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The paradox of aggression in adolescent depression: A systematic review

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Abstract

Teenagers who have aggressive or irrational outbursts could be hiding depression. Overt depression is evident when it manifests as melancholy, weeping fits, low self-esteem, loss of interest, and similar symptoms. Persistent actions like aggression, impatience, use of force, attack, hurt, and violence should raise the possibility of sadness masquerading as hostility. At times, adolescent depression can manifest as inner-directed behaviors like deliberate self-harm, compulsive stealing and fire-setting, chronic abdominal pain without biological cause, and anorexia-bulimia. If outer-directed, at an extreme, they can even show up as homicides, assaults, and robberies. There are also active and passive forms of aggression. This narrative review is exclusively concerned with adolescent depression that presents as aggression and is based on secondary sources of 83 published studies in indexed journals. This compilation, prepared based on PRISMA guidelines, is presented and discussed on themes, timelines, and format of the publications along with their implications for contemporary clinical practice and directions for future research.

Keywords: Teenage; Violence; Self-harm; Suicide; Hostility

1. Introduction

Teens who express persistent angry or violent outbursts may be an indication of depression. A strong association between depression and aggression is reported. Patients with depressive symptoms are more likely to exhibit physical aggression and increased violence. Biaggio & Godwin (1987) were the first investigators to use formal or standardized measures like the MMPI Depression Scale, the Hostility and Direction of Hostility Questionnaire, the Over-Controlled Hostility Scale, the Anger Expression Scale, and the State-Trait Anger Scale to report an intense experience of inwardly directed hostility and a poor sense of anger control in university-level students with depression. People with depression are noticed to have increased feelings of anger and irritability (Piko & Tamas, 2014; Knox et al. 2000). Aggression is a common counter-indicator of depression. Research has shown how depression is linked to intimate partner aggression (spousal homicide or child abuse) and self-harm. Genetics, personality variables, and insecure attachments aggravate the link between depression and aggression in teens along with their excessive smoking and alcohol use, isolation, rumination, impulsivity, internalized anger, and emotional flooding (Dutton & Karakanta, 2013; Whalen et al. 2001; Haddad et al. 2008).

The comorbidity of depression with aggression exists at all ages (Kwon, 2015; Van der Glessen et al. 2013; Weiss & Catron, 1994) and across different conditions like intellectual disabilities (Reiss & Rojahn, 1993), dementia ()Lyketsos et al. 1999), and conduct disorders (Benarous et al. 2015). Micro episodes of depression with unprovoked aggressive violence are part of schizophrenia, PTSD, substance abuse, ODD, delinquency (Mestre, Vidal & García, 2017; You & Lim, 2015), and antisocial personality (Ben-Amos, 1992). The diagnosis of "Mood Dysregulation Disorder" is recently added

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in DSM-5 for those aged 6-18, who present persistent irritability and frequent episodes of violent behavior towards people or property across different settings like home, school, or playground (Rao, 2014). Regarding gender, adolescent girls-more than boys showed one and a half times greater aggression originating from depression and by at least about four times in rural women (Yu et al. 2017; Meyrueix et al. 2015) against matched non-aggressive subjects (Gavray & Boulard, 2021; Llorca, Malonfa & Samper, 2016; Messer & Gross, 1994). Persons with depression against those with no history of depression matched by age and gender are noticed to have a three times greater risk of committing crimes like homicide, assault, and robbery (Krakowski & Nolan, 2017), with such tendencies evident by their fifth or sixth grade.

There are many types of aggression. Inappropriate aggression is maladaptive and dysfunctional as in the angry reaction to perceived danger which hides depression. Some depressed adolescents are angrier than their healthy peers and may not appear outwardly to be sad. Their aggression may be defensive, offensive, relational, or harmful to oneself. Aggression may be direct or indirect. Direct aggression is overt to causing harm. Relational aggression is indirect, involving isolating the target, threatening to stop talking to them, giving silent treatment, or spreading rumors. There can be reactive/defensive to a provocation in response to a threat or impulsive without instigation. Some forms of adolescent aggression are planned, intentional, pre-meditated, peer-directed, or romantic (as in breaking a relationship since they said or did something). Some of them are self- or other-directed as in the verbal (use of cuss words, swearing, name-calling, shouting, threatening, gossiping, starting or graffiti writing, spreading rumors, arguing, harsh or abusive language), physical (beating, biting, hitting, kicking, stabbing, vandalization, extortion, possession of a weapon, group fighting, assault, animal abuse, damaging property). Signs of aggression may be active or passive. Passive aggression is indirectly expressing negative feelings instead of opening them. Addressing problems, people, or issues through inactivity or omission is a feature of passive aggression. Sulking, passing back-handed compliments, procrastination, withdrawal, giving excuses, refusing to communicate, or showing avoidance are signs of passive aggression-also signs of depression (Rudolph & Clark, 2001; Schanz et al. 2022; Rey-Pena & Pacheno, 2012).

