

ANGER SUPPRESSION IN LATE CHILDHOOD  
*A CASE ANALYSIS*

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**Abstract**

Research on anger in childhood typically refers to “difficult” children. In academic, social, and family settings, anger is not being addressed unless it is causing a noticeable disturbance such as screaming and/or hitting. The negative attention associated with anger expression is part of the socialization of anger. Society has labeled anger as a negative emotion and this view leads to the suppression of this emotion to avoid negative attention. The literature on emotions in childhood highlights the negative outcomes that emotional suppression can create. A child’s expression of emotions is a combination of their external environment and their ability to regulate their emotions. This thesis will explore a case in which a child is afraid to express his anger and displays as fearful and sad. I will explore the familial socialization of anger and expressive suppression through reviewing current literature and focusing on this case study.

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## Introduction

Anger is an emotion that is often accompanied by a negative connotation. When someone is described as angry, it is because they are typically displaying undesired social behavior that is physically and/or verbally aggressive. Research on anger in childhood and adolescence typically refers to “difficult” children. Anger is often addressed because the expression of this emotion is causing some level of disruption. This implies that unless anger is causing a disturbance it does not need to be addressed. Much of the negative stigma attached to anger is a result of society’s unwritten rules about socially acceptable behavior (i.e. how the majority responds to the expression of anger). These unwritten rules that individuals internalize and abide by can be labeled as socialization. Socialization occurs throughout life and in various settings, but our first experience of being taught how to express ourselves typically occurs in the home.

As a clinical social work intern, I facilitated group therapy sessions and engaged in one-to-one therapy sessions with clients. I worked with Jacob (pseudonym), an 11-year-old boy who has expressed that he is afraid of expressing his own anger, because it is scary to see his brother angry. Jacob’s little brother becomes verbally and physically aggressive when angry and yells and attempts to physically harm others. Jacob has also shared that his peers' aggressive behavior (yelling, making threats, and hitting) make him anxious and hesitant to express his own anger. For Jacob, anger is being socialized as a negative emotion that is dangerous and therefore, he feels that not expressing this emotion is the best decision. However, the literature on emotional suppression highlights the connection between emotional suppression and psychological disorders in children. How can we teach children to express all of their emotions in a manner that is not harmful to themselves or others and also does not suppress their freedom of expression? This thesis will reflect on my ongoing work with Jacob who is afraid to express his anger and

displays as fearful and anxious. I will explore the definition of anger, the socialization of anger, and the regulation of emotions through reviewing current literature and focusing on this case study.

## Literature Review

### **What is Anger?**

Emotions are conceptualized as multidimensional constructs. They are composed of dimensions that distinguish the pleasantness or unpleasantness of the emotion, the degree of arousal, and the direction of one's motivation (moving toward or away from the stimuli). Arousal refers to the body's reaction to the emotion such as increased heart rate, heavy breathing, or sweating palms. Anger is typically conceptualized as unpleasant, highly arousing, and directionally motivated (approaching versus withdrawing from stimuli) (Angus & Harmon-Jones, 2018). It is an emotion that can be displayed in healthy or maladaptive ways, but often carries a negative connotation. Anger is fluid in that an individual can move between functional and dysfunctional forms of the anger-emotion experience; an individual can begin the anger-experience by appropriately explaining their point of view and swiftly shift into physically assaulting someone. It is an emotion that serves as corrective feedback in a relationship and is necessary for relationship adaptation (Butler, Meloy-Miller, Seedall, & Dicus, 2017). Anger is unavoidable because it signals that the individual needs protection and that a relationship warrants repair. Without anger, healing and forgiveness would not be possible. "Anger is useful because it prepares a person mentally, physiologically, and cognitively to manage any obstacles that interfere with the pursuit of important goals" (Kashdan et al., 2015, p.738). Above everything else, anger is a normal emotion.

### ***What Triggers Anger?***

In 1894 G. Hall Stanley collected 2,184 questionnaires as he embarked on an effort to scientifically study anger. Hall gathered information on people's experience of anger in regards to "what provoked them, what they did, how they felt later, and physical and mental changes"

(Tavris, 1989, p. 71). Tavris (1989) highlights three categories of anger as presented in G. Stanley Hall's 1894 study. The first category of anger incitement is "The Stupid Inanimate Object" where an individual becomes upset because an object is not functioning the way that it was designed to function. This type of anger may result in throwing and breaking the object in question. The second category of anger incitement is "Special Aversions"; this category focuses on idiosyncrasies that we find irritating. In Hall's study, 130 women reported that men wearing earrings served as a source of irritation for them. The third category of anger incitement is anger caused by one person's treatment of another, also known as relational anger. During Hall's study this third category of anger incitement drew the most attention and passion. The responses in the relational anger category were a combination of physical reactions and mental perceptions.

