Anger Management and Temper Control: Critical Components of Posttraumatic Stress Disorder and Substance Abuse Treatment†

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Abstract—Recent studies have shown associations among combat experience, PTSD, anger and hostility, and involvement in violence. Clinical observations of veterans enrolled in the Substance Use/Posttraumatic Stress Disorder Team (SUPT) program at the San Francisco Veterans Affairs Medical Center revealed relatively high levels of anger and aggressive behavior, including physical assaults and property damage. In response to this anger and aggressive behavior, an anger management treatment was added to the SUPT program’s treatment of substance abuse and PTSD. Anger management consisted of a 12-week cognitive-behavioral group treatment. Session topics included identifying the physical, emotional, and situational cues to anger, developing individualized anger-control plans, recognizing and altering destructive self-talk, utilizing time-out, practicing conflict resolution techniques, and using the group to discuss and evaluate high-risk anger situations. Special attention was given to self-monitoring anger-escalating behavior (using an anger meter) and avoiding negative consequences. This article describes the components of the anger management treatment. A clinical vignette is also presented to illustrate the benefits of anger management treatment.

Keywords—anger management, posttraumatic stress disorder, substance abuse, treatment

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Posttraumatic stress disorder (PTSD) requires comprehensive and intensive treatment. The recurrent and intrusive distressing recollections that are a central feature of PTSD may require behavioral therapy or long-term psychotherapy. PTSD in Vietnam combat veterans poses particular problems that may complicate these treatments. According to the National Vietnam Veterans Readjustment Study (NVVRS), 22.2% of male Vietnam veterans with a current PTSD diagnosis suffered from alcohol abuse and dependence, in contrast with 9.2% of male Vietnam veterans without a current PTSD diagnosis (Kulka et al. 1990). The NVVRS data also show that 6.1% of Vietnam veterans with a current PTSD diagnosis
suffered from drug abuse and dependence (other than alcohol), in contrast with 1.0% of male Vietnam
veterans without a current PTSD diagnosis. Many explanations have been offered for these elevated
prevalence rates of substance abuse. One plausible explanation that has attracted attention is the self-
médication hypothesis (Khantzian 1985). According to this hypothesis, combat veterans use alcohol or
other drugs to modulate either the physiological hyperarousal or the numbing and avoidance common with
PTSD.

Self-medication is not a sufficient explanation for alcohol or other drug use among Vietnam
veterans with PTSD; however, it is a primary contributor. Alcohol and other drugs may be poor regulators
of negative affect—such as anger, mood lability, irritability, and temper—but they do offer some relief to
the combat veteran who suffers from PTSD. Anecdotally, combat veterans in treatment for PTSD and
substance abuse commonly describe having used psychoactive substances during the Vietnam War to
tolerate stress of combat, fear of death, and boredom associated with foreign military duty. Alcohol and
other drugs were readily available and, for many combat veterans, alcohol and other drug use was viewed
as a viable coping strategy; however, this coping strategy offered only short-term benefits. In the long term,
alcohol and other drug use resulted in many disadvantages. First, alcohol and other drug addictions may
have contributed to the onset of PTSD by allowing veterans to avoid addressing unpleasant emotions
elicited during combat. Second, the cyclical effects of the drugs and the lifestyle associated with drug use
may maintain the symptoms associated with PTSD. Third, substance abuse and PTSD interact to such a
great extent that treatment is especially complicated. PTSD, for example, is associated with increased
symptoms of irritability, anger, and mood lability, which may in turn lead to a slip or a relapse.

Because this subpopulation of veterans has problems with anger control (Chemtob et al. 1994),
adjunctive treatments for PTSD are needed to address these secondary problems. This article describes a
12-week anger-management group intervention for individuals with PTSD who abuse
drugs and have anger control problems. A case vignette is also presented to help clarify
the procedures.

