A CLINICAL STUDY ON THE EFFECTIVENESS OF INDIGENOUSLY ADOPTED NOVACO'S MODEL OF ANGER MANAGEMENT FOR INDIVIDUALS HAVING PSYCHIATRIC PROBLEMS IN PAKISTAN

BY

Sumara Naz

Reg. No. 07/FSS/PHDPSY/F-10

Supervised By
Dr. Muhammad Tahir Khalily

Department of Psychology,
Faculty of Social Sciences,

International Islamic University, Islamabad

2014

PHD
150
SUC

Psychology

Human behavior - psychology

A CLINICAL STUDY ON THE EFFECTIVENESS OF INDIGENOUSLY ADOPTED NOVACO'S MODEL OF ANGER MANAGEMENT FOR INDIVIDUALS HAVING PSYCHIATRIC PROBLEMS IN PAKISTAN

BY

Sumara Naz

Supervised By
Dr. Muhammad Tahir Khalily

A Dissertation submitted to

Department of Psychology

International Islamic University, Islamabad (Pakistan)

in partial fulfilment of the requirement for the Degree of

DOCTOR OF PHILOSOPHY
in

Psychology

2014

A CLINICAL STUDY ON THE EFFECTIVENESS OF INDIGENOUSLY ADOPTED NOVACO'S MODEL OF ANGER MANAGEMENT FOR INDIVIDUALS HAVING PSYCHIATRIC PROBLEMS IN PAKISTAN

By

Sumara Naz

Dissertation Approved By

Supervisor

External Examiner

External Examiner

Dean Faculty of Social Sciences
International Islamic University, Islamabad
Pakistan

CERTIFICATE

It is certified that the PhD dissertation entitled "**A Clinical Study On the Effectiveness of Indigenously Adopted Novaco's model of Anger Management for Individuals having Psychiatric Problems in Pakistan**" prepared by **Miss Sumara Naz** has been approved for submission to International Islamic University, Islamabad, Pakistan.

Supervisor

(Dr. Muhammad Tahir Khalily)
Associate Professor
International Islamic University, Islamabad
Pakistan

Table of Content

ACKNOWLEDGEMENTS

Foremost, I would like to thank my supervisor Dr, Muhammad Tahir Khalily, for the continuous support, his patience, motivation, and immense knowledge shared with me during this period. His guidance helped me through out the research and writing of the dissertation. I have been extremely lucky to have a supervisor who cared so much about my work, responded to my questions, understood my problems and facilitated me in every step of research. I could not imagin having a better advisor and mentor for my Ph. D.

Besides my supervisor I must express the deepest gratitude to Dr, Seema Gul, Incharge of Psychology Department female campus, for her loving attitude, affectionate behaviour and words of encouragement that motivated me through out the research.

A sincere thanks to International Islamic University for providing me an opportunity to study here. I am also grateful to all the hospitals which allowed me to collect data.

I would never have been able to finish my dissertation without help of my friends and colleagues. They were always supporting me and encouraging me with their best wishes.

Words can not express how grateful I am to my mother and sister for all of the sacrifices that they have made on my behalf. Their prayers for me were what sustained me thus far. I would also like to say thanks to my husband for his support.

Finally I thank Allah for letting me through all the difficulties. I have experienced His guidance every day. He is the One who has enabled me to finish this dissertation. I pray that Allah's mercy always shine on me.

List of tables

List of Figures

List of Appendices

Abstract

The present study was designed to indigenously adopt Novaco's model of anger management and to look at its efficacy for individuals having psychiatric problems in Pakistan. The study was carried out in four phases. The first phase was to develop an indigenous model for anger management, so Novaco's model was integrated with an indigenous model grounded in Islamic teaching to manage anger. In the second phase, assessment scales, such as the Novaco Anger Inventory (NAI) and the Anger Self-Report Questionnaire (ASR) were translated into Urdu by using the back translation method. An Urdu version of the Depression Anxiety Stress Scale (DASS) was used to double check the diagnoses of patients. In the third phase, a pilot study was conducted to compute the psychometric properties of the translated scales. Results of test-retest reliability ($p < .01$) showed that the translated versions of the scales were psychometrically strong and appropriate to the cultural content. The fourth phase was the main study; it was a quasi-experimental research, which includes a sample composed of two groups: a treatment group (received the indigenous model of anger management) and a control group (received general counseling). Initially, 100 individuals participated in the study; however, 37 individuals in the treatment group and 39 individuals in the control group completed the recommended package of sessions. Results of the study confirmed that there was a significant ($p < .05$) positive correlation between anger and psychological disorders. Statistics from repeated measures ANOVA indicated that, in the treatment group, individuals' scores on the NAI and ASRQ were significantly ($p < .01$) decreased during three assessments. Similarly, results of the two-way repeated measures ANOVA revealed that the individuals in the treatment group significantly ($p < .01$) scored low on the NAI and ASRQ (at post-assessment) as compared to the control group. Therefore, it was concluded that the indigenous model of anger management was more effective than general counseling for anger management.

Introduction

This study aims to examine the efficacy of an indigenously adopted Novaco's model of anger management for individuals having psychiatric problems in Pakistan. For the purpose of this study, psychiatric problems are defined as any psychological or behavioral patterns that are not according to cultural development and associated with distress, impaired functioning, and/or increased risk of death (Dan, Katharine, Phillips, Fulford, John, & Kenneth, 2010). Psychiatric problems among the general population are increasing globally and, according to a report, approximately 10%–16% of the general population in Pakistan is suffering from mental health disorders (Gadit, 2007). The number has been increasing in recent years and varies in the context of rural and urban areas. In addition, there has been a dire shortage of professional workers for mental health care (Khalily, 2011) and the problem becomes more deleterious when practitioners ignore uncontrolled anger as a co-morbid entity of psychiatric illness. The patients with Post traumatic stress disorder, anxiety disorder, and depression have frequently reported anger episodes or alternatively suppressed anger manifestation (Posternak & Zimmerman, 2002).

Anger has long been recognized as one of the primary emotions, and is frequently provoked by the perception of being attacked or treated badly. There is no consensus on the definition of anger, as it is often blend with violence, aggression and hostility (Glancy & Siani, 2009). However, the American Psychological Association (2003) defines anger as a normal human emotion but it turns problematic when it becomes uncontrolled, and effects one's social life. From an emotion-prototype perspective, the manifestation of anger is typically marked by faulty cognition that trigger physiological reactions and expressions and effect the social interactions (Fehr, Baldwin, Collins, Patterson, & Benditt, 1999). Similarly,

Novaco (2000) has described four components of anger i.e cognitive, emotional, behavioral, and physical. The cognitive component of the anger indicates one's negative thoughts, feelings, or hostility about the world and toward others or places. The emotional or affective part of the anger linked to the one's response towards anger provoking situation. The behavioral part of the anger relates to the people's physical actions, which can be positive or negative, in response to the anger provoking situation.

The above mentioned definitions show that anger is a complex emotion that not only has affective/emotional elements, but it also includes cognitive, behavioral, and physical factors. These definitions also reflect that like many other human emotions, anger also used to interpret the surroundings and reacts accordingly. It has been observed that mostly anger is formed when a person realizes that he or she has been hurt by violation of the important personal rules, and/or the particular situation is not according to expectations (Greenberger & Padesky, 1995; Khalily, 2013). Therefore, in the section below, different psycho-theoretical models are mentioned to explain anger from different perspectives to have a profound understanding of this basic emotion.

Theoretical Models of Anger

The following models were developed to explain anger in the context of individuals feeling. Why individuals get angry in response to a specific situation and yet others do not get angry in the same situation and react according to their own perspective.

Discrete emotion theories

This model is based on Darwin's (1872/1998) belief about human and animal's emotion. It suggests that all primary emotions such as anger, fear, happiness, sadness, and disgust are biologically programmed. Responses to a particular situation can be identified by facial expression (Ekman, 2004). Anger and fear are defined as two opponent responses to a

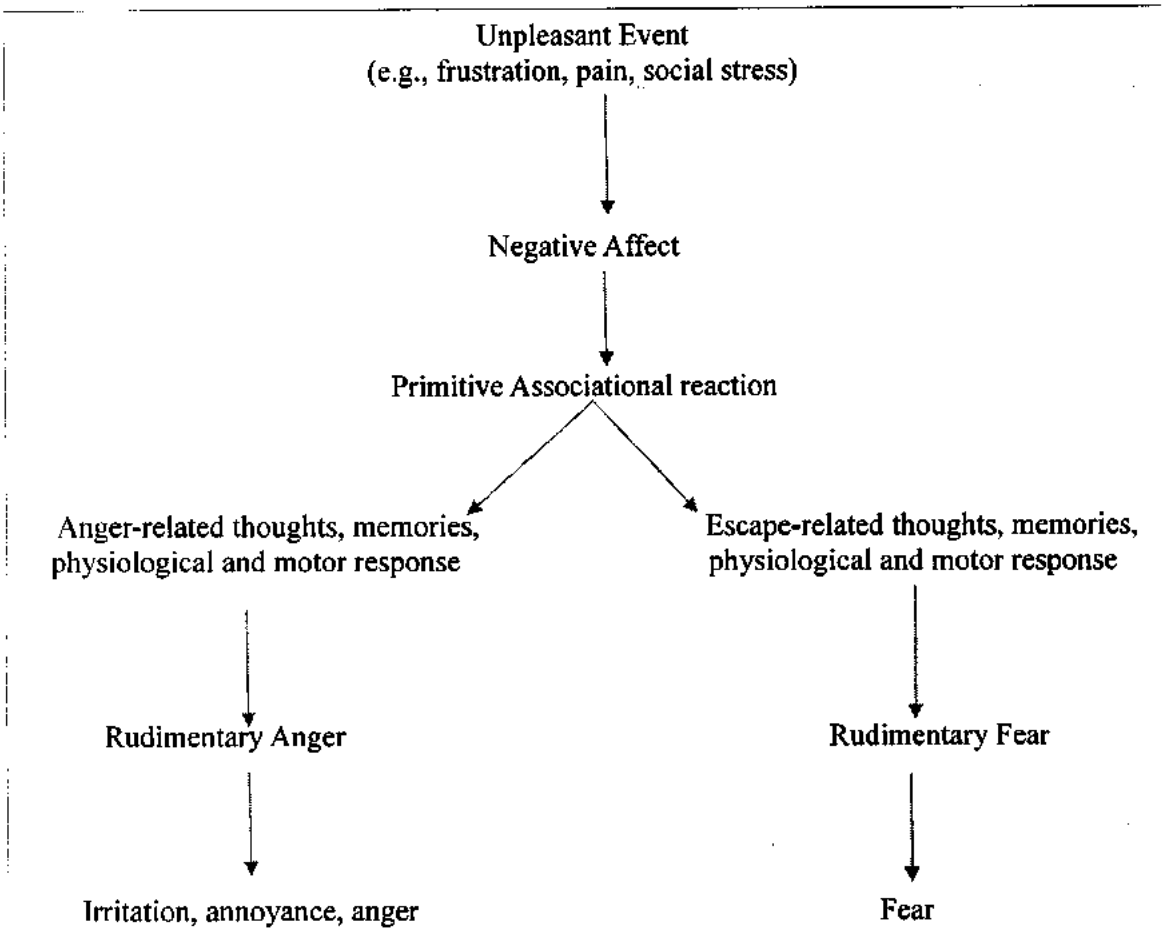
threatening situation, that often can leads to fight or flight(Izard, 1993). Although this approach helps to understand the general prediction that anger can be felt in response to a threatening situation but the individual differences are not explained in terms of anger expression and actions. However it does not explain that variety of responses to the same situation for different individuals and how they learn to react (Potegl & Stemmler, 2010).

Neo-associationist model

This is a learning-based model in which unpleasant event inclines the individual to a negative affect. An unpleasant event or stimulus may cause feelings of sadness, pain, or frustration, and a negative affect that resides in the memories. As these memories are triggered by stimuli, the person interprets these basic feelings and the psychological and physiological responses associated with flight or fight (Figure 1.1). These associations are based on feelings of fear and anger respectively. This processing also involves the evaluation of the outcomes of memories in a social norm context (Berkowitz, 1993; Pedersen, Bushman, Vasquez, & Miller, 2005).

This model further elaborated the theoretical assumption that every person's memory system differently organizes the thoughts and feelings, associated with a particular situation. But it does not explain that how this organization occurred and how it would effect the emotional reaction of the individuals (Berkowitz & Harmon-Jones, 2004). It shares some of the attributes with the dimensional model which is given below.

Figure 1.1: **The Neo-associationist Model of Anger**



Source: Adapted from Berkowitz, 1993, p 57

Dimensional model

This model primarily focuses on the subjective feelings of anger. Generally, there are two dimensions of this model, "*valence* (feeling good or bad)" and "*arousal* (degree of felt activation)". Protagonists of this model (Russell, 2003) suggest that the emotional response to an event or situation is explained in context of these two dimensions, i.e., strong, negative valence and high arousal. The person who reports anger instead of feeling sad, awful, or guilty is based on the observational learning, past experiences, and related memories. Therefore, when adults label a child's behavior as angry or rude, children learn to label

someone else's behavior in a similar pattern. They extract information and integrate it with past information that is already stored in memory. This approach helps to explain the linguistic origins of emotions and their categories. Individuals learn to label and communicate emotional experiences on the basis of observational learning, social exposure, and training. However, it does not depict the rudimentary procedures that find out how an individual's personal feelings are affiliated with anger, and how these communicative and behavioral responses are deviced and planned (Russell & Fehr, 1994).

Componential Appraisal Model (CPM)

The componential appraisal model has been developed to capture the complexity of the emotions. It explains how and why emotions emanate as a dynamic episode in the life of an individual. This model explains that the stimulation of emotions is determined by the cognitive process of evaluations (Ellsworth & Scherer, 2003; Frijda, 2006; Roseman, 1991; Scherer, 2001). The primary belief of the model is that people constantly scan the surroundings, identify the situations, and prepare themselves for the appropriate actions. Furthermore, individuals quickly respond to the situation which would be relevant to the stimuli and good for their own psychological, physical or personal growth. The relevance of the situation is evaluated by a number of appraisal checks (see Appendix A), which are based on past experience, personal characteristics, and current motivation. Hence, individuals become attentive to the most relevant situations and events which are important for their current objectives. So, it can be concluded that the personally important and relevant events triggered the emotions. Therefore, sometimes we shows strong emotions in response to an event which is not important for others. Similarly it justifies others over- reaction about an event or situation that is an ordinary event for us. In this way, all emotions depict, which event or situation is important for a person who experiences that emotion (Ellsworth &

Scherer, 2003).

When the event has been perceived as relevant or important, the individual finds out the best mode of action in response to that particular situation (Smith & Lazarus, 1993; Scherer, 2001). Individuals who generally blame external cause for the negative situations called "(*Externals*)" were reported as more angry as compared to those who generally attribute negative situations to internal causes called "(*Internals*)" (Roseman & Kaiser, 2001). During a performance task it was observed that the frequency of anger for *"Internals and Externals"* was the same; however, the style of anger experienced by these two groups was different. The anger reported by *" Internals"* was generally towards themselves, whereas the anger reported by *" Externals"* was mostly directed at partner of the performance task (Wranik, 2005; Wranik & Scherer, 2009). Thus, attribution styles consistently influence the type of anger, expressed in reaction to the same event.

After evaluation of the relevance of the situation and determining the implication, the person chooses an appropriate response. One's coping potentials help to differentiate between responses (Lazarus & Monat, 1991). The individuals who believe in themselves often engage in proactive actions. Therefore, they have more capacity to deal with and find solutions of any kind of situations than others and they always have an optimistic view about their future (Bandura, 1997; Seligman, 1998). As feeling angry is a human basic reaction towards unpleasant event so these people also experience anger but their reactions are modified by the cultural influence (Mondillon, et al., 2005; Scherer, Wranik, Sangsue, Tran, & Scherer, 2004).

Significance of the event and action is also evaluated in terms of one's cultural values, self concept, and social norms. For example there are individuals, for whom meeting with their internal standards is more important, whereas some others are more concerned about the approval of people and societal or cultural standards. Partly, such deviations are the result of

cultural values, but some other aspects such as being dependent on others can also play an important role to strengthen this behavior (Scherer, 2001). These individual differences explain the normative significance of appraisal biases, for example, the individuals who preferred their internal standards are more perfectionist and generally show anger at themselves rather than on others (Hawley, Zuroff, & Blatt, 2006). The Componential Processing Model described various characteristics which are similar to some of the other appraisal models. This model unambiguously suggests a number of appraisal checks that unfold the cognitive process of anger response that has been confirmed by a number of empirical studies (Aue, Flykt, & Scherer, 2007; Grandjean & Scherer, 2008;Lanctot & Hess, 2007).

So far it has been demonstrated that the appraisal process can prompt a mixture of resentment encounters and practices. But what types of individuals experience more outrage as compared to others is still not cleared. The clinical counselors and psychologists, working for anger management affirm that individuals with high trait anger are exhibited more anger (Kassinove & Tafrate, 2002; Schiraldi & Kerr, 2002). There are various elements that influence the frequent anger, including personal characteristics (Kuppens, 2005), physical illness (Santos, Caeiro, Ferro, Albuqierque, & Figueira, 2006), agony and maladjustment (Fraguas et al., 2005; Orth & Wieland, 2006), brain injury (Ashwin, Wheelwright, & Baron-Cohen, 2006; Graham, Devinsky, & Labar, 2007;Lawrence, Goerendt, & Brooks, 2007), or formative and didactic components (Crowell, Evans, & O'Donnell, 1987) and/or heredity (Giegling, Hartmann, Möller, & Rujescu, 2006).

Appraisal biases

Most of the time hereditary and biological reasons are considered as core element for the uncontrolled anger but on the other hand, appraisal biases are also important. As

emotional responses are generated and regulated by personal appraisal processes, so it is quite logical that different individuals perceive a situation differently and encode it accordingly (Kuppens & van Mechelen, Meulders, 2007; Mischel & Shoda, 1998; Vansteelandt & van Mechelen, 2006). Appraisal process and evaluation influenced by the perspective taking skills, social learning, and cultural norms. Therefore some people, always seems to complain that the world is a place of unjust for them while others constantly look for someone (person or circumstances) to blame, when things are not in their favor (Schmitt, 1996; Seligman, 1998). Whereas, in some other cases, these attributes may only be activated in response to the particular situational factors, for example, people mostly blame someone else in an achievement settings where they have competition with others but not in a relationship setting (Stemmler, 1997). So the interpretations of angry expression can be depending on individual's personality, gender, status, and culture (Lewis, 2000; Tiedens, 2000)

Cultural Theory

Culture is the fundamental component of individual's behavior and can play an important part in the existence of emotions. Cultural norms define how a particular structure of stimulation or physiological changes should be labeled as a specific emotion. Therefore, knowledge about culture is important to differentiate the physiological responses as emotion or reaction of physical activity. For example, one must know, whether an increased heart rate is a symptom of excitement or fear. The physical or body changes, behavioral actions and facial expression are attributed as emotional response or expression (Fitness, 2000). Previously, Ekman (1982) and Izard (1977) have presented some facial expression which are universal for primary emotions but for most of the emotions there does not exist universal expression. Furthermore, different emotions might be expressive in similar pattern, a person might smile to show happiness or to hide anxiety or shame. In addition to this ambiguity,

there are also cross-cultural differences in expression of gestures. People in the United States, smile in general meetings while Polish people only expect smiling as a sincere expression of happiness (Wierzbicka, 1999). This example emphasized on the importance of culture in expression of emotion.

Likewise, Rosenberg (1990, 1991) concluded that culture is a crucial to distinguishing and exhibiting our emotions. The Goffman's (1989) work described that we often use emotions as cues in analyzing and reacting to an interaction and in each element of interaction, culture plays an important role to define the focus of attention, by enabling verbal communication, delineating perceptions, and creating harmony. In addition, the interaction involves the stream of feelings among individuals within the society. So the culture sets the norms and criteria for the acceptable behaviors within a society, and individuals must learn these norms to judge the situation and to make appropriate decision about reactive behavior. Hence, the behaviors must be interpreted in a cultural context and consider the culture influence on the perception of anger (Matsumoto & Wilson, 2008).

Different cultures have their own unique characteristics and individuals belong to certain cultures acquired those characteristics and their behaviors represent their cultural norms. As cross-cultural studies have revealed that individualistic cultures focused on individualism and encourage to interact with strangers. Whereas oppressing the personal interests and attaining the conformity is a primary feature of collectivistic cultures (Elfenbein & Ambady, 2003; Hofstede, 2001; Oyserman, Coon, & Kemmelmeier, 2002). Thus, individuals in collectivistic cultures tend to show more emotions towards in-group to preserve and facilitate group cohesion, harmony, or cooperation (Matsumoto, 1991). Therefore, in collectivistic cultures, individuals feel guilt if they cannot meet the societal expectations. They continuously bear social pressure in obtaining conformity. In individualistic cultures,

people are more likely to feel shame for not attaining their internal standards and identifying themselves as a unique personality (Mesquita & Walker, 2003).

So if the anger could be researched or studied into parts such as perception and cognitive process, regulation, expression, and behavior associated with anger expression—then it would be clear that anger not only transpire from specific situational or biological factors, but also by the individuals style of evaluating a particular situation within a cultural context. This shows that besides anger provoking stimulus, every person itself is also responsible for his or her own angry behavior. One can say that the subjective quality of anger is something intrinsically unpleasant (Fernandez & Kerns, 2008; Fernandez & Turk, 1995). So uncontrolled anger could occur as a result of negative appraisals and an unsettled temperament that often manifested as behavioral problems in normal and clinical population (Potegal, Stemmler, & Speilberger, 2010).

It has already been mentioned that anger has appeared as a co-morbid feature in a wide variety of psychiatric disorders that activate aggressive behavior among psychiatric patients. A study carried out in Agha Khan University and Hospital (AKUH) also indicated that approximately 14% of total patients in a psychiatric unit showed violent behavior during their stay in the hospital (Iqbal, Naqvi, & Saddiqui, 2006). In another similar study among 4000 inpatients in California State Hospital, the primary clinicians reported that approximately 35% were those who "gets easily angry and annoyed" (Novaco, 1997). Clinical staff reported that anger is a salient problem in a wide range of psychiatric disorders, e.g., mood disorders, many personality disorders, schizophrenia, especially paranoid schizophrenia, and impulse control dysfunctions which is linked to assaultive and aggressive behavior (McNeil, Eisner, & Binder, 2003). It will not be out of place to mention here that the staff members working with psychiatric patients have a stressful occupation and they have

often reported PTSD due to patients' assault (Doyle & Dolan, 2006; Novaco & Taylor, 2004).

In Germany, nine state mental health institutions reported violent attacks by the patients that caused moderate to severe physical injuries (e.g., scratches, lack of consciousness, broken bones) as well as psychological disturbances among staff members (Richter & Berger, 2006). Monahan et al. (2001) explored that the patients who had shown high anger in hospital during assessment were more often found to become violent in the community within one year of their discharge from hospital than those who had shown low anger during assessment. Moreover, Posternak and Zimmerman (2002) found that among 1300 non-hospitalized psychiatric outpatients, a certain number had an extreme level of anger. It can be concluded that in clinical problems "dysregulation" is the key feature of anger as its stimulation, expression, and reaction occurs without appropriate control. Alternatively in such clinical conditions, there is a considerable lack of care from anger management professionals, which is required for optimal short-term and long-term functioning (Scherer et al., 2004).

Unfortunately, anger in psychiatric patients has not gained much attention in the literature to highlight its significance (DiGiuseppe, 1999) and it has not been recognized by the "Diagnostic and Statistical Manual of Mental Disorders" (American Psychiatry Association, 2000). Anger has been studied as a ward atmosphere variable but have not been examined in relation to psychiatric problems (Eklund & Hansson, 1997; Rossberg & Friis, 2003). Therefore, anger is often viewed as a symptom of other diagnosable psychiatric disorders, such as mood disorder, anxiety disorder, personality disorder, conduct, and anti-social personality disorder (Kassinove & Tafrate, 2002; Olatunji, Sawchuk, Lohr, & de Jong, 2004).

Intermittent Explosive Disorder (IED) is the most closely linked to anger, which is

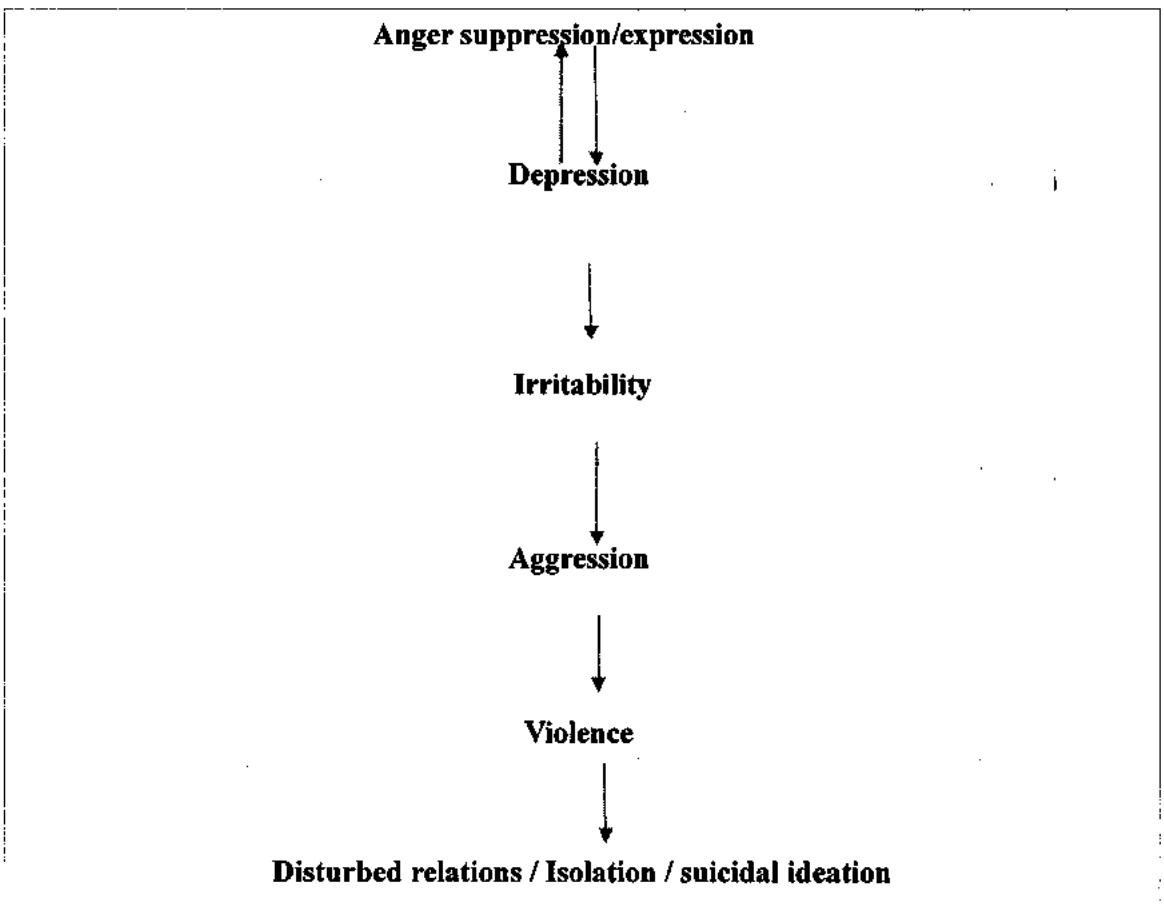
one of the impulse control disorders in the DSM-1V (Kessler et al., 2006). It is evident in the IED literature that anger attack and violent behavior are among the prominent features of IED which fit in the general criteria of abnormality and psychopathology (Potegal, Stemmler, & Spielberger, 2010). It has been found that IEDs are more prevalent among aggressive drivers (Galovski, Blanchard, & Veazey, 2002; Malta, Blanchard, & Friedenberg, 2005). However, McElroy (1999) noted bipolar disorder as life time co-morbid of IED and individuals with depressed mood, euphoria, and mania reported anger (irritability/rage) during the aggressive episodes. People with depression often present as self-harming or exhibiting suicidal behaviors (Wilkowski & Robinson, 2008). But still anger has not been conceived as a main contributor to depression and not even considered to be important for the treatment (Kuyken, Watkins, & Beck, 2005; Schuyler, 2003). The psycho-pharmacologists believe that anger could be a symptom of depression disorder but not the major cause and it can be treated with medication. Psychoanalytic theories, on the other hand, describe anger as an integral component of depression (Busch, Rudden, & Shapiro, 2004).

