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Chapter 11

THE RELATIONSHIP BETWEEN ANGER AND TRAUMA: SOME IMPLICATIONS FOR PROGRAMS THAT HELP MANAGE PROBLEMATIC ANGER

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ABSTRACT

Despite the widely acknowledged association between exposure to traumatic events and the experience of angry feelings, most contemporary approaches to treating problematic anger focus on how angry provocations are perceived and responded to. Only passing attention is paid to the underlying cause. In this chapter the ways in which psychological trauma can influence anger expression are discussed, and treatment strategies are suggested for use with those who experience problematic anger with histories of trauma.

In recent years psychological interventions designed to improve the regulation of anger, commonly known as anger management programs, have been developed to treat a wide range of physical and mental health problems. The rationale for treatment is based on research that has demonstrated an association between anger and, for example, cardio-vascular disease (Harenstam, Theorell, and Kaijser, 2000), personality disorder (Trull, Useda, Conforti, and Doan, 1997), substance abuse (Bond, Verheyden, Wingrove, and Curran, 2004), and organic brain disorders (Rosen et al., 2002). However, given that anger is most commonly identified as an important antecedent to aggression (Novaco, 1997; Novaco, Ramm, and Black, 2001),

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one of the primary reasons for referring someone to an anger management program is to reduce the risk of aggressive and violent behaviour occurring.

A series of meta-analytic reviews of treatment effectiveness, such as those conducted by Edmondson and Conger (1996) and DiGiuseppe and Tafrate (2003), have reported that while the effect sizes associated with anger management are generally moderate, treatment outcomes are sufficiently positive to be considered as producing reliable clinical change (see also Deffenbacher, Oetting, and DiGiuseppe, 2002). Indeed, Beck and Fernandez (1998) in their meta-analysis of fifty outcome studies concluded that individuals receiving cognitive-behavioral anger management therapy were 75% better off (in terms of anger reduction) than untreated controls. Nonetheless, there are some groups who experience anger problems who appear to be particularly difficult to treat. For example, there is only limited evidence to support the use of anger management with violent offenders (Dowden and Serin, 2001; Howells et al., 2005; Heseltine, Howells, and Day, 2010), perhaps because violent offenders commonly experience a range of co-morbid problems which potentially interfere with their progress in treatment. For example, many serious offenders experience co-morbid problems of substance abuse, personality disorder, family dysfunction, or mental illness that decreases the chances of them engaging therapeutically in any process of behavioral change (Howells and Day, 2003). The aim of this chapter is to explore the idea that some of the most difficult to treat clients who present with anger-related problems are those whose difficulties can be best understood in relation to their historical experiences of trauma. Although there is a strong association between symptoms of trauma and dysregulated anger, most current anger management programs do not directly address experiences of historical trauma. It is suggested that attention to such issues may help to identify new methods of intervention, prove to be more engaging for clients and, ultimately, improve therapeutic outcomes.

**WHAT IS ANGER MANAGEMENT?**

Anger management programs typically involve a number of component modules. For example, they nearly always employ cognitive-behavioral methods, begin by seeking to identify the client’s understanding of the nature of the problem, identifying and modifying immediate triggering events and contextual stressors, and changing causal cognitive inferences and dysfunctional schemata. Treatment then proceeds to more skills based interventions, such as improving coping responses, control over physiological arousal, preventing escalation, and strengthening the commitment to change (Howells, 1998). A major focus of most contemporary anger management programs is on addressing deficits related to social information-processing, particularly in relation to the ability of the aggressor to take the perspective of the victim. This involves examining the way in which each participant responds to perceived provocations, both at the time of the event (e.g., judgments of who was responsible or who was to blame), and subsequently (e.g., rumination about grievances that intensify the emotional experience). An important part of anger management is thus to review those events that trigger anger episodes, with the aim of demonstrating to participants that their perceptions of threat or malevolence may not actually be accurate, and that their anger is either unnecessary or counter-productive. This aspect of treatment can sometimes be experienced by participants as critical of the ways in which they have reacted and, as such,
the manner in which it is approached by the therapist is often critically important to treatment outcomes. Approached badly, it has the potential to cause what Safran, Muran, Samstag, and Stevens (2002) have called ‘ruptures’ in the therapeutic process, particularly when participants maintain that they were the recipients of wrong-doing and that their anger was not only justified, but also legitimate.

