A psychodynamic contribution to the understanding of anger - The importance of diagnosis before treatment

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ABSTRACT

This paper starts from the claim that a shared understanding of anger, in both its normal and psychopathological dimensions, is missing and that there are various therapeutic paths that seem to be less effective than those related to other pathologies. A major limitation of anger research and of its treatments lies in the lack of precise clinical diagnoses to inform therapy. For this reason, the first aim of our work is to survey critical literature in order to find useful elements to differentiate anger, starting from the evidence of negative and positive outcomes of treatments. Such evidence will then be enhanced in our proposal of interpretation and intervention, within a dynamic framework and with particular reference to Orefice's thought. The core focus is to explore the different functions that anger has for the patient and to investigate the elementary functioning of the self. Our reading of the phenomena related to anger will provide useful tools both for understanding the dynamics underlying anger and as a guide for clinical intervention.

Key words: Anger; diagnosis; affective structure; treatment; function of anger.

Introduction

Anger is a component of every living being, of every historical epoch, of every society, although its forms and ways of expression are different. The complexity of this emotion emerges even just by focusing on individual expressions of anger, regardless of historical, social, and family contexts. In fact, there are several elements that constitute anger, as well as that support and modulate its expression: arousal, cognition, anger regulation, physiological and behavioural display. Moreover, when anger is induced, various networks are activated: Mentalizing network self-referential, Salience Network threat detection, Habit Network automatic approach, Self-regulation Network response evaluation selection (Alia-Klein *et al.*, 2020). Perhaps due to such complexity, there is no single, shared definition of anger, nor equally shared criteria for differentiating between pathological and physiological expressions. As far as the definition is concerned, there have been many proposals. As a way to summarise the most widespread definitions, we could say that anger is an emotional state, of different intensity (Moscoso, Spielberger, 2011, Deffenbacher, Demm, & Brandon, 1986), 'related to but conceptually separable from behavior associated' (Deffenbacher 2011, pg. 212), accompanied by physiological activation - muscular tension, neuroendocrine and autonomic nervous systems (Spielberger, 1999) -, cognitive elaborations and coping resources (Deffenbacher 2011). Anger can often be associated with forms of antagonism (Novaco, 1994), sensitivity to challenges or threats (Kennedy, 1992), destructive fantasies, aggressive planning, or ideas of persecution (Garaigordobil, 2014), specific cognitive and perceptual distortions and deficits (*e.g.*, misappraisals, errors, and attributions of blame, injustice, preventability). Anger can be motivated by both a need for security and a need for domination; it can therefore be used to manage fear (reduce security

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threats) or to increase a sense of reward, from the act of dominating others.

There are also differences in the connotation of anger. According Novaco and Welsh (1989) while anxiety and depression are clinical conditions, anger is an emotion that - although unpleasant for the person experiencing it - is not a pathological condition itself. Anger may increase the risk factor for violent behaviour but, on the other hand, it can also be a source of strength, prompting subjects to assert themselves. Anger can therefore have both negative and positive connotations (Menninger, 2007; Panksepp & Biven, 2012).

With respect to the expression of anger, there are diverging positions. According to catharsis theory, expressing anger is positive because it allows for an improvement in mood (Bushman, Baumeister & Phillips, 2001; Bushman, Baumeister, & Stack, 1999). The recalibrational theory (Sell, 2011) also recognises the adaptive function of anger, because it restores more acceptable welfare trade-off ratio. Other research show that rumination increased rather than decreased anger and aggression. Doing nothing at all was more effective than venting anger (Bushman, 2002). For others, neither the suppression of anger nor its expression is absolutely positive or negative (Tavris, 2017).

In short, scholars agree on more descriptive features of anger, whereas there are different and even antithetical positions on other characteristics of anger. This lack of an articulate and shared definition and understanding of anger is particularly significant when we try to understand and treat those who suffer from pathological expressions of anger. Even more so if we consider that the dysregulation of anger is prototypically transdiagnostic, as it is often accompanied by other pathological expressions (comorbidity). A shared taxonomy, with a clear distinction of subcategories, could provide tools for a diagnosis also aimed at choosing the best path for psychotherapeutic intervention.

Consistently, if we consider the pathological expressions of anger, we see that the DSM-5 does not cover anger disorders, with the exception of disruptive mood dysregulation disorder which has its own nosological class. The criterion for which anger reactions 'become clinical problems when they are too frequent, too intense, or endure too long' (Kassinove, Tafrate 2010) may certainly be useful for an approximate screening but is not enough for a clinical assessment. As Lee and DiGiuseppe (2018) argue, we do not yet have an accepted taxonomy of anger and aggression problems that informs treatment research.

