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Resolution of Interpersonal Trauma Through Adaptive Anger

The preceding chapters dealt with strengthening clients' sense of self by helping them work through fear, avoidance, and shame during Phase 2 of emotion-focused therapy for trauma (EFTT). This is necessary before clients can hold offenders accountable for harm, fully grieve losses, and thereby resolve their issues with offenders and attachment figures. This chapter marks the beginning of Phase 3 of EFTT, which is defined not by a particular session number but by establishing a more sustained focus on resolving interpersonal issues. As such, we open this chapter with a brief review of theory and research related to the resolution of trauma. After that, the lion's share of this chapter focuses on anger. This is because the catalyst for resolution in this phase is full experience and expression of previously inhibited adaptive anger at maltreatment and sadness at loss, which lead to meaning exploration and change. Once these emotions are accessed, the process of resolution typically moves forward relatively quickly; this arousal and resolution phase of therapy may take only a few sessions. To that end, we describe research supporting the benefits of healthy anger expression and intervention principles and strategies, first for reducing maladaptive anger, then for accessing adaptive anger in response to maltreatment during the imaginal confrontation (IC) procedure.

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REVIEW OF THEORY AND RESEARCH ON THE RESOLUTION OF INTERPERSONAL TRAUMA

All treatments for complex trauma recognize that repeated betrayal and maltreatment at the hands of caregivers and loved ones cause a more complex array of disturbances than exposure to a single traumatic event (Ford & Courtois, 2020). EFTT is a distinct treatment approach in its emphasis not only on reducing current symptom distress and self and interpersonal problems but also on resolving past issues with specific attachment figures (and offenders) that continue to be sources of distress.

EFTT Definition of Relational Trauma Resolution

Resolution of relational trauma in EFTT involves developing increased emotional competence and more adaptive views of the self and specific others (i.e., perpetrators) who are the focus of therapy. More adaptive emotional processes include reduced negative feelings concerning the other (e.g., hurt, fear, shame, anger, sadness) and an increased ability to acknowledge and attend to one's needs. When the client continues to be in a relationship with past offenders, it could also mean letting go of the hope that these individuals will meet their needs (e.g., attention, approval, respect) and letting go of expectations that the other will acknowledge responsibility for harm, apologize, or change. However, clients do not give up on their own needs but rather find alternative ways to meet them.

Resolution also includes increased self-esteem, despite the other's opinions. It involves reducing the self-blame for one's victimization and an increased ability to assert and stand up for oneself. Overall, there is a growing detachment or increased separation from the other and the traumatic events. Changes in client perceptions of the other include a shift from globally negative views of the other (the "bad object") to a more differentiated and realistic perspective, a better understanding of the other's position and actions toward the client, and clearly holding others responsible for the harm they have caused. The client may or may not feel more positively toward the other or feel forgiving. The relationship between resolution and forgiveness becomes important here and is discussed in the following section. Resolving issues in relationships with attachment figures and forging a strong therapeutic relationship generalizes to reduced symptom distress, increased self-esteem, and reduced general interpersonal problems. These changes help cultivate or restore the capacity for interpersonal connectedness that all too often was shattered by the trauma. This definition of resolution in EFTT shares features with the construct of posttraumatic growth (Tedeschi et al., 2018). According to this idea, after struggling to come to terms with traumatic experiences, people report personal growth that exceeds their pretrauma levels of functioning. Thus, out of the devastation of trauma, there is the possibility of constructing something new. These new (rather than recovered) benefits include increased personal strength, greater clarity about values

(e.g., the importance of relationships), closer connections with family and loved ones, and a generally stronger sense of spirituality or personal meaning in life.

The process of interpersonal resolution in Phase 3 of EFTT develops from the process of clients fully acknowledging the damage and harm that has been done to them and identifying the cause of damage and the person(s) responsible (e.g., "His rages terrified me, destroyed my mother, ruined our family, made me take on a responsibility for the family that was way beyond my years"). This can be accomplished only by allowing and fully expressing feelings of anger and sadness about the other and traumatic events (e.g., "I hate him for what he did to me and my mother," "I feel so sad that we all missed out on so much"). In EFTT, this occurs in the context of the IC procedure (or alternative) whereby clients directly (or indirectly) confront imagined perpetrators of harm.

The Question of Forgiveness

The construct of forgiveness in EFTT overlaps with but is not identical to resolution and is particularly relevant to resolution through anger. Facilitating forgiveness is controversial partly because it sometimes comes with moral and religious imperatives that may seem distasteful to some individuals. It is also unclear whether forgiveness is appropriate in situations of extreme cruelty and childhood abuse and whether forgiveness, as a therapeutic outcome, affords additional benefits beyond other forms of resolution (Chagigiorgis & Paivio, 2006). In any case, forgiveness does not involve condoning the behavior of offenders and bypassing anger but rather acknowledging offenses and working through anger.

Widely held definitions of forgiveness suggest that it requires both psychological separation from and increased affiliation with offenders. An analysis of posttherapy interviews with clients in EFTT indicated that although most clients (82%) reported resolving issues with perpetrators, only a small portion (23%) of those who resolved their issues also reported forgiving the perpetrators (Chagigiorgis & Paivio, 2006). This is consistent with findings from a study of emotion-focused therapy for the forgiveness of "emotional injuries" using the empty-chair intervention (Greenberg et al., 2008). Even in that study, with a nonclinical sample that explicitly aimed at forgiveness, less than half of clients actually forgave offenders (more "let go" of their anger).

In EFTT, specifically, clients more often forgave neglectful as opposed to abusive others (Chagigiorgis & Paivio, 2006). These neglectful others tended to be nonprotective mothers. As a case in point, recall that the client Monica was able to forgive her dead mother by the end of therapy. This suggests that clients may be more motivated to forgive primary attachment figures. This also could be a function of more time spent on task because more time in treatment was spent focusing on issues with primary attachment figures (e.g., as opposed to estranged abusive fathers or nonfamily members). Research on forgiveness also indicates that people's motivation to forgive is a function of

many factors, including religious or moral beliefs and the belief that forgiveness will reduce personal distress (for a review, see Chagigiorgis & Paivio, 2006). Moreover, clients in emotion-focused therapy for couples were more likely to forgive a romantic partner when they believed that partner truly regretted and felt shame about the transgressions (Woldarsky Meneses & McKinnon, 2019). This finding likely also applies to forgiveness of perpetrators in EFTT.

