Anger Management for Everyday Life: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Anger Management for Everyday Life: Practitioner Guide

Delivering the programme as guided self-help

A practitioner guide · 8 contacts · to accompany the workbook

TALKING THERAPIES UK

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First edition, 2026.

This guide accompanies the Anger Management for Everyday Life programme on the Talking Therapies UK self-help platform and its workbook. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 12. This printing was set on 8 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

Contents

How to use this guide 1

Part 1 The approach and the evidence 2

1. The model behind the programme 2
2. What the research shows 7

How to use this guide

This guide is for qualified practitioners who support clients through the Anger Management for Everyday Life programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The model behind the programme: anger as a normal emotion with a purpose, the difference between healthy and problematic anger, the four-component model of an episode and its four intervention points, and how the eight modules are built
- Chapter 2, What the research shows: how common problem anger is, the evidence for cognitive behavioural anger treatment and its limits, what the research says about venting and about sleep, and where the programme sits

CHAPTER 1

The model behind the programme

Anger is not the problem

The programme starts from a position the practitioner needs to share and to convey early: anger is a normal human emotion with a clear purpose, not a flaw or a moral failing. It is produced by the same fight-or-flight system that produces fear. Fear readies the body to escape a threat; anger readies it to push back against one, and in particular against a wrong: an injustice, a boundary crossed, a goal blocked, someone the person cares about harmed. Healthy anger tells a person that something matters, gives them energy to act, and stands down once the matter is being dealt with. The aim of the programme is not to remove anger, which is neither possible nor desirable, but to change the anger that has come to cost the client what they care about: their relationships, their work, their health, their own sense of who they are.

This framing matters in practice. Clients who come for help with anger very often arrive ashamed, braced to be told that they are aggressive or that something is wrong with them, and sometimes sent by someone else. Shame is one of the strongest fuels of anger, and a practitioner who adds to it will see the client defend, minimise or leave. The opposite error is as unhelpful: a practitioner who colludes with the client's account that everyone else is the problem leaves the pattern untouched. The stance the programme needs is respectful, curious and direct: anger is understandable, its costs are real, and the client can learn to choose what they do with it.

Healthy and problematic anger

The distinction between healthy and problematic anger has roots in the cognitive behavioural anger work begun by Novaco (1975), whose experimental anger control treatment combined education about anger, self-instruction and relaxation, and which set the pattern for most of the treatments since. Healthy anger is proportionate to its trigger, arrives at an appropriate intensity, is expressed without damaging relationships or violating others' rights, and informs constructive action. Problematic anger is disproportionate, too intense, expressed in damaging ways, or slow to stand down. The programme describes four patterns of problematic anger: the hair-trigger pattern, in which anger fires too fast and too often on small things; the simmering pattern, in which it builds slowly and stays raised for hours or weeks; the explosive pattern, in which anger is held in and then erupts out of all proportion; and overflow into aggression, in which anger becomes action that harms.

The last pattern marks a boundary the practitioner must hold. The programme is designed for problematic anger in the mild to moderate range. Anger that has involved physical violence, violence to objects in a way meant to intimidate, threats of violence, or controlling behaviour towards a partner or family member is not a self-help presentation, and Module 8 says so plainly. The assessment for the programme is, among other things, a careful screen for this, described in the next section of this guide.

The four components of an episode

The programme's central model divides an anger episode into four components: the trigger, what observably happened, or a memory or thought that arrived; the appraisal, the meaning the mind attached to the trigger; the physiological response, the body's readying for a fight; and the behavioural response, what the person actually did. The model draws on the cognitive behavioural account of anger set out by Deffenbacher (1999), in which anger is elicited by the interaction of a trigger, the person's state at the time it arrives, and their appraisal of it, and in which the main treatments are relaxation and arousal reduction, cognitive restructuring, problem-solving and communication skills, used alone or together. Its great practical value is that each component is a separate place to intervene. A client who experiences anger as one indivisible event has no choice point within it; a client who can see four parts has four.