Fear, anxiety, stress, and frustration are some immediate reasons for aggression. An aggressive cycle typically has five phases, including trigger event, escalation, crises, recovery, and post-crisis depression. Aggression is behavior intended to harm self or others. It can be hostile (intended to harm for its own sake) or instrumental (as a means to an end and not an end by itself)(Kaltiala-Heino, Fröjd, & Marttunen, 2010). Peer rejection, exposure to violence, harsh parental discipline, family instability, or those with poor inter-group relationships and alienation show a greater risk for depression camouflaged as aggression (Beeson, Brittan & Vaillancourt, 2020; Sijtsema et al. 2014; McClellan et al. 2004). Heredity, social anxiety, low self-esteem, academic pressures, family fissures, brain chemistry, childhood trauma, and romantic breakups are factors in mediating or moderating emotion dysregulation to cause aggression in adolescent depression (Rothenberg et al. 2019; Callaghan et al. 2017; Garthe & Schacht, 2012). Factors like friendship intensity (Castillo-Eito et al. 2020), perceived parental rejection (Hale et al. 2008; 2005), and ruminating about victimization experiences (Harmon et al. 2019; Mathieson et al, 2014) are shown as directly proportional to the severity of aggressive-depressive symptoms.

Objectives

Separately, many publications address adolescent aggression and depression. However, research on adolescent depression that is presented as aggression is scant. This study set out with a need, rationale, and justification to conduct a review of the literature on depression showing up as aggression in adolescents. Does depression show up as aggression during adolescence was the major research question posed. If "yes," the aim was to describe the prevalence, forms, types, symptom presentation, etiology, and management of teenage depression and aggression in the literature. Are there any depression-related disorders that go undetected and untreated in adolescence? What is the current state of the evaluation instruments available only for measuring aggression caused by depression in adolescence? What effects does knowing the relationship between depression and aggression have on clinical practice?

2. Method

A series of research articles were enlisted following keyword searches of terms like depression, aggression, adolescence, teens, and their types, linkages, or measures. Both, offline/online searches with standard publication identifiers like DOI/ISSN/ISBN were compiled, coded, categorized, and classified by title, theme, year, and names of author/s or journals. Search engines included Google Scholar, JSTOR, PUBMED, PsycINFO, ERIC, and the Web of Science until March 31, 2023. Descriptive essays on the theme in newsletters, periodicals, in-house magazines, proceedings of seminars, webinars, or conferences, mimeographs, video or audio materials, and unpublished pre-doctoral doctoral or post-doctoral dissertations were excluded. Incomplete, misleading, repeated, and unverified cross references from available full text articles and books were also excluded. Inter-observer reliability checks undertaken by two mutually blinded independent coders for at least a quarter of the entries in the overall sample to minimize risk of bias yielded a robust

correlation coefficient (r: 0.95). The ethical issues as enshrined in the official mandate were followed (Venkatesan, 2009). A descriptive and interpretative statistical analysis was carried out using SPSS/PC (Pallant, 2020). Effect sizes were analyzed using Cohen's guidelines (Cohen, 1992). The production of this publication for this review followed as many PRISMA standards as possible.

3. Results

The aggregated data of references on depression-aggression were classified into harvest plots by their format (books, chapters, original research articles, experimental, observational, or empirical data based, descriptive reviews or essays), decade-wise publication, to specific topics of study. Almost half of the compiled list of publications on depression as aggression in this review are data-based empirical papers (N: 42 out of 83; 50.60%), followed by books (N: 14 out of 83; 17.07%), descriptive essays (N: 11 out of 83; 13.42%) and so on. By timelines, there is a growing frequency of publications every decade. As per the topic for research, proposing, exploring, examining, establishing, or correlating the linkage between depression-aggression during adolescence is the major concern of most of the publications (N: 20 out of 83; 24.09%). This is followed by a search to extract factors, validate, or develop objective measures of aggression in adolescent depression (N: 10 out of 83; 12.05%). Less work is done on theories/models combining adolescent aggression-depression although some address separately on adolescent aggression and depression (N: 9 out of 83; 10.84%).