Therefore, as noted earlier, EFTT does not advocate forgiveness as a treatment goal but rather leaves this up to the individual client. If forgiveness of the other has been an appropriate and desired goal for the client, this issue will surface again during Phase 3 of therapy as the client moves closer to resolution. Issues of forgiveness also could emerge for the first time during this phase as perceptions of self and other evolve. In either case, tracking clients' perspectives on this issue may be a key part of the resolution process.

The Process of Interpersonal Trauma Resolution in EFTT

The process of interpersonal resolution in EFTT is based on steps in the model introduced in Chapter 6 and presented in Figure 6.1. This resolution process also parallels the general process of change shown in Figure 3.1 of Chapter 3. In both these figures, we see that pathways to resolution and change are through anger and sadness or grief, which is the focus of the next chapter. Full expression of adaptive anger in EFTT occurs following the reduction of fear and shame (the focus of Phase 2 and the preceding chapters). At the emergence of adaptive anger, clients are encouraged to reengage in the IC (or evocative exploration) procedure and express anger directly to the imagined other. Again, the relatively uninhibited expression of adaptive emotion to imagined offenders marks the shift into Phase 3. Although resolution through anger does not necessarily occur before grieving losses, the strength that comes with anger frequently helps clients face the vulnerability of sadness and loss.

ANGER AND TRAUMA ACROSS THEORETICAL PERSPECTIVES

There is abundant literature documenting the centrality of anger in trauma. Anger at violation and maltreatment is a healthy emotion that motivates self-defense but becomes problematic when it is overgeneralized, underregulated, used to cover more vulnerable emotional experience, or turned against the self. Because areas of the brain responsible for affect regulation develop in the context of secure attachment relationships, failure of brain development may account for the hair-trigger anger response observed in many survivors of child abuse trauma (Schore, 2003). Anger and aggression are also learned responses and ways of coping. There is considerable evidence supporting a link between both childhood physical abuse and exposure to violence with aggressive behavior later in life (Wolfe, 2007). Anger dysregulation is a particular

problem among war veterans who have been exposed to prolonged and extreme violence (Novaco & Chemtob, 2015). Dysregulated anger is also a feature of borderline personality disorder that is associated with a history of childhood abuse.

Promoting the experience and expression of anger in therapy is controversial. Anger is a powerful emotion, and when accompanied by aggressive behavior, it can have destructive personal, interpersonal, and societal consequences. Moreover, most research has demonstrated that although increasing anger arousal (venting or catharsis) can produce immediate relief, it does not reduce anger in the long term (Fernandez, 2016). Therefore, with few exceptions, reducing maladaptive anger is the focus of most approaches to trauma therapy when anger is identified as a problem (e.g., Linehan, 2015; Novaco & Chemtob, 2015). However, some recent cognitive behavior therapy (CBT) approaches to therapy for complex trauma (e.g., Jackson et al., 2020) also acknowledge fear of anger as a problem. These approaches also include training in emotion awareness and assertive communication skills.

However, EFTT distinguishes among different types of anger and specifies criteria for adaptive anger experience and expression, as well as the circumscribed parameters under which anger intensification in therapy is appropriate. Criteria for the healthy expression of adaptive anger in EFTT (described later) are compatible with principles that would be applied in CBT assertiveness training (e.g., Linehan, 2015)—even if those treatment theories do not explicitly differentiate between different kinds of anger. When researchers examined the benefit of skills training in dialectical behavior therapy for borderline personality disorder, they found increases in assertive anger (rather than a reduction in anger, per se) mediated the benefits of treatment (Kramer et al., 2016). This finding is consistent with EFTT theory. However, to promote these adaptive emotional experiences, EFTT focuses more on exploring the personal meaning of disavowed anger than on the behavioral aspects of skills training.

Traditional psychodynamic approaches also focus on the meaning associated with defensive anger, or "anger turned inward," and help clients acknowledge the underlying feelings or express anger at the appropriate source. Meanwhile, intensive short-term dynamic psychotherapy (Abbass & Town, 2013) emphasizes increasing arousal to increase awareness of suppressed anger and unconscious impulses. EFTT includes anger intensification strategies under specific conditions—increasing arousal is only appropriate for accessing inhibited adaptive anger to access the associated adaptive information. Paradoxically, a healthy anger experience can sometimes facilitate forgiveness. For example, Monica had been unable to forgive her mother, who had committed suicide, largely because Monica's anger at her mother had been invalidated and suppressed for so many years. Once one's anger has been acknowledged, validated, assertively expressed, and understood, people feel stronger and more self-confident, and they are freer to focus on, empathize with, and forgive others.

Several research studies support the benefits of adaptive anger expression in EFTT and similar approaches. First, indirect support comes from outcome

and process–outcome studies that support the treatment model, in general, with its emphasis on adaptive anger expression (Paivio et al., 2010; Paivio & Nieuwenhuis, 2001). Similar results have been reported for comparable emotion-focused therapies for other disorders (see Greenberg & Goldman, 2019a) in which expression of inhibited anger is a key therapy process. A host of emotion-focused therapy process studies on a range of treatment concerns have used observational methods to track healthy assertive anger and shown that it predicts symptom reduction post-session and at the end of treatment (Pascual-Leone & Kramer, 2019). One of those studies specifically examined EFTT and showed that when a client's expression of assertive anger—among other primary adaptive emotions—increased over the course of therapy, it more than doubled the likelihood of good treatment outcome (Khayyat-Abuaita et al., 2019).

Direct support for the benefits of anger expression comes from studies that specifically examined the role of anger in EFTT. In one study (Holowaty & Paivio, 2012), 50% of the episodes identified by clients as helpful had anger as the most predominantly expressed emotion (followed by sadness, fear, and shame). Furthermore, results indicated that emotional arousal was significantly higher in helpful episodes than in a group of control episodes. Another study found that higher arousal during both IC and evocative exploration predicted the outcome in EFTT, and again, the dominant emotion during these episodes was anger (Ralston, 2006). Furthermore, anger expression in EFTT does not appear to be simply a function of clients' compliance with their therapists' directives and the treatment model. At pretreatment, 64% of clients identified anger-related problems among the three target complaints they wanted to address in their therapy. Of these, the most frequently identified were unresolved anger toward perpetrators of abuse and difficulties stemming from limited access to anger experience (e.g., powerlessness, nonassertiveness). Thus, many victims of complex trauma entered therapy with a limited capacity to access anger and its associated healthy strivings.