Appraisal theory proposes that our emotions are based on our perceptions of events. In line with appraisal theory it has been suggested that anger is sometimes triggered by an elevated level of testosterone and the attribution of blame. According to Kim (2014), both the physiological and the contextual are necessary to trigger an anger experience. The physiological process of anger such as body language and facial expressions may appear consistent across individuals, but giving meaning to the emotion itself is based on a person's mental constructs. Language and memory play a significant role in every expression of anger, both of which are shaped primarily by culture. When assessing a situation before attributing blame, individuals are looking at the world through their unique lens. This lens is a product of culture and upbringing. "In other words, if language, memory, and "personal world views" are components of every account of cognitive appraisal, then culture, ideology, and history must play a role in the production of anger" (Kim, 2014, p. 27).

When we look at anger from an evolutionary perspective, anger is triggered when an individual finds it difficult to reach a goal due to an obstruction. In order for anger to manifest, the person who is triggered must assign responsibility (or blame) to someone or something. Once blame has been assigned the anger-emotion experience serves as a source of motivation to problem solve with the assigned party (Kashdan et al., 2017). This motivation to problem solve highlights the human skill of adapting for the sake of survival which is the basis of an evolutionary perspective. Kashdan et al. (2017) found that the most dysregulating anger experiences were those triggered by an undifferentiated source. Undifferentiated sources of anger are essentially anger triggers that the individual cannot clearly identify such that the person feels as if they are angry for no reason. Since anger is inherently meant to motivate an individual to seek change and improvement it becomes difficult to regulate when you are unable to understand the emotional experience. This inability to understand what is happening is referred to as poor emotion differentiation (Kashdan et al., 2015). “Poor emotion differentiators are more likely to misinterpret, amplify, and dwell on physiological responses to emotional arousal” (Kashdan et al., 2015, p. 745). If you are unable to identify the problem that is being highlighted by the presence of anger, then you are unlikely to find a solution. Unresolved anger leads to an increase in anger intensity and increased difficulty in regulating emotions.

### ***A Holistic Transactional Anger Model***

At its origins, anger is biological and psychological. However, it is shaped based on context. “Simultaneous striving for both relational symmetry and safety in belonging, juxtaposed with individual being and survival, guarantees moments of deep, meaningful connection as well as moments of intense, painful relational difference, discord, disconnection, and offense” (Butler et al., 2017, p. 818). Essentially, the desire for both personal safety and

relational harmony will at some point result in conflict. Anger is a functional human emotion that serves as a signal that something needs to change (Butler et al., 2017). Traditionally, anger is classified as a negative emotion, but anger is not inherently dysfunctional. As with all emotions, anger has biological, psychological, and relational elements. At its onset, anger is experienced biologically as an individual is physiologically aroused (for example changes in body temperature and heart rate). The experience of anger then transitions to a psychological experience as the individual processes the threat. The final stage of the anger-emotion experience is relational as the individual acts out their current emotional state; acting out can be towards themselves, someone else, and/or objects. The negative connotation associated with anger does not stem from the emotion itself, but from the way that people respond to this signal that calls for self-protection. “The careful shaping of anger allows it to be organized and expressed productively, and can guide corrective action, repair, and healing following interactional collision” (Butler et al., 2017, p. 817).

Butler et al. (2017) formulate their model by focusing on how anger manifests from the lens of the self in relation to others. If anger is meant to be self-protecting and relational correcting, then it is important to highlight how the individual who is experiencing the anger-emotion views themselves relationally with others involved. An individual with an inflated sense of self tends to operate under the notion that others are unworthy and their own desires are more important than anyone else involved. An individual with a collapsed sense of self believes that they are unworthy and that the desires of others are what is most important when faced with conflict. An individual with a balanced sense of self values their personal desires and the desires of others. Individuals with an inflated or collapsed sense of self are likely to enact anger in a dysfunctional manner, because only one party involved in the relationship is being prioritized

(Butler et al., 2017). A dysfunctional manifestation of anger can be when someone starts a fight, because they are irritated. However, individuals with a balanced sense of self are likely to enact anger in a functional manner that promotes self-protection and relationship repair. For example, starting a petition because you do not support a law.

### **The Socialization of Anger**

For children, learning the difference between right/wrong and good/bad begins in the home; children are primed by their families and they enter the general social arena with the lens of their personal experiences. According to affect theory, a parent(s) response to a child's emotional expression can be labeled as emotional socialization (Oneal, et al., 2017). Parents respond to their children's emotional expression based on their own values. A parent that believes that crying is a valuable form of expression may respond by asking their child what is upsetting them. However, a parent who believes that crying is negative and displays weakness, may respond to their crying child by yelling for them to stop. "Angry, abusive parents may produce angry, abusive children not just by the example they set but by the injuries they inflict" (Tavris, 1989 p. 75). A parent's emotional response to their children include psychological and physical factors. In both of the previously mentioned situations the parents will have a psychological emotional experience that is shared with the child and a physical experience through body language. In the case of the parent that views crying as negative there may also be a physical contact experience where the parent inflicts physical abuse on the child.

