Why *DSM-V* Needs to Address Anger

To the Editor: It has been called "the chief enemy of public happiness and private peace."[1] 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[23]: 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?

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.[24] It would also be important for treatment. For example, cognitive psychology is but one important discipline whose terminology (eg, *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[25] (attention-deficit/hyperactivity disorder, bipolar disorder, oppositional defiant disorder) entirely miss developmental, cultural, or systems[26] 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.[27] At present, faced with systemic pressures to encapsulate all angry childhood behaviors within a disease-driven framework, clinicians are forced to give unwieldy labels such as "not otherwise specified."[28]

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[29] 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.[30]

Proposed iterative models[31] 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 aggravating 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[32] along with the 5-factor personality model.[33] 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.[34] 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[31] 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[35] 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 Kraeplinian paradigms? (Even Robins and Guze[36] 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,[37] 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 described. 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.

References

1. Meltzer H. Students' adjustment in anger. *J Soc Psychol.* 1933;4:285–309.
2. Posternak MA, Zimmermann M. Anger and aggression in psychiatric outpatients. *J Clin Psychiatry.* 2002;63(8):665–672.
3. *World Report on Violence and Health*. Geneva, Switzerland: World Health Organization; 2002.
4. Novaco RW. Anger control in psychoanalytical theory. In: Cavell TA, Malcolm KT, eds. *Anger, Aggression and Interventions for Interpersonal Violence*. Mahwah, NJ: Lawrence Erlbaum; 2007:25–37.
5. Benazzi F, Akiskal H. Irritable-hostile depression: further validation as a bipolar depressive mixed state. *J Affect Disord.* 2005;84(2-3):197–207.
6. Franklin CL, Posternak MA, Zimmerman M. The impact of subjective and expressed anger on the functioning of psychiatric outpatients with post-traumatic stress disorder. *J Interpers Violence.* 2002;17(12):1263–1273.
7. Tedlow J, Leslie V, Keefe BR, et al. Axis I and Axis II comorbidity in unipolar depression with anger attacks. *J Affect Disord.* 1999;52(1-3):217–223.
8. Neuman JH, Baron RA. Workplace violence and workplace aggression: evidence concerning specific forms, potential causes, and preferred targets. *J Manage.* 1998;24(3):391–419.
9. Edwards DW, Scott CL, Yarvis RM, et al. Impulsiveness, impulsive aggression, personality disorder and spousal violence. *Violence Vict.* 2003;18(1):3–14.
10. Klassen D, O'Connor WA. Demographic and case history variables in risk assessment. In: Monahan J, Steadman HJ. *Violence and Mental Disorder: Developments in Risk Assessment*. London, UK: University of Chicago Press; 1994:229–257.

11. Kessler RC, Coccaro EF, Fava M, et al. The prevalence and correlates of DSM-IV intermittent explosive disorder in the National Comorbidity Survey Replication. *Arch Gen Psychiatry.* 2006;63(6):669–678.
12. Brown GL, Goodwin FK, Ballenger JC, et al. Aggression in humans correlates with cerebrospinal fluid amine metabolites. *Psychiatry Res.* 1979;1(2):131–139.
13. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Third Edition, Revised. Washington, DC: American Psychiatric Association; 1987.
14. Monopolis S, Lion JR. Problems in the diagnosis of intermittent explosive disorder. *Am J Psychiatry.* 1983;140(9):1200–1202.
15. McElroy SL, Hudson JI, Pope HG, et al. The DSM III-R impulse control disorders not elsewhere classified: clinical characteristics and relationships to other psychiatric disorders. *Am J Psychiatry.* 1992;149(3):318–327.
16. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association; 2000.
17. Kassinove H. The confusing problem of anger and aggression. In: Cavell TA, Malcolm KT, eds. *Anger, Aggression, and Interventions for Interpersonal Violence*. Mahwah, NJ: Lawrence Erlbaum Associates; 2007:84–87.
18. Beck A. *Prisoners of Hate. The Cognitive Basis of Anger, Hostility and Violence*. New York, NY: Harper Collins; 1999.
19. Bandura A. Psychological mechanisms of aggression. In: Green RG, Donnerstein EI, eds. *Aggression: Theoretical and Empirical Reviews*. Vol 1. New York, NY: Academic Press; 1983.
20. Weinshenker NJ, Siegel A. Bimodal classification of aggression: affective defense and predatory attack. *Aggress Violent Behav.* 2002;7(3):237–250.
21. Coccaro EF, Kavoussi RJ. Fluoxetine and impulsive aggressive behavior in personality-disordered subjects. *Arch Gen Psychiatry.* 1997;54(12):1081–1088.
22. Widiger TA, Clark LA. Toward *DSM–V* and the classification of psychopathology. *Psychol Bull.* 2000;126(6):946–963.
23. Andreasen NC. DSM and the death of phenomenology in America: an example of unintended consequences. *Schizophr Bull.* 2007;33(1):108–112.
24. Losel F, Bliesener T, Bender D. Social information processing, experiences of aggression in social contexts, and aggressive behavior in adolescents. *Crim Justice Behav.* 2007;34(3):330–347.
25. Carlson GA. Who are the children with severe mood dysregulation, aka "rages"? *Am J Psychiatry.* 2007;164(8):1140–1142.
26. Huey SJ, Henggeler SW, Brondino MJ, et al. Mechanisms of change in multi-systemic therapy: reducing delinquent behavior through therapist adherence and improved family and peer functioning. *J Consult Clin Psychol.* 2000;68:451–467.
27. Underwood MK, Coie JD, Herbsman CR. Display rules for anger and aggression in school aged children. *Child Dev.* 1992;63(2):366–380.
28. Anand S. It's not just anger…it's bipolar II. *Acta Neuropsychiatrica.* 2007;19(5):325–326.
29. Gabbard GO. A neurobiologically informed perspective on psychotherapy. *Br J Psychiatry.* 2000;177:117–122.
30. Krueger RF. Continuity of Axes I and II: toward a unified model of personality, personality disorders, and clinical disorders. *J Pers Disord.* 2005;19(3):233–261.
31. Widiger TA, Samuel DB. Diagnostic categories or dimensions? a question for the *Diagnostic and Statistical Manual of Mental Disorders*—Fifth Edition. *J Abnorm Psychol.* 2005;114(4):494–504.
32. Spielberger CD. *STAXI-2: State-Trait Anger Expression Inventory-2: Professional Manual*. Odessa, FL: Psychological Assessment Resources; 1999.
33. Costa PT, McCrae RR. *Revised NEO Personality Inventory (NEO-PI-R) and NEO Five Factor Inventory Professional Manual*. Odessa, FL: Psychological Assessment Resources; 1992.
34. Deffenbacher JL. Anger disorders. In: Coccaro EF, ed. *Aggression: Psychiatric Assessment and Treatment*. New York, NY: Marcel Dekker; 2003:89–111.
35. Feighner JP, Robins E, Guze SB, et al. Diagnostic criteria for use in psychiatric research. *Arch Gen Psychiatry.* 1972;26(1):57–63.
36. Robins E, Guze SB. Establishment of diagnostic validity in psychiatric illness: its application to schizophrenia. *Am J Psychiatry.* 1970;126(7):983–987.
37. Krueger RF, Skodol AE, Livesley WJ, et al. Synthesizing dimensional and categorical approaches to personality disorders: refining the research agenda for DSM-V Axis II. *Int J Methods Psychiatr Res*. 2007;16 (suppl 1):S65–S73.

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