

Clinical Anger, Affective And Somatic Symptoms In Depressed Patients

Uzma Zaidi

Abstract: The current study aimed to investigate the relationship among clinical anger, affective and somatic symptoms in depressed patients. It was hypothesized that there would be significant relationship between clinical anger, affective and somatic symptoms in depressed patients. The sample of Seventy diagnosed patients was selected from different psychiatry departments of hospitals of Lahore. Clinical Anger Scale was used to assess clinical anger, affective and somatic symptoms in depressed patients. Pearson product moment correlation was calculated for data. Results showed that there is significant relationship among clinical anger, affective and somatic symptoms in depressed patients. The result can be helpful for psychologists and other professionals to plan the therapeutic interventions for depressed patients.

Index Terms: Affective symptoms, Anger, Clinical Anger, CAS, Depression, Depressed Patients, Somatic symptoms.

1 INTRODUCTION

Some of the mental disorders are considered as most prevalent world widely and depression is one of them. It is manifested as depressed mood, anhedonia, disturbance in sleep or appetite, poor concentration, feelings of guilt or low self-worth, and low energy (APA, 2013). These symptoms may prolong or intermittent that can result in impaired social and occupational functioning of an individual irrespective of age, gender and ethnic background. According to World Health Organization (2014), almost 121 million people suffer from depression. Currently, depression is the 2nd cause of DALYs in the age range of 15-44 years for both genders. It is reckoned that depression will take 2nd place in the ranking of DALYs calculated for all ages and both sexes till the year 2020. In Pakistan, Gadit and Mugford (2007), found different prevalence rate of depression among Lahore (53.4%), Quetta (43.9%) and Karachi (35.7%). Moreover, they found that significant relationship between depression and socio-demographic variable (i.e. age, gender and level of education). Another study (Ali, Rahbar, Naeem, Tareen, Gul, Samad, 2002) conducted in Karachi, explored significant relationship of extended family system with depression. According to Freudian Psychology, depression is termed as 'anger turned inward'. Then psychodynamic technique focuses on catharsis and finds its root in part (Rammel & Hoffman, 1975 as cited in Robberts & Greene, 2002). According to Granvold, (1994) and Beck, (1990) (as cited in Robberts & Greene, 2002) cognitive theory has been characterized by a here and now orientation, a belief that thoughts affect feelings, people who are depressed demonstrate a certain set of cognitive distortions (such as negative thinking, black and white thinking, catastrophizing, overgeneralization, selective abstraction, magnification and minimization etc.).

The first cognitive explanation also revolves around the notion that depressed individuals have negative cognitive sets that leads them to focus their attention on personal shortcomings and other reasons to be depressed, and thinking negative thoughts leads to be depressed (e.g. Beck, 1967; 1976). To understand these negative cognitive sets develop and operate; psychologists have applied what we know about human information processing. The information processing approach has three components that is depressed individual are thought to have strong and active associative networks that link together memories, Second, because of their active depression networks, depressed individuals are more likely to attend to depressing things around them, third because of extensive depression networks keep developing, depressed individuals are more likely to recall depressing information (Holmes, 2005). Anger is a common human emotion (Lacan, 1977). Spielberger (1988) defined anger as an emotion in which feeling diverges in intensity. Sometimes it may be expressed in form of irritation and at times in form of fury or rage. Many professionals have explored the phenomena of anger in past several years (Averill, 1983; Biaggio & Maiuro, 1985; Feshbach, 1986; Rubin, 1986; Spielberger, Jacobs, Russell, & Crane, 1983, as cited in Snell, 2002). Clinical anger is a syndrome consisting of various manifestations which varies in intensity from individual to individual (Biaggio & Maiuro, 1985; Spielberger et al., 1983; Spielberger et al., 1985, as cited in Snell, 2002). Furthermore, outcome of the studies mentioned that there was a relationship between depression and various aspects of clinical anger (Snell, 2002). Clinical Anger may be exhibited in form of many symptoms such as angry about self, wanting to hurt others, anger about failure, anger about present situation, anger about things, anger about the future, annoying others, hostile feelings, shouting at people, irritated now, angry misery, alienating others. More over there might be fatigue as well as social, work, decision, sleep, thinking, appetite and sexual interference (Cox, Stabb & Bruckner, 1999). Over all these symptoms may be categorized in two major classes of somatic symptoms as well as affective symptoms (Beck, 1967). Somatic symptoms of anger may be displayed in form of sudden occurrence of sweating, trembling, tachycardia, and hot flashes. Emil and Coccaro (2003) concluded that depressed patients experienced more anger attacks as compared to normal people. They identified 30-45 % prevalence of anger attacks in depressed population. Though, anger outbursts are not considered as direct feature of depression but patients reported it frequently and it is followed

