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Anger profiles in social anxiety disorder

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ABSTRACT

Individuals with social anxiety disorder (SAD) exhibit elevated levels of anger and anger suppression, which are both associated with increased depression, diminished quality of life, and poorer treatment outcomes. However, little is known about how anger experiences differ among individuals with SAD and whether any heterogeneity might relate to negative outcomes. This investigation sought to empirically define anger profiles among 136 treatment-seeking individuals with SAD and to assess their association with distress and impairment. A latent class analysis was conducted utilizing the trait subscales of the State-Trait Anger Expression Inventory-2 as indicators of class membership. Analysis revealed four distinct anger profiles, with greatest distress and impairment generally demonstrated by individuals with elevated trait anger, a greater tendency to suppress the expression of anger, and diminished ability to adaptively control their anger expression. These results have implications for tailoring more effective interventions for socially anxious individuals.

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1. Introduction

Social anxiety disorder (SAD) is characterized by an intense fear of being negatively evaluated by others (Diagnostic and Statistical Manual of Mental Disorders, 5th edition; DSM-5; American Psychiatric Association [APA], 2013). Individuals with SAD report experiencing greater impairments in friendships and romantic relationships than peers (Montesi et al., 2013; Rodebaugh, 2009) and experience greater academic and occupational dysfunction (Aderka et al., 2012; Bruch, Fallon, & Heimberg, 2003; Schneier et al., 1994). SAD typically has an early onset, is chronic, and displays a low recovery rate among affected individuals (Davidson, Hughes, George, & Blazer, 1993). SAD is associated with deficits in emotion regulation (Spokas, Luterek, & Heimberg, 2009), typically defined as the active role individuals play in influencing their experienced emotions, how they experience and express emotions, and in which situations they experience certain emotions (Dennis, 2007; Gross, 1998). Individuals with SAD report avoidance and suppression of emotional expression (Spokas et al., 2009; Werner, Goldin, Ball, Heimberg, & Gross, 2011). This may partially stem from the beliefs that emotional expression is a sign of weakness and that emotions should be controlled at all times (Spokas et al., 2009).

Individuals with SAD experience difficulty regulating anger. Elevated anger is an important clinical indicator of symptom severity in psychopathology, as it is associated with a variety of impairments, including a higher incidence of depression (Tafrate, Kassinove, & Dundin, 2002), a greater risk for suicide (Hawkins & Cougle, 2013), and increased stress (Clay, Anderson, & Dixon, 1993). Individuals with SAD report elevated levels of anger relative to nonanxious peers, including a greater disposition towards experiencing anger in a variety of situations (i.e., trait anger) and more frequently expressing anger in response to criticism or negative evaluation (angry reaction) and without provocation (angry temperament) (Erwin, Heimberg, Schneier, & Liebowitz, 2003). Further work has demonstrated that individuals with SAD also spend more time throughout the day experiencing anger than their nonanxious peers (Kashdan & Collins, 2010). Despite high levels of anger *experience*, individuals with SAD have also been shown to suppress the *expression* of anger more frequently than their nonanxious peers (Erwin et al., 2003; Moscovitch, McCabe, Antony, Rocca, & Swinson, 2008).

Few studies have examined the direct association between anger-related concerns and broader impairment in SAD. In one such investigation, treatment-seeking individuals with SAD who endorsed greater trait anger, angry reaction, and anger suppression exhibited greater social anxiety and depression and lower perceived quality of life (Erwin et al., 2003). In addition, greater

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pre-treatment anger suppression and angry reaction predicted higher post-treatment scores on indices of social anxiety and depression, and greater trait anger predicted early attrition from treatment.

The association between SAD and elevated anger may be understood if one thinks of anger as a socially contingent emotion. Anger is predominantly experienced during interpersonal interactions (Averill, 1983) and is typically thought of as a response to an impeded interpersonal goal (Berkowitz & Harmon-Jones, 2004). In the context of SAD, in which the goal is to achieve social acceptance, the belief that one is being negatively evaluated in social situations may lead to fears of social rejection, which has been demonstrated to provoke anger in socially anxious individuals (Fitzgibbons, Franklin, Watlington, & Foa, 1997; Leary, Twenge, & Quinlivan, 2006). Thus, their angry response may be related to the perception that rejection is an obstacle to belonging. In support of this line of reasoning, elevated social anxiety is associated with greater state anger after listening to vignettes designed to elicit social rejection (Breen & Kashdan, 2011).

The majority of individuals with SAD display passive interpersonal behavior theoretically consistent with the diagnosis (e.g., lack of assertiveness, submissive behavior, suppression of anger expression); however, there appears to be a subset of individuals with SAD who exhibit externalizing behavior, including outwardly directed anger expression, contrary to the prototypical presentation of SAD (Galbraith, Heimberg, Wang, Schneier, & Blanco, 2014; Kachin, Newman, & Pincus, 2001; Kashdan, Elhai, & Breen, 2008; Kashdan & Hofmann, 2008; Kashdan, McKnight, Richey, & Hoffman, 2009). This pattern was demonstrated in 21% of persons with SAD in a large community sample (Kashdan et al., 2009). This subgroup was also more likely to engage in problematic substance use and other high-risk behaviors. It is possible that these behaviors have multiple functions, including ingratiating oneself to a deviant peer group, but they may also represent an attempt to keep other people at a distance to reduce anxiety or the possibility of rejection.