Anger and Depression

Individuals with depression show increased levels of covert hostility. Therefore, for many years in psychiatry, it was believed that patients with depression experience inward anger (Khalily, 2013). The frequently suppressed anger and fear was found as a prominent feature in outpatients with depression (Goldman & Haaga, 1995). It was suggested that patients with depression do not aggressively expressed their anger because they have lack of practice (Wolfersdorf & Kiefer, 1998) while the association of aggression and violence to depression is evident and it is reported that individuals with depression, report anger that often leads to aggressive behavior and violence (Pasquini, Picardi, Biondi, Gaetano, & Morosini, 2004). The presence of violence and anger attacks in patients with depression was

found higher than for those with bipolar disorder and schizophrenia (Cautin, Overholser, & Goetz, 2001; Perlis et al., 2004; Painuly, Sharan, & Matto, 2005). Results of another study, conducted with in-patients of depression, also supported the idea that the anger is positively correlated with the depression, but there was no difference in degree of inward or outward expressed anger (Fava, 1998). So it can be concluded that the unhealthy expression of anger may appear in a variety of detrimental responses including self-defeating blaming, violence, suppression and/or internalization of the emotions, and verbal aggression (Greenberger & Padesky, 1995).

Figure 1. 2: **Anger leads to serious problems**



Although not all violent and aggressive behaviors among depressed patients are

triggered by anger, anger is a significant emotional factor for interpersonal violence (Eckhardt, Norlander, & Deffenbacher, 2005). The relationship between anger and depression is still complex and not well understood. It is a general conception that patients with depression exhibit more anger than anxiety with the exception of post-traumatic stress disorder (PTSD). However, irritability is a prominent feature of anxiety disorder especially in generalized anxiety disorder (GAD) and social phobia (American Psychiatric Association, 2000). Hostility, verbal aggression, and physical aggression are specific components that contribute to GAD (Deschênes, Dugas, Fracalanza, & Koerner, 2012). Similarly, Erwin, Heimberg, Schneier, and Liebowitz (2003) found that anger expression and angry feelings among patients with social phobia were high as compared to non-anxious individuals.

Anger and Anxiety Disorders

Anxiety is not only strongly correlated with general anger expression, but the various dimensions of anger are also associated with worry and anxiety. For example, boiling, with anger, inside without showing it, is a strong predictor of Generalized Anxiety Disorder (GAD). Moreover, hostility and suppressed anger have been found to be contribute to the intensity of GAD symptoms (Germine, Goddard, Woods, Charney, & Heninger, 1992). Five anxiety disorder group was compared with a nonclinical sample and it was found that the patients scored higher on anger/hostility/aggression measures (Moscovitch, McCabe, Antony, Rocca, & Swinson, 2008). There was a significant difference of anger found between patients with Obsessive–Compulsive Disorder (OCD) and the non-clinical population of the university students (Whiteside & Abramowitz, 2005).

Barlow's (1991) model of emotional disorder explained the relationship of anger and anxiety. He differentiated anger from fear and stated that stress is a significant moderator in the relationship of anxiety and anger. Therefore, anger is identified as a major component of

PTSD and associated with trauma-exposed adults (Orth & Wieland, 2006). Researches identified that the events which cause trauma to the person, effect the relationship of anger and PTSD. These traumatic events could be related to natural disaster, health related issues, crime victimization, or environmental situations as it has also been observed that anger is strongly associated with warfare PTSD (Beckham, Moore, & Reynolds, 2000; Biddle, Creamer, Forbes, Elliot, & Devilly, 2002; Castillo, Fallon, C'de Baca, Conforti, & Qualls, 2002; Elhai, Frueh, Gold, Gold, & Hamner, 2000; Novaco & Chemtob, 2007). The family members and clinicians, working with the soldiers who came with the problem of PTSD, often reported anger as a key feature of their mood (Biddle et al., 2002) and it was a prominent symptom of PTSD that hinders the treatment (Koenen, Stellman, Stellman, & Sommer, 2003). Furthermore, it has been reported that higher anger is not only associated with poorer treatment response (Forbes, Creamer, Hawthorne, Allen, & McHugh, 2003) but it could contribute to the chronicity and severity of PTSD.

Similarly, trauma found as a significant predictor of anger for non-combat population. Results of several studies depicted high degree of anger among individuals who survived from different kinds of trauma e.g., the survival of sexual assault, (Feeney, Zoellner, & Foa, 2000), road accident victims, (Ehlers, Mayou, & Bryant, 2003; Mayou, Ehlers, & Bryant, 2002), individuals with mental health problems (Franklin, Posternak, & Zimmerman, 2002), victims of domestic violence (Chemtob & Carlson, 2004; Jarvis, Gordon, & Novaco, 2005), prisoners (Schutzwohl & Maercker, 2000), and refugees (Hinton, Hsia, Um, & Otto, 2003). So overall in the combat population, anger can be caused by suppressing fear and energizing attack behaviors, which reduce the fighting efficiency by impairing the control of behavior. While in the outside combat population, anger is a maladaptive behavior that appears as a problem, when an individual is unable to regulate the intensity of anger and expression in

accordance to situational requirements (Beckham et al., 2000).

Novaco and Chemtob (2002) proposed an anger regulatory deficits model. They hypothesized that individuals suffering from PTSD have lower thresholds to perceiving situations as threatening, as prior experience of threat leads them to perceive a threat in the environment when it is not really present. Then, these individuals entered into survival mode, which heightened arousal, hostile appraisal, and counter behavior in response to the perceived threat. This process negatively impacts the cognitive abilities to regulate anger. Similarly, the social-information-processing model depicts that anger interferes with rational cognitive processing, which leads to impairment of the problem-solving skills and results as violence (Lemerise & Arsenio, 2000).

It has been consistently found that during anger induction procedures, individuals with PTSD committed violence against their partners. Thus, anger has been found to be a problematic emotion among survivors of trauma. In fact, it has been suggested that PTSD should include specifiers such as prominent anger (Monson et al., 2006). In general, anger dysregulation is indicative of distress for patients, which extends to families, friends, associates, and care providers. Deschênes et al. (2012) also supported the notion that if anger contributes in the maintenance of the anxiety then it could hinder the treatment of disorder. Therefore, it is important to treat the symptoms of anger while treating a mental disorder so that patient gets maximum benefit from the treatment. The hospitalized patients who reported symptoms of anger along with other psychological problems are treated with psychotropic drugs for their anger. However, psychologists emphasized that appropriate psychotherapies were found effective when compared it with other mode of treatments. Results of many research experiments also confirmed the statement that patients who received psychotherapies showed rapid improvement in their problem (Beck & Fernandez, 1998; Del

Vecchio & O'Leary, 2004; DiGuiseppe & Tafrate, 2003; Edmonson & Conger, 1996; Sukhodolsky, Kassinove, & Gorman, 2004).

Anger Management

For anger management, there is a range of psycho-therapeutic techniques described in literature. These techniques have been empirically proved and successfully applied in the treatment of anger by clinical practitioners (Bunt & Pavlicevic, 2004). There are some techniques which are not based on any particular school of thought, these are called ***"standalone techniques"***. Music is one of example of the standalone technique. Musicians and non-musicians alike have been found to consider that music has healing power. The researchers who used music for anger management often reported that it has potential to alter the emotions regardless the role of client. Whether the client is composing, performing or just listening, it would help to reduce anger. It often blended with acting to alter the anger specially for children (Fischetti, 2001). Although researchers have been fascinated by the powerful effect of music on emotions and made development in the field of music and emotion but most of them could not explain the clear relationship between music and emotion (Grandjean & Scherer, 2008).

The Muslim Scholar, Al-Farabi (872-950) known as "Alpharabius" in western cultures, is considered to be as first ever practitioner of music therapy. He presented philosophical principles about music, its cosmic qualities and its influences. He wrote treatise "meanings of the Intellect" which dealt with music therapy and discussed the therapeutic effects of music on the soul to heal the mental problems (Haque, 2004b).

Yet other techniques which have philosophical or religious backgrounds. Some of the important patterns or trends in the field of psychotherapy for anger management are given below.

Psychological Approaches

Various psychological models have their own unique anger management styles. The well known anger management techniques are based on different psychological approaches such as; psychoanalysis, Gestalt therapy, behavioral therapy and cognitive behavioral therapy.

Psychoanalytic Approach

This approach is grounded in Freudian theory. Psychoanalysis is considered to be effective for the treatment of various psychiatric problems including personality disorders, eating disorders, substance-related disorders, mood disorders, and some of the anxiety disorders, especially generalized anxiety disorder. According to this approach, anger is an instinct emotion that is reside in unconscious mind but sometimes manifested in behavior, masked by some other emotion-prototype i.e., guilt, frustration, irritation (Leichsenring & Leibing, 2007). It is one of the most frequently used methods in the treatment of clinical psychiatric problems and has also been successfully used for the anger management of adults (Glancy & Siani, 2009). Psychotherapy is a long-term therapy and therapists allow their clients to express their anger, which is called catharsis. Psychoanalysts believe that present anger is rooted in past negative events and the client should talk about those events to get rid of anger (Ambrose & Mayne, 1999). For a long time, psychoanalysis was the only effective way of anger management but the length of the treatment and other structural issues weaken the efficacy of this therapy, and the client's non-verbal communication is also important for gaining insight into the anger (Knafo & Moscovitz, 2006).

Gestalt Therapy

Nonverbal behavior such as facial expression is important for the Gestalt therapists because these expressions were regarded as more informative than verbal expressions (Perls,

1973). Gestalt therapists pointed out that such non-verbal expressions are important to bring awareness in client about his/her anger. The "empty chair" technique is a hallmark of Gestalt therapy (Conoley, Conoley, McConnell, & Kimzey, 1983). The advantage of this method is that the anger is not directed towards the counselor but the clients also can vocalize their anger and get it off their chest. While practicing this technique, it is recommended that the therapist should keep in mind that encouraging a client to express his anger should not be attempted with someone who has a history of violence or someone who clearly has difficulties in controlling his actions. In this method, the main emphases of psychologist is to bring the suppressed anger to the conscious mind to make the client aware of anger and then it could safely released (Schimmel & Jacobs, 2011).

Role play is another important technique of getslt therapy for anger management. In this technique client adopts the role of another person and tries to handle the situation in a different way. During the role play, client takes the perspective of another person, where one understands others point of view and sees oneself from others eyes (Day, Howells, Mohr, Schall, & Gerace, 2008). One disadvantage of gestalt therapy is that therapist focuses on present and ignore the past events which is focus of attention in psychoanalysis. Therefore, some of the anger-related behaviors such as tantrum can be extinguished by simply ignoring them and just focusing on the present. So some of the techniques of gestalt therapy are successfully used in anger management but there is no evidence that gestalt therapy is effective for anger management (Wagner-Moore, 2004).

Behavioral Therapy

There are many behavioral techniques which are applied in clinical settings for the treatment of psychiatric disorders and anger management. One of the technique that has long been used in anger management which is popular for anxiety control is "Systematic

desensitization". In systematic desensitization, client's anger arousal diminished by relaxation training as it was theorized that like anxiety, anger arousal can also be inhibited by relaxation (Echeverry, 1997). Therefore, with the help of clients and subjects a hierarchy of potentially anger provoking scenario was constructed. In counseling session, client is asked to relax at the height of anger arousal to extinguish the angry response. Once the anger has been declined, therapist asked the client to imagine next intense anger provoking scenario from the hierarchy, and so on. This method continues until client learned to keep relax in the intense anger provoking situations by adopting systematic desensitization (Rimm, deGroot, Boord, Heiman, & Dillow, 1971).

Relaxation training skills have demonstrated effectiveness in reducing general anger in various situations. Relaxation training involves progressive techniques and skills. Relaxation through deep breathing and imagination, muscles relaxation, and cue-controlled relaxation are the most important and used techniques (Deffenbacher & Stark, 1992). Cognitive appraisal and interpretation also play a significant role in the initiation and regulation of anger (Deffenbacher, Huff, Lynch, Oetting, & Salvatore, 2000).

Cognitive Behavioral Therapy (CBT)

The therapist who follows the cognitive behavioral school of thought also use relaxation techniques to alter the emotions. The most common and convenient form of relaxation is deep breathing and muscle relaxation, which often use to reduce the physical arousal in anxiety and anger management (Ellis & Dryden, 1997).

Unlike other psychotherapies, cognitive behavioral therapy has received extensive research as this approach identifies and modifies the cognition, behaviors, and physical responses through a variety of techniques. The goal of CBT is to make a person understand and monitor the thoughts, behaviors and emotions associated with anger arousal. It

emphasizes to reduce the symptoms of anger by focusing on the present unlike past childhood events and to learn the strategies to solve the problems in future (McGinn & Sanderson, 2001). The meta analysis of CBT demonstrated its effectiveness for the management of general, suppressed, and dysfunctional anger (Fernandez & Beck, 2001; Galovski & Blanchard, 2002; Siddle, Jones, & Awenat, 2003). It also effective for the modification of dysfunctional coping tendencies by altering them with functional problem solving skills (Willner, Jones, Tams, & Green, 2002). A study conducted by Dykeman (2000) demonstrated that an eight week cognitive behavioral therapy program significantly reduced students in appropriate expression of anger. However, it was suggested that a prolonged program could give more extensive results to treat situational aspects of anger.

Likewise, in a study of Vietnam War combat veterans with severe PTSD and high anger, participants received 18-months follow-up treatment and showed a significant decrease in anger expression (Chemtob, Novaco, Hamada, & Gross, 1997). This finding is consistent with theories of PTSD, which emphasize deficits in cognitive and regulatory processes as the core dysfunction of the disorder. Galovski and Blanchard's (2002) findings also indicate the effectiveness of a cognitive-behavioral intervention on aggressive behaviors of drivers.

There are a number of factors that can influence the efficacy of a psychotherapy (Echeverry, 1997). These factors can be the client's personality factors (age, gender, educational level) or cultural factors (religious beliefs, degree of socialization, national origin). The National Institute of Mental Health Strategic Plan for Reducing Health Disparities (1999) highlighted that diagnoses of mental disorders vary across cultures and cultural beliefs influence the treatment of any condition (Bernal & Scharron-del-Rio, 2001). This idea has been supported by many other researches e.g., the ethnic minority communities in USA tend to to respond differently to treatment than do non-minorities (Arroyo,

Westerberg, & Tonigan, 1998; Flaskerud & Liu, 1991; McMiller & Weisz, 1996).

A study conducted in 32 countries also described that each of the specific responses was different for different individuals when they were angry on a cultural value scale. It was further explored that cultures valued greater power distance, hierarchy, and long-term orientation that supported more neutralization and masking of anger. The people from individualistic cultures are independent, concerned about their own goals, and more expressive in anger whereas collectivist cultures encourage to control angry expressions by neutralizing or hiding the anger. These cultural differences in preferred modes of anger expression regulation provide strong implications for the understandings of inter-cultural interactions (Hofstede, 2001; Schwartz, 2004). So there is a great need to discover or adopt culture-based treatment manuals and instruments for anger management.

Culturally Sensitive Anger Management Interventions

Over the years, a variety of terms have been used to refer to the consideration of culture, including "culturally sensitive," "culture centered," "culturally competent," "multicultural competence," or "culturally responsive." All of these terms consider cultural norms including language-related issues in any psychological intervention (Pedersen, 1997). There is an increasing movement toward the integration of culture in intervention and treatment research. A number of authors have encouraged the treatments in which culture becomes the basis for understanding social interactions, behavior, and the immediate responding actions (Casas, 1995; Echeverry, 1997; Ramírez, Valdez, & Perez, 2003; Sue, 1998). The pioneers of culturally informed treatment, first worked with Latinos. They proposed to consider the concept of "contexualism" that means an individual's behavior should be viewed with reference of environment or culture (Szapocznik et al., 1989).

So it is recommended that during the development or adaptation of a culturally

sensitive intervention, one must be aware of culture, acquire the knowledge about the specific culture (e.g., norms, customs, religion etc.) and be capable of distinguishing between cultural responses and pathology (Zayas, Torres, Malcolm, & DesRosiers, 1996). There are eight domains, including language, metaphor, content, and goal, that must be assimilated into cultural based treatments to increase the validity of a treatment plan. In addition, technical and theoretical issues must also be considered (Pedersen, 2003).

Language is usually a bearer of culture; thus, for the integration of the treatment, it is mandatory to deliver the treatment in the native language so for an effective cultural based intervention the knowledge of language must be associated with knowledge of culture (Sue, 1998). Furthermore, language is not only major component of the culture but also a primary tool to express the emotions. If a therapist is not fully familiar with the language of the targeted population, he or she may misconceive the emotional responses, that could affect the course of the treatment (Barona & Santos de Barona, 2003). Thus, language is an important component for the culturally based intervention. So it is not necessarily direct translated the treatment plan but must use the cultural appropriate language, taking into consideration the regional or subgroup differences.

The second dimension of culture is *persons.* It described the importance of client and therapist relationship for the success of a treatment plan. One must considered the racial, ethnic, and religious differences and similarities in the client- therapist relationship. As it helps to know the clients feelings and expectations about the therapy (Barona & Santos de Barona, 2003). *Metaphor,* is the next dimension presented in the cultural framework. Every culture has some symbolic language or concepts that called metaphors. These metaphors have their own meanings and use of these metaphors could be helpful in a cultural based treatment plan. So therapist must be aware of the cultural metaphors because it helps the client to feel

comfortable with therapist (Muñoz, 1982).

The cultural *content* knowledge refers to norms, customs, and traditions of a culture. These cultural concepts should be incorporated into all parts of a treatment process such as, assessment and treatment planning especially when working with minorities. Theoretical *Concepts* of a particular theory, used in a treatment plan are important to be discuses with the client. The way in which the presenting complaints of a client are conceived and transmitted back to him or her is very important. In this procedure, the harmony between culture and context is essential for treatment efficacy. If this consistency is absent, the therapist's credibility will be reduced and inevitably the treatment efficacy may be threatened (Pedersen, 2003).

The sixth domain, *goals*, expresses the formation of an agreement between the therapist and client to set the goals of treatment. The goals of treatment must be established taking into consideration the client's cultural norms, customs, and traditions that reflect a certain level of cultural knowledge. The domain of *methods* refers to the strategies to follow for the accomplishment of the treatment goals. As can be expected, the development of a culturally centered treatment should integrate procedures that are congruent with the client's culture. Finally, the element of *context* refers to the consideration of the client's broader social, economic, and political contexts. Additionally, it is essential to consider cultural processes, such as stress of social adjustment in a culture, developmental stages, availability of social support, and the client's relationship to his or her culture of origin (Bernal & Saez-Satiago, 2006).

So it can be concluded that cultural and social processes must be considered in treatment, interventions, and mental health services (Bernal, Trimble, Burlew, & Leong, 2003; Marín & Marín, 1991). Therefore, the field of psychology is gradually accepting the

multiculturalism in almost every dimension of psychology. American Psychological association (2003) presented a guideline for the multiculturalism so the framework of a culturally sensitive treatment must be consistent with these guidelines. Many psychologists have been started to considered culture, language, and religion in integration with modern psychotherapies in their researches. It has been acknowledged that religion and spirituality have a salient role to play in the psycho-therapeutic process for the resolution of mental health problems (Pargament, Murray-Swank, & Tarakeshwar, 2005). It has been evident that religious practices and spirituality bring many positive outcomes. These can improve the ability to cope with stress, reduce depression and anxiety, decrease suicidal ideation, diminish consumption of alcohol, and reduce drug abuse (Gartner, 1996; McCullough & Larson, 1999). In some societies religion is the center and integral part of that culture, so it is imperative to involve religious practices for the management of mental health illnesses (Bernal & Scharron-del-Rio, 2001; Nagayama-Hall, 2001; Sue & Sue, 2003). Therefore, in recent years, some psychotherapists have integrated religious teachings in their clinical ssttings (Dein & Loewenthal, 1998; Richards & Bergin, 1997) and have successfully combined with cognitive behavioral therapy for patients with the symptoms of depression, anxiety, and bereavement (Azhar & Varma, 1995a; Beitel et al., 2007; Razali, Hasanah, Aminah, & Subramaniam, 1998), with the schema-focused therapy for characterological problems (Khalily, 2012).

Role of Religion in Culturally Sensitive Interventions

The integration of religiosity and spirituality in clinical treatment is not new. In the era of ancient Greece, therapists or healers provided spiritual treatment along with physical care. During those days, it was not strange or uncommon to receive medical and physical advice from the same person. This concept began to change after the fourth century, which

was called the era of modern medicine but even then physicians did not completely separate religious treatment from health issues (Becker, 2001). However, during the seventeenth century, spirituality was clearly seperated from physical health and challenged the role of the church in the treatment of physical health and allowed a dichotomy to emerge between the church and physician Thus, spirituality and medicine were starting to be perceived as two distinct entities (Becker, 2001). On the other hand, the integration of religiosity in psychotherapy was mainly influenced by Freud's views. As he believed that religion and spirituality is the root cause of all the mental disorders and one should avoide to practice religious or spiritual activities to cure mental health problems (Paul & Kelly, 2005). Behaviorist also had similar point of view. They claimed that if mental health practitioners incorporated religion in their practices, psychology would not be remained a science. Therefore, the behavioral community did not accept and integrate spirituality and religion into research studies or treatment modalities (Badri, 1979; Paul & Kelly, 2005).

Psychologists appeared to have rediscovered religion and spirituality in the twenty-first century (Hartz, 2005; McMinn & Dominquez, 2005; Plante & Sherman, 2001; Richards & Bergin, 2005; Shafranske & Sperry, 2005). As religion and spirituality comprise a cultural and personal factor that has a prominent impact on one's behaviors, thoughts, values, health and illness patterns. Therefore, multicultural competency have been adapted by a number of professionals in their clinical practices to cure mental health problems (Badri, 2013; Rose, Westefeld, & Ansley, 2001). An ongoing quality research has begun to provide a scientific foundation for the integration of religion and spirituality in psychotherapy (Hill & Pargament, 2003; Koenig, 2007; Plante & Sherman, 2001).

Currently, religious based techniques and concepts are increasingly integrated with cognitive behavioral therapy. These interventions aim to replace the maladaptive, irrational,

damaging daily thoughts with adaptive, rationale and positive beliefs that must be consistent with core religious values and attributions (Martin & Booth, 1999). It has been evident that religious based cognitive behavioral therapy is more effective in counseling as compared to general or non- religious CBT (Hawkins, Tan, & Turk, 1999; Johnson, 2001; Johnson & Ridley, 1992; Johnson, DeVries, Ridley, Pettorini, & Peterson, 1994; Nielsen, Johnson, & Ellis, 2001). Researchers demonstrated significant results in comparison of religious and non-religious CBT for example, Propst, Olstrom, Watkins, Dean, and Mashburn (1992) provided religion based imagery procedures and religious arguments to replace irrational thoughts and reported significant improvement in individuals with clinical depression.

Religion-based cognitive-behavioral therapies have different types of techniques that range from daily religious activities to special supplication or ways of meditation. It also included the religious relationship between client and therapist. Some of the other techniques are participation of religious supportive groups and lessons of holy book (Hawkins, Tan, & Turk, 1999). Previously, many of researchers have incorporated spirituality with cognitive behavioral therapy to attain the spirituality growth for the well being of a person (Sperry, 2005). Hodge (2006) proposed that spiritually modified cognitive-behavioral therapy centers help the clients to identify unproductive thoughts and underlying problems and assist them to substitute these thoughts with more functional and productive self-statements by utilizing spiritual interventions.

Spiritual interventions

There is a variety of spiritual techniques used in psychotherapy to modify the maladaptive behavior. Some of those are prayer, meditation, and surrender to God (Richards & Bergin, 2005). These spiritual interventions are briefly described below to identify their potential effects.

Prayer: Prayer is a commonly used religious intervention in psychotherapy as it is not confined to a particular religion. It can be defined as an individual's inward (verbal or non-verbal) conversation with God (Meisenhelder & Chandler, 2000; Richards, Hardman, & Berett, 2008). In Islamic teaching prayer is actually a time-bound practice, when our mind and heart turn to God (La Torre, 2004). There exists a wide diversity of prayers, each with a different purpose and goal. For example, people often pray to deal with life's problems or medical issues and to overcome the fears of life (McCullough & Larson, 1999). This approach can give inner peace and help an individual to become more self-aware. It also relaxes an individual and can improve the mood (Christiansen, 2008; Farah & McColl, 2008; Peloquin, 2008; Smith, 2008). At the same time, the therapeutic relationship can be strengthened by prayer because at that time both client and therapist are on equal grounds and can seek guidance from Allah (Farah & McColl, 2008). But some controversies exist in the clinical world whether the clinician should pray with their clients or not. A counsellor should employ prayer in treatment only when he is competent to exercise the skill, the client is receptive, and the workplace allows for prayer. Then there are different ways to incorporate prayer into practice. Prayer can occur vocally with the client in a session or the therapist can also encourage the client to pray outside of therapy sessions (La Torre, 2004; Richards & Bergin, 2005). Secular counsellors often feel uncomfortable to utilize prayer in counseling sessions (Weld & Eriksen, 2007).

Meditation: Meditation is identified as a relaxation technique and it may be utilized with clients in the therapeutic setting (Marlatt & Kristeller, 1999). Meditation can be performed by different ways. The meditative process involves calmness and all attention to expunging irrational thoughts through visualization, relaxation training, focusing or reciting some specific Qura'nic words (Mohr, 2006). Individuals blocked ut all the destructive

thoughts by adopting meditative techniques and focus on present (Richards & Bergin, 2005).

Surrender to Allah: Our expectation about an event or reaction to a situation depends upon our locus of control. Locus of control can be explained as the fact that some people believe they have control over life events, and so each person is responsible for his or her own actions. This awareness is called internal locus of control. Whereas some other people belive that they have no or little control over life, and events are a result of luck, fate, or unpredictable surroundings, which is called external locus of control (Fournier & Jeanrie, 2003). This belief system takes charge of a situation. Cole and Pargament (1999) suggested that the therapist should explain to the client that there are certain events that are uncontrollable, such as death, illness, and accidents, in which we have to surrender to Allah. Often, clients stick to issues that are out of their control and do not rest on the support and guidance from God, thereby creating additional stress in their lives. Forgiveness (give up or give way to anger) allows one to surrender emotional burdens and concerns (Sanderson & Linehan, 1999). The authors recommended forgiveness as a focus in treatment by working toward acceptance of life, processing the feelings of anger, and then moving toward feelings of love (Richards & Bergin, 2005).

Contribution of Muslim Scholars in Psychotherapy

It is important to explore the contribution of Muslim scholars in psychotherapies because many of the psychological theories and principles were originated by Muslim scholars which are successfully use in western societies. Most important of all that majority of their work was based on Islamic knowledge and is relevant to all time and places (Haque, 2004b). Though lot of their work in psychology is scattered and sparse and is not readily available in English language.

Contemporary Muslim psychologists have highlighted Ibn al-Haytham's (965–c.1040

CE) contributions to experimental psychology and psychophysics made before Bacon and Fechner (Khaleefa, 1999). The contribution of Ibn Sina (Avicenna; 980–1037 CE) to medicine and psychology on the subject of associative learning in adaptive and maladaptive responses was further developed by Al-Ghazali (1058–1128 CE). Al-Ghazali's theory of dynamic interaction deals with human emotions and their control, and he showed that ethical and emotional habits can be acquired and changed by learning and training. Ibn al-Qayyim (1981; 1292–1350 CE) stated in his book "*Al-Fawa'id*" that every action of a human person starts first as an inner thought or concealed speech or internal dialogue called "*Khwatir*" in Arabic. Al- Razi (862-934) promoted psychotherapy and stated that a patient encouraged by the optimistic suggestions of doctors that promoted the speedy recovery in mental illness (Khalili, Murken, Reich, Shaha, vahabzadeh, 2001).