Perhaps not surprisingly, much of the critical literature proposes an approach to anger addressed to specific categories of subjects defined on the basis of descriptive typologies - such as age, the fact of being detained, intellectual disabilities - or of manifestations of violence. Thus, with regard to adults, studies have been published on sexual offenders and gender-based violence (Echeburúa & Fernández-Montalvo, 2009; Marshall, 1999; Olver *et al.*, 2014; Stefanska *et al.*, 2017), on drivers (Galovski, Malta, & Blanchard, 2006; Pelin *et al.*, 2021), on those who have committed violent crimes (Megargee, 2012), on chronic alcoholics (Tivis, Parsons & Nixon, 1998), on those who have experienced severe trauma (Pascual-Leone & Paivio, 2013), on male violent offenders in prison (Polaschek, 2010, Serin, Gobeil & Preston, 2009), on those who live in communities (Hatcher *et al.*, 2008), on military veterans (Donahue, Santanello, & Marsiglio 2017), and on subjects with intellectual disabilities (Hamelin, Travis, & Sturmey, 2013; Nicoll, Beail, & Saxon, 2013). This can be useful, but it is not enough: what is missing is the demonstration that all subjects belonging to the different categories share a common psychological functioning. Therefore, since we do not have criteria for a clinical diagnosis, we incur the risk of offering therapeutic pathways that are somehow undifferentiated or based on non-clinical distinctions.

While shared diagnostic criteria are scarce, there is, on the other hand, a wealth concerning the psychotherapeutic models that have been used for the treatment of anger, sometimes adapting the interventions to the specificity of the problem and the characteristics of the subjects treated.

In scientific publications on treatments the most widely used approach is the cognitive-behavioral treatment (CBT) (Echeburúa & Fernández-Montalvo 2009; Geffner *et al.*, 2013; Lochman, Whidby, & FitzGerald, 2000; Marshall, 1999; O'Reilly *et al.*, 2010; Yates, 2003); there are also other more recent developments such as the acceptance and commitment therapy (ACT) (Donahue, Santanello, & Marsiglio 2017; Eifert & Forsyth 2011), the emotion-focused therapy (EFT) (Jarry & Paivio, 2006; Kassinove & Tafrate, 2010; Paivio & Carriere, 2007), and the dialectical behaviour therapy (DBT) (Frazier & Vela, 2014; Kramer *et al.*, 2016), attachment-based family therapy (ABFT), emotion-focused therapy (EFT) (Diamond *et al.*, 2016; Steinmann *et al.*, 2017), compassion-focused therapy (CFT), metacognitive therapy (MCT), and functional analytical psychotherapy (FAP) (Byrne & Ghráda, 2019) There is also a psychopharmacological approach (Edwards 2006), a Buddhist approach (Bankart, 2006), an Adlerian approach (Eckstein *et al*., 2006), an integrative approach of assimilative psychodynamic psychotherapy (Gold, 2006), self-psychology (Ornstein, 1999), *etc.*

We emphasize that each approach collects functional data for diagnosis in line with the theoretical approach adopted. This is how it should be. This confirms the scientific nature and rigour of the intervention but makes the comparison more challenging. Each approach identifies different etiological aspects, emphasizes different characterizations, proposes different interpretations, and therefore sets different intervention targets. The various approaches also differ with respect to the evaluation of the

elements that promote change; consequently, the treatments aim to enhance different skills that are considered essential in adaptive anger management.

Table 1 shows the core of several readings of anger, as summarized by Feindler and Byers (2006).

As for the effectiveness of treatments, DiGiuseppe and Tafrate (2003), in '*Anger Treatment for Adults: A Meta-Analytic Review*', registered some positive effects of various treatments of anger, but the overall average effect size was moderate (d=0.71), all the more so when compared with that of treatments for anxiety and depression. They found reductions in the effect of anger, reductions in aggressive behaviours, and increases in positive behaviours. What also emerged from their analysis is that individual treatments are more effective in increasing positive behaviours and are associated with more consistent results on aggressive behaviours.

A subsequent review of meta-analyses (Lee & DiGiuseppe, 2018) included, unlike the aforementioned one, not only treatments based on cognitive and behavioural theories but also studies based on psychodynamic therapy (only 2 studies), client-centred approaches, Gestalt theory, pathways related to family systems, relaxation pathways, and support of social skills; in this second meta-analysis, the authors highlighted a greater variability in the effectiveness of treatments. The examination of all types of treatments aimed at anger in adults, however, produced an average effect size of 0.71, confirming the data that had already been reported. In fact, fifteen years later more effective treatments do not seem to have been developed. Although the range of treatments to be offered has expanded, CBT treatments remain the most frequent ones, with more numerous studies on their effectiveness (Deffenbacher, 2006; Fernandez & Johnson, 2016; Kulesza & Copeland, 2009).

In addition, we have also noticed that the best outcomes in interventions based on cognitive dimensions usually come from individuals who prefer the Thinking function rather than the Feeling function (Jinkerson *et al.*, 2015).

