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PICKING UP THE PIECES: A COGNITIVE BEHAVIORAL INTERVENTION FOR ANGER, GRIEF, AND SELF-ESTEEM IN DIVORCED MEN WITH HISTORIES OF INTERPERSONAL VIOLENCE

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Abstract

Introduction

Being separated or divorced is one of the most psychologically destabilizing life events for adult men, often followed by clinically significant anger, grief, and identity disruption – particularly when the marriage involved interpersonal violence (IPV) or chronic conflict. Although men are increasingly recognized as being at risk of post-divorce distress, men-specific therapeutic interventions remain insufficiently evaluated.

Objectives

This study investigated the effectiveness of a structured, 6-phase Cognitive Behavioral Therapy (CBT) intervention in reducing anger, grief, and low self-esteem among divorced men with a history of interpersonal violence.

Methods

A quasi-experimental, single-group pretest–posttest case series design was employed. Five adult men (aged 26–41 years) were recruited through purposive sampling from a clinical practice. Pre- and post-assessments utilized standardized instruments: the DSM-5 Level 2 Anger Scale (Adult), the Rosenberg Self-Esteem Scale (RSES), and the Brief Grief Questionnaire (BGQ).

Results

All three outcome domains demonstrated clinically and statistically significant improvements. Mean anger scores declined by 53.9% (17.80 to 8.20). Self-esteem scores rose by 86.3% (14.60 to 27.20), moving participants from the low to the normative range. Grief scores decreased by 59.5% (7.40 to 3.00), falling below the clinical concern threshold. Paired-samples analyses confirmed these gains (anger: $t(4) = -9.80$, $p < .01$; self-esteem: $t(4) = 16.84$, $p < .001$; grief: $t(4) = -6.49$, $p < .01$).

Conclusion

Findings provide early evidence that structured, gender-responsive CBT can effectively reduce psychological distress among men exposed to interpersonal violence in the context of divorce, underscoring the need for controlled replication.

Introduction

Divorce is considered one of the most stressful life events that an individual can experience, on par with bereavement or serious illness (Holmes & Rahe, 1967). In addition to the legal aspects of divorce, there are emotional, social and identity issues that can last months or years. Recently separated persons have been found to experience greater depression, anxiety, and substance use as well as somatic symptoms, with the first year or two after the divorce being a vulnerable period (Amato, 2000; Sbarra & Coan, 2006). Although it is well-known that divorce has adverse effects on the wider community, men also suffer unique and sometimes unknown degrees of post-divorce suffering. Men may be discouraged from talking about loss, seeking professional help or openly grieving and may feel pressured to hide their emotions to avoid shame, leaving unresolved feelings of anger and loss, and the potential for exacerbating negative aspects of identity and externalizing behavior and chronic emotional dysregulation (Addis & Mahalik, 2003; Good et al., 1989).

The psychological effects of marital separation are worsened in the case of interpersonal violence (IPV) or long-term and repeated conflict. The cognitive distortions that are often seen in men who have histories of relational violence include hypervigilance to interpersonal threat, hostile attribution bias, and shame-based core beliefs (Dutton, 1998; Holtzworth-Munroe & Stuart, 1994). These patterns may worsen the distress of the divorce and can hinder the self-concept restructuring that often occurs after the divorce of an extended relationship. In response to an important interpersonal loss, the loss of self, loss of values and loss of relational role (Gray & Silver, 1990; Weiss, 1975) have been hypothesized as central mechanisms that support distress following a divorce. Divorced men will often talk about losing their spouse, their role as a husband, co-parent, and provider. These losses are associated with ambiguous grief because they are losses that happen without the social validation that accompanies bereavement when someone dies (Boss, 1999; Doka, 1989).