PTSD AND SUBSTANCE ABUSE

PTSD consists of a complex and heterogeneous set of symptoms. The essential feature of the syndrome is the
development of symptoms following exposure to an extreme traumatic stressor. According to DSM-IV
(American Psychiatric Association 1994), the response to the stressor must be a direct personal
experience of an event and involve actual or threatened death or serious injury, or a threat to
physical integrity of self or others. The response to the event can take many forms, such as recurrent and
intrusive distressing recollections or dreams of the event, acting or feeling as if the traumatic event were
recurring, and intense psychological distress or physiological reactivity on exposure to internal or external
cues symbolizing the traumatic event. Individuals with PTSD tend to avoid stimuli associated with the
event and to show a numbing of general responsiveness. Persistent symptoms of increased arousal are also
present; they include irritability or outbursts of anger, difficulty concentrating, and hypervigilance.

The etiology of PTSD is still unclear, but a consensus is beginning to form regarding the necessary
phases of treatment (Kiyuna, Kopriva & Farr 1993). Many treatments are psychodynamic and consist of
helping clients reevaluate their past trauma and construct a more appropriate inner
representation of their traumatic experiences (Emery, Emery & Berry 1993). Horowitz and colleagues (Marmar & Horowitz 1988; Horowitz 1986, 1979),
for example, have outlined the healing process of PTSD as a four-stage sequence. In the first stage of treatment,
emphasis is placed on establishing rapport with the client and creating an atmosphere of safety and support.
Once psychological and emotional stabilization is achieved, the second stage consists of engendering a
sense of hope within the client. In the third stage, the client develops a new understanding of the trauma by
reexperiencing the event: the client “tells his story” and is helped to explore the intrusive occurrences in
affective and cognitive processes. Completion of treatment is signaled by a functional reintegration of
the traumatic experience, either within the client’s existing cognitive schemas or through newly established
ones. This four-stage sequence is characteristic of many treatments of PTSD in that the initial stages
concern forming an alliance with the therapist, while subsequent stages concern reexperiencing or uncovering a traumatic experience that has not yet been resolved.

Establishing rapport with the client and creating an atmosphere of safety and support is an essential aspect of early treatment of PTSD. Unfortunately, building rapport and creating a supportive environment is often complicated in Vietnam combat veterans with PTSD by substance abuse (McFall, Mackay & Donovan 1992; Hyer et al. 1991; Keane, Caddell & Taylor 1988) and anger and violence problems (Kulka et al. 1990; Hyer et al. 1986; Carroll et al. 1985; Escobar et al. 1983). PTSD clients who display anger and violence problems, for example, are more likely to continue using alcohol and other drugs, or relapse to these substances. In addition, treatment programs are often reluctant to enroll these clients; or if enrolled, they are more likely to be discharged from treatment for disciplinary reasons.

The Substance Use/Posttraumatic Stress Disorder Team (SUPT) at the San Francisco Veterans Affairs Medical Center, a treatment program for Vietnam combat veterans, developed a multistage treatment model consistent with Horowitz’s four-stage model of treatment. In phase one of the SUPT program, clients attend a structured open group designed to engage, stabilize, and further assess the client. The focus of this phase is on addressing substance abuse problems and anger management. Abstinence is encouraged, but is not required. This more tolerant approach has been taken based on the belief that the independent complications of substance abuse and PTSD interact to such a great extent that they hinder engagement. In phase one of treatment, clients are encouraged to address the difficulty of changing their situation, the extent PTSD contributes to their substance abuse, and their attitudes toward institutional settings, especially those operated by the government.

In phase two, psychoeducational issues and continued anger management are emphasized. Psychoeducational issues include the ways that PTSD and substance abuse interact, distortions of thinking associated with substance abuse and PTSD, and models of relapse prevention.

Consistent with the Horowitz model, treatment staff establish rapport with clients and provide a safe and supportive environment in phases one and two of treatment. Once these conditions are established, the focus of treatment shifts in phase three to combat trauma.

THEORETICAL MODEL

The objectives of anger management treatment are (1) to teach clients to identify the specific cues and triggers to anger, and (2) to help clients develop strategies for controlling their anger in the form of individualized control plans. The treatment also has the secondary objectives of examining the associations among substance abuse, anger, and violence, as well as the way substance abuse escalates anger and violence.

The treatment approach is a form of self-instructional training (Meichenbaum 1985) based, in part, on the early work of Novaco (1975). The approach also borrows from a treatment model that has been used successfully by the Domestic Abuse Project in Minneapolis (Edelson & Grusznski 1988; Reilly & Grusznski 1984).