- Uzma Zaidi is associate Professor in Clinical Psychology Track, Department of Health, College of Health and Rehabilitation Sciences. Princess Nourah Bint Abdulrahman University, KSA,
- PH-966118240636. E-mail: uazaidi@pnu.edu.sa

by repentance (Emil & Coccaro, 2003). Martin and Dahlen, (2005) found that cognitive emotion regulation is considered as the predictor of psychological problems. Moreover, they found that self-blame, contemplation, catastrophization, and positive reappraisal were predictors of negative emotions. Another study (Painuly, Sharan, & Mattoo, 2006) reported that anger attacks may have adverse effects on the lives of depressed patients as well as their family members. Simultaneously, depressed patients may experience irritability, apprehension, anger expression, trait-anger, psychotic features, and poor quality of life (Troisi & D'Argenio, 2004). It is also found that youngsters with high hopelessness tend to perceive their families and peers as providing little support, to express their anger overtly and aggressively, and to demonstrate more negative emotions than youngsters with low hopelessness (Kashani, Suarez, Allan, & Reid, 1997). The ratio of depression is increasing and alarming in Pakistan. Many factors affect depression such as clinical anger, perceived social support, age, gender, education, current stress, insecure attachment, hostility, prevalence amongst other disorders or diseases, difficulties with finance and problematic social interaction. There are fewer researches in Pakistan particularly on clinical anger in depressed patients that's way the present research was conducted to investigate the relationship of clinical anger, affective and somatic symptoms in depressed patients.

1.1 Hypotheses

In the light of literature review, the following hypotheses are formulated:

- Clinical anger would be significantly correlated with affective symptoms in depressed patients.
- Clinical anger would be significantly correlated with somatic symptoms in depressed patients.

2 METHODOLOGY

2.1 Research Design

The present research utilized correlational research design as it aimed to find out the relationship among clinical anger, affective and somatic symptoms in depressed patients.

2.2 Sample

A sample for the present study consisted of (N=70) diagnosed patients of Major Depressive Disorder. Sample was recruited from different psychiatry wards of different hospitals in Lahore that included Mayo Hospital, Services Hospital, Jinnah Hospital, Punjab Institute of Mental Health and Ganga Raam Hospital through purposive sampling technique. Patients were included in the sample who has diagnosed with Major depressive disorder by psychologist and psychiatrist and only hospitalized patients were taken for the present study. Patients were excluded who were diagnosed with Axis II and patients with co-morbidity on Axis-I along with Major Depression. Demographic characteristics of the entire sample are presented in table 1.

TABLE 1
DESCRIPTIVE STATISTICS OF DEMOGRAPHIC
VARIABLES (N= 70)

Characteristics	F	%
(1) Age		
21-30 year	28	40.0
31-40 year	28	40.0
41-50 year	10	14.29
51-60 year	4	5.71
(2) Gender		
Male	42	60.0
Female	28	40.0
(3) Employment		
Yes	39	55.72
No	31	44.28
(4) Socio-Economic Status		
Low	53	75.71
Middle	16	22.86
High	1	1.43
(5) Education		
Illiterate	16	22.86
Primary	16	22.86
Middle	8	11.43
Matriculation	17	24.28
Intermediate	4	5.71
Bachelor	9	12.86
(6) Marital Status		
Married	48	68.57
Unmarried	15	21.43
Divorce	7	10