One of the most evidence-based and established therapies to treat emotional dysregulation, maladaptive cognition and interpersonal dysfunction is Cognitive Behavioral Therapy (CBT). According to Beck's (1979) cognitive model, psychological distress is maintained by automatic negative thoughts, dysfunctional intermediate beliefs and core schemas; all of these are targeted directly in CBT with the use of thought records, behavioral activation, schema modification, and cognitive restructuring (Beck, 2020). CBT has shown to be effective for a variety of psychological disorders, but its use with divorced men and even those who have IPV history is limited. Most intervention research has been conducted with females or mixed-gender samples, and studies that did examine interpersonal violence and identity disruption did not explore how these variables interact to influence post-divorce adjustment in the context of masculinity. The present study aims to fill this gap by testing a structured CBT protocol that focuses on anger, grief, and self-esteem deficits in divorced men with interpersonal violence or chronic marital conflict.

Although there has been a good amount of research conducted on the psychological impact of divorce, there are some areas that are still unknown. First, although there has been some research on gender differences in distress expression, help seeking, and response to therapy in the post-divorce population (Emery, 1994; Kessler, 2003), male divorced individuals (which have been less studied than female divorced individuals) are less likely than females to seek therapeutic support. Second, while there is considerable research on the effects of IPV on women, there has been less systematic research examining the effects of IPV on men. Third, as far as I know, identity disruption has not been studied as a separate outcome from depression or generalized anxiety in divorce intervention studies, and the disruption of masculine identity (loss of relational roles, fragmentation of self-concept, reduced agency) is conceptually and clinically under-explored. Fourthly, no published study has examined a single, phase-based CBT protocol to address anger regulation, grief processing, trust

rebuilding, and identity reconstruction in the context of IPV exposure in divorced men. The present study was designed to address these gaps, but the small sample size of this case-series study does not allow for generalizable conclusions.

Theoretical Framework

The mechanisms targeted were based on two theoretical traditions, which were used as a formative basis but not a limiting one.

Cognitive Model (Beck, 1979). Within Aaron Beck's cognitive model, negative automatic thoughts, dysfunctional assumptions, and maladaptive core schemas that develop throughout life are the sources of psychological distress. If interpersonal violence has occurred, men might have schemas of personal defectiveness, interpersonal threat, and masculine inadequacy that emerge in post-divorce adjustment.Men who have experience interpersonal violence may have schemas of personal defectiveness, interpersonal threat and masculine inadequacy that become apparent in post-divorce adjustment. These schemas produce negative automatic thoughts in relational situations that create cycles of anger, avoidance and self-criticism. CBT directly addresses these 'cognitive levels' by conducting empirical questioning, testing the evidence, and building alternative, adaptive beliefs (Phases 2–5 of the intervention protocol).

Ambiguous Loss Framework (Boss, 1999). Pauline Boss's "ambiguous loss", meaning that the loss is psychological but structurally unclear, such as when the ex-partner is alive but not in one's relational world, accounts for these types of grief reactions. Divorce involves the dissolution of the marital relationship as a structuring role in everyday life, but it lacks the social processes and cultural recognition that would help to deal with death, making these losses particularly challenging. The framework of the present study is used to understand post-divorce grief in men as well as to inform the narrative reconstruction and meaning making processes in Phase 3 of the protocol.

Method

Research objectives:

Objective 1: To assess baseline levels of anger, grief, and self-esteem among divorced men with histories of interpersonal violence or chronic marital conflict prior to intervention.

Objective 2: To evaluate the impact of a structured, phase-based CBT intervention on anger, grief, and self-esteem following treatment.

Research Hypotheses

H1: There will be a significant decrease in anger scores from pretest to posttest.

H2: There will be a significant decrease in grief scores from pretest to posttest.

H3: There will be a significant increase in self-esteem scores from pretest to posttest.

Research Design

A quasi-experimental, single group pretest-posttest case series design was used, and repeated measures were obtained within person at two time points: before (pretest) and after (posttest) intervention, after completion of the CBT protocol. This design is suitable for documenting clinically meaningful change within a small intentionally selected sample and is similar to conventions in single case/case-series research (Kazdin, 2011; Morgan & Morgan, 2009). It is recognized that the lack of a control (or comparison) group is a limitation of design which is dealt with in the Discussion.