The prominent Muslim thinker in field of psychology was Abu Zayd al- Balkhi (850-934) who was the first to differentiate between cognitive and medical psychology. He was the first to classify neurotic disorders into four emotional disorders: fear and anxiety, anger and aggression, sadness and depression, and obsession. He was the pioneer in cognitive therapy to treat these disorders (Khalili et al, 2001).

In his book "*Masalih al-Abdan wa al-Anfus* (*Sustenance for Body and Soul*)", he has been successfully discussed the diseases related to the body and soul. He used the term "*al-Tibb al-Ruhani*" to described the spiritual and psychological treatment, and the term "*Tibb al-Qalb*" to described the mental medicine. He criticized the doctors of his era who empahsized only on physical illnesses and ignored the psychological or mental illness of a client, and argued that "since man's construction is from both his soul and his body, therefore, human existence cannot be healthy without the "*ishtibak*" [interweaving or entangling] of soul and body (Haque, 2004b). Al-Balkhi traced back his ideas on mental health to verses of

the Quran and hadiths attributed to Muhammad (PBUH).

"In their hearts is a disease." (Quran, 2:10)

"Truly, in the body there is a morsel of flesh, and when it is corrupt the body is corrupt, and when it is sound the body is sound. Truly, it is the *qalb* [heart]."

(Sahih al-Bukhari, Kitab al-Iman).

There are number of other early Muslim philosophers who contributed in development of Islamic psychology. The contemporary Muslim psychologists are in process of reviving the traditions of their predecessors by inculcation of earlier insight into the discipline of psychology e.g., Achoui (1998), Ajmal (1986), Ansari (1992), Badri (1976, 1978, 1996), (Kahlily, 2013), Mohamed (1995, 1998), and Shah (1996, 2001).

Integration of Cognitive Behavioral Therapy with Islamic Teaching/Practices

The Islamic psycho-therapeutic approaches address the social, biological and spiritual aspects of personality and the problem of clients should be handled within a societal context (Haque, 2004). Several studies have found that a form of religious psychotherapy may be effective with Muslim clients who suffer from anxiety, depression, and bereavement (Azhar, Varma, & Dharap, 1994; Azhar & Varma, 1995a, 1995b; Badri, 1979). It has been revealed, during religious psychotherapy, one major cause of illness is negative thoughts which can be modified by the cognitive behavioral techniques that have been described in Qur'an and Hadith ("sayings and customs of the Prophet Muhammad") (Razali et al., 1998). Patients are encourage to recognize practical religious values and crop these in their thoughts, actions, and emotions. These practical values have been seen as to be essential and a key factor to the success of therapy. Azhar and Varma (1995a) identified forgiveness as another additional aspect in the treatment of depressed patients. In this therapeutic interventions, therapist encourage the clients to repent when feel guilty or realize their sin or bad deeds that are

against the value system. When they feel that their repentance had been accepted by Allah and they are forgiven by Allah and they had started to adopt right values then their symptoms of distress would start to decrease (Haque, 2004b). Another aim of these religious psychotherapies is to restore spiritual strength as a way of coping with the illness or situation. During the counseling process, the client may be reminded to rely on Allah in times of difficulties, to supplicate to Allah in times of need, to turn to Allah in repentance when in error, and to focus on the five daily prayers and reading of the Qur'an. Prayer, in particular, is viewed as a form of meditation that promotes relaxation and a general sense of well-being (Hamdan, 2008).

There have been many examples of CBT techniques adapted in relation with Islamic teachings that can be integrated into the counseling process with Muslim clients (Badri, 2013). Following the cognitive behavioral therapy, the client's dysfunctional automatic thoughts and core beliefs may be identified and modified through alternative explanations. The cognition techniques based on Islamic faith to alter the dysfunctional thoughts that could lead to different disorders including depression and anxiety. It is worth mentioning that the techniques applied to the clients merely depend upon the needs of each client (Ali, 2007).

Focusing on the Hereafter: Muslims have a strong faith that this world is temporary and one must be rewarded in another world with heaven or hell according to their deeds in this world. So the concept of focusing on the world Hereafter can also a beneficent way to alter the thinking. The problems and worries of this world can be intense, but if the person thinks about the life after death, he could be content and determined. One can learn to forgive others and to control anger for the sake of Allah and a good reward in *Jannah* (Paradise). When a person focuses on the life after death, one prepares to meet Allah in the best state and faulty thinking can be modified by productive thoughts. During the treatment session, the

therapist can explain to the client about the purpose of life in this world and the other with the reference of Qur'an and Hadith (Hamdan, 2008).

Say, "Shall I inform you of [something] better than that? For those who fear Allah will be gardens in the presence of their Lord beneath which rivers flow, wherein they abide eternally, and purified spouses and approval from Allah. And Allah is Seeing [i.e., aware] of [His] servants" (Qur'an, 3:15)

This approach can be effective with those who have significant worries and stress about their current situations. They are unable to focus and resolve the problems, or stick with the bad events.

Benefits of distress and afflictions: As described previously that every good act will be rewarded in Jannah, similarly every stress and worry is beneficial for a man because Allah removes the sins of the person at the cost of worry.

Prophet Muhammad said, "No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick he receives from a thorn, but that Allah expiates some of his sins for that" (University of Southern California-Muslim Student Association [*USC-MSA*], 1999).

From this hadith, it is comprehended that any distress and worries (physical or mental) is the compensation of sins or to make a person closer to Allah by enhancing good deeds. This is beneficial for humans because they will be judged in the Hereafter according to their deeds. The person will have the hope of earning reward from Allah for submitting to Him and the events that He has planned.

"And We will surely test you with something of fear, and hunger and a loss of wealth and lives and fruits, but give glad tidings to the patient (as-Sabirin)" (Qur'an, 2:155).

Prophet Muhammad PBUH) said, "No Muslim is struck with an affliction and then says

Istirja (Truly, to Allah we belong and truly, to Him we shall return) when the affliction strikes, and then says, (O Allah! Reward me for my loss and give me what is better than it) but Allah will do just that" (*USC-MSA*, 1999).

A client may have negative thoughts such as "Why is this happening to me?", "Why not someone else?", "Why did Allah choose me for this unbearable trial?," or "Allah is punishing me for my disobedience." Understanding the purpose of trials and tribulations can be an effective counter to unproductive thoughts (Azhar & Varma, 1995).

Tawakkul (Trusting in Allah): The concept of locus of control drives the person's emotional reactions. If one believes that we cannot control everything and Allah runs all affairs, then the person can be less blaming of self and others. For example, in the case of patients with depression and bereavement, individuals blame themselves or others for the event and react angrily. If they trust in Allah and accept the reality of their situation, they can come out of their illness. Allah has decided some limits for every person and no one can go beyond those set limits. If a person understands this reality then he would happily submit himself to Allah and hand over all the matters in hands of Allah. In turn, person will get relief from distress and depression that are concerned about this world. As stated in Qur'an,

"And when you have decided, then rely upon Allah. Indeed, Allah loves those who rely [upon Him]" (Qur'an, 3:159).

Narrated Abu Huraira: Allah's Apostle said, "The example of a believer is that of a fresh tender plant; from whatever direction the wind comes, it bends it, but when the wind becomes quiet, it becomes straight again. Similarly, a believer is afflicted with calamities (but he remains patient till Allah removes his difficulties.) And an impious wicked person is like a pine tree which keeps hard and straight till Allah cuts (breaks) it down when He wishes." (Sahi Bukhari, Hadith No. 545)

This understanding can be particularly helpful for those who have thoughts such as "I feel that I am no longer able to cope," "Life is too difficult for me," or "No one is there for me."

"Understanding that After Hardship There Will be Ease: 'So verily, with the hardship, there is ease (relief); verily with the hardship, there is ease'" (Qur'an, 94:5–6).

In this verse, Allah has promised that He will make a way out for the person. The more intense the stress and depression, the closer one is to assistance and relief. Similarly, Prophet Muhammad (PBUH) said, "Know that victory (or achievement) comes through patience, and that ease comes through hardship" (Zarabozo, 1999, hadith 19, p. 730).

Reading the Qur'an and remembrance of Allah: Various types of psychological or emotional distress can be healed by reading the Qur'an. It has a beneficial effect on the individual's body, mind, and soul and relieves stress and anxiety. One of the easiest forms of worship is is to remember Allah by reciting His names, being thankful to His blessings, and praising Him. There are different du'aas and ayat that one can recite for the remembrance of Allah and the greatest way is to recite and follow the Qur'an (Hamdan, 2008).

"Those who have believed and whose hearts are assured by the remembrance of Allah. Unquestionably, by the remembrance of Allah hearts are assured" (Qur'an, 13:28).

Prophet Muhammad said: Allah says, "I am just as My man thinks of Me, and I am with him if he remembers Me. If he remembers Me in himself, I too, remember him in Myself; and if he remembers Me in a group of people, I remember him in a group that is better than that. And if he comes one span nearer to Me, I go one cubit nearer to him; and if he comes one cubit nearer to Me, I go a distance of two outstretched arms nearer to him. And if he comes to me walking, I go to him running (Al-Mundhiri, 2000, n.d., book 60, chapter 1, p. 997).

Du'aa (Supplication): Supplication is another powerful method for overcoming anxiety, distress, and anger. When a person is angry and makes *duaa* to seek refuge from the evil of *shaitaan*, then Allah grants him peace and patience.

"And when My slaves ask you (O Muhammad) concerning Me, then (answer them): I am indeed near. I respond to the invocations of the supplicant when he calls on Me"

(Qur'an,2:186).

Prophet Muhammad said: There is no-one who is afflicted by distress and grief, and says, "O Allah, I am Your slave, son of Your slave, son of Your maidservant; my forelock is in Your hand, Your command over me is forever executed and Your decree over me is just. I ask You by every name belonging to You which You have named Yourself with, or revealed in Your Book, or taught to any of Your creation, or You have preserved in the knowledge of the Unseen with You, that You make the Qur'an, the life of my heart and the light of my breast, and a departure for my sorrow and a release for my anxiety," but Allah will take away his distress and grief, and replace it with joy (Al-Munajjid, 1999, pp. 28–29).

Supplication can also be used as a form of protection. The supplicant can turn to Allah and pray for refuge from distress and anger. There are some duaa's for grief, distress and anger that are prescribed for Muslims which one should recite throughout the day. For example, the Prophet Muhammad said to make a du'aa like, "O Allah, I seek refuge with You from grief and worry, from incapacity and laziness, from cowardice and miserliness, from being heavily in debt and from being overpowered by men" (*USC-MSA*, 1999).

These researches have pointed out the efficacy of cognitive behavior therapy based on religion and spirituality. These techniques were developed for the treatment of anxiety, depression, and stress (Shafranske, 2002). Yet, the field of anger management has been slow to embrace integration (Worthington & Sandage, 2002) and in Pakistan it is at the level of

infancy.

Rationale of the Study

Mental health in Pakistan has remained a subject of debate over the last few years. Although there is no national epidemiological study to provide the precise statistics of mental health problems in Pakistan, clinicians report that these problems are alarmingly increasing every day. Along with depression, anxiety, and stress, violence and anger are also prominent problems of Pakistani society as a consequence of continuous trauma and insecurities (Khalily, 2011). A major focus of the present study is to explore the presence of uncontrolled anger in psychiatric patients in order to devise a strategy in line with the cultural and religious values that have been previously ignored by researchers. Uncontrolled anger among psychiatric patients often leads to violent acts toward staff and practitioners (Iqbal, Naqvi, & Siddiqi, 2006). So a dire need exists to develop or adapt intervention plans to manage the uncontrolled anger among psychiatric patients in Pakistan. As we reviewed above, anger expression and management is largely effected by cultural norms, customs, and religious values and culture-based interventions have been found to be more effective (Bernal, Trimble, Burlew, & Leong, 2003). Therefore, Novaco's model of anger management, which has been successfully used previously in many contexts, has been integrated with Islamic techniques of anger management for the present research.

Religion and spirituality are successfully integrated with cognitive behavioral therapy for other psychiatric problems (e.g., anxiety, depression, PTSD). Unfortunately, it has been ignored for anger management. Most of the counselors in Pakistan are practicing the Western mode of counseling, which does not fit in the cultural context and clients cannot relate themselves to those techniques. In Pakistan, the majority of the people identify themselves with Islam (Hackett & Grim, 2012), so the above-mentioned anger management strategies,

grounded in Islamic values, can be helpful to treat anger. But there was no literature available in Pakistan providing guidelines for framing the anger management in the light of Islam except a few (e.g., Khalily, 2013). So the current study has made an effort to empirically validate this anger management intervention for individuals with psychiatric problems. It forms the foundation for bringing Islamic teaching to the forefront to deal with anger problems.

The current study organizes all the techniques in line with Novaco's model of anger management to provide a guideline for practitioners to use for angry individuals with psychiatric problems. Its usage will deepen the relationship between client and therapist as both seek help from Allah and people can familiarize themselves with the described techniques. The current study provides a milestone toward including religious teaching with modern psychotherapy for anger management in Pakistan.

Thus, keeping in view the prior literature and observations, the following objectives and hypotheses were formulated:

1. Investigate anger problems in individuals experiencing psychiatric disorders.
2. Indigenously adopt Novaco's model of anger management
3. Provide psycho-education to the individuals with anger problems about recognition and anger provocation.
4. Explore the effectiveness of an indigenously adopted anger management model to reduce anger intensity in psychiatric patients and enhance the efficacy of treatment.
5. Explore the effect of an indigenously adopted anger management model for psychiatric problems.

Hypotheses

1. There is positive correlation between depression anxiety, stress, and anger.

2. An indigenously adopted anger management model significantly reduces anger in individuals experiencing psychiatric problems as compared to the general counseling.

3. Individuals in the treatment group (at post-assessment) have low scores on the Novaco Anger Inventory, as compared to the individuals in the control group.

4. Individuals in the treatment group (at post-assessment) have low scores on the Depression Anxiety Stress Scale (DASS), as compared to the individuals in the control group.

Chapter II

Method

Sample

It was a quasi-experimental study that included a pre- post- test design for both the treatment and control groups. The sample comprised of 100 individuals (50 per group) 18–50 years old (M = 32, SD = .98) with psychiatric disorders from government and private hospitals of Islamabad, Rawalpindi, and Wah Cantt. The subjects were selected for the current study on the basis of inclusion and exclusion criteria given below.

Inclusion criteria.

- Individuals who were assessed and diagnosed by qualified mental health professionals for having psychiatric problems.
- Individuals who reported uncontrolled anger problems and expressed genuine concern about their anger.
- Individuals with uncontrolled anger problems and psychiatric disorders, referred by qualified mental health practitioners.
- Individuals who gave consent and having the ability to attend the planned intervention.
- Individuals who scored between 76-100 on Novaco Anger Inventory.

Exclusion criteria.

- Individuals do not have uncontrolled anger or psychiatric problems.
- Individuals did not diagnose by a medical professional for psychiatric problems.
- Individuals with schizophrenia or a history of a brain injury or dementia did not qualify for this study

- Individuals with a major risk of committing suicide, or who had a forensic history.

Operational Definition

As reported by practitioners, anger is a state of arousal involving facial and body changes and tendencies toward action. For the purpose of present study individuals who scored 76 and above on the Novaco Anger Inventory were considered angry.

Instruments

Demographic Sheet: participant's personal details (e.g., age, gender, education, occupation, etc. (see Appendix B) were collected.

Novaco Anger Inventory (Short Version, 1975): has 25 items that is a short form of the original 90-item version of the Novaco Provocation Inventory (Novaco, 1975). The alpha coefficient reliability of the inventory was 0.93. The NAI is a self-report inventory that measures the intensity of anger, when people imagine themselves to placed in certain situations. It is a five-point Likert-type inventory ranging from *"a little"* to *"a lot"*. The respondents rated on each item the frequency of their anger to the incident described in each statement. The inventory was translated into Urdu for the current study (Appendix C).

Anger Self-Report Questionnaire (ASR): Reynolds, Walkey, and Green (1994) developed the ASR, which is a 30-item single-scale questionnaire to measure anger, derived from an original 89-item scale. The items included in the short version of the ASR represented all of the original scale's subscales except guilt and mistrust/suspicion. Nine items were from the awareness subscale, three from general expression, six from physical anger, five from verbal anger, three from condemnation, and four items represented the total expression subscale. It was a six-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree). As there was no right or wrong answer, participants rated only the

frequency of their anger. The questionnaire was translated into the Urdu language and alpha coefficient of the scale was 0.92 (Appendix D).

Depression Anxiety Stress Scale: is a 42-item questionnaire developed by Lovibond and Lovibond (1995). An Urdu-translated (Aslam, 2007) version of the scale was used in the present study (Appendix E). It has three self-reported subscales, which measure depression, anxiety, and stress. Each subscale consists of 14 items. The depression scale assessed dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The anxiety scale assessed autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The items on the stress scale, which are sensitive to levels of chronic non-specific arousal, assess difficulty with relaxation; nervous arousal; and being easily upset/agitated, irritable/over-reactive, and impatient. It is a four-point scale ranging from 0 (does not apply) to 3 (applies to me most of the time). The alpha coefficient of the scale was 0.87. All items were positively scored. Higher scores represented higher levels of disorder.

Research plan: present study was completed into four parts

Part I: Indigenous adoption of Novaco's model of anger management

Part II: Preparation of the Instruments

Part III: Pilot Study

Part IV: Main Study (Implementation of indigenously adopted model)

Part I: Indigenous adoption of Novaco's model of anger management

Indigenously adapted model for anger management was based on Novaco's model of anger. The following three steps were followed;

Cognitive preparation: Clients were familiarized about anger provocation, maladaptive anger by self monitoring, intensity and knowing the type of anger.

Skill acquisition: In this step clients were taught to cope with maladaptive anger by restructuring their thoughts, thought stopping exercise, communication and social skills.

Application training (rehearsal phase): Clients were exposed to anger provoking situation. It was done through imagery, story narration and role playing.

And these three steps were covered into 12 sessions. Every session was comprised of 30 -35 minutes (see Appendix F).

Committee approval for the indigenous model of anger management: Indigenous model of anger management was approved by the committee of clinical psychologists which was headed by a senior faculty member who was trained in the Novaco model and attended Novaco accredited workshops. After approval of the model it was implemented on two clients who were diagnosed as depression and scored high on Novaco Anger Inventory. After the successful trial of the model it was finalized to use for the main study.

Part II: Preparation of the Instruments

Following method was used to translate the scales of the study:

Selection of scales

Face validity of the Novaco Anger Inventory and Anger Self Report Questionnaire was determined before final decision to use these scales for main study. A committee approach was adopted to finalize the selection of scales. The committee comprised five members including researcher from psychology Department of International Islamic University Islamabad. Items of the scales were examined by the members of committee to check its cultural relevance. All the items were found appropriate in the context of Pakistani culture and the scales were approved by the committee to use in the main study. It was suggested by the committee that scales should be translated into Urdu so that it become easier

for the patients to understand. The researcher took permission via email from the authors of the scales to use and translate these scales into Urdu language for the current study (see Appendix R).

Translation of the Scales

Translation of the scales was completed in two steps. In step I, research scales were translated into Urdu and their content validity was determined. While in step II, equivalence of English and Urdu versions of the research scales were assessed. Different samples were taken in both steps. For step I; sample consisted of psychiatric patients from the Pakistan Ordinance Factory (POF) hospital, Wah Cantt and Benazir Bhutto Hospital Rawalpindi. The sample was taken to look that the language of the translated items was clearly understandable for the targeted population. While to assess the equivalence of English and Urdu versions of the scales, in step II, it was required that individuals must understand both English and Urdu languages. So for the purpose of equivalence of the scales, a sample of students (both males and females) were selected from International Islamic University (IIU) Islamabad and University of Wah.

Urdu translation of the NAI and ASR: For the translation of scales into Urdu, original English versions of the scales were presented to five bilingual (Urdu and English) experts. Three of them were psychologists, one Urdu lecturer and one English lecturer. They were introduced to the variables, nature, and purpose of the research and they were requested to translate the scales into Urdu. The Urdu translated scales were then presented to a committee that was consisted of four members, an assistant professor (psychology), two lecturers (english), and a Ph.D (psychology) scholar, who minutely analyzed the Urdu translated items and compared those with the English version to assess the equivalence between Urdu and English version of the scales. Committee members evaluated the translated

items with reference to the context, grammar, and wording. A few words, which were difficult to understand, were altered with some easier words. After completing the item selection process, only those items were enlisted which conveyed closest meaning to original as Urdu translated version of the scales.

Back-translation of NAI and ASR: To determine the authenticity of Urdu translation, the scales were translated back into English language. A standardized method of back translation (Brislin, 1980) was used to established the cross cultural validity. Urdu translated versions were presented to four bilingual experts who were not exposed to the original English versions of the scales. They translated those Urdu scales back into English and those English translations were again evaluated by the same committee, who critically analyzed the back translated items of the scales and selected the items for final Urdu version of the scales. All the members of the committee were agreed on the accuracy of the translation of the scales. Then the final selected translated versions of NAI and ASRQ were administered (try out) to the clinical sample to see the understandability of the content and to the university students to find out the reliability of the scales.

Part III: Pilot Study

Prior to the main study, a pilot study was conducted for the tryout of the scales, the Urdu translated scales were presented to 20 psychiatric patients. The sample was taken from Benazir Bhutto Hospital Rawalpind, and Pakistan Ordinance Factory (POF) hospital, Wah Cantt. For test- retest reliability, these scales were re-administered to the same individuals with the time interval of 10 to 15 days. In second administration five individuals dropped out. So the remaining sample for tryout was 15.

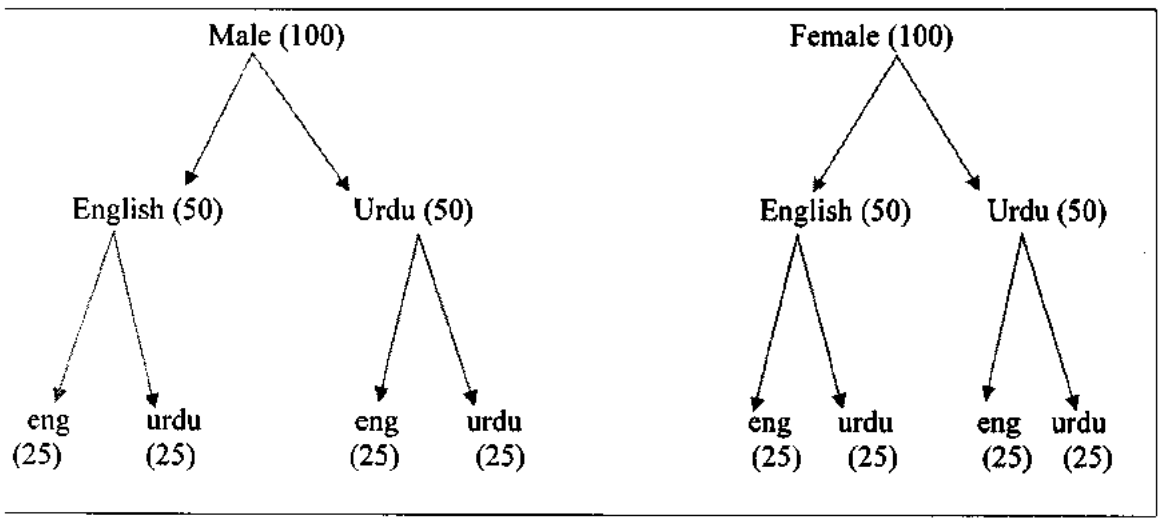
Alpha Coefficient was measured and result showed that reliability of Novaco Anger Inventory was 0.87 and Anger Self Report Questionnaire was 0.71. Test- retest reliability was

also measured. Test- retest reliability is the correlation of the total scores of individuals taken in two different times. So there was a significant correlation (0.95, $p< .01$) between two administrations of Novaco Anger Inventory and Anger Self Report Questionnaire (0.79, $p< .01$).

Cross Language Validation of Scales

To determine the cross language validation of the scales, a group of 200 (100 females and 100 males) students, with age range 19- 27(M= 22 years, SD = 1.03), was selected from different departments of International Islamic University and University of Wah. The researcher introduced herself to the group and explained the purpose of the research. Volunteer students were selected to participate in research and a written consent form was taken from the every participant and it was made sure that all the information would remain confidential. The sample was divided into two groups with equal number of participants. Group 1 completed original English version of the scales while group 2 completed Urdu translated version of the scale. After 15 days of 1st administration, scales were re-administered on the same participants. This time each group 1 and 2 further divided into two groups, 25 individuals in each subgroup. The group who was exposed to the original version, now divided into two halves and on half of them exposed to the translated and half of them to the same original version. Following figure explains the procedure of group division and administration.

Figure2.1: **Summary of group division and administration for pilot study**



Result of the Pilot Study

Test re-test reliability and inter item correlation was computed for the scales. Following are the results of pilot study:

Table 1

Cross language test-retest reliability of Novaco Anger Inventory (NAI) for non clinical population (N = 200)

n	1st Administration	2nd Administration	r
50	NAI Urdu	NAI English	.54*
50	NAI English	NAI Urdu	.62*
50	NAI Urdu	NAI Urdu	.83**
50	NAI English	NAI English	.73**

*P<.01, **p<.05

Table 1 shows a significant correlation between Novaco Anger Inventory Urdu and English versions. It shows that there is high consistency between English and Urdu versions of the inventory.

Table 2
Cross language and Test-Retest Reliability of Anger Self Report Questionnaire (ASR) for Non clinical Population (N = 200)

n	1st Administration	2nd Administration	r
50	ASR Urdu	ASR English	.48**
50	ASR English	ASR Urdu	.49*
50	ASR English	ASR English	.75*
50	ASR Urdu	ASR Urdu	.63**

*P<.01, **p<.05

Table 2 shows significant correlation between Anger Self Report Questionnaire (ASR) Urdu and English versions are significant. It shows that there is high consistency between English and Urdu version of the questionnaire.

Table 3
Inter Item Total Correlation of Novaco Anger Inventory (NAI)

Inventory items	Corrected item total correlation
Q1	.66
Q2	.67
Q3	.22
Q4	.63
Q5	.64
Q6	.52
Q7	.30
Q8	.37
Q9	.74
Q10	.66
Q11	.62
Q12	.61
Q13	.02
Q14	.30
Q15	.48
Q16	.31
Q17	.58
Q18	.56
Q19	.31
Q20	.63
Q21	.48
Q22	.34
Q23	.41
Q24	.36
Q25	.69

Table 3 shows correlation between items and total score of inventory which ranged from 0.30 to 0.69. Results indicate that all items are positively correlated with total score

except item No 3(.22) and 13(.02). If these items deleted then reliability can be raised but alpha coefficient showed high reliability of the inventory in clinical and non-clinical population so it does not effect if these items retained in inventory.

Table 4 shows correlation between items and total score of the questionnaire which ranged from 0.30 to 0.72. Results indicate that all items are positively correlated with total score except item No 14(.10) and 29(.21). If these items deleted then reliability can be raised but alpha coefficient showed high reliability of the questionnaire in clinical and non-clinical population so it does not effect if these items retained in Questionnaire.

Part IV: Main Study

Main study was conducted by following the procedure described below.

Procedure

Research proposal was approved by the research Ethics Committee of International Islamic University. After approval of the research proposal participants of the current study were approached by the permission of the head of psychiatric departments of hospitals (permission letters- see Appendix S). Twelve sessions of the intervention plan were completed in nine weeks. First six sessions were provided in three weeks, two sessions in a week and remaining were six weekly sessions. For the treatment group 50 individuals were approached, consent form was secured from participants to attend all the sessions of the treatment plan but there were only 37 individuals who attended all the 12 sessions. There were six individuals who attended nine sessions and gave mid assessment and four individuals attended less than nine sessions. There were three individuals who did not come back after first or second session. Similarly 50 individuals for control group were approached who had to received general counseling. There were 39 individuals who attended general counseling within nine weeks.