The parental responses to children act as practice for emotional responses when children are outside of the home. Parental response to a child's emotional experience encourages or discourages the expression of emotion. Theoretically, children whose emotions are validated and supported develop emotion and behavior patterns that are prosocial (the child is able to relatively

process and regulate their emotional experiences). However, children who lack parental support during difficult emotional experiences may experience heightened and extended periods of unpleasant arousal as they attempt to avoid emotions (Breux, Mcquade, Harvey, & Zakarian, 2017). It should be noted that parental support does not necessarily mean making the child feel better in the moment. Parental support during emotional experiences means that the parents provide a safe space where the child can express their feelings and the child is met with skills for how to process what is happening. If a child is angry, then parental support may involve validating the child's anger, identifying what triggered the anger, and brainstorming effective coping mechanisms. This support does not guarantee that the child will not feel angry about the situation, but the child is learning how to understand their emotions and develop skills to generalize across time, place, and situation.

Parental emotion socialization changes as the child develops. When responding to an infant or young child mirroring prosocial displays of emotion is useful based on their stage of development. However, as children grow older their cognitive abilities become more sophisticated and the shift from mirroring to modeling becomes more appropriate (Mirabile, Oertwig, & Halberstadt, 2016). Mirroring younger children serves as a form of positive reinforcement of their current behaviors and expressions. Modeling for older children shows children prosocial methods of processing, reacting, and interacting with others. For example, if a child accidentally steps on their mother's foot this serves as an opportunity to model the prosocial expression of pain and anger. The mother may respond by informing the child that they stepped on her foot, identifying that this action made her feel pain and anger, and suggesting that the child be more careful in the future. Alternatively, the mother could have yelled at the child

and given them a punishment. Theoretically, the second method might instill dysfunctional behavior patterns within the child.

Emotional socialization goes beyond the child-parent interaction itself; the child is also learning how to experience their emotions by watching the adults in their family interact with each other. Some parents believe that by hiding “negative” emotions from their children they are protecting them. In actuality, the child is missing the opportunity to build skills to deal with a variety of emotions in a manner that is effective for both themselves and others. A study analyzing the indirect effects of parenting practices on internalizing among adolescents found that inconsistent discipline, corporal punishment, and poor monitoring were related to youth emotional distress. This connection is theoretically explained by the notion that chronic stress during a child’s upbringing leads to difficulties in mastering emotional regulation (Balan, et al., 2016).

It has been theorized for years that males and females are socialized differently when it comes to adopting norms for emotional expression. In American culture, females are expected to be approachable and relationship oriented. However, males are expected to be assertive and aggressive (Chaplin, Cole, & Zahn-Waxler, 2005). These stereotypes have become standard in American society leading to assertive and/or aggressive behavior by a female being labeled as inappropriate. Similarly, empathetic and/or caring behavior displayed by a male is labeled as weak. Chaplin et al. (2005) looked at submissive and disharmonious emotions and found that parents responded differently to the emotions of their children based on gender as early as preschool. For the purposes of this study submissive emotions refer to sad-anxious expressions and disharmonious emotions refer to angry expressions. Parental attention to emotions seemed to affect what emotions were expressed nonverbally between girls and boys. When it came to

submissive emotions girls expressed more submissive emotions than boys. It was found that over time the expression of submissive emotions in the presence of their parents remained stable for girls from preschool to school age. However, for boys the expression of anxiety and sadness in the presence of their parents decreased by 50% from preschool to school age (Chaplin et al., 2005). We can conclude that in the aforementioned study parents paid less attention to the expression of submissive emotions from boys which discouraged their desire to express these emotions. In regards to disharmonious emotions this study did not find differences between genders. Chaplin et al. (2005) highlighted a limitation to their study stating that “the setting elicited frustration and was also a game context with family. In game contexts, slight expression of anger at losing may be seen as acceptable for both boys and girls” (p. 86). However, it was mentioned that in other studies girls were shown to mask their anger in the presence of a non-family member, but not in the presence of their mothers (Chaplin et al., 2005).