Another study examined the contributions of anger expression specifically in the resolution of child abuse trauma in EFTT (Paivio & Carriere, 2007). Client dialogues during the IC procedure were analyzed using criteria for healthy anger expression. The results indicated a moderate relationship between healthy anger expression and the resolution of abuse issues and interpersonal dimensions of change, particularly at 12 months after treatment. Together, these results support the beneficial effect of healthy anger expression during IC on treatment outcome in EFTT, particularly on interpersonal dimensions of functioning.

PROCESS DIAGNOSIS: DISTINGUISHING DIFFERENT TYPES OF ANGER

Anger is a powerful emotion that has a profound influence on self-organization and interpersonal relations. There are important societal implications concerning displays of anger and its connection to aggressive behavior that account for the existing emphasis in the literature on anger regulation (Sturmey, 2017).

Anger involves surges of adrenaline; a loud, firm voice; erect body posture; and direct eye contact with the target, all of which ready a person to thrust forward and attack.

Adaptive Anger

The following subsections describe anger that has an adaptive function and specify criteria for healthy anger expression in therapy.

Primary Adaptive Anger

Like other basic affects, adaptive anger is an immediate and direct response to real threat or infringement in the environment that is not preceded or mediated by obvious cognitive or other affective components. Anger at interpersonal violation and maltreatment quickly mobilizes self-protective resources and action. It provides energy and a sense of power that readies the individual for self-defense or to protect one's integrity and boundaries. Interpersonally, anger signals others that an offense has occurred, creates separation and distance, and signals them to back off. Difficulties here concern modulating the intensity of anger, which can result in either dysregulation (i.e., too much anger) or overcontrol (i.e., too little anger, when it would be appropriate and adaptive). In either case, the information associated with the anger experience is unavailable to guide adaptive action. The negative consequences of overwhelming anger are obvious. Negative consequences of anger avoidance include a pervasive sense of victimization, recurrent bouts of depression, difficulties with assertiveness, and problems with establishing appropriate interpersonal boundaries. Chronic suppression of adaptive anger can also result in hypertension and instances of "bottle up–blow up" such that the tension of repeated suppression eventually results in explosive outbursts of anger that are disproportionate to the situation (Novaco & Chemtob, 2015).

Criteria for Healthy Anger Expression

EFTT defines healthy anger expression according to specific criteria that are consistent with the definition of primary adaptive emotion (Greenberg & Paivio, 1997; Paivio & Carriere, 2007; Pascual-Leone, 2018). These criteria inform and guide interventions intended to promote anger expression—for example, when confronting perpetrators of harm during IC.

Criteria for healthy anger expression are as follows. First, the anger must be directed outward toward the perpetrator rather than inward toward the self, and it must concern actual and specific harms, transgressions, or violations. As a guideline, if it is unclear what the angry client is fighting for and what unmet needs are being asserted, it is probably not a healthy expression of anger. Second, the anger must be differentiated from other emotions, such as sadness, guilt, or fear. Anger expression mixed with tears or fear, for example, does not allow the individual full access to the cognitive, motivational, or somatic information specifically associated with the anger experience. Third, the anger is expressed assertively with the ownership of experience rather

than aggressively, passively, or indirectly. For example, clients use "I" statements rather than referring to themselves in the third person or blaming and complaining or attacking or hurling insults at others. Anger that is inappropriately expressed does not have the desired effect on the environment, and consequently, adaptive needs for respectful treatment or distance are not met. Fourth, the intensity of anger expression must be appropriate to the situation. Intense emotional expressions that are a catalyst for change are not the same as catharsis, although relief and release of tension can play a role. Appropriate intensity is assessed through verbal and nonverbal indicators of arousal, including body posture, vocal quality, and facial expressions congruent with anger and the situation. Inappropriate anger intensity includes both rage that is overwhelming and anger that is lacking in conviction or energy. Again, in both instances, the associated adaptive information is neither available to guide one's action nor a clear social message of assertion communicated to others. Finally, anger expressions must include some elaboration and exploration of meaning. Healthy anger is not a verbal tirade but rather involves working with anger to understand it. This is consistent with the fundamental principle underlying EFTT that client experiencing is the primary source of new information used in promoting resolution and change.

Problematic Anger

Most therapeutic approaches focus on reducing maladaptive anger but typically do not distinguish among subtypes. However, distinct kinds of problem anger require different intervention strategies (Pascual-Leone et al., 2013). The following subsections describe clinically relevant distinctions among subtypes of problematic anger.

Primary Maladaptive Anger

Most forms of maladaptive anger are inappropriate to the situation and long lasting rather than immediate, fleeting responses to specific violations. *Primary maladaptive anger* is an immediate but overgeneralized response to a perceived environmental threat and is frequently associated with posttraumatic stress reactions. A rape victim, for instance, might react with rage at being touched by men; a survivor of child abuse, whose trust has been betrayed, might react with anger to others' displays of affection. In many ways, primary maladaptive anger is a characterologically entrenched style of responding that now undermines effective functioning.

Secondary Anger

Secondary anger is a response to maladaptive cognitions that produce, perpetuate, or escalate the anger (e.g., erroneous attributions of malicious intent or dwelling on revenge fantasies). Alternatively, secondary defensive anger masks more vulnerable core emotions, such as sadness, fear, or shame. Obvious examples are anger and aggression in response to the shame (i.e., humiliation fury) or fear of abandonment (i.e., the rage of desperation), as observed in

some clients with borderline personality disorder or some male perpetrators of intimate violence. In these instances, secondary anger serves the maladaptive function of momentarily alleviating painful feelings of vulnerability, and this is reinforcing when it is repeatedly successful.

