Case Report

Depression is More Than Just Sadness: A Case of Excessive Anger and Its Management in Depression

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ABSTRACT

People with depressive illness often have symptoms of overt or suppressed anger. Those with anger traits face exaggerated problem during symptomatic period of depression. Pharmacological management helps in control of depressive and anxiety symptoms, but rarely address anger symptoms. Non-pharmacological management like cognitive-behavioral therapy (CBT) is effective in depression as well as in anger management, but is not used frequently in anger associated or exacerbated by depression. We present the case of a 27-year-old male suffering from moderate depressive episode with associated anger outburst. He underwent CBT, which resulted in a significant decrease in anger symptoms as well as in severity of depression.

Key words: *Anger, anger management, depression*

INTRODUCTION

Anger is a universal emotion, found across all cultures and nationalities. However, excessive uncontrolled anger and that triggered by trivial issues is often considered harmful. Anger has been thought to play an integral role in depression. Several psychoanalytic theorists and clinicians have suggested that conflicts and difficulties in coping with anger play a central role in the onset and persistence of depression.[1,2] Depression has also been conceptualized as a kind of self-directed anger and noted a propensity toward hatred and hostility has been noticed in patients with depression, based on temperament or early experience.[3] In line with this, a positive association has been found between the severity of depression and levels of hostility and anger experience, but could not be related to measures of expressed anger and could only be partially related to suppressed anger.[4,5]

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Non-pharmacological approaches play a significant role in the management of depression and anger individually. They have an additive effect to pharmacological treatment and also are considered as first line of management in mild-moderate cases of depression as well as anger. Cognitive-behavioral therapy (CBT), the most frequently practiced non-pharmacological therapy aims to reduce symptoms directly and to implement strategies designed to build better problem-solving skills.[6] In a meta-analysis, the efficacy of CBT in anger management was found to have a large effect size of 0.7 and had an impact on all dimensions-anger reduction, anger suppression, anger provocation, anger-related physiological arousal and in managing dysfunctional coping tendencies associated with anger.[7]

Though anger symptoms are more common among depressed patients, there are limited literatures on its management in depressed patients. We present the case

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of a male suffering from moderate depressive episode with associated anger outburst and had a significant decrease in anger symptoms due to add-on CBT unmanageable with only pharmacotherapy.

CASE REPORT

Mr. A, a 27-year-old single Hindu male, educated up to intermediate, with no significant past history of any psychiatric or medical illness, presented with chief complaints of depressed mood, initial and terminal insomnia and diminished appetite, excessive easy fatigability, anhedonia, excessive irritability, frequent anger outbursts, physical and verbal abuse, acts of deliberate self-harm for a duration of 3-4 months with progressive increase in intensity of symptoms over the time. His pre-morbid history revealed impulsive traits, frequent irritability and outbursts of anger, inability to handle criticism and difficulty in maintaining friends and relationships. However, there was no history of physical violence or conflict with others. However, currently, there was a significant increase in intensity and frequency of anger outbursts and irritability along with the depressive symptoms. Birth and developmental history was unremarkable.

Depressive episode of moderate intensity was diagnosed and rating on beck depression inventory (BDI) and Hamilton Depression Rating Scale (HDRS) were 11 and 18 respectively. Escitalopram was started, which was gradually increased from 5 to 20 mg/day. Though his depressive symptoms showed response to medications, there was no improvement in anger and irritability.

Non-pharmacological treatment based on cognitive-behavioral approach was started mainly to deal with his anger-related problem. The total therapy lasted over 4 weeks, which included a total of 11 sessions of 45-90 min/session. The objective of the therapy was to decrease impulsivity, arousal and expression of anger, increase his capacity to tolerate anger, channel his energy in prosocial ways and exert a better control over tension and anxiety even in tense situations. Psychoeducation, activity scheduling, self-monitoring of anger and associated physical cues and negative thoughts, relaxation and distraction techniques and cognitive restructuring were used to attain the above objectives.

First, patient was psychoeducated about depression and nature and importance of anger. Second, he was asked to maintain a diary of his anger outbursts, which included recording the antecedents, behaviors and consequences of his anger. In addition, patient was also instructed to rate and record the intensity of anger on a scale of 0 to 10. An activity schedule was prepared in collaboration with the patient and he was advised to follow it regularly in a proper way. Themes that emerged out of the assessment was that trivial events like things not done as per subject's wish and cues like heartbeat, hot flushes and irregular breathing increased his anger. This often led to impulsive acts like self-harm or violent behavior, which later led to the deep sense of guilt and disturbed his inter-personal relationship(s). To control the autonomic cues, Jacobson's progressive muscular relaxation training and deep breathing was taught. Distraction technique was suggested in the form of moving away from the arousing situation, keep calm and at the same time imagine pleasurable image or fantasy and feel good about it. Cognitive restructuring helped in replacing anger-provoking thoughts with more rational ones. Patient was instructed to practice repeatedly.

Following 11 sessions of CBT, there was a significant improvement in his anger and impulsivity. He reported that whenever he got angry, he was able to identify the feeling that caused anger (e.g., fear, hurt, disappointment). Further, he could contain his anger, used positive thoughts and expressed it in a respectful way. Overall, there was about 70% improvement in his perceived ability to control his anger. A decrease in BDI and HDRS scores from moderate to mild severity was also noticed during this time, which finally resolved over time. Before termination of sessions, importance of practicing the techniques even after resolution of depressive symptoms was emphasized to manage his anger outbursts.

DISCUSSION

The main aim of CBT in anger management is regulation of anger by understanding and monitoring personal anger patterns and acquisition of skills involving more adaptive alternatives to provocation. Previous studies have revealed that patients with anger attacks are significantly more depressed, anxious and have ideas of hopelessness compared to patients without anger attacks and they were more likely to meet criteria for cluster B (histrionic, narcissistic, borderline and antisocial) personality disorders in comparison to depressed patients without anger attacks.[8,9] This case highlights the efficacy of CBT as a maintenance treatment for depressive illness with expressed anger, without any significant side-effect. Patient had improvement in anger outburst, mood and overall social functioning, where pharmacotherapy alone failed to show a response. Patient attributed his overall positive outcome to the combination of CBT and pharmacotherapy. However, he described a greater sense of control over his anger due to CBT. These

findings are in line with those of previous studies. In a 15-month follow-up study on anger reduction among college students, the treatment groups reported a significant decrease in intensity and frequency of trait anger, provoked anger, anger-related physiological arousal, anger suppression and expressed anger compared to control group.[10] Similar results have been demonstrated among male adolescents with conduct disorder and forensic patients with added improvement in anger control, more positive expression of anger and use of more adaptive strategies for coping with stress.[11,12] CBT has also been proved to be efficacious in decreasing anger and aggressive driving behaviors in response to common anger-provoking stimulus among general population.[13]

To conclude, this case report demonstrates the efficacy of CBT in specifically decreasing anger symptoms among subjects with depressive disorder, which was not manageable with pharmacotherapy. Thus, there is a need to focus on practicing specific anger management techniques on patients with axis-1 disorder(s), which has irritability and anger as its symptoms.

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