### ***The Role of Parent Psychopathology***

“Children who grow up in families characterized by parental psychological difficulties are at increased risk for developing social-emotional behavior problems, even when these difficulties are in the subclinical range” (Pol et al., 2016, p. 3367). Parental psychopathology symptoms can affect children’s emotional socialization through spillover, crossover and compensatory processes. The spillover effect involves the transfer of emotional functioning from one domain to another. Parental psychopathology may be accompanied by a difficulty with regulating their own emotions and this can create increased parental vulnerability when their child presents with a negative affect. Increased parental vulnerability is likely to interfere with the parent’s ability to effectively communicate with their child as they are experiencing a difficult emotional episode. As the parent attempts to reduce their own distress the focus shifts

from the child to the parent and may result in less supportive reactions to the child (Breux, Harvey, & Lugo-Candelas, 2015). The crossover effect highlights how psychopathology symptoms displayed by one parent can interfere with how their partner interacts with the child. The parent who is not experiencing psychopathology may respond negatively to the child's difficult emotional experiences. This is a result of a strain being placed on the partner due to the symptomatology of the other parent. Compensatory effects are similar to crossover in that parental psychopathology affects the interaction between their partner and child. However, compensatory effects are when the parent that does not display psychopathology symptoms compensates for their partner by responding to the child with support and sensitivity (Breux et al., 2015).

In a study conducted by Breux et al. spillover, crossover, and compensatory effects were observed for mothers. Maternal psychopathology symptoms were significantly associated with their use and their partner's use of non-supportive responses when the child was experiencing a difficult emotional episode. There was also a slight association between maternal psychopathology symptoms and paternal compensatory responses (i.e. supportive responses to difficult emotion experiences). However, in regards to paternal psychopathology symptoms there was no significant association with maternal non-supportive or supportive responses. This highlights the notion that maternal psychopathology plays a greater role in the emotional socialization of children (Breux et al., 2015).

Psychopathology symptoms in parents such as anxiety, depressed mood, and antisocial traits have been associated with children displaying withdrawn behavior and aggression. Several studies that have focused on the relationship between maternal psychopathology and parenting found that disorders such as schizophrenia and anxiety are related to lack of parental monitoring

and harsh parenting (Pol et al., 2016). Both of these affect the emotional socialization process between parent and child. It is known that individuals that experience anxious symptomatology have difficulty processing and regulating their emotions as they experience negative emotions intensely. As psychopathology symptoms impair emotional functioning, the parent's emotional socialization behaviors are affected. How the parent expresses their emotions around their child, how the parent responds to their child's emotions, and how the parent discusses emotions with their child is all affected when the parent deals with psychopathology (Pol et al., 2016).

### ***Emotion Socialization in Anxious Children***

Youth with anxiety disorders experience negative emotional experiences at a higher intensity than their non-anxious peers. In addition, anxious youth display heightened reactivity to perceived social threats (Oppenheimer, et al., 2016). For example, if a peer walks by an anxious youth in the hallway without speaking, the anxious youth may assume that they were ignored or their peer does not like them. Then for the rest of the day that anxious youth is focused on trying to figure out what they did wrong. Whereas a non-anxious youth may not have even noticed that their peer did not speak or assumed that they were trying to get to class. As youth transition into adolescence there is an increase in the desire for peer acceptance. The combination of anxious symptomatology, increased autonomy from parents and an increased desire for peer acceptance makes anxious youth vulnerable to negative emotional experiences within the peer context. Oppenheimer et al. (2016) found that positive parenting responses during stressful situations buffered negative emotional responses to real-world events. Within this study the parent/child relationship was a predictor of the child's peer relationships, but not a predictor of non-peer related performance (i.e. academic achievement). When parents respond with warmth and affirmation as their anxious child experiences intense emotions the child is likely to learn how to

regulate those difficult emotions. However, the parent/child relationship typically shifts as the child transitions into adolescence. Due to the increased autonomy from parents, positive parenting may decrease and child-parent conflict may increase. This poses a dilemma for the anxious youth as child-parent conflict creates a negative schema for peer interactions (Oppenheimer, et al., 2016). A consistent and positive parent-child relationship is important for anxious children as they transition into adolescence to decrease the likelihood of exacerbated anxious symptomatology.

### **Self-Regulation**

Self-regulation is our ability to manage the various stressors that occur in life. The more aware we are of our stressors the better we are able to reduce the intensity of chaos in our life (Shanker & Barker, 2017). It is a process in which cognitive skills are utilized to guide our goal-directed behavior across time, place, and circumstance. Humans are inherently relational beings; self-regulation skills allow us to engage with others appropriately and effectively. In children, the ability to self-regulate improves the number of positive peer and teacher relationships in addition to improved academic outcomes. Studies have shown that parental styles that focus on guidance result in children with strong self-regulation skills. However, parental styles that focus on behavior correction result in children with weaker self-regulation skills (Morawska, Dittman, & Rusby, 2019). Children are more receptive when parents acknowledge their children for engaging in successful regulation and model effective strategies as opposed to parents who demand their children to act a certain way. “The ability to monitor, regulate, and beneficently express anger is tightly integrated with forgiveness, thus making anger an essential element of a holistic affective, cognitive, and behavioral system for relationship adaptation and repair” (Butler et al., 2017, p.181).