Instrumental Anger

When anger is used, consciously or unconsciously, to manipulate or control others, it is *instrumental*. Thus, the social impact of angry, aggressive behavior can act as a means for attaining a desired interpersonal goal (i.e., control). This, too, can be a reinforcing pattern of behavior. Aggression without affect is a similar but more highly antisocial behavior, although even people without personality disorders are susceptible to the instrumental function of anger.

Complexity of Anger Processes

The same individual can experience and express different types of anger. The complexity of anger experience and its accurate assessment are illustrated in the client Paul, who was described in earlier chapters. He had been physically abused by his father and sexually molested by a male relative, and he frequently experienced adaptive anger and secondary defensive anger covering shame. Paul also had a history of using anger and aggression to control others and prove his masculinity. Moreover, he often felt betrayed and insulted by his wife and held cultural beliefs that children should respect their parents, blowing up at perceived signs of disrespect. Finally, he also had difficulty acknowledging feelings of anger about his father's abuse because he feared this would jeopardize their current relationship, which he had worked so hard to achieve. Each of these distinct anger processes required different intervention strategies.

Feelings of contempt and disgust also are related to anger experience. Like anger, these are maladaptive when directed at the self (as discussed in the preceding chapter) but can be adaptive when directed at others in response to legitimate moral transgressions and despicable behaviors (e.g., sexual abuse). *Contempt* involves looking down on an object with a sneer or curled lip of disdain ("You worm!"), whereas *disgust* involves wanting to rid oneself of the object by revulsion or throwing up ("You make me sick!"). Although similar principles apply, accurate intervention with anger, contempt, and disgust involves accurate perception and empathically responding to the nuances in meaning associated with these different emotions.

INTERVENTION PRINCIPLES

Many of the intervention principles discussed in earlier chapters also apply to working with anger. In the following sections, we present examples of the specific ways these principles are implemented in the context of this specific emotion.

Regulation

Clients may inhibit their legitimate anger toward abusive or neglectful others for a variety of reasons, including fear of losing control, fear of being like the offender, or concern about unfairly blaming the other. In these cases, EFTT interventions validate client concerns and, at the same time, promote acknowledgment of legitimate angry feelings and model, shape, and teach appropriate and assertive expression of these feelings.

However, anger that is underregulated does not serve an adaptive function, even if the anger itself is a legitimate and adaptive response to harm. High levels of arousal overwhelm both the angry individual and the person being confronted with that anger. As emotional arousal increases, the specificity of meaning the client can attend to deteriorates, so what may have been productive loses its focus (Pascual-Leone et al., 2013). Similarly, chronic defensive anger covering a more vulnerable experience of hurt, sadness, or shame cuts the person off from the information associated with that more primary experience.

Gradual Engagement

When clients are afraid of, deny, or believe that anger is socially unacceptable, the change principle resembles that of gradual exposure to or engagement with threatening experience. Intervention involves successive approximations of the experience (e.g., moves from "I don't like . . ." to "feeling annoyed or resentful" to "feeling angry" to "feeling outraged and furious" at the extreme end). When clients deny feeling angry at situations that normally would evoke anger, therapists must use empathic responses, questions, or challenges to elicit a reaction or open a door for acknowledging the experience (e.g., "Sounds like you thought that was pretty unfair," "Did you like what she did?" "I would have been so pissed off!"). Here, clients are also implicitly learning the range and appropriate modulation of anger experience, where lived experience helps to challenge maladaptive beliefs that all anger is dangerous. At other times, intervention can focus on client actions that emerge spontaneously and then encourage them to put words to these actions (e.g., "What does that type of voice say—'how dare you'?"). Similarly, a therapist might ask the client to put words and meaning to their body posture, as in "I notice your fist is clenched as you speak. . . . Can you put words to that?" Secondary emotions that cover anger (e.g., guilt, fear, defeat, helplessness) are bypassed or implicitly discouraged by making selective reflections. Instead, the therapist validates and supports the client's authentic, spontaneous expression of anger at injustice, unfairness, or maltreatment.

A good example of gradual engagement with anger is in the client John, presented in previous chapters, who, following the death of his mother, was sent to an orphanage where he was physically and sexually abused. Initially, he was completely resistant to acknowledging any anger about his life experiences. Intervention first needed to explore the client's resistance ("It isn't

'Christian' to be angry . . . I just want to be a good person"), then educate him about anger, and eventually used successive approximations to help him acknowledge his anger.

THERAPIST: When you think now about those things [*beatings, sexual molestation*] happening to other young boys, like maybe your nephew, how do you feel?

CLIENT: Well, I don't like it. It bothers me.

THERAPIST: I'm sure it does. Can you stay with that? Say more—what bothers you about it?

Eventually, John was able to say that the abusive priests in his residential school "shouldn't have done what they did; it wasn't right. They are to blame for all the emotional problems I've had." He was able to acknowledge his anger at "the system" for putting him in an orphanage and depriving him of his family and Indigenous culture and his anger at individual priests for abusing him.

Anger expression, especially toward parents, also is prohibited in certain cultures. In many Asian cultures, for example, strong social norms exist about respecting parents and elders. In these instances, intervention involves education about the role of adaptive anger, validating the client's desire to be respectful, and distinguishing parental intentions to discipline and wanting the best for their children from what crossed the line into cruelty and abuse. For example, the therapist might ask, "Do you think he had your best interests at heart?" The principle of gradual engagement is relevant here—from "It was not right," "It was too extreme," "It was cruel" to "I hated it," "I did not deserve that," to "It was abusive." The actual label of "anger" is not as important as generating sufficient arousal to activate the emotion scheme and associated adaptive information. For example, one client of Chinese heritage felt uncomfortable using the word "anger" during IC with his rageful, harshly critical father. His confrontations during the procedure were initially measured and controlled and focused on "correct" assertive communication. The therapist validated his discomfort and provided information about "healthy anger" (vs. his father's "rage") and explicit directives for engaging in IC ("This is not about the perfect response. What do you really feel inside imagining him railing at you like that? What do you want to say—from your gut?"). The client immediately said to his imagined father, "Back off! Leave me alone!" The therapist helped him elaborate on this response ("Say more; tell him what is so toxic about his behavior") and eventually set boundaries (e.g., "What are you willing or not willing to put up with from him, your 'line in the sand?'").