Therefore, research on anger should be further improved in the following directions: i) there is no agreed definition and connotation of anger in both physiology and pathology; ii) there is no taxonomy of the pathological expressions of anger, which instead appear to be transdiagnostic; iii) there is a variety of interventions on anger which, albeit achieving good results, are not as effective as interventions related to other disorders, such as anxiety and depression; iv) over the last fifteen years, interventions have not become more effective.

In this context, we believe that a possible priority could be to try and identify elements that are primarily useful for diagnostic (and therefore therapeutic) purposes. A similar process is highlighted by de la Parra *et al.* (2017) with respect to depression.

Our contribution to this complex subject field is meant as an attempt to work in this direction.

Aims

From what has emerged from critical literature and from our personal clinical work with some patients struggling with anger management disorders, the need to focus research on the possibility to make a more precise diagnosis became clear: can we make distinctions between different psychic functioning in the generic definition of maladaptive anger management?

We thus tried to find useful elements in critical literature to differentiate anger-related problems and provide tools for a not merely descriptive or symptom-related diagnosis.

Our second aim was to evaluate which elements resulting from such a survey can be enhanced, and to what degree, in a psychoanalytically oriented approach focused on anger.

Methodology

Our paper is divided into two stages. To highlight some elements that could contribute to better differentiate

Table 1. The core of several readings of anger, as summarized by Feindler and Byers (2006).

Psychodynamic models	Anger is conceptualized as a repetition of past conflicts and a defensive effort to deny vulnerability
CBT	Anger problems can be interpreted as classically conditioned automatic reactions with little awareness
DBT	Anger is constituted by maladaptive behaviours that evolve from defective problem-solving in response to intolerable painful affective states
Couple and family therapy	The outbursts of anger would therefore be at the service of the maintenance functions of family interaction patterns. The primary focus is to see individuals in the context of the system
EFT model	Mismanagement of anger is linked to problems in the regulation of affects such as upregulated or downregulated
Buddhist approach	Anger is a way of coercing compliance from those who disobey or disagree with us
Adlerian therapy	Anger as a negative direction of self-protection, intimidation, and self-centeredness; the themes of domination and power are central
Psychodynamic Assimilative Psychotherapy	Anger is the result of painful and traumatic developmental experiences that have been repressed, denied, or rationalized

the construct of anger, especially in a diagnostic key, Scopus and PsychINFO databases have been explored using the key words: anger, rage, theory, model, treatment, outcomes, adult, relevant articles were obtained. We then tried to pinpoint the elements in the different anger treatments that have been effective, and above all we tried to identify the elements, or the characteristics of patients, for which interventions were little effective. This information could contribute to a better understanding of anger no longer meant as a monolithic phenomenon and could therefore be useful for more precise diagnoses.

The second and core aim of this paper is to offer a reading of problematic anger that considers some elements already highlighted by critical literature, framing them in a dynamic perspective. The aim is to propose a way of taking care of these patients based on coherence between diagnosis and treatments. In our proposal, clinical practice has been integrated with what has emerged from our survey of critical literature.

Big or small results

All the studies, as mentioned, show moderately positive results, but our intention is to focus on what works and what does not in order to shed light on the different functions and refine the diagnostic and therefore therapeutic approach This is possible because some works highlight not only the positive results but also the limitations of the adopted interventions. For example, in the assessment of the degree of change achieved by sexual offenders, followed in the community for an average of 5.42 years post-release, Olver *et al.* (2014) observed positive results with respect to the measures of physical aggression and anger, but small to moderate pre-treatment and post-treatment changes with respect to the measures of cognitive distortions, aggression/hostility, empathy, loneliness, social intimacy, and sex offenders' acceptance of responsibility. With this kind of violence, sexual offense specific treatment, as measured by the sexual deviance factor of the VRS-SO - which includes static items (*e.g.*, criminal history, offender and victim demographics) and dynamic items reflecting domains of psychological, social, emotional, and interpersonal functioning - is strongly predictive of sexual reoffending (Eher *et al.*, 2020); the evaluation of sexual abuse shows statistically significant improvements on some, but not all, measures of self-regulation of cognitive distortions, empathy, interpersonal skills, self-regulation, and relapse prevention (O'Reilly *et al.*, 2010).

There is interesting evidence with respect to dialectical behaviour therapy (DBT) - used with borderline patients aimed at the regulation of emotions, particularly with regard to the regulation of problematic anger. Neacsiu, Rizvi and Linehan (2010) found that, although emotion regulation skills were a mediator of therapeutic change in these treatments, they had no effect on problematic anger, whereas in a later study, in which the distinction between assertive and rejecting anger was assumed, they better focused on the fact that BPD patients, after being treated, show improvements in their assertive anger, but not in terms of anger rejection (Kramer *et al.*, 2016).

Moeller *et al.* (2021) in a CBT case study focused on rumination (RfCBT) show a reduction in repetitive negative thinking disorder, but no alleviation of depressive and anxious symptoms.

