

Intermittent Explosive Disorder: Common but Underappreciated

January 1, 2007

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Publication Article

Psychiatric Times

Psychiatric Times Vol 24 No 1

Volume 24 Issue 1



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In exclusive interviews, Ronald Kessler, PhD, professor of health care policy at Harvard Medical School, and Emil Coccaro, MD, Ellen C. Manning professor and chair of the University of Chicago's department of psychiatry, discussed their recently released study of the prevalence and correlates of IED¹ and current as well as planned treatment research.

Depending on how it is defined, IED affects between 5.4% and 7.3% of adults (11.5 to 16 million Americans) in their lifetimes. The prevalence study, funded by the National Institute of Mental Health, was based on data from the National Comorbidity Survey Replication, a national representative, face-to-face household survey of 9282 US adults aged 18 years and older. The diagnoses used in that survey emanated from version 3.0 of the World Health Organization Composite International Diagnostic Interview, which included an assessment of DSM-IV IED.

Findings of the survey indicate that IED is a lot more common than it was previously thought to be, Kessler told *Psychiatric Times*. It is more common than panic disorder, and anger attacks are more common than panic attacks.



"When you look at the impairment data about the impact on people's lives, IED is very important there, too, because it not only affects the person who has it, but . . . the people around the person with the disorder-the people whom the lamp gets thrown at rather than the person who is throwing the lamp," Kessler added. "Isn't it amazing that something this important has been going on . . . under the radar screen?"

Explaining why IED has gone relatively unnoticed in the psychiatric community, Kessler pointed out that people who are angry have not traditionally sought help in the same way as people who are depressed or anxious. Most of the persons with IED identified in the prevalence study were found to have received treatment for emotional problems at some time in their life but not for their anger. "So what it is telling us is that a lot of these people are sitting in mental health professionals' offices, but the clinicians don't ask and the patients don't volunteer that they have this problem," Kessler said. "They are there talking about their alcoholism, depression, or anxiety, but not about their anger."

Problems with diagnostic criteria

Mental health professionals don't ask about anger, Kessler speculated, because they don't know what to do once they find out about it. Another contributing factor to underappreciation of the prevalence of IED, he said, relates to the varied and changing conceptualizations of the disorder in different diagnostic systems. Coccaro confirmed that "the criteria were never very good in the DSMs," making it more difficult to conduct research on the disorder.

DSM-IV criteria for IED are as follows:

- Several discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property.
- The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressors.
- The aggressive episodes are not better accounted for by another medical disorder.

Unfortunately DSM-IV sets no minimum requirements for how frequently the aggressive behaviors must occur and over what period, and it fails to specify how severe the behaviors must be.

For use in the Composite International Diagnostic Interview, the aggressive episodes criterion was defined by requiring the respondent to report at least 1 of 3 types of anger attacks: suddenly losing control and breaking or smashing something

worth more than a few dollars; hitting or trying to hurt someone; or threatening to hit or hurt someone. The "several episodes" criterion was delineated by using narrow versus broad definitions: 3 or more attacks during one's lifetime (the broad definition) or 3 attacks in the same year (the narrow definition).

Coccaro recommends that the narrow definition of IED be included in DSM-V, since it is "really more compatible with a pathologic condition that you treat. If somebody has 3 big attacks in the course of their life and they are 50 years old, what are you going to treat?"

In the prevalence study, persons fitting the narrow definition of IED, when compared with those fitting the broad definition, were found to have a much more persistent and severe disorder as measured by the monetary value of objects damaged during anger attacks and the number of times someone needed medical attention because of an anger attack.

Onset, duration, impairment

As determined in the prevalence study, IED usually begins in childhood or adolescence, is quite persistent over the life course, is associated with substantial role impairment, and is highly comorbid with other DSM-IV mood, anxiety, and substance use disorders. Both Kessler and Coccaro noted that the early age at onset means that IED temporally precedes many of the other DSM-IV disorders with which it is comorbid.

"It would be very useful to carry out some studies to see how effective it would be to find and treat kids who have these problems before they get out of school and then follow them up over time to see what the impact would be on the course of the illness and on the occurrence of secondary conditions," Kessler said. "A lot of depression occurs in these people sometimes a number of years after the anger attacks."