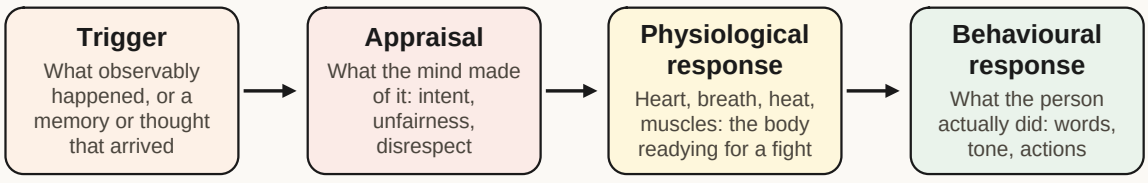


FIGURE 1.1 The four components of an anger episode
The programme's central model. An episode that feels like one event is a sequence of four parts, and each part is a separate place to intervene: the trigger can be anticipated, the appraisal examined, the body brought down, and the behaviour chosen.

The appraisal carries particular weight. Beck (1999) described anger and hostility as arising from

appraisals in which the person sees themselves as wronged: the other person's act is seen as intentional, unjustified and directed at them, and a personal rule about how others should behave has been broken. Hostile attributions of intent, rigid rules expressed as "should" and "must", and global labels of the other person are the thinking patterns that turn an event into an episode, and the programme's seven distortions are versions of them. Module 4 teaches the client to catch, name and examine these appraisals.

Why the body sometimes comes first

The cognitive work has a limit, and the programme is unusually clear about it. Examining an appraisal needs the parts of the brain that deliberate reasoning depends on, and these are partly suppressed when the threat system is at full activation. The programme's rule of thumb, on a scale of 0 to 10, is that below about 6 most people can do meaningful cognitive work in real time, and above about 7 most people cannot. At high activation, the body has to come down first, through skills that act directly on the physiology, such as the TIPP skills of dialectical behaviour therapy (Linehan, 2015), or through a structured time-out. The cognitive and body-first skills then work together: the body-first skills make the thinking possible again, and the thinking makes the next episode rise less fast.

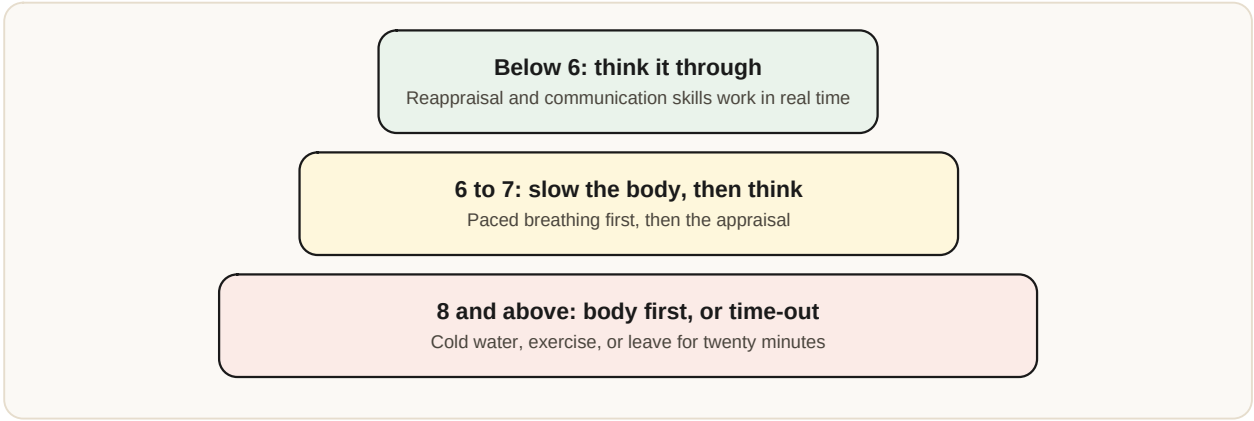


FIGURE 1.2 Which skill works at which level of activation
The programme's rule of thumb, on a scale of 0 to 10. Thinking skills need the parts of the brain that high activation suppresses, so above about 7 the body comes first; the cognitive work becomes possible again once the body has come down.

