

## X. Assessment and Treatment of Anger in Combat-Related PTSD

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Veterans of Operation Iraqi Freedom who suffer from symptoms of PTSD are likely to have difficulties with anger regulation given the centrality of anger in the human survival response. Research among military veterans has consistently shown that those with PTSD are higher in anger, hostility, aggression, general violence, and relationship violence and abuse than those without the disorder (e.g., Jordan et al., 1992). “Irritability and outbursts of anger” represent one of the diagnostic criteria for PTSD (American Psychiatric Association, 1994) and can have a debilitating impact across several domains. Anger dysregulation typically has a deleterious impact on the veteran’s relationships with family members and other loved ones, and may significantly interfere with other social and occupational functioning. These interpersonal difficulties may have a profound negative effect on the veteran’s social support network, which places him or her at risk for PTSD exacerbation, and possibly for cardiovascular disease and other health problems that have been associated with anger, hostility, and PTSD. Angry outbursts may also place the veteran at risk for legal problems and may lead to severe consequences for those who are exposed to these outbursts.

Although little theory or research explicates the role of PTSD with respect to anger, one important theory for anger problems among veterans with PTSD emphasizes the role of context-inappropriate activation of cognitive processes related to a “survival mode” of functioning (Chemtob, Novaco, Hamada, Gross, & Smith, 1997).

This response includes heightened arousal, a hostile appraisal of events, a loss in the ability to engage in self-monitoring or other inhibitory processes, and resulting behavior produced to respond to this perceived severe threat. These processes lead the veteran to see threats in the civilian environment that do not objectively pose any significant danger, and he or she may respond in an aggressive manner to such threats. This “survival mode,” while adaptive in combat situations, typically becomes maladaptive when the individual interacts with his or her environment in civilian life. Therefore, in therapy with this population, an important treatment target often involves the detection of cognitive biases with respect to environmental threats and the detection of disconfirming evidence. This sense of heightened threat may be particularly acute among individuals who served in Operation Iraqi Freedom because the enemy was not always clearly defined and military personnel were forced to be vigilant to attack at all times.

### Assessment of Anger and Related Constructs

Anger, hostility, and aggression are typically assessed via self-report questionnaire measures of these constructs. Two of the most widely used measures are the Buss Durkee Hostility Inventory (BDHI; Buss & Durkee, 1957) and the State-Trait Anger Expression Inventory (STAXI; Spielberger, 1988).

The BDHI (Buss & Durkee, 1957) is the most widely used measure of hostility. The measure consists of 75 true-false items, and 8 subscales: Assault, Indirect Hostility, Verbal Hostility, Irritability, Negativism, Resentment, Suspicion, and Guilt. The measure has received criticism based on methodological grounds (e.g., low predictive validity, poor reliability), and was recently revised by Buss and Perry (1992). The new measure, called the Aggression Questionnaire, consists

of 29 items that are rated on a 5-point Likert scales. An advantage of this measure is that it taps not only anger, but also the related constructs of hostility and aggression. Specifically, subscales include Anger, Hostility, Verbal Aggression, and Physical Aggression. This new measure and its subscales have been found to exhibit good psychometric properties.

The STAXI (Spielberger, 1988) is a 44-item measure that consists of subscales tapping State Anger, Trait Anger, and Anger Expression. This measure has some benefits over other existing anger measures. First, it distinguishes state anger and trait anger, and further distinguishes between the experience of anger and the expression of anger. Subscales can also be derived to assess whether individuals tend to keep in their anger (Anger-In), or express their anger openly (Anger-Out), or whether individuals effectively control and reduce their feelings of anger (Anger Control). These distinctions may be particularly important with veterans returning from Iraq. As described in the sections that follow, these men and women are likely to have problems with holding anger in and/or acting outwardly aggressive, and may vacillate between these two extremes. Therefore, this fine-grained assessment of the individual's anger expression style may assist in treatment planning.

### Challenges for Anger Interventions

Veterans with PTSD frequently report that anger is one of their most troublesome problems, and anger often prompts their treatment entry. However, evidence suggests that anger and violence are often the precipitants for early termination from treatment, and higher anger levels are associated with poorer outcomes in treatment for PTSD more generally. This section highlights a number of important challenges for intervention with PTSD-positive veterans who have anger regulation problems.

