Assessment of anger, depression symptoms, offence-related shame and guilt levels in women patients with migraine

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ABSTRACT

Objective: Many psychological factors have an effect on the formation and course of migraine disease. The aim of this study is to assess the levels of anger, offence-related guilt and shame, and depression of female migraine patients and the correlation of these feelings with each other.

Method: Our study included 50 patients attending the headache clinic with migraine diagnosis according to the diagnostic criteria of the International Classification of Headache Disorder 2004 and 40 control subjects. Participants completed a sociodemographic form, Offence-Related Shame and Guilt Scale (ORSGS), State-Trait Anger Expression Inventory (STAEI), and Beck Depression Inventory (BDI).

Results: Members of the migraine patient group were found to have significantly higher scores for the guilt and shame dimensions of the ORSGS, the BDI, and the trait anger and anger-out subdimensions of the STAEI compared to the control group. The scores for the shame dimension showed strong positive correlation with the anger-in subdimension.

Conclusion: Migraine patients experience anger more intensely than healthy individuals. Emotions of offence-related guilt and shame may be associated with migraine headaches. Assessing guilt and especially feelings of shame in the psychological treatment of migraine is considered important.

Keywords: Anger, female, guilt, migraine, shame

INTRODUCTION

Migraine is a frequently observed recurrent, unilateral, complex, multifactorial, hereditary neurovascular disorder that may cause incapacity (1).

Nearly 15% of the world population experience migraine. In the United States of America (USA), every year 18% of women and 6% of men are recorded as migraine patients. The lifelong risk is 43% for women and 18% for men. The lifelong social risk in Europe is between 12 and 28%. Every year, 14-35% of women and 6-15% of men experience migraine (2).

Studies researching the correlation between migraine and anger indicated that migraine patients experience more feelings of anger (3), have anger control problems (4), and they are especially characterized by high levels of internally directed anger (5). At the same time, migraine patients were identified to have higher levels of internally...
directed and externally directed anger than healthy persons (6). Interestingly, another study found externally directed anger levels to be greater among treated and healthy migraine patients (7).

Loker (8) stated that individuals making a wrong choice may become angry with themselves after conscious assessment and then suppress the negative feelings caused by this offence into the subconscious. Additionally, the half-head headache in migraine was interpreted as sending a subconscious message indicating that the offending individual is half-wit, acts semi-blindly, and harms him- or herself. Personal offences causing feelings of shame and guilt are problematic feelings perceived as a result of experiencing failures or behavior contrary to social norms. The negative mood caused by these feelings acts as a punishment for immoral behavior. Feelings of shame focus on a person’s identity, while feelings of guilt focus on behavior (9). To the best of our knowledge, there is no study in the literature assessing the feelings of guilt and shame experienced in relation to offence among migraine patients.

Wolf et al. (10) described migraine patients as having perfectionist, rigid, orderly, ambitious, and competitive personality traits. This definition played a pioneering role in studies determining the personality traits of migraine cases. Patients with migraine and stress-type headache are associated with neuroticism (11), while these patients experience more depression compared to healthy controls (12). Additionally, migraine patients were identified to have higher scores for the “neurotic three” (hypochondriasis, hysteria, and depression) on the MMPI (Minnesota Multiphasic Personality Inventory) (13). The personality profile of patients with migraine who are more prone to suppress their emotions (14) is an important determinant of the disease (15). On the other hand, it has been reported that personality traits of migraine patients with markedly affected social and professional functionality are a strong predictor of migraine (16).

A review of the literature has revealed several studies emphasizing the importance of the association of migraine with anger. However, to our knowledge, there is no research that has assessed offence-related shame and guilt among patients with migraine. The relation between migraine and the emotions of guilt and shame in women, who are generally more prone to sense these feelings than men, is a subject of debate (17,18). Similarly, our literature search did not reveal any study that focused on the association between these three emotions and somatic signs of neurological disease. Thus, to our knowledge, this is the first study that has been designed to fill the gap described above and may thus contribute to the understanding of the psychopathology underlying migraine.

