

# ANGER AND MILITARY VETERANS

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*Anger problems are most evident in veterans who are diagnosed with Posttraumatic Stress Disorder (PTSD) and have been exposed to combat. Because of the institutionalized role anger plays in military training, identity, and culture, anger problems are also an issue for former soldiers who have neither PTSD nor combat experience. Consequently, anger problems are an issue for many veterans whose inability to manage and express their anger constructively inhibits psychosocial functioning in multiple areas, including personal relationships, employment, self-esteem, and behavioral self-control. Empirically supported group interventions addressing this issue adhere to the principles of evidence-based practice and are particularly important given the current geopolitical climate. This paper reviews some of the current literature on clinical interventions for veterans experiencing anger problems and acknowledges the increasingly important role social workers are playing as mental health service providers to veterans with anger problems at institutions such as the Department of Veterans Affairs.*

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Anger is described as an emotional response to a perceived physical or psychological threat that induces feelings of vulnerability, powerlessness, and anxiety (Hollinworth, Clark, Harland, Johnson, & Partington, 2005). Anger can become a problem in multiple respects if it is experienced or expressed inappropriately. Physically, prolonged feelings of intense anger strain certain areas of the nervous system, increase blood pressure and heart rate, and may contribute to such health problems as hypertension, heart disease, and diminished immune system efficiency (Reilly & Shopshire, 2002). Psychologically, anger problems may inhibit psychosocial functioning and contribute to aggressive, anti-social behaviors, such as physical violence and verbal abuse. These behaviors carry many potentially negative consequences, including incarceration, assault, being viewed as untrustworthy, losing the emotional support of family and friends, expulsion from a substance abuse or other community support program, and feeling remorse, shame, or self-loathing (Reilly & Shopshire).

Due in part to the rise in demand for mental health services placed upon agencies by the current geopolitical climate, the treatment of problematic anger among veterans is an issue of pressing clinical significance (Hoge,

Auchterlonie, & Milliken, 2006). Anger problems among the members of this population (primarily male, although increasingly diverse) are associated with multiple factors related to military service including combat exposure, military culture, and war-induced psychological trauma (Gerlock, 1994). Veterans who were exposed to combat and are diagnosed with Posttraumatic Stress Disorder (PTSD) are most likely to suffer from anger problems, although former soldiers who have neither PTSD nor combat experience are also at risk (Calhoun et al., 2002; Chemtob, Hamada, Roitblat, & Muraoka, 1994; Novaco & Chemtob, 2002). Current treatments used to address this issue follow a group format based upon the principles of cognitive behavioral therapy that is time-limited, goal-oriented, and supported by empirical research attesting to its clinical efficacy (Beck & Fernandez, 1998; Gerlock, 1996; Reilly & Shopshire, 2002; Tang, 2001). The Department of Veterans Affairs uses these interventions because they are congruent with the practical and ethical expectations of evidence-based practice as well as the professional objectives of clinical social work.

### The Etiology and Psychosocial Implications of Anger Problems in Military Veterans

Prior to 1920, psychological models focused solely on the sexual drive, or libido, as the primary behavioral and cognitive drive among humans (Horowitz, 1988). According to these early models, aggression is the result of sexual repression and is evident throughout the course of psychosexual development prior to the successful resolution of the Oedipus/Electra Complex. The identification of aggression as a separate drive element in 1920 introduced the notion that anger is instinctual and part of a natural dichotomy between two inherently opposed impulses: Eros, the ego and libidinal instinct for survival, and Thanatos, the death instinct. In this paradigm, negative energy displaced onto others to prevent the self-destruction of the individual is considered to be the basis of aggression and is first apparent in the infantile desire to possess and destroy the maternal breast (Hinshelwood, 1989).

The development of relational models in the 1940s rejected drive theory's emphasis on aggression as an independent energy source and replaced it with the view that aggression is the behavioral expression of an induced emotional state that occurs due to the inability to achieve primary motivational aims (Greenberg & Mitchell, 1983). This approach provided the groundwork for the idea that feelings of anger and their subsequent behavioral expressions

are ostensibly elicited by anger-provoking events that trigger thoughts of disappointing and unresolved conflicts. According to this latter perspective, trigger events vary from individual to individual and are dependent upon one's personal experiences and worldview. Similarly, anger cues — or the physical, emotional, behavioral, and cognitive reactions that occur in response to anger-provoking events — vary according to individual, as well as societal and cultural norms.

