domestically, in traffic, or as mass shootings, few would dispute that entered the public vernacular. And, whether the anger manifests and depression. 2 “Mood swings” and “anger management” have a reason for patients to seek mental health treatment as anxiety Needs to Address Anger Why DSM-V

To the Editor: It has been called “the chief enemy of public happiness and private peace.” In fact, anger is now as common a reason for patients to seek mental health treatment as anxiety and depression. 2 “Mood swings” and “anger management” have entered the public vernacular. And, whether the anger manifests domestically, in traffic, or as mass shootings, few would dispute that “dysfunctional” anger (including but not limited to aggression) is a significant public health concern. 3 Yet, curiously, anger is poorly addressed by the DSM. Maintaining an historical anachronism, 4 DSM-IV details various types of pathological depression and anxiety, but has no such ascriptions for anger. As a symptom, anger features significantly among several Axis I disorders. 5-6 None of these “account for” patients whose primary problem is anger, however. A subgroup of patients with “anger attacks” was first identified almost 2 decades ago. 7 But a shared symptomatology and biology with depressive and (especially) panic disorder continues to question the very validity of “anger attacks” as an independent Axis I disorder. 7

The antisocial, paranoid, and borderline personality disorders are readily associated with dysfunctional anger. Indeed, studies have consistently linked them with workplace violence 8 and spousal abuse. 9 The terms features and traits more correctly identify aspects of the personality that predispose individuals to dysfunctional anger; yet, even they do not detail the basic cognitive or behavioral pathways believed to underlie the most common examples of dysfunctional anger. In any case, insurance pressures/reimbursement disincentives (in the United States) to diagnose Axis I over Axis II result in even these terms being clinically underutilized. Axis II defenses and Axis IV situational and relational factors that might better contextualize most anger-related behaviors are similarly underutilized, despite their recognized importance as risk factors for violence. 10

For want of better descriptors, intermittent explosive disorder (IED) appears to be DSM’s default “anger disorder.” Conceived as an uncommon diagnosis of exclusion, paradoxically, the incidence of IED has risen sharply. 11 Although impulsive aggression was originally validated as a clinical construct because of biologic correlates, 12 doubts have always existed about whether a syndrome of impulsive aggression can, in practice, be delineated from the antisocial and borderline personality disorders, 13,14 or indeed from other Axis I impulse control disorders in which the biology and symptomatology are thought to overlap considerably. 15 In addition, by attributing aggression solely to an “irresistible” impulse, the current IED criteria (and IED-revised [IED-R] criteria) 16 fail to detail pertinent phenomenology—including anger itself.

Proponents of Axis I “anger disorders” have already begun to address this important conceptual relationship. 17 In fact, research dates back decades on cognitive propensities toward anger and how it culminates in aggression. 18,19 None of this work has permeated successive revisions of the DSM. “Predatory” and “impulsive” subtypes of aggression 20 have been delineated, as has the pharmacologic responsivity of the latter. 21 While the biology of impulsive aggression has been studied in the psychiatric literature, though, configuration of anger’s relationship to aggression appears confined to the psychological literature. This dearth of research “cross-fertilization” has clearly impeded anger’s clinical conceptualization. 22

Meanwhile, the DSM’s ongoing weakness remains phenomenology: its inability to capture the syndromic “essence” of psychopathology such as anger, including how the multivariate elements of anger interact: thoughts, emotions, and manifest behaviors. Hence, a classification system is needed that is focused less rigidly on criteria and more on understanding patterns and linkages, as well as the nature of subjective distress and psychosocial disruption: a mild departure of sorts, from the mentality of evidence-based medicine. Disorders such as IED seem artificial precisely because DSM categorizes only some intrapsychic events. Interpersonal triggers remain entirely marginalized to its V code section, thereby ignoring context and emphasizing the biologic and categorical far above the relational. Surely DSM’s wide cross-disciplinary usage necessitates its being informed by paradigms beyond just those mentioned above.

Why DSM-V Needs to Address Anger

The antisocial, paranoid, and borderline personality disorders are readily associated with dysfunctional anger. Indeed, studies have consistently linked them with workplace violence and spousal abuse. The terms features and traits more correctly identify aspects of the personality that predispose individuals to dysfunctional anger; yet, even they do not detail the basic cognitive or behavioral pathways believed to underlie the most common examples of dysfunctional anger. In any case, insurance pressures/reimbursement disincentives (in the United States) to diagnose Axis I over Axis II result in even these terms being clinically underutilized. Axis II defenses and Axis IV situational and relational factors that might better contextualize most anger-related behaviors are similarly underutilized, despite their recognized importance as risk factors for violence.