Eifert and Forsyt (2011) found a relatively large (medium to large) effect size (d=0.76) of ACT treatment on problem behaviours, but no impact on trait anger. Trait anger has not mediated the reduction of problematic behaviours associated with anger. This indicates that the problematic behaviour of anger can be changed without changing the dispositional experience of anger. In this case, even more than others, it could be relevant to verify the results in an extended follow-up (Table 2).

Some forms of anger (*e.g.*, there is still no treatment for anger rejection) and some patients with serious psychopathologies or having committed serious crimes such as sexual abuse therefore seem to be more difficult to treat. With respect to sexual abusers, cognitive distortions and affective disorders remain. Moreover, a study by Condino *et al.* (2016) highlighted that, regardless of intervention strategies, according to victims' reports approximately one in three cases will have a new episode of IPV within 6 months; failure, therefore, also involves behavioural control.

With respect to treatment-resistant expressions of anger, there are interesting contributions have been offered. Pascual-Leone *et al.* (2013) take as a conceptual frame of reference the general model of emotion focused therapy, which makes an interesting distinction between primary emotions (adaptive or maladaptive), secondary emotions, and instrumental emotions. Whereas primary emotions are basic genuine responses and are subject to change, secondary emotions are secondary responses to other (reactive) emotions, are difficult to regulate, generally have a defensive purpose or can reflect complex reactions; therefore, they often interfere with adaptive emotional functioning. Finally, instrumental emotions indicate that the emotion is used to achieve a purpose. According to the authors, problematic anger is never a primary emotion. In their review, they describe, also through clinical examples, the following four conditions: 'I Hate Myself', 'I Hate You', 'I can't remember why I'm angry... but I am!, 'I Hate Everybody'. Especially when anger and hatred are turned against oneself, *e.g.*, in forms of self-criticism, the authors argue that a sense of the self as bad, broken, defective is activated. Punitive self-hatred would in fact be a secondary response to the primary emotion of shame. Another expression of problematic anger is related to secondary defensive hatred ('I hate you for not loving me') and is a form of defence against primary and underlying vulnerable feelings. When fear,

shame, or emotional pain become intolerable, they are eclipsed by secondary anger, which brings a reduction in anxiety along with a sense of power. The rejection of anger also belongs to this category. Finally, chronic anger can be traced back to undifferentiated secondary anger, characterized by high states of excitement and low significance, or to instrumental anger, or to both.

In line with the previous contribution, the study by Kramer *et al*. (2016), highlights how assertive anger can be effectively increased in patients with BPD as a short-term treatment goal, 'that explicit skills training and behavioural prompting may offer sufficiently powerful scaffolding to facilitate the increase of assertive anger as a healthy change process' (pg. 199). The question is different for rejecting anger, which needs to be processed in a long-term treatment. This is clearly the most difficult type of anger, and the fact that the various treatments have had good but not impressive results is likely to be partly due to this type of anger, which was probably not recognised. Another significant clinical suggestion implies the importance to gain access to primary maladaptive fear and shame, as well as pain, as a gateway to trigger assertive anger (Kramer *et al.*, 2015).

This suggests that such expressions of anger are rooted in deep-seated aspects of the subject, which need to be processed in order to have a different pathological expression. This is clearly the most difficult type of anger, and the fact that various treatments have had good but not impressive results is likely to be partly due to the presence of a form of anger grounded in primitive or deep-seated functioning of the subject.

Anger therefore appears to be a symptomatic manifestation, but treatment must be aimed at understanding the congruent functioning and emotions underlying these symptoms. A similar approach can be adopted with regards to patients with serious diagnoses or having committed serious offences: in order to treat anger in these cases, deeper dynamics and/or acquisitions must be considered.

As for effective indicators, that is the understanding of what the 'active ingredients' of psychological therapy are, Rudge, Feigenbaum and Fonagy (2020), in a critical review of DBT and CBT therapy for borderline personality disorder, identified the following mechanism of change: emotion regulation and self-control via the therapeutic alliance and investment in treatment. Other relevant issues are the alliance with patients, the timeliness of their involvement, and the dropout. Holdsworth *et al.* (2014) in a review about offender engagement highlight that 'treatment factors are more consistently associated with engagement than offender characteristics' (pg. 102). 'Engagement determinant variables comprise inter-related variables that are either cognitively-based (offender motivation), treatment-based (program responsivity, counsellor rapport, peer support) or dependent on offenders living situations (social support, out of session environments)' (ib. pg. 116). The conclusion of this work is of great importance. The authors wrote: 'In conclusion, the maximization of offenders' engagement in treatment and change largely depends on the therapeutic skills of facilitators, requiring the appropriate training and support from treatment providers' (ib. pg. 119).

Table 2. Results of some anger treatments.