**TRAUMA AND ANGER**

The concept of trauma can be understood in terms of the emotional shock that results from particular events, and which leads those who are traumatised to feel numb, afraid, vulnerable, and isolated (McAusland, 2008). Post-traumatic stress disorder (PTSD) is a formal psychiatric diagnosis that refers to psychological impairment, triggered by exposure to a traumatic event, in which the individual perceives a threat to either his or her safety or physical integrity (or that of others), and during which he or she experiences fear, helplessness or horror (APA, 1994). PTSD is characterised by the intrusive recollection or re-experiencing of the traumatic event, such as ‘flashbacks’ or nightmares; avoidance of situations or stimuli which may trigger memories of the event; emotional numbing; and hyper-arousal symptoms (such as impulsivity, insomnia, irritability and anger, as well as generalised anxiety). Although research into PTSD has historically identified fear as the defining emotion of the disorder, greater attention has been given in recent years to anger as the key emotion associated with hyper-arousal. In fact, anger has been shown to be strongly associated with PTSD severity - a meta-analysis of 39 studies of trauma exposed adults conducted by Orth and Weiland (2006), concluded that anger and hostility were strongly associated with PTSD (mean effect size of .48, with weighted mean effect sizes for the relation between anger expression variables, and PTSD of .29 for ‘anger out’, .53 for ‘anger in’, and .44 for ‘anger control’). This analysis also reported that, on average, the strength of the association between anger and PTSD increased over the first few months following exposure to a traumatic event, before slowly decreasing over time.

One group of people for whom anger dysregulation appears to be particularly problematic are those who experience what has been termed ‘complex PTSD’ (or ‘disorders of extreme stress not otherwise specified’ (APA, 1994). The term complex PTSD is sometimes used to account for the types of problems that often present in those who experience early onset, protracted, and repeated trauma, such as experiences of torture, childhood abuse, domestic violence, chronic combat exposure, and severe social deprivation (Herman, 1992). A number of studies have demonstrated that rates of both aggression and violence are elevated in those who experience PTSD and report a history of severe child sexual abuse (e.g., Begic and Jokic-Begic, 2002; Dodge, Pettit, Bates, and Valente, 1995; Weaver, Chard, Mechanic, and Etzel, 2004), leading Dyer et al. (2009) to observe that one of the most ‘clinically pressing’ aspects of complex PTSD is problematic anger, and the associated high levels of aggression and self-harm.
THEORETICAL PERSPECTIVES

A number of possible explanations have been put forward to explain the association between traumatic experience and anger. Anger regulation theory (Chemtob, Novaco, Hamada, Gross, and Smith, 1997), for example, suggests that during exposure to stress, anger activates attack or survival behaviors, suppresses feelings of helplessness, and thereby allows the individual to gain a sense of control over the situation. Exposure to trauma may, however, also be associated in the longer term with a loss of self-monitoring (and a consequent reduction in the internal inhibitors of aggression following anger arousal) after the traumatic threat has passed. In other words, it is proposed that traumatised individuals develop a propensity to perceive situations as threatening, and the perception of threat activates a biologically predisposed survival mode which includes fear and flight reactions as well as anger and fight reactions. They are then less able to regulate anger and, as a consequence, more likely to experience problematic anger and act aggressively. As Novaco and Chemtob (1998) put it: "anger regulation is affected by traumatic experience, which resets activation and inhibition patterns in accordance with perceived threat, and by the shift into 'survival mode' functioning" (pp.170-171).

