Anger in the Combat Zone

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A U.S. Army Reserve Combat Stress Control prevention team was dispatched to Afghanistan in support of Operation Enduring Freedom to provide preventative mental health care to a U.S. Army airborne division and Special Operations forces. The team’s mission was to ensure mental health readiness of units in the area of operations. In Bagram, Afghanistan, the Combat Stress Control team identified anger as a very prevalent emotion in the combat zone. Anger management interventions with individual and group counseling were implemented to help soldiers cope with anger. Of 7,000 military personnel stationed there during the team’s rotation, there was not one completed suicide or homicide. This article describes how the 113th Medical Company identified, treated, and controlled anger at Bagram Airbase, Afghanistan, between June 20, 2002, and December 20, 2002, with anger management interventions. This article does not address the psychophysiological features of anger.

Introduction

United States Army Mental Health has played a crucial role in ensuring a mentally healthy and mission-effective combat force. The mission of the U.S. Army Mental Health/Combat Stress Control team in combat is to maintain presence with the soldier, maintain the health of the command, save lives, remove the disabled from the battlefield, provide quality care, and return soldiers to duty.1 Historically, CSC teams were very effective in several conflicts, including Operations Desert Shield and Desert Storm and Somalia. After the tragic events of September 11, 2001, the U.S. Army responded by sending combat troops to Afghanistan. This CSC prevention unit provided several interventions, including command consultations, preventative mental health training, and individual and group therapies. Soldiers were treated for depression, adjustment disorders with depressed mood, combat stress, anxiety, and occupational problems. Anger was the common emotion. The team originally consisted of five members, i.e., two psychiatrist team leaders, each serving a 90-day rotation, a social work officer, a senior mental health specialist, and a mental health specialist. A psychiatric nurse, another senior mental health specialist, and a second mental health specialist were later operationally attached from a combat support hospital (CSH), bringing the total number to eight behavioral health personnel. The 113th Medical Company was attached to an airborne medical command task force in northeast Afghanistan and conducted treatment services near the CSH. Angry dangerous soldiers raised serious concerns for the safety of other soldiers, because of the accessibility of numerous weapons in the combat zone. With the CSC prevention team, the treatment of psychiatric casualties and angry outbursts was performed on basic principles of proximity, immediacy, expectancy, and simplicity. Treatment was provided close to the front lines, with the expectation of return to duty.

The provision of early intervention services for soldiers to cope with stress included command consultations, focus groups, smoking cessation groups, after-action debriefings, redeployment surveys, and reunion briefings. Treatment interventions for psychiatric illness were individual counseling, anger and depression group therapies, Alcoholics Anonymous/Narcotics Anonymous meetings, and medication management.

Definitions

Although definitions of anger vary, psychologist Charles Spielberger2 stated, “Anger is an emotional state that varies in intensity from mild irritation to intense fury and rage. Like other emotions, it is accompanied by both physiological and biological changes; when you get angry, your heart rate and blood pressure go up, as do your levels of energy hormones, adrenaline, and noradrenaline.”

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, which is used for psychiatric diagnoses, has no definition of anger and it is not classified as a mental disorder. However, in the same glossary, anger is noted as “an example of affect or expression of a feeling state.”3

Research involving combat veterans has shown that anger and rage are prevalent emotions in post-traumatic stress disorder.4 Soldiers in a combat zone are subjected to multiple stressors, including threats from enemy combatants, environmental hardships, and lack of physical comforts, which contribute to feelings of anger, frustration, and rage. Anger is mediated by the fight-or-flight response, which motivates soldiers to complete their missions. When anger becomes uncontrolled, however, soldiers become a danger to themselves or others, reducing combat readiness and effectiveness and the morale of the unit. When anger was the cause of combat misbehaviors, soldiers were referred to the CSC unit for anger management therapy.

