Title: Cross-Cultural Lessons on Anger and Social Connectedness

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I first started thinking about anger and its role in the experiences of people who have fought in wars when I was in Sierra Leone, about a year after the cease-fire ended the civil war. I was working as a research assistant on a study with girls who had been child soldiers and had given birth to children during the war. We were living in a community in the west, on the border with Guinea. At first, we met only a few young women. We listened to their stories – about the war, and about what life had been like for them and their children since the end of hostilities. As days passed, word got around in this rural community that women had come to listen to the experiences of young mothers who had been child soldiers. Girls and young women living in small huts in the jungle surrounding the town, or sharing a house on the edge, began to come with their babies and introduce themselves and tell us their stories. Amidst the grief and despair, the worry about how they would have enough food for the next day, from many young women, I could hear a simmering rage: anger at not just what had occurred during the war, but how they had been treated when they returned.

I got to know stories like the ones told to us in that western village much more intimately over the next several years, as I co-coordinated a participatory action research study with young mothers in Sierra Leone, Liberia, and northern Uganda aimed at understanding more about what reintegration meant to these young women and their children (McKay, Veale, Worthen, & Wessells, 2011). Over the course of the study, the participants conducted research on what their experiences were like and how they could improve their daily life and the lives of their children. With a small budget that the participants controlled, they implemented interventions aimed at improving their wellbeing. Finally, we collaboratively assessed the study's findings and impact. At the core of the study's approach was the idea that building community and common connection between marginalized young mothers, facilitated by caring adults, would itself be impactful.

I had an opportunity to both listen in on conversations between the young mothers and to speak with them individually and in groups. In the first year, anger consistently emerged as an obstacle to their ability to develop healthy relationships with other people and to participate in community activities. Though on the surface many appeared tough, the young women longed for inclusion, and recognized their anger reactivity as a barrier. One young woman shared a recent experience she had had in which she had gone to a market, someone called her a name and then she blew up at them, screaming and yelling, throwing punches. Eventually she was kicked out of the market. Others listened, nodding their heads, and recalling similar experiences they had each had. A common strategy was simply to avoid going into town.

This was around 2006 – 2007, and the news where I am based, in the United States, was of soldiers who had fought in the wars in Afghanistan and Iraq coming home and getting into fights, violently assaulting spouses and children, and getting into trouble with the law. *The New York Times* began a series in early 2008 looking at “veterans of the wars in Iraq and Afghanistan who have committed killings, or been charged with them, after coming home.” In the United States, posttraumatic stress disorder (PTSD) was often mentioned in connection with aggressive or violent behavior by former service members. In Sierra Leone, a country with few doctors or

trained therapists, where over half of the population had been displaced due to the war, and a country that remains one of the poorest on earth, a diagnosis of PTSD might be accurate but not very useful. No one was going to try to implement Western-developed PTSD treatment on the scale required to make a dent in these post-conflict settings, and PTSD treatment was low on young mother's identified priorities for reintegration (McKay and Wessells, 2004).

What I began to notice from our study participants was that they found that they could be patient with one another in their small group meetings. Or that they could get angry and still be welcomed back. That in fact, if they left a meeting angry, a day or two later, someone might come and visit them and check on them. As they developed caring relationships amongst each other – and with the research partners and community advisory council members supporting the study – they gained more trust in their ability to forge relationships and handle strong emotions without being physically aggressive.

Over the course of the study, anger became a less common problem. The study took place in twenty field sites in three countries, but in each, the pattern was more or less the same. As participants diligently worked together they became closer. Their interventions focused on reducing stigma and marginalization and increasing their livelihoods. They wanted to increase access to education and medical care for themselves and their children and did so through a combination of negotiations with service-providers and increased livelihoods. Reducing stigma came first. There was deep mistrust between the young mothers and community members as a result of wartime experiences. In some cases, young mothers had returned to communities where they had committed atrocities. Often, the young mothers and their children were considered a painful and persistent reminder of a community's inability to protect their girls from rape and abuse during the war or of the violations of social norms during the war. Young mothers in many communities, if not all, were engaged in transactional sex work for subsistence, which was offensive to some in the community. Finally, there were misconceptions that young mothers had profited from looting during the war and were not destitute, but were instead hiding vast wealth. As one community advisory board member in Liberia noted, if the young women had tried to increase their livelihood by, for example, planting a garden, angry community members would have stomped on their seedlings. If they had tried to do petty trading, no one would have bought their goods. The relationships between the young women and community members needed to be attended to first. Once the community was invested in their success, they could undertake livelihood activities and be supported.

Back in the U.S., I wondered about how anger, PTSD, and reintegration were related among returning U.S. service members. Research with Vietnam era veterans had established a strong link between anger and aggression and PTSD. A prevailing theory, by Novaco and Chemtob (1998), was that anger becomes dysregulated in people with PTSD, and this is due to regulatory deficits in cognitions, arousal, and behavior interacting with perceived threats. I wondered whether this anger dysregulation was a universal reaction to wartime experience and PTSD – something that, if I looked for it, might be described among the young women I was working with in Africa. While Novaco and Chemtob's explanatory model of anger looked at PTSD and wartime experiences like exposure to combat, it did not take into consideration the experience of returning to civilian life (reintegration) after war. Given that their model was mostly based on work with Vietnam veterans, I wondered how the reintegration experiences of those veterans may have impacted their experiences with anger. Vietnam era veterans returned to a country in turmoil, and were often stigmatized and blamed for their participation in the conflict. In contrast, Iraq and Afghanistan veterans were generally being either ignored or

welcomed back to their communities. The communities that U.S. soldiers were returning to were largely unaltered from when the soldiers had deployed. Only 1% of Americans were in the military. And like PTSD, many of the wounds that these service members returned with were invisible, like traumatic brain injury, which was beginning to be known as the hallmark injury of the Global War on Terror.

