was based upon a limited range of anger-related issues.

This study is focused upon the initial phase of task analysis—that is, the discovery phase. Unfortunately, we could not locate further anger episodes in our data set and so could not test this model on an independent group of episodes. Because of the intensive analyses that go into the discovery phrase, however, it is common to present this stage as an initial study (e.g., Greenberg & Foerster, 1996; Safran, Muran, & Samstag, 1994). As a result, it is beyond the scope of this article to include a quantitative verification of this model. Future work should validate the model using a separate set of anger episodes. This study, however, does help to elucidate common processes used across psychotherapies in working with anger. It provides a model in which exploration of anger in therapy can lead to gains in coping and insight and which can be used to guide practice and to train therapists.

ACKNOWLEDGMENT

We thank the Career and Psychological Counseling Center at the University of Memphis for their support with this research project.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Beutler, L. E., Daldrup, R., Engle, D., Guest, P., & Corbishley, A. (1988). Family dynamics and emotional expression among patients with chronic pain and depression. *Pain*, *32*, 65–72.

Beutler, L. E., Engle, D., Mohr, D., Daldrup, R., Bergan, J., Meredith, K., et al. (1991). Predictors of differential response to cognitive, experiential, and self-directed psychotherapeutic procedures. *Journal of Consulting and Clinical Psychology*, *59*, 333–340.

Cox, D. L., Stabb, S. D., & Bruckner, K. H. (1999). *Women's anger: Clinical and developmental perspectives*. Ann Arbor, MI: Braun-Brumfield.

Elliott, R. (1985). Helpful and nonhelpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology*, *32*, 307–322.

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process–experiential approach to change*. Washington, DC: American Psychological Association.

Glaser, B. J., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.

Greenberg, L. S. (2007). A guide to conducting a task analysis of psychotherapeutic change. *Psychotherapy Research*, *17*, 15–30.

Greenberg, L. S., & Foerster, F. S. (1996). Task analysis exemplified: The process of resolving unfinished business. *Journal of Consulting and Clinical Psychology*, *64*, 439–446.

Greenberg, L. S., Rice, L. N., & Elliot, R. (1993). *Facilitating emotional change*. New York, NY: Guilford.

Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, *58*, 768–774.

Kassinove, H., & Tafrate, R. (2002). *Anger management: The complete treatment guide for practitioners*. Atascadero, CA: Impact.

Kassinove, H., & Tafrate, R. (2006). Anger-related disorders: Basic issues, models, and diagnostic considerations. In E. L. Feindler. (Ed.), *Anger related disorders: A practitioner's guide to comparative treatments* (pp. 1–27). New York, NY: Springer.

Levitt, H. M., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology*, *53*, 314–324.

Masters, R. A. (1999). Until the fire is but light: An interdisciplinary psychospiritual investigation of anger. *Dissertation Abstracts International 60*(5-B). (UMI No.9934606)

Mayne, T. J., & Ambrose, T. K. (1999). Research review on anger in psychotherapy. *Journal of Clinical Psychology*, *55*, 353–363.

Novaco, R. W. (1975). *Anger control: The development and evaluation of an experimental treatment*. Lexington, MA: Lexington Books.

Paivio, S. C., & Greenberg, L. (1995). Resolving ''unfinished business'': Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology*, *63*, 419–425.

Paivio, S. C. (1999). Experimental conceptualization and treatment of anger. *Journal of Clinical Psychology*, *55*, 311–324.

Pascual-Leone, A., & Greenberg, L. S. (2007). Emotional processing in experiential therapy: Why ''the only way out is through.'' *Journal of Consulting and Clinical Psychology*, *75*, 875–887.

Ramirez, J. M., Santisteban, C., Fujihara, T., & Van Goozen, S. (2002). Differences between experience of anger and readiness to angry action: A study of Japanese and Spanish students. *Aggressive Behavior*, *28*, 429–438.