Literature on the History of Anger

A review of the literature of the history of anger in war mentions that the Egyptian pharaoh Ramses II, to prevent his armies from being decimated by the Hittites, signed a peace treaty with Hattusis III, King of Hatti, in the area of what is now modern Turkey, as early as 1280 BC.5 In psychiatry and law, there were two mental defenses for misconduct, i.e., cognitive defense, an inability to understand, and volitional defense, an inability to exhibit self-control. Most states have continued to accept cognitive defense but no longer accept anger or extreme...
emotions as a mental defense. Consequently, crimes of passion may receive sympathy from a jury, but the condition is no longer an acceptable mental defense. Army legal policy states that mental health officers providing care for the U.S. Army Medical Department must adhere to the Tarasoff ruling, a Health and Welfare statute originating from a 1976 California court decision, whereby an intended victim must be notified when there is a verbalized direct threat by the patient to do harm. Therefore, Army mental health clinicians have a duty to warn intended victims if a person, during therapy, verbalizes a premeditated plan to do harm.

### Anger Theories

#### Biological

According to the psychiatric literature, there are several theories for the causes of anger. The four predominant causes are biological, cultural, social, and psychological. There is the nature vs. nurture theory. The nature or biological determinism theorists view people as naturally aggressive, looking for war and fighting their neighbors because of their inability to control their violent impulses.

The nurture position involves the cognitive-environmental theorists, who believe that humans learn what actions pay off in the environment. The cognitive-environmental theory states that humans learn in life with the fight-or-flight response and that unpleasant situations cause unpleasant emotional responses, including anger and hostility. In relation to this theory, soldiers in a combat zone quickly respond to the perception of being under attack with aggressive responses for survival.

#### Cultural

Social psychologist Carol Tavris explained that each society or culture maintains both implicit and explicit rules for expressions and for conflicting emotions. A reference group, by modeling ways to deal with anger, teaches its members acceptable anger responses. Children from a certain society may learn from their parents to value positive peer relationships and to express their anger in a negotiated nonviolent manner.

#### Psychological

Cognitive theorists believe that a person’s thinking processes about experienced events, elicits emotions, which bring about behavioral responses. The soldier may perceive himself being treated unfairly, based on a false assumption about rules of fairness, and behaves angrily.

In 1939, Dollard formulated the frustration-aggression hypothesis, which states that anger is an inner drive striving to gain expression. As a drive, anger seeks to express itself in two directions, either displacement or catharsis. Displacement occurs when the aggression is deflected away from the actual target and toward a safer target. Catharsis, or venting, occurs when the person is able to express feelings that have built up and are released to "get it off one’s chest." As research by McKay et al. noted, catharsis or ventilation does not appear to decrease anger; rather, it leads to continuing anger and aggression.

#### Social

There are several theories that explain how anger leads to aggression. According to the social learning theory, Bandura believes that aggression is learned two different ways, i.e., by observing aggressive role models and by receiving and expecting rewards after aggressive behaviors. The rewards come in different forms, (1) building self-esteem, (2) receiving recognition for committing aggressive acts, (3) reducing tension, and (4) obtaining financial rewards. For example, soldiers are taught in basic training that one responds to threats to personal safety by using aggressive behaviors. The social learning theory is an observational learning process where people observe and imitate others. There are four cognitive components impacted by the observers behavior after exposure to models. They are memory retention, personal motivation, motor reproduction, and attention. Risk factors in the combat zone that increase anger are shown in Table I.

### Manifestations of Anger

#### Symptoms

Symptoms are subjective manifestations of anger and were self-reported by the soldiers during therapy sessions. The team identified symptoms using a classification system developed by Madlow, wherein verbalizations and behaviors indicated anger and aggression. Indirect behavioral symptoms were self-reported by the soldiers as feelings of difficulty with one’s temper or impulses, depression, guilt, crying, tiredness, withdrawal, irritability, fatigue, or being accident-prone in the combat zone. Direct verbal statements indicating anger were comments of hatred, contempt, disgust, criticism, suspicion, blame, revenge, and self-hatred.

#### Signs

Signs of anger were objective manifestations of anger that were observed by team members during clinical assessments or therapy sessions. Indirect behavioral signs included clenched fists, angry affect, tearfulness, hyperactivity, difficulty focusing, and pressured speech. Assault-type signs were threatening, aggressive, or violent behaviors observed and reported by witnesses during the

### Risk Factors in Afghanistan that Increased Anger

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<td>Spouse at home with poor money management</td>
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<td>Housing</td>
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<td>Interpersonal disputes</td>
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<td>Drug and alcohol use</td>
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precipitating event, such as when an airman threatened to harm another airman in his unit while brandishing an M-16.