Table 1 Harvest plot showing the frequency distribution of compiled literature on aggression in adolescent depression

Variable	Sub themes	N	%
Format	Data-based Empirical	42	50.60
	Books	14	17.07
	Descriptive Essays	11	13.42
	Reviews	6	7.32
	Case Reports	5	6.10
	Chapters	3	3.66
	Correlation	2	2.44
Timelines	<2000	14	16.87
	2001-2010	25	30.12
	2011-2020	39	46.99
	2020>	5	6.02
Topics	Linkages	20	24.09
	Measures	10	12.05
	Theories-Models	9	10.84
	Family-Parent-Peer	9	10.84
	Kleptomania/Pyromania/Bulimia/Bully	8	9.64
	Treatment	8	9.64
	Self-harm	4	4.82
	Review	3	3.62
	Development	2	2.41
	Bio/Genetic	2	2.41
	Gender	2	2.41
	Self-esteem	1	1.21

	Atypical	1	1.21
	Passive-Aggressive	1	1.21
	Others	3	3.62
Total		83	100.00

3.1. Self-Harm

Self-inflicted injury-a form of inner-directed aggression in adolescence is not suicide, even though it may appear to be so (Tuisku et al.2009; Harrington, 2001). Self-harm is an unhealthy way to deal with intense anger, emotional pain, or frustration in adolescent depression. It can result in an immediate or temporary sense of calm and release from tension. But it will be followed by guilt or shame. The act gives a short-lived feeling of control over one's own body, feelings, or life situations (Fox & Hawton, 2004). Forms of self-inflicted injury include cutting with a blade (self-laceration), carving words or symbols on the skin, breaking bones, hitting or punching self, head banging, biting, pulling out hair, picking at or preventing wound healing, burning self with camphor, and self-poisoning. These are common symptoms of girls of the same age with borderline personality, depression, and eating disorders (Singtakaew & Chaimongkol, 2021; Karriker-Jaffe et al. 2008).

3.2. Other disguised forms

The age-old notion that kleptomania in adolescence could be a disguised form of aggression in reactive depression is being increasingly revived for treatment in combination with anti-depressants (Talih, 2011; Grant & Kim, 2002; Fishbain, 1987). Similarly, unusual symptoms or conditions like pyromania (compulsive fire-setting)(Boyce et al. 2017; Hoste, Lebow & Le Grange, 2015), chronic abdominal pain, and anorexia-bulimia can be covert forms of adolescent depression (Presnell et al.2009; García-Alba, 2004; Odgers, Moretti, Dickon, 2005; Borum, 1996).

4. Discussion

While evaluating suicidal intent, thoughts, or potential of patients with depression is common, the assessment of their risk for violence is often ignored. Impulsivity and emotional dysregulation, as part of depression, can result in self-directed or other-directed violence and aggression (Borum, 2000; Pinals, 2021; Jackson & Roesch, 2015). Tools for measuring risk for violence, their predictive validity, and legal admissibility are questioned (Lakdawalla, Hankin, & Mermelstein, 2007; Bernaras, Jaureguizar, & Garaigordobil, 2019).

Adolescent depression linked to aggression is explained by a few theories: (a) biological (which stresses the role of tryptophan, a building block for serotonin depletion causing depression); (b) insecure attachment; (c) lack of reinforcement of previously-reinforced behaviors; (d) negative interpersonal relations and relations with one's environment and the resulting negative consequences; (e) attributions made by individuals about themselves, the world, and their future; and (f) sociocultural changes. The origins and triggers of human aggression are also explained by instinct theories, social learning theory (Blain-Arcaro & Vaillancourt, 2017), and the frustration-aggression hypothesis. Cognitive theories of depression developed by Beck (Hopelessness Theory and Response Style Theory) have limited evidence and are limited by poor measurements (Yang et al. 2015).

Freud explains depression as aggression directed inwards towards the self, resulting from exaggerated self-blame and guilt, although this basic tenet lacks empirical validation. James Lange's theory of depression notes that body changes come first, followed by emotions like anger or depression. Bowlby's theory views depression as the result of failed early life attachments. Behavioral models explain depression as the result of a lack of reinforcement or an excess of avoidance behaviors. Cognitive models are based on an understanding of negative attributions that lead to a sense of learned helplessness. The information processing model explains depression as caused by the cognitive triad of negative views about oneself, the world, and the future. Deficits in self-control processes like self-monitoring, self-evaluation, and self-administration by way of recognizing only immediate, short-term consequences are another model for explaining adolescent depression. In sum, no single theory can fully explain the genesis and persistence of depression—especially its link with aggression during adolescence (Zimer-Gembeck et al. 2016). Many assume that feelings come before the body's reactions. The James-Lange theory runs contrary to this common-sense notion. Instead, the feelings are perceptions of the body's reactions.

