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Anger in Anxiety Disorders: A Review

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ABSTRACT

This article reviewed the literature to study the association between and the co-occurrence of anger and anxiety in individuals diagnosed with an anxiety disorder. DSM 5 and ICD 10 include various disorders for pathological anxiety; however, they do not include many diagnostic categories for pathological anger. Clinically, the co-occurrence of anger and anxiety is well-known; however, it is the literature that lags behind in its support for this notion. Studies conducted between 1986 and 2020 with the term's "anger", "anxiety disorder", or both in the title were considered for review. Based on the literature review, we found that anger as an emotion is often not paid due clinical importance. The research on the association between anger and experienced anxiety in anxiety disorders was sparse and fragmented, requiring more attention. We also noted that based on the existing studies, anger and hostility appeared to be differentially elevated across anxiety disorders. The experience and expression of anger across the various anxiety disorders is heterogeneous. We conclude that more evidence-based research is required in this domain that may help in refining treatment protocols.

Keywords: Literature review, Anger, Anxiety, Anxiety disorder, Evidence-based research

INTRODUCTION

Theorists have conceptualized anger and anxiety as a state (state anxiety; state anger) and a trait (trait anxiety; trait anger). A variety of disorders for pathological anxiety are included in DSM 5, such as social anxiety disorder (SAD), specific phobias, panic disorder (PD), and GAD, and formerly also included Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD; [1]). Excessive fear or anxiety is a common characteristic of anxiety disorders; however, they differ in the nature of the fear or anxiety-provoking stimulus and associated symptoms. For example, PD is linked with fear of arousal-related physical sensations, SAD with fear of social situations and negative evaluation and negative construal of vague social cues, specific phobias with fears regarding specific animals, objects or situations, OCD with anxiety induced by invasive thoughts or images and their respective situational cues, PTSD with anxiety induced by the memories of a traumatic event, and GAD with anxiety provoked by the possibility of a negative future event. However, DSM 5/ICD-10 does not include many diagnostic categories for pathological anger.

Previous empirical research has focused less on anger than anxiety. Only a few researches have examined the co-occurrence of anger and anxiety. In 2017, in a comprehensive state-wise study of burden of mental illness, it was reported that 197.3 million people had mental disorders in India, including 44.9 million with anxiety disorders. The prevalence of anxiety disorders was 3.3%, reportedly higher among females [2].

More than half of a sample of anxiety disorder patients reported frequent anger outbursts [3]. Researchers [4] found that anger attacks occurred not only in panic disorders but also in patients with other anxiety disorders. Moreover, the occurrence of anger attacks was twice more likely among patients with depressive diagnoses than among anxiety patients. It is important to distinguish between feeling anger and expressing anger when understanding it as a construct. These two facets of anger are not always congruous. Some may experience intense anger but never express it, whereas others express anger (verbally or physically) whenever they

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experience it. These patterns can have negative consequences for the individual, and existing evidence suggests that different pattern of anger experience and expression may occur in different anxiety disorders [5].

In a National Comorbidity Survey Replication (NCS-R) among 5692 participants with anxiety disorders, it was reported that a unique relationship existed between various categories of anxiety disorder and anger experience and expression [6]. In a sample of 328 depressive and anxiety disorder patients, it was found that anger attacks were common and associated with more anxiety and irritability and lesser quality of life [7].

Bridewell and Chang [8] found that internalized anger and lack of anger control played an important role in predicting both depressive and anxious symptoms. Studies have also reported elevated levels of anger and hostility (the cognitive component of anger) among individuals with different anxiety disorders, including PD [5], OCD [5,9], and SAD [10,5]. Researchers [11] found that relative to healthy controls, a sample of 50 patients with Panic Disorder with or without agoraphobia demonstrated a higher frequency and intensity of anger experience, and increased control and decreased expression of emotional experiences (i.e., "smothering feelings"). Similarly, on comparing a sample of 71 OCD patients and 71 college students, Whiteside and Abramowitz [12] found higher levels of anger among patients with OCD. However, they attributed these differences to between-group differences in general distress. Another study [5] also found that compared with non-anxious controls, patients with OCD, SAD, and PD experienced higher levels of anger. They also found that individuals with PD are more likely to lose their temper and express anger aggressively than individuals with OCD.