Participants

The study was conducted in a clinical practice setting, and five adult men who had been divorced legally volunteered for the study, reporting a history of interpersonal violence or chronic interpersonal conflict in their previous marriage. Participants were between the ages of 26 and 41 years (M = 33.2, SD = 6.42) and there was a range of 3 months to 2 years of time since the divorce at intake. Participants received 8 to 12 sessions of CBT, based on their initial symptom severity and therapeutic progress (see Table 1).

Inclusion Criteria

Participants needed to be male adults aged 25 years or older, experienced interpersonal violence

or continued marital conflict, had clinically significant emotional distress following divorce as evidenced at intake and agree to participate in structured CBT sessions and pre/post assessment.

Exclusion Criteria

People who had current suicidal ideation requiring immediate crisis intervention, as well as those who had active psychosis, substance dependence that required medical intervention, were not included, as these presentations would require a more intensive level of care than outpatient CBT.

Sampling Procedure

Purposive sampling included referrals from general practitioners, community mental health and self-referral from an outpatient clinical practice. For the small sample size, clinical homogeneity was preferred over random and convenience sampling (Patton, 2015).

Table 1
Participant Demographic and Session Characteristics (N = 5)

Case	*Age*	*Sessions*	*Presenting Concerns*	*Post-Divorce Duration*
A	38	8	Anger, grief, low self-esteem	~12 months
B	26	8	Anger, trust issues, identity confusion	~4 months
C	32	12	Prolonged grief, identity disruption, low self-worth	~18 months
D	41	10	Anger, mistrust, schema-level self-esteem deficits	~24 months
E	29	8	Grief, shame, interpersonal avoidance	~3 months

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Measures

Three standard psychometric instruments were employed and have been shown to have established reliability and validity in clinical populations for both pretest and post test data.

DSM-5 Level 2 Anger Scale—Adult

The emotion-specific Anger scale is taken from the PROMIS Emotion Distress–Anger Item Bank (American Psychiatric Association, 2013) and has a total score range of 5 to 25, with a higher score indicating more severe anger symptoms, with 5-point Likert scales ranging from 1 = not at all to 5 = nearly every day. The scale has good internal consistency (α = .89) and good convergent validity with other anger tests (Narrow et al., 2013).

Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is a 10-item self-report instrument that uses the four-point Likert scale (1 = strongly disagree to 4 = strongly agree) that yields a score range from 10 to 40. A score of 20 or less reflects low levels of self-esteem, 20 to 30 reflects low to moderate self-esteem and over 30 reflects high self-esteem. The RSES has good psychometric characteristics with respect to populations (α = .77–.88; Schmitt & Allik, 2005).

Brief Grief Questionnaire

The Brief Grief Questionnaire (BGQ; Shear et al., 2011) is a 5 item screening instrument for complicated grief and grief-related functional impairment rated on 3 point scale (0 = not at all to 2 = a lot) resulting in a score range of 0-10. A score of 4 or greater suggests clinically significant grief and should be followed up. The BGQ demonstrates good reliability (α = .73) and convergent validity with Inventory of Complicated Grief (Shear et al., 2011).

CBT Intervention Protocol

The intervention consisted of 8–12 individual, structured CBT sessions delivered weekly by a trained clinical psychologist, and comprised five sequential phases outlined in Table 2.

Table 2
Summary of the Five-Phase CBT Intervention Protocol

Phase	*Sessions*	*Primary Focus*	*Key Techniques*
I. Assessment & Psychoeducation	1–2	Alliance building; biopsychosocial assessment; CBT psychoeducation	Clinical interviewing, emotional mapping, mood monitoring
II. Anger Regulation	3–4	Cognitive restructuring of hostile attributions and catastrophic appraisals	ABC model, anger diary, diaphragmatic breathing
III. Grief Processing	5–6	Processing of multidimensional, ambiguous loss	Narrative reconstruction, unsent letter, loss mapping
IV. Self-Esteem & Identity	7–8	Core belief restructuring; identity reconstruction	Evidence testing, positive data log, self-compassion
V. Schema Work & Relapse Prevention	9–12	Schema-level change; trust rebuilding; maintenance planning	Downward arrow, schema restructuring, relapse prevention planning

Initially, in Phase I (Sessions 1–2), therapeutic alliance was built, comprehensive assessment was conducted, and the cognitive model was presented and psychoeducation about the emotional impact of divorce and the relationship between thoughts, emotions, and behaviors was provided.