### *Valuation Systems*

Before we specifically explore emotion regulation it is important to first understand valuation systems. “Our emotions may emerge and differ primarily because of the situations in which they occur and because of the interpretations that we give to our bodily states” (Tavris, 1989, p.73). Prior to emotion regulation we place a value on the emotion that has been triggered (i.e. good versus bad). Engaging in valuation involves comparing perceptions of the world to our representation of what the world should be (i.e our goal). When discrepancies occur between perceptions and expectations, we are motivated to lessen the gap. Valuation systems develop as a result of genetics and environment; they are a form of socialization. Children learn values and beliefs from their parents and through cultural experience. These values are the lens through which children interpret the world around them (Gross & Cassidy, 2019).

### *Emotion Regulation*

Emotion regulation is defined as “the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one’s goal” (Loevaas, et al., 2018, p.2). Emotion regulation is a form of influence as the individual attempts to alter their emotional experience (i.e. what they feel, when they feel, and how they express themselves). For an individual to successfully regulate their emotions they must be able to adapt. Emotion regulation strategies include, but are not limited to, help seeking, avoidance, attentional redirection, suppression, and problem solving. Gross and Cassidy (2019) highlight two types of emotion regulation: antecedent-focused and response-focused. Antecedent-focused regulation is when an individual intervenes in their emotion experience before an emotional response has begun or fully activated. For example, a child may prepare themselves for a long class by thinking about the benefits of learning new

things instead of focusing on how long they have to stay seated. Response-focused regulation is when an individual intervenes in their emotion experience after the response has been activated. An example of response-focused regulation would be deep breathing to calm down after yelling at a classmate.

The process model of emotion regulation elaborates further on this, as it “views emotions as loosely coupled changes in subjective experience, behavior, and physiology” (Gross & Cassidy, 2019, p. 1939). Is the process model different from the paragraph before it? Or something else you have already mentioned? This model divides the emotion regulation process into three stages: identification, selection, and implementation. In the identification stage the individual decides if it is necessary to initiate emotion regulation. You may ask yourself: Am I comfortable with my current emotional state? If the response is no, then emotion regulation is initiated. During the selection stage an individual who has decided to engage in regulation will choose one or more strategies that they perceive will be successful in reducing the intensity of the unpleasant emotion. Finally, in the implementation stage the individual enacts the strategies that were identified in the previous stage. According to Gross and Cassidy (2019) this process can occur on the conscious and unconscious levels.

### **Expressive Suppression**

Loevaas, et al. (2018) presents the connection between emotion regulation and psychological disorders theoretically. When a child is unable to effectively regulate intense and unwanted feelings there is an increase in those unwanted feelings. As those feelings increase, the child attempts to regulate (again) and begins to experience psychological distress as they fall into this negative cycle of ineffective regulation. Loevaas, et al. (2018) predicts that over time this cycling can lead to anxiety and depressive disorders. Expressive suppression is a form of

emotional regulation and can be defined as “when children conceal outward displays of emotion” (Gross & Cassidy, 2019, p. 1938). While emotional regulation is crucial for development and being able to respond appropriately to stressors throughout life, suppression has been predicted to have negative outcomes. Expressive suppression is categorized as a form of response-focused regulation and is considered a distinct form of suppression because of this. Other forms of suppression such as thought and feeling suppression occur prior to the emotion experience. Gross and Cassidy (2019) summarize the findings of a meta-analysis where expressive suppression was significantly related to symptoms of depression and anxiety. Although this meta-analysis focused on ages 13-years to 18-years, this link has been found across cultures and ages (7-years to 18-years). These findings support the growing research which suggest that expressive suppression is associated with negative outcomes.

Expressive suppression is a method of “holding back” behaviors that are deemed unacceptable. However, the suppression of anger can lead to an increase in both negative emotions and behavior (Sullivan & Kahn, 2019). In the moment, suppression may appear as effective self-regulation. If a child is extremely angry and they do not express this anger, then others may see this as a good thing because they were able to control themselves. It is important to note that there is a difference between self-regulation and self-control. Self-regulation is our ability to manage the various stressors that occur in life (Shanker & Barker, 2017). When we engage in self-regulation, we are addressing our current emotional state and formulating lasting solutions. Self-control serves as a temporary fix as an individual acts in a manner that hides their current emotional state; it is a surface level solution.