Explore Secondary Anger

Secondary anger typically needs to be changed. On the one hand, anger generated by maladaptive thought processes is changed by accessing, exploring, and

restructuring these maladaptive cognitions. Thus, working with secondary anger can have a more rational or cognitive intervention style (i.e., "But is this really working for you?"). On the other hand, if possible, changing anger that masks more vulnerable feelings is best accomplished by simply bypassing the angry, blaming reaction. This is because the goal ultimately is to access more core emotional experience and associated information as quickly and efficiently as possible. When defensive anger cannot be easily bypassed, it needs to be explicitly explored again to access core primary experiences. The client who routinely expresses anger at signs of interpersonal slight, for example, needs to gain awareness of the underlying feelings of hurt, rejection, or sadness that likely give rise to the defensive anger.

Identify the Instrumental Function of Anger

Appropriate intervention for instrumental anger involves confronting and interpreting the instrumental function of this anger and teaching more adaptive ways of getting one's needs met. Both secondary and instrumental anger can be problematic at the level of intensity, and, in this case, intervention needs to include teaching anger regulation strategies. All the types of anger can be problematic at the level of chronicity or frequency, such that anger might be the dominant emotion some clients experience or express. These individuals typically have limited awareness or experience of other (subdominant) feelings, and therapeutic intervention requires emotion awareness training. This consists of empathic responses that direct client attention to and help them accurately label their other feelings. It can also can include structured exercises that explicitly teach emotion awareness skills (see Linehan, 2015). In many ways, instrumental emotion is addressed by reflecting on the narrative and social context of the client's emotional experience—for example, their need to control or overpower others in their life to ensure that their wants and needs are met (Pascual-Leone, Paivio, & Harrington, 2016).

Symbolize Meaning

Through exploring the experience of anger, clients come to understand their anger—its associated values and needs, the effects maltreatment or injustice has had on them, perceptions of self and offending others, and so on. This new information is used to construct new personal meaning. In cases of maladaptive or secondary anger, the maladaptive meaning (e.g., misattributions of hostile intent) can be examined and modified.

INTERVENTIONS FOR CHANGING MALADAPTIVE ANGER

The following subsections describe EFTT's approach to reducing maladaptive anger, beginning with reducing dysregulated anger and aggression.

Regulating Anger

Before turning our attention to the process of resolving interpersonal trauma through the promotion of healthy anger experiences, it is important first to clarify what types of anger not to promote and how to work with them. As noted earlier, chronic and underregulated anger are frequently associated with exposure to trauma, particularly complex interpersonal trauma. Problems with anger dysregulation and associated aggressive behavior can be difficult to change (Novaco & Chemtob, 2015; Pascual-Leone et al., 2013) because they might be reinforcing and part of the individual's personality style. Just as in recovery from phobia, neural pathways never completely disappear, but motivated clients can carve out more preferred pathways, and old responses can fade with time and disuse (Lane & Nadel, 2020; LeDoux, 2012). Maladaptive anger interferes with interpersonal trauma resolution; the client is stuck in an earlier stage of emotional processing, characterized by hostile blaming and rejecting anger (refer to Figures 3.1 and 6.1).

Although EFTT has an affinity with CBT strategies with respect to this area, EFTT is not an anger management therapy. Rather, strategies for regulating or reducing this type of anger must be integrated into the resolution process; it should be part of the personal meaning-making process, not an isolated skill for reducing the intensity of a specific emotion. In many instances, it will be more important for clients with chronic anger problems to focus on grief and sadness expression (instead of anger) as a route to the resolution of complex trauma. However, the dilemma is that anger in response to injustice, violation, and maltreatment also has legitimacy and should not be avoided. Therapy must validate clients' experiences of adaptive anger and find ways to help them express it appropriately.

Moving Beyond Secondary Anger

The first step in working with chronic anger in EFTT is assessing the client's capacity to attend to and identify the internal experiences associated with anger and the factors (internal and external) that contribute to escalating and perpetuating anger. Limited awareness must be increased for clients to gain control of their anger experience (e.g., the therapist might say, "So, when you think your kids don't respect you and dwell on that; you feel yourself getting more and more angry"). The next step is to help clients distinguish between different types of anger experience, so they know when to accept, express, modulate, or bypass their anger and attend to more core vulnerable experience. If necessary, intervention will include strategies for downregulating emotion, such as breathing, relaxation, time-out, or distraction, that have been well articulated in the CBT literature. Memory evocation strategies, such as those described in the preceding chapters, can be used to help clarify the triggers for problematic anger reactions. In instances of secondary anger, the underlying cognitive–affective processes need to be brought into awareness and maladaptive aspects changed. Of course, EFTT characteristically

focuses more on exploring meaning than directly challenging maladaptive cognitions (e.g., the therapist might ask the client, "What's that all about, this sense that disrespect from your teenage kids is so intolerable?"). Anger at perceived disrespect, as in the case of Paul, discussed earlier, also could be understood as a defense against hurt or shame, in which case the therapist directs client attention to the core experience (e.g., "So it triggers some sense that you're a bad father, incompetent? That must hurt a lot. Let's stay with that; it's important").

In terms of confronting offenders in the IC procedure, anger intensification is avoided with clients who have a history of problems with anger control. However, the therapist models and sometimes directly teaches appropriate assertive expression skills, using the guidelines for healthy anger expression presented earlier. For the client whose dominant emotion is anger, resolution of past trauma will include acknowledging appropriate anger at abuse, but resolution may largely occur through accessing hurt and sadness, which is less available.

An example of this is Paul, who had a history of anger and aggression problems. He recognized that his violent father had been a bad role model and that he, himself, used anger to feel powerful and control others. He was motivated to change this behavior but still was quick to anger, and anger experience initially dominated therapy sessions.

Early in therapy, the therapist observed that Paul's anger dominated and threatened to derail the therapy process. She collaborated with him on shifting this focus from anger to accessing more vulnerable feelings. Paul was able to attend to his internal experience and had learned strategies for deescalating anger arousal, so he was able to explore the thoughts and feelings that contributed to his anger and its escalation. Different types of anger and underlying vulnerable experience were identified and explored as they emerged in sessions ("hot" processing). Over time, the client allowed himself to be vulnerable with the therapist. Resolution of past trauma finally involved the client acknowledging his contribution to his pain through maladaptive anger and grieving the many losses he had endured. In particular, he was able to acknowledge and express, both in session and to his aging father in real life, the deep sadness he felt at having missed out on a healthy and supportive relationship with his father when he was growing up. This, in turn, strengthened his current relationship with his father.