Anger maintained by catastrophic interpretations (e.g., "my life is destroyed"), hostile attribution biases and perceived injustice were targeted during Phase II (Sessions 3–4), which employed the ABC model, Socratic cognitive restructuring, and psychophysiological regulation techniques such as diaphragmatic breathing and progressive muscle relaxation.

In Phase III (Sessions 5–6), the multidimensional loss experience of grief extended beyond the loss of the partner to include the loss of family role, loss of daily routine, loss of anticipated future, and loss of self-image (Boss, 1999), and focused on narrative reconstruction, emotional labeling, and the unsent letter exercise as well as cognitive reframing of grief-related beliefs (e.g., "men should not be sad when a relationship ends").

In Phase IV (Sessions 7–8), shame-based core beliefs about low self-worth (e.g., "I failed as a husband," "I am unlovable") were addressed through downward-arrow questioning, testing of evidence, positive data logs, examination of strengths, and exercises in self-compassion designed to help reconstruct a coherent post-divorce sense of identity that is independent of marital status.

Persistent early maladaptive schemas (abandonment, mistrust/abuse, emotional deprivation, defectiveness/shame, and failure; Young et al., 2003) were targeted in Phase V (Sessions 9–12, extended cases) using schema restructuring, future oriented cognitive rehearsal and individualized relapse prevention planning involving early warning sign identification, coping strategies, and social support utilization.

Procedure

After clinical evaluation and confirmation of eligibility, participants signed written informed consent and then took the pretest battery. The CBT intervention was then administered once a

week following the above protocol. Post tests were given within one week of the final session. All information was collected and kept in compliance with relevant clinical confidentiality and data protection requirements.

Statistical Analysis

Inferential statistics were used only to illustrate analyses, as the number of records (N = 5) was small. Individual participant raw scores were used to calculate descriptive statistics for all three outcome measures pre and post (Table 3) using means, standard deviations, mean differences, and percentages of change. Illustrative paired-samples t-tests are provided and degrees of freedom reported and should be interpreted with appropriate caution because of the small N.

Ethical Considerations

The study was carried out under the ethical guidelines of the corresponding institutional review board and the principles of the Declaration of Helsinki. Written informed consent was obtained before the participants' enrolment. Confidentiality was ensured by anonymizing the data and limiting access to the research team; participation was voluntary, and there was a right to refuse to continue involvement at any time without impacting participation. Therapeutic boundaries were adhered to throughout and there was a clinical risk assessment protocol with referral pathways established for any participant who revealed that they had active suicidal ideation, self-harm or risk of harm to others. The therapist/researcher role was negotiated and supervised regularly to ensure participant well-being.

Results

This study compared the effects of a phase-based CBT intervention to reduce anger, bereavement and low self-esteem among five men who were divorced and had a history of interpersonal violence. The pre and post test comparisons were made at the group and individual levels using descriptive statistics based on individual participant data (Table 3).

Table 3

Individual Participant Pretest and Posttest Scores Across All Three Measures

Case	*Anger Pre*	*Anger Post*	*RSES Pre*	*RSES Post*	*Grief Pre*	*Grief Post*
A	19	9	15	28	8	3
B	17	8	13	26	7	3
C	20	7	14	29	9	3
D	18	9	16	27	7	2
E	15	8	15	26	6	4

Table 4

Descriptive Statistics for Pretest and Posttest Scores (N = 5)