In 2010, I began researching U.S. service member's experiences with anger. I conducted a qualitative study, interviewing recently returned service members in California, and a quantitative study, surveying over 1,000 service members. What I found was that anger was a substantial burden for male and female service members and that veterans perceived anger as disrupting their ability to function as they desired. Indeed, about half of the participants in the survey identified themselves as having problems with anger; while there was a strong association with PTSD, anger was a problem for many without PTSD as well. One thing that was clear, however, was that those who had more social support had fewer problems with anger.

Through the qualitative study, I began to get a clearer image about how anger problems manifested. I identified three different patterns to the anger. For most veterans, anger was an adjustment challenge – something that was most burdensome in the first year after exiting the military as they tried to adjust to civilian life. Many of the veterans identified their problems as relating to a loss of structure after exiting the military. Anger was caused by a disconnect between their expectations of how people should behave based on their military experience and how people in the civilian world actually were behaving. For example, a veteran attending school at community college would be enraged when other students chewed gum loudly or answered their phones in class. But outbursts like these became less and less common as months passed and veterans became used to the civilian world.

Another pattern of anger seemed to fit the descriptions I was reading about moral injury. Litz et al. define potentially morally injurious experiences as “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (Litz et al. 2009, p. 700). Moral injury can occur with or without PTSD and is characterized by different, but overlapping sequelae (Delima-Tokarz, 2016). The most prominent characteristic of moral injury is shame, which often leads to self-condemnation, avoidance, and withdrawal. Veterans in my study who described morally injurious experiences had persistent angry outbursts, shame about their behavior, and thought of themselves as “different from normal people.” These problems with anger were persistent, lasting years. Often veterans isolated themselves, avoiding situations where they might be in a group of people or have to engage in conversation. They identified their avoidance behavior as specifically about avoiding situations where they might get angry.

The final pattern of anger was associated with PTSD. While not all veterans in my qualitative study who disclosed that they had been diagnosed with PTSD shared that they had problems with anger, those that did struggled with angry outbursts and expressed fear of their own anger. Like those with moral injury, the participants with PTSD struggled with anger for years and even with treatment for their PTSD, still told me that anger was a problem for them. Yet even with this explosive anger, it was through the ties of connection that the participants had hope that their anger would become less disruptive. A young man in my study described in vivid detail the life sustaining support he received from his counselor at the VA – he did not describe the therapy as being productive, but rather that her faith in him and his humanity was significant. He told me about one episode where he had lost his temper at work, gotten in his car and drove straight to the VA because he knew he would be welcomed there. He credited that relationship

with helping him be a father to his infant son, another relationship that provided purpose to his life and motivation to learn to modulate his anger reactivity.

From my many conversations and years of research, I have come to believe that anger is a socially produced and performed emotion and behavior (c.f. Parkinson, 1996). Anger is an important problem for war affected people and can become an obstacle to obtaining the most important things that can heal people after difficult times – love, human connection, and social support. Anger can be best modulated and modified in a social context. I believe this may be easier to do in an African context, where culture is collectivist and being together in groups is natural. In my first work with young mothers fifteen years ago, they shared that the only time they experienced joy was when they were together in a group, singing and dancing. The structure of improvised song facilitated social support: each person takes a turn improvising a verse, which can contain emotionally raw lyrics, and there is a common chorus, that all sing together that supports the lyrics of the verse. People clap and dance while singing, processing the strong emotion physiologically, in a way that appeared to me to be similar to what is observed through Eye Movement Desensitization and Reprocessing (EMDR) and other cognitive behavioral therapies. This practice is done collectively, however, and brings people together, diminishes isolation, and modifies anger reactivity.

In contrast, in our individualist society, U.S. service members often had to work through their emotions alone, and withdrawal from social contact happens too easily. Anger is considered a feature of clinical disorders resulting from trauma, including but not limited to PTSD. While the VA offers group therapy, anger management is still conceptualized as an individual treatment. Cognitive behavioral approaches focus on individual education about anger and techniques for arousal reduction, self-monitoring, training and practicing arousal regulation during role play with a skilled therapist (Lee & DiGiuseppe, 2018). The social aspect of anger and the potentially moderating effect of experiencing inclusion, being cared for and listened to, understood and supported, are missing in this individualistic model.

When I first pivoted from working with former child soldiers in Africa to working with U.S. service members, I thought it would help me understand the neurobiology of what was occurring for the child soldiers. What I learned instead was that the interventions developed by the young mothers in Africa could help me challenge the pervasive ideas about treatment of anger in the U.S. Anger became less of an obstacle for these young mothers not because of individualized therapy, but because of social connectedness. While veterans may benefit from therapy, perhaps it is also worth attempting community-based interventions that focus not just on the veteran with anger dysregulation, but on the fabric of the social ties that connect that service member with others in his or her family and community.

Indeed, anger is a common problem in traumatized populations – whether we are talking about survivors of mass shootings or communities living with systemic racism. Perhaps it is time for more interventions that focus on strengthening social connections. Social connections are protective against so many challenges in life, so a broader focus aimed at wellbeing and community resilience would have positive spillover effects in other important domains aside from reducing anger and aggression.

Recommended Readings:

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