Verbally aggressive comments were statements threatening to harm either self or others. An example is when a soldier threatened to lose his ability to control his temper if his command did not allow him compassionate leave to visit his sick wife. Hurtful-type comments were statements criticizing others, intended to damage the reputation of others, and were made by soldiers who felt powerless to deal with others. An example is when a soldier spread malicious gossip about a supervisor he believed he could not communicate with. Rebellious-type comments were statements the soldier made that showed he had become angry with or had lost confidence in his supervisor and he would no longer follow the commands of his leadership.

Philosophy of Anger Management

The team used a cognitive-behavioral approach in treatment. Research has found that cognitive behavior therapy is effective in reducing anger and depression, and it seemed effective for dealing with soldiers with time limitations imposed by combat mission requirements. The treatment team maintained the philosophy that soldiers take personal responsibility to control their anger responses and to commit to behavioral changes. Therefore, we emphasized in individual or group therapy that one could choose alternative behavioral responses by developing a repertoire of skills to modulate anger.

Consequently, the focus in therapy was to help each soldier understand how he thought, felt, and behaved when angry. We assisted the soldier in committing to behavioral changes by recognizing causes of anger and in substituting anger-inducing thoughts with anger-reducing thoughts.

Goals of Anger Management

The team maintained four key anger management goals, i.e., cognitive, affective, behavioral, and restoration. In the cognitive area, the soldier learns that personal interpretations of life events cause anger. He is taught anger identification (identifying thoughts and perceptions that produce anger) and cognitive restructurings (thinking more realistically and optimistically). The therapeutic goal is to change anger-producing thoughts into anger-reducing thoughts by increasing problem-solving skills, realistic thinking, perspective, reasoning abilities, positive attitude, and hope.

In the affective area, the soldier understands the relationship between anger feelings and physiological processes and learns anger modulation (the ability to control anger responses). The therapeutic goal is to feel less angry by learning progressive relaxation, meditation, focusing techniques, and deep breathing exercises.

In the behavioral area, the soldier learns alternative behaviors to cope with anger. The soldier is taught anger management application, coping with traumatic events by substituting maladaptive behaviors with an adaptive, self-empowering repertoire of coping skills. The therapeutic goal is to learn anger control through appropriate behavioral patterns. The soldier is taught pain management techniques, networking for support, time-outs, exercise, avoidance, “counting-to-ten,” and behavioral rehearsal with positive imagery.

In resolution, the soldier is provided assistance in establishing a support system for returning to duty. A “get-well” plan is developed with leadership to keep the soldier productive while maintaining overall unit morale and effectiveness. The therapeutic goal is to learn assertive communication skills, negotiation, and limit setting.

Our goals of anger management therapy were similar to those in a 1996 study of an anger therapy program using cognitive-behavioral interventions with Vietnam veterans with post-traumatic stress disorder and intense anger. The study showed promising results with anger control therapy, using a “stress inoculation” method to reduce anger with three main components, i.e., cognitive modification, arousal reduction, and behavioral skills training.

Therapeutic Process

Anger was assessed clinically with Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, criteria and not with psychometric testing, such as with the Clinical Anger Scale. A mental status evaluation, which was used to gather biogenetic history, (precombat) psychiatric history, family history of expressing anger, family history of violence, criminal history, individual history of expressing anger, current precipitating factors, and magnitude of the incident, was conducted to determine the diagnosis and to identify anger, aggression, and level of risk, for the development of a treatment plan. Angry soldiers were treated with crisis intervention counseling, individual therapy, or group therapy. A command consultation with the unit leadership was conducted, with recommendations for a unit support network.

Risk management was used for soldiers assessed to be immediately dangerous to themselves or others. Administratively, command decisions were made after clinical consultation, to protect the safety of the soldier and the unit. The soldier was relieved of his weapon, assigned a one-to-one escort to monitor his movements, given a “no-contact” order for other soldiers in the unit, administered Uniform Code of Military Justice action, or placed in a detention facility. For psychiatry, clinical decisions were made for the provision of treatment to anger-dangerous soldiers with mental disorders by recommending a 1- or 3-day restorative hold, providing individual therapy, placing the soldier in an anger or depression group, administering medications, or arranging for a behavioral health evacuation.