In the present study, it was aimed to compare the level of guilt or shame and the level and expression of anger in migraine patients with the control group. The other objective of this study is to investigate the association between anger expression and offence-related guilt and shame.

For this purpose, the following hypotheses have been put forward:

H1: Patients with migraine experience higher levels of offence-related shame and guilt compared to the control group.

H2: Migraine patients experience a higher level of anger than the control group.

H3: The anger expression styles of migraine patients are related with offence-related shame and guilt.

**METHOD**

**Sample**

The study sample included 50 female migraine patients with previous or new diagnosis by a neurologist according to the diagnostic criteria of the International Classification of Headache Disorder 2004 who attended the SBU Okmeydani Education and Research Hospital's headache clinic. A total of 40 healthy female control subjects with similar age, educational level, and marital status as the patients were included in the control group. This study was conducted between February 20 and May 15, 2020. The control group comprised healthy individuals with no headache complaints or mild headaches occurring less than 4 times per year with no other bodily or physical complaints and no previous neurologic or psychiatric treatment.

Individuals forming the control group were selected among the hospital attendants of patients treated at hospital departments other than psychiatry and neurology and from our hospital staff. Patients with migraine and healthy controls were evaluated by an expert psychiatrist using Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I).

Inclusion criteria for the migraine patient group were an age between 18 and 60 years, being female, literate, and volunteering for participation in the study. Exclusion criteria were having any neurologic or chronic disease apart from migraine, previously diagnosed psychiatric disease, acute psychosocial stressors that might affect test results, antidepressant use, and presence of mental disability.
All patients consecutively admitted to the neurology outpatient clinic who were diagnosed with migraine were invited to participate in this study. Among the patients who agreed to participate, those who met the inclusion criteria and none of the exclusion criteria were first administered an informed consent form, followed by a data collection form and the forms administered by the interviewer, in a quiet and suitable venue. Eight patients were excluded from this study, including some who were using antidepressants, had recently lost a relative, or who were illiterate.

Both groups completed the sociodemographic data form, Offence-Related Shame and Guilt Scale (ORSGS), State-Trait Anger Expression Inventory (STAEI), and Beck Depression Inventory (BDI). This study was conducted in compliance with the Helsinki Declaration; the participants were informed about this study and gave verbal and written consent.

Measures

Sociodemographic Form: This form included sociodemographic data like age, sex, marital status, and educational level of individuals participating in the study.

Structured Clinical Interview for the DSM-IV Axis-1 Disorders (SCID-1): This is a semi-structured interview form that was developed by First et al. (19) in 1997 to assess and diagnose axis-1 disorders according to DSM-IV. Our study employed the Turkish version of the form, for which validity and reliability studies had been performed by Corapcioğlu et al. (20).

Offence-Related Shame and Guilt Scale (ORSGS): The original scale was developed by Wright and Gudjonsson (21). Comprising 10 items, the scale uses a 7-point Likert-type scale for scoring (“1” not at all – “7” completely). The scores that can be obtained from the scale range from 7 to 70. The internal consistency reliability coefficient of the scale is very good with 0.87 for the shame subscale and 0.86 for the guilt subscale. The Turkish adaptation of the scale was shown to be valid and reliable for the ORSGS levels of individuals (22).

State-Trait Anger Expression Inventory (STAEI): This measure was developed by Spielberger (23); validity and reliability studies for the Anger Expression Scales (AngerEx) in Turkey were performed by Ozer (24). The scale measures feelings of anger and forms of expression with a 4-point Likert-type scale comprising 34 questions. It contains 4 subdimensions: trait anger, anger-in, anger-out, and anger control. Adaptation studies for the scale established criterion-related validity and performed factor analysis. Reliability studies found item-total score correlations between 0.14 and 0.56, with Cronbach’s alpha internal consistency coefficients from 0.73 to 0.84 (25). Additionally, Cronbach’s alpha internal consistency coefficients for the sample group in this research were determined as 0.72 for trait anger, 0.60 for anger control, 0.59 for anger-out and 0.48 for anger-in.