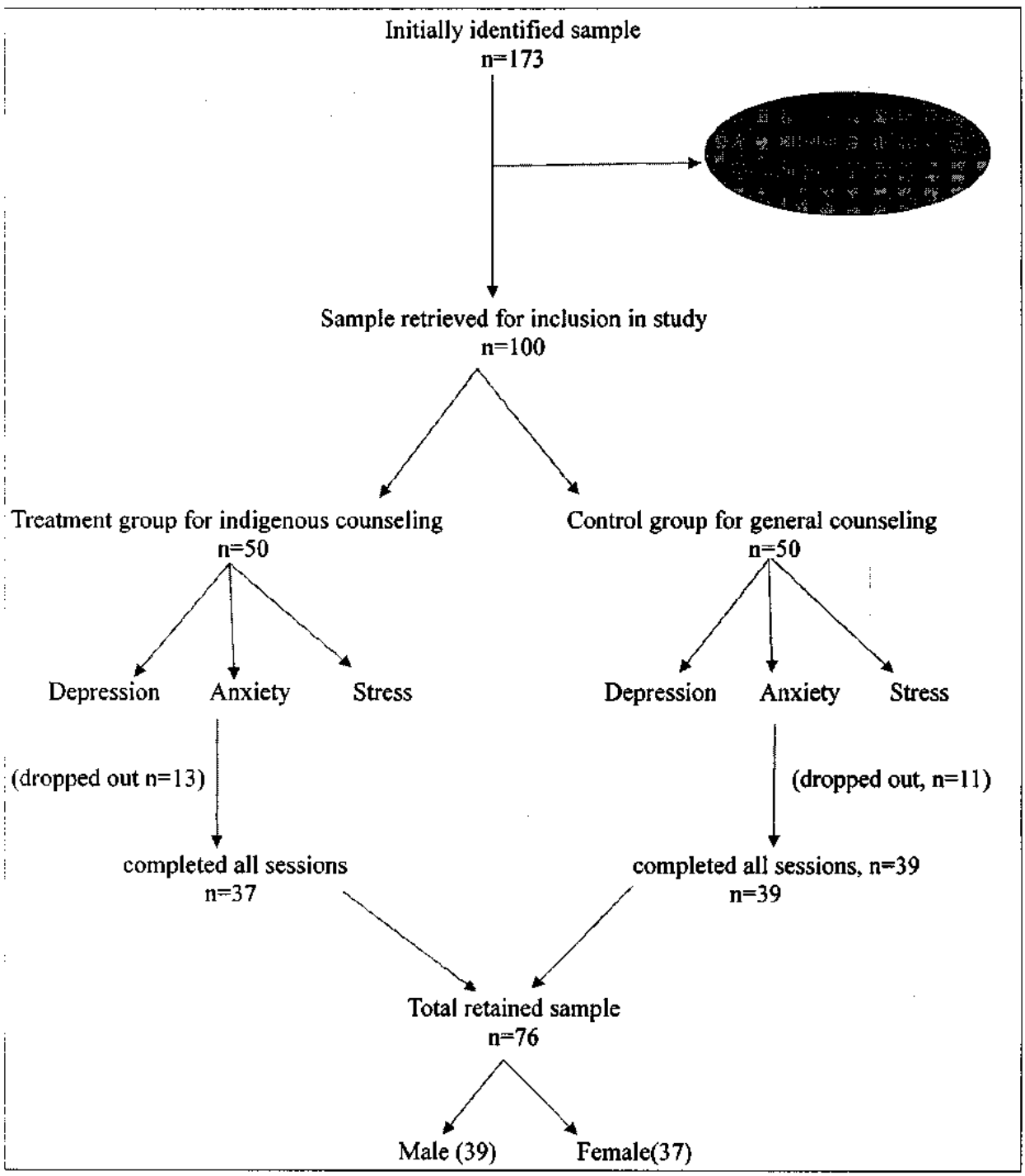
Researcher tried to contact those individuals who dropped out the treatment plan. Though it was not possible to contact all drop outs because some of them did not provide contact information but different reasons were sorted out to drop out the study which are

Table 4
Corrected item Total Correlation of Anger Self Report Questionnaire (ASR)

Items	Corrected item total correlation
Q1	.31
Q2	.41
Q3	.32
Q4	.30
Q5	.31
Q6	.56
Q7	.51
Q8	.31
Q9	.35
Q10	.47
Q11	.69
Q12	.51
Q13	.32
Q14	.10
Q15	.59
Q16	.42
Q17	.49
Q18	.61
Q19	.37
Q20	.51
Q21	.46
Q22	.65
Q23	.71
Q24	.42
Q25	.72
Q26	.49
Q27	.72
Q28	.39
Q29	.21
Q30	.31

given below.

***Figure 2.2*: Sample Flow Sheet for Main Study**



Personal factors: Some patients reported that they forgot the appointment dates, some caregivers reported that patients were not feeling well or not willing to visit hospital. Some patients were old or dependent on others and sometimes caregivers were not available to bring them hospital.

Poor insight: Patients or caregivers did not feel that anger is a serious problem to deal with other psychiatric problems. They were living with this problem so they or their caregivers thought that it's important to deal with only psychiatric problems.

Economic reasons: Patients or caregivers who brought them to hospitals could not take off from job, some were not able to bear transport charges and for private hospitals they could not afford consultancy charges.

Novaco Anger Inventory was used to assess the intensity of anger of individuals having psychiatric problems; Anger Self Report Questionnaire was used to assess the type of anger. Only those individuals who were participated in the current study were diagnosed by professional psychiatrists but to double check, clients were assessed on DASS. Pre, mid and post assessments were taken from the individuals, on Novaco Anger Inventory, Anger Self Report Questionnaire and Depression Anxiety Stress Scale, who completed the intervention plan.

Data analysis

Statistical Package for Social Sciences (SPSS 20) was used to analyse the data.

Chapter III

Results

Table 5
Descriptive Statistics for Demographic Variables for Treatment Group (N = 37)

		f	%
Age	25-30	6	16.2
	31-35	12	32.4
	36-40	13	35.1
	41-45	6	16.2
Gender	Male	20	54.1
	female	17	45.9
Education	5-10	17	45.9
	11-14	12	32.4
	15>	8	21.6
Monthly income	5,000-10,000	5	13.5
	11,000-15,000	14	37.8
	16,000-20,000	9	24.3
	21,000-25,000	9	24.3
Family system	Joint	20	54.1
	Nuclear	17	45.9
Marital status	Married	13	35.1
	Unmarried	18	48.6
	Divorcee	6	16.2
Illness	Depression	12	32.4
	Anxiety	16	43.2
	Stress	9	24.3
Patient status	Inpatient	22	59.5
	Outpatient	15	40.5
Duration of illness	6 months	11	29.7
	1-2 years	18	48.6
	3-4 years	8	21.6

Table 5 shows the demographic variables frequency of individuals in the treatment group.

Table 6

Descriptive Statistics for Demographic Variables for Control Group (N = 39)

		f	%
Age	25-30	7	17.9
	31-35	11	28.2
	36-40	13	33.3
	41-45	8	20.5
Gender	Male	19	48.7
	female	20	51.3
Education	5-10	16	41
	11-14	14	35.9
	15>	9	15.4
Monthly income	5,000-10,000	6	15.4
	11,000-15,000	14	35.9
	16,000-20,000	11	28.2
	21,000-25,000	8	20.5
Family system	Joint	22	56.4
	Nuclear	17	43.6
Marital status	Married	17	43.6
	Unmarried	17	43.6
	Divorcee	4	10.3
	Widow	1	2.6
Illness	Depression	15	38.5
	Anxiety	18	46.2
	Stress	6	15.4
Patient status	Inpatient	18	46.2
	Outpatient	21	53.8
Duration of illness	6 months	13	33.3
	1-2 years	21	53.8
	3-4 years	5	12.8

Table 6 shows the demographic variables frequency of individuals in the control

group.

Table 7
Reliabilities of Scales at Three Levels of assessment for the Treatment Group (N = 37)

	No. of Items	Pre-Test	Mid-Test	Post-Test
Novaco Anger Inventory (NAI)	25	.61	.71	.71
Anger Self-Report Questionnaire (ASR)	30	.71	.67	.65
Depression Anxiety Stress Scale (DASS)	42	.62	.63	.62

Table 7 shows the alpha coefficients on three assessments of the NAI, ASR, and DASS for the treatment group. The results indicate that all the scales used in this study are internally consistent and the alpha coefficient reliability of the scales is satisfactory.

Table 8
Reliabilities of Scales at three Levels of Assessment for the Control Group (N = 39)

	No. of Items	Pre-Test	Mid-Test	Post-Test
Novaco Anger Inventory (NAI)	25	.71	.72	.71
Anger Self-Report Questionnaire (ASR)	30	.73	.72	.73
Depression Anxiety Stress Scale (DASS)	42	.63	.61	.64

Table 8 shows the alpha coefficients on the three assessments of the NAI, ASR, and DASS for the control group. The results indicate that all the scales used in this study are internally consistent and the reliability of the scales is satisfactory.

Table 9

Relationship between Novaco Anger Inventory (NAI), Anger Self-Report Questionnaire (ASR), Depression Anxiety Stress Scale (DASS) and its Subscales for the Treatment Group (N = 37)

	ASR	DASS	Depression	Anxiety	Stress
NAI	.33*	.21*	.24*	.26*	.04
ASR	-	.23*	.07*	.46**	.25
DASS	-	-	.48*	.32*	.54**
Depression	-	-	-	-.69*	.27
Anxiety	-	-	-	-	.07

*$p < .05$, **$p < .01$

Table 9 shows that in the treatment group, the NAI is significantly positively correlated with the ASR and DASS ($p < .05$). The NAI is also significantly positively correlated with the depression and anxiety subscales ($p < .05$). Similarly, the ASR is significantly positively correlated with the DASS and the depression and anxiety subscales ($p < .01$), whereas both of the scales are not significantly correlated with the stress subscale. The DASS is significantly positively correlated with its subscales.

Table 10

Relationship between Novaco Anger Inventory (NAI), Anger Self-Report Questionnaire (ASR), Depression Anxiety Stress Scale (DASS) and its Subscales for the Control Group (N = 39)

	ASR	DASS	Depression	Anxiety	Stress
NAI	.35*	.33*	.15*	.32*	.05
ASR	-	.13*	.14*	.42**	.02
DASS	-	-	.56**	.64**	.85**
Depression	-	-	-	-.45	.32*
Anxiety	-	-	-	-	.29

*$p < .05$, **$p < .01$

Table 10 shows that in the control group, the NAI is significantly positively correlated with the ASR and DASS, and it is also significantly positively correlated with the depression and anxiety subscales (p <.05), whereas it is not significantly positively correlated with the stress subscale. Similarly, the ASR is significantly positively correlated with the DASS and its subscales (p <.01), except the stress scale, which with it is not significantly positively correlated. The DASS is significantly positively correlated with its subscales.

Table 11
Relationship between Subscales of Anger Self Report Questionnaire and Depression Anxiety Stress Scale (n = 76)

	dep	anxiety	stress	awareness	General. ex	Phy anger	Verbal anger	condem	Total. ex
dep	-	.69**	.23*	.53**	.56**	.39*	.29	.14	.64**
anxiety	-	-	.06*	.23	.41*	.34**	.48**	.21	.45**
stress	-	-	-	.25	.08*	.22	.29*	.11	.17*
awareness	-	-	-	-	.42*	.20	.04*	.53**	.34*
General.ex	-	-	-	-	-	.13	.06	.27	.75**
Phy. anger	-	-	-	-	-	-	.11*	-.01	.28*
Verbal anger	-	-	-	-	-	-	-	.47	.11*
condem	-	-	-	-	-	-	-	-	-.23

***p<.01, * P<.05*
Note: please read dep=depression, general.ex= general expression, Phy.anger=Physical Anger, Condem= condemnation, total.ex= total expression.

Table 11 shows the result of relationship among subscales of Anger self Report (ASR) Questionnaire and Depression Anxiety Stress Scale. Results indicated that depression is significantly (p<.05) positively correlated with all the subscales of ASR except verbal anger and condemnation (p>.05). Similarly anxiety is significantly (p<.05) positively correlated with all the subscales except condemnation (p>.05). Stress is significantly (p<.05) positively correlated with general expression of anger, verbal anger and total expression of anger and it

is non-significant (p >.05) correlated with other awareness scale, physical anger and condemnation.

Table 12
Repeated-Measure Analysis of Variance (ANOVA) for Three Assessments of the Novaco Anger Inventory (NAI) for the Treatment Group (N = 37)

Factors	*M*	*SD*	I	J	Mean Difference (I-J)	*p*
Pre-assessment	91.35	6.72		2	3.94	.00
			1			
				3	5.73	.00
Mid-assessment	87.41	7.15		1	-3.94	.00
			2			
				3	1.78	.00
Post-assessment	85.62	6.64		1	-5.73	.00
			3			
				2	-1.78	.00

Between subject effect	SS	MS	*df*	*F*	*p*
	636.18	609.89	2	32.42	.00

Table 12 shows the results of a repeated-measures ANOVA for the treatment group. Results using the Greenhouse-Geisser correction show that the mean NAI scores significantly differ between time points (F[1.04, 37.55] = 32.42, p = .00). Post hoc tests using Bonferroni correction reveal that indigenous counseling elicits a significant reduction in NAI scores from pre-assessment to post-assessment (M = 91.35, SD = 6.72 vs. M = 85.62, SD = 6.64, respectively), which is statistically significant (p < .01). Therefore, it can be concluded that an indigenous intervention plan for psychiatric patients significantly reduces scores on the NAI.

Table 13

Repeated-Measure Analysis of Variance (ANOVA) for Three Assessments of the Novaco Anger Inventory (NAI) for the Control Group (N = *39)*

Factors	*M*	*SD*	I	J	Mean Difference (I-J)	*p*
Pre-assessment	79.44	10.23	1	2	.36	.21
				3	.46	.07
Mid-assessment	79.08	10.45	2	1	-.36	.21
				3	.10	.13
Post-assessment	78.97	10.37	3	1	-.46	.07
				2	-.10	.13

Between subject effect	SS	MS	*df*	*F*	*p*
	4.58	4.58	2	4.57	.13

In Table 13, the results of a repeated-measures ANOVA with the Greenhouse-Geisser correction are depicted. This test determined the mean NAI scores for the control group. Results indicate that there is a non-significant difference between the three assessments of the NAI (F[1.09, 41.75] = 4.57, $p > .05$). Post hoc tests using Bonferroni correction reveal that general counseling for anger management elicits a slight reduction in the NAI scores of psychiatric patients at their pre- and post-assessments (M = 79.44, SD = 10.23 vs. M = 78.97, SD = 10.37, respectively), which is non-significant (p = .13). Therefore, it can be concluded that general counseling for psychiatric patients for their anger management does not reduce their anger.

Table 14

Repeated-Measure Analysis of Variance (ANOVA) of Three Assessments of the Anger Self-Report (ASR) Questionnaire for the Treatment Group (N = 37)

Factors	*M*	*SD*	I	J	Mean Difference (I-J)	*p*
Pre-assessment	109.45	14.69	1	2	4.05	.00
				3	13.43	.00
Mid-assessment	105.40	17.14	2	1	-4.05	.00
				3	9.38	.01
Post-assessment	96.02	12.71	3	1	-13.43	.00
				2	-9.38	.01

Between subject effect	SS	MS	*df*	*F*	*p*
	3512.77	2973.82	2	14.75	.00

Table 14 shows the results of a repeated-measures ANOVA for the treatment group. Results using the Greenhouse-Geisser correction determined that mean scores of the ASR significantly differ between time points (F[1.18, 42.52] = 14.75, p = .00). Post hoc tests using Bonferroni correction reveal that indigenous counseling elicits a significant reduction in NAI scores from pre-assessment to post-assessment (M = 109.46, SD = 14.69 vs. M = 96.03, SD = 12.71, respectively), which is statistically significant (p < .01). Therefore, it can be concluded that an indigenous intervention plan for psychiatric patients significantly reduces scores on the ASR.

Table 15

Repeated-Measure Analysis of Variance (ANOVA) of Three Assessments of the Anger Self-Report (ASR) Questionnaire for the Control Group (N = 39)

Factors	*M*	*SD*	I	J	Mean Difference (I-J)	*p*
Pre-assessment	113.03	7.91		2	.26	.02
			1			
				3	.51	.10
Mid-assessment	112.77	8.1		1	-.26	.02
			2			
				3	.25	.77
Post-assessment	112.51	7.89		1	-.51	.10
			3			
				2	-.25	.77

Between subject effect	SS	MS	*df*	*F*	*p*
	5.12	5.12	2	3.51	.06

Table 15 shows the results of a repeated-measures ANOVA using the Greenhouse-Geisser correction, which determined the mean ASR scores for the control group. Results indicate a non-significant difference among the three assessments (F[1.22, 46.39] = 3.51, p > .05). Post hoc tests using Bonferroni correction reveal that general counseling for anger management elicits a slight reduction in the ASR scores of psychiatric patients at their pre- and post-assessments (M = 113.03, SD = 7.91 vs. M =112.51, SD = 7.89, respectively), which is not significant (p = .06). Therefore, it can be concluded that general counseling for psychiatric patients for their anger management does not reduce anger.

Table 16

Repeated-Measures Analysis of Variance (ANOVA) of three Assessments of the Depression Anxiety Stress Scale (DASS) for the Treatment Group (N = 37)

Factors	*M*	*SD*	I	J	Mean Difference (I-J)	*p*
Pre-assessment	87.51	5.73	1	2	.97	.31
				3	3.97	.00
Mid-assessment	86.54	4.93	2	1	-.97	.31
				3	3.00	.00
Post-assessment	83.54	5.06	3	1	-3.97	.00
				2	-3.00	.31

Between subject effect	SS	MS	*df*	*F*	*p*
	317.35	222.88	2	15.94	.00

Table 16 shows the results of a repeated-measures ANOVA for the treatment group. Results using the Greenhouse-Geisser correction determined that mean scores of the DASS significantly differed among time points ($F[1.42, 51.26] = 15.94$, $p = .00$). Post hoc tests using Bonferroni correction reveal that indigenous counseling elicits a significant reduction in NAI scores from pre-assessment to post-assessment ($M = 83.54$, $SD = 5.73$ vs. $M = 87.51$, $SD = 5.06$, respectively), which is statistically significant ($p < .01$). Therefore, it can be concluded that an indigenous intervention plan for psychiatric patients significantly reduces their scores on the DASS.

Table 17

Repeated-Measures Analysis of Variance (ANOVA) of three Assessments of the Depression Anxiety Stress Scale (DASS) for the Control Group (N = 39)

Factors	*M*	*SD*	I	J	Mean Difference (I-J)	*p*
Pre-assessment	86.49	6.34	1	2	.64	.00
				3	.97	.00
Mid-assessment	85.85	6.32	2	1	-.64	.00
				3	.33	.34
Post-assessment	85.51	6.03	3	1	-.97	.00
				2	-.33	.34

Between subject effect	SS	MS	*df*	*F*	*p*
	18.51	18.51	2	15.96	.00

The results of a repeated-measures ANOVA using the Greenhouse-Geisser correction are presented in Table 17 and indicate the mean difference of the DASS scores for the control group. Results show a significant mean difference in the scores of patients in the control group for DASS ($F[1.72, 65.25] = 15.96$, $p < .01$) during three assessments. Post hoc tests using Bonferroni reveal that there is a reduction in DASS scores from pre-assessment to post-assessment ($M = 86.49$, $SD = 6.34$ vs. $M = 85.51$, $SD = 6.03$, respectively), which is statistically significant ($p = .00$). Therefore, it can be concluded that there is a reduction in the psychiatric problems of the patients over time.

Table 18

Mixed Repeated-Measures Analysis of Variance (ANOVA) to Compare three Assessments of the Treatment and Control Groups for the Novaco Anger Inventory (NAI) (N = 76)

Group type	Time point assessment	M	SD		
Treatment group	1	91.35	6.73		
	2	87.41	7.15		
	3	85.62	6.64		
Control group	1	79.43	10.25		
	2	79.01	10.45		
	3	78.97	10.37		
Source	SS	MS	*df*	F	*p*
Time	363.90	363.90	1	49.91	.00
G.type	4576.69	4576.90	1	20.46	.00
Time*G.type	263.47	263.47	1	36.14	.00
Error	539.49	7.29	74		

**G.type = group type (treatment and control group)*

Table 18 shows there was a significant main effect of the treatment to reduce anger across the assessments over three time points ($F[1, 74]= 49.91$, $p < .01$). The between group result shows that there was a significant interaction between the time and group type ($F[1,74] = 36.14$, $p < .01$). Thus, the psychiatric patients who received the indigenous intervention plan showed significantly lower scores on the NAI when compared to those who received general counseling.

Table 19

Mixed Repeated-Measures Analysis of Variance (ANOVA) to Compare Three Assessments of the Treatment and Control Groups for the Anger Self-Report (ASR) Questionnaire (N = 76)

Group type	Time point assessment	*M*	*SD*		
Control	1	109.46	14.69		
	2	105.41	17.14		
	3	96.03	12.71		
Treatment	1	113.03	7.91		
	2	112.77	8.10		
	3	112.51	7.89		
Source	SS	MS	*df*	*F*	*p*
Time	1846.18	1846.18	1	24.17	.00
G.type	4757	4757	1	15.44	.00
Time*G.type	1584.61	1584.61	1	20.74	.00
Error	7596.65	102.65	74		

**G.type = group type (treatment and control group)*

Table 19 shows that there was a significant main effect of the indigenous intervention plan reduce anger ($F[1, 74]= 24.17$, $p < .01$). Result reveals that anger decreased proportionately across the three point assessment. The comparison of the control and treatment groups shows that there was a significant interaction among the ASR scores and group type ($F[1,74] = 15.44$, $p < .01$). Thus, the psychiatric patients who received the indigenous intervention plan showed significantly lower scores on the ASR when compared

with those who receive general counseling.

Table 20
*Two-Way Repeated-Measures Analysis of Variance (ANOVA) to Compare Three Assessments of the Treatment and Control Groups for the Depression Anxiety Stress Scale (DASS) (*N = *76)*

Factors		*M*	*SD*	Mean Difference (I-J)	*p*
Group type	Control	85.45	6.31	.41	.74
	Treatment	85.86	5.23		
Source	SS	MS	*df*	*F*	*p*
DASS	393.05	393.05	1	48.36	.00
G.type	9.66	9.66	1	.10	.74
DASS*G.type	21.68	21.68	1	2.66	.10
Error	2257.5	30.51	74	.10	.02

Table 20 shows the results of a two-way repeated-measures ANOVA for the comparison of the control and treatment groups with the DASS. Result reveals that there is a significant main effect of the indigenous intervention plan on the treatment group to reduce illness ($F[1,74] = 48.36$, $p < .01$), which means that there is a significant difference across the three levels of assessments for DASS. The comparison of the control and treatment groups reveals no significance in the interaction among DASS scores and group type ($F[1,74] = 2.66$, $p > .05$). Thus, it can be concluded that the indigenous intervention plan did not effect more on the psychological problem of the patients.

Table 21

Two-Way Repeated-Measure Analysis of Variance (ANOVA) to Compare Gender Differences for the Novaco Anger Inventory (NAI) for Three Levels of Assessment in the Treatment Group (N = 37).

Factors		*M*	*SD*	Mean Difference (I-J)	*p*
Gender	Male	87.61	7.20	1.11	.60
	Female	88.72	6.52		
Source	SS	MS	*df*	*F*	*p*
NAI	636.65	610.35	1	31.6	.00
Gender	33.89	33.89	1	.27	.60
NAI*gender	1.14	1.14	1	.07	.79
Error	1437.89	41.10	35	.27	.60

Table 21 shows the results of a two-way repeated-measures ANOVA for the comparison of gender scores for the NAI in the treatment group. Result reveals that there is significant main effect of the indigenous intervention plan on the treatment group to reduce anger ($F[1,35] = 31.6$, $p < .01$). But there is a non-significant interaction between gender and the NAI ($F[1,35] = .07$, $p > .05$). The effect suggests that there is no significantly different effect of treatment regarding gender. A non-significant mean difference shows that both males and females responded the same to the indigenous intervention plan.

Table 22

Two-Way Repeated-Measures Analysis of Variance (ANOVA) to Compare Scores of In/Out Patients for the Novaco Anger Inventory (NAI) for Three Assessments in the Treatment Group (N = 37).

Factors		*M*	*SD*	Mean Difference (I-J)	*p*
Patient Status	In-Patient	86.89	6.62	3.94	.04
	Out-Patient	89.06	6.87		

Source	SS	MS	*df*	*F*	*p*
NAI	552.68	552.68	1	41.47	.00
P.status	128.01	128.01	1	1.06	.31
NAI*P.status	45.27	45.27	1	2.88	.04
Error	1406.52	40.18	35	1.06	.31

Table 22 shows the results of a two-way repeated-measures ANOVA for the comparison of in-patients with out-patients for the NAI scores in the treatment group. Result reveals that there is a significant main effect of the indigenous intervention plan on the treatment group to reduce anger ($F[1,35] = 41.47$, $p < .01$). There is also a significant interaction between patient status (in/out) and the NAI ($F[1,35] = 2.88$, $p < .05$). The effect suggests that there is a significant difference among the scores of in-patients and out-patients for repeated assessments of the NAI. A significant mean difference shows that in-patients score low when compared with out-patients. Thus, result shows that patients who are hospitalized reduce their anger.

Chapter IV

Discussion

Anger among individuals with psychiatric problems is taken as a residual of other disorders and its management is a serious issue all over the world, especially in countries like Pakistan where environmental factors (security threats, terrorism, inflation, unemployment) are making it more difficult to handle for mental health practitioners (Khalily, 2012). Based on the hypotheses, the data were tested to find out the relationship between anger and psychiatric problems. Results indicated that there is positive correlation between depression, anxiety, stress and anger. These were supported by the prior researches, which demonstrate that there is general association between anger and certain types of pathologies including depression, anxiety, and post-traumatic stress disorder (PTSD) (Moscovitch et al., 2008). Furthermore, in the current study, it was determined that patients with depression were significantly aware of their anger and express the anger generally but they were negatively correlated with physical and verbal anger. On the other hand, patients with diagnosis of anxiety and PTSD were not aware of their anger and significantly positively correlated with physical and verbal anger. Staff of the Psychiatry Ward also reported that patients with depression did not show physical or verbal anger.

Similar results have been reported in previous researches that persons who are clinically depressed report anger suppression and they usually report anger directed at themselves or inward anger (Koh, Kim, & Park, 2002). Several authors have reported that anger is suppressed when it is not accepted to reflect out, and it is replaced with anxiety or depression as a result. For example; Clay, Anderson, and Dixon (1993) found inwardly

directed anger to be a significant predictor of depression, while Kellner, Hennanders, and Pattak (1992) found depression to be an important predictor of self-reported anger inhibition. The individuals with anxiety disorders have difficulties in emotion evaluation. Therefore, they experience difficulties in the control of anger (Mook, Van De Pleog, & Kleijin, 1990). Deschênes et al. (2012) reported that hostility, physical aggression, verbal aggression, and anger expression contribute to generalized anxiety disorder.

Uncontrolled anger, among psychiatric patients, is usually treated by psychotropic medications but there is a great deal of research that places the emphasis on the importance of culture-based psycho-therapeutic interventions to manage anger (Siani, 2009). The current study adopted Novaco's model of anger management. Novaco's (1977) model was actually the adaptation of Stress Inoculation Training (SIT) for anger management. SIT was based on three steps: First, an individual must be cognitively prepared and have the insight of their problem (stimulus, triggers, emotions, behavioral effects); Second, one must have acquired the skills to cope with the problem; and at the third step, the client practices the learned skills in anger-provoking situations. During this performance-based intervention, the client is exposed to cognitive re-framing, relaxation training, imagery, modeling, and role-playing to enhance his or her ability to cope with problematic situations. So it can be said that this model was actually based on cognitive behavioral therapy. In a survey of the literature, it was found that the majority of the researchers utilized cognitive behavioral therapy for the effective management of anger (Dodge, 1993; Mahoney, 1993; Van-Balkom et al., 1994). Furthermore, it is recommended to consider cultural and social norms in psychosocial interventions (Bernal & Scharron-del-Rio, 2001; Nagayama-Hall, 2001; Sue & Sue, 2003). Therefore, the current study integrated cognitive behavioral therapy with the cultural and religious values of Pakistani society. Pakistani culture is a part of the contemporary Islamic

civilization, which draws its values and traditions from the rich Islamic history. Within this culture, a distinctive understanding of uncontrolled anger and management strategies exists that could be implemented at the cognitive and behavioral stages (Khalily, 2013).