Beneath the anger

The programme's last layer is what lies beneath the anger. Emotion-focused therapy distinguishes primary emotions, the person's first and most direct response to a situation, from secondary emotions, reactions to those primary feelings that can obscure them (Greenberg, 2002). Anger is very often secondary: it arrives in place of hurt, fear, shame or grief, which are more exposed and harder to show. Module 7 helps the client look beneath the surface of their own episodes, and adds the related idea, drawn from the non-violent communication tradition, that anger often signals an unmet need, for connection, respect, autonomy, competence, being seen or safety. The module is honest that this is the slowest work of the programme and the place where individual therapy most often adds something self-help cannot.

How the programme works

The programme follows the model in order. Module 1 explains what anger is and asks the client to recognise their patterns and set three goals. Module 2 teaches the four components and starts the anger diary. Module 3 maps the client's triggers and the vulnerability factors that lower their threshold. Module 4 teaches the seven distortions and five-step reappraisal. Module 5 teaches the TIPP skills and a structured time-out. Module 6 turns to communication: assertive, aggressive and passive styles, DEAR MAN and validation. Module 7 looks beneath the anger. Module 8 builds a maintenance plan on the relapse prevention model and sets out the criteria for stepping up.

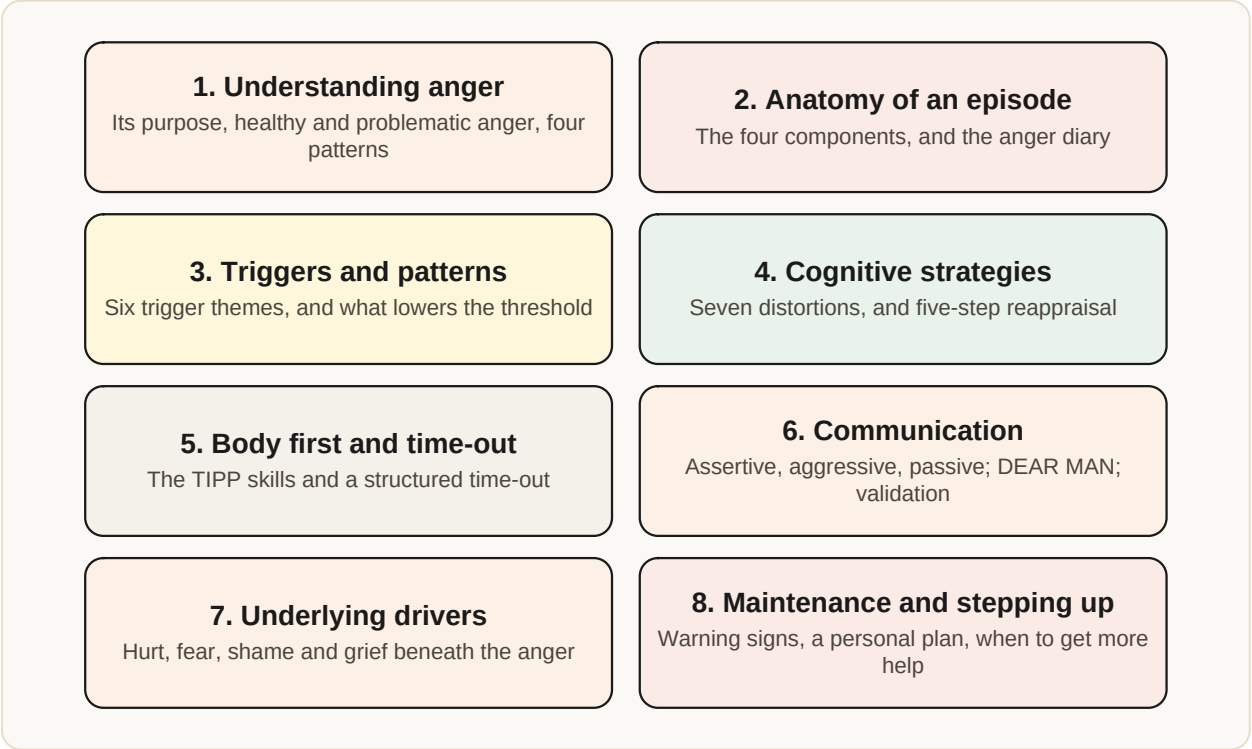


FIGURE 1.3 The eight modules and what each works on
The programme works through the components of an episode in order, then turns to what lies beneath the anger, and ends with a plan that travels with the client and clear criteria for stepping up.

How the modules are built

Each module has an introduction, one to three teaching sections with worked examples, a sorting exercise that gives practice in recognising the module's ideas in other people's episodes, a practical worksheet, a closing summary with practice for the week ahead, and a reflection, "Taking this forward", which asks what the client most wants to keep, when it will be hardest to use, and what exactly they will do then. The programme takes four check-ins: the PHQ-9, the Work and Social Adjustment Scale and the CORE-10 in Module 1, and the PHQ-9, GAD-7, WSAS and CORE-10 in Modules 4 and 8. The CORE-10, a ten-item measure of general psychological distress designed for routine use in the psychological therapies (Barkham et al., 2013), catches the distress that often accompanies problem anger better than the depression and anxiety measures alone. Take the GAD-7 at assessment too.