Among military veterans, anger problems are associated with trigger events and cues related to specific aspects of military experience, namely combat exposure, combat related psychological trauma, and military culture. Anger problems are especially prevalent in those who were exposed to combat and have been diagnosed with PTSD (Calhoun et al., 2002; Chemtob et al., 1994; Novaco & Chemtob, 2002). As noted in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.: DSM-IV-TR; American Psychiatric Association, 2000), problematic expressions of anger are a persistent symptom of PTSD, an Axis I diagnosis that may develop after one experiences, witnesses, or is confronted with a life-threatening event. Combat-exposed military veterans with PTSD are more likely than other veterans to suffer from anger problems that lead to impaired relationships, social isolation, and feelings of helplessness (Novaco & Chemtob). Research conducted by Calhoun et al. indicated that combat-exposed veterans with PTSD report more frequent arousals of unchecked anger accompanied by a hostile attitude towards others in a variety of situations. Similarly, Chemtob et al. reported that combat veterans with PTSD have significantly more incidents of problematic anger towards their partners and are also more likely to experience employment difficulties due to their inability to express anger in socially acceptable ways.

Veterans who were not exposed to combat and do not have PTSD typically exhibit fewer anger symptoms than those who were in combat and do have PTSD (Calhoun et al., 2002; Chemtob et al., 1994; Iversen et al., 2005; Novaco & Chemtob, 2002). Nevertheless, non-combat veterans, too, are at risk of suffering from anger problems and may seek anger treatment for similar or related symptoms. According to Gerlock (1994), this may be due to the role of unchecked anger as an integral part of military culture. Anger is presented in the military environment as a necessary element of the idealized version of masculine identity that defines the psyche of the successful combat soldier. Military training emphasizes the need to repress feelings such as sadness and fear so that soldiers are psychologically equipped for external

expressions of aggression (Gerlock). For the soldier, anger thus becomes a mechanism that enables him or her to ignore and overcome the emotional challenges inherent to the combat experience without succumbing to the deep and complex psychological reactions associated with such traumatic events as witnessing the death of a comrade.

### Treating Anger Problems in Military Veterans

Current interventions that address anger problems in military veterans generally utilize a treatment plan based upon the principles of cognitive behavioral therapy (CBT) (Beck & Fernandez, 1998; Gerlock, 1996; Reilly & Shopshire, 2002; Tang, 2001). The group format of the cognitive behavioral model postulates that interventions should include five to ten participants and meet once per week for a period of up to 12 sessions. CBT interventions for anger problems are based upon the Stress Inoculation Training (SIT) model, which consists of three parts: (1) cognitive preparation, (2) skill acquisition, and (3) application training (Beck & Fernandez; Dwivedi & Gupta, 2000). According to Gerlock, a typical CBT anger management intervention follows a curriculum that focuses on identifying situational triggers, learning coping skills, and practicing role rehearsal through exposure to anger-provoking stimuli. Group sessions are typically divided into two parts. A didactic portion examines cues to anger, learned responses to anger, anger triggers, personal vulnerabilities to anger, and short-term payoffs versus long-term consequences of anger. A practice component included in each session offers structured role-plays and break-out periods during which participants may test their newly learned social skills.

Experts believe using CBT in the treatment of anger is justified by its effectiveness in achieving desired treatment goals via a time-limited, goal-oriented intervention format that empirically evaluates clinical change (Beck & Fernandez, 1998). For example, Tang's (2001) retrospective quasi-experimental study on the effectiveness of a CBT anger management group for patients with mental health problems used the Anger Control Inventory (ACI) and the State-Trait Expression Inventory (STAXI) to measure clinical outcomes. The study revealed that the participants experienced a decrease in overall feelings of anger and an increase in anger coping skills as evidenced by reductions in maladaptive cognitions and behaviors, cognitive deficits, and behavioral deficits (Tang).