It was hypothesized that a religion-based indigenous model of anger management can reduce anger among psychiatric patients. The research results suggest, with a certain degree of confidence, that there was a change in the overall Novaco Anger Inventory score at three levels of assessments. Similar results were observed for the three assessments of the Anger Self-Report Questionnaire. These findings strengthen the hypothesis and are supported by previous researches that the majority of clients potentially want to discuss religiosity in counseling sessions (Rose et al., 2001). Furthermore, researches have indicated that the clients who were receiving counseling with an element of religiosity showed successful progress toward their goals to overcome problems (Morrison, Clutter, Pritchett, & Demmitt, 2009). However, the group that received indigenous treatment was compared to the group that received general counseling and was found to be significantly different on the basis of therapeutic outcome. The treatment group showed significant reduction on the scores of anger measurement as compared to the control group. This outcome supported the hypothesis that individuals who received indigenous treatment for anger management showed significantly reduced anger as compared to the individuals who received general counseling. Christian religious cognitive therapy was compared with non-religious cognitive therapy in counseling and it was found that the former was much more effective in managing the psychiatric problems of the clients (Koenig, 2007). Similar results can be traced in the study of Razali et al. (1998), who utilized cognitive techniques guided by the Qur'an and hadith for the treatment of anxiety and depression and reported that it was more effective for the Muslim clients as compared to the conventional therapy.

It was hypothesized that this treatment will also reduce the psychiatric problems of the patients. The Scores on DASS of the treatment group and control group were compared on three assessments and it was found that individuals in the treatment group showed low scores at post-assessment as compared to the control group but it was non- significant. These findings contradict the previous researches as different researches showed that anger management interventions reduced anxiety, depression, and symptoms of PTSD (Coon, Thompson, Steffen, Sorocco, & Gallagher-Thompson, 2003). However, it has also been reported that the effect of anger treatment on psychiatric problems is relatively smaller than anxiety and depression treatment (DiGuiseppe & Tafrate, 2003). Individuals in the control group were receiving general counseling and the focus of the therapist was to overcome the psychiatric problems, while in the treatment group, anger management was the main goal of the researcher. But mental health care practitioners and staff reported that individuals in the treatment group behaved well and showed less resistance after receiving anger management training. Similarly, it was found that the patients who were hospitalized showed better performance during anger management sessions and there was significant difference between scores of in-patients and out-patients on NAI and ASR.

Conclusion

The present study found a correlation between anger and psychiatric problems and put the emphasis on the importance of managing anger along with other psychological disorders. Ignoring the uncontrolled anger with clinical problem could be harmful for the mental health care staff, for the care givers, and for the patients. For the most part, uncontrolled anger is treated with psychotropic medicines or traditional psychotherapies. However, the researcher focused on a distinctive strategy, which includes contemplation of cultural and religious norms in anger management. Therefore, the current study adopted Novaco's model of anger

management by integrating the strategies extracted from the Qur'an and Sunnah. Later on, this indigenous model was compared with general counseling and it was found that individuals who obtained indigenous treatment scored low on anger measurement at post-assessment as compared to individuals who got general counseling. Furthermore, the individuals in the treatment group also scored low on DASS as compared to the control group. This indicated that anger could hinder the treatment of disorders and it should be appropriately treated.

Limitations and Recommendations

One of the limitation of this research was the dropped out cases. The individuals who dropped out from the study and did not complete their full course of sessions would be approached. In this research it was not possible to hold the contact information of all the participants. So it is suggested that in future, researcher must hold all the contact information so that one can contact to them. If they are not interested in the session then it should be included in the reason and/or measure the scores of anger on scales to know their level of anger after a certain time period.

On other hand extraneous variables of the results should be controlled to obtain better results. It was observed in the current study that in-patients, in treatment group, scored low on anger scales at post assessment as compared to the out-patients of same group. They were less affected by external factors, e.g., family environment, social support, traveling, and economic problems etc. So it is suggested for the future research that control the extraneous variables and make it true experiment research by conducting it in control environment (take only in-patients or out- patients). Otherwise these extraneous variables could be taken as moderators and see the effect of these variables on anger management.

In current study indigenous model of anger management was compared to the general counseling that was involved eclectic approach. It is suggested for the future researches that indigenous adopted Novaco's model of anger management should be compared with the unmodified Novaco's model of anger management.

Furthermore, it was recommended for future studies that one should consider BioPsychoSocial models in relation to anger provocation and management and see that which component is more influential.

References

Achoui, M. (1998). Human nature from a comparative psychological perspective. *The American Journal of Islamic Social Science, 15,* 71–95.

Ajmal, M. (1986). *Muslim contributions to psychotherapy and other essays.* Islamabad: National Institute of Psychology.

Ansari, Z. A. (Ed.). (1992). Quranic *concepts of human psyche.* Islamabad, Pakistan: International Institute of Islamic Thought.

Al-Munajjid, M. S. (1999). *Islam's treatment for anxiety and stress.* Riyadh, Saudi Arabia: International Islamic Publishing House.

Al-Mundhiri, Z. A. (2000). *The Translation of the Meanings of Sahih Muslim.* Saudi Arabia: Darussalam Publishers and Distributors

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

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental DisordersFourth Edition Text *Revision (DSM-IV-TR).* Washington, DC: American Psychiatric Publishing.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377– 402.

Arroyo, J. A., Westerberg, V. S., & Tonigan, J. S. (1998). Comparison of treatment utilization and outcome for Hispanics and non-Hispanic Whites. *Journal of Studies on Alcohol, 59,* 286–291.

Ashwin, C., Wheelwright, S., & Baron-Cohen, S. (2006). Finding a face in the crowd: Testing the anger superiority effect in Asperger syndrome. *Brain and Cognition, 61,* 78–95.

Aslam, N. (2007). *Psychological disorders and resilience in earthquake affected individuals.* Unpublished M.Phil dissertation. National Institute of Psychology, Quaid-i-Azam University, Islamabad, Pakistan.

Aue, T., Flykt, A., & Scherer, K. R. (2007). First evidence for differential and sequential efferent effects of goal relevance and goal conduciveness appraisal. *Biological Psychology, 74,* 347–357.

Azhar, M. Z., & Varma, S. L. (1995a). Religious psychotherapy in depressive patients. *Psychotherapy and Psychosomatics, 63,* 165–168.

Azhar, M. Z., & Varma, S. L. (1995b). Religious psychotherapy as management of bereavement. *Acta Psychiatrica Scandinavica, 91*(4), 233–235.

Azhar, M. Z., Varma, S. L., & Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica, 90*(1), 1–3.

Badri, M. B. (1976). *Islam and alcoholism.* Washington, DC: American Trust Publications.

Badri, M. B. (1978). *The dilemma of Muslim psychologists*. London: M.H.W. Publishers.

Badri, M. (1979). The Dilemma of Muslim Psychologists. London: M.W.H.

Badri, M. B. (1996). Counselling and psychotherapy from an Islamic perspective. *Al-Shajarah: Journal of the International Institute of Islamic Thought & Civilisation (ISTAC, Kuala Lumpur),* 1–240.

Badri, M. (2013). Innovative Treatment of a rare Exaggerated Obsessive- compulsive reaction to Smell. *ASEAN journal of psychiatry,* 14(1).

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York: Freeman.

Barlow, D. H. (1991). Disorders of emotion. *Psychological Inquiry, 2,* 58–71.

Barona, A., & Santos de Barona, M. (2003). Recommendations for the psychological treatment of Latino/Hispanics populations. In Council of National Psychological Associations for the advancement of ethnic Minority Interests (Ed.). Psychological treatment of ethnic minority populations (pp. 19–23). Washington, DC: Association of Black Psychologists.

Beck, R., & Fernandez, E. (1998). Cognitive-behavioural self-regulation of the frequency, duration, and intensity of *anger. Journal of Psychopathology and Behavioural Assessment, 20,* 217– 229.

Becker, D. M. (2001). Integrating behavioral and social sciences with public health. In N. Schneiderman, M. A. Speers, J. M. Silvia, H. Tomes & J. H. Gentry (Eds.), *Public Health and Religion* (pp. 351- 368). Washington, DC: American Psychological Association.

Beckham, J. C., Moore, S. D., & Reynolds, V. (2000). Interpersonal hostility and violence in Vietnam combat veterans with chronic post-traumatic stress disorder: A review of theoretical models and empirical evidence. *Aggression and Violent Behaviour, 5,* 451–466.

Beitel, M., Genova, M., Schuman-Olivier, Z., Arnold, R., Avants, K. S., & Margolin, A. (2007). Reflections by inner-city drug users on a Buddhist-based spirituality-focused therapy: A qualitative study. *American Psychological Association, 77*(1), 1-9.

Berkowitz, L. (1993). *Aggression: Its causes, consequences, and control.* New York: McGraw-Hill.

Berkowitz, L., & Harmon-Jones, E. (2004). Toward an understanding of the determinants of anger. *Emotion, 4,*107–130.

Bernal, G., & Saez- Santiago, E. (2006). Culturally centred psychosocial interventions. *Journal of Community Psychology, 34* (2), 121-132.

Bernal, G., & Sharron-del-Rio, M. R. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity & Ethnic Minority Psychology, 7*, 328–342.

Bernal, G., Trimble, J. E., Burlew, A. K., & Leong, F. T. L. (2003). Handbook of racial and ethnic minority psychology (pp. 487–503). Thousand Oaks, CA: Sage.

Biddle, D., Creamer, M., Forbes, D., Elliot, P., & Devilly, G. (2002). Self-reported problems: A comparison between PTSD- diagnosed veterans, their spouses, and clinicians. *Behaviour Research and Therapy, 40*, 853–865.

Brislin, R. W. (1980). Translation and Content Analysis of Oral and Written Material. In: H.C. Triandis and J. W. Berry (eds.), Handbook of Cross-Cultural Psychology, (vol. 2, pp. 389-444). Boston: Allyn & Bacon.

Bunt, L., & Pavlicevic, M. (2004). Music and emotion: Perspectives from music therapy. In P. N. Juslin & J. A. Sloboda *(Eds.), Music and emotion: Theory and research. New York: Oxford University Press.*

Busch, F. N., Rudden, M., & Shapiro, T. (2004). *Psychodynamic Treatment of Depression.* American Psychiatric Press.

Casas, M. (1995). Counselling and psychotherapy with racial/ethnic minority groups in theory and practice. In B. Bongar & L.E. Buetler (Eds.), Comprehensive textbook of psychotherapy: Theory and practice (pp. 311–335). New York: Oxford University Press.

Castillo, D. T., Fallon, S. K., C'de Baca, J., Conforti, K., & Qualls, C. (2002). Anger in PTSD: General psychiatric and gender differences on the BDHI. *Journal of Loss and Trauma, 7*, 119–128.

Cautin, R. L., Overholser, J. C., & Goetz, P. (2001). Assessment of mode of anger expression in adolescent psychiatric inpatients. *Adolescence, 36*, 163–170.

Chemtob, C. M., & Carlson, J. G. (2004). Psychological effects of domestic violence on children and their mothers. *International Journal of Stress Management, 11*, 209–226.

Chemtob, C. M., Novaco, R. W., Hamada, R. S., Gross, D. M., & Smith, G. (1997). Anger regulation deficits in combat-related post-traumatic stress disorder. *Journal of Traumatic Stress, 10*, 17–36.

Christiansen, C. H. (2008). The dangers of thin air: A commentary on exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75* (1), 12-15.

Clay, D. L., Anderson, W. P., & Dixon, W. A. (1993). Relationship between anger expression and stress in predicting depression. *Journal of Counselling and Development, 72*(1), 91-94.

Cole, B. S., & Pargament, K. L. (1999). Spiritual surrender: A paradoxical path to control. In W. R. Miller (Ed.), *Integrating spirituality in treatment: resources for practitioners. (*pp. 179-198). Washington, DC: American Psychological Association.

Conoley, C., Conoley, J., McConnell, J. A., & Kimzey, C. E. (1983). The effect of the ABC's of rational emotive therapy and the empty-chair technique of Gestalt therapy on anger reduction. *Psychotherapy: Theory, Research and Practice, 20*, 112–117.

Coon, D. W., Thompson, L., Steffen, A., Sorocco, K., & Gallagher-Thompson, D. (2003). Anger and depression management: Psycoeducational skill training interventions for women caregivers of a relative with dementia. *The Gerontologist, 43*, 678–689.

Crowell, D. H., Evans, I. M., & O'Donnell, C. R. (1987). Childhood aggression and violence. New York: Plenum.

Dan. J. S., Katharine, A., Phillips, D. B., Fulford, K., John, Z. S., Kenneth, S. K. (2010).What is a Mental/Psychiatric Disorder? From DSM-IV to DSM-V. *Psychol Med 40 (11)*: 1759-1765.

Darwin, C. (1872/1998). *The expression of emotion in man and animals*. New York: Oxford University Press.

Day, A., Howells, K., Mohr, P., Schall, E., & Gerace, A. (2008). The development of CBT programmes for anger: The role of interventions to promote perspective-taking skills. *Behavioural and Cognitive Psychotherapy, 36*, 299–312.

Deffenbacher, J. L., & Stark, R. S. (1992). Relaxation and cognitive-relaxation treatments of general anger. *Journal of Counseling Psychology, 39*, 158–167.

Deffenbacher, J. L., Huff, M. E., Lynch, R. S., Oetting, E. R., & Salvatore, N. E. (2000). Characteristics and treatment of high-anger drivers. *Journal of Counselling Psychology, 47*, 5–17.

Dein, S., & Loewenthal, K. M. (1998). Holy healing: The growth of religious and spiritual therapies. *Mental Health, Religion & Culture, 1*(2), 85–89.

Del Vecchio, T., & O'Leary, K. D. (2004). Effectiveness of anger treatments for specific anger problems: A metaanalytic *review. Clinical Psychology Review, 24*, 15–34.

Deschênes, M. J. Dugas, K., Fracalanza, N., & Koerner, K. (2012). The Role of Anger in Generalized Anxiety Disorder. Cognitive Behaviour Therapy, 41(3), 261 doi:10.1080/16506073.2012.666564

DiGiuseppe, R. (1999). End piece: Reflections on the treatment of anger. *Journal of clinical psychology, 55*(3), 365-379.

DiGuiseppe, R., & Tafrate, R. C. (2003). Anger treatments for adults: A meta-analytic review. *Clinical Psychology: Science and Practice, 10,* 70–84.

Dodge, K. A. (1993). *The structure and function of reactive and proactive aggression.* In D. J. Pepler & K. H. Rubin (Eds.), The development and treatment of childhood aggression (pp. 201–218). Hillsdale, NJ: Lawrence Erlbaum.

Doyle, M., & Dolan, M. (2006). Evaluating the validity of anger regulation problems, interpersonal style, and disturbed mental state for predicting inpatient violence. *Behavioural Sciences and the Law, 24,* 783–798.

Dykeman, B. (2000). Cognitive-behaviour treatment of expressed anger in adolescents with conduct disorders. *Education, 121,* 298.

Echeverry, J. J. (1997). *Treatment barriers: Assessing and accepting professional help*. In G. García & M.C. Zea (Eds.), Psychological interventions and research with Latino populations (pp. 94–124). Boston: Allyn and Bacon.

Eckhardt, C., Norlander, B., & Deffenbacher, J. (2005). The assessment of anger and hostility: A critical review. *Aggression and Violent Behaviour, 9,* 17–43.

Edmonson, C. B., & Conger, J. C. (1996). A review of treatment efficacy for individuals with anger problems: Conceptual, assessment, and methodological issues. *Clinical Psychology Review, 16,* 251–275.

Ehlers, A., Mayou, R. A., & Bryant, B. (2003). Cognitive predictors of post-traumatic stress disorder in children: results of a prospective longitudinal study. *Behaviour Research and Therapy, 41*, 1–10.

Eklund, M., & Hansson, L. (1997). Relationships between characteristics of the ward atmosphere and treatment outcome in a psychiatric day-care unit based on occupational therapy. *Acta Psychiatrica Scandinavica, 95*, 329–335.

Ekman, P. (1982). *Emotion in the Human Face.* Cambridge: Cambridge University Press.

Ekman, P. (2004). What we become emotional about. In A. Fischer, A. S. R. Manstead, & N. Frijda (Eds.), *Feelings and emotions: The Amsterdam symposium* (pp. 119–135). New York: Cambridge University.

Elfenbein, H. A., & Ambady, N. (2003). Cultural similarity's consequences: A distance perspective on cross-cultural differences in emotion recognition. *Journal of Cross-Cultural Psychology, 34*(1), 92–110.

Elhai, J. D., Frueh, B. C., Gold, P. B., Gold, S. N., & Hamner, M. B. (2000). Clinical presentations of posttraumatic stress disorder across trauma populations: A comparison of MMPI-2 profiles of combat veterans and adult survivors of child sexual abuse. *The Journal of Nervous and Mental Disease, 188*, 708–713.

Ellis, A. & Dryden, W. (1997). *The practice of rational emotive therapy (2nd ed.).* New York: Springer.

Ellsworth, P. C., & Scherer, K. R. (2003). *Appraisal processes in emotion.* In R. J. Davidson, H. Goldsmith, & K. R. Scherer (Eds.), *Handbook of the affective sciences.* UK: Oxford University Press: New York/Oxford.

Erwin, B. A., Heimberg, R. G., Schneier, F. R., & Liebowitz, M. R. (2003). Anger experience and expression in social anxiety disorder: Pretreatment profile and predictors of attrition and response to cognitive-behavioural treatment. *Behaviour Therapy, 34*, 331-350.

Farah, J., & McColl, M. A. (2008). Exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75*(1), 5-17.

Fava, M. (1998). Depression with anger attacks. *Journal of Clinical Psychiatry, 59*, (518), 18–22.

Feeney, N. C., Zoellner, L. A., & Foa, E. B. (2000). Anger, dissociation, and posttraumatic stress disorder among female assault victims. *Journal of Traumatic Stress, 13*, 89–100.

Fehr, B., Baldwin, M. W., Collins, N., Patterson, S., & Benditt, R. (1999). Anger in close relationship: An interpersonal script analysis. *Personality and social psychology Bulletin, 25*, 299- 312.

Fernandez, E., & Kerns, R. D. (2008). *Anxiety, depression, and anger: The core of negative affect in medical populations.* In G. J. Boyle, D. Matthews & D. Saklofske (Eds.), International Handbook of Personality Theory and Testing: Vol. 1: Personality Theories and Models (pp. 659–676). London: Sage.

Fernandez, E., & Turk, D. C. (1995). The scope and significance of anger in the experience of chronic pain. *Pain, 61*, 165–175.

Fernandez, E., & Beck, R. (2001). Cognitive-behavioral self-intervention versus self-monitoring of anger: Effects on anger frequency, duration, and intensity. *Behavioural and Cognitive Psychotherapy, 29,* 345–356.

Fischetti, B. A. (2001). Use of play therapy for anger management in the school setting. In Drewes, A. A., Carey, *L. J., & Schaefer, C. E. (Eds.), School-based play therapy* (pp. 238–255). Hoboken, NJ: Wiley.

Fitness, J. (2000). Anger in the workplace: An emotion script approach to anger episodes between workers and their superiors, co-workers and subordinates. *Journal of Organizational Behaviour, 21,* 147–162.

Flaskerud, J. H., & Liu, L. (1991). Participation in and outcome of treatment for major depression among low income Asian-Americans. *Psychiatry Research, 53,* 289–300.

Forbes, D., Creamer, M., Hawthorne, G., Allen, N., & McHugh, T. (2003). Comorbidity as a predictor of symptom change following treatment in combat-related post-traumatic stress disorder. *Journal of Nervous and Mental Disease, 191,* 93–99.

Fournier, G., & Jeanrie, C. (2003). Positive psychological assessment: A handbook of models and measures. In S. J. Lopez & C. R. Snyder (Eds.), *Locus of Control: Back to basics,* (pp. 139-154).

Fraguas, R., Papakostas, G. I., Mischoulon, D., Bottiglieri, T., Alpert, J., & Fava, M. (2005). Anger attacks in major depressive disorder and serum levels of homocysteine. *Journal of Biological Psychiatry, 60,* 270–274.

Franklin, C. L., Posternak, M. A., & Zimmerman, M. (2002). The impact of subjective and expressed anger on the functioning of psychiatric outpatients with post-traumatic stress disorder. *Journal of Interpersonal Violence, 17,* 1263–1273.

Frijda, N. H. (2006). *The laws of emotion.* Mahwah, N. J: Lawrence Erlbaum Associates.

Gadit, A. A. (2007). Psychiatry in Pakistan: 1947- 2006, a new balance sheet. *J Pak Med Assoc,57,* 453- 463.

Galovski, T., & Blanchard, E. (2002). The effectiveness of a brief psychological intervention on court-referred and self-referred aggressive drivers. *Behaviour Research and Therapy, 40,* 1385–1402.

Galovski, T., Blanchard, E. B., & Veazey, C. (2002). Intermittent explosive disorder and other psychiatric co-morbidity among court-referred and self-referred aggressive drivers. *Behaviour Research and Therapy, 40,* 641–651.

Gartner, J. (1996). Religious commitment, mental health, and prosocial behavior: A review of the empirical literature. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 187–214). Washington, DC: American Psychological Association.

Germine, M., Goddard, A. W., Woods, S. W., Charney, D. S., & Heninger, G. R. (1992). Anger and anxiety responses to *m*-chlorophenylpiperazine in generalized anxiety disorder. *Biological Psychiatry, 32,* 457–461.

Giegling, I., Hartmann, A. M., Möller, H. J., & Rujescu, D. (2006). Anger- and aggression-related traits are associated with polymorphisms in the 5-HT-2A gene. *Journal of Affective Disorders, 96,* 75–81.

Glancy, G., & Siani, M. (2009). An evidence based review of psychological treatment of anger and aggression. *Brief Treat Crisis Interven, 5,* 229- 248.

Goffman, E. (1989). On Field Work. *Journal of Contemporary Ethnography, 18,* 123-132.

Goldman, L., & Hagga, D. A. (1995). Depression and the experience and expression of anger in marital and other relationships. *J Nerv Ment Dis, 183,* 505–509.

Graham, R., Devinsky, O., & LaBar, K. S. (2007). Quantifying deficits in the perception of fear and anger in morphed facial expression after bilateral amygdala damage. *Neuropsychologia, 45,* 42–54.

Grandjean, D., & Scherer, K. R. (2008). Unpacking the cognitive architecture of emotion processes. *Emotion, 8*, 341–351.

Greenberger, D., & Padesky, C. A. (1995). *Mind over mood: Change how you feel by changing how you think.* New York: Guillford Press.

Hackett, C., & Grim, B. J. (2012). The Global Religious Landscape: A Report on the size and distribution of the world's MajorReligious Groups as of 2010. Pew Research Centre Retrieved from httpp:// www. Pewforum.org/global-religious-landscape.aspx

Hamdan, A. (2008). Cognitive Restructuring: An Islamic Perspective. *Journal of Muslim Mental Health, 3*, 99-116

Haque, A. (2004a). Religion and Mental Health: The case of American Muslims. *Journal of Religion and Health, 43* (1),45-50.

Haque, A. (2004b). Psychology from Islamic Perspective: Contributions of Early Muslim Scholars and Challenges to Contemporary Muslim Psychologists. *Journal of Religion and Health, 43 (4)*, 357-377.

Hartz, G. W. (2005). Spirituality and mental health: Clinical applications. Binghamton, NY: Haworth Pastoral Press.

Hawkins, R. S., Tan, S., & Turk, A. A. (1999). Secular versus Christian inpatient cognitive-behavioural therapy programs: Impact on depression and spiritual well being. *Journal of Psychology and Theology, 27*(4), 309-318.

Hawley, L. L., Zuroff, D. C., & Blatt, S. J. (2006). The relationship of perfectionism, depression, and therapeutic alliance during treatment for depression: Latent difference score analysis. *Journal of Consulting and Clinical Psychology, 74,* 930–942.

Hill, P., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist, 58*, 64–74.

Hinton, D., Hsia, C., Um, K., & Otto, M. W. (2003). Anger-associated panic attacks in Cambodian refugees with PTSD; a multiple baseline examination of clinical data. *Behaviour Research and Therapy, 41*, 647–654.

Hodge, D. R. (2006). Spiritually modified cognitive therapy: A review of the literature. *Social Work, 51*(2), 157-166.

Hofstede, G. H. (2001). *Culture's consequences: Comparing values, behaviours, institutions and organizations across nations (2nd ed.)*. Thousand Oaks, CA: Sage Publications.

Iqbal, S., Naqvi, H., & Siddiqi, N. (2006). Psychiatric in-patient violence: use of chemical and physical restraint at a university hospital in Karachi, Pakistan. *Journal of Pakistan Psychiatric Society, 3* (1); 35-38.

Izard, C. E. (1977). *Human Emotions*. New York: Plenum.

Izard, C. E. (1993). Four systems for emotion activation: Cognitive and non-cognitive processes. *Psychological Review,100*, 68–90.

Jarvis, K. L., Gordon, E. E., & Novaco, R. W. (2005). Psychological distress of mothers and children in domestic violence emergency shelters. *Journal of Family Violence, 20*, 389–402.

Johnson, W. B. (2001). To dispute or not to dispute: Ethical REBT with religious clients. *Cognitive & Behavioural Practice, 8*(1), 39–47.

Johnson, W. B., & Ridley, C. R. (1992). Brief Christian and non-Christian rationale motive therapy with depressed Christian clients: An exploratory study. *Counselling and Values, 36*, 220-229.

Johnson, W. B., DeVries, R., Ridley, C. R., Pettorini, D., & Peterson, D. R. (1994). The comparative efficacy of Christian and secular rational-emotive therapy with Christian clients. *Journal of Psychology and Theology, 22*(2), 130–140.

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

Kellner, R., Hernandez, J., & Pathak, D. (1992). Self-rated inhibited anger, somatization and depression. *Psychotherapy and Psychosomatics, 57*(3), 102-107.

Kessler, R. C., Coccaro, E. F., Fava, M., Jaeger, S., Jin, R., & Walters, E. (2006). The prevalence and correlates of DSM-IV intermittent explosive disorder in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 63*, 669–678.

Khaleefa, O. (1999). Who is the founder of psychophysics and experimental psychology? *The American Journal of Islamic Social Sciences, 16*, 1–26.

Khalily, M. T. (2011). Mental health problems in Pakistani society as a consequence of violence and trauma: a case for better integration of care. *Int J Integr Care* 11: et 128.

Khalily, M. T. (2012). Schema Perpetuation and Schema Healing: A Case Vignette for Schema Focused Therapy in Islamic Perspective. *Islamic Studies, 51* (3), 327–336.

Khalily, M. T. (2013). Anger or the hostage of hate, anger management in the light of sunnah. *Journal of insight, 3*(2), 33-66.

Knafo, D., & Moscovitz, S. (2006). Psychoanalytic treatment of anger and aggression. In E. L.Feindler (Ed.), Anger related disorders: A practitioner's guide to comparative treatments (pp. 97–114). New York: Springer.

Koenen, K. C., Stellman, J. M., Stellman, S. D., & Sommer, J. F. (2003). Risk factors for course of posttraumatic stress disorder among Vietnam veterans: A 14-year follow-up of American Legionnaires. *Journal of Consulting and Clinical Psychology, 71*, 980–986.

Koenig, H. G. (2007). Spirituality and depression. *Southern Medical Association, 100*(7), 737-739.

Koh, K. B., Kim, C. H., & Park, J. K. (2002). Predominance of anger in depression disorders compared with anxiety disorders and somatoform disorders. *Journal of Clinical Psychiatry, 63*, 486–492.