	Patients	Positive results	Negative or mediocre results
Olver *et al.*, 2014	Sexual offenders	Physical aggression and anger	Measures of cognitive distortions, aggression/hostility, empathy, loneliness, social intimacy, and acceptance of responsibility
O'Reilly *et al.*, 2010	Sexual abusers	Some but not all self-report measures of cognitive distortions, empathy, interpersonal skills, and self-regulation skills (cognitive distortions subscale of the Children and Sexuality Questionnaire and the adversarial sexual beliefs subscale score of the Burt Endorsement of Violence, Victim Empathy Scale, Emotional Loneliness, self-esteem, anger awareness subscale of the Relapse Prevention Scale Scale and the Assertiveness Scale, self-esteem, anger awareness subscale of the Relapse Prevention Scale)	Measures of self-regulation, cognitive distortions
Neacsiu, Rizvi & Linehan 2010	BPD patients regulation of problematic anger	Emotion regulation	Problematic anger
Kramer *et al.*, 2016	BPD patients	Assertive anger	Anger rejection
Eifert & Forsyt (2011)	Problem anger	Problematic behaviours	Trait anger
Moeller *et al.*, (2021)	Schizotypal personality disorder (SPD) RfCBT	Anger rumination	Depressive and anxious symptoms

In conclusion, an approach focusing on the therapist's engagement skills and exploring deeper or more primitive aspects of the subject could be useful in dealing with situations in which it is more difficult for change to take place. A psychodynamic approach could be the answer. The attention to the relationship aspects is at the core of psychoanalytic approaches, where the relationship with the patient is a pivotal element of the process of understanding and treatment, by paying attention to the therapist-patient alliance, to its fractures and to transfer dynamics (Locati F *et al.*, 2016).

In a dynamic framework, a proposal for understanding and intervening

In the psychoanalytical field, many theories (Garaigordobil, 2014) allow us to interpret anger and also to describe its evolution within the evolutionary process.

In Psychodynamics there are two main models: the conflict model and the deficit model. In the first model the symptom appears as compromise formations among the conflicting and competing instances (wishes, desires, inner moral influences, ideals, affects, *etc*.). In this case, the therapeutic intervention aims not so much at the overt symptom, but at the awareness of the personality factors that support it. Among them, it is worth mentioning Menninger's contribution (2007), according to whom anger is a 'response to a wound of the self' (ib. pg.119), *i.e*., a response to traumatic events and to the perception of lack of control in one's own life. In his perspective, anger therefore represents an attempt to regain control and a sense of integrity.

The themes of the narcissistic wound and of the inability to integrate conflicting experiences are also key concepts in Kohut's thought (1971, 1978), especially the notion of narcissistic anger. Kohut adheres to the deficit model because he saw 'anger, and especially anger, as a reflection of the' disintegration 'of a central self in response to the empathic failures of the environment' (Knafo & Moscovitz, 2006, pg. 102). Narcissistic wounds, resulting from the lack of an empathic relationship, bring archaic structures to be disconnected and repressed instead of being integrated and balanced, thus causing their re-emergence in threatening situations. Narcissistic wounds can therefore produce feelings of embarrassment and anger, but also feelings of shame and violent anger. The relationship between narcissism and anger is also pointed out by Wiener (Wiener 1998), and by Kernberg (2018).

Although dated, Winnicott's contribution is still topical, as it allows us to delineate the transition from a normal dimension to a pathological one. Winnicottian theory (1971), distinguishing aggression from anger, violence, and destructiveness: the latter three ones are the failed outcome of a pathway in which aggression has not been acknowledged and modulated in a containing relationship. The encounter between personal characteristics and the environment, with its function of recognition, regulation and legitimation, helps to adequately manage anger, which can thus be used to build secure boundaries between oneself and the outside world and for a healthy and desirable self-assertion. Within this theoretical framework, it clearly appears that it is the legitimation, both internal and external to the subject, and the recognition of aggression in its ambivalence of feelings that turn aggression into a vital feeling. When the possibility of being aggressive is not granted during the development of the self, aggression can be held back, with the risk of exploding in violent acts, or of being directed against the self, in depressive manifestations: both cases represent the manifestation of a personal inability to assert oneself or the inability of the environment to express such recognition and to be supportive.

Kernberg integrated the theory of drives with the object relations and then 'the concept of inborn dispositions to excessive or inadequate affect activation' (Kernberg, 1994, pg. 702)

The theory of mentalization (Fonagy, 2004) also fits into the deficit model: the individual is unable to reflect on emotional experience and to comprehend its meanings. This is a very interesting construct, whose importance in relation to anger (Josephs & McLeod, 2014) and in different clinical populations, such as those suffering from personality disorders (Bateman *et al.*, 2016; Gagliardini *et al*., 2018), have been stressed in recent studies.