Interventions involving client samples consisting of current and former

members of the military suggest clinical outcomes similar to the results presented by Tang (2001) regarding the efficacy of CBT group therapy in the treatment of problematic anger. Conducted at a Veterans Affairs outpatient mental health center, Gerlock's (1994) retrospective quasi-experimental study revealed that an anger management group using a CBT approach leads to significant improvement in anger coping mechanisms and a significant drop in sensitivity to anger provocation as evidenced by significant decreases in respondents' self-reported feelings of anger. Similarly, a 4-session CBT anger management group study conducted by Linkh and Sonnek (2003) in a setting frequented by current and former members of the military concluded that a brief cognitive behavioral psychoeducational approach to treat anger problems is empirically justified; participants experienced a marked reduction in their subjective experience of anger and in potentially aggressive expressions of anger.

### Strengths and Weaknesses of the Current Approach to Treatment

CBT anger management groups, such as those tested by Gerlock (1994), Linkh and Sonnek (2003), and Tang (2001), are particularly useful in the treatment of the military veteran population because they induce clinical change in clients from all genders, cultures, races, and ethnicities. This is particularly important given the increasingly diverse nature of the military veteran population. According to Reilly and Shopshire (2002), the strategy of identifying trigger events, cues to anger, and developing personalized coping skills effectuates equally positive clinical outcomes among members of both gender groups. Interventions based upon the CBT model can also successfully accommodate the culture-specific needs and situations of individuals from various racial and ethnic groups (Reilly & Shopshire). Finally, CBT anger management groups are valuable because they have been found to be effective in treating clients who have a history of substance abuse or who are diagnosed with co-occurring psychiatric disorders. For such clients, participation in CBT anger management groups leads to clinical improvement so long as participants abstain from drugs and alcohol, adhere to the stipulations of their medication treatment plan, and receive appropriate care for co-occurring disorders (Reilly & Shopshire). This latter point is especially relevant to treating military veterans, who, as was previously mentioned, often trace their anger problems back to combat experiences that precipitated the onset of psychiatric disorders, such as PTSD.

Despite its apparent clinical supremacy, shortcomings exist in the CBT approach that may call into question its position as the intervention of choice for the treatment of problematic anger. These shortcomings relate to CBT's ability to affect long-term clinical improvement, as well as its capacity to address specific clinical symptoms vis-à-vis other types of interventions. Concerning the former shortcoming, Durham et al. (2005) suggested that improvements immediately following CBT treatments often fail to translate into lasting results and cannot be maintained by simply extending the CBT treatment. On the other hand, psychodynamic interventions have been shown to effectuate lasting clinical improvement. A study conducted by Muratori, Picchi, Bruni, Patarnello, and Romagnoli (2003) revealed that participants who received an intervention consisting of short-term psychodynamic psychotherapy were more likely to experience long-lasting clinical improvements than the members of the control group. Finally, psychodynamic group interventions have proven to be better able to improve clients' behavioral control and coping despite CBT's emphasis on these goals (Sandahl, Gerge, & Herlitz, 2004).

These clinical shortcomings call into question the two non-clinical elements that make CBT so appealing, namely its time-limited and cost-saving qualities. Participants in CBT anger management groups may have to participate in the group multiple times or receive another form of follow-up intervention given the increase in the number of veterans seeking treatment for anger management problems and other forms of psychological trauma. This is a critical point, especially in the wake of Operation Iraqi Freedom and Operation Enduring Freedom, as well as the limited amount of resources available to put towards treatment of veterans.

### Implications for Clinical Social Work Practice

The need to treat military veterans with anger problems in a way that is clinically effective, ethical, and cost-efficient has never been greater. Military campaigns in Iraq, Afghanistan, and elsewhere mean more troops are being exposed to combat and other stressful situations that put them at risk of returning home with anger problems. A recent study conducted by Hoge et al. (2006) indicated that 19.1% of veterans returning from Iraq and 11.3% of veterans returning from Afghanistan reported a mental health problem. Overall, 35% of all returning Operation Iraqi Freedom veterans requested mental health services. As with previous research, this study indicated that

combat-exposed veterans are more likely to report and request services for mental health problems than other veterans. Given the relationship between combat exposure, psychiatric trauma, and problematic anger, this may mean more veterans will present with significant anger problems that require clinical intervention in the near future.