Anger control problems are conceptualized from a cognitive-behavioral perspective. A fundamental assumption of this approach is that it is not specific persons or events that produce emotional and behavioral responses, but the cognitive appraisal of these events. Anger can be described rather easily within this cognitive framework: anger results from the belief that we, or our friends, have been unfairly slighted, which causes us both painful feelings and a desire or impulse for revenge (Lazarus 1991). Anger is an adaptive emotion that signals threat or harm, quickly energizes behavior, and mobilizes resources, directing a behavioral response to reduce the threat (Novaco 1976). For some individuals, however, anger is experienced frequently and with intense arousal. When experienced in this extreme form, anger can lead to health problems, verbal abuse, or violence.

Various approaches have been used for the treatment of anger, but the SUPT program decided to base its treatment model on Meichenbaum’s (1985) self-instructional training. According to Meichenbaum, responses such as anger and violence are socially learned, reinforced, and practiced to the extent that these responses soon become automatic. Individuals display these responses without deliberate thought and without thinking of the consequences of their actions. Responses that are learned, however, can
be unlearned. Meichenbaum’s approach can be used to teach clients to think and plan before they act: to stop, look, and listen before behaving impulsively (Liebert & Spiegler 1994).

The anger management treatment is organized around Meichenbaum’s three phases of treatment: conceptual, skill acquisition and rehearsal, and application and follow-through. The conceptual phase consists of creating a working relationship with clients, and helping them better understand the nature of their anger. Clients are taught a basic conceptual framework for understanding anger. Initially, the focus is on reconceptualizing anger in terms of the persons, situations, and events that elicit anger, as well as the thoughts, images, and physical cues that indicate an escalation of anger. The focus is also on the role that cognitions and other emotions, such as shame and guilt, play in eliciting and escalating anger.

In the skill-acquisition and rehearsal phase, clients are provided with a variety of behavioral and cognitive coping techniques, which they can then use to control their anger. Clients differ regarding their ability to use these techniques, so they are encouraged to consider what works best for them and to consolidate these strategies into a specific and individualized anger-control plan.

The application and follow-through phase in Meichenbaum’s approach consists of arranging for transfer and maintenance of change from the therapeutic situation to the real world. Transfer is encouraged throughout the 12 weeks of treatment. At the start of each session, for example, clients “check in” by describing an event during the past week that had produced an escalation of anger. Clients are encouraged to describe how they managed their anger by using one of the specific cognitive-behavioral strategies outlined in group.

### DESCRIPTION OF TREATMENT

#### Sessions 1 and 2: Cues to Anger and the Anger Meter

The first two sessions consist of a set of didactic presentations in which clients are presented with a basic conceptual framework for understanding their anger. Clients are taught to examine the cues indicating an escalation of anger. Cues are presented as belonging to four cue categories: physical, emotional, fantasies and images, and red-flag words and situations.

Physical cues to anger escalation can be either internal or external. Internal cues include rapid heartbeat, tightness in the chest, and feeling hot or flushed. External cues include clenched fists, a glaring stare or agitated pacing back and forth. Emotional cues are the other emotions that coincide with anger and further increase the escalation of anger. For many clients, anger is a reaction to feeling hurt, shamed, or powerless. In these instances, anger is used to increase feelings of power and control. Other emotions indicating this loss of control may include fear, jealously, hurt, and humiliation. Fantasies and images can also indicate anger, and may include elicitors of anger, such as imagining that one’s spouse is having an affair, or behavioral reactions following anger, such as mental rehearsals and fantasies of committing a violent assault. Red-flag words and situations are the specific issues and events from an individual’s past that may continue to elicit anger. For example, clients may react with anger when called a particular name they were teased with during their childhood. Specific criticisms, such as “you’ll never be any good,” can also elicit anger. Other examples are thoughts about ex-spouses, references to Vietnam, or the frustrations associated with having unstable living and financial circumstances. Clients are taught that these cues may differ across individuals, and emphasis is placed on the specific cues that they use to monitor their escalation phase.