Beck Depression Inventory (BDI): This instrument developed by Beck et al. (26) measures the bodily, emotional, and cognitive symptoms observed in depression. It is a self-report scale containing 21 symptom categories. The highest score that can be obtained is 63. A higher total score shows greater severity of depression. A validity and reliability study of the BDS in Turkey was performed by Hisli (27).

Statistical Analysis

Statistical analyses used the Number Cruncher Statistical System (NCSS) 2007 package (Kaysville, Utah, USA). When assessing study data, descriptive statistical methods (mean, standard deviation, median, frequency, proportion, minimum, maximum) were applied. For quantitative data, Student’s t-test was used to compare variables with normal distribution in two groups and the Mann-Whitney U test when comparing non-normally distributed variables in the two groups. Pearson’s chi-square test and Fisher-Freeman-Halton test were used to compare qualitative data. For analysis of correlations between quantitative variables, Pearson correlation analysis and Spearman correlation analysis were carried out. Significance was assessed at a level of p<0.05. Multiple linear regression analysis was used to determine whether migraine patients’ anger expression styles predicted guilt and shame.

RESULTS

Our study included 50 migraine patients and 40 controls. All of the migraine cases included in our study were female with a mean age 39.30±9.67 years, while the mean age in the control group was 37.75±8.89 years (t=-0.783; p=0.436). There were no significant differences between migraine patients and control group regarding education and marital status (Table 1).

Data obtained from the ORSGS, BDI and STAEI scales for the migraine patients and the healthy control group were analyzed. The migraine patients were found to have statistically significantly higher scores for the guilt and shame dimensions of the ORSGS compared to the control group (p<0.01). The migraine patient group members had significantly higher points for the BDI (p<0.01) and STAEI trait anger and anger-out subscales.
compared to the control group ($p<0.05$) (Table 2). Correlation analyses investigated the correlations between the guilt and shame dimension scores on the ORSGS, BDI scores, and STAEI subscale scores between migraine patients and healthy control group. For BDI scores, there was a weak level of positive correlation with the shame dimension and a weak level of negative correlation with the anger control subscale ($r=0.330; r=-0.303$).

The guilt dimension scores on the ORSGS had a positive strong correlation with shame scores ($r=0.728$), a weak positive correlation with trait anger scores ($r=0.306$), and a moderate positive correlation with anger-in scores ($r=0.433$). For the shame dimension, there was a weak positive correlation with the trait anger subscale ($r=0.397$), a strong positive correlation with the anger-in subscale ($r=0.618$), and a weak positive correlation with the anger-out subscale ($r=0.302$) (Table 3). Multiple regression analysis performed to predict the guilt dimension found that of the four dimensions, only anger-in was a significant predictor. These dimensions explain 18% of the guilt size variance. In multiple regression analysis to predict the size of shame, again only anger-in was found to be a significant predictor. These dimensions explain 39% of the variance in size (Table 4).

### DISCUSSION

The aim of this study was to compare offence-related guilt and shame, anger, and depression scores of migraine patients with healthy controls. The ORSGS score of the migraine patients was significantly higher than that of the healthy controls. Significant correlations were found between ORSGS score and trait anger-anger expression scores.

Headache is a common symptom that shows association with psychiatric disorders affecting the quality of life and may be triggered by an accompanying psychiatric disorder, personality traits, and stress factors (28). The risk of depression is increased in migraine patients (16). As expected, in our study migraine

### Table 1: Distribution of demographic characteristics according to group

<table>
<thead>
<tr>
<th></th>
<th>Control (n=40)</th>
<th>Migraine (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Min.-Max.</td>
<td>Mean</td>
</tr>
<tr>
<td>Age</td>
<td>22-57</td>
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<tr>
<td>Education status</td>
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<td>Primary/High school</td>
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<tr>
<td>University</td>
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<td>77.5</td>
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<tr>
<td>Marital status</td>
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<td></td>
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<tr>
<td>Single</td>
<td>15</td>
<td>37.5</td>
</tr>
<tr>
<td>Married</td>
<td>25</td>
<td>62.5</td>
</tr>
<tr>
<td><strong>p</strong></td>
<td>a0.436</td>
<td>-0.783</td>
</tr>
<tr>
<td><strong>χ²/t</strong></td>
<td>c0.632</td>
<td>0.226</td>
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</table>