Fear avoidance theory (Foa, Riggs, Masie, and Yarczower, 1995) postulates that anger following trauma essentially represents an emotional avoidance strategy, comparable to cognitive avoidance strategies such as distraction. In effect, anger is seen as a psychological defense, providing a welcome focus of attention for those are motivated to avoid trauma-related fear (activated by post-traumatic intrusions). This idea is not altogether incompatible with anger regulation theory - Amstadlet and Vernon (2008) have suggested that while fear is an essentially prospective emotion, arising during the event and concerned with the potential for future harm, other emotions such as anger and guilt can be considered to be retrospective emotions which arise largely from post-trauma appraisals of the event and its consequences. Support for this idea comes from studies which show that anger tends to increase over time after a traumatic event, whereas fear tends to decrease. What might be termed 'traumatic anger' can, therefore, be understood as arising from the appraisals that are made after the incident about the violation of safety rules that occurred and/or the perceived unfairness of the incident (see Ehlers and Clark, 2000).

For Whiting and Bryant (2007), this work is consistent with appraisal models of anger arousal more generally (see Smith and Kirby, 2004). Appraisals can be understood as an evaluation of the significance of the change in relation to the person, and are thought to determine the subsequent emotion. Smith and Lazarus (1993) have distinguished between primary appraisals which are concerned with how the encounter is relevant to the person's well-being (termed 'motivational relevance' and 'motivational congruence'), and secondary appraisals which relate to judgments of accountability, the ability to cope, and expectations about the future. They propose that anger elicitation is caused by a reduction in motivational congruence, an increase in motivational relevance, and an increase in other-accountability. The core relational theme of anger is thought to be 'other-blame' (which combines the primary appraisals of increased motivational relevance and reduced motivational congruence with the secondary appraisal of other-accountability). Applying this idea to the experience of trauma would suggest that problematic anger is most likely to occur when another person is held responsible for the traumatic event. More recent research, however, has also identified a
range of other appraisals (in addition to ‘other-blame’), such as frustration and perceived unfairness, that also potentially lead to anger arousal (Berkowitz and Harmon-Jones, 2004).

Dyer et al.’s (2009) study of complex trauma identified what they termed as ‘alterations in self-perception’ as a substantial correlate of anger, aggression, re-experiencing, avoidance, and arousal. It emerged as the only significant predictor of aggression after social desirability was controlled for. The term ‘alterations in self-perception’ is used here to refer to feelings of shame, ineffectiveness, guilt, responsibility, isolation, and being permanently damaged, leading Dyer and colleagues to conclude that post-traumatic shame may play a major role in both anger and aggression in traumatised individuals. They refer to Wilson, Drozdck, and Turkovic’s (2006) model of post-traumatic shame as consisting of devalued self-appraisal and a perceived loss of moral goodness that underpins both emotion and impulse control difficulties. Such work is of interest given that it identifies more global negative evaluations of the self following trauma (rather than specific appraisals), as contributing to anger dysregulation. It also offers some developmental understanding of how historical events (such as child abuse and neglect) may, for some people at least, lead to the development of more stable personality traits such as high levels of trait anger and a decreased threshold for anger expression.

Whiting and Bryant (2007) note that trauma-exposed people also continue to experience significant stressors after the traumatic experience has passed, and that these additional stressors themselves contribute to PTSD (see also King, King, Fairbank, and Keane, 1996). Given the strong association between anger and the frequency and severity of daily ‘hassles’ in non-clinical populations (Thomas and Donnellan, 1991), Whiting and Bryant propose that the experience of hassles following trauma may also play an important role in the development and maintenance of post-traumatic anger. Their study found that although daily hassles were strongly associated with levels of anger, its influence was mediated by maladaptive appraisals.