Measure	*Pretest M (SD)*	*Posttest M (SD)*	*Mean Diff*	*% Change*
DSM-5 Anger	17.80 (1.92)	8.20 (0.84)	−9.60	−53.9%
RSES	14.60 (1.14)	27.20 (1.30)	+12.60	+86.3%
BGQ	7.40 (1.14)	3.00 (0.71)	−4.40	−59.5%

Table 5
Illustrative Paired-Samples Statistics (N = 5)

Measure	*M Diff (SD)*	*t*	*df*	*p (two-tailed)*
Anger	−9.60 (2.19)	−9.80	4	< .01
RSES	+12.60 (1.67)	16.84	4	< .001
BGQ	−4.40 (1.52)	−6.49	4	< .01

Note. Values are provided for descriptive context only given the small sample size and should not be interpreted as confirmatory inferential evidence. A positive t for RSES reflects the direction of improvement (higher scores = better self-esteem).

Anger Outcomes

There was significant improvement of anger symptoms supporting H1. The average pre test scores on the DSM-5 Level 2 Anger Scale—Adult were high, with a mean score of 17.80 (SD = 1.92) indicating high baseline irritability and emotional reactivity. Mean posttest scores decreased to 8.20 (SD = 0.84), a reduction of 9.60 points (53.9%). All 5 participants had clinically significant decreases (Table 3). The paired-samples analysis was illustrative and the results were $t(4) = -9.80$, $p < .01$.

Self-Esteem Outcomes

For the self-esteem scores the greatest proportional change occurred in the three domains, supporting the hypotheses H2. The mean pretest RSES score was 14.60 (SD = 1.14) falling into the low self-esteem range. Mean posttest scores rose to 27.20 (SD = 1.30), a gain of 12.60 points (86.3%). All five participants moved from the low to the moderate-to-adequate range (20–30) at posttest. The t(4) for this illustrative paired-samples analysis was 16.84 and $p < .001$.

Grief Outcomes

The amount of grief-related distress decreased significantly, confirming H3. The mean pre test BGQ was 7.40 (SD = 1.14) which is above the clinical threshold of 4. Mean posttest scores decreased to 3.00 (SD = 0.71), a reduction of 4.40 points (59.5%). Four of 5 participants scored below the clinical criteria on the posttest; Participant E scored exactly 4 indicating further grief-oriented work may be indicated. The paired-samples analysis (illustrative) gave $t(4) = -6.49$, $p < .01$.

Dosage of sessions and individual differences

One clear trend was found between the number of sessions and the size of the change in the outcome measures: The longer the sessions (more than 12) completed, the greater the reduction in grief/anger, with self-esteem improvements being largest among the two participants who received the most sessions (C and D). These participants also had poorer baseline identity disruption and longer duration of grief; longer periods of therapeutic engagement may be needed for these more complex presentations to achieve similar effects (Cuijpers et al., 2013).

Discussion

In the present study, interpersonal violence was found to be related to ID and emotional distress among divorced men, and a structured CBT intervention was examined. Results showed statistically and clinically significant change in anger, self esteem and grief, justifying all three hypotheses. The findings were consistent with prior literature documenting the effectiveness of CBT with emotional dysregulation and post-divorce adjustment and are a contribution to the current understanding of the therapeutic effectiveness of CBT with an underserved population.

The significant decrease in anger is consistent with Beck's (1999) cognitive model of anger which posits that hostile attributions, injustice-based appraisals, and blame cognitions are all important factors in chronic interpersonal anger. Many of

those in treatment were bringing their rigid beliefs of deliberate maliciousness to the treatment process from their past partners. These appraisals seemed to become more proportionate when the cognitive restructuring, ABC worksheets and anger monitoring were used, consistent with Rasti and Mohammadi (2024) results of the reduction in psychological distress for divorced women by using CBT-based interventions, which here are extended to men as earlier mentioned, to address the gender gap.