The current study sought to further elucidate the association between anger and SAD and to capture variations of anger presentations across individuals with SAD. To do so, we utilized latent class analysis (LCA) to examine whether there are distinct patterns of anger-related symptoms among individuals with SAD. We also assessed the external validity of anger profiles by evaluating their association with a range of clinical features related to SAD and anger expression (severity of social anxiety; fear of negative evaluation; interpersonal problems related to being vindictive, non-assertive, or socially inhibited; fearful reactions to one's own anxious or angry emotions; shame; depression; and a history of childhood emotional abuse or neglect). We expected (1) that there would be distinct anger profiles among individuals with SAD, (2) that at least some of these classes would differ on the degree of anger experienced, the tendency to outwardly express anger, and the tendency to suppress the expression of angry feelings, and (3) that these classes would vary on indices of distress and impairment.

2. Method

2.1. Participants

Participants ($N = 136$) were individuals with a principal diagnosis of SAD who sought treatment at the Adult Anxiety Clinic of Temple University (AACT) between 2004 and 2014. The mean age was 28.95 years (SD = 11.01, range 18–68 years), and 52.9% were male. A majority of the participants were Caucasian ($n = 87$, 64%) and similar percentages of individuals were employed full-time ($n = 41$, 30.1%) or full-time students ($n = 40$, 29.4%). The majority of individuals were single and had never been married ($n = 102$, 75%). All data were collected at baseline before the initiation of treatment, which was delivered as part of randomized controlled trials (RCTs) or open treatment. Because participants were drawn from both RCT and open treatment samples, there were no specific exclusion criteria for this study. Only those criteria that were related to a participant's ability to complete the diagnostic interview and questionnaires or to give valid informed consent applied, e.g., active suicidality or self-harm, substance use, or cognitive impairment. All procedures of the original studies for which participants were recruited were conducted in accordance with the ethical standards of the responsible committee on human experimentation and with the Helsinki Declaration of 1964, as revised (World Medical Association, 2013). Informed consent was obtained from all participants, both for the use of their data in the original RCTs (if applicable) and for the use of their deidentified data in later research.

2.2. Measures

2.2.1. Diagnostic interview

2.2.1.1. Anxiety disorders interview schedule for DSM-IV: lifetime version (ADIS-IV-L). The ADIS-IV-L (Brown, Di Nardo, & Barlow, 1994) is a semi-structured clinical interview assessing DSM-IV criteria for anxiety, depressive, somatoform, and substance use disorders. Each disorder is assigned a clinician's severity rating (CSR) of symptom-related distress and impairment ranging from 0 (*None*) to 8 (*Very Severe*), and CSR scores of 4 or higher indicate distress and impairment sufficient to meet diagnostic thresholds. All clinicians using the ADIS-IV-L were doctoral students with the equivalent of master's degree training, postdoctoral fellows in clinical psychology, or clinical psychologists who were trained to reliability standards put forth by the ADIS developers (Brown, Di Nardo, Lehman, & Campbell, 2001). The social anxiety module of the ADIS-IV-L has demonstrated excellent inter-rater reliability for the current principal diagnosis of SAD ($\kappa = .77$; Brown, Di Nardo et al., 2001). A random sampling of 20 ADIS-IV-L interviews from the AACT was reviewed by blind reliability coders. There was 100% ($\kappa = 1.00$) agreement with the original principal diagnosis.

2.2.2. Indicators of latent class membership

2.2.2.1. State-trait anger expression inventory, 2nd edition (STAXI-2). The 57-item STAXI-2 (Spielberger, 1999) was used to determine latent classes of anger symptoms. The STAXI-2 measures anger both as an emotional state (state anger; not included in the present analyses) and dispositional trait, as well as how individuals express and control their angry feelings. Trait, but not state, subscales were used in the LCA, as we sought to examine the hypothesis that there would be distinct classes based on more-or-less enduring patterns of anger experience and expression. The trait anger-angry temperament (T-ANG/T), trait anger-angry reaction (T-ANG/R), anger expression-in (AX-I), anger expression-out (AX-O), anger control-in (AC-I), and anger control-out (AC-O) subscales were used in this study. Each of the trait anger subscales consists of 4 items. Items from the trait anger subscales use the stem "How I generally feel. . ." and examples include "Quick-tempered" (T-ANG/T) and "I get angry when I'm slowed down by others' mistakes" (T-ANG/R). The anger expression and anger control subscales consist of 8 items. Items from the anger expression subscales use the stem "How I generally react or behave when angry or furious. . ." and examples include "I strike out at whatever infuriates me" (AX-O, an index of the tendency to express anger outwardly toward other people/objects in the environment) and "I boil inside, but I don't show it" (AX-I, an index of the tendency to suppress the expression of angry feelings). Items from the Anger Control subscales also use the stem "How I generally react or behave when angry or furious. . ." and examples include "I take a deep breath and relax" (AC-I, an index of generally

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