Kuppens, P. (2005). Interpersonal determinants of trait anger: Low agreeableness, perceived low social esteem, and the amplifying role of the importance attached to social relationships. *Personality and Individual Differences, 38*, 13–23.

Kuppens, P. I., Van Mechelen, I. V., & Meulders, M. (2007). Every cloud has a silver lining: Interpersonal and individual differences determinants of anger-related behaviours. *Personality & Social Psychology Bulletin, 30*, 1550–1564.

Kuyken, W., Watkins, E., & Beck, A. T. (2005). Cognitive–behaviour therapy for mood disorders. In *Oxford Textbook of Psychotherapy* eds GO Gabbard, JS Beck, J Holmes):111–26. Oxford University Press.

La Torre, M. A. (2004). Prayer in psychotherapy: An important consideration. *Perspectives in Psychiatric Care, 40*(1), 2- 4.

Lanctot, N., & Hess, U. (2007). The timing of appraisals. *Emotion, 7*, 207–212.

Lawrence, A. D., Goerendt, I. K., & Brooks, D. J. (2007). Impaired recognition of facial expression of anger in Parkinson's disease patients acutely withdrawn from dopamine replacement therapy. *Neuropsychologica, 45*, 65–74.

Lazarus, R. S., & Monat, A. (1991). *Stress and coping: An anthology* (3rd ed.). New York: Columbia University Press.

Leichsenring, F., & Leibing, E. (2007). Psychodynamic psychotherapy: a systematic review of techniques, indications and empirical evidence. *Psychology and Psychotherapy: Theory, Research and Practice 80*(Pt 2).

Lemerise, E. A., & Arsenio, W. F. (2000). An integrated model of emotion processes and cognition in social information processing. *Child Development, 71,* 107–118.

Lewis, K. M. (2000).When leaders display emotion: How followers respond to negative emotional expression of male *and female leaders. Journal of Organizational Behaviour, 21,* 221–234.

Lovibond, S. H., & Lovibond, P. F. (1995). Manual for the Depression Anxiety Stress Scales. (2nd Ed) Sydney: Psychology Foundation.

Mahoney, M. J. (1993). Human change processes: The scientific foundations of psychotherapy. New York: Basic Books.

Malta, L. S., Blanchard, E. B., & Friedenberg, B. M. (2005). Psychiatric and behavioural problems in aggressive drivers. *Behaviour Research and Therapy, 43,* 1467–1484.

Marín, G., & Marín, B. V. (1991). Research with Hispanic populations. Newbury Park, CA: Sage.

Marlatt, G. A., & Kristeller, J. L. (1999). Mindfulness and meditation. In W. R. Miller (Ed.), *Integrating spirituality in treatment: Resources for practitioners* (pp. 6784). Washington, DC: American Psychological Association.

Martin, J. E. & Booth, J. (1999). Behavioral approaches to enhance spirituality. In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners.* (pp. 161-175). Washington, DC: American Psychological Association.

Matsumoto, D. (1991). Cultural influences on facial expressions of emotion. *Southern Communication Journal, 56*, 128–137.

Matsumoto, D., & Wilson, J. (2008). Culture, emotion, and motivation. In R. M. Sorrentino, & S. Yamaguchi (Eds.), *Handbook of motivation and cognition across cultures.* New york: Elsevier.

Mayou, R. A., Ehlers, A., & Bryant, B. (2002). Post-traumatic stress disorder after motor vehicle accidents: 3-year follow-up of a prospective longitudinal study. *Behaviour Research and Therapy, 40*, 665–675.

McCullough, M. E., & Larson, D. B. (1999). Religion and depression: A review of the literature. *Twin Research, 2*(2), 126–136.

McElroy, S. L. (1999). Recognition and treatment of DSM-IV intermittent explosive disorder. *Journal of Clinical Psychiatry, 60*(15), 12–16.

McGinn, L. K., & Sanderson, W. C. (2001). What allows cognitive behavioral therapy to be brief: Overview, efficacy, and crucial factors facilitating brief treatment. *Clinical Psychology: Science and Practice, 8*, 23–37.

McMiller, W. P., & Weisz, J. R. (1996). Help-seeking preceding mental health clinic intake among African-American, Latino, and Caucasian youths. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1086–1094.

McMinn, M. R., & Dominquez, A. W. (2005). *Psychology and the church.* Hauppauge, NY: Nova

McNeil, D. E., Eisner, J. P., & Binder, R. L. (2003). The relationship between aggressive attributional style and violence by psychiatric patients. *Journal of Consulting and Clinical Psychology, 71*, 399–403.

Meisenhelder, J. B., & Chandler, E. N. (2000). Faith, prayer and health outcomes in elderly Native Americans. *Clinical Nursing Research, 9,* 191-203.

Mesquita, B., & Walker, R. (2003). Cultural differences in emotions: A context for interpreting emotional experiences. *Behaviour Research and Therapy, 41, 777–793.*

Mischel, W., & Shoda, Y. (1998). Reconciling processing dynamics and personality dispositions. *Annual Review in Psychology, 49,* 229–258.

Mohamed, Y. (1995). Fitrah and its bearing on the principles of psychology. *The American Journal of Islamic Social Sciences, 12,* 1–18.

Mohamed, Y. (1998). *Human nature in Islam.* Kuala Lumpur: A. S. Noordeen.

Mohr, W. K. (2006). Spiritual issues in psychiatric care. *Perspectives in Psychiatric Care, 42*(3), 174-183.

Monahan, J., Steadman, H. J., Silver, E., Appelbaum, P. S., Robbins, P. C., & Mulvey, E. P. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. Oxford: Oxford University Press.

Mondillon, L., Niedenthal, P. M., Brauer, M., Rohmann, A., Dalle, N., & Ichida, Y. (2005). Beliefs about power and its relation to emotional experience: A comparison of Japan, France, Germany, and the United States. *Personality and Social Psychology Bulletin, 31,* 1112–1122.

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74,* 898-907.

Mook, J., Van De Pleog, H. M., & Kleijin, W. C. (1990). Anxiety, Anger and Depression: Relationship at the trait level. *Anxiety Research,* 3, 17-31.

Morrison, J., Clutter, S., Pritchett, E., & Demmitt, A. (2009). Perceptions of clients and counselling professionals regarding spirituality in counselling. *Counselling and Values, 53*(3), 183.

Moscovitch, D. A., McCabe, R. E., Antony, M. M., Rocca, L., & Swinson, R. P. (2008). Anger experience and expression across the anxiety disorders. *Depression and Anxiety, 25*, 107–113.

Muñoz, R. F. (1982). The Spanish speaking consumer and the community mental health centre. In E. E. Junes and S.J. Korchin (Eds.). Minority mental health (pp. 362–398). New York: Paege Publishers.

Nagayama-Hall, G. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502–510.

National Institute of Mental Health. (1999). Strategic plan on reducing health disparities (draft).

Nielsen, S. L., Johnson, W. B., & Ellis, A. (2001). *Counseling and psychotherapy with religious persons: A rational emotive behaviour therapy approach*. Mahwah, NJ: Lawrence Erlbaum Associates.

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

Novaco, R. W. (1977). Stress inoculation: A cognitive therapy for anger and its application to a case of depression. *Journal of Consulting and Clinical Psychology, 45,* 600–608.

Novaco, R. W. (1997). Remediating anger and aggression with violent offenders. *Legal and Criminological Psychology, 2*, 77–88.

Novaco, R. W. (2000). Anger. In A. E. Kazdin (Ed.), *Encyclopedia of psychology.* Washington, D. C.: American Psychological Association and Oxford University Press.

Novaco, R. W., & Chemtob, C. M. (2002). Anger and combat-related post-traumatic stress disorder. *Journal of Traumatic Stress, 15*(2), 123–132.

Novaco, R. W., & Chemtob, C. M. (2007). Anger and combat-related PTSD in the National Vietnam Veterans Readjustment survey. Paper presented at the meeting of the American psychological Association, San Francisco, CA, August.

Novaco, R. W., & Taylor, J. L. (2004). Assessment of anger and aggression in offenders with developmental disabilities. *Psychological Assessment, 16,* 42–50.

Olatunji, B. O., Sawchuk, C. N., Lohr, J. M., & de Jong, P. J. (2004). Disgust domains in the prediction of contamination fear. *Behaviour Research and Therapy, 42,* 93-104.

Orth, U., & Wieland, E. (2006). Anger, hostility, and posttraumatic stress disorder in trauma exposed adults: A metaanalysis. *Journal of Consulting and Clinical Psychology, 4,* 698–706.

Oyserman, D., Coon, H. M., & Kemmelmeier, M. (2002). Rethinking individualism and collectivism: Evaluation of *theoretical assumptions and meta-analyses. Psychological Bulletin, 128*(1), 3–72.

Painuly, N., Sharan, P., & Mattoo, S. K. (2005). Relationship of anger and anger attacks with depression. *European Archives of Clinical Neuroscience, 255,* 215–222.

Pargament, K. I., Murray-Swank, N. A., & Tarakeshwar, N. (2005). An empirically based rationale for a spiritually integrated psychotherapy. *Mental Health, Religion and Culture, 8*(3), 155–165.

Pasquini, M., Picardi, A., Biondi, M., Gaetano, P., & Morosini, P. (2004). Relevance of anger and irritability in outpatients with major depressive disorder. *Psychopathology, 37*, 155–160.

Paul, P., & Kelly, C. (2005). With God as my shrink. *Psychology Today, 38*(3), 62-68.

Pedersen, P. D. (1997). Culture-centered counselling interventions: Striving for accuracy. Thousand Oaks, CA: Sage.

Pedersen, P. D. (2003). Cross-cultural counselling: Developing culture-centered interactions. In G. Bernal, J.E. Trimble, A.K. Burlew, & F.T.L. Leong (Eds.), Handbook of racial and ethnic minority psychology (pp. 487–503). Thousand Oaks, CA: Sage.

Pedersen, W. C., Bushman, B. J., ,Vasquez, E. A., & Miller, N. (2005). Chewing on it can chew you up: Effects of rumination on triggered displaced aggression. *Journal of Personality and Social Psychology, 88*, 969–983.

Peloquin, S. M. (2008). Mortality pre-empts modality: A commentary on exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75* (1), 15-16.

Perlis, R. H., Smoller, J. W., Fava, M., Rosenbaum, J. F., Nierenberg, A. A., & Sachs, G. S. (2004). The prevalence and clinical correlates of anger attacks during depressive episodes in bipolar disorder. *Journal of affective disorders, 79*, 291–295.

Perls, F. S. (1973). *The Gestalt approach. Palo Alto.* CA: Science and Behaviour Books.

Plante, T. G., & Sherman, A. S. (Eds). (2001). Faith and health: Psychological perspectives. New York: Guilford Press.

Posternak, M. A., & Zimmerman, M. (2002). Anger and aggression in psychiatric outpatients. *Journal of Clinical Psychiatry, 63*, 665–672.

Potegal, M., Stemmler, G., & Spielberger, C. (Eds). (2010). *International Handbook of Anger:* Constituent and Concomitant Biological, Psychological, and Social process. New York: Sringer.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and non-religious cognitive-behavioural therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60*(1), 94–103.

Ramírez, M., Valdez, G., & Perez, M. (2003). Applying the APA Cultural Competency Guidelines: A cultural and cognitive flex perspective. *The Clinical Psychologist, 56,* 17–23.

Razali, S. M., Hasanah, C. I., Aminah, K., & Subramaniam, M. (1998). Religious-socio-cultural psychotherapy in patients with anxiety and depression. *Australian and New Zealand Journal of Psychiatry, 32(6),* 867–872.

Reynolds, N. S., Walkey, F. H., & Green, D. E. (1994). The Anger Self report: A Psychometrically Sound (30 Item) Version. *New Zealand journal of Psychology, 23,* 64-70.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counselling and psychotherapy.* Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2005). Religious and spiritual practices as therapeutic interventions. In A. E. Bergin, *A spiritual strategy for counselling and psychotherapy (2nd Ed)* (pp. 251-279). Washington, DC: American Psychological Association.

Richards, P. S., Hardman, R. K., & Berrett, M. E. (2008). Patient's perceptions of the role of spirituality in treatment and recovery. In P. S. Richards, R. K. Hardman & M. E. Berrett (Eds.), *Spiritual approaches in the treatment of women with eating disorders* (pp. 259-274). Washington, DC: American Psychological Association.

Richter, D., & Berger, K. (2006). Post-traumatic stress disorder following patient assaults among staff members of mental health hospitals: a prospective longitudinal study. *BMC Psychiatry, 6,* 15.

Rimm, D. C., deGroot, J. C., Boord, P., Heiman, J., & Dillow, P. V. (1971). Systematic desensitization of an anger *response. Behaviour Research and Therapy, 9,* 273–280.

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counselling: Clients' beliefs and preferences. *Journal of Clinical Psychology, 48*(1), 61–71.

Rosenberg, M. (1990). "Reflexivity and Emotions." *Social Psychology Quarterly, 53,* 3-12.

Rosenberg, M. (1991). "Self-Processes and Emotional Experiences." Pp. 123-142 in *The Self-Society Dynamic: Cognition, Emotion, and Action,* edited by J. A. Howard and P. L. Callero. Cambridge: Cambridge University Press.

Roseman, I. J. (1991). Appraisal determinants of discrete emotions. *Cognition and Emotion, 5,* 161–200.

Roseman, I. J., & Kaiser, S. (2001). Applications of appraisal theory to understanding and treating emotional pathology. In K. R. Scherer, A. Schorr, & T. Johnstone (Eds.), *Appraisal Processes in Emotion: Theory, Methods, Research*(pp. 249-267). Oxford, England: Oxford University Press.

Rossberg, I. J., & Friss, S. (2004). Patients' and staff's perception of the psychiatric ward environment. *Psychiatric services,* 55(7). doi: 10.1176/appi.ps.55.7.798.

Russell, J. A. (2003). Core affect and the psychological construction of emotion. *Psychological Review, 110*, 145–172.

Russell, J. A., & Fehr, B. (1994). Fuzzy concepts in a fuzzy hierarchy: Varieties of anger. *Journal of Personality and Social Psychology, 67*, 186–205.

Sanderson, C., & Linehan, M. M. (1999). Acceptance and forgiveness. In W. R. Miller (Ed.), *Integrating spirituality into treatment: Resources for practitioners* (pp. 199216). Washington, DC: Association Press.

Santos, C. O., Caeiro, L., Ferro, J. M., Albuqierque, R., & Figueira, M. L. (2006). Anger, hostility and aggression in the first days of acute stroke. *European Journal of Neurology, 13*, 351–358.

Scherer, K. R. (2001). Appraisal considered as a process of multi-level sequential checking. In K. R. Scherer, A. Schorr, & T. Johnstone (Eds.), *Appraisal processes in emotion: Theory, methods, research* (pp. 92–120). New York and Oxford: Oxford University Press.

Scherer, K. R., Wranik, T., Sangsue, J., Tran, V., & Scherer, U. (2004). An actuarial approach to emotions: Emotions in everyday life. *Social Science Information, 43*, 499–570.

Schimmel, C. J., & Jacobs, E. (2011). Ten creative counseling techniques for helping clients deal with anger. Retrieved from http://counselingoutfitters.com/vistas/vistas11/Article_53.pdf

Schiraldi, G. R., & Kerr, M. H. (2002). *The anger management sourcebook*. New York: McGraw Hill.

Schmitt, M. (1996). Individual differences in sensitivity to befallen injustice (SBI). *Personality and Individual Differences, 21*, 3–20.

Schutzwohl, M., & Maercher, A. (2000). Anger in former East German political prisoners: Relationship to post-traumatic stress reactions and social support. *Journal of Nervous and Mental Disease*, *188*, 483–489.

Schuyler, D. (2003). Cognitive therapy for depression. *Primary Psychiatry, 10*,33–6.

Schwartz, S. H. (2004). Mapping and interpreting cultural differences around the world. In H. Vinken, J. Soeters, & P. Ester (Eds.), *Comparing cultures, dimensions of culture in a comparative perspective* (pp. 43–73). Leiden, The *Netherlands: Brill.*

Seligman, M. E. P. (1998). *Learned optimism*. New York: Pocket books.

Shafranske, E. P. (2002). *The necessary and sufficient conditions for an applied psychology* of religion. *Psychology of Religion Newsletter, 27(4).* Retrieved from http://www.apa.org/divisions/div36/Newsltrs/v27n4.pdf

Shafranske, E. P., & Sperry, L. (2005). Addressing the spiritual dimension in psychotherapy: Introduction and overview. In L. Sperry & E. P. Shafrankske (Eds.), *Spiritually-oriented psychotherapy* (pp. 11-29). Washington, DC: American Psychological Association.

Shah, A. A. (1996). *Islamic approach to psychopathology and its treatment*. Paper presented at the National Seminar on Islamization of Psychology, Department of Psychology. Kuala Lumpur: International Islamic University Malaysia.

Shah, A. A. (2001). *Islamic therapeutic approach to mental health.* Paper presented at The First International Congress on Religion and Mental Health, Tehran, University of Medical Sciences.

Siani, M. (2009). A Meta- analysis of the Psychological Treatment of Anger: Developing Guidlines for Evidence- Based Practice. Journal of American Academy of Psychiatry and the Law online, *37* (4). 473-488.

Siddle, R., Jones, F., & Awenat, F. (2003). Group cognitive behaviour therapy for anger: A pilot study. *Behavioural and Cognitive Psychotherapy, 31,* 69–83.

Smith, C. A., & Lazarus, R. S. (1993). Appraisal components, core relational themes, and the emotions. *Cognition and Emotion, 7,* 233–269.

Smith, S. (2008). Considering ideology, context and client-centered language: A commentary on exploring prayer as a spiritual modality. *Canadian Journal of Occupational Therapy, 75* (1), 16-17.

Sperry, L. (2005). Integrative spirituality oriented psychotherapy. In L. Sperry & E. P. Shafrankske (Eds.), *Spiritually-oriented Psychotherapy* (pp. 141-152). Washington, DC: American Psychological Association.

Stemmler, G. (1997). Selective activation of traits: Boundary conditions for the activation of anger. *Personality and Individual Differences, 22,* 213–233.

Sue, S. (1998). In search of cultural competence in psychotherapy and counselling. *American Psychologist, 53,* 440–448.

Sue, S., & Sue, L. (2003). Ethnic research is good science. In G. Bernal, J.E. Trimble, A.K. Burlew, Rockville, MD: Author Science

Sukhodolsky, D. G., Kassinove, H., & Gorman, B. S. (2004). Cognitive-behavior therapy for anger in children and *adolescents: A meta-analysis. Aggression and Violent Behaviour, 9,* 247–269.

Szapocznik, J., Santisteban, D., Rio, A., Perez-Vidal, A., Santisteban, D. A., & Kurtines, W. M. (1989). Family effectiveness training: An intervention to prevent drug abuse and problem behaviours in Hispanic youth. *Hispanic Journal of Behavioural Sciences, 1,* 4–27.

Tiedens, L. Z. (2000). The effect of anger on the hostile inferences of aggressive and non-aggressive people: Specific *emotions, cognitive processing, and chronic accessibility. Motivation and Emotion, 25,* 233–251.

University of Southern California-Muslim Student Association [USC-MSA]. (1999). *Translation of Sahih Bukhari.* Retrieved February 14, 2008 from http://www.usc.edu/dept/MSA/fundamentals/hadithsunnah/bukhari/

Vansteelandt, K., & van Mechelen, I. (2006). Individual differences in anger and sadness: In pursuit of active situational features and psychological processes. *Journal of Personality, 74,* 871–909.

Van- Balkom, A. J. L. M., van Oppen, P., Vermeulen, A. W. A., van Dyck, R., Nauta, M. C. E., & Vorst, H. C. M. (1994). A Meta analysis on the treatment of Obsessive Compulsive disorder: A comparison of anti-depressent and cognitive behavioural therapy. *Clin Psychol Rev.* 14, 359-381.

Wagner- Moore, L. E. (2004). Gestalt Therapy: Past, Present, Theory, and Research. *Psychotherapy: Theory, Research, Practice, Training, 4*(2), 180-189.

Weld, C., & Eriksen, K. (2007). Christian clients' preferences regarding prayer as a counselling intervention. *Journal of Psychology and Theology, 35*(4), 328-341.

Whiteside, S. P., & Abramowitz, J. S. (2005). The expression of anger and its relationship to symptoms and cognitions in obsessive-compulsive disorder. *Depression and Anxiety, 21,* 106–111.

Wierzbicka, A. (1999). *Emotions across Languages and Cultures: Diversity and Universals.* Cambridge: Cambridge University Press.

Wilkowski, B. M., & Robinson, M. D. (2008). The cognitive basis of trait anger and reactive aggression: An integrative analysis. *Personality and Social Psychology Review, 12*, 3–21.

Willner, P., Jones, J., Tams, R., & Green, G. (2002). A randomized controlled trial of the efficacy of a cognitive-behavioural anger management group for clients with learning disabilities. *Journal of Applied Research in Intellectual Disabilities, 15*, 224–235.

Wolfersdorf, M., & Kiefer, A. (1998) Depression and aggression. A control group study on the aggression hypothesis in depressive disorders based on the Buss Durkee Questionnaire. *Psychiatrische Praxis,25*, 240–5.

Worthington, E. L., Jr., & Sandage, S. J. (2002). *Religion and spirituality.* In J. C. Norcross (Ed.), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients (pp. 383–399). New York: Oxford University Press.

Wranik, T. (2005). *Personality under stress, who get's angry and why? Individual differences in appraisal and emotion.* Doctoral Dissertation, 336, University of Geneva, Switzerland.

Wranik, T., & Scherer, K. R. (2009). *Anger at work: Why do I get angry?* A componential appraisal approach. In M. Potegal, G. Stemmler, & C. Spielberger (Eds.), *International handbook of anger* (pp.243–266). New York, NY: Springer

Zarabozo, J. M. (1999). *Commentary on the forty Hadith of Al-Nawawi*. Boulder, CO: Al-Basheer Company for Publications and Translations.

Zayas, L. H., Torres, L. R., Malcolm, J., & DesRosiers, F. S. (1996). Clinicians' definitions of ethnically therapy. *Professional Psychology: Research and Practice, 27*, 78–82.

APPENDICES

Appendix A

Checks for the componential appraisal model

1. How relevant is the situation or event for me? (*relevance detection*) • Is it novel, sudden, familiar, and predictable? • Is it pleasant or unpleasant? • Does it directly affect me or my social reference group?
2. What are the implications or consequences of this event and how do they affect my well-being and my immediate or long-term goals? (*implications*) • Who is responsible? • Did he or she act intentionally? • What are the probabilities of different outcomes? • Did I expect this to happen? • Is this favorable or useful for my current goals or needs? • How urgent is it that I take action?
3. How well can I cope with or adjust to these consequences? (*coping potential*) • Do I have the necessary control to do something? • Do I have the necessary power to translate my strategies into action? • Can I deal with the consequences of the situation?
4. What is the significance of this event for my self-concept and to social norms and values? (*normative significance*) • How does the situation or event relate to my personal values and principles? (*internal standards*) • How will the situation or event influence my status or what other people think of me? (*external standards*)

Appendix B

Demographic Sheet

شعبہ نفسیات، بین الاقوامی اسلامی یونیورسٹی، اسلام آباد ایک ایسا شعبہ ہے جو تعلیم و تدریس کے علاوہ انسانی و معاشرت نفسیات سے متعلق مختلف موضوعات اور مسائل پر تحقیق کرتا ہے۔

اس تحقیق کا مقصد یہ جاننا ہے کہ آپ کو کس طرح کے حالات میں کس حد تک غصہ آتا ہے اور غصے کے اظہار یا کنٹرول کے بارے میں کہاں تک آگاہی ہے۔ اس سلسلے میں مختلف بیانات دیے گئے ہیں۔ براہ مہربانی ہر بیان کو غور سے پڑھیں اور اپنی ذات کے حوالے سے جواب دیں۔ کسی بھی بیان کو خالی نہ چھوڑیں۔

آپ کو یقین دلایا جاتا ہے کہ آپ کی دی گئی تمام معلومات صیغہ راز میں رکھی جائیں گی اور صرف تحقیقی مقاصد میں استعمال کی جائیں گی۔

تعاون کا شکریہ۔

ذاتی کوائف

تاریخ: _____

نام: _____ عمر: _____

جنس: _____ تعلیم: _____

پیشہ: _____ ازدواجی حیثیت: _____

خاندانی نظام: مشترکہ / علیحدہ ماہانہ آمدنی: _____

بہن بھائیوں کی تعداد: _____ والدین: دونوں / ایک

بہن بھائیوں میں نمبر: _____ گھر میں کل افراد: _____

Appendix C

Novaco Anger Inventory (short Form)

اس سکیل میں کچھ ایسی صورت حال بیان کی گئی ہیں جو غصہ دلانے والی ہیں۔ ایسا تصور کرنے کی کوشش کریں کہ یہ واقعہ آپ کے ساتھ پیش آیا ہو تو آپ کو کس حد تک غصہ آئے گا۔ اور اسکی شدت کے مطابق نشان لگائیں۔ حقیقت میں کچھ اور وجوہات بھی غصہ کی شدت پر اثر انداز ہو سکتی ہیں (مثلاً صورت حال کیا تھی ، کیسے ہوا، کس وجہ سے ہوا) جو اس میں بیان نہیں کی گئی ہے۔ یہ سکیل آپ کے عمومی ردعمل کے بارے میں ہے۔ اسلئے خاص وجوہات کو حذف کر لیا ہے۔ براہ مہربانی اپنے جوابات عام ردعمل کے طور پر ہی دیں۔

مندرجہ ذیل صورت حال میں آپ کو کتنا غصہ آئے گا۔ غصہ کی شدت والے خانے میں (درست) کا نشان لگائیں۔ (براہ مہربانی کسی ایک خانہ میں ہی نشان لگائیں)۔

نمبر شمار	صورت حال	بہت کم	کم	کسی حد تک (درمیانہ سا)	زیادہ	بہت زیادہ
1۔	آپ نے مشین کھولی جو ابھی لے کر آئے تھے اسکو چالو (ON) کیا اور پتہ چلا کہ یہ کام نہیں کرتی۔					
2۔	کسی نے آپ سے کوئی چیز ٹھیک کروانے کے زیادہ پیسے لے لئے ہوں۔					
3۔	صرف آپ کو غلطی سدھارنے کو کہا جائے جب کہ دوسروں کا بھی عمل نظر انداز کر دیا جائے۔					
4۔	جب آپ کی گاڑی کیچڑ یا ریت میں پھنس جائے۔					
5۔	آپ کسی سے بات کر رہے ہوں اور وہ آپ کو جواب نہ دے					
6۔	جب کوئی خود کو ویسا ظاہر کرے جیسا وہ نہیں ہے۔					
7۔	آپ کیفے ٹیریا میں چار کپ کافی اپنی میز کی طرف لے جانے کی کوشش کر رہے ہو کوئی آپ سے ٹکرا جائے اور کافی گر جائے۔					
8۔	آپ نے اپنے کپڑے لٹکائے ہوئے تھے کسی نے نیچے گرا دیے اور اٹھا کر واپس نہیں لٹکائے۔					
9۔	جوں ہی آپ سٹور میں داخل ہوئے ایک سیلز مین آپ کے ساتھ ساتھ پھرنے لگا۔					
10۔	آپ نے کسی شخص کے ساتھ کہیں جانے کا انتظام کیا ہوا اور وہ آخری منٹ پر جانے سے انکار کر دے۔					
11۔	کوئی آپ کو غلط مزاج کا نشانہ بنائے۔					