Teaching clients to self-monitor their anger is a second important goal of treatment. As described by Meichenbaum (1985), responses such as anger have been learned to the extent that they appear to occur spontaneously, without deliberate thought or control. Self-monitoring allows clients to understand the events and situations that elicit anger, the cues that indicate an escalation of anger, and the thoughts and cognitions that maintain and further escalate anger.

To help clients monitor their anger more objectively, they are asked to rate their anger on the anger meter (see Figure 1)—a 1-10 thermometer-type scale in which 1 represents a state of complete calm and 10 represents a complete loss of control, which usually results in aggression, such as verbal abuse or violence, and consequences, such as a loss of intimacy, freedom, a job, or a benefit. Levels of anger arousal between these two anchors are assigned intermediate values on the anger meter. In the fourth session, the anger
meter is linked to a cycle of violence or aggression (Walker 1979). During the first two sessions, however, the anger meter is presented in its simplest terms.

**Sessions 2 and 3: Anger-Control Plans and Anger as a Secondary Emotion**

In sessions 2 and 3, the concept of an anger-control plan is presented. Each client is asked to begin formulating a plan for controlling anger. Developing the anger-control plan corresponds to Meichenbaum’s skill-acquisition and rehearsal phases. During group sessions, specific cognitive and behavioral strategies are presented and discussed. Clients are encouraged to use a combination of traditional cognitive-behavioral regulation strategies and individual strategies they develop themselves. Examples of traditional cognitive-behavioral strategies presented in subsequent sessions include time-out, relaxation training, exercise, monitoring negative self-talk, and conflict resolution models. Individual strategies developed by clients include attending 12-Step meetings, and talking about an anger-provoking situation with a friend or relative. Regardless of the strategies used, the individual nature of these strategies is emphasized and clients are encouraged to use the strategies that work best for them. A specific example is presented in Figure 2.

After the concept of an anger-control plan is introduced, other emotions are discussed that may coincide with, or elicit, anger. Group members complete a structured exercise where they are asked to identify the underlying emotions coinciding with their outbursts of anger. The manner in which anger can be a reaction to fear, insecurity, jealously, or humiliation is discussed.

**FIGURE 1**

ANGER METER USED TO MONITOR ANGER

| 10* | *Explosion, violence, loss of control, negative consequences—You lose! |
| 9   |                           |
| 8   |                           |
| 7   |                           |
| 6   |                           |
| 5   |                           |
| 4   |                           |
| 3   |                           |
| 2   |                           |
| 1   | You have a choice!       |
| 0   | Use your anger control plan and avoid hitting 10! |

**Session 4: Time-out and the Aggression Cycle**

Time-out can be used formally or informally. Formally, time-out is associated with established relationships with family members and friends. A formal arrangement is made between the client and a friend or family member. Specific rules of the interaction are set forth, and both parties agree to follow these rules. Either party can call a time-out. The person calling the time-out leaves the situation for a specific period, and thus prevents the further escalation of anger. The person then returns to the situation and checks in with the other party. Together, they can decide to finish the transaction or postpone the issue for a time when both parties believe they can resolve the conflict successfully.

Many group members have used time-out more informally, meaning to take a few deep breaths and think before reacting. Time-out may also refer to leaving a noninterpersonal situation that is producing an escalation of anger. For example, riding a crowded bus elicits anger in many clients. An example of a time-out strategy in this situation is getting off the bus and boarding a less crowded bus.
The aggression cycle is based on Walker’s (1979) cycle of violence. The SUPT program modification of the cycle consists of three phases: escalation, explosion, and postexplosion. Anger arousal increases during the escalation phase, in which individuals may deny or minimize the importance of tension or conflictual situations. They may increase hostile self-talk or attempts to intimidate others through body language. If arousal is left unchecked, an individual may display aggression or violence during the explosion phase. Clients are taught that these outbursts usually involve a destructive and uncontrollable discharge of anger. Both verbal abuse and physical aggression are considered to be destructive and uncontrollable behavior because in many instances the consequences to the individual may be equally severe. The postexplosion phase involves the consequences of the explosion phase, which may include jail, termination from treatment or a service program, financial costs, or loss of family or loved ones. Other consequences include feelings of regret, remorse, or guilt.