None of these measures anger itself, and an anger measure is worth adding. The Dimensions of Anger Reactions-5 asks five questions about how often the person feels angry, how intensely, for

how long, and how much anger has interfered with their relationships and their work or life, each rated from 1 to 5; it is short, free to use, and in its validation study a score of 12 or more distinguished people with high trait anger (Forbes et al., 2014). Take it at the start, the midpoint and the end. The worked examples in this guide follow one composite client, Dean, through all eight contacts.

What the practitioner adds

The programme carries the teaching. The practitioner's part has three particular demands in anger work. The first is safety: asking, at assessment and throughout, about violence, threats, intimidation and control, about children in the home, and about the safety of the people around the client, and acting on the answers (Chapter 10). The second is the stance described above: neither shaming nor colluding, taking the client's anger seriously as a signal while being clear about its costs. The third is practice. Anger skills are needed at exactly the moments when they are hardest to use, so knowing them is not enough; they have to be rehearsed in calm moments, tried on small episodes first, and reviewed honestly afterwards, including the times they failed. The anger diary is the instrument of all three, and the contacts are where it is read.

CHAPTER 2

What the research shows

How common problem anger is

Problem anger is common and under-recognised, partly because it has no diagnosis of its own in the main classifications, and so is rarely counted. A large national survey of more than 34,000 adults in the United States found that 7.8 per cent reported inappropriate, intense or poorly controlled anger, defined as anger triggered by small things or hard to control, frequent temper outbursts, or hitting people or throwing things in anger (Okuda et al., 2015). Such anger was more common in men and in younger adults, was associated with poorer psychosocial functioning, and was linked with adverse experiences in childhood and adulthood and with a wide range of other mental health problems. Clients who arrive with anger as their main concern frequently have low mood, anxiety, alcohol use or relationship difficulties alongside it, which is one reason the programme's check-ins and the practitioner's assessment look beyond anger itself.