INTERVENTION FOR PROMOTING PRIMARY ADAPTIVE ANGER

Unlike problematic anger that needs to be reduced, difficulties with anger also concern its constriction. In short, sometimes the problem is not enough healthy anger. This problem is frequently addressed in the context of resolving issues with perpetrators of abuse and neglect.

Model of Resolution Using Imaginal Confrontation in Phase 3

The model of resolution using IC was presented in Chapter 6 (see Figure 6.1). We review it here, focusing on later stages in the process and the specific role of adaptive anger in the resolution process. Recall that IC is initially introduced around Session 4 at the end of Phase 1 once a safe therapeutic relationship has been established. It is then used in conjunction with other procedures throughout Phase 2 of therapy (i.e., memory work, working through self-interruption, self-criticism). The frequency of client participation in IC over the course of therapy will vary depending on individual client processes and treatment needs.

As fear and shame are worked through and clients come to tolerate working with trauma material, client difficulties with confronting imagined perpetrators during the IC procedure gradually diminish. Clients become more able to freely express previously inhibited feelings directly to the imagined other. Then, Phase 3 of EFTT begins with the clear and uninhibited expressions of adaptive emotion—in this case, anger at the maltreatment they have suffered. The Degree of Resolution Scale presented in Appendix C can be used to track client progress and set session-by-session process goals. The following example of a client, "Julie," working through sexual abuse in EFTT, illustrates the three stages in the model. Because the process of resolution is a dynamic and reiterative one, later sessions (e.g., in Phase 3) sometime recapitulate aspects of the previous phases. This excerpt shows such rapid recapitulation of previous work and then advances through steps in the resolution process (see Figure 6.1).

CLIENT: He [*her father*] is such a disgusting pig! Who treats their own daughter like that?

THERAPIST: I hear how much you hate him, despise him. Tell him over there [*points to chair*] what you hate. Make him understand.

CLIENT: Yes, I hate the way you manipulated and corrupted me for your own selfish needs. You perverted everything. I was innocent, and you ruined my childhood; you made sex disgusting. I hope you rot in hell! [*sighs, withdraws*]

THERAPIST: What happened just now, Julie—you sigh and kind of collapse?

CLIENT: I don't like it. I sound just like him.

THERAPIST: But you're not him; you're nothing like him. You're justifiably angry, and you want to see him punished for his despicable behavior, for his crimes. Tell him.

CLIENT: Yes, I do want to see you punished. You deserve to be punished for all the harm you've done. You fucked me up royally. My life has been such a mess, but I'm not going to let you ruin my life anymore.

THERAPIST: How do you feel saying that?

CLIENT: It feels right. He was the adult; I was just a little kid. I deserved love and security, not the twisted life he imposed on me.

THERAPIST: How do you imagine your father over there would react if he knew how you felt—defensive, remorseful, blaming and angry . . .?

CLIENT: It's funny. He used to seem so huge and powerful; now, I see just a pathetic old man. I don't think he's capable of understanding, but it doesn't matter anymore. I know the truth.

In this example, therapist interventions supported the client's anger and entitlement to justice and helped her begin to articulate the effects of the abuse and hold the perpetrator accountable for harm.

One of the goals here is for clients to develop a more realistic perspective of the other. An important step toward this is to elicit the client's understanding of the imagined perpetrator's response to such a confrontation. Enacting or imagining the other can elicit clients' empathic resources. This can be particularly important when healing attachment relationships is appropriate and important for the client. For example, a client may come to understand that one or both parents had themselves been victims and would have regretted their behavior with respect to the client. In contrast, when healing the attachment relationship is not appropriate, as in the example of Julie, helping clients imagine (and perhaps even enacting) the other's response can help them view the other as more human and less powerful.

Therapist Operations During IC: Anger Expression in Phase 3 of Therapy

The following discussion focuses on specific steps in the model of resolution using the IC intervention that occurs during Phase 3 of EFTT (as outlined in Chapter 6, Figure 6.1). This section describes interventions that facilitate processes in both self and other chairs. Difficulties with resolution, in general, are discussed in Chapter 12 in the context of termination. Before anger can be expressed assertively, it must be differentiated from other emotions. Therapists must decide which, among the different specific emotional constituents a client presents, should be focused on first. At this stage, the client has made considerable progress in working through self-related issues (and the maladaptive emotions of fear and shame), but the trauma is not yet resolved. The decision to now focus on anger, therefore, is based on verbal and nonverbal indicators that anger is the most salient client experience in the moment and needs to be fully experienced and expressed. In the context of memory work or exploring self-critical process in two-chair enactments (Phase 2), the client might have spontaneously expressed anger at a parent for harsh criticism or other forms of abuse. This serves as a marker for switching to express that anger to the imagined parent in IC. Frequently, however, the therapist's decision

concerns which adaptive emotion—anger or sadness—to focus on when both emotions are present and expressed at the same time (e.g., anger mixed with tears). This choice is based on previous in-session processes, the individual client's history, and treatment goals. Repeated client concerns with issues of autonomy, justice, fairness, and respect are indicators for promoting the expression of adaptive anger. Historical information about the client also informs clinical judgment as to whether increasing empowerment or accessing vulnerability will be the most transformative. In general, therapists are attuned to and focus on the affect and meaning that has been least available or least salient (subdominant) in the client's repertoire.

Assuming that anger is the most appropriate emotion to activate, interventions direct the client's attention to microsignals of anger (e.g., "Lots of feelings here. For now, let's focus on your anger; stay in touch with that"). If the client shifts back to feelings of fear, guilt, shame, or hurt, the therapist again explicitly redirects the client's attention to anger. Notice that this oscillation between emotions is the client moving "two steps forward and one step back" in the sequence described in Figure 3.1 (for empirical research on that pattern, see Pascual-Leone, 2009). In the example of Julie, the therapist directly challenged the client's fear that she was like her father, and this was enough to help her push past her fear. In other instances, a therapist might say, "If you can, let's not go there. Try to stay away from your hurt feelings for now; stay with your anger," or "So, her criticism really hurts your feelings, but I also hear you saying it borders on abuse, is out of line—and that it makes you angry." Assuming the client agrees, the therapist would continue to encourage adaptive anger expression, "Okay, well that's worth saying too! Tell her how angry you are."