We need to remember that while suppression is an emotional regulation technique it is not necessarily effective. Emotional suppression has been “associated with heightened general

negative affect, diminished general positive affect, and reduced well-being including self-esteem and life satisfaction” (Sullivan & Kahn, 2019, p.1). In a study examining suppression during social interactions, researchers found that those who suppressed their emotions remembered less facts about the interaction and were able to recall more of their emotions from the social interaction. This highlights two of the interpersonal effects of suppression: memory loss and increased self-focus. Due to the increased focus on the self, those engaging in suppression may reduce their ability to effectively communicate as they miss important social cues and are less responsive to others. (Karnilowicz, Waters, & Mendes, 2019). This is true for parenting; as parents attempt to suppress emotions when interacting with their children, they are focused on themselves and not the content of their child’s current emotional experience. When the parent responds to the child, they are likely to respond out of context due to their attention being divided between the interaction and suppression. The child then walks away from the experience with learning how to self-control in the moment. What the child needed was an opportunity to learn how to self-regulate so that they can successfully navigate similar emotional experiences in the future. When parents fail to support children as they experience difficult emotions, the child is forced to find ways to cope on their own. Since a child’s cognitive abilities are not developed to the capacity of an adult, this can lead to the child experiencing further dysregulation. Repeated experiences as the one I just described may lead to children avoiding emotions that receive negative responses as opposed to expressing them. Research that focuses on the link between caregiver/child attachment and emotion regulation has found that secure attachments promote a flexible expression of a range of emotions. This is because a secure attachment has its foundation in caregivers accepting and responding sensitively to a range of emotional experiences (Gross & Cassidy, 2019).

### **The Moderating Role of ADHD Symptomatology**

Studies have shown that children with attention-deficit hyperactivity disorder (ADHD) experience significant difficulty when it comes to regulating their emotions. We know that parental responses play a role in the emotional socialization and regulation of typically developing children (Breux, Mcquade, Harvey, & Zakarian, 2017). Breux and colleagues specifically focus on the moderating role of ADHD symptomatology between parental socialization and child emotion regulation. Research suggests that difficulties in regulating emotions for children with ADHD may be more biological (i.e. dysfunction in areas of the brain) than influenced by external factors such as parenting. However, there is evidence that suggests that children with ADHD are sensitive to their environment and that positive feedback influences adaptive emotion regulation skills. Breux et al (2017) found that children with higher levels of ADHD symptoms were more susceptible to parent emotion socialization practices which were both positive and negative. Children whose parents engaged in non-supportive reactions were at risk for greater emotional lability and intense emotional reactions in their daily life.

### **CBT as Treatment for Anger Dysregulation**

Cognitive Behavioral Therapy (CBT) is an evidence-based therapeutic intervention model; it is the result of combining two schools of thought: cognitive theory and behavior theory. Cognitive approaches assist clients with developing alternative ways of thinking and behavior approaches help to reinforce these new ways of thinking with adaptive behavior patterns (Walsh, 2013). The goal of CBT is to reduce the occurrence of client symptomatology by encouraging clients to understand the connection between their thoughts, feelings and behaviors. CBT teaches clients how to find solutions for their current problems by being actively involved in the therapeutic process (Boyd-Franklin, Cleek, Wofsy, & Mundy, 2016). The therapist encourages

the client not to depend on others for problem solving as the cognitive-behavior approach instills skills within the client that they can utilize across time, place, and situation. CBT focuses on addressing the client's negative thoughts, because it is often the client's perception of an event(s) that causes a negative emotional experience and not the event itself (Boyd-Franklin et al., 2016). For example, a client who is anxious about flying because they believe that the plane will crash will avoid situations that require them to fly on a plane. This client has never had a personal experience with a plane crash, but this is their automatic belief. Their perception is that flying on a plane is dangerous. As a result, this client limits their opportunities to grow at work as promotions in their department require frequent travel. The client is left feeling helpless, because of their stagnant position in the company after years of dedication and diligence. CBT assists clients with analyzing these negative automatic thoughts (which may otherwise go unnoticed) by focusing on the actual thought instead of the client's interpretation of the automatic thought (Boyd-Franklin et al., 2016). In the example the client's automatic thought is "the plane will crash" and their interpretation of the thought is "planes are dangerous". During CBT, the therapist would work with the client to fact check "the plane will crash" and over time reduce the client's fear of flying.

The negative automatic thoughts described above are at the foundation of cognitive distortions. Cognitive distortions are errors in thinking that lead to the misinterpretation of events. Examples of cognitive distortions are: all-or-nothing thinking (using absolute terms such as "never" and "always"), catastrophizing (negatively predicting the future), discounting the positive, labeling (i.e. "I am a loser"), and mind reading (assuming that you know what others are thinking and holding your assumptions as truth). All of these distortions lead to negative emotional experiences that influence behavior. By directly targeting negative thought patterns,

CBT indirectly modifies behavior patterns. Therapists help clients to modify their core beliefs and then practice utilizing effective coping skills through exposure and role playing (Boyd-Franklin et al., 2016).