Statistically significant sociodemographic correlates of broadly defined lifetime IED revealed in the study included being male and young and having low education level and low family income.

Recognition and treatment

IED is not just another name for bad behavior, Coccaro emphasized to Psychiatric Times. It is a real disorder with a biologic basis.² "There are brain networks that are altered in IED whereby the frontal part of the brain doesn't work as well as it should, so it doesn't inhibit the lower centers of the brain, which are actually hyperactive in response to threat," he said. Diagnosing IED is "pretty easy . . . because you are

basically asking about behaviors," said Coccaro, whose team has evaluated nearly 500 persons for IED research studies. The only tricky aspects are judging whether someone has mostly impulsive aggression as opposed to premeditative aggression, determining to what degree the impulsivity and aggression are impairing function, and ensuring that the patient does not have bipolar illness or another mental disorder that would better account for the behavior.

Both medications and psychotherapy have been used to treat IED, according to Coccaro. "We use fluoxetine [Prozac, others]. . . We think any of the SSRIs will work because they increase serotonin, and by doing that, they increase the threshold at which somebody is going to explode, given whatever provocation they have," he said. "Other drugs that will work are some of the mood stabilizers. Lithium [Eskalith, Lithobid] has been shown to work in aggression in general. We haven't studied it in IED, but I'm pretty sure it would work. Other mood stabilizers that have been tried have been divalproex [Depakote] and carbamazepine [Tegretol]. . . . In the divalproex study, we didn't really get a [positive] finding in the overall sample, but we did get a finding in a subsample of impulsive-aggressive people who had cluster B personality disorders."

Currently, Coccaro and his team are conducting an NIMH-sponsored trial comparing divalproex with fluoxetine or placebo for the treatment of IED. The study will examine the relationship between serotonin receptors and response to treatment with fluoxetine or divalproex. In addition, it will examine people with IED and those without the condition to determine whether there are differences in their serotonin receptor and transporter systems. The data from the study, Coccaro said, won't be available for analysis for another year or so.

Psychotherapeutic approach

Coccaro's colleague, Michael McCloskey, PhD, assistant professor of psychiatry at the University of Chicago, is studying a psychotherapeutic approach to treating IED. It is a system of treatment called cognitive relaxation coping skills training (CRCST). Patients meeting both research and DSM criteria for IED are randomly assigned to 12 weeks of individual treatment, group treatment, or wait list. Primary outcome measures will assess aggressive behavior, anger, and the presence of an IED diagnosis during posttreatment, at 6-month, and at 12-month follow-up periods.

Recently, Coccaro and his team submitted a grant proposal to NIMH to compare the combination of fluoxetine and CRCST with fluoxetine alone or CRCST alone. "They work differently.

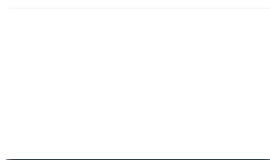
Increasing serotonin should increase the threshold at which you explode, but CRCST works on the cognitive or thinking aspects of aggression-it works on cognitive distortions that people have, such as their tendency to attribute hostility to other people, which, of course, will increase the chance that you are going to aggress against somebody," Coccaro said. "Each one brings about a full remission in about 30% of people. So the thinking is if you combine the treatments that you get a bigger effect, either a synergistic effect or additive effect."

Meanwhile, Kessler and his colleagues are currently working with the World Health Organization to assess and compare the prevalence of IED in 30 countries. "We are doing cross-national comparisons, using exactly the same instrument as we used in the prevalence study in United States so we can make [an] apples to apples comparison," Kessler said. "We hope to be done in 6 months."

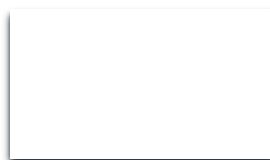
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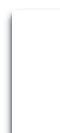
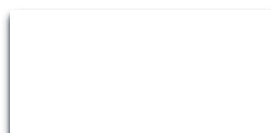
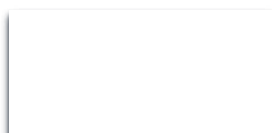


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