

Fear and Loathing: A Meta-Analytic Review of the Specificity of Anger in PTSD

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The available empirical literature suggests that anger may be characteristic of posttraumatic stress disorder (PTSD). Meta-analytic strategies were used to evaluate the extent to which the experience of anger is specific to PTSD rather than anxiety disorders in general. Thirty-four anxiety disorder patient samples ($n=2,169$) from 28 separate studies were included in the analysis. Results yielded a large effect size indicating greater anger difficulties among anxiety disorder patients versus controls. Compared to control samples, a diagnosis of PTSD was associated with significantly greater difficulties with anger than was any other anxiety disorder diagnosis. Other anxiety disorder diagnoses did not differ significantly from each other. However, the specific association between PTSD and anger did vary depending on the anger domain assessed. Difficulties with anger control, anger in, and anger out significantly differentiated PTSD from non-PTSD anxiety disorder samples, whereas difficulties with anger expression, state anger, and trait anger did not. These findings are discussed in the context of future research on the role of anger in PTSD.

EMOTION THEORISTS HAVE LONG recognized the association between anxiety and anger, placing both in a larger context of defensive reactions to threat marked by activation of the sympathetic nervous system (e.g., Cannon, 1929; Konorski, 1967; Lang, Cuthbert, & Bradley, 1998). Physiologically, both emotions are modulated by the amygdala (Whalen et al., 2001) as well as overlapping frontal and temporal cortical regions (Kimbrell et al., 1999). Peripheral physiological responses, although not identical, show substantial overlap including increased heart rate and blood pressure, increased electrodermal activity, and vasoconstriction (e.g., Stemmler, Heldmann, Pauls, & Scherer, 2001). Anger may also be regarded as a dimensional state of antagonism toward someone or something perceived to be the source of an aversive event that consists of physiological, cognitive, subjective, and behavioral components (see Eckhardt, Norlander, & Deffenbacher, 2004, for review).

The association between anger and anxiety may reflect dysregulation of shared biologically prepared affective processes that are central for survival. Anger and fear are closely related in different theories of emotion and may correspond differentially to the prototypical fight-or-flight reaction observed across the anxiety disorders. The “flight” component may represent the behavioral action tendency of fear, whereas the “fight” component (resistance to a dangerous threat and/or attack) is primarily driven by the emotion of anger (Barlow, 2002). Given that anger is characterized by a sense of mastery and control (Lang, 1994), it

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may represent an attempt among individuals with excessive anxiety to actively cope with or “fight” threat in the environment. Contemporary models conceptualize anger as a multidimensional construct. For example, anger difficulties may manifest in the tendency to suppress angry feelings (*anger in*), the tendency to express anger outwardly towards individuals or objects through physically or verbally aggressive behavior (*anger out*), or the inability to diminish the occurrence of angry feelings (*anger control*; Spielberger et al., 1986). Dimensions of anger may also include the experience of current angry feelings (*state anger*) versus the experience of angry feelings over time and in response to a variety of situations (*trait anger*; Spielberger, 1988).

Patients with anxiety problems commonly endorse anger-related problems (see Lara, Pinto, Akiskal, & Akiskal, 2006, for a theoretical review). Among the anxiety disorders, the intersection of anxiety and anger appears to be most prominent in posttraumatic stress disorder (PTSD). For example, in a recent meta-analysis of the strength of the relationship between anger and PTSD, Orth and Wieland (2006) found large effects for anger-hostility, anger out, anger in, and anger control; the weighted mean effect size (r) for anger in was .53 versus just .29 for anger out. A recent study also found that greater trait anger during training predicted greater PTSD symptoms at 1 year among police recruits (Meffert et al., 2008). Furthermore, the correlation between anger and PTSD does not substantially decrease when items measuring anger in PTSD scales are removed (Novaco & Chemtob, 2002). The unique association between anger and PTSD has led to the hypothesis that PTSD is characterized by inefficient regulation of psychophysiological arousal and subsequent elevated readiness to anger (Chemtob, Novaco, Hamada, Gross, & Smith, 1997). In line with this notion, Beckham and colleagues (2002) found that compared to veterans without PTSD, veterans with PTSD exhibited angry responses more quickly on a relived anger task and had greater associated heart rate and diastolic blood pressure. Indeed, “irritability or outbursts of anger” is identified as a diagnostic symptom of PTSD (American Psychiatric Association [APA], 2000). Although anger in PTSD is commonly associated with combat veterans, there is evidence to suggest that PTSD, rather than war zone duty *per se*, is associated with anger difficulties (McFall, Wright, Donovan, & Raskind, 1999). Therefore, anger may be a characteristic of patients with PTSD who have been exposed to a diverse range of traumatic events. The demonstration of elevated

anger in PTSD has clinical implications, with one study finding that the degree of anger experienced during an exposure task negatively predicted outcome (Foa, Riggs, Massie, & Yarczower, 1995).

In addition to its implication in PTSD, elevated anger has also been implicated in other anxiety disorders. Previous investigators have suggested that anger may play an important role in obsessive-compulsive disorder (OCD) (i.e., Rachman, 1993; Walker & Beech, 1969), social phobia (Erwin, Heimberg, Schneier, & Liebowitz, 2003; Hofmann, Heinrichs, & Moscovitch, 2004), panic disorder (Baker, Holloway, Thomas, Thomas, & Owens, 2004; Hinton, Hsia, Um, & Otto, 2003), and generalized anxiety disorder (GAD) (Mennin, Heimberg, Turk, & Fresco, 2002).

Thus, it is not clear whether excessive anger is particularly characteristic of PTSD versus a characteristic of anxiety disorders in general. A quantitative analysis of the available literature that addresses the question of the specificity of the anger-PTSD association could allow for stronger inferences to be made regarding the role of anger in PTSD. Therefore, the present study offers a meta-analysis of the literature on anger, PTSD, and the anxiety disorders. Specifically, anxiety disorder patients were compared with different controls on overall anger; it was predicted that anxiety disorders, broadly categorized, would be associated with elevated levels of anger compared to control samples. Given the multidimensional conceptualization of anger (Spielberger, 1988), the present investigation also examined differences in specific anger domains across anxiety disorders compared to control samples. It was predicted that anxiety disorder patients would be characterized more by internalized and chronic manifestations of anger (anger in/trait anger) than externalized and acute anger responses (anger out/state anger). Comparing PTSD patients to non-PTSD anxiety patients, it was predicted that difficulties across different domains of anger would be greater in PTSD relative to non-PTSD anxiety disorders.

Method

SELECTION OF STUDIES

Appropriate studies were identified by conducting searches in both PsycINFO and PubMed between May and August of 2007. Seven separate searches were conducted in each database and the search criteria were limited to studies that were printed in English and key words that appeared in the abstract and/or title of the study. The searches were: (1) “phobia” and “anger”; (2) “social phobia” and “anger”; (3) “panic disorder” and “anger”; (4)

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