Institutions that offer services to returning veterans find themselves under increasing demands to treat more clients with fewer resources. These institutions are simultaneously incorporating elements of evidence-based practice into their institutional culture that are congruent with the ethical demands of accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations, and the financial realities of managed care. This is particularly true of the Department of Veterans Affairs (VA). As one of the nation's primary providers of medical and psychiatric services to military veterans, the VA medical system is the largest integrated health care system in the country; it has a health care budget of approximately \$30 billion, employs 196,000 health care professionals, and maintains 1,300 sites of care (Department of Veterans Affairs, 2006). The VA provided health care services to over 5 million veterans via its system of inpatient and outpatient clinics and hospitals in 2004. This represents an increase of 22% in the number of patients treated since the end of fiscal year 2001 (Department of Veterans Affairs, 2005).

The VA is also known for its position as the employer of over 4,000 licensed social workers and for its desire to become the employer of choice for qualified clinical social workers (Department of Veterans Affairs, 2004). Social workers at the VA fill a variety of roles that reflect the diversity of the social work profession. Social work services provided at VA medical centers include psychosocial screening and evaluation, pre-admission planning, discharge planning, psychosocial diagnosis and intervention, patient advocacy, end of life planning, and bereavement services (Department of Veterans Affairs). In the realm of mental health, social workers provide a specific array of services using a psychiatric, *DSM IV-TR*-based assessment, diagnostic, and treatment model. Services provided include individual psychotherapy, group psychotherapy, and psychosocial assessments. Social workers facilitate their interventions in partnership with other mental health professionals and are considered to be integral members of an interdisciplinary mental health team consisting of psychiatrists and psychologists.

## Conclusion

Participation in the military exposes individuals to numerous potentially traumatic situations that can have long-lasting psychological, economic, and social ramifications (Dalenberg, 2000; Friedman, 2005; Iversen et al., 2005; Solomon & Kleinhaus, 1996). As a result, military veterans face multiple psychosocial stressors, one of the most salient of which is problematic anger. Anger problems, which are particularly chronic among combat veterans with PTSD, are believed to be due in part to the socially constructed role of aggression in military identity and culture, as well as combat exposure and war-induced psychological trauma (Calhoun et al., 2002; Chemtob et al., 1994; Gerlock, 1994; Novaco & Chemtob, 2002). Veterans with anger problems are at increased risk of suffering from economic, interpersonal, psychological, and physical problems. Multiple studies have illustrated the efficacy of CBT anger management groups in causing clinical change among military veterans who suffer from anger problems (Gerlock; Linkh & Sonnek, 2003; Tang, 2001).

Clinical social workers play an integral role in clinical work with military veterans who have anger problems at such institutions as the VA. Social workers' efforts are sorely needed as demands for psychosocial services among military veterans are increasing and more anger-prone veterans are expected to return in dire need of assistance as a result of current military engagements overseas. To improve the odds of effectively helping returning veterans with anger problems, research might be conducted to assess the level of stigma perceived by veterans regarding obtaining mental health services. Though beyond the scope of this paper, additional research could look at how women in the military experience anger. Research might also address the current racial, gender, and other forms of demographical diversity that exist in today's military. Greater empirical knowledge in each of these areas could be incorporated in culturally competent CBT anger management group interventions that are increasingly cognizant of how veterans with anger problems can be treated in a manner that is ethical, empirically-based, and resource efficient.