Note. f= frequency, %= percentage

2.3 Measure

2.3.1 Clinical Anger Scale

The Clinical Anger Scale (Snell, 2002) is a self-report inventory which explicitly measure clinical anger. It comprised of 21 statements that are rated on a 4-point likert scale ranging from 0-3. The total score of CAS calculated by adding up each item's score (0-63). Higher scores on CAS indicate high level of clinical anger. The internal consistency of the CAS is .94 that indicate reliable instrument for measuring clinical anger (Snell, 2002). The scale has been translated into Urdu by adapting standard procedure. Psychometric properties was also calculated for the translated version ($\alpha = .75$) to check the homogeneity of the scale in Pakistani culture.

2.4 Ethical Considerations

Before using the scales, permission was sought from authors to use and translate scales to use in the study. The scale was translated and its validity and reliability was checked through SPSS. Permission was taken by the Hospital authorities to collect data from their hospital and an authority letter was signed by the hospital authorities. Before administering the scale, participants were clearly explained the purpose and nature of study and written consent was taken from each participant.

2.5 Procedure

Formal permission was taken to the concerned psychiatric ward's authorities of hospital. Participants were assured of full confidentiality of all the information obtained from them. A written consent was taken from patients after describing the purpose and nature of the study. Demographic information form was used to collect information such as age, gender,

class, education, father's occupation, mother's occupation, father's income and family system. Rapport was built before starting the formal procedure. After that the patients were given Clinical Anger scale to complete, they were asked to choose the best option which describes their feelings. It took maximum 10 minutes to complete. Questionnaire was filled by the participant.

2.6 Scoring and Statistical Analysis

Standard scoring procedures were used for scale used in the resent study. SPSS (statistical package for social sciences) version 17.0 was used to analyze data. Firstly descriptive statistics was used to calculate the frequency and percentage to describe the socio demographic variable. Pearson Product Moment Correlation was applied to examine the relationship of the variables of clinical anger, affective and somatic symptoms in depressed patients.

3 RESULTS

The present study was conducted to determine the relationship of clinical Anger, affective and somatic symptoms in depressed patients. It was hypothesized that there would be significant relationship among clinical anger, affective and somatic symptoms in depressed patients. For demographic information descriptive statistics was used and frequencies and percentages were calculated. Pearson Product Moment Correlation was applied to find the relationship among the variables of clinical anger, affective and somatic symptoms in depressed patients.

TABLE 2
PEARSON PRODUCT MOMENT CORRELATION BETWEEN CLINICAL ANGER AND AFFECTIVE SYMPTOMS IN DEPRESSED PATIENTS

<i>Affective Symptoms</i>	<i>Clinical Anger</i>
Anger About the Future	.52**
Anger About the Failure	.66**
Anger About Things	.58**
Angry Hostile Feelings	.51**
Annoying Things	.42**
Angry About Self	.48**
Angry Misery	.31*
Wanting to Hurt Others	.22
Shouting At People	.25
Alienating Others	.56**

$df = 68$, * $p < .05$, ** $p < .01$ (two-tailed)

Results of the table (2) shows that clinical anger is significantly correlated with affective symptoms i.e. ; anger about the future, failure, things and self, angry hostile feelings, annoying things, angry misery and alienating others ($r = .52, .66, .58, .51, .42, .48, .31$; $p < .01, .05$). While results also showed that clinical anger is not significantly correlated with wanting to hurt others and shouting at people ($r = .22, .25$; $p > .05$). Thus hypothesis is partially proven.