Suicide

Afghanistan was an austere combat environment. Factors such as the fast operational tempo, extreme weather, unknown length of deployment, and difficult terrain, combined with individual genetic composition, developmental history, psychiatric illness or substance abuse, a significant emotional event involving feelings of loss, separation, or changes in the soldier’s self-esteem, caused depression and anger, triggering suicidal behaviors.

As previously mentioned, there were no suicides at Bagram during our tour. However, feelings of depression, anger, and loss were common in the majority of diagnosed treatment cases in Operation Enduring Freedom (June through December 2002). The 634 soldiers seen in individual therapy were diagnosed with the following: depression (25%), adjustment disorders with mixed emotional features (25%), anxiety disorders (10%), occu-
pational problems (20%), combat stress (5%) (T. Hicklin, unpublished data), bereavement (5%), and others (10%).

In comparison, there were 17 suicides for soldiers deployed in support of Operation Iraqi Freedom (between January and October 2003). The same report of behavioral health disorders showed diagnosed cases of adjustment disorders (39.43%), affective disorders (including bipolar disorder, depressive disorder, dysthymic disorder, major depressive disorder, and mood disorder) (25.09%), anxiety disorders (19.35%), and others (5.02%).

Comparison of Suicide Rates in Afghanistan and Iraq

In Afghanistan, there was a smaller population, approximately 7,000 soldiers at the time, compared with 145,000 soldiers in Iraq. Several factors contributed to no soldier completing a suicide, including the smaller numbers of soldiers on the ground, closely knit Special Forces units, strong camaraderie among members of reserve units, and the surveillance and reporting of suicidal behaviors by the chaplains of the unit ministry teams, who organized a rapid response trauma team. Members of smaller units could respond more quickly to intervene when someone displayed obvious suicidal tendencies. The CSC team had high visibility because they had performed numerous command consultations with commanders, unit ministry team members, division surgeons, and medics. The CSC team was close to the front, alongside combat units and easily accessible near the CSH. After a soldier was brought in for crisis counseling, the CSC staff established a monitoring system for high-risk behaviors, which emphasized individual case management. CSC clinicians designated a network of continuing care providers, including “buddies,” and supportive supervisors, to monitor the soldier for suicidal behaviors. CSC staff members established early and ongoing communication with the soldier’s commander about the treatment plan. A treatment plan, including intensive daily individual counseling, 3-day/week anger and depression group therapies, and restoration (ability to provide food and opportunity to rest), was provided to control the symptoms. Although the CSC unit did not have a restoration section (additional staff members and a tent to provide 72-hour holds for observation and treatment), soldiers were provided with either a hold area in an adjacent counseling room or an empty bed in the intermediate care ward of the nearby CSH, where their symptoms could be closely monitored and stabilized.

A review of the same report about suicides during Operation Iraqi Freedom provides several explanations for the 17 suicides, or a rate of 15.6 suicides per 100,000 military personnel. This rate was higher than Army historical rates for an 8-year period from 1995 to 2002, ~11.9 suicides per 100,000 military personnel. Although there were personnel trained in the Army Suicide Intervention Skills Training Program, which taught soldiers to recognize signs of suicide and get help for buddies who needed it, organizational factors that contributed to the suicides appeared to be wider access to loaded weapons among soldiers assigned in Iraq, the fast operational tempo, and many widely dispersed units isolated from forward-deployed behavioral health units.

Group Therapies

The goals of the anger and depression groups were to help soldiers change their behaviors by identifying anger triggers and discover alternative ways of controlling anger in a supportive setting. There were seven group modules. The goal of the first class was to develop a definition of anger, for the identification of anger and for learning alternative ways of controlling anger. The focus of the second group was to discuss the concept of anger triggers, which produce angry responses. The emphasis of the third group was the identification of early childhood experiences and unresolved interpersonal/family issues causing anger in the “here-and-now.” The purpose was the acceptance of the past and the decision for the development of an alternative set of cognitive responses and behaviors. The focus of the fourth group was learning to identify how anger results in negative consequences. The purpose of the fifth group was to identify personal levels of intensity that maintained anger responses. Soldiers were asked to identify how their anger responses were influenced by their parents or reference group. The emphasis of the sixth group was developing alternative anger responses. Soldiers learned behavioral responses most suited for their abilities. The focus of the seventh group was to practice alternative behaviors with group members who provided support for behavioral changes.