*Student’s t-Test, aPearson’s Chi-Square Test, bFisher-Freeman-Halton Test

### Table 2: Assessment of scale points according to group

<table>
<thead>
<tr>
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<th>Control (n=40)</th>
<th>Migraine (n=50)</th>
<th>Test value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Min.-Max.</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>2-16</td>
<td>8.33</td>
<td>3.38</td>
</tr>
<tr>
<td>Offence-Related Shame and Guilt Scale</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Guilt Dimension</td>
<td>10-31</td>
<td>21.35</td>
<td>5.35</td>
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<tr>
<td>Shame Dimension</td>
<td>7-32</td>
<td>17.65</td>
<td>6.27</td>
</tr>
<tr>
<td>State-Trait Anger Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trait Anger</td>
<td>14-31</td>
<td>20.95</td>
<td>4.18</td>
</tr>
<tr>
<td>Anger-In</td>
<td>9-29</td>
<td>16.63</td>
<td>3.97</td>
</tr>
<tr>
<td>Anger-Out</td>
<td>11-25</td>
<td>16.20</td>
<td>3.43</td>
</tr>
<tr>
<td>Anger Control</td>
<td>14-31</td>
<td>22.13</td>
<td>3.77</td>
</tr>
</tbody>
</table>

*Student’s t-Test, dMann-Whitney U Test
patients’ depression scores were found to be significantly higher compared to healthy individuals. The depression scores of patients were 14.7±7.8, indicating that they experienced mild levels of depression (29).

Migraine patients in our study had higher trait anger scores than healthy people, again as expected. This result shows that migraine patients experience more feelings of anger, which is similar to findings in the literature (30).

Internally-directed anger was shown to be a possible predictive factor for migraine alone (5). However, contrary to this observation, in our study externally-directed anger scores were higher than in healthy individuals. This finding contradicts the consensus about suppressed anger in migraine patients reported in the literature, emphasizing the fact that migraine patients may sometimes suppress their anger, while occasionally they may express their anger externally. However, the reason for the identification of mild levels of depression in our patients may be related to more external expression of anger.

Though it is reported that migraine disease may be associated with feelings of guilt and shame (31), no study was encountered that investigated the correlation
of guilt/shame feelings with offence in migraine patients. A study in prisoners researched the relationship of offence-related guilt and shame feelings with somatization. A correlation was only found between shame and somatization (32). This study showed that the ORSGS may assess subconscious defense mechanisms. In addition to these findings, Tangney reported that somatization was correlated with both of these feelings but more with shame (33). In addition, guilt and shame are negative emotions that evoke strong aversive feelings and psychological pain (34).

In our study, the guilt and shame scores related to offence in migraine patients were identified to be significantly higher compared to healthy controls. A sensitive point of our study is that feelings of guilt and shame are affected by the severity of depression. However, the mild levels of depression among patients are a desired result. Hence, considering that depression severity increases levels of guilt and shame (35), our study may be considered to show that mild levels of depression have limited effect on guilt and shame levels. As a result, in our study it can be said that guilt and shame levels were assessed more in relation to personality traits rather than depression. As the suppressed feelings of migraine patients cause headache with psychosomatic mechanisms (36), the high levels of feelings of guilt and shame in our patients may increase the level of migraine headache via somatization. In other words, the half-head headache observed in migraine may be a subconscious message with the thought that the patient is “acting like a half-wit” after offences. Similarly, eye pain may be a subconscious message that “you can't see what's happening in front of you, end this!” (8).

Gender differences regarding shame and guilt are not just founded on results from self-report-based scales. Studies representing real shame and guilt experiences obtained similar results. In a study with children aged 2.5-5 years, Alessandri and Lewis (37) revealed that girls displayed more shame behavior (collapsed body, dipped head, etc.) compared to boys in situations of failure. In a study of children newly beginning to walk, researchers observed that girls displayed more behavior representing shame (avoiding behavior, etc.) than boys after breaking toys. The results were contradictory in relation to guilt behavior (38).