TABLE 3
PEARSON PRODUCT MOMENT CORRELATION BETWEEN CLINICAL ANGER AND SOMATIC SYMPTOMS IN DEPRESSED PATIENTS

<i>Somatic Symptoms</i>	<i>Clinical Anger</i>
Anger Now	-.04
Irritated Now	.01
Social Interference	.47**
Decision Interference	.49**
Work Interference	.58**
Sleep Interference	.06
Fatigue	.16
Appetite Interference	.64**
Health Interference	.66**
Thinking Interference	.52**
Sexual Interference	.39**

$df = 68$, ** $P < .01$ (two-tailed)

Results of the table (3) showed that there is significant correlation between clinical anger and somatic symptoms including social interference, decision interference, work interference, appetite interference, health interference, thinking interference, and sexual interference ($r = .47, .49, .58, .64, .66, .52, .39$; $p < .01$). While results also showed that clinical anger is not significantly correlated with anger now, irritated now, sleep interference and fatigue ($r = -.04, .01, .06, .16$; $p > .05$). Thus, hypothesis is partially proven.

4 DISCUSSION

The present research aimed at investigating the relationship of clinical anger, affective and somatic symptoms in depressed patients. It was hypothesized that there is a significant correlation between clinical anger, affective and somatic symptoms in depressed patients. Affective symptoms consist of anger about things, annoying others, anger about the future, angry about self, anger about failure, wanting to hurt others, angry-hostile feelings, shouting at people, angry misery and alienating others. Result of the hypothesis was partially confirmed. Results of the table (2) shows that clinical anger is significantly correlated with affective symptoms i.e. ; anger about the future, anger about the failure, anger about things, angry hostile feelings, annoying things, angry about self, angry misery and alienating others and affective symptoms at clinical anger is not significantly correlated with wanting to hurt others and shouting at people. Results confirm the previous studies that clinical anger have significant relationship anger hostile feelings (Heponiemi, Elovainio, Kivimäki, Pulkki, Puttonen & Keltikanga, 2006). The patients express their anger and results also showed significant relationship with clinical anger (Kashani, Suarez, Allan, & Reid, 1997). There is significant relationship between clinical anger and alienating others (Kroner & Reddon, 1995). Collectively, available evidence suggest that aggressive, outward violent behavior is associated with an increased risk of symptoms of depression (Salmon, James & Smith, 1998; Kaltiala-Heino, Rimpela, Marttunen, Rimpela, & Rantanen, 1999). Results from table 3 indicate significant correlation between clinical anger and somatic symptoms in depressed patients. Whereas somatic symptoms consists of anger now, social interference, decision

interference, work interference, sleep interference, fatigue, appetite interference, health interference thinking interference, and sexual interference. A result of the third additional hypothesis was partially confirmed. Results of the table (3) showed that there is significant correlation between clinical anger and somatic symptoms including social interference, decision interference, work interference, appetite interference, health interference, thinking interference, and sexual interference. While results also showed that clinical anger is not significantly correlated with anger now, irritated now, sleep interference and fatigue ($r = -.04, .01, .06, .16$; $p > .05$) Excessive anger and irritability are among the most common of health problems. Depression can appear as anger and discouragement rather than feelings of hopelessness and helplessness. Anger is "a feeling of displeasure resulting from injury, mistreatment, opposition, etc., and usually showing itself in a desire to fight back at the supposed cause of this feeling." Anger is specific to a particular issue. Anger is an emotion and it induces changes in appetite (Macht, 2008). There is significant relationship between clinical anger and appetite interference. Researches show history of extreme violence in the result of unexpressed violence (Davey, Day & Howells, 2005). Researches showed that there is relationship of clinical anger with somatic symptoms (Saboonchi & Lundh, 2003). Result indicated that there is no significant relationship between clinical anger and irritated now which is consistent with the previous study (Vieillard & Guidetti, 2009). It may be due to the age range of the participant as in this age, depressed patients do not feel irritated (APA, 2013). Clinical anger also has no significant relationship with fatigue which is consistent the findings of Fernandez and Turk (1995). It may be due to the effect of medication.