An analytical (long-term) treatment could clearly also bring anger problems to resolution, but serious issues related to the involvement and motivation of possible patients would probably arise. Patients with anger problems are not easily engaged and drop-out rates are high. The dropout rates were of between 50% and 70% (Daly & Pelowski, 2000) and 15% of institutional samples and 45% of community (McMurran & Theodosi 2007). Berta and Zarling (2018) observed that, although CBT-based interventions have received empirical support, these are not universally effective, and treatment abandonment continues to present difficulties.

Ways of intervention for patients who have had little or partial benefit from treatments need to be further explored. Unlike other patients, who may also wish to gain greater knowledge of themselves and of their own unconscious dynamics, subjects with anger-related issues may be only aware of and interested in these specific problems and sometimes also have an extrinsic motivation, *i.e*., a reduction in their criminal sentence. To engage with these patients, priority attention must be paid to this problematic aspect. The examined reasons why the patient cannot engage in therapeutic work are very often closely linked to the patient's elementary functioning. For these people, this is the only way to relate to other human beings and they have never learned how to do it in a different way. Therefore, what seems to be a disorder in the therapist-patient alliance must accordingly be viewed as the

expression of their pathological relationship connected to a serious emotional disorder, which must be diagnosed as it dominates the subject's whole existence. In this sense, such dysfunctional behaviours are connected to a core functioning of the patient who displays an infantile way of feeling and thinking that has never evolved (Orefice seminar, 2013). Dealing with the patient by showing a genuine interest in what he/she is experiencing requires specific acts/technical choices. This can be done during the diagnostic process, which is central in clinical practice and becomes even more important in this case both for the patient and the therapist. The patient is offered a space - definite and limited in time - in which every therapeutic action is suspended and whose aim is to understand what is happening. It is a joint work between the patient and the therapist that leads to a functional diagnosis, which adds to and enriches the nosographic-descriptive approach with the aim of recognising the patients' basic psychic functioning, by understanding their history, the quality of their early relationships and the pathogenic family climate in which they grew up. This work allows the therapist to identify important clinical elements, which are crucial for understanding violent behaviours. We would like to argue that the analysis of the functions of anger plays a pivotal role in this context. Such investigation, first of all, implicitly tells the patient that what he/she is doing, however maladaptive it may be, is not simply to be eliminated but to be understood. The patient's (also) violent behaviours are not to be justified and it is important that they are fully aware of socially sanctioned/sanctionable behaviours, but what they have done or are doing stems from needs that can be acknowledged and legitimised. This approach is functional to building a collaborative (or alliance) relationship. Exploring the functions of anger is also essential for therapists, as it provides tools to assess the underlying functioning of the subject, beyond anger.

In the early stages of life, when one takes possession of basic functions, *i.e.*, those that have to do with the acquisition of a sense of continuity of the self, of a first corporeal and then mental and affective boundary, and of a sense of belonging. These acquisitions contribute to structuring basic trust, and wounds of different entity to these fundamental functions influence the subjects' relationships with themselves, with their body, with others, and often define and determine the fate of future relationships as well as the elementary functioning of the self (Orefice, 2002, 2013).

The attention to the ways of feeling and the emotions that subjects may have developed from the encounter between their 'basic equipment' and the relationship with their primary environment, together with attempts to modify them and to give a different course to life, are useful indexes to the understanding of psychopathology. As long as one is not aware of them, the feelings of the self-force their presence in people's minds and lives in an overbearing and pervasive way. Feelings about the self are, therefore, the 'organizer' that is responsible for the insurgence of psychopathology, because they determine the ways one feels and are able to structure different psychopathological conditions: as Del Corno, Lang, and Colson argue, in Orefice's approach the 'organizer' is first of all identified with an elementary affective structure, which describes the prevailing structure of the patients or their relational style in particularly significant conditions, and which organizes their psychopathological structure (Del Corno, Lang and Colson 2013, pg. 92). Our approach to anger is therefore aimed to identify both the possible primitive alteration of the feelings of the self, which occurred in the early stages of development, and the function of anger within the subject's overall functioning. In a more preventive perspective, it could help the clinician to diagnose the possible dangerousness of the patient and to devise a strategy to better address some situations.

In order to understand which feelings are involved in an angry/violent reaction, the right to exist is particularly relevant. When violent reactions take place, specific and primary feelings of the self-seem to be involved, which can range from feeling unworthy of love, excluded, to not feeling entitled to be in the world. We suggest that, in situations of extreme violence, it is precisely this right to exist that is being undermined. Such a threat can elicit a corresponding need to suppress the other. We can rightfully assume that the more fear has to do with a feeling of not belonging and with the denied right to be in the world (existence), the more it will be able to induce inhuman feelings and experiences, thus generating particularly violent behaviours - especially if we consider that it is as if existence itself were at stake.