نمبر شمار	صورت حال	بہت کم	کم	کسی حد تک (درمیانہ سا)	زیادہ	بہت زیادہ
12۔	ٹریفک سگنل پر آپ کی گاڑی کا انجن بند ہو جائے اور آپ کے پیچھے والا آدمی مسلسل ہارن دے رہا ہو۔					
13۔	آپ نے کار پارکنگ میں غلطی سے غلط طرف موڑ لیا، جیسے ہی آپ گاڑی سے نکلے تو کوئی آپ پر چلانے لگے "تم نے گاڑی چلانا کہاں سے سیکھی"۔					
14۔	کوئی شخص خود غلطی کر کے اس کا الزام آپ پر لگا دے۔					
15۔	آپ پوری توجہ سے کوئی کام کرنا چاہیے ہیں لیکن ساتھ بیٹھا ہوا آدمی مسلسل اپنا پاؤں زمین پر مار رہا ہو۔					
16۔	اگر آپ کسی کو کوئی اہم کتاب یا چیز ادھار دیں اور وہ واپس نہ کرے۔					
17۔	آپ کا دن بہت مصروف گزرا ہو اور آپ جس کے ساتھ رہ رہے ہو وہ آپ سے گلہ کرے کے جو کام کرنے کو کہا تھا وہ آپ بھول گئے۔					
18۔	آپ اپنے بہت قریبی شخص سے کوئی بہت اہم بات کرنا چاہتے ہو لیکن وہ آپ کو اپنی بات بتانے کا موقع نہیں دے رہا۔					
19۔	کسی ایسے شخص سے بحث پر جس کو موضوع کے بارے میں بہت کم علم ہو لیکن وہ اپنی بات پر ڈٹا رہے۔					
20۔	جب آپ کسی سے بات کر رہے ہوں اور کوئی تیسرا اس میں مداخلت کرے۔					
21۔	آپ کو کہیں پہنچنے کی جلدی ہو اور آپ کے آگے جانے والی کار 60 کلومیٹر گھنٹہ جانے والی لین میں 40 کلومیٹر گھنٹہ سے جا رہی ہے اور آپ اس سے آگے بھی نہیں جا سکتے۔					
22۔	اگر آپ کا پاؤں چیونگم پر آ جائے۔					
23۔	جب آپ کہیں سے گزریں اور لوگوں کا ایک گروہ آپ کا مذاق اڑانے لگے۔					
24۔	کہیں پہنچنے کی جلدی میں آپ کا بہترین سوٹ کسی نوکیلی چیز سے الجھ کر پھٹ جائے۔					
25۔	آپ نے فون ملانے کے لئے آخری سکہ استعمال کیا لیکن اس سے پہلے کہ نمبر ملے فون کٹ گیا اور سکہ ضائع ہو گیا۔					

Appendix D

Anger Self Report Questionnaire

مندرجہ ذیل بیانات کو غور سے پڑھیں اور جس حد تک آپ کے متعلق درست ہیں نشان لگائیں۔ اس میں کوئی بھی درست اور غلط جواب نہیں ہیں۔ ہم صرف یہ جاننا چاہتے ہیں آپ کیسا محسوس کرتے ہے۔ ہر بیان کے سامنے جس حد تک آپ متفق یا غیر متفق ہیں (درست) کا نشان لگائیں۔

مندرجہ ذیل ہر بیان پر نشان لگائیں۔ اگر کوئی بیان سمجھ نہیں آتا تو اس پر (?) کا نشان لگائیں اور اگر کوئی بیان آپ کے متعلق نہیں ہے تو اس پر (X) کا نشان لگائیں۔ مگر کسی بھی بیان کو خالی نہ چھوڑیں۔ شکریہ۔

نمبر شمار	بیانات	بہت زیادہ متفق	کسی حد تک غیر متفق	تھوڑا سا غیر متفق	تھوڑا سا متفق	کسی حد تک متفق	بہت زیادہ متفق
1۔	میں بہت جلد غصہ میں آجاتی ہوں۔						
2۔	اگر کوئی مجھے مارنے میں پہل کرے بھی تو میں بہت کم جواب دیتی ہوں۔						
3۔	میں نے کبھی اپنے گھر والوں کے لئے نفرت محسوس نہیں کی۔						
4۔	میں شدید غصہ میں بھی سخت زبان استعمال نہیں کرتی۔						
5۔	جب میں غصہ سے پاگل ہو جاؤں تو لوگوں کو پتہ چل جاتا ہے۔						
6۔	کبھی کبھار مجھے محسوس ہوتا ہے کہ میں کسی کو زخمی کر دوں گی						
7۔	اگر کوئی تنقید کا مستحق ہو تو اسکے منہ پر کہہ دوں گی۔						
8۔	مجھے لگتا ہے کہ میں کسی پر اس وقت تک غصہ نہیں کر سکتی جب تک وہ مجھے بری طرح نقصان نہ پہنچائے۔						
9۔	حتی کہ لوگ مجھ پر چلاتے ہیں تو بھی میں ان پر جواباً نہیں چلاتی۔						
10۔	کبھی میری شدید خواہش ہوتی ہے کہ میں کوئی چونکا دینے والا نقصان دہ کام کر دوں۔						
11۔	میرے اپنے گھر کے افراد کے ساتھ کئی جھگڑے ہوئے۔						
12۔	میں قسم کھانے کے بعد ملامت محسوس نہیں کرتی۔						
13۔	غصہ محسوس کرنا تکلیف دہ عمل ہے۔						

نمبر شمار	بیانات	بہت زیادہ متفق نہیں	کسی حد تک غیر متفق	تھوڑا سا غیر متفق	تھوڑا سا متفق	کسی حد تک متفق	بہت زیادہ متفق
14۔	میں جھگڑے/لڑائی کے دوران کسی کو زخمی بھی کر چکی ہوں۔						
15۔	کسی وقت مجھے محسوس ہوتا ہے کہ میں چیزوں کو تہس نہس کر دوں گی۔						
16۔	مجھے لوگوں پر غصہ کرنا آسان لگتا ہے۔						
17۔	اگر میں نے کسی کو بے جا تنگ کرنے کی کوشش کی تو میرا ضمیر مجھے سزا دے گا۔						
18۔	میں نے شاید ہی کبھی قسم کھائی ہو۔						
19۔	میں شدید غصے کے باوجود کسی کو مارتی نہیں ہوں۔						
20۔	مجھے شاید ہی کبھی غصہ آیا ہو۔						
21۔	کسی کے لئے بھی برا سوچنا میرے لئے مشکل ہے۔						
22۔	کسی کو مارنے کے لئے مجھے کبھی بھی کسی خاص وجہ کی ضرورت نہیں ہوتی۔						
23۔	میں بہت کم فساد یا ہنگامہ برپا کرتی ہوں۔						
24۔	اس کے باوجود کے میرے والدین نے مجھ سے جیسا بھی برتاؤ رکھا۔ میں نے ناراضگی کا اظہار نہیں کیا۔						
25۔	میں کسی کو اس کے مقام/جگہ پر نہیں رکھ سکتی حتیٰ کہ یہ ضروری بھی ہو۔						
26۔	جب میں غصہ سے بے اختیار ہو جاؤں تو کسی کو بھی تھپڑ لگا سکتی ہوں۔						
27۔	میرے لئے یہ بہت آسان ہے کہ میں ان سے جھگڑا نہ کروں جن سے مجھے پیار ہے۔						
28۔	اگر کوئی مجھے ناراض کرے تو میں اس کے بارے میں کیا سوچتی ہوں، مجھ میں وہ بتانے کی اہلیت ہے۔						
29۔	غصہ کرنا بالکل فضول ہے۔						
30۔	اگر کوئی مجھ سے جھگڑا کرے تو میں ان کو اسی طرح سے جواب دیتی ہوں۔						

Appendix E

ڈی۔اے۔ایس۔ایس۔اسکیل

ہدایات:

مندرجہ ذیل فقرات کو غور سے پڑھیں اور جو فقرہ آپکی کیفیت، خیالات اور احساسات کے مطابق ہو اُس کے سامنے 3,2,1,0 میں سے کسی ایک پر دائرہ لگائیں جو آپ کے لئے شدت کے لحاظ سے پچھلے سال کی کیفیت کو مناسب طور پر ظاہر کرے۔ آپ کے جوابات کو صحیح یا غلط تصور نہیں کیا جائے گا۔ کسی بھی فقرہ پر غور و فکر کرنے کے لیے زیادہ وقت ضائع نہ کریں۔ کسی بھی جواب کے شدت کے معیار کو جاننے کے لیے پیمانہ درج ذیل ہے

0۔ یہ مجھ پر ہرگز لاگو نہیں ہوتا ہے
1۔ کبھی کبھار کسی حد تک مجھ پر لاگو ہوتا ہے
2۔ زیادہ تر وقت/ مناسب حد تک مجھ پر لاگو ہوتا ہے
3۔ اکثر اوقات/ بہت زیادہ حد تک مجھ پر لاگو ہوتا ہے

نمبر شمار	فقرات	بالکل نہیں	کبھی کبھار/ کسی حد تک	زیادہ تر وقت/ مناسب حد تک	اکثر اوقات/ بہت زیادہ حد تک
S 1۔	میں بہت "معمولی باتوں پر پریشان رہا/رہی۔	0	1	2	3
A 2۔	مجھے یوں محسوس ہوتا رہا جیسے میرا منہ خشک ہو رہا ہے۔	0	1	2	3
D 3۔	میں ہرگز خوشگوار احساسات محسوس نہیں کر سکا/سکی۔	0	1	2	3
A 4۔	میں نے جسمانی تھکاوٹ محسوس کیے بغیر سانس لینے میں دقت محسوس کی۔	0	1	2	3
D 5۔	میں خود کو کام کرنے کے لیے مستعد نہ پا سکا/سکی۔	0	1	2	3
S 6۔	میں نے بعض صورتحال میں غیر مناسب ردِ عمل کا اظہار کیا۔	0	1	2	3
A 7۔	میں نے کپکپاہٹ محسوس کی (جیسے میں گرنے والا/والی ہوں۔	0	1	2	3
S 8۔	میں نے ذہنی طور پر بہت کم سکون محسوس کیا۔	0	1	2	3
A 9۔	میں ایسے حالات سے بھی گزرا/گزری جو میرے لیے بے حد پریشان کن تھے اور اُن حالات سے نکل کر میں نے خود کو بہت پرسکون پایا۔	0	1	2	3
D 10۔	میں نے محسوس کیا کہ میرا مستقبل تاریک ہے۔	0	1	2	3
S 11۔	مجھے محسوس ہوا کہ میں جلدی پریشان ہو جاتا/جاتی ہوں۔	0	1	2	3
S 12۔	میں نے محسوس کیا کہ میں نے کام کرنے کے لیے بہت زیادہ ذہنی توانائی صرف کی۔	0	1	2	3
D 13۔	میں نے خود کو بہت غمزدہ اور افسردہ محسوس کیا۔	0	1	2	3
S 14۔	جب بھی مجھے کسی بھی وجہ سے انتظار کرنا پڑا میرے لیے ناقابل برداشت ہو گیا۔	0	1	2	3
A 15۔	مجھے دم گھٹنے اور غشی پڑنے کا احساس ہوا۔	0	1	2	3
D 16۔	مجھے محسوس ہوا کہ کسی بھی کام میں میری دلچسپی نہیں رہی۔	0	1	2	3
D 17۔	میں نے محسوس کیا کہ میری کوئی اہمیت نہیں ہے۔	0	1	2	3
S 18۔	مجھے محسوس ہوا کہ میں بہت حساس ہوا/	0	1	2	3

A	19۔	مجھے زیادہ درجہ حرارت یا جسمانی مشقت کے بغیر بھی بے حد پسینہ آتا رہا۔	0	1	2	3
A	20۔	بغیر کسی مناسب وجہ کے میں خوفزدہ ہو جاتا/ جاتی تھی۔	0	1	2	3
D	21۔	میں نے محسوس کیا کہ زندگی کی کوئی اہمیت نہیں۔	0	1	2	3
S	22۔	میرے لیے غصے پر قابو پانا مشکل ہو جاتا تھا۔	0	1	2	3
A	23۔	میں نے کھانا نگلنے میں دقت محسوس کی۔	0	1	2	3
D	24۔	میں اپنے کسی بھی کام سے لطف اندوز نہیں ہوا/ ہوئی۔	0	1	2	3
A	25۔	بغیر کسی جسمانی مشقت کے میرے دل کی دھڑکن تیز ہو گئی۔	0	1	2	3
D	26۔	میں نے محسوس کیا جیسے میرا دل بیٹھ گیا ہو اور میں اداس ہوں۔	0	1	2	3
S	27۔	میں نے جھنجھلاہٹ اور چڑچڑاپن محسوس کیا۔	0	1	2	3
A	28۔	میں نے محسوس کیا جیسے میری پریشانی حد سے بڑھ گئی تھی۔	0	1	2	3
S	29۔	میں نے محسوس کیا کہ جب کسی وجہ سے میں پریشان ہوا/ ہوئی تو میرے لیے پرسکون ہونا مشکل ہو گیا۔	0	1	2	3
A	30۔	مجھے ڈر تھا کہ مجھے کسی معمولی لیکن غیر مانوس کام کی ذمہ داری سونپی جائے گی۔	0	1	2	3
D	31۔	میں کسی بھی کام کے بارے میں پُر جوش نہیں رہا/ رہی۔	0	1	2	3
S	32۔	اپنے ذمہ کام میں کسی کی مداخلت برداشت کرنا میرے لیے مشکل تھا۔	0	1	2	3
S	33۔	میں ذہنی تناؤ کی حالت میں رہا/ رہی۔	0	1	2	3
D	34۔	میں نے خود کو بے حد غیر اہم محسوس کیا۔	0	1	2	3
S	35۔	میرے لیے اُس چیز یا شخص کو برداشت کرنا مشکل تھا جو میرے کام میں رکاوٹ پیدا کرے۔	0	1	2	3
A	36۔	میں بے حد خوفزدہ رہا۔	0	1	2	3
D	37۔	مجھے مستقبل میں کوئی چیز ایسی نظر نہیں آتی جسکے متعلق میں پر اُمید ہو سکوں۔	0	1	2	3
D	38۔	میں نے محسوس کیا کہ زندگی بے معنی اور بے مقصد ہے۔	0	1	2	3
S	39۔	میں نے خود کو ضدی محسوس کیا۔	0	1	2	3
A	40۔	میں ایسے حالات کے متعلق پریشان ہوا/ ہوئی جن میں میرے بے وقوف بننے اور میری بے چینی بڑھنے کا خدشہ تھا۔	0	1	2	3
A	41۔	میں نے اپنے جسم میں کپکپاہٹ محسوس کی۔	0	1	2	3
D	42۔	مجھے کسی کام کے کرنے کے لیے پہل کرنا مشکل محسوس ہوا۔	0	1	2	3

Appendix F

Indigenous model of anger management

As it has been described in main document that the cultural development influence the anger provocation and expression. Different individuals respond differently to the similar situation. So they should be treated according to their cultural development. Religion plays an important role in cultural development. American Psychological Association (APA, 1992) and American Counselling Association (ACA, 1992) also acknowledged religion in their ethical guideline to consider in counselling. So current study was an effort to made a religion based indigenous model for anger management. Previously, a theoretical religion based indigenous model for anger management was proposed in Pakistan (Khalily, 2013) that was based on Novaco's model of anger management and the current model is empirical extension of that proposed model.

Session 1: Introduction

Session Aims:

- Introduction to client
- Getting information about client through demographic sheet
- Assessment on scales to find the intensity and type of anger

Agenda:

Therapist introduce her/himself to the client.

Give a consent form (Appendix G) to the client to assure that all the information will be remained confidential.

Ask the client to introduce him/herself by telling name, work, education.

Ask about the client's expectation for this treatment.

For rapport building ask the client to share some of angry experiences.

Take the anger assessment on Novaco Anger Inventory and Anger Self Report Questionnaire.

Briefly discuss the anger management plan by telling that it will be consisted of 12 sessions and it is an indigenous model of treatment. The techniques will be based on religious teaching of Islam to

control anger.

Session 2: Psycho education about Anger

Session Aims:

- Explore the events or situations which provoked anger.
- Psycho-educate the client that unmet needs or desires often leads to anger. Sometimes undesired result of an event provoke anger.
- Develop skills to identify the feelings.

Agenda:

- Identify that when does client get angry.
- Write down all the examples which are described by the client or take the examples from Novaco anger Inventory on which they scored high.
- Explain to the client that anger is a cue on the basis of which one makes an interpretation of injustice, abuse, or threat.
- Suggest that, like all other emotions, anger is a natural response to a perceived situation; you have a right to the feeling angry, but this does not automatically mean it is "justified."
- Clarify the physical, cognitive, emotional and behavioural cues associated with anger.

Physical Cues: involve the ways our bodies respond when we become angry. For example, our heart rates may increase, we may feel tightness of muscles, or we may feel hot and flushed.

Cognitive Cues: refer to the thoughts that occur in response to the anger provoking event. When people become angry, they may interpret events in certain ways. For example, we may interpret a friend's comments as criticism, or we may interpret the actions of others as demeaning, humiliating, or controlling. Some people call these thoughts "self-talk" because they resemble a conversation we are having with ourselves.

Emotional Cues: are the feelings that may occur concurrently with our anger. For example, we may become angry when we feel afraid, discounted, disrespected, guilty, humiliated, impatient, insecure, jealous, or rejected. These kinds of feelings are the core or primary feelings that underlie our anger.

Behavioural Cues: *represented the* behaviours we display when we get angry, which are observed by other people around us. For example, we may clench our fists, pace back and forth, slam a door,

or raise our voices.

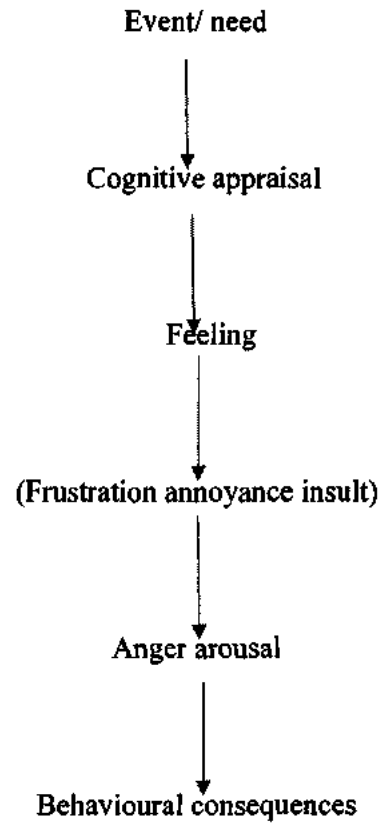
Home work assignment:

- Encourage the clients to interrupt their normal anger behaviour, and take a "time out" to identify their feelings with feeling identification chart (see Appendix H)
- Ask the clients to pay particular attention to whether anger is the true emotion they experience, or whether it masks another emotion
- Give anger diary (Appendix I) to client to note the triggering events and their intensity and associated behaviour.

Session 3: Introduce the Strategies to control Anger

Session Aims:

- Explain the anger model



Agenda:

- Discuss homework assignment
- Take an example of anger from the anger diary and discuss during session.
- Ask the client to imagine the situation and identify what they wanted from that particular situation. What they were expecting but did not receive.
- Ask the client what they did when they got angry
- Note down the strategies, they used to overcome or to deal with angry situation.
- Teach the relaxation technique and rehearse during imagination of angry situation.

Relaxation training: can be accomplished very easily through breathing deeply, and can, Insha Allah, it can help to control and soothe anger.

Here are some simple steps:

- Breathe deeply, from your diaphragm; breathing from your chest won't relax you. Picture your breath coming up from your "gut."
- Slowly repeat a calm word or phrase such as "relax," "take it easy" or even "Laa ilaaha ilallah (There is no God except Allah)." Repeat it to yourself while breathing deeply.
- Recite the following du'as: (1) A`oodhu billahi mina ash-shaytaani ar-rajeem ("I seek refuge with Allah from Satan, the accursed."). This du'a comes from the following agreed upon hadith: Sulaiman bin Sard said, "I was sitting with the Prophet (PBUH) when two men abused each other and one of them became so angry that his face became swollen and changed. The Prophet (PBUH) said, 'I know a word that will cause him to relax, and this was "I seek refuge with Allah from Satan, the accursed." If he says these words, his anger will cool down.' (Reported in Sahih Muslim and Bukhari) (2)Allaahumma innee a`oodhu bika min hamazaati ash-shayaateen; wa a`oodhu bika rabbi an yahdhuroonee (O Allah, I seek refuge in You from the whisperings of devils; and I seek refuge in You from their presence around me). (3)Astaghfiru Allah (I ask Allah for forgiveness) three times. (4) Rabbi qinee sharra nafsee; rabbi qinee sharra sam`ee; rabbi qinee sharra basaree; rabbi qinee sharaa lisaanee (My Lord, save me from the evils of my own self; my Lord, save me from the evils of my hearing; my Lord, save me from the evils of my seeing; my Lord, save me from the evils of my tongue.) You can also simply make the following tasbeeh: Subhaan

Allah, al-hamdu lillah, laa ilaha illa Allah, wa laa hawla wa laa quwwata illa bi-llah (Sublime is Allah; praise be to Allah; there is no god but Allah; there is no power or strength except by the will of Allah)."

Homework Assignment: Anger Diary, relaxation practice while getting angry.

Session 4: Knowing the bad effects of anger

Session Aims:

- Explain the negative effects of anger for oneself and to others.
- Narrate some of Islamic teachings regarding bad effects of Anger.
- Introduce the strategy replacement chart.

Agenda:

- Discuss the anger diary.
- Describing the bad consequences of anger.
- Explain the client that how anger could lead to social disaster and weakened the relationships.
- Describing the preaching of Prophet Muhammad (PBUH) about anger management.

The following story contains a valuable lesson: 'Ilqimah ibn Waa'il reported that his father (may Allah be pleased with him) told him: "I was sitting with the Prophet (peace and blessings of Allah be upon him) when a man came to him leading another man by a rope. He said, 'O Messenger of Allah, this man killed my brother.' The Messenger of Allah (peace and blessings of Allah be upon him) asked him, 'Did you kill him?' He said, 'Yes, I killed him.' He asked, 'How did you kill him?' He said, 'He and I were hitting a tree to make the leaves fall, for animal feed, and he slandered me, so I struck him on the side of the head with an axe, and killed him.' (Reported by Muslim, 1307, edited by al-Baaqi).

Anger could be dangerous for physical health as described by the doctors that that high blood pressure, tachycardia (abnormally rapid heartbeat) and hyperventilation (rapid, shallow breathing), which can lead to fatal heart attacks, diabetes are often caused by anger. When someone is angry, he/she tend to curse, swear, or use offensive or dark language. Islam warns us about what we may inadvisedly say during times of anger. In the Qur'an, Allah warns us: "O ye who believe! Let not a folk deride a folk who may be better than they (are), nor let women (deride) women who

may be better than they are; neither defame one another, nor insult one another by nicknames. Bad is the name of lewdness after faith. And whoso turneth not in repentance, such are evil doers." (Al-Hujurat: 11)

- Explain the strategy replacement chart to the client. In previous session client told about the strategies he used in angry situation. In this session he will be introduced that he should be replaced irrational or maladaptive strategies with the rationale and adaptive techniques as taught in this previous and this session which are actually the teachings of Islam.

Homework assignment: Anger diary (rate the intensity of anger in an angry situation), Revised strategy form (Appendix J).

Session 5: Restructure the Errors in Thinking

Session Aims:

- Explain the errors in thinking through examples given in "Error in thinking handout" (Appendix K)
- Explain through anger model that why sometimes same event does not provoke anger because anger is actually how one labels the results of event.
- Teach the skills of cognitive restructuring.

Agenda:

- Discuss the anger diary and see either intensity of anger reduced or not.
- See the consequences of anger after replacement of strategy.
- Explain that how faulty thoughts leads to misunderstandings and conflicts.
- Introduce the skills of cognitive restructuring.
- Practice thought stopping exercise.

Cognitive Restructuring: This means modifying the way one thinks. When angry, you are under stress, and may be experiencing threat rigidity effects. Either you have difficulty in thinking, or you may tend to exaggerate what is happening. After using the techniques listed under relaxation, try replacing these dark thoughts with more rational ones. For instance, instead of telling yourself, "this person is an absolute jerk, "tell yourself," Allah likes those people who forgive others, so I need to

give him or her some latitude." Do not forget that very often it takes two people to create a conflict-oriented situation. Ask yourself (when you have calmed down) what your role was in the conflict. Surely, it was not only the other person who caused the situation to escalate? Remind yourself that getting angry does not solve anything, and may actually escalate the situation.

Cognitive restructuring also includes thinking about Allah. Here is an example: in a hadith narrated in Sahih Al Bukhari by Abu Musa Al Ashari (volume 9, #394), Allah's Apostle was asked about things which he disliked, and when the people asked too many questions, he became angry and said, "Ask me (any question)." A man got up and said, "O Allah's Apostle! Who is my father?" The Prophet replied, "Your father is Hudhaifa." Then another man got up and said, "O Allah's Apostle! Who is my father?" The Prophet said, "Your father is Salim, Maula Shaiba." When 'Umar saw the signs of anger on the face of Allah's Apostle, he said, "We repent to Allah." Please notice that 'Umar by referring to Allah and implicitly apologize for the participants asking trivial questions from the Prophet (s) was (1) encouraging everyone to refocus on and think about Allah, and (2) recognizing the role of the participants in causing stress to the Prophet (s).

According to the Islamic scholars when a person is in anger, he should think of Allah's attributes. The first attribute of Allah that we Muslims are reminded (of) is Ar Rahman-Ar Rahim that is, Kind and Merciful. God Himself said, my mercy overtakes my wrath, and He told in one of the Hadith Qudusi,'O son of Adam, when you get angry, remember Me." Thus, remembrance of God will put us on the right track. One can utter the word "ya Halim" (Patient), which is one of the attributes of God, being the Mild One.

Thought Stopping: A second approach to controlling anger is called thought stopping. It provides an immediate and direct alternative to the A-B-C-D Model. In this approach, you simply tell yourself (through a series of self-commands) to *stop* thinking the thoughts that are getting you angry. In thought stopping exercise, usually it is recommended to use rubber band technique or reverse counting technique. The purpose of these techniques is to divert attention from anger provoking stimulus. The remedy for anger is that when a person who is angry should control his anger.

Prophet Mohammad (PBUH) had advised us that when angry, one should try to change his body position. Meaning, if you're standing up, sit down. In hadith reported in Ahmad and Tirmidhi (#1322), Allah's Messenger (PBUH) said, "When one of you becomes angry while standing he

should sit down. If the anger leaves him, well and good; otherwise he should lie down." If this didn't work, then go and make wudhu and get prepared for praying. In other words, move away from the source of your anger, and refocus by thinking of your Creator. The rationale for making wudu and praying when angry is explained by the Prophet (PBUH) in a hadith related by Atiyya As-Sa'di in Sunan Abu Dawood (#2227): "AbuWa'il al-Qass said: We entered upon Urwah ibn Muhammad ibn as-Sa'di. A man spoke to him and made him angry. So he stood and performed ablution; he then returned and performed ablution, and said: My father told me on the authority of my grandfather Atiyyah who reported the Apostle of Allah (peace be upon him) as saying: Anger comes from the devil, the devil was created of fire, and fire is extinguished only with water; so when one of you becomes angry, he should perform ablution.

In another hadith (#1331) reported in Al Tirmidhi by AbuSa'id al Khudri, the Prophet (s) said, "Some are swift to anger and swift to cool down, the one characteristic making up for the other; some are slow to anger and slow to cool down, the one characteristic making up for the other; but the best of you are those who are slow to anger and swift to cool down, and the worst of you are those who are swift to anger and slow to cool down." He continued, "Beware of anger, for it is a live coal on the heart of the descendant of Adam. Do you not notice the swelling of the veins of his neck and the redness of his eyes? So when anyone experiences anything of that nature he should lie down and cleave to the earth." When a person is lying on earth he becomes humble because this is the quality of the earth due to it being low and not bursting. This is the opposite to fire which is the origin of shaytaan which results to pride.

Homework assignment: Anger diary, ABCD model (Appendix L)

Session 6: Putting it Altogether

Session Aims:

Review the previous sessions

Agenda:

- Client review their anger meter, anger diary and intensity of anger
- Review the skills which have been learnt yet now.
- Assessment of anger on Novaco Anger Inventory.
- Discuss the efficacy or benefit of learnt skills in daily life to manage anger.

Session 7: Identifying the Anger Style

Session Aims:

Introduce the idea of anger style

Identify the anger style of client by discussing how they behave in angry situations.

Explore that how they express anger to their immediate family, friends and co workers.