5 CONCLUSION

Hence the clinical anger is anger when the person is out of control. Clinical anger consist of two factors i.e., affective and somatic. Both factors have relationship with depression. Findings of the study will be helpful for psychologist and other mental health professionals to plan the therapeutic interventions for depressed patients. However, the present research has some limitations. The sample size was small, so the results cannot be generalized. During data collection focus was on hospitalized patients. Only Major depressive disorder patients were taken. In order to overcome these limitation some of the suggestions are presented here for future study. The sample size should increase so that we can generalize our results back to the population from which sample was taken. Studies can also be conducted to find out clinical anger with other disorders.

REFERENCES

- [1] A. A. M. Gadi, and G. Mugford, "Prevalence of Depression among Households in Three Capital Cities of Pakistan: Need to Revise the Mental Health Policy". *PLoS ONE*, Vol. 2, no.2, p. 209. 2007.
- [2] A. Beck, "Depression: Integration of Psychodynamic and Cognitive Behavioral Therapies". In A. R., Robberts and G. J. Greene. *Social Workers' Desk Reference*. New York: Oxford University Press. p. 353. 2002.
- [3] American Psychiatric Association . *Diagnostic and statistical manual of mental disorders* (5th ed) Arlington,

VA: American Psychiatric Association. 2013.

- [4] A. T. Beck, *Depression: Causes and Treatment*. Philadelphia: University of Pennsylvania Press. 1967.
- [5] A. T. Beck, *Cognitive Therapy and the Emotional Disorders*. Penguin Books. 1976.
- [6] A. Troisi, and A. D'Argenio, "The Relationship between Anger and Depression in a Clinical Sample of Young Men: The Role of Insecure Attachment". *Journal of Affective Disorders*, Vol. 79, no.1-3, pp. 269-272. 2004.
- [7] B. S. Ali., M. H. Naeem, S. Rahbar, A.. L.. Tareen, A. Gul, and L. Samad, "Prevalence of and Factors Associated With Anxiety and Depression Among Women In A Lower Middle Class Semi-Urban Community of Karachi", In H. Naqvi. *Depression in Pakistan: An epidemiological critique*. *Journal of Pakistan Psychiatric Association*, Vol. 4, no.1, pp. 1-10. 2007.
- [8] C. D. Spielberger, *Professional Manual for the State-Trait Anger Expression Inventory*. Odessa FL: Psychological Assessment resources. 1988.
- [9] C. D. Spielberger, E. H. Jacobs, S. Russell, and R. S. Crane, "Clinical Anger: Construct, Measurement Reliability, Validity". In W. E., Jr. Snell, *Progress in The Study of Physical and Psychological Health*. Cape Girardeau, MO: Snell Publications. 2002.
- [10] D. G. Kroner, and J. R. Reddon, "Anger and Psychopathology in Prison Inmates". *Personality and Individual Difference*, Vol. 18, no. 6. 783-788. 1995.
- [11] D. K. Granvold, (1994). "Depression: Integration of Psychodynamic and Cognitive Behavioral Therapies". In A. R., Robberts and G. J. Greene. *Social Workers' desk reference*. New York: Oxford University Press. p. 353. 2002.
- [12] D. L. Cox, S. D. Stabb, and K. H. Bruckner, *Women's anger clinical and developmental perspective*. U.S.A: Braun-Brumfield. p. 93.1999.
- [13] D. S. Holmes, *Abnormal Psychology*. (4th ed.). New York: Addison-Wesley Educational Publishers. 2005.
- [14] F. Emil, and E. F. Coccaro, *Aggression : Psychiatric Assessment and Teatment*. U.S.A : Marcel Dekker. 2003.E. Fernandez, and D. C. Turk, "The Scope an Significance of Anger in The Experience of Chronic Pain". *Pain*, Vol. 61, no. 2, pp. 165-175. 1995.
- [15] F. Saboonchi, and L. G. Lundh, "Perfectionism, Anger, Somatic Health, and Positive Affect". *Personality and Individual Difference*, Vol. 35, no. 7. pp. 1585-1599. 2003.
- [16] G. Salmon, A. James, and D. M. Smith, "Bullying in Schools: Self -Reported Anxiety, Depression, and Self- esteem in Secondary School Children". *British Medical Journal*, Vol. 317. pp. 924-925. 1998.