Throughout the process, interventions facilitate client enactment or vivid experiential memories of the imagined other to evoke anger experience and track a client's shifting perceptions of the other (top of Figure 6.1). As clients become more self-aware and assertive, they also begin to see the other in a different light. The following steps in the IC procedure are characteristic of Phase 3 in therapy (as outlined in Figure 6.1).

Promote Expression of Adaptive Anger Toward the Other

Guidelines for promoting anger expression during IC are based on the criteria presented earlier in the chapter. Anger is usually first expressed concerning the specific damaging actions or behaviors of the other. Moreover, fully and quickly activating anger and its associated meaning is only possible when the verbal and nonverbal elements of emotional expression are congruent with the presenting situation or context. Although therapists need to avoid being overly directive and concerned about "appropriate" expression, clients can be encouraged to look at the imagined other (or therapist) and to sit up straight, with their feet planted firmly on the floor, and speak firmly from the belly (not the throat).

In terms of appropriate levels of arousal, traumatic experiences vary in severity, and the intensity of associated anger will similarly vary, from rage over rape to resentment over invalidation and neglect. Likewise, clients differ

in expressive style and their history of emotion regulation problems. For clients who tend to be overcontrolled, intensification strategies are useful and appropriate, but they are contraindicated for clients with anger control problems. Ideally, markers of clients' self-doubt about anger experience can be bypassed, but if not, they need to be further processed by returning to treatment principles from Phase 2.

Dealing with revenge fantasies can be a problem both for clients who find them disturbing and avoid them as well as for clients who perseverate and ruminate on them. Clients are encouraged to disclose their revenge fantasies to therapists rather than keep them secret but not to dwell on them. For most clients, these angry fantasies need to be validated as normal reactions to injustice and maltreatment, reframed as unresolved hurt and anger and a desire for justice. Next, therapists need to provide reassurance that working through and resolving one's trauma will reduce these feelings of tension and the desire to hurt the other. It is important to note that in many instances of childhood abuse, the offender's behavior was, in fact, criminal, and this also needs to be communicated to clients to help validate the severity of the maltreatment and entitlement to justice.

The expression of assertive anger should include the use of "I" language and the specification of wants, needs, and expectations regarding the other, as well as preferred alternative behaviors and articulating the positive effects that these would have had. For example, the client might say, "I was your daughter. You should have believed me, so I didn't have to spend a lifetime second-guessing myself. This would have made such a difference." Healthy expression of assertive anger also can involve explicitly setting limits and boundaries, particularly in current relationships. This is a central part of promoting a client's sense of entitlement to previously unmet needs, which is an essential processing step toward resolution.

Again, the EFTT approach to assertiveness "training" involves gradually shaping client behavior through modeling and successive approximations rather than by explicit teaching. In the initial activation stage of IC, the client should not be concerned about "saying it right." Indeed, such a preoccupation can interfere with clients acknowledging the complexity of their feelings. As clients are chastising or telling the other off (e.g., "You cared more about your bottle and your boyfriends than you did about me, your own daughter!"), the therapist should instead promote ownership of anger experience and symbolization of meaning (e.g., "Yes, so furious about all the damage she caused; tell her more about what makes you so angry"). In this final phase of therapy, clients who do not spontaneously shift to more assertive expressions can be explicitly directed and coached to do so (e.g., "Try saying 'I hated it when you . . .'"). In any case, it is essential that interventions help clients use clear and specific anger words. Interventions that hint at or imply anger are not specific enough and may tacitly reinforce the inhibition of anger and rumination.

Finally, healthy anger expression requires interventions that promote experiencing (see the guidelines in Chapter 5). To that end, it is essential to help the client maintain a balance between outward expression and inward

attention to the bodily referents of emotion. Verbal expression should emerge from authentic experience (rather than the performativity of scripted, rehearsed, or premeditated expressions). Because of the expressive and interactional nature of IC, a common pitfall of novice therapists is to neglect the experiencing part of this process. Some therapists also get carried away and derailed by the drama of anger expression. An effective EFTT therapist looks for congruence between the client's internal experience and outward expression and frequently asks the client to "check inside" to ensure that verbal expressions still fit with their internal experience. Interventions that help promote anger exploration focus on the impact of the other's behavior on the self. This is like formulating a victim impact statement but one that also includes affective arousal in vivo. Sometimes clients ask whether they could formally prepare such a statement for homework or write a letter to the perpetrator (but not send it). These exercises can be effective when they are read aloud by the client in session, and their experience of doing this is explored. Such in-session experiences typically are quite evocative.

Promote Expression of Unmet Needs

An essential component of meaning exploration is the clear expression of unfulfilled needs and expectations in relation to the other. In the case of anger, these include the need for autonomy or personal control, to defend oneself against threat or harm, and to correct injustices, as well as expectations concerning fair and respectful treatment from others. These needs are motivating and move the process forward. Clients, therefore, are explicitly directed to attend to and tell the other what they wanted or needed (or still want and need) and did not get. Sometimes expressing unmet needs leaves the client feeling vulnerable vis-à-vis the other, particularly when it is a cruel or callous perpetrator. In that situation, the client can be pulled out of the imaginal enactment and encouraged to explore their unmet needs with the therapist. Nonetheless, this includes identifying what was damaging about the other's actions toward them, how clients feel they should have been treated, and why. For example, the therapist might say to a client, "Instead of your rages and criticism and living in constant fear, tell him what you needed as a child," or "Tell her how important it would have been if she had actually shown some interest in you."

Track Perceptions of Self and Other

Interventions highlight the quality of client expressions toward or regarding the imagined other (e.g., "You sound pretty clear," or "It's still not easy to stand up to him, is it?"). These client expressions are also markers for eliciting a response from the other (e.g., the therapist might ask, "How do you imagine he would respond to your demands?"). The quality of this relational process serves as a behavioral index of internalized object relations, which evolve as the client becomes increasingly able to express authentic feelings and needs. It is essential to track these evolving perceptions as indicators of the client's stage in the resolution process (see the Degree of Resolution Scale in Appendix C). The

purpose of this tracking is for therapists to offer metacognitive reflections about the client's process and also as an ongoing assessment of treatment change.