For many who have served in Operation Iraqi Freedom, the thought of openly discussing their difficulties with anger and finding alternatives to threatening or intimidating responses to everyday frustrations may seem to have life-threatening implications. The individual's anger and aggressive behavior may have been very functional in the military and in combat situations and may serve as a valuable source of self-esteem. Therefore, attempts to change an anger response may be met with considerable resistance. The advantages of disadvantages of the individual's anger expression style should be discussed in order to move him or her in the direction of behavior change. Generally, veterans will list several serious negative consequences of their anger regulation problems and few benefits that cannot be achieved by other, more appropriate means. Therefore, discussion of the "pros" and "cons" of their anger style often serves as a powerful technique for enhancing motivation.

Veterans may resist attempts to participate in treatment for anger problems because they may associate authority figures with distrust. Angry veterans may also become impatient during the treatment process due to their desire to gain relief from their anger problems and their general heightened level of hostility and frustration. They may become easily frustrated when changes do not immediately occur as a result of therapy, and may become hostile or otherwise resistant to therapy. It is important that the treatment provider fully discusses each of these concerns with the veteran, who should be encouraged to appropriately communicate his or her concerns during the course of treatment. Given the difficulty of the therapeutic endeavor, it is critical that the provider and veteran establish and maintain a positive therapeutic relationship. The provider should also be very clear in his or her expectations for treatment. He or she should stress to the veteran that one's

anger expression style is learned, and the skills required to alter anger patterns will take time to master.

Several psychiatric problems tend to be highly comorbid with PTSD, such as depression and substance abuse. These problems also pose potential barriers for effective treatment of anger problems among those with PTSD. In addition, veterans with PTSD are more likely to suffer from physical health problems, and often suffer from severe social and occupational impairments. These factors serve to increase stress and ameliorate emotional and tangible resources for the veteran, placing him or her at additional risk for anger dysregulation and violence perpetration. Further, these factors may lead to a reduced ability to make use of treatment for anger problems. The veteran's capacity to marshal the cognitive resources to do the work of therapy (e.g., participate in self-monitoring exercises or practice communication skills) and to comply with the demands of treatment may be compromised. The treatment provider, therefore, must fully assess for comorbid problems and their impact on both the veteran's anger and his or her compliance with therapy, and should ensure that the veteran receives appropriate treatment for comorbid problems. For example, substance abuse must be addressed due to its disinhibiting effects with respect to anger and aggression.

### Anger Management Intervention

Most PTSD treatment programs recommend and offer varied modalities and formats for the treatment of anger problems among veterans. Programs typically offer individual and group therapies, and cognitive-behavioral treatments for anger appear to be the most common. Increasingly, PTSD programs are utilizing manualized or standardized group treatments for anger treatment, and there is some research evidence for the effectiveness of such treatments (Chemtob, Novaco, Hamada, & Gross, 1997). Below, we briefly outline session content derived from a 12-week standardized cognitive behavioral group treatment for anger among veterans with PTSD. Although this material derives from a group treatment approach, the issues raised are relevant for other therapy formats and modalities.

**Overview of the treatment.** The goal of our anger management group is for veterans to learn to understand and to better regulate their anger responses through greater awareness of their anger triggers and an application of constructive anger management strategies. Additionally, veteran's appraisals of threat in their environment and daily experience of anger are targeted as they learn to prepare back-up responses (e.g., timeouts, relaxation, cognitive restructuring, ventilation, and positive distraction). Each session consists of group discussions and skills-building exercises. We have found that each group of veterans will present with special needs and the sessions should be adapted accordingly. Group leaders vary their coverage of the material to best complement the unique needs of their group, and make efforts to encourage group cohesion and a safe and supportive group atmosphere.

The first two sessions of group are devoted to orienting the veterans to treatment, discussing treatment goals and expectations of therapy, enhancing motivation to work on anger management, and providing psychoeducation on the anger response and the impact of PTSD on anger. Sessions 3 through 7 are devoted to self-monitoring exercises so that the veteran may better understand his or her anger response, developing an understanding of the distinction between different forms of anger expression, learning to use relaxation strategies for managing anger, and exploring motivational issues that may be impeding progress. The remaining sessions focus on

communication skills and learning to communicate assertively, barriers to anger management posed by comorbid problems, and wrapping up.