Rennie, D. L. (1992). Qualitative analysis of the client's experience of psychotherapy: The unfolding of reflexivity. In S. G. Toukmanian & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 211–23). London, England: Sage.

Rennie, D. L. (2004). Reflexivity and personcentered counseling. *Journal of Humanistic Psychology*, *44*, 182–203.

Rogers, C. (1961). *On becoming aperson: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin.

Safran, J. D., Muran, J. C., & Samstag, L. W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 225–255). New York, NY: John Wiley.

Seigman, A. W., & Snow, S. C. (1997). The outward expression of anger, the inward experience of anger and CVR: The role of vocal expression. *Journal of Behavioral Medicine*, *20*, 29–45.

Spielberger, C. D., Reheiser, E. C., & Sydeman, S. J. (1995). Measuring the experience, expression, and control of anger. *Issues in Comprehensive Pediatric Nursing*, *18*, 207–232.

Stein, N. L., & Levine, L. J. (1989). The causal organization of emotional knowledge: A developmental study. *Cognition and Emotion*, *3*, 343–378.

Warwar, S., & Greenberg, L. (2002). *Emotional arousal session report measure*. Unpublished manuscript, York University, North York, ON, Canada.

Whatley, S. L., Foreman, A. C., & Richards, S. (1998). The relationship of coping style to dysphoria, anxiety, and anger. *Psychological Reports*, *83*, 783–791.

AUTHOR NOTE

Divya Kannan, M.S., is a doctoral candidate in clinical psychology, at the University of Memphis, Memphis, Tennessee. Her research interests include factors that influence therapist development such as therapist self-criticism, as well as clients' therapy process factors, such as the resolution of difficult emotions. Her therapy orientation is integrative, within an experiential framework.

Jennifer R. Henretty, Ph.D., is a primary therapist at the Center for Discovery and Adolescent Change, a residential treatment center for adolescents with eating disorders, in Los Angeles, CA. Her main research focus

is the process of psychotherapy, with particular interests in client emotion and therapist self-disclosure. She is an integrative psychotherapist, utilizing both humanistic-experiential therapies-especially emotion-focused therapy– and cognitive-behavioral therapies-especially dialectical behavioral therapy.

Elizabeth Piazza-Bonin, M.S., is a doctoral candidate in clinical psychology at the University of Memphis, Memphis, Tennessee. Her research focuses on psychotherapy processes across orientations, including the study of significant moments, emotion, and narrative, as well as wisdom-based processes in therapy and training. Her therapy orientation is integrative, within a humanistic-experiential framework.

Heidi M. Levitt, Ph.D., is an Associate Professor of clinical psychology, at The University of Massachusetts Boston. Her research concentrates on processes of personal change that span psychotherapy orientation. Within this broad rubric, she has studied topics such as significant moments, emotion, values, narrative, and silence within psychotherapy. As well, she has studied the construction of gender and experiences of minority stress within sexual minority communities and has conducted research on the intersection of domestic violence and faith. She is an integrative experiential psychotherapist and her approach to both therapy and research is rooted within humanistic and constructivist traditions.

Rachel A. Coleman, M.S., is a doctoral candidate in the Clinical Psychology program at The University of Memphis. Her research focuses on psychotherapy process and outcome, including how clients view their role in psychotherapy.

Manda Bickarest-Townsend worked as an undergraduate intern for Dr. Heidi Levitt at the University of Memphis. She intends to pursue graduate studies in clinical psychology specializing in eating disorders.

Susan S. Mathews, Ph.D. is a Senior Staff Psychologist at the University of Kentucky Counseling Center: Consultation and Psychological Services. She coordinates the group therapy clinical training program and is a generalist practitioner with particular interest in working with gender and sexual minorities, couples, women's issues, hypnosis, and international students. Her therapeutic work is guided by an integration of humanistic, experiential, constructivist, and feminist theories. Dr. Mathews' research interests include multicultural-feminist international consultation and therapeutic process and outcome studies in counseling centers.