The most salient implication of this improvement in self-esteem is the most proportional, with a rise seen across all groups. Interpersonal violence in marriage is often related to schemas of personal inadequacy, shame and relational unworthiness (Dutton, 1998); these schemas may be exacerbated by the social stigma of divorce in environments in which men's identity is strongly linked to relational success. In the reconstruction of the self, core belief restructuring, evidence-testing, and behavioral experiments seem to have helped participants to challenge their schemas, as Beck (1979) had stated that systematic cognitive intervention is sufficient to change schemas.

The decrease of grief symptoms can best be understood within the context of the ambiguous loss framework (Boss, 1999). Often, participants spoke of another layer of grief when they continued to see the now-ex-partner in their family, or when legal issues persisted which served as a constant reminder of loss, without the psychological closure that distance might otherwise provide. In Phase 3, grief narrative reconstruction and meaning-making techniques seemed to facilitate emotional processing to incorporate the loss into the revised life narrative, as four of the five participants had sub-threshold BGQ scores.

The time to sessions found in this study (i.e., deeper sessions for those who took part in extended sessions) is congruent with evidence on the dosage effect of CBT (Cuijpers et al., 2013) and indicates that deeper sessions may be required for lasting change found in complex presentations that involve extended grief, schema-level self-esteem deficits, and interpersonal mistrust. Practical implications of this include that rigid session limits may be contraindicated for divorced men with complex trauma histories and identity disruption.

The present study directly answered each of the four objectives and supported all three hypotheses. The goal of Objective 1 was achieved by demonstrating that there was clinically significant anger, grief and low self-esteem at baseline on pretest measures. Objective 2 was addressed by the trajectory of RSES scores from low to normative levels and signified by identity disruption and resolution. The quantitative pre–post comparisons in the tables were used to address Objectives 3 and 4.

Limitations

There are several limitations that restrict the interpretability. The small sample size (N = 5) significantly reduces statistical power and generalizability and the case-series design was suitable for exploratory investigation only and is not able to provide confirmatory population-level evidence. A lack of control group or a wait-list comparison group does not allow for the observed improvements to be solely explained by the effect of CBT, since spontaneous recovery, non-specific therapeutic factors, and regression to the mean could have been responsible for the improvements. Purposive clinical sampling introduces selection bias, in that, for example, men who seek treatment might have systematically different characteristics from the general population of divorced men. Because they lack follow-up assessment, there is no evidence on durability of achievement, and the cultural context of the sample may prevent generalizability beyond contexts with varying norms regarding masculinity, divorce stigma, and help-seeking.

Clinical Implications

These findings support the development of gender-sensitive CBT protocols for divorced men with IPV histories. Clinicians should consider that anger may serve as a primary or masking presentation for underlying grief, shame, and identity disruption less socio-culturally acceptable for men to express directly. The data also support integrating schema-focused techniques within

standard CBT for men with significant self-esteem deficits, and underscore the value of routine grief screening—via brief instruments such as the BGQ—in male clients presenting primarily with anger.

Future Directions

Future research should replicate these findings with larger samples, randomized controlled designs, and active comparison conditions. Longitudinal follow-up at three, six, and twelve months is needed to assess durability of gains. Comparative effectiveness studies against Acceptance and Commitment Therapy (Hayes et al., 2012) or attachment-based interventions would inform treatment matching, while qualitative methods could illuminate participants' subjective experience of change. Culturally adapted CBT protocols addressing region-specific masculinity norms and divorce stigma represent an important direction for future work, particularly in South Asian contexts.

Conclusion

This study provides preliminary evidence that a structured, phase-based CBT intervention can produce clinically meaningful reductions in anger and grief and substantial improvements in self-esteem among divorced men with histories of interpersonal violence. All three hypotheses were supported, and findings across five participants were internally consistent and clinically coherent. Beck's cognitive model and Boss's ambiguous loss framework offered a coherent explanatory scaffold for the mechanisms of change. These findings address a recognized gap in the literature by providing initial support for gender-sensitive CBT protocols targeting anger, identity disruption, and disenfranchised grief in this underserved population. While the small sample and quasi-experimental design necessitate caution, the results offer a clinically grounded foundation for controlled research and carry immediate implications for developing targeted psychological services for divorced men.

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