The evidence for cognitive behavioural anger treatment

Cognitive behavioural anger treatment has been studied for nearly fifty years, since the work of Novaco (1975), and its effects are consistently moderate to large. A meta-analysis of cognitive behavioural therapy for anger found an average effect of around 0.7 (Beck and Fernandez, 1998), and a later meta-analysis of anger treatment for adults found effects of a similar size, maintained at follow-up (DiGiuseppe and Tafrate, 2003). Del Vecchio and O'Leary (2004) restricted their review to non-institutionalised adults with anger demonstrated on standardised measures; across 23 studies they found medium to large effects, with cognitive therapies best supported for driving anger, anger suppression and trait anger, and relaxation for state anger. This is part of the reason the programme combines both. A review of the meta-analyses concluded that anger treatments are at least moderately effective in both non-clinical and psychiatric populations, while the results of treatments aimed at aggression are less consistent (Lee and DiGiuseppe, 2018).

Two cautions belong beside these findings. The first concerns measurement. A systematic review of the research on cognitive behavioural therapy for anger since 2000 found 42 relevant studies, most of them randomised trials, nearly all reporting significant results, but it also noted that the field relies heavily on self-report and has rarely assessed the tendency to present oneself favourably, which may inflate apparent effects (Fernandez et al., 2018). This is one reason the programme's goals are framed in observable terms, and why the practitioner asks, with the client's agreement, how the people around them see the change. The second concerns aggression. Anger management informed by cognitive behavioural principles has been studied extensively with men convicted of offences: a meta-analysis found a 23 per cent reduction in general reoffending and a 28 per cent reduction in violent reoffending (Henwood et al., 2015). These are meaningful effects, but they come from structured programmes in criminal justice settings, and they are not evidence that a self-help programme is suitable for someone who has been violent. That presentation needs a specialist service.

Venting does not help

A belief the practitioner will meet often is that anger needs to be let out, by shouting, hitting a pillow or punching a bag, or it will build up and explode. The research does not support it. In an experiment, angered participants who hit a punching bag while thinking about the person who had angered them felt angrier and behaved more aggressively afterwards than those who hit the bag while thinking about getting fit, and both did worse than those who did nothing at all; doing nothing was more effective than venting (Bushman, 2002). Rumination about the provocation, which venting usually involves, keeps anger going. The programme's body-first skills are different in kind: they reduce physiological activation without rehearsing the grievance, which is why Module 5 insists that a time-out is not used for going over the argument.

Sleep and the threshold

Module 3's emphasis on vulnerability factors, and on sleep in particular, has a clear basis. In a brain imaging study, after about 35 hours without sleep, the brain's emotional centres were more than 60 per cent more reactive to negative images than after a normal night, and their connection with the prefrontal regions that regulate them was weakened (Yoo et al., 2007). Total sleep deprivation is not the same as the chronic short sleep of a client who starts work at six, but the direction of the finding fits what clients report: on short sleep, triggers fire faster and harder. The practitioner can use this to make sleep, food and alcohol part of anger work rather than a digression from it.

Keeping the gains

Anger work, like other behaviour change, tends to follow a pattern of focused practice, improvement, and then gradual drift back towards the old pattern unless something keeps the practice alive. The relapse prevention model, developed in the addictions field by Marlatt and Gordon (1985), plans for this by identifying early warning signs and high-risk situations in advance, pairing each with a response, and treating a lapse as information rather than as proof of failure. Module 8 applies the model to anger, and the practitioner's part is to make the warning signs early, specific and the client's own.

What this means for the programme

There is no NICE guideline on anger, which is not a diagnosis, and no trial has tested this programme in its present form. Its content applies the best-supported elements of cognitive behavioural anger treatment, the analysis of episodes, arousal reduction, cognitive restructuring and communication skills, alongside skills from dialectical behaviour therapy and an emotion-focused account of what lies beneath anger. It is suitable for guided self-help where problem anger in the mild to moderate range is the main difficulty, and where there has been no violence, no threats or intimidation and no controlling behaviour, and no more serious picture, such as severe depression, post-traumatic stress, or alcohol or drug dependence, is driving the anger.