Feelings of guilt are linked to constructive reactions like compensatory behavior. By contrast, feelings of shame are associated with psychological adjustment problems like depression. While feelings of guilt are directed toward the behavior perceived as offensive by a person, feelings of shame are directed toward the person's self (39). Similarly, in our study, the shame scores had a positive correlation with depression scores, which may show that feelings of shame target the self. Tangney et al. (33) attributed the fact that the feeling of guilt is not related to psychological problems, in these studies, the feeling of shame and guilt were evaluated together. In other words, a tendency toward guilty feelings without a feeling of shame may not be related with psychological symptoms in some situations.

Guilt scores in our study were identified as having a positive correlation with trait anger and anger-in scores. In addition, the regression analysis applied determined that the anger-in dimension was a predictor of the guilt dimension, which appears to be related to a mechanism of internalizing anger by not blaming others for negative experiences but undertaking responsibility for the offensive behavior (40).

Lutwak et al. (41) found a positive correlation between the tendency toward feelings of shame and internalized anger and a negative correlation between the tendency toward feelings of guilt and externalized anger. In our research, the strong positive correlation between shame scores and anger-in scores was identified with no correlation with anger-out scores. In addition, regression analysis found that the anger-in dimension was a strong predictor of the shame dimension. This result appears to show that migraine patients internalize anger related to disappointments occurring with offence, which negatively affects the self and may impact the severity of the shame feeling.

Fedewa et al. (42) revealed that negative perfectionism has a positive significant correlation with feelings of both guilt and shame. Given that migraine patients may display perfectionist personality traits (10), the high levels of guilt and shame in migraine patients in our study compared to healthy controls are thought to be evidence for perfectionist personality traits of patients. Further, Lutwak and Ferrari (43) show women reporting feelings of shame and guilt at higher rates than men. Additionally, feelings of shame in women are loaded with both self-critical cognition and perfectionism, and this perfectionism is especially associated with socially-determined perfectionism.

However, the “neurotic three” personality trait of hypochondriasis (13) identified in migraine patients was found to be correlated with feelings of guilt, shame, and anger. In our study, which supports this correlation,
the high levels of guilt, shame, and anger feelings in migraine patients may be related to hypochondriac personality traits.

An important limitation of this study is that cases were not controlled for depression. Low patient numbers, inclusion of female cases only in the study group, and the use of scales to screen for psychiatric symptoms are other limitations of our research. It is not possible to make inferences about general society, given that women have a greater tendency to feel shame and guilt compared to men (17). Another limitation is that patients have mild depressive symptoms. One of the important limitations of such studies, when considering the comorbidity of migraine and depression, is to find migraine patients without depression. It is difficult to predict the effects of migraine medications used by the patients diagnosed with migraine before on our present research. It would be unethical to conduct a study while stopping these patients’ medications, which poses an inherent limitation for studies on migraine. Another limitation is the failure to assess clinical features such as duration of migraine, pain intensity, and pain frequency among the psychometric parameters that have been studied.

In the light of these results, our study emphasizes that female patients with migraine may experience anger and feelings of guilt and shame related to offence intensely. It seems important to assess feelings of guilt and shame in addition to anger in psychotherapy to be implemented within the psychological dimension of migraine treatment. There is a need for studies assessing the correlation between migraine and feelings especially of shame among female migraine patients. Furthermore, fMRI studies on shame and guilt discovered perfusion changes in the prefrontal cortex, temporal-parietal cortex, and limbic areas (44), but in migraine, those changes were more common in the hypothalamus, thalamus, basal ganglia, and limbic cortex areas (45). While our findings show a relationship between guilt/shame and migraine psychologically, adding neuroimaging studies may be interesting.

**Ethics Committee Approval:** Before the study, both groups provided voluntary consent forms and were provided with detailed information about the study. The study was approved by the Ethics Committee of SBU Okmeydani Education and Research Hospital (18.2.2020/48670771-514.10/40).

**Informed Consent:** Written informed consent obtained.

**Peer-review:** Externally peer-reviewed.

**Conflict of Interest:** The authors have no conflict of interest to declare.

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