In the context of primary feelings, the specific wounds to bodily and psychological boundaries play an important role in creating the conditions for violent action. In subjects at risk, we expect a perception of the world with specific qualities of hostility or inaccessibility, which generates unbearable feelings of exclusion or, on the contrary, the fear of being invaded. In the first case, this boundary can be perceived as a barrier that should not be there or as a wall that must be torn down, also through violence, since it stands between the subject and the world. In the second case, the lack of a boundary can generate the fear of being in the hands of the other, who can exclude or seduce at will. The angry reaction therefore becomes an 'attempt', on the part of the subjects, to fight that feeling of inexorable exclusion or to defend themselves from a painful invasion. The legitimation of one's own space therefore shines forth as crucial: the more one's mental and emotional spaces are perceived as legitimate; the less subjects will be in the condition of having to claim them with violence or to inexorably renounce assertive affirmations of their self.

An important first step could, therefore, be to shift the subjects' attention to their own internal dynamics and help

them to recognise what feelings are at stake in their angry behaviour. The reason for anger is often identified exclusively in the event itself or in the 'other' and not in what the event causes within to the self (in fact, the real trigger of anger). The impossibility of recognizing one's own internal dynamics risks maintaining rancorous and angry feelings towards the outside, which is perceived as the only responsible to 'war with', without being able to envision a different solution to get out of one's subjection to the world. When anger is not understood within a coherent system of meanings, it is particularly difficult for the subject, who remains substantially at the mercy of anger, to manage and modulate it. In addition to focusing on the feelings of the self, it is important to help subjects to become aware of what they are trying to achieve or modify through anger.

Within this picture, anger can be seen as an activity of the Self whereby patients respond to their need to get rid of the painful feelings they cannot manage. For example, when anger is expressed through excessive reactivity or properly in a violent act, it can be interpreted as an attempt to change a feeling of physical and psychic subjection in relation to others and to the world in general. This subjection can be related to the 'other', to the outside world or to destiny perceived as something completely overwhelming. In this sense, anger can also be a way of managing a feeling of expropriation of the self, which is rooted in the subjects' conviction to be the victim of an adverse destiny, sentencing them to a sense of failure and absolute unworthiness.

Anger can also be a sign of the continuous struggle that subjects engage to free themselves from such feelings. In this case, the violent act can be an extreme expression of rebellion against adverse fate. Subjects, when they experience the feeling of having the 'world on them' and feel the impossibility of getting rid of it, can react with various degrees of violence, with which they attack the surrounding world, with the intention of breaking everything and with everything, just like in a liberating act. Anger can be sought for its 'transformative' power, that is, it can become a way through which the individual seeks a feeling of strength and self-control: the subject is transformed from the one who suffers to the one who takes control. The violent act can thus be experienced as a real rebirth and repudiation of what one is or what one fears to be as a sort of 'transformative' ritual. Being perceived as the only means to acquire strength, anger can become unavoidable; for this reason, subjects will be induced to resort to it whenever they feel the need to change the feeling of themselves and perceive themselves as strong, and it can also become the only way to make radical changes to the self (Table 3).

The factors highlighted can contribute to the reading of domestic violence. In fact, it is in intimate and important relationships that identity aspects and the fragility of the self are most involved and exposed. We could say that the intensity of the pathological bond is related to the intensity of rage.

To conclude, it is possible to claim that what the subject does and feels, however dysfunctional it may seem, responds to some necessity linked to fundamental needs. Therefore, there is a meaning in what happens to the subjects, although their reactions are not adaptive yet. It is not a question of justifying violence, but of trying to understand it, seeking, under the violence, the wounds of the patients in order to help them to change.

Discussion

Even if each theoretical approach has its own specificity in the way they frame the problems of anger and in the clinical intervention they propose, there are also consonances on various issues and aspects, which we would like to highlight. First of all, there is broad agreement on considering anger as a universal, primary emotion and also with adaptive functions. In some cases, and in some patients, anger occurs in a pathological form, and in this context some (Kramer *et al*., 2016; Pascual-Leone *et al.*, 2013, 2017; Robinson, Traurig, & Klein, 2020) (and we among them) identify different qualities. In particular, the work of Pasqual-Leone and Kramer (2017) - which explores the patient's global distress by distinguishing the components of rejection in anger, compared to shame/fear - is very important and useful.

In other areas, significant points of contact can be identified, even if not explicitly, such as in CBT. CBT recognises that anger arises in response not only to external triggers but also to internal stimuli, both cognitive and emotional, and that ratings are related to

Table 3. Relationship between anger and prevalent (non-exclusive) impairments of primary functioning.

