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Clinicians' diagnosis of a case with anger problems

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Abstract

Psychiatrists and psychologists responded to case vignettes to assess the prevalence, severity, and diagnostic confidence clinicians had concerning treating anger disordered clients compared with clients with generalized anxiety disorder. Five hundred and forty-two clinicians (a response rate of 30%) assessed one of two matched case histories by mail. One described generalized anxiety disorder (GAD) and the other a case of anger disorder (AD). Cases were identical except for thoughts and affect relevant to the disorders. Both male and female versions were used. More than 95% of the participants viewed the cases they received as pathological. The disorders were rated as equally common. The clinicians reported treating equal numbers of patients with similar anger or anxiety symptoms in the past year. Although the case histories were alike in length and detail, AD participants rated their case as less complete and had lower confidence in their diagnoses. The diagnostic consensus was high for GAD clinicians, but low for AD. Forty-three percent of participants selected an Axis II diagnosis for AD, compared with 3% for GAD. Clinicians appeared to encounter patients with chronic anger about as frequently as they see GAD, but they displayed diagnostic confusion and bias toward personality disorder diagnoses when presented with the anger symptoms. The findings support the development of a diagnostic category for primary anger. The wide dispersion of diagnoses for anger underscores the need for focused differential assessment.

Keywords: Anger; Diagnosis; Clinical practice

1. Introduction

Over the past two decades several authors have proposed a disorder with frequent, intense and enduring anger resulting in destructive personal and social effects as its primary symptom (e.g., DiGiuseppe and Tafrate, 1994; DiGiuseppe et al., 1993; Hecker and Lunde, 1985; Eckhardt and Deffenbacher, 1995 (pp. 1–26); Novaco, 1985). Anger can interfere with psychological adjustment, problem solving and performance (Lazarus, 1991), instigate aggression and violence (Maiuro et al., 1988), lead to physiological reactions that contribute to coronary artery disease (Matthews and Hayes, 1986) and other medical disorders (such as hypertension, Diamond, 1982).

In support of this anger disorder thesis, clinical case reports of anger-related affective disorders have been published (e.g., Fava et al., 1990; Kaufmann and Wagner, 1972; Smith, 1973; Novaco, 1985). Spielberger and DiGiuseppe have developed anger assessment instruments (DiGiuseppe and Tafrate, 2004; Spielberger, 1988; Spielberger, 1999). Significant research exists supporting the destructive nature of anger (DiGiuseppe and Tafrate, in press). Clinical treatments, based primarily on cognitive-behavioral protocols, are effective treatments for disturbed anger (DiGiuseppe and Tafrate, 2003). Specifically, Deffenbacher and colleagues have evaluated cognitive, relaxation, behavioral skills, and

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combined treatment protocols on angry clients with all treatments producing equivalent results (Hazaleus and Deffenbacher, 1986; Deffenbachera and Stark, 1992).

Despite this growing body of literature, anger research is sparse and no official diagnostic category or criteria presently exist. The most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994) contains no category for anger disorders, and lists anger, irritability or hostility only as possible criteria for several disorders. Severe, episodic aggression falls under the diagnosis of Intermittent Explosive Disorder but this disorder refers to irresistible "impulse" rather than anger, and requires serious assaults or destruction of property for diagnosis.

Most theorists do not suggest that all experiences of anger are necessarily dysfunctional (e.g., Averill, 1983; Deffenbacher, 1994; Novaco, 1985; Rothenberg, 1971). To constitute a disorder, the frequency, intensity, or duration must cause harmful or distressing consequences. These include effects that are not observable, such as disruption of cognitive processes, prolonged emotional upset and impairment of health, or might include observable or aggressive behaviors, such as physical injury to self or others, or damage to property or relationships (Deffenbacher, 1994; Novaco, 1985).

Anger treatment research has been conducted within a diagnostic vacuum, raising important questions. This study assessed the frequency with which clients present with anger issues to clinicians as the primary symptom, the severity of disturbance that clinicians perceive for anger and anxiety disordered clients, and the diagnostic confidence and reliability for anger or anxiety symptoms presented in a vignette. We also wanted to explore whether clinicians would report treating equal numbers of patients who present anger and anxiety as the primary symptom. Likewise, the number of clinicians who view each case as pathological would be equivalent, as would be the evaluation of the severity of symptoms (GAF). Clinicians would also generate more Axis I and Axis II diagnoses for the anger disordered vignettes, a sign of lower reliability. It was also hypothesized that the lack of an anger diagnosis would result in clinicians having difficulty diagnosing anger, which would lead them to rating the case as incomplete and having less confidence in their conclusions. Previous research on anger diagnosis has not explored whether a professional's or a client's gender affect diagnosis, therefore, these variables were examined.

2. Methods

2.1. Design

The study used a three factor, between-subjects design. The three factors were case type (anger disorder and generalized anxiety disorder), case gender (male and female) and profession of participant (psychologist and psychiatrist). The dependent measures assessed included severity of symptoms, completeness of case history, diagnostic category, diagnosis, confidence in diagnosis, and prevalence. Case histories were delivered by mail and responses were elicited by a mail-back response form. Since researchers (Deffenbacher et al., 1987; DiGiuseppe et al., 1993) have identified an anger disorder as an affective disorder, this study used a matched case history of generalized anxiety disorder (GAD) as a control condition. This allowed participants' ratings for the severity, prevalence, diagnostic confidence, completeness of presentation, and actual diagnosis of the anger disorder to be compared with ratings for GAD.

2.2. Participants

Of the 542 clinicians who responded, 529 (97.6%) stated that the cases represented psychopathology. These 529 psychologists and psychiatrists responded to a mailing sent to 2000 clinicians who were randomly selected from Yellow Page telephone listings in the 50 largest cities in the US. The average age of participants was 53 years (SD = 11.3) and most had practiced for well over a decade.

2.3. Materials

Case histories [1] were developed to present two affective disorders: generalized anxiety disorder (GAD) and anger disorder (AD). Male and female versions were identical except names, pronouns, and spouse gender. Cases were restricted to one page, and were similar to those in the DSM-IV Case Book (American Psychiatric Association, 1994), which present symptoms with little historical, medical, or mental status data. The case of GAD met diagnostic criteria as stated in DSM-IV. The case of AD met criteria for anger/hostility disorder as proposed by DiGiuseppe and Tafrate (2004) and for generalized anger disorder as proposed by Eckhardt and Deffenbacher (1995, pp. 27–39). Both cases were reviewed by a group of psychologists to ensure that diagnostic criteria were met and that other attributes of the patients were held constant across the two disorders. Cases were identical except that the patient's ideas and affect represented either chronic anger or chronic anxiety. Both patients had a temperamental predisposition ("worry" vs. a "short fuse."), and had a previous episode of intense, chronic upset during which he or she was "let go" from a job because assignments were not finished. No history of alcohol or substance abuse was present.

[1] Case histories can be obtained by e-mailing the author: digiuser@stjohns.edu.