- [17] J. H. Kashani, L. Suarez, W. D. Allan, and J. C. Reid, "Hopelessness in Social Support and Hostility on Depressive Tendencies". *Social Science & Medicine*, Vol. 63, no, 5, pp. 1374-1382. 2006.
- [18] Inpatient Youths: A Closer Look at Behavior, Emotional Expression, and Social Support". *Journal of the American Academy of Child & Adolescent Psychiatry*, Vol. 36 no. 11, pp.1625-1631. 1997.
- [19] J. Lacan, "Aggressivity in psychoanalysis." In *Écrits: A selection*, trans. Alan Sheridan (New York: W. W. Norton), pp. 8–29. 1977.
- [20] J. R. Averill, "Studies on Anger and Aggression". In W. E, Snell. (2002). *Progress in The Study of Physical and Psychological Health*. Cape Girardeau, MO: Snell Publications. 2002.
- [21] J. Rubin, "The Emotion of Anger: Some Conceptual and Theoretical Issues". In W. E, Snell. *Progress in The Study of Physical and Psychological Health*. Cape Girardeau, MO: Snell Publications. 2002.
- [22] L. Davey, A. Day, and K. Howells, "Anger, Over-Control and Serious Violent Offending". *Aggression and Violent Behavior*, Vol.10, no. 5, pp.624-635.2005.
- [23] M. K. Biaggio, and R. D. Maiuro, "Recent Advances In Anger Assessment". In W. E, Snell. *Progress in The Study of Physical and Psychological Health*. Cape Girardeau, MO: Snell Publications. 2002.
- [24] M. Macht, "How Emotions Affect Eating by A Five-Way Model". *Appetite*, Vol. 50, no. 1. pp. 1-11. 2008.
- [25] N. Painuly, P. Sharan, and S. K. Mattoo, "Antecedents, Concomitants and Consequences of Anger Attacks in Depression". *Psychiatry Research*, Vol, 153, no.1, pp. 39-45.2006.
- [26] R. C. Martin, and E. R. Dahlen, "Cognitive Emotion Regulation in The Prediction of Depression, Anxiety, Stress, and Anger". *Personality and Individual Differences*, Vol. 39, no. 7, pp. 1249-1260. 2005.
- [27] R. Kaltiala-Heino, M. Rimpela, M. Marttunen, A. Rimpela, and P. Rantanen, "Bullying, Depression, and Suicidal Ideation in Finnish Adolescents: School Survey". *British Medical Journal*, Vol. 319, pp. 348-351. 1999.
- [28] S. Feshbach, "Reconceptualization of Anger: Some Research Perspectives". In W. E, Snell. *Progress in The Study of Physical and Psychological Health*. Cape Girardeau, MO: Snell Publications. 2002.
- [29] S. Vieillard, and M. Guidetti, "Children's Perception and Understanding of (dis)Similarities among Dynamic Bodily/Facial Expressions of Happiness, Pleasure, Anger, and Irritation". *Journal of Experimental Child Psychology*, Vol. 102, no. 1, pp.78-95. 2009.
- [30] T. Heponiemi, M. Elovainio, M. Kivimäki, L. Pulkki, S. Puttonen, and L. Keltikanga, "The Longitudinal Effects of
- [31] W. E., Jr. Snell, *Progress in The Study of Physical and Psychological Health*. Cape Girardeau, MO: Snell Publications. 2002.
- [32] W. Rammel & H. G. Hoffman, "Depression: Integration of Psychodynamic and Cognitive Behavioral Therapies" in Robberts, A. R., and Greene, G. J. *Social Workers' desk reference*. New York: Oxford University Press. p.353. 2002.
- [33] World Health Organization, *Mental Health: Depression*. Retrieved from <http://www.who.int/mentalhealth/management/depression/definition/en>. June, 2014.