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Anger in psychological disorders: Prevalence, presentation, etiology and prognostic implications

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HIGHLIGHTS

- Anger and its variants e.g., irritability are highly prevalent in five DSM disorders.
- Anger is prognostically important in these disorders.
- Past research suggests differences in phenomenology and etiology of anger across disorders.
- Transdiagnostic views of anger consider cognitive processes, temporal dynamics, and neurochemistry.

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ABSTRACT

Anger is present as a key criterion in five diagnoses within DSM-5: Intermittent Explosive Disorder, Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Borderline Personality Disorder and Bipolar Disorder. This review amasses scientific literature demonstrating that within each of these disorders, anger is a central clinical feature that is highly prevalent and predictive of important outcomes. For each disorder, we also discuss the phenomenology and etiology of anger. Although models of anger have been quite distinct across these disorders, few empirical studies have truly tested whether anger stems from different etiological factors across these different conditions. We end with a discussion of transdiagnostic research that draws from cognitive psychology, affective science, and the neuroscience of anger, and that also fits with integrative approaches to treatment.

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1. Anger in five psychological disorders

This review covers five DSM-5 diagnoses in which anger is a key criterion: Intermittent Explosive Disorder, Oppositional Defiant Disorder, Disruptive Mood Dysregulation Disorder, Borderline Personality Disorder and Bipolar Disorder. For each disorder, we describe the prevalence of anger, the form of anger, and models of the etiology of anger. Where available, data are also presented on key outcomes that have been related to anger within the disorder. We then turn to a discussion of how the compartmentalized literature on anger within each of these disorders could be usefully consolidated under a transdiagnostic model of anger in psychopathology.

2. Conceptualization of anger

Anger has been described using different shades of meaning and emphasis, but there is little disagreement that it belongs in the realm of negative affect. Consistent with the cognitive-motivational view of emotions (Lazarus, 2000; Scherer, 2013), anger is tied to an appraisal of wrongdoing and an action tendency to counter/undo that wrongdoing in ways that may range from resistance to retaliation. Similar cognitive-motivational components have been identified in implicit lay perceptions of anger (Smedslund, 1993).

Anger, like fear and sadness, can be differentiated in terms of intensity and form. It can range "in intensity from irritation or annoyance to fury or rage" (Smith, 1994, p. 25). Anger can also assume the form of emotion, mood, or temperament: the first of these is a momentary episode, the second is relatively mild but prolonged, and the third implies a proneness to recurrent bouts of anger (Fernandez & Kerns, 2008). Thus, in the varied and nuanced vocabulary of anger, words such as rage and fury reflect the phasic bursts of anger, whereas irritability and irascibility imply anger that is ongoing or tonic; hostility, by contrast, is reserved for a pattern of frequent occurrence that suggests dispositional rather than situational anger (Buss, 1961; Ramírez & Andreu, 2006). As can be inferred, these different forms of anger are representable as unique configurations on basic dimensions such as frequency, duration, and intensity. Individuals also differ in the threshold and latency of their typical anger responses (Fernandez, Arevalo, Torralba, & Vargas, 2014).

Physiological accounts of anger are beyond the scope of this clinical review, though a few summary statements are in order. The Jamesian view of emotions as sensed bodily changes ushered in an era of search for autonomic correlates or anger. In his critical review of this history, Stemmler (2010) identified a somatovisceral physiology of anger in which alpha-adrenergic activation and blood pressure increases are coordinated to facilitate readiness to react. However, on the basis of meta-analytic evidence, he concluded that only on a subset of recordable variables could anger be differentiated from other emotions. The advent of fMRI has been greeted with more hope in finding a neural signature for anger. This too has turned out to be far more elusive than expected. An incisive meta-analysis of 15 years of neuroimaging research produced little evidence for the view that emotions such as anger are localized in specific brain sites (Lindquist, Wager, Kober, Bliss-Moreau, & Barrett, 2012). Rather, the results provided support for a psychological constructionist view of anger.

At the core of the psychological characterization of anger is the distinction between experience and expression (Spielberger, Reheiser, & Sydeman, 1995). The former refers to the person's subjective feelings, whereas the latter pertains to how anger is displayed or communicated. The expression of anger is an important factor in determining whether or not anger is pathological.

Two major "red flags" that anger expression has reached a pathological level are aggression which is physical or verbal behavior that is intended to hurt, and violence which is behavior that intentionally culminates in actual physical injury or damage. Though often taken as proxies for anger, aggression and violence can be instrumental behaviors (Card & Little, 2007; Day & Fernandez, 2015; Fontaine, 2007) as in armed robbery which need not involve anger. Factor analytic research provides evidence for the separability of affective and behavioral aspects of anger (e.g., Burke, Hipwell, & Loeber, 2010). As argued by Averill (1983), anger, whether functional or dysfunctional, can certainly occur in the absence of aggressive or violent behavior and vice versa. This is important clinically because many clients present with difficulties in coping with felt emotion that is not overtly expressed. Within this review, we focus on anger rather than violence, although violence receives mention in instances where it is preceded by anger.

Motivational theories characterize anger as an approach emotion (Carver & Harmon-Jones, 2009). That is, anger is often triggered by thwarting of attempts to attain goals. This contrasts with fear and anxiety, which tend to be triggered by threatening stimuli that lead to avoidance. Consistent with these motivational roots, anger impels efforts to counter barriers to goal attainment. With appropriate expression, then, anger may have functional benefits in removing barriers to goal attainment. Nonetheless, some individuals have difficulty expressing anger appropriately and remain thwarted in their attempts to address these barriers. This may be a particular concern for those with passive-aggressive tendencies (Morey, Hopwood, & Klein, 2007). Certainly, there is a wide spectrum of anger expression styles, each with its own intended outcomes.

3. Anger as an important predictor of outcomes

A growing literature points toward adaptive outcomes associated with appropriate levels of anger in certain contexts. For example, faced with difficult negotiation tasks, people tend to prefer activities that increase their anger, and this in turn can enhance their performance (Tamir, Mitchell, & Gross, 2008). Hence there may be important ways in which anger is functional, when it is present at the right levels, with the "right" skills for expression, in the right context.

Although deciding when anger should be considered pathological remains a matter of some clinical judgment, several dimensions are worth considering, including context appropriateness, frequency, intensity, and duration. Physically aggressive or violent anger would typically

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