What is anger for?	Prevailing (non-exclusive) lesions of primary functioning	
To break down the hard barrier that separates oneself from others To defend oneself against an intrusive world	Boundaries between oneself and others	Primary functioning
To preserve the self by placing the causes of the problems on the outside To give a feeling of compactness to the self To counteract the feeling of shame	Continuity of the self	or
To shake off the message that you have no right to exist ('you are not worthy to live' 'you are nothing')	Belonging	Basic trust

personal experiences. Therefore, there may be different levels of bias in the assessment and different qualities of anger. Experiences are crucial elements for us too. With reference to the conceptual framework here outlined, different degrees of pathology, ranging from ineffective anger management to problematic anger, or rage, have their roots in important impairments of the primary functioning of the self, and so in the events that have characterised primary relationships. The quality and depth of the injury determine both the characteristics of anger, including how dangerous it is, and how it is handled. We hypothesize that, where treatment pathways fail, there is probably a deeper component of anger a wound that has not been (seen and) healed. An indirect confirmation comes from the work of Howells and Day (2003) which highlights how people at high risk of violent behaviour usually suffer from comorbid problems, such as substance abuse, personality disorders, family dysfunction, and mental illness. Our orientation is in line with Ornstein's contribution (1999) and specifically with the idea that there is a specific wound beneath anger.

Another shared element is the compensatory function of anger/rage with respect to emotional states that involve feelings of vulnerability (Anderson & Bushman, 2002; Berkowitz, 1989; Bernstein *et al*., 2007; Keulen de Vos, Bernstein, & Arntz 2014; Keulen-de Vos *et al*., 2016; Ornstein, 1999). The vulnerability linked to shame (Lewis, 1993; Rogier *et al.*, 2019) brings forth feeling of exclusion, humiliation, nurtured anger and violent, revengeful fantasies.

There are some shared features, such as the idea that anger is appropriate, the reduction of personal responsibility and the attribution of blame to others, the idea that anger is useful, legitimate, and can be used to remove obstacles to one's goals (Howells & Day, 2003); according to us, they can be traced back to the outcomes of primary functioning. In this framework, these characteristics are not read as 'impediments' to build an alliance but as valuable indicators of the patient's underlying functioning. As a consequence, we see the 'focus' on anger, understood as a self-healing effort, as crucial and for this reason the symptom is not to be taken as the initial target of the intervention. Patients will stop resorting to anger when they are able to use different resources to respond to those needs for which they used anger.

This mental habitus is central also for the construction of an alliance, a theme already mentioned as crucial. Howells & Day (2003) summarized the central themes of the alliance in three points: i) the collaborative nature of the relationship; ii) the emotional bond between client and therapist; iii) the ability of the client and therapist to agree on goals and processing tasks. In our opinion (also in the light of clinical practice) an attitude that is initially exploratory, aimed at understanding, with the client, the function of anger, refraining from any judgment on the matter and also from the intent to eliminate it, lowers the defences of patients and promotes the alliance. Starting the analysis of the function of anger with the patient allows to distinguish between normal and common needs, aspirations, desires (*i.e*., the basic trust acquisitions), from the inadequate tool - anger - used to respond to those missed acquisitions. The investigation on the function of anger is crucial, since it can prevent the frequent risk of reinforcing in patients the feeling of being wrong and that what they feel and do is wrong, triggering conflicts with the therapist, favouring abandonment. The perception of being wrong is often just what the patient tries to get rid of through anger in order to achieve a feeling of strength and self-control. This is a way of working that seems to us to respond to the difficulties of engaging patients and maintaining their motivation over time, focusing on building an alliance, primarily diagnostic and then therapeutic.

In summary, our contribution, though framed in a psychodynamic horizon, aims to propose a reading of anger, which can also be used by operators with a different conceptual framework of reference, starting from the exploration of what the function of anger is in a patient and what are the feelings of the self that generate it. This contribution helps to understand the problematic cognitions, emotional states, and frequently engaged coping mechanisms that characterize the individuals at risk of aggression.

Conclusions

The dysfunctional experience of anger is a relevant issue from both an individual and a social point of view. Moving within a dynamic frame of reference, but also integrating scientific evidence pertaining to different theoretical frameworks, the authors have proposed some reflections that can provide a guide to clinicians in their diagnostic, preventive, and therapeutic work. A more articulated diagnosis is proposed with respect to anger and experiences of, more or less, intense threat to the feelings of the self.

Beyond the different definitions, connotations, and expressions of anger, we want to propose to the clinician a useful theoretical reference, a method of access to the patient, and a specific way of intervening which, on the one hand, do not confine the patient in theoretical schemes (thus losing the specificity of the individual) and, on the other hand, help the clinician not to be too frightened. The emotional levels are most effective in producing, maintaining, or modifying a psychopathological situation. A closer attention to the underlying emotional dynamics, the function, and the purpose of anger within the subject's overall functioning would allow not only to better understand it, but also to outline more effective ways of intervention.

The validity of this proposal is confirmed in clinical practice, although it must be evaluated in further clinical

findings. Further confirmation could come from future research; in particular, based on the constructs here described, a questionnaire is being studied, which could allow to evaluate the statistical validity of the factors and encourage clinicians to explore such delicate areas.

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