Of the anxiety disorders, the diagnostic criteria of PTSD and GAD include certain elements of anger. Particularly, PTSD includes irritability or anger outbursts as diagnostic symptoms; consequently, several studies and meta-analyses indicate that anger is elevated and troublesome in individuals with PTSD [6,13-17]. Another study [18] suggest that PTSD involves more aspects of anger than the two diagnostic symptoms in its criteria. In a meta-analytic study, scientists [15] compared anger across anxiety disorders and found anger to be significantly associated with all anxiety disorders, excluding SAD and SP. Compared with other anxiety disorders, anger was more highly associated with PTSD. Gresham, Melvin and Gullone [19] found that among adolescent's anger correlated positively with the symptoms of PD, GAD, and depression, but not social phobia.

Another study [20] found that higher levels of trait anger, anger suppression, and hostility was reported by GAD analogues (individuals meeting GAD diagnostic criteria) than less anxious participants. Relative to the control condition, the negative interpretive style and the belief that uncertainty is unfair and ruinous was more enhanced among participants in the anger condition. Consistent with previous research, this finding suggests that when angry, individual's interpretive style resembles that of an anxious individual. They also studied the cognitive mechanisms behind anger and anxiety. Owen [21] found evidence suggesting high trait anger to be associated with selective attention to hostile cues, the tendency to infer others' behavior as indicating potential hostility, and the tendency to ruminate over previous anger-provoking incidents.

Influenced by Lazarus' [22] theory of emotion (cognitions influence emotional responses), Clark and Beck [23] suggested that biases in interpretive processing (i.e., consistently negative processing regardless of the event) play a role in the development and maintenance of anxiety disorders. Using this explanation, another study [20] found that individuals with GAD interpreted ambiguous situations as threatening and ambiguous intent as hostile. Analyses by Walsh et al. [24] supported a significant relationship between trait anger and anxiety severity among youth diagnosed with an anxiety disorder. GAD, PD, and social phobia were strongly associated with trait anger and anger attacks [25].

In a sample of 136 individuals with Social Anxiety Disorder (SAD), another study [26] sought to empirically define anger profiles. Their analysis revealed four distinct anger profiles suggesting heterogeneity in anger experience and expression across different individuals with SAD and different associations with distress and impairment. Despite experiencing elevated anger, individuals with SAD have also been found to suppress their anger more frequently compared with non-anxious individuals [10,5]. The perception that rejection is an obstacle to belonging may underlie their angry response. However, suppression could disrupt communication and magnify blood pressure responses in the suppressors' partners [27]. Suppression also decreased rapport and hindered relationship formation. Furthermore, participants with SAD judged more ambiguous morphed faces as angry in an emotion recognition task as compared with healthy controls [28]. A modulating role of voice sound-intensity on amygdala hyperresponsivity to angry prosody in SAD was demonstrated by another study [29]. They suggested that abnormal processing of interpersonal threat signals in amygdala extended beyond facial expressions in SAD.

In a sample of 103 participants, researchers [30] found a positive correlation between trait anxiety and trait anger ($r=0.44$, $p< 0.05$). Also, individual differences in trait anger correlated positively with bilateral dorsal amygdala reactivity to angry facial expressions; however, such a correlation was found only among men scoring high on trait anxiety.

Contradicting these findings, studies [5] reported that experience of anger in anxiety disorders is mainly related to symptoms of depression.

Researchers [26] also suggested that assessment of anger experience and expression among SAD individuals may be useful in improving diagnostic assessment and planning treatment.

A literature review by Trivedi and Gupta [31] revealed the paucity of Indian research on the epidemiology, phenomenology, course, outcome, and management of anxiety disorders. Tertiary centers have conducted majority of the published research, which includes small sample sizes and may not present the real picture.

In a cross-sectional study on anger attacks with a sample of 42 participants with OCD, studies [32] found anger attacks to be present in half of the sample. These 21 participants with OCD also presented a significantly higher prevalence of panic attacks and co-morbid depression. They also engaged in aggressive actions towards significant others such as shouting, intimidating, etc.

Utreja and Rizvi [33], in a small sample study, i.e., 35 Indian patients diagnosed with an anxiety disorder (GAD, OCD, or SAD) were found to experience anger along with anxiety both as a general disposition (trait) as well as in particular situations (state). They were also more likely to suppress their anger than express it in a verbally or physically aggressive manner.

To summarize, among emotional disorders, anger is considered the "forgotten emotion" because it is rarely addressed in treatment despite its clinical presence. The sparse and fragmented previous research suggests a relationship between anxiety disorders and anger problems. Anger and hostility (the cognitive component of anger) appears to be differentially elevated across anxiety disorders. There is heterogeneity in the experience and expression of anger across the various forms of anxiety disorders. Therefore, more research on the relation between specific dimensions of anger and forms of anxiety disorders and treatment is needed.

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