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Letters to the Editor

1478 J Clin Psychiatry 70:10, October 2009

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Psychiatry’s overt focus on biology has arguably resulted in these and other paradigms for anger receiving just such short shrift. Yet, use of defenses, interpersonal psychology, or social learning theory might better account for aggressive behaviors or angry reactions to situations. This might be especially pertinent when the DSM is used (despite its theoretical disclaimers) to explain behaviors in a forensic context. It would also be important for treatment. For example, cognitive psychology is but one important discipline whose terminology (e.g., cognitive distortions) is already being applied in clinical practice (cognitive-behavioral therapy) for both diagnosis and treatment of dysfunctional anger.

In child psychiatry, arguments over whether a child’s “rage” is attributable to a one-size-fits-all categorical disorder or disorders (attention-deficit/hyperactivity disorder, bipolar disorder, oppositional defiant disorder) entirely miss developmental, cultural, or systems paradigms that might offer clinicians greater perspective, and even greater clinical utility, when they are asked to appraise common clinical scenarios. It would then be possible to better differentiate the pathological from the normal, while helping families appreciate the reasons why anger manifests in a particular way. At present, faced with systemic pressures to encapsulate all anger childhoood behaviors within a disease-driven framework, clinicians are forced to give unwieldy labels such as “not otherwise specified.”

What this reflects are pervasive assumptions in psychiatry that appear dichotomous and reductionistic. Thus, while talk of comorbidities is commonplace in the journals, such arguments hinge on those same biologic and categorical models, instead of the more dynamic interaction of different models that most likely occurs in reality.

Paradigm changes have already been advocated in DSM’s approach to the construct of Axis II: namely from the categorical to the dimensional. Researchers also now recognize that the interface between Axis I and Axis II is clinically more fluid than indicated by DSM’s original design.

Proposed iterative models for personality classification could therefore prove equally important for the categorization of anger. For example, they could illustrate, in incremental ways, how and why anger becomes destructive and intense as it becomes progressively pathological. Such models could also outline the process whereby trait “hostility,” for example, becomes Axis I dysfunction when cofactored with aggression and psychosocial elements. Several treatment foci could then be identified simultaneously: cognitive appraisal schema, defenses, and interpersonal and temperamental aspects, for example.

To this end, researchers have suggested covarying existing anger rating scales along with the 5-factor personality model. Such individualization, identifying anger’s context-dependent and personality-dependent “amplifiers,” would equip psychiatrists to evaluate the full spectrum of angry patients, not force them to pathologize them all, while allowing formulation of more tailored patient interventions.

Eight “anger disorders” have also been proposed. The advantage of these DSM-derived models is that anger’s subsyndromal components have been elucidated: specifically, the affective, physiologic, and cognitive. In addition, the oft-blurred distinction between anger and aggression is made explicit. Lastly, the parameters of a disorder are identified clearly, using existing DSM terminology.

The construct validity of some of these proposed disorders remains problematic, however; for example, distinguishing situational anger disorders from existing adjustment disorders on the basis of assumptions that anger should be the predominant “emotion.” Therefore, epidemiologic studies are still required to establish the true prevalence and differing treatment outcomes of these proposed disorders. Valid and reliable rating scales will also help consolidate their qualitative differences.

Altogether, such models indicate that we have arrived at an important conceptual juncture. Are we to remain comfortable with existing atheoretical, categorical definitions of disorder (drawn from Feighner criteria), or are we now able to tolerate more fluidity and “blending into the norm,” as well as explanations—if we are truly in search of phenomenological accuracy and authenticity? Merely side-stepping etiology seems to have failed by allowing biology to fill the void; hence, the biologically based IED. Perhaps it is time, then, that psychiatry began integrating the historically disparate Jasperian and Kraepelinian paradigms? (Even Robins and Guze recognized the importance of capturing “a single striking feature” while continuing to advocate their empirically based classification system.)

Wholesale abandonment of the DSM is not being advocated, but rather retention of that which has utility, plus addition of other frameworks. Lesser degrees of anger would be better accounted for by a reconfigured Axis II, while retaining agreed-upon boundaries and definitions for anger that is prima facie “dysfunctional” (Axis I). In addition, detailed psychopathology would allow for better pattern-recognition and differentiation of various anger syndromes. Ultimately, psychology, sociology, and biology would play their rightful roles, in a more holistic approach than is currently permitted by DSM-IV.

To begin with, a more refined lexicon of terms for anger will be necessary, so that degrees and types of anger can be accurately used. Use of such descriptive nosology might also enhance understanding of how anger culminates in aggression—by advancing conceptual links between triggers, temperamental tendencies, and various cognitive concomitants (such as information-processing deficits or socially internalized “rules”). Foremost, it is this lack of operationalized descriptions that does the greatest clinical disservice. If the layperson is already categorizing anger by the “pressing of buttons,” surely it behooves psychiatrists to begin characterizing what those “buttons” actually are.

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Financial disclosure: None reported. Funding/support: None reported.
doi:10.4088/JCP.08S04786whi
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