HOSPITAL PHYSICIAN®

PSYCHIATRY BOARD REVIEW MANUAL

STATEMENT OF EDITORIAL PURPOSE

The *Hospital Physician Psychiatry Board Review Manual* is a study guide for residents and practicing physicians preparing for board examinations in psychiatry. Each manual reviews a topic essential to the current practice of psychiatry.

NOTE FROM THE PUBLISHER:
This publication has been developed without involvement of or review by the American Board of Psychiatry and Neurology.

Intermittent Explosive Disorder

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Table of Contents

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INTRODUCTION

Intermittent explosive disorder (IED) was once considered a rare disorder; however, recent studies have indicated that IED is much more prevalent than previously thought.[1] IED is associated with a high degree of social impairment. In a study of 253 individuals in a community sample diagnosed with IED, 81.3% reported psychosocial difficulties, 50% admitted to difficulties within their life due to their behavior, and 62.5% noted significant difficulties with relationships.[2] IED may lessen in intensity as individuals become older.[3] Diagnosis is difficult, in part due to the vagueness of the DSM diagnostic criteria.[4] Further, the paucity of IED studies makes identifying and treating IED a challenge. Despite these limitations, physicians must assess these impulsive and aggressive patients and be aware of available treatment options for these individuals.[5]

DIAGNOSTIC AND ASSOCIATED FEATURES

IED is characterized by short-lived episodes of impulsive aggression that are substantially out of proportion to the inciting stressor, resulting in destruction of property or serious assaultive acts.[6] IED is currently listed in the DSM-IV under impulse-control disorders not elsewhere classified.[6] Diagnostic criteria and the name of the disorder have changed over time. In DSM-I, IED was referred to as passive-aggressive personality, aggressive type, and in DSM-II, IED was termed explosive personality disorder. It was not until DSM-III that the term IED was used; however, the DSM-III criteria excluded patients with antisocial personality disorder[7] and generalized aggression or impulsivity,[1] and in the DSM-III-R, patients with borderline personality disorder were excluded. The DSM-IV criteria for diagnosing IED no longer excludes patients with impulsivity or generalized aggression[7] but includes the criterion that another mental disorder, substance abuse, or general medical condition must not better account for the aggressive acts (**Table 1**).[6] Impulsive aggression is not unique to IED and can be seen in multiple psychiatric and medical conditions. Thus, IED is a diagnosis of exclusion.[3] Of note, some studies use terms such as "episodic dyscontrol" or "rage attacks" to describe aggression, making it difficult to pinpoint how many patients meet the criteria for IED.[4] In addition, some doubt that IED is an actual diagnosis and believe that impulsive aggression is a symptom that can be experienced in multiple diseases.[8]

The aggressive episodes are often described by patients as "spells" or "attacks," and the symptoms often appear and resolve in minutes to hours. Symptoms have been described as an "adrenaline rush" or "seeing red."[1] As with other impulse-control disorders, there is often a feeling of release of tension after the episode. Aggression related to IED is often ego-dystonic and patients feel a sense of remorse and regret after the aggressive act.[3] In a study of 27 patients who met current or past DSM-IV criteria for IED, 33% complained of physical autonomic symptoms such as palpitations, tingling, and tremor prior to the episode, and 52% complained of a change in their level of awareness.[8]

In a study of 443 violent men, those who met DSM-III criteria for IED (n = 15) felt that an intimate partner would most likely provoke them. Their attacks usually occurred without warning, and all of the men denied wanting the outburst to occur prior to the episode. Men often attempted to console their victim after their rageful outburst.[9]

Impulsive aggression often has different motivations. If motivation includes monetary gain, vengeance, self-defense, social dominance, expressing a political statement, or when it occurs as a part of gang behavior, IED should not be the diagnosis.[3] The impulsive aggression seen in IED is not the same as the willingly performed and thought out aggression often seen in criminal behavior. Thus, when behavior is premeditated, individuals should not be diagnosed with IED.[4]

Because DSM-IV exclusion criteria created difficulties in diagnosing IED, integrated research criteria (IED-IR) have been formed. A study that examined the convergent and discriminate validity of the IED-IR criteria found that IED-IR individuals who met DSM-IV diagnostic criteria for IED were no more aggressive or impaired than IED-IR individuals who did not meet these criteria.[4] In another attempt to clarify diagnostic