Additionally, (1) the failure model; (2) the acting out model; and, (3) a reciprocal model also explains the link between aggression-depression (Wang & Sang, 2020). Aggressive behaviors in depression were re-modeled in animal

experiments using rodents to prove the neural basis linking the two variables. The sensitivity model highlights the unique roles of anxiety, anger, blame, withdrawal, and retribution (Velotti, Elison, & Garofalo, 2014). The Status-Shaming Model shows how social status and shaming experiences influence the risk of anger, aggression, and depression. Adolescents with shaming experiences show 2-4 times increased risk of being involved in physical and verbal aggression (Åslund, Leppert, Starrin, & Nilsson, 2009; Åslund, Starrin, Leppert, & Nilsson, 2009; Achenbach, 1992; Mcconaughy & Achenbach, 2001; Silver, 2005).

4.1. Measures

There are no measures that exclusively focus on adolescent depression showing as aggression. Existing scales have a specific domain measure for "rule-breaking and aggressive behavior" (Child Behavior Checklist; Rusby et al. 2005), or for "self-control problems-aggression" as in the Semi-structured Clinical Interview for Children and Adolescents (SCICA; Casper et al. 2017). The Draw-a-Story Assessment Form is used to investigate suspected abuse histories, severity, meaning, and consequences of adolescent depression manifesting as aggression. This tool consists of drawings as a stimulus for subjects to select, picture an event occurring between the selected drawing, and narrate. The subject's fantasies and feelings are revealed through this open-ended task, which is then scored on a 5-point Likert scale. On this measure, a correlation coefficient of .806 or higher is provided as an indicator of judge dependability. The use of lethal forms of humor (about death or annihilation), gallows humor, self or others' disparaging humor, ambivalent or ambiguous humor, and playful humor were noticed to be high by adolescent respondents having aggression camouflaged as depression (Costelli et al. 2020). The Overt and Relational Aggression Participant Role Behavior Scales are designed to measure aggression, assisting, reinforcing, defending, victimization, and outsider behavior during acts of peer aggression experienced in the last 30 days on a scale of 0–7, from not at all to 10 or more times per day (Jackson et al. 2011). Reviews show that this tool has not been used as much as anticipated in research on adolescent depression as aggression (Connor, 2004).

4.2. Treatment

Several treatment options are available for defusing the adolescent depression-aggression dyad to promote a better quality of life. Apart from the primary identification of depression for treatment using antidepressants and mood stabilizers, the use of additional or adjunct anger control techniques, maintenance of mood diary, use of CBT, de-escalation strategies, environmental manipulation, behavior modification, regular vigorous physical exercise, deep breathing, relaxation, and mindfulness training is recommended. Skill training therapies, exposure, and cathartic therapies.

Systematic reviews and meta-analytic studies have shown small-to-medium effects in the use of interventions like cognitive-behavior therapy and acceptance and commitment therapy, the use of incentives, token economy systems, contingency reinforcements, response cost, time-out techniques, and planned ignoring of attention-seeking behaviors (Spoth, Redmond, & Shin, 2000). Based on the understanding of the role of the household environment in anger reactivity and expressions (Jones, 2023), studies on family-based interventions have been tried successfully (Fava & Leibenluft 2019). Treatment options depend upon the client's stage of the depression-aggression cycle. In the beginning, stage, eliminating the trigger, or responding to the event is needed. In the escalation phase, eliminating the anger, diverting attention, removal of the person from the setting is recommended. In the crisis stage, defusing the anger and maintaining the safety of self and others is targeted. During the stage of recovery, one must refrain from analysis, assigning blame, or imposing disciplinary action as that may prolong or rekindle the anger state. Eventually, the post-crisis phase is set aside to engage in reflection and problem-solving (Larson & Lochman, 2010; Jones, 2021; Kassinov, 2013). At any given point in time, browsing on the net shows many more references available on negative emotions like guilt, anxiety, depression, aggression, hostility, and anger than on positive emotions. Anger does not directly instigate aggression but usually accompanies it to attack a target. Aggression is a forceful act used to dominate another individual. It can be an argumentative, harmful, or destructive mode of behavior, especially when instigated by frustration. Anger can be fear of failure, anxiety, or stress induced, by peer pressure,

5. Conclusion

Most studies on this theme are cross-sectional or retrospective. Long-term prospective studies with follow-up are needed to further confirm these linkages. There is still a need for research on developing measures, evaluating genetic, biological, developmental, gender-related, and passive-aggressive forms of adolescent depression. Cross-cultural comparative studies, research using randomized control trials, and meta-analytic reviews are needed to provide future directions for research in this area. If adolescent depression is strongly substantiated as the substratum of their aggression, treatments can also be focused accordingly in the future.

Compliance with ethical standards

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Disclosure of conflict of interest

No conflict of interest.

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