**Setting treatment goals and exploring motivation.** As discussed previously, it is extremely important that veterans with PTSD set realistic and attainable goals with respect to anger management, in order to prevent frustration with the therapy process and to reduce dropout. Both at the outset of therapy and throughout the course of treatment, motivational issues and barriers to successful barrier change should be explored. Also as discussed, for many veterans, anger dysregulation and aggressive behavior have served several adaptive functions, and anger expression styles may have been learned and reinforced throughout the life of the veteran. Therefore, discussions should center not only on the negative consequences of anger dyscontrol, but also on those factors that are maintaining these maladaptive behaviors, as well as more adaptive behaviors that may serve as substitute for identified problematic behaviors.

**Psychoeducation on anger and PTSD.** In order for veterans to better understand their anger dysregulation and to develop skills to better manage anger, it is important that they understand the constructs of anger and PTSD, and how the two are related. Veterans have often been noted to experience considerable relief upon the realization that their anger problems are directly related to their PTSD symptoms, and that others are experiencing the same difficulties. In addition to providing definitions of anger and PTSD, group leaders discuss the different components of the anger response (thoughts, emotions, physiology, and behaviors), and how these components are inter-related and negatively affected by PTSD. Further, it should be stressed that the goal of treatment is not to eliminate anger completely, since the anger response is a survival response that when communicated in a constructive manner, can be very useful and healthy. Therefore, group leaders stress that the goal of anger treatment is to learn to manage anger better and express anger in an assertive manner.

**Self-monitoring.** In order for veterans to learn new ways of handling their anger, they must first come to recognize when they are beginning to get angry, and recognize the thoughts and feelings associated with anger, as well as changes in their physiology. Many veterans returning from the war in Iraq may find this to be a difficult task, as their anger responses may be conditioned to respond immediately to the slightest risk of threat in their environment. That is, they may view their anger and aggression occurring instantly upon exposure to a perceived threat. However, upon completion of self-monitoring homework and in-group exercises, most group members will learn to identify signs of anger (e.g., heart racing, thoughts of revenge, feelings of betrayal) prior to an angry outburst. It is very important for veterans to develop this recognition as early as possible in the anger cycle, so that they may take active steps to avoid escalation to aggression (e.g., by taking a time-out, using relaxation strategies, etc.). Self-monitoring exercises also provide important information regarding the veteran's perceptions of threat in his or her environment, which may be appropriately challenged in the therapy context.

**Assertiveness training.** Many veterans have learned to respond to threats or other potentially anger-provoking stimuli either in an aggressive manner (e.g., physical or verbal assaults) or in a passive manner. Veterans may fear their own aggressive impulses and may lack self-efficacy with respect to controlling their anger, and therefore, they are more likely to "stuff" their anger and avoid conflict altogether. Not surprisingly, this overly passive behavior often leads to feelings of resentment and a failure to resolve problems, which in turn, leads to a higher likelihood of subsequent aggressive behavior. Therefore, considerable time in treatment is devoted to making

the distinctions clear between passive, aggressive, and assertive behavior, and group members are encouraged to generate and practice assertive responses to a variety of situations.

**Stress management.** In combating anger regulation problems, stress management interventions are critical to reduce the heightened physiological arousal, anxiety, depression, and other comorbid problems that accompany PTSD and contribute to anger problems. In our protocol, we implement an anger arousal exercise followed by a breathing-focused relaxation exercise to assist the veteran in becoming more aware of how thoughts are related to anger arousal and how relaxation exercises can assist in defusing the anger response. The aim is to assist the veteran in creating an early warning system that will help him or her recognize and cope with anger before it escalates to aggressive behavior. In addition to the implementation of relaxation strategies, several other stress management strategies are discussed and emphasized (e.g., self-care strategies, cognitive strategies) and the importance of social support in managing anger (e.g., talking with a friend or family member when angry) is stressed throughout the course of treatment.

**Communication skills training.** Anger dysregulation often results from a failure to communicate effectively and assertively, and likewise, heightened anger and PTSD hinder communication. In our group treatment for anger problems, we cover several communication strategies (e.g., active listening, the “sandwich technique”) and tips (e.g., using “I statements,” paraphrasing, refraining from blaming or using threatening language) for effective communication. In this regard, is important to emphasize both verbal and nonverbal communication, as veterans with PTSD often unknowingly use threatening or intimidating looks or gestures to maintain a safe distance from others.

### References

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