Promote an Increased Sense of Entitlement to Unmet Needs

The goal here is to help a client not only identify unmet needs but also understand the self in terms of legitimate wants and needs. Ultimately, there is a shift from client self-doubt (e.g., "Maybe I did something to bring it on?") and the sense that their needs are unrealistic or unattainable to a sense of conviction. Clients come to believe that, like everyone, they deserve to be treated fairly and with respect, to be protected, and to have had a childhood of freedom and innocence, regardless of the opinions, behaviors, or limitations of the other (e.g., "I may not have been the easiest kid, but I was still just a kid! I needed guidance"). Such healthy entitlement helps the client hold the other accountable (e.g., "You were the adult! You should have provided this regardless!") and motivates efforts to get needs met in current life and relationships.

Markers for promoting entitlement are clients' assertive expressions of need (e.g., "I needed encouragement, not those constant put-downs") or expectation from others (e.g., "I deserve to be treated with respect, just like anyone else"). Interventions validate these client assertions (e.g., "Yes, of course, all people need and deserve this") and then direct them to express these clearly to the imagined other. Working with anger in a way that promotes entitlement typically includes the use of verbs such as "will," "will not," "insist," and "refuse." Once again, it is essential to have clients check whether these expressions fit with their internal experience. If the client is still uncertain about how deserving they are, therapy needs to spend more time exploring and working this through by exploring the raw experience of an unmet need and what it means to be deserving or not. Fully experiencing entitlement to protection, dignity, love, care, and so forth (as opposed to superficial self-affirmations) strengthens self-confidence and self-esteem.

Support Clients' Emerging New View of Self

As treatment approaches resolution, interventions associated with anger experience promote and support self-empowerment and gradual separation from the other, letting go of unmet needs and expectations. Clients' enmeshment with perpetrators is evident in the attention they focus on the other or their dwelling on past injustices and offenses. In situations in which there is current and ongoing interaction with the other, the client may engage in extraordinary efforts to please these others, have difficulty asserting themselves for fear of offending them, or try to force the other to apologize, admit they were wrong, or change.

Interventions should first heighten client awareness of enmeshment, victimization, and powerlessness (e.g., "It's like you can never be happy; unless she changes, you are doomed!") or exaggerate a client's maladaptive efforts to force the other to change (e.g., "Try saying, 'I will force you to apologize; I demand that you apologize'," or "Try saying, 'I cannot live until you respect me'"). Alternatively, the therapist might role-play the imagined other's response

to promote a client's letting go of unmet needs (e.g., "And so, what if the response is like, 'It doesn't matter what you do; you can turn yourself into a pretzel, but I will never give you what you want'?"). These are obviously paradoxical interventions that can help a client react to the feared outcome in concrete ways or perhaps abandon the fruitless hope the other will change. Through this kind of enactment or imagining, clients eventually come to see that they cannot force the other to change or acknowledge wrongdoing.

Letting go emerges partly from fully experiencing a sense of deserving or entitlement to unmet needs in an earlier step. Here, clients no longer feel like defenseless children and no longer seek the other's approval to feel good about themselves. For instance, one client who was taken from his family, stripped of his language and culture, and sexually and physically abused in an "Indian residential school" for Indigenous children naturally wanted official recognition and an apology from the church, government, and individual perpetrators. Partly through the expression of his anger and then validation from the therapist, this client began to feel that an apology was owed and deserved, even though he may never get one. Many clients also become more aware of how important issues of justice and respect are to them and resolve to promote these values in their current life. For example, another client who had been abused as a child decided to become a lawyer, another volunteered to work for Victim Services, and yet another vowed to become a better parent.

Support the Emerging New View of the Other and Relationship

In the early phase of therapy and IC, the other is perceived narrowly and negatively—one client viewed her physically abusive and rejecting mother as "the devil." However, at this step, people can see the other more realistically, partly because their own feelings and needs have been expressed and validated. Thus, as the client gets closer to resolution, the goal of enacting the imagined other shifts. Rather than using the imagined other strictly as a stimulus for evoking feelings in the client, the emphasis now is more on promoting experiencing while the client is in the "other" chair. This helps flesh out the imagined other's perspectives, feelings, and motives. Ultimately, this process draws on clients' capacity for empathy. Therapists can ask clients, for example, how they imagine the other would feel "on the inside" or "in their heart," even if they cannot imagine the other expressing remorse or directly apologizing. Clients develop an increasingly rich understanding of the other and may develop an appreciation of the limitations and frailties of those who have mistreated them. Whether or not clients feel compassion toward the other, they come to see their perpetrators as more human, life-sized, and less powerful.

Importantly, compassion and forgiveness of the other come through acknowledging and expressing legitimate anger and its associated meaning, not through denying anger. In the ideal situation, the client might imagine that the other regrets and takes responsibility for the harm done (or feels regret but could never admit it). In these cases, resolution is more likely to be accompanied by forgiveness. As we have discussed, this is particularly true when the other is or was a neglectful primary attachment figure with whom the client wishes

to restore relations. In other instances, clients begin to accept that the other will never respond to their feelings and needs—the other does not have what is required. Some clients come to perceive the other as mentally ill or pathetic. In any case, forgiveness, as we define it, is not excusing or condoning the other's behavior, instead clearly and appropriately holding the other accountable for harm.

End Contact With the Imagined Other and Process the Meaning of the IC Experience

These last two steps take place at the end of each IC and are particularly important aspects of the final IC and therapy termination. However, it also is essential to identify and accept the degree of resolution achieved in each session, whatever it is. If issues with the other remain unfinished, clients should be encouraged to say so and state their intention to return to the issue in the next session. Resolution is a cyclical and reiterative process, so therapists can use the Degree of Resolution Scale (Appendix C) to evaluate a client's progress and set process goals for the next session.

In this chapter, we reviewed the model of interpersonal trauma resolution that is the basis for EFTT. This model specifies experience and expression of adaptive emotion as the catalyst for change. We also reviewed the model with a particular focus on the role of anger in resolution. The next chapter focuses on the role of sadness in resolution.