## **Case Study**

### **Agency Background Information**

My work with Jacob took place at an outpatient behavioral health agency for youth and young adults ages 18 months to 21 years. This organization provides support for young children, adolescents, and young adults who are struggling with neuro-biological disorders, emotional regulation difficulties, and/or mental illness. Jacob attended the partial care day program five days a week for five hours. The program is composed of different variations of therapeutic interventions which include: cognitive behavioral therapy, social skills training, educational instruction, sports and cooperative activities, art therapy and mindfulness. The day program that Jacob attended was composed of two hours of educational instruction followed by three hours of therapy. The three-hour block for therapy was broken into four separate group sessions that varied each day. However, cognitive behavioral therapy was included every day. For Jacob's age category the group sessions ranged from three to ten clients per session.

Before a client begins a program at the agency, a biopsychosocial assessment is conducted by interviewing the client and their caregiver(s). Typically, intakes begin by a counselor meeting with the caregiver(s) and then meeting with the prospective client separately. The purpose of this separation is to gain insight into how the presenting problem is understood through the perspective of the caregiver(s) and client without either party influencing the other. However, the agency allows the family to decide if they are comfortable with being separated.

When families are comfortable with being separated, the prospective client meets with a different counselor to build rapport, tour the facility, and complete a nutritional habits questionnaire.

### **Client Background Information**

Jacob is an 11-year-old who self identifies as a male. He attended a Montessori school and expressed interest in reading. Jacob began experiencing physical discomfort and anxiety about three years ago. Originally, his parents thought the anxiety was school related, but Jacob began to express fear and experience anxiety across situations. When Jacob was younger, he feared fires and falling; his anxieties manifested as physical discomfort. Jacob has verbalized that he is aware of his experiences with anxiety and is open to building effective coping skills. Jacob lives with his parents and younger brother (8-years-old). There is no reported trauma or abuse history within the family. Jacob's mother works from home while his father travels often for work. His mother experiences anxiety and she is prescribed medication for treatment. However, Jacob has not previously nor is he currently on medication and no hospitalizations have been reported by his parents. Jacob has difficulty with gross motor skills, coordination, and speech. He has undergone testing to identify the cause of his symptoms and has been diagnosed with attention deficit hyperactivity disorder (ADHD), general anxiety disorder (GAD), speech sound disorder, and developmental coordination disorder.

### **Presenting Problem**

Jacob presents as anxious and often reports psychosomatic symptoms such as headaches, stomach aches, and generalized body pain. He experiences general anxiety in addition to specific fears of zombies, the future, failing tests, and leaving the house. Jacob's anxiety has led to school refusal. His parents have reported that when Jacob goes to school, he frequents the nurse's office

as he is fearful of getting hurt and/or sick. Due to his difficulty with going to school, his school has requested a therapy treatment plan.

### **Response to Treatment**

During group therapy sessions Jacob interacts appropriately with peers and counselors when there is group cohesion. He has previously expressed that he gets upset when people do not listen and/or follow directions. When the group cohesion is disrupted because one or more of the group members is engaging in an off-topic activity, Jacob withdraws from the group. As mentioned in Jacob's background he enjoys reading and he uses this as an escape. He has identified "reading and being in my head" as coping skills for when he is experiencing difficult emotions such as anger, sadness, and anxiety. Jacob has displayed anger during the program as a result of being misunderstood stating, "I get annoyed if people do not understand something". In these situations, Jacob will begin to defend his point, but if the receiving person does not seem to understand Jacob's clarification, he will often isolate himself from the group. Jacob's clinician and I have encouraged him to request a break from the group when he is feeling annoyed or sad or anxious so that he can express himself, problem solve with a counselor, and return to the group. Jacob was receptive to this suggestion as he requested breaks more often. There were also times when Jacob would be prompted to take a break because he displayed as having difficulty regulating his emotions and would not comply. During breaks Jacob was provided with the opportunity to express the source of discomfort. Often, I would guide Jacob in identifying what coping strategies he could utilize in the moment such as deep breathing and essential oils.

During one of our individual sessions, Jacob and I discussed what things make him angry. He identified four triggers for his anger: having to engage in an undesirable task, illogical thinking, not being able to read during therapy groups, and being misunderstood. For each

trigger, Jacob was able to identify at least one coping strategy. His coping strategies included accepting the situation, explaining himself and removing himself from the situation.

