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Cognitive-behavioral treatment of high anger drivers

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Abstract

Relaxation and cognitive-relaxation interventions were compared to a no treatment control in the treatment of high anger drivers. The cognitive portion of the cognitive-relaxation condition adapted the style of Beck's cognitive therapy, particularly use of Socratic questions and behavioral experiments and tryouts, to driving anger reduction. Both interventions lowered indices of driving anger and hostile and aggressive forms of expressing driving anger and increased adaptive/constructive ways of expressing driving anger. The cognitive-relaxation intervention also lowered the frequency of risky behavior. Both interventions lowered trait anger as well. Limitations and implications for treatment and research were discussed. © 2002 Elsevier Science Ltd. All rights reserved.

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Angry, aggressive drivers and 'road rage' have received increasing public attention with the most serious incidents involving some form of physical assault increasing 7% a year in the US during the early 1990s (American Automobile Association, 1997). Highway safety officials estimate that between one-third and two-thirds of injury accidents involve aggressive driving (Martinez, 1997; Snyder, 1997). Additionally, research has shown that court referred and self-

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referred aggressive drivers show high levels of intermittent explosive disorder as well as considerable other psychopathology (Galvoski, Blanchard, & Veazey, in press).

Other research (Deffenbacher 1999, 2000; Deffenbacher, Deffenbacher, Richards, & Lynch, 2001; Deffenbacher, Huff, Lynch, Oetting, & Salvatore, 2000; Lynch, Deffenbacher, Filetti, & Dahlen, 1999) has shown that highly angry drivers are an at-risk group. Compared to low anger drivers, high anger drivers are angered 2.7 times more often on the road and experience more intense anger as well. For example, high anger drivers report more anger in day-to-day driving, commonly occurring situations such as ordinary and rush hour traffic, high impedance situations such as being slowed in bumper to bumper traffic or being unable to pass a slow driver, and circumstances involving interpersonal conflict (e.g. another driver yelling at the person about his/her driving or stealing a parking spot for which the person had been waiting). High anger drivers also engage in more roadway aggression. For example, both driving diary studies and surveys of three-month rates of aggression showed that high anger drivers engaged in 3.5–4.0 times more aggression (e.g. cutting another driver off in anger or yelling at or making hostile gestures to another driver). They were also more likely to damage their vehicle and injure themselves as a result of directing their anger toward their vehicle (e.g. such as smashing the windshield or kicking in a door). Moreover, they engage in more risk-enhancing behavior as well. For example, driving diaries and three-month reports revealed 1.5–2.0 times more risky behavior while driving. They were also more likely to experience close calls and loss of vehicular control, about twice as many moving violations, more minor accidents, and a greater lifetime history of accidents, although not major injury accidents. In laboratory research involving a low impedance driving simulation, they drove significantly faster and more erratically than low anger drivers and significantly higher proportions drove 10 mph (40 vs 10%) and 20 mph (12 vs 0%) over the speed limit. In high impedance simulations, they had shorter times and distances to collisions and roughly twice the crash rates (i.e. 55 vs 23% when unable to pass a slow driver safely and 37 vs 16% in slow bumper to bumper driving). In summary, high anger drivers experience more frequent and intense anger while driving, engage in more aggressive and risky behavior, and are at elevated risk for a number of adverse outcomes.

These findings support the need for interventions to reduce driving anger and the consequent risks to angry drivers and those who ride or share the road with them. Little research addressing treatment of driving anger has been conducted to date, however. An early study (Rimm, DeGroot, Boord, Heiman, & Dillow, 1971) suggested desensitization was effective, but findings were compromised by serious methodological flaws (e.g. the primary outcome measure was pre-post change on intensity ratings of items from the hierarchy, making the outcome measure highly sensitive to demand characteristics). A second study (Deffenbacher et al., 2000) adapted self-managed relaxation coping skills (RCS) and a stress inoculation-like combination of cognitive and relaxation coping skills (CRCS) to driving anger. Both interventions reduced driving anger, but effects favored RCS on some measures of driving anger and CRCS on risky driving. Lessened effects for CRCS, in part, may have been due to how the cognitive component was implemented. CRCS introduced and focused upon a different type of cognitive distortion each session (e.g. catastrophizing one session and absolutistic thinking the next). The cognitive focus of a given session, therefore, may not have touched critical cognitive processes involved in the driving situations addressed in that session. Cognitive change may have been more efficacious if it were more situation-focused. That is, if clients identified cognitive distortions and developed alternative

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