**Implications for Treatment**

While it is apparent that anger plays a significant role in the development of PTSD following a traumatic event (Andrews, Brewin, Rose, and Kirk, 2000), and that angry reactions compromise treatment efficacy in people with PTSD (Taylor et al., 2001), there has been little previous work examining the ways in which traumatic symptoms might impact on the outcomes of anger management programs. Thus, while PTSD treatments have been developed to address both the experience and expression of angry emotion (e.g., Cahill, Rauch, Hembree, and Foa, 2003; Chemtob, Novaco, Hamada, and Gross, 1997), most contemporary anger management programs employ skills based interventions (such as improving coping responses, control over physiological arousal, preventing escalation, and strengthening the commitment to change), rather than seeking to address traumatic experiences in their own right. Exposure to trauma may have a number of other effects (e.g., dissociative amnesia, dissociated identity, borderline personality) that directly reduce the extent to which traumatized individuals are aware of their emotional states and affect their ability to participate meaningfully in anger management programs (Howells and Day, 2006). Indeed, problematic anger (higher levels of trait anger, anger expression, and lower levels of
anger control) has also been associated with the longer-term, rather than acute, effects of trauma such as the type of difficulties that are sometimes associated with an inadequate sense of self and personal identity (Day et al., 2008). Many mainstream anger management programs may simply be too brief (or shallow) to adequately address problems of this nature.

At the same time, there is considerable overlap between the types of intervention that are widely accepted to be important in the successful treatment of both PTSD and problematic anger. For example, anger management programs systematically aim to change the ways in which perceived provocations are perceived and appraised (such that they do not lead to angry arousal). Interventions for PTSD also focus on the trigger (in this case the experience of trauma) and how it is subsequently perceived and processed. The literature reviewed above suggests that in addition to attending to appraisals of ‘other-blame’, there may be a case for anger management programs to also consider appraisals of ‘self-blame’, as is more typically the case in treatment for PTSD. This would appear to be particularly relevant for those who present with post-traumatic symptoms, and especially so for those who might be classified as experiencing complex trauma. Although interventions have been developed specifically to change the appraisal of other-blame (e.g., forgiveness therapy, see Day et al., 2008 or empathy training, see Day Casey, and Gerace, 2010), there has been less attention paid to changing self-blame in anger management programs, despite some preliminary application of techniques that aim to reduce the motivational relevance of traumatic events (such as mindfulness, see Day et al., 2009).

Of some interest clinically are the findings of the meta-analytic review of studies investigating the association between anger and trauma (Orth and Weiland, 2006) which reveal a lower correlation between ‘anger-out’ and PTSD than for ‘anger-in’ and PTSD. This suggests that experiences of trauma are often associated as much with the inhibition of anger, as they are with outward emotional expression. Such findings, although to be expected when one considers the similarities between angry rumination and the re-experiencing of traumatic symptoms that is characteristic of PTSD, suggest that anger management programs which focus on emotional control may not necessarily be the most appropriate treatment for those who over-regulate angry emotion. The psychopathology, and certainly the treatment of the individual who is generally low in anger but then unexpectedly and unpredictably acts aggressively has generally received limited attention in the literature. A notable exception to this is Megargee’s (1966) work on the classification of violent offenders as either under- or over-controlled, and subsequent re-workings to account for the mechanisms involved in anger summation and inhibition by Blackburn (1993) and Tice and Baumeister (1993). Davey, Day, and Howells (2005) have argued that teaching specific strategies to those who already overuse these strategies is likely to be, at best, ineffective and, at worst, counter-productive in so far as it is likely to reinforce and entrench the problem. They suggest that careful review of a number of recent anger provoking situations can identify which regulation strategies are routinely employed by a particular individual before any decision can be made to refer to an anger management program. For many of those who have been traumatised, it may be that angry outbursts are associated with a pathological over-control (under-expression) of anger and, as such, treatment should attend to the build up of frustration and perceptions of injustice (related both to the traumatic event as well as to daily hassles) such that skills in emotional expressiveness can be developed.
CONCLUSION

Although anger management is an effective and empirically supported treatment for the majority of clients who present with anger regulation problems, this chapter argues that those who have experienced traumatic events may be particularly difficult to treat, and that different approaches to intervention may need to be considered. Further research and theorising is required to further explore the association between dysregulated anger and traumatic experience and to understand the origins, development, and maintenance of problematic anger such that even more effective interventions can be developed.

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