### **Analysis and Reflection**

Based on the aforementioned research we can describe Jacob's fear of expressing his anger as expressive suppression. Jacob has been socialized to believe that anger is a negative emotion that only causes disruption and destruction. At home Jacob's younger brother displays anger in the form of physical and verbal aggression. During group therapy Jacob has witnessed his peers engage in physical altercations, screaming, and object throwing. In both of these situations Jacob's brother and peers are responded to with attempts to decrease the intensity of their emotional experience. At home, a physical struggle may arise between Jacob's brother and parents and at group therapy one of his peers may have to be restrained if necessary. Because Jacob experiences general anxiety and specific fears, his responses to stimuli are heightened as compared to individuals that do not experience anxiety. For Jacob his perception that anger is negative is being reinforced by his environment and mental health symptomatology. During a group session where the task was to identify emotions Jacob represented anger with grunting, punching, heavy breathing, and pretend head banging. It seems that his only mental representation of anger is aggressive.

For Jacob, emotion regulation can present as a difficult task as he juggles the symptomatology of multiple diagnoses. He experiences sensitivity to temperature change, psychosomatic body discomfort, generalized anxiety, and auditory hallucinations. Jacob's intrapersonal conflicts coupled with his brother's aggressive behavior and his mother's anxious symptomatology create an intense home environment to learn and practice emotion regulation

skills. While therapy presents an environment that is sensitive to Jacob's needs, he is still engaging in therapy with the perspectives that he leaves the house with.

While therapy is designed to be a safe environment for clients to process and grow, it is impossible for a clinician to have 100% control over a group of clients with varying ages, personalities, and diagnosis. During the group therapy sessions, compromise was crucial in order to engage everyone in the group. This typically meant that there were days or moments when Jacob was dissatisfied, because he was not interested in the group activity. As I mentioned previously, having to do something that he does not want to do is one of Jacob's triggers for anger. During group sessions when Jacob was not interested, he typically responded by being silent during the group or sitting away from his peers. In these instances, prompting from the counselors to join the group or to take a break were not successful for Jacob. However, Jacob was receptive to his peers prompting him to join the group. This highlights the importance of peer acceptance as youth transition into and through adolescence. During group sessions the clients were supportive of each other when someone displayed happiness or joy. The group members expressed concern when someone displayed sadness, fear, anxiety, or pain; the group made efforts to problem solve and assist the peer in distress. However, displays of anger (in the case of Jacob's group this was verbal and physical aggression) were met with further displays of anger. Even in the context of peer relationships, anger was being categorized as a negative emotion.

My plan with Jacob was to work with him weekly during individual sessions to assist him with identifying and expressing his anger. Due to the public health pandemic my time at my field placement ended abruptly and early. Before I left the agency, Jacob and I had begun identifying his triggers and current coping skills. Jacob was able to identify things that made him angry, but

in moments that he experienced anger, he shifted to sadness before he had the opportunity to express his anger. I believe that part of Jacob's willingness to express sadness over anger was due to the reaction towards each emotion. During group sessions Jacob's peers often expressed anger by engaging in verbal and/or physical aggression. This was often met by clients being removed from the group for the moment or for the day (this was dependent on the severity of the client's actions). Whereas, sadness and anxiety elicited attention from counselors and peers, impromptu individual sessions, and/or group problem solving. Due to his own experience and being a witness to the experience of others it is possible that Jacob coded sadness and anxiety as acceptable and anger as unacceptable, causing Jacob to ignore feelings of anger. If anger is truly a means of warning an individual that there is a threat, then what is truly being ignored each time that Jacob denies his anger?

Jacob and I experienced a gap in our individual sessions as Jacob began to experience difficulty attending the program due to an increase in the frequency of his auditory hallucinations. Beyond identifying triggers for anger and coping strategies, my plan with Jacob was to gain an understanding of how he views anger and create a space where he felt comfortable expressing his anger. The plan was to specifically focus on anger because Jacob was open about other emotions. In discussion with Jacob's clinician we felt that his avoidance of anger could potentially be blocking aspects of his treatment.

### **Conclusion**

The research presented highlights three major concepts about anger and emotions in general: anger is necessary, the anger-emotion experience is different for each individual, and socialization of certain emotions as negative can hinder one's comfort with emotional expression. The normalization of emotions such as anger is necessary for children like Jacob to

effectively learn and implement coping skills. When children are taught that some emotions are good and others are bad it is difficult for them to feel comfortable expressing the “bad” emotions. Emotions that are suppressed become difficult to effectively regulate and for some individuals, their suppression exacerbates mental and physical discomfort. I cannot help but to wonder if some of Jacob’s psychosomatic symptoms are a result of anger suppression. The labeling of anger as a negative emotion creates a cycle where children are left to believe that they have to hide their true emotions in an attempt to avoid negative feedback from parents, other adults, and peers. However, research shows that anger is not inherently dysfunctional and it can serve as a catalyst for change. Anger itself has been socialized by the majority of society as negative, but what makes anger dysfunctional is how it is expressed. The anger-emotion experience is more than rage, it is a biological, psychological, and social experience that is necessary for growth and survival.

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