Clients are taught that the escalation phase is the critical point in the aggression cycle where the intervention is most effective. During the escalation phase, clients can choose alternatives to violent behaviors and prevent further escalation. Many clients believe that their anger and violence is sudden, spontaneous, and without warning. They also believe, however, they would be less violent or aggressive if they had advance warning. By using the aggression cycle, and by identifying the cues that indicate an escalation of anger, clients learn that their anger and violence are never sudden and unpredictable, and that they can control their anger by monitoring their cues and using appropriate cognitive-behavioral strategies.

Session 5: Self-Talk Model

Self-monitoring of verbal statements that escalate and maintain anger is central to self-instructional training. As with other cognitive theorists, Meichenbaum (1985) contends that individuals respond to events with an inner dialog or “self-talk.” Ellis (1973) takes a similar approach, contending that the beliefs and expectations of an event produce emotional responses. Thus, from the perspective of anger management, a core set of beliefs underlies an escalation of anger. Ellis developed a straightforward A (activating event), B (belief), C (consequence) model of cognitive appraisal. Beliefs or expectations are thought to mediate the emotional response (C) to the activating event (A). Stated simply, changing beliefs and expectations is the most direct way of changing emotional responses. This model is presented to SUPT clients and some of the possible beliefs they may use during the escalation phase of the aggression cycle are discussed.

Session 6: Relaxation Training

Relaxation training is another specific behavioral technique available to clients. In this session the basic rationale for relaxation training is examined, and clients practice deep-breathing exercises and other basic techniques. They are encouraged to set aside time to practice these exercises.

Session 7: Conflict Resolution Model

The conflict resolution model is introduced as a strategy to resolve conflicts and to solve problems. The model consists of four steps: (1) identify the event producing the conflict, (2) explore the feelings associated with the conflict, (3) examine the consequences of the conflict, and (4) develop a solution or compromise to resolve the conflict.

Sessions 8 and 9: Analysis of Most Violent Incident

The “Analysis of Most Violent Incident” is a structured exercise in which each group member analyzes his most aggressive or violent incident from his past. At this point in treatment, clients are aware of their own specific cues indicating an escalation of anger and have begun to develop specific anger-control plans. The purpose of this exercise is to help clients reevaluate an episode where they were extremely violent. Clients review the episode and explore how they might have controlled their anger had they used the anger management strategies they have learned in group. The exercise consists of describing where the incident occurred, the events leading up to it, the client’s expectations regarding violence, the type of violence displayed, if alcohol or other drugs were involved, or whether memories of combat experience played a role during the incident. Clients then discuss the advantages and disadvantages of using violence to cope with this incident. Identifying the advantages and payoffs of using violence is important because this assists clients in understanding the motivation driving their behavior.
FIGURE 2
JOHN’S ANGER CONTROL PLAN

Specific Cognitive-Behavioral Strategies
1. Take a time-out.
2. Take a 20-minute walk.
3. Slow down and take a few deep breaths.
4. Use the conflict-resolution model.
5. Talk about stressful events with Bill, Tom, or Fred.
6. Try to understand my red-flag situations by talking about them to the anger management support group.
7. Accept others rather than expecting them to live up to my expectations.
8. Listen to music.
9. Attend the 42nd Street AA meeting.
10. Work out three times a week at the YMCA.

Sessions 9 and 10: Anger in Family of Origin

“Anger in Family of Origin” is an exercise consisting of a series of questions designed to help clients explore how they were influenced by the expression of anger and other emotions in their families. Clients are asked to describe how anger was expressed in their families; how other emotions were expressed; how they were disciplined, how they responded to the discipline; the role they played; the most frequent phrase they heard; the messages they received about their parents and men and women in general; the thoughts, behaviors, and attitudes that carry over into their adult lives and relationships; and the current purpose these behaviors serve. Finally, clients are asked to discuss the difficulty of changing these behaviors. The Anger in Family of Origin exercise is meant to help clients understand the manner in which past behavior may influence current behavior.