## References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., text rev.). Washington, DC: Author.



- Beck, R., & Fernandez, E. (1998). Cognitive behavioral therapy in the treatment of anger: A meta-analysis. *Cognitive Therapy and Research*, 22(1), 63-74.
- Calhoun, P., Beckham, J., Feldman, M., Barefoot, J., Haney, T., & Bosworth, H. (2002). Partners' ratings of combat veterans' anger. *Journal of Traumatic Stress*, 15(2), 133-136.
- Chemtob, C., Hamada, R., Roitblat, H., & Muraoka, M. (1994). Anger, impulsivity, and anger control in combat-related Posttraumatic Stress Disorder. *Journal of Consulting and Clinical Psychology*, 62(4), 827-832.
- Dalenberg, C. (2000). Countertransference and the management of anger in trauma therapy. *PTSD Clinical Quarterly*, 9(3), 39-45.
- Department of Veterans Affairs. (2004). Clinical social work Veterans Health Administration: Twenty-first century employer of choice. Retrieved March 5, 2006, from <http://www1.va.gov/socialwork/docs/SWBrochure2004.pdf>
- Department of Veterans Affairs. (2005, June). Facts about the Department of Veterans Affairs. Retrieved October 11, 2005, from <http://www1.va.gov/opa/fact/vafacts.html>
- Department of Veterans Affairs. (2006, February). Feeley appointed to senior VA health care post. Retrieved March 5, 2006, from <http://www1.va.gov/opa/pressrel/PressArtInternet.cfm?id=1077>
- Durham, R., Chambers, J., Power, K., Sharp, D., Macdonald, R., Major, K., et al. (2005). Long term outcome of cognitive behavioral therapy trials in central Scotland. *Health Technology Assessment*, 9(42), 1-174.
- Dwivedi, K., & Gupta, A. (2000). "Keeping cool": Anger management through group work. *Support for Learning*, 15(2), 76-81.
- Friedman, M. (2005). Veterans' mental health in the wake of war. *The New England Journal of Medicine*, 352(13), 1287-1290.
- Gerlock, A. (1994). Veterans' responses to anger management intervention. *Issues in Mental Health Nursing*, 15(4), 393-408.
- Gerlock, A. (1996). An anger management intervention model for veterans with PTSD. *NCP Clinical Quarterly*, 6(3), 61-64.
- Greenberg, J., & Mitchel, S. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.
- Hinshelwood, R. (1989). *A dictionary of Kleinian thought*. London, UK: Free Association Books.
- Hoge, C., Auchterlone, J., & Milliken, C. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the*

- American Medical Association*, 295(9), 1023-1031.
- Hollinworth, H., Clark, C., Harland, R., Johnson, L., & Partington, G. (2005). Understanding the arousal of anger: A patient-centered approach. *Nursing Standard*, 19(37), 41-47.
- Horowitz, M. (1988). Introduction to psychodynamics: A new synthesis. New York, NY: Basic Books.
- Iversen, A., Nikolaou, V., Greenberg, N., Unwin, C., Hull, L., Hotopf, M., et al. (2005). What happens to British veterans when they leave the armed forces? *The European Journal of Public Health*, 15(2), 175-184.
- Linkh, D., & Sonnek, S. (2003). An application of cognitive-behavioral anger management training in a military/occupational setting: Efficacy and demographic factors. *Military Medicine*, 168(6), 475-478.
- Muratori, F., Picchi, L., Bruni, G., Patarnello, M., & Romagnoli, G. (2003). A two-year follow up of psychodynamic psychotherapy for internalizing disorders in children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(3) 331-339.
- Novaco, R., & Chemtob, C. (2002). Anger and combat-related Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, 15(2), 123-132.
- Reilly, P., & Shopshire, M. (Eds.). (2002). *Anger management for substance abuse and mental health clients: A cognitive behavioral therapy model*. Rockville, MD: U.S. Department of Health and Human Services.
- Sandahl, C., Gerge, A., & Herlitz, K. (2004). Does treatment focus on self-efficacy result in better coping? Paradoxical findings from psychodynamic and cognitive-behavioral group treatment of moderately alcohol-dependent patients. *Psychotherapy Research*, 14(3), 388-397.
- Solomon, Z., & Kleinhaus, M. (1996). War-induced psychic trauma: An 18-year follow-up of Israeli veterans. *American Journal of Orthopsychiatry*, 66(1), 152-160.
- Tang, M. (2001). Clinical outcome and client satisfaction of an anger management group program. *Canadian Journal of Occupational Therapy*, 68(4), 228-36.

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