Agenda:

- Review anger diary and discuss if something is unusual or need to be discussed.
- Discuss that we all keep on behaving in a particular pattern. Sometimes it becomes our habits and we are not aware of it.
- Sometimes our relationships effect by our behaviours but we do not alter the.
- Discuss the hidden reasons of repetitive behaviours e.g: Avoiding the anxiety associated with change

Changing behaviour can change your personality and other people will not take you same as you were before (loose authority or face isolation etc). Arguments can lead to major issues.

- Therapist should emphasize and make it clear to client that with passage of time our angry responses become habitual and sometimes they do not serve the purpose in solving the problems. Sometimes we have to change the anger pattern.
- Anger response can be vary with relationships and according to situation for conflict management.
- Motivate the client to explore his/her anger style.
- Read "anger style handouts" (Appendix M) to facilitate the client to identify his anger style.

It is very important to identify anger style because the next techniques to mange anger will be based on the anger style. Some people have passive anger while others have expressive and they need different techniques to deal with anger.

Homework assignment: Anger Diary, Ask the clients to write their anger style in detail and how it is effective or ineffective in conflict management. Encourage the client to discuss with friends and family about the anger expression style in their family members.

Session 8: Time Out Technique

Session aims:

- Trained the clients to take time before reacting in angry situation.
- Practice time out techniques during session.

Agenda:

- Review the Anger diary and discuss the feelings of client about treatment of anger.
- Emphasize the new behaviour and patterns of handling conflicting situations.
- Suggest that ultimately, we cannot change other people, we can only change ourselves; you can't tell another person what (s)he "should" think or feel.
- Suggest that the best we can do is to clarify our own position in a non-blaming way, and to maintain emotional closeness with the other person while doing so.
- Suggest that if others are unwilling to accept our position and our feelings, we may need to re-evaluate the situation.

To re- evaluate the situation client needs to take time to think and react to the situation. So it is important to take time out or keep silent for a while or for some hours. Angry people tend to be defensive and reactive, and tend to come to hasty, and flawed conclusions. The first thing to do if you're in a rage is slow down and think through your responses. Don't say the first thing that comes into your head. Take a time out, count to 10 (silently), and do not blurt out. Any of two members in conflict with one another can call out, "Time out". This means that neither party can say or do anything about the current situation until a couple of hours have passed, and both are calm enough to deal constructively with one another. The reason for a time out is that words once spoken can never be recalled, but do not make the time out so long that one of the parties just keeps boiling on the inside for an extended period of time.

Prophet Muhammad (PBUH) was known as a man who could and would even under dire circumstances control his anger. Imam Ahmad recorded that Prophet Muhammad (PBUH) also advised that "If any of you becomes angry, let him keep silent." If a person is trying to be silent, it will obviously restrict his ability to fight or utter obscenities and harsh words.

Ali ibn Abi Talib narrated that once during war, the leader of the non-Muslim army attacked him. Ali managed to overcome him and was on the verge of killing him, when his opponent spat in Ali's face. Ali immediately stepped back and left the man alone. The man said, "You could have killed me, why did you stop? Ali answered, "I have no personal animosity toward you. I was fighting you

because of your disbelief in and rebellion against God. If I had killed you after you spat on my face, it would have been because of my personal anger and desire for revenge, which I do not wish to take."

The Prophet (PBUH) once asked his Companions, "Whom among you do you consider a strong man?" They replied, "The one who can defeat so-and-so in a wrestling contest." He said, "That is not so; a strong man is the one who can control himself when he is angry". As always if a person is unsure about how to act in any situation he need only look to Prophet Muhammad (PBUH) or our righteous predecessors to find the best way to act.

Homework assignment: Anger Diary, Practice to use time out technique.

Session 9: Problem Solving Techniques

Session Aims:

- Discuss the anger style again in depth.
- If it is passive anger practice assertiveness technique.
- If it is over expressive anger practice better communication techniques.

Agenda:

- Review the anger diary and homework.
- Discuss the anger style in detail to clarify the clients style of anger.
- Take an example from anger diary and ask the client how did he/she reacted in this situation and ask the question either it was passive or expressive anger.
- Discuss with client what could be healthier expression of anger.
- As it has been discussed in previous session that sometimes we have to alter the anger style to manage the situation so if a person is passive he must learn assertiveness.
- Narrate the example that how one can talk about conflicting issues (see Appendix N assertiveness techniques)

Some *ayat* (verses of the Qur'an) and *hadiths* (recorded sayings of the Prophet Muhammad) are relevant to this; that Allah will not change us until we start the process of change in ourselves; and that our Islam must reach our hearts, and not just stop at the level of our necks. To achieve a state of peace and 'salaam' with people, especially those within our own families, we may sometimes have to speak out in the face of tyranny, or refuse to do an un-Islamic thing that is being required of us,

or not be coerced into acting in an un-Islamic manner ourselves. For example, we should not co-operate in dishonesty, or malice, or cruelty, or back biting, or neglect of those in our charge. Sometimes it is necessary to consider the well known hadith - 'If you see evil, you must try to stop it by your hands; if you cannot do that, then at least speak out against it; and if you cannot do that, then at the very least do not accept it in your heart but that is the weakest position for a person of faith.' (Muslim 70).

Assertiveness Training: anger involves expressing feelings, thoughts, and beliefs in a harmful and disrespectful way. Passivity or non assertiveness involves failing to express feelings, thoughts, and beliefs or expressing them in an apologetic manner that others can easily disregard. Assertiveness involves standing up for your rights and expressing feelings, thoughts, and beliefs in direct, honest, and appropriate ways that do not violate the rights of others or show disrespect. LADDER describes a six-stage process for handling problems in an assertive way. These are:

L –Look at your rights and what you want

A –Arrange a meeting with the other person to discuss the situation

D –Define the problem specifically

D –Describe your feelings so that the other person fully understands how you feel about the situation

E –Express what you want clearly and concisely

R –Reinforce the other person by explaining the mutual benefits of adopting the site of action you are suggesting.

When Prophet Muhammad (PBUH) became angry due to someone's incorrect actions or their words, he never expressed it with his hand and used only mild words. In fact those that did not know him well did not even suspect that he was angry.

Better communication: The people who over express their anger need to learn better communication. An angry man can be abusive and say hatred words to others which can complex the situation. So they must learn to use appropriate words and tone to express their complains. The irrational and hurtful words and behaviour resulting from anger are why the Prophet (peace and blessings be upon him) advised a man who had come to ask him for advice saying, "Don't get angry"; when the man repeated the same question three times, the Prophet repeated his answer three times. What the Prophet meant was that we are not to allow ourselves to be carried away by our

anger so that we do or say things that are either unIslamic, hurtful and/or undesirable; Effective communication is only possible when both the speaker and listener take care to allow each other the time to speak, and the time to listen.

When someone critiques you, do not react negatively. The Prophet (PBUH) is reported to have said: "Whoever can guarantee (the chastity of) what is between his two jaw-bones and what is between his two legs (i.e., his tongue and his private parts), I guarantee Paradise for him." (Reported by Al-Bukhari). Therefore, do not launch into a diatribe against the other person. Instead, listen to the meaning behind the words. Getting angry will put an immediate end any meaningful discussion. Make it a point of allowing the person to finish what he/she is saying. If you are not clear about the meaning the other person is trying to convey. Ask polite and courteous questions to clarify any misunderstanding, and then formulate your answer. Please note that in some situations, it may be better to request more time before providing a hasty answer. Umar (r) used to consider any positive criticism he received as being equal to a treasure that he was being given; the reason is that such criticism would allow him to improve. He did this in spite of his notoriously quick temper!

Communication Skills: Focus on your own feelings and experience through using non-blaming "I" statements.

· When talking about the other person, focus on specific behaviours, not character (avoid character judgements).

· Make specific requests, rather than vague ones, i.e "I want you to stop putting my ideas down in front of other people," as opposed to "I want you to be less critical."

Homework assignment: Anger Diary, Ask the client to practice assertiveness or communication skills in an angry situation.

Session 10 & 11: Rehearsal of the Training

Session Aims:

- Reinforce need to turn new behaviours into habit (practice!)
- practice the skills what they have learned.

Agenda:

- Review the anger diaries and discuss the intensity of anger.

- Discuss the client that how anger intensity decreased with passage of time.
- Review all the techniques they have learnt in previous weeks.
- Narrate the stories and role play (see Appendix P) to practice the learnt techniques during session.

Narrate the story and ask the following questions:

What are the desires or need of the character?

What was his faulty interpretation?

What were his behavioural options?

What did he do?

What were the consequences of his behaviour?

Was it healthy or appropriate?

How would you behave if you would be in his place?

Draw the anger model and describe where the character of the story did wrong and how it would be replaced to avoid the faulty thinking, and to manage the anger.

Session 12: Post Assessment

Session Aims:

- Client will review his/her anger control plans, rate the treatment components for their usefulness and familiarity.
- Assessment on Novaco Anger Inventory, and Anger Self Report Questionnaire

Agenda:

Ask questions like

- What have you learned about anger management?
- List anger management strategies on your anger control plan. How can you use these strategies to better manage your anger?
- In what ways can you continue to improve your anger management skills? Are there specific areas that need improvement?
- Ask the clients to be committed to practice the learned techniques in daily life to manage their anger.
- A certificate of congratulation can be provided to clients to encourage them.

*Source

Beekum, R. (2011). Islam and Anger Management: Strategies to keep Anger at Bay. Retrieved from http://theislamicworkplace.com/2008/01/10/anger-management-in-islam-part-1-strategies- to-keep-anger-at-bay

Hamdan, A. (2008). Cognitive Restructuring: an Islamic perspective. *Journal of Muslim Mental Health*, 3,99–116.

Haque, A. (2004a). Religion and Mental Health: The Case of American Muslim. *Journal of Religion and Health*, 43(1), 45-50.

Khalily, M. T. (2013). Uncontrolled anger and its Management in light of Sunnah. *Journal of Insight*, 3(2), 33-66.

Appendix G

Consent Form

I belong to Department of Psychology, International Islamic University, Islamabad. Psychology department is doing a tremendous research work in understanding human behaviour and providing suitable interventions from problematic behaviours. Current study is also an effort to contribute in to develop an indigenous model of anger management to control the problematic anger. Researcher wants to know about how much you get angry in a particular situation and how you control your anger. Further it will be provided the anger management plan which will be comprised of 12 session to manage your anger.

It assured you that all information taken from you will be remained confidential and will be used only and purely for research purpose.

Thanks for your cooperation.

Appendix H

Feelings Identification Chart

Event	Physical cues	Cognitive cues/thoughts	Emotional cues	Behaviour	Intensity (1-10)

Appendix I

Anger Diary

Day	How many times did you get angry	What was the situation	On a scale of 1-10 what was the angriest you got?	What were three (3) physical, emotional or mental symptoms of your anger during the angriest event?	What did you do when you were the angriest? (Actions)
Example	2	*1. Partner forgot to pay the power bill 2. Stuck in traffic*	7	*1. Raised voice 2. Tight shoulders 3. Feeling life is unfair*	*Yelled at my partner*
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

CASE # _____ SESSION: _____ WEEK: _____ Date: _____

Source: www.mensline.org.au

Appendix J

Revise the Strategy

Situation:

_____

_____

Expectations:

_____

_____

Interpretation:

_____

_____

Feelings:

_____

_____

Strategy (what you did): _____

_____

Consequences of situation:

1. Feelings toward self_____
2. Effect on other (how they felt)_____
3. Response of other (how they acted in response to your behavior)

_____

Revising Your Strategy:

If you found that the consequences of your behavior were not positive, there are several ways to intervene in your anger model so that you can adopt more "healthy" expressions of anger. Try focusing on your needs and / or revising your interpretation.

Express your desires:

(focus on your own feelings & needs, avoid blaming statements, make specific requests)

New Behaviour:

_____

_____

_____

_____

Consequences of Behavior:

1. Feelings toward self_____
2. Effect on other (how they felt)_____
3. Response of other (how they acted in response to your behavior)_____

Appendix K

Errors in Thinking Handout

1. **Dichotomous thinking.** We think that something has to be "all or nothing," and see things in black and white: either it is exactly the way we want it to be, or else it is a failure. Example: "Unless I get an A on the exam, I am a failure."

2. **Selective abstraction.** We tend to selectively pick out facts or ideas from an event that support our beliefs. Example: A ballplayer focuses on the one error he made (despite many successes) during a game to draw negative conclusions about himself and to feel depressed.

3. **Mind Reading.** Mind reading refers to the assumption that we know what another person thinks about us. Example: "She didn't want to go shopping with me, so she must hate me."

4. **Negative Prediction**: We expect the worst, even if there's no evidence to support this expectation. Example: A student expects she's failed an exam, although she's never had trouble passing exams in the past.

5. **Catastrophizing.** We take one event about which we are concerned, and exaggerate the feared outcome. Example: "I know if I'm late he will hate me forever."

6. **Overgeneralizing.** We make an all-encompassing rule, based on a few negative events. Example: "Because I didn't do well on my first Algebra exam, I can't do Math at all."

7. **Magnification and Minimization.** We magnify the bad, and minimize the good aspects of a situation. Example: Despite the many times a husband has told his wife she's beautiful, the one time he suggests she wear a different color, she believes he thinks she's ugly.

8. **Personalization.** We take an event that is unrelated to us and make ourselves the center of

its meaning. Example: An acquaintance walks by, not saying hello. He is actually distracted about something else, but I assume he doesn't like me or is mad at me for some reason.

(Source: Anger The Clearinghouse – www.utexas.edu/student/cmhc/clearinghouse)

Appendix L

A-B-C-D Model

A = Activating Situation or Event

B = Belief System

- What you tell yourself about the event (your self-talk)

Your beliefs and expectations of others

C = Consequence

how did you behave or how did you act in that situation?

D = Dispute

Examine your beliefs and expectations
Are they realistic or rational?

Is this according to teaching of prophet Muhammad (PBUH)?

Is this culturally acceptable?

Appendix M

Anger Styles Handout

The Under-expresser of Anger…

· Seeks emotional distance or physical space when stress is high.

· Considers self to be self-reliant and private person—more "do-it-yourselfer" than help-seeker.

· Has difficulty showing needy, vulnerable, and dependent sides.

· Receives such labels as "emotionally unavailable," "withholding," "unable to deal with feelings" from significant others.

· Manages anxiety in personal relationships by intensifying work-related projects.

· May cut off a relationship entirely when things get intense, rather than hanging in and working it out.

· Opens up most freely when (s)he is not pushed or pursued.

The Over-expresser of Anger…

· Handles anxiety by seeking greater togetherness in a relationship.

· Places high value on talking things out and expressing feelings, and believes that others should do the same.

· Feels rejected and takes it personally when someone close wants more time and space alone or away from the relationship.

· Tends to pursue harder and then coldly withdraw when an important person seeks distance.

· May negatively label self as "too dependent" or "too demanding" in relationship.

· Tends to criticize partner as someone who can't handle feelings or tolerate closeness.

*(*Source: Goldhor Lerner, H. (1985). The Dance of Anger: A Woman's Guide to Changing the Patterns of Intimate Relationships. New York: Harper & Row Publishers.)*

Appendix N

Example of Assertiveness technique without getting angry

Suppose it is a case of your son/husband/anyone continuously doing something that really makes you unhappy such as a teenager bringing in a tribe of noisy and untidy friends without asking permission, and – even worse - leaving you with all the debris to clear up.

Stage One - State the problem clearly and specifically, making sure they take on board what the problem actually is.

'Dear Son, I noticed on Thursday that you had your friends in the living room again, and when they went you walked off and left me all their debris to clear up. This has happened six times this month at least.'

Stage Two - Make it clear how what they are doing affects you. Express it in terms of 'I', and not 'You'. That way, they can't argue with it.

'This meant that I had to stay out of the way and I felt like an intruder in my own house, particularly when they smoked and I don't like the smell of it. I felt angry because you had not told me they were coming, let alone asked me, and just assumed I would move out of your way and would also clear up after them.'

Stage Three - State clearly what you want.

'I would prefer it in future if you would let me know in advance, and check with me if it is convenient for you all to use our family space. I don't mind sitting in my room on odd occasions, so long as I know about it, or you ask very nicely. If not, I'd like you to entertain in your room, please, and in any case, to be responsible for clearing up.'

Stage Four - State what you hope the results of all this co-operation will be. You trust them to understand your very reasonable point of view, and to respond responsibly and make the right decisions.

Stage Five What if they don't take you seriously, and just ignore it all? Don't let the matter drop; persevere, stand your ground. Don't get angry or upset, but be firm. Remember that to

many spouses or teenagers this is a game. They expect to win, but usually give in and accept with good grace eventually so long as they can see you are in the right.

Stage Six - If you still fail, take direct action. For example, you could go and sit in your teenager's room, open their 'secrets' cupboard or fiddle about with some of the things they cherish, and leave some of your own mess there. That would most likely make the point. Or if it was a case of their playing very loud music, go ahead and play some of your own music very loudly at the same time. Whatever. Just make the point.

The real point is not to wade in to the attack (which you will almost certainly lose) with cries of 'You ALWAYS do.....' or 'You NEVER do.....' Switch it all round so that what you are saying is that 'Whenever you do this, I feel that.' They cannot tell you that you do *not* feel that way. Then, if they know they are upsetting you and still continue to do so, the burden of guilt falls upon them, and they must take the responsibility of the results of making you so unhappy.

I would like to end with a prayer adapted from one that is well-known in the Christian world from which I came, and which is very helpful.

'O our dear Lord, please give me the power to change what I can change, to accept patiently that which I cannot change, and the grace to know the difference. Amin.'

Appendix P

Sample Stories

Room mates in hostel

Saeed came home on a Friday afternoon, tired and hungry from classes, and looking forward to relaxing in front of his favourite TV show with some dinner. His stomach growling, he opened the room refrigerator, only to find that Hamza, his room-mate, had eaten all of the food he'd bought the day before. Saeed was furious! He thought to himself, "This is just another example of how Hamza has no respect for me at all. He thinks his needs have priority over mine. He acts like this is his room and all his stuff, and I have no rights at all!"

Saeed was so consumed with his anger toward Hamza that he couldn't even enjoy his TV show. He resolved that when Hamza will came home, he would really give him a piece of his mind. When hamza finally came home, though, Saeed lost his nerve. Instead of confronting his friend, he blatantly ignored him. Hamza knew, from Saeed's sullen mood and glares that something was up. He finally asked him what was bothering him so much. Saeed just grumbled something unintelligible and retreated to his room. He picked up the phone and called Majid, who was a common friend of both, with Hamza's lack of consideration and respect.

After venting, he did feel a little relief. However, he also felt a bit immature and guilty for talking behind his friend's back. Furthermore, he felt a little cowardly for not confronting him face-to-face. For the next couple weeks, Saeed was cool and distant toward hamza, throwing in the occasional snide comment about his lack of manners. Unaware of the source of Saeed's bad mood, hamza figured he was just being mean for no reason and he, in turn, began to resent Saeed.

Two weeks after the "missing food" incident, Saeed was getting ready for the annual dinner of the department. He wanted to wear his brand-new sweater, but was unable to find it anywhere. Later that night, he saw hamza out at a party, decked out handsomely in that very same sweater…

(Source: Anger The Clearing house – www.utexas.edu/student/cmhc/clearinghouse)

Husband and wife's confrontation

Wife says…

The problem is all with my husband, First of all, he's a workaholic. He becomes a stranger to his own family! He expects me to run the kids and the household all myself, and then when something goes wrong, he tells me I'm crazy for reacting so emotionally!

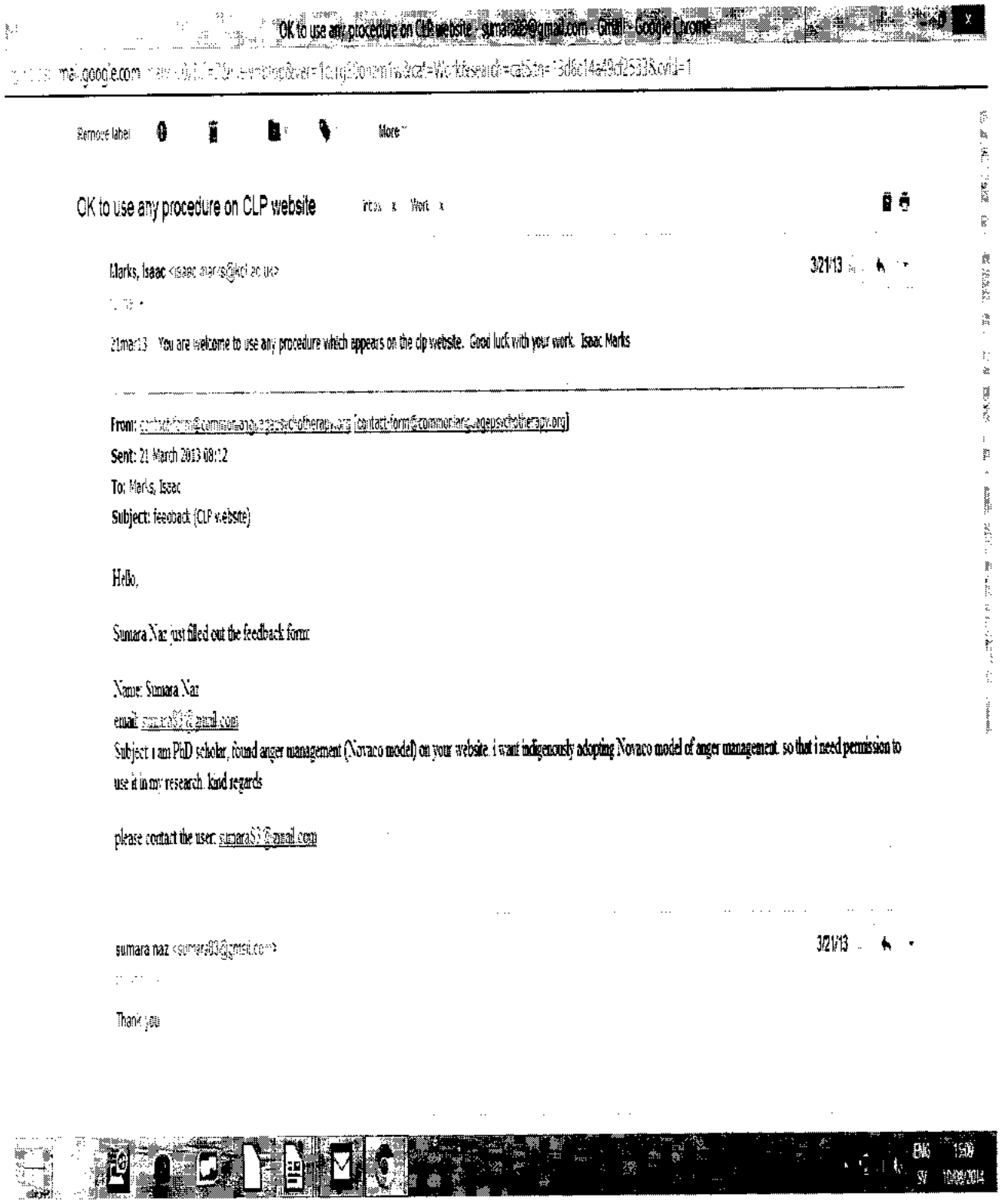
The fact is, he neglects the kids and he neglects me. And then when he decides he wants to be a father, he just waltzes in and takes over like he's the only one in charge—like when he went out and bought our daughter this excessive gift without even consulting me! He always accuses me of overreacting to things. He's never available and he never expresses his feelings over things that legitimately should bother him. It's completely impossible to confront him. He never wants to discuss anything, just wants to be left alone. It's like he doesn't even know how to fight! Whenever I raise an issue, he'd rather read a book or watch sports.

Husband says…

The problem is, my wife is not supportive enough. She's always on my back. I walk in the door at six o'clock, and I'm tired and wanting some peace and quiet. And she's rattling on about the kids' problems or her problems, or just complaining in general. I can't sit down for five minutes without her needing to talk to me about some earth shattering matter—like the broken garbage disposal. She's over-reactive and overemotional. She creates problems that don't even exist. She worries too much about the kids too. I guess I need some space.

Appendix R

Permission to use scales



OK to use any procedure on CLP website - sumara86@gmail.com - Gmail - Google Chrome

mail.google.com

Remove label More

OK to use any procedure on CLP website

Marks, Isaac <isaac.marks@kcl.ac.uk> 3/21/13

21mar13 You are welcome to use any procedure which appears on the clp website. Good luck with your work. Isaac Marks

From: [redacted] (contact-form@commoninterest.net)
Sent: 21 March 2013 08:12
To: Marks, Isaac
Subject: feedback (CLP website)

Hello,

Sumara Naz just filled out the feedback form:

Name: Sumara Naz
email: [redacted]
Subject: i am PhD scholar, found anger management (Novaco model) on your website. i want indigenously adopting Novaco model of anger management. so that i need permission to use it in my research. kind regards

please contact the user: [redacted]

sumara naz <[redacted]> 3/21/13

Thank you

Remove label More

Permission to use Anger self Report Questionnaire

sumara naz 3/25/13

Hello professor Walkey, I am Sumara Naz from Pakistan, student of psychology...

Frank Walkey <...> 3/25/13

to me

Hello Sumara Naz,

You are very welcome to translate and to use the Anger Self Report Questionnaire.

As it is many years since I worked with the questionnaire, I am unable to answer your questions immediately, but I will look back through my materials and see if I can find the answers. If you do not hear from me in a few weeks, feel free to send me a reminder about this.

Good luck with your project.

sumara naz <sumara86@gmail.com> 3/26/13

to Frank

Thank you professor Walky

Appendix S

Permission letters from hospitals to collect data

INTERNATIONAL ISLAMIC UNIVERSITY

ISLAMABAD – PAKISTAN

FACULTY OF SOCIAL SCIENCES

Department of Psychology

P.O. Box No. 1243 Telegram ALJAMIA Telex.54068 IIU PK, Tel: 9258008, Fax No.9019338

TO WHOM IT MAY CONCERN

It is certified that Ms. Samara Naz, Registration No. 7-FSS/PHDPSY/F10 is student of PhD. Psychology at Department of Psychology (Female Campus), International Islamic University Islamabad. Her course work has been completed and currently her research work is in progress. Kindly allow her to collect Data for her research work from your prestigious Institute.

Dr. Seema Gul
Acting Chairperson,
Deptt. Of Psychology,
Female Campus, IIUI.

DR. SEEMA GUL
Acting Chairperson
Department of Psychology
International Islamic University Islamabad.

To, 1.3

The Commandant.
POF Hospital, your comments
Wah Cantt. HOD Psychiatry

POFs HOSP WAH	
Comdt	
Dy Comdt.	
Head Clk	
Date	6/4
Dy No	3054
Job	Adm

Subject: Permission for internship in Psychiatry ward

Sir,

It is stated that I am doing PhD in Psychology from International Islamic University. To fulfill the requirement of degree I have to do internship in Psychiatry ward. I want to do it in your prestigious institute. I will be grateful if you allow me for "two months". Reference letter from university is attached with application.

Your Truly,
Sumara Naz

SUMARA NAZ
PhD Scholar (Psychology)
International Islamic University, Islamabad
Dated: 5-4-2013.

only data collection may be allowed as requested by chairperson Psychology IIU Isl.
(FARGAM) 10/4/13
M. Daud

The head of psychiatry department,

Capital Development Authority (CDA) Hospital,

Islamabad.

Subject: Permission to collect data from psychiatry department.

Sir,

It is stated that I am doing PhD in psychology from International Islamic University, Islamabad. My research topic is "Anger management in individuals having psychiatric problems" I have to take those patients who have psychological problem with prominent feature of anger. This anger management plan will be consisted of follow up sessions that will be completed in 6 weeks. I will be grateful if you allow me to collect data from your prestigious institute.

Reference letter from university is attached with the application.

Yours Truly

Sumara Naz

PhD scholar, psychology Department,

International Islamic University,

Islamabad.

Dated: 18-4-2013

Dir (Admn.) ICT

Allowed

Dr. Ahmed

MUHAMMAD FAYYAZ LODHI
Director Administration
Capital Hospital CDA
Islamabad