

Validation of the Interview Module for Intermittent Explosive Disorder (M-IED) in children and adolescents: a pilot study

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Abstract

We identified a subset of impulsive, aggressive children as having symptoms that met criteria for Intermittent Explosive Disorder (IED) using the Interview Module for Intermittent Explosive Disorder (M-IED). The M-IED was administered to 34 children and adolescents between the ages of 10 and 17. These data provide initial evidence for the M-IED as a useful instrument in the diagnosis of IED in adolescents. The M-IED displayed a high level of inter-rater reliability and adequate test–retest reliability. Construct validity was supported by the fact that the subjects with IED symptomatology had significantly more lifetime aggression, oppositionality, inattention and hyperactivity/impulsivity compared to community controls. In addition, the subjects with IED symptomatology had a significantly greater number of episodes of lifetime physical aggression and documented episodes of aggression while in residential treatment compared to psychiatric controls. The subjects with IED symptomatology had a greater number of positive screening questions for DSM-IV diagnoses using the Swanson, Nolan and Pelham questionnaire (SNAP-IV), particularly those related to IED and posttraumatic stress disorder than psychiatric controls. © 2001 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

Intermittent Explosive Disorder (IED) is characterized by discrete episodes of aggressive impulses that result in serious assaultive acts toward people or destruction of property. As specified in DSM-IV, these aggressive acts are grossly out of proportion to the precipitating psychosocial stressor and are not better accounted for by another mental condition. More than a decade ago, a single study estimated the incidence of IED to be between 0.1 and 2.4% when inpatient psychiatric records were reviewed and compared to the DSM-III criteria for IED (Monopolis and Lion, 1983).

Violent behavior in adolescents is a major public health issue (Stanton et al., 1997). IED, however, has not been studied in adolescence despite evidence that this disorder begins during these years. In a literature review of Impulse Control Disorders, McElroy et al. (1992) noted that IED or episodic aggressive outbursts often began in childhood, adolescence or early adulthood and followed a chronic course. In a further study, three-quarters of 27 subjects who met DSM-IV criteria for IED reported their explosive behavior began in adolescence, with the mean age of onset being 14 years of age (McElroy et al., 1998).

Recent attempts to clarify the subtypes of aggression in children and adolescents have suggested the following broad categories: an impulsive–reactive–hostile–affective subtype (RA); a controlled–proactive–instrumental–predatory subtype (PA); and a mixed group that displays both features (Vitiello and Stoff, 1997). Dodge et al. (1997) classified both a large population of third graders and a group of juvenile offenders as showing either proactive or reactive aggression. In the sample of third graders, the reactive aggressive group demonstrated more aggressive problem-solving responses, while the proactive aggressive children anticipated positive outcomes for aggression. In the juvenile sample more encoding errors, judged by the ability to remember details of video vignettes, were found in the reactive aggressive children. Reactive aggressive adolescents are described as explosive, with poor impulse control. Based on animal models, this

behavior is thought to be primarily defensive in nature, driven by fear, anger and cognitive distortion of environmental circumstances, with high levels of autonomic arousal (Vitiello and Stoff, 1997). McElroy et al. (1998) noted adults with IED consistently described their aggression as defensive, as an ‘adrenaline rush’, and as having a high affective component, i.e. rage. It is possible that these highly impulsive aggressive children have a high degree of overlap with IED.

Insufficient impulse control is associated with poor outcomes in pediatric populations. Steiner et al. (1999) used the Weinberger Adjustment Inventory to classify delinquents into four groups based on distress and restraint. Youths with low levels of restraint were more likely to have prior convictions and to receive punishment while incarcerated. The two low restraint groups, a non-reactive (low restraint, low distress) and the reactive group (low restraint, high distress), had the highest level of recidivism with 88.9 and 71% being rearrested after 4 years, respectively. Evidence suggests that many of these children with poor impulse control suffer from Attention Deficit Hyperactivity Disorder (ADHD). Atkins and Stoff (1993) have classified children into subtypes of hostile aggression (intended to inflict injury or pain) and instrumental aggression (which provides reward or advantage to the aggressor). They reported that the hostile aggressive group had higher levels of poor impulse control (Atkins et al., 1993), as well as problems with ADHD (Atkins and Stoff, 1993). In two separate studies, children with the combination of Conduct Disorder and Attention Deficit Hyperactivity Disorder (CD/ADHD) had a greater occurrence of becoming delinquent (Farrington et al., 1989) and of being multiple offenders (Loeber et al., 1988), compared to controls, and children with either CD or ADHD alone.

Research on IED in pediatric populations has been severely hampered by lack of a valid and reliable instrument to make the diagnosis in children. Coccaro et al. (1998) devised the M-IED in adults with personality disorders. He used the ‘Revised criteria’ whereby episodes of severe verbal aggression were included for caseness (see Table 1). In this study, the IED-Revised subjects

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