Session 11: Assertiveness Training

The assertiveness skills presentation is provided to teach group members the definitions and differences between assertive, aggressive, nonassertive, and passive-aggressive behaviors. Group members are taught that these behaviors are learned, and are not rigid unchangeable predispositions. Clients are encouraged to practice assertive behaviors; they are asked to consider how aggressive or nonassertive behaviors can be expressed assertively.

Session 12: Final Session

In the final session, group members review their anger control plans and discuss the specific ways they have learned to manage their anger.

CASE VIGNETTE

A male veteran diagnosed with PTSD and substance abuse was enrolled in the SUPT program and received anger management treatment. He began attending the anger management groups in May 1992 and continues to attend a drop-in anger management support group regularly.
John is a 45-year-old, divorced, Hispanic, Vietnam veteran, with a 25-year history of alcohol and heroin dependence. He grew up in Texas, graduated from high school, and served in the Navy from July 1969 to April 1971. During his tour in Vietnam, John saw significant combat, including friendly and hostile incoming fire. He took part in amphibious invasions and engaged the enemy in fire fights. John saw many of his comrades killed, including his best friend who died several feet away from him from an exploding land mine. He also witnessed many atrocities, including the killing of Vietnamese civilians.

John began using alcohol and heroin while in Vietnam. Following his discharge, he experienced symptoms of depression, fearfulness, hypervigilance, and isolation. John began to increase his alcohol and heroin use in an attempt to decrease these feelings. Although trained as a welder, John was unable to hold steady employment. Prior to his entry into treatment for PTSD, he was hospitalized on several occasions for depression and two suicide attempts. John was arrested more than 30 times for assault and disorderly conduct.

In 1991, John began outpatient treatment in the Posttraumatic Stress Disorder Clinic at the San Francisco Veterans Affairs Medical Center. He engaged in group psychotherapy and received psychopharmacotherapy; however, he continued to abuse alcohol and heroin and displayed significant behavioral difficulties, including occasional assaults. In December 1991, John was hospitalized in the inpatient PTSD program following an escalation of angry outbursts, including an incident in which, apparently without provocation, he swung a stick at a man he encountered on a walk.

At the time of his admission to both the SUPT program and the anger management group in May 1992, John reported that he had not used alcohol or other drugs for one month. He complained, however, of intrusive thoughts and memories, nightmares, flashbacks, sleep disturbance, poor concentration, and frequent outbursts of anger.

During his initial sessions in the anger management group, John reported high levels of irritability and anger, and very low frustration tolerance. On one occasion, he destroyed personal property during an episode of rage. Over the course of several weeks in the group, though, John became skilled at monitoring his anger by using the anger meter and identifying the physical, emotional, and situational cues that led to his escalation of anger. He also became aware of his hostile self-talk, and began changing these negative thoughts to more positive thoughts. Soon, he reported experiencing less anger; John began to use anger management strategies, such as time-out and an exercise program, to control his anger effectively. By the eighth week of treatment, John was regularly practicing assertiveness techniques, such as conflict resolution. His improvement is exemplified by an incident that occurred during his tenth week of treatment. John reported that he had become angered when he learned that his landlord had let his ex-wife into his apartment without his permission. Rather than acting out aggressively against the landlord or destroying property, John spoke directly to his landlord, resolving the incident assertively.

John has continued to make significant progress. He completed the 12-week group and continues to attend an anger management support group for SUPT clients. He has maintained his abstinence throughout his treatment in the SUPT program. He has become significantly less isolated, having formed friendships with group members, and has enrolled in a work training program. He has progressed from angry outbursts and violently acting out to taking brief time-outs and assertively resolving conflicts. John is now more confident in his ability to negotiate difficult situations, can identify anger-provoking situations, and can manage his anger effectively with specific cognitive and behavioral techniques.

CONCLUSION

John exemplifies the complications associated with the treatment of PTSD and substance abuse. Many of these clients display outbursts of anger that may complicate treatment. In response to these problems, a cognitive-behavioral group treatment for anger management was developed. The treatment consists of teaching clients to monitor their anger, to identify their cues to anger, and to develop anger management strategies. Many clients have described the anger management treatment as a critical component of their substance abuse treatment. Clients use these anger management techniques to control their anger effectively, which in turn helps them remain abstinent and stay in treatment.

REFERENCES