The cognitive-behavioral approach used in our group therapies compares with a 1996 research study of an anger management group intervention model for Vietnam veterans with post-traumatic stress disorder that used cognitive-behavioral theories. The components included accountability, responsibility, and “anger logs.” Results from a 4-year evaluation found a significant decrease in anger for the majority of participants.

Our groups used common threads of accountability and responsibility for change but used self-reporting instead of anger logs. There were 118 soldiers who attended the anger and depression groups. While participating in group therapy, all were returned to duty. None of the soldiers who attended the groups demonstrated any suicidal behaviors or was evacuated for behavioral health reasons.

Principles for Working with Angry Soldiers in the Combat Zone

The team minimized the risk of aggression by removing the firearm from the soldier (Table II). When a potentially violent patient was being interviewed, precautions were taken to minimize physical risks to both the therapist and the soldier. Before the interview, weapons were removed and secured in a weapons rack. A plan of escape was devised for the therapist. Two clinicians conducted the interview, accompanied by an escort.
"buddy," i.e., another soldier of the same rank, was assigned support and supervision to the client. "Buddies" were assigned escort duty to and from counseling sessions, served as medical attendants during inpatient stays in the CSH, and provided escort on behavioral health evacuations.

A "no-contact" order was given to a dangerous soldier who threatened harm to an intended victim. As stated in the Tarasoff decision, a provision was made to warn the intended victim and a plan for safety was developed.

All witnesses to the misconduct behavior were interviewed. Interviews with collateral witnesses to the crisis provided clinicians with a more realistic perspective on the soldier's working relationships and coping styles, enabling a more effective treatment plan.

Findings

The effectiveness of cognitive behavioral therapy in Bagram could be extrapolated from statistics for 5 months, namely, June, July, October, November, and December 2002. The rates of return to duty reflect the following. There were 365 soldiers seen in individual therapy on a follow-up basis. Of these, 23 soldiers were considered operational losses, unable to return to duty, resulting in a 94% rate of return to duty (V. Reyes, unpublished data). This compares with a 95% rate of return to duty found in the 2003 Mental Health Advisory Team survey of 756 soldiers who experienced combat in Operation Iraqi Freedom.

Regarding homicides, there were no soldier-on-soldier homicides committed in June to December 2002. There were no available data on homicide rates for Operation Iraqi Freedom for 2003.

In terms of evacuations, only four soldiers, or an average of one soldier per month (a rate of 1% per month), were evacuated, because they were imminently dangerous to themselves, severely depressed, or dangerous to others. This was substantially lower than the Operation Iraqi Freedom behavioral health evacuation rate from January to October 2003, which was 7.1%.

Conclusions

Anger management intervention based on the cognitive-behavioral approach was effective in helping soldiers control their anger. There were high rates of return to duty, low rates of behavioral health evacuation, high rates of attendance in group therapies, no suicides, and no homicides. A unified model of therapy seemed best suited for a combat environment characterized by a fast operational tempo, harsh mission requirements, and an accessible but undermanned behavioral health team (8 total for 7,000 soldiers). The reporting, accessibility to treatments, and management of misconduct attributable to anger were highly attentive and responsive because of several factors, including the high visibility of the forward-deployed CSC team and an organized collaborative system for trauma response (including unit ministry teams).

However, statistical reporting of treatment cases for use in research was inadequate and needs improvement for future behavioral health operations. A longitudinal study of soldiers who were provided with anger management techniques is also needed, to determine long-term effects, such as individual adjustment to re-deployment and adjustment to reunification with family members.

Acknowledgments

We gratefully acknowledge LTC Ansar Haroun, MC USAR, for his guidance and expertise. We also acknowledge the valuable work of MAJ Michelle Ryerson, USAFR NC, in Afghanistan. We thank Marissa Camanga-Reyes, RN MN, for her invaluable assistance in preparing this manuscript.

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