A case of intermittent explosive disorder

Amitabh Saha

Department of Psychiatry,
Military Hospital, Jodhpur, India

Address for correspondence:
Dr. Amitabh Saha,
Department of Psychiatry,
Military Hospital,
Jodhpur - 342 001, India.
E-mail: sahaing@gmail.com

A B S T R A C T

A case of impulse control disorder was observed and managed. In this case, the serving soldier of the Indian army presented with explosive outbursts of extreme violence and anger, which was not clearly directed. Following this act of aggression, he would experience a sense of gratification and relief. The episodes were recurrent and resulted in assaults or destruction of property. The aggression displayed was out of proportion to any perceived provocation and the individual felt increasing tension or arousal before committing the act. He did not have any feelings of regret, remorse or guilt about the behavior.

Keywords: Gratification, intermittent explosive episodes, relief

Intermittent explosive disorder comes under the rubric of habit and impulse disorders as per the ICD10 classification. The disorders in this grouping are characterized by the failure to resist an impulse, drive or temptation to perform some act that is harmful to the patient or others. The person senses increasing tension prior to committing the act and experiences pleasure, gratification or relief during or following the act. In 1838, Jean Etienne Esquirol proposed the term "monomanies instinctives" to describe behaviors characterized by irresistible urges and without an apparent motive. The impulse control disorders were first categorized in the third edition of DSM (DSM-III). The degree of aggression is always out of proportion to any precipitating factors that might be present.[1] Typically, these individuals do not take responsibility for their loss of control, but instead blame the victim, other circumstances in their life or some third party who may have told them something or said something that "caused" their uncontrolled anger. Lack of control is a central part of the problem, and inability to accept responsibility for the aggression helps to alleviate guilt. It also prevents the individual from making any changes.

Impulsive behavior seems to have an underlying predisposition, which may or may not be related to existing mental health or medical conditions, but research over the past decade has stressed on the substantial comorbidity of impulse control disorders with mood disorders, anxiety disorders, eating disorders, substance abuse, personality disorders and with other specific impulse control disorders.[2,3] It can become clinically difficult to disentangle them from one another, with the result that the impulsivity at the core of the disorders is obscured. Traumatic brain injury had earlier resulted in some individuals developing impulsive behaviors or impulse control disorders. This is particularly true when the damage has been to the frontal cortex area. Substance abuse appears to be commonly associated with impulsivity, although this is not included among the specific disorders of impulse control as defined in the DSM-IV-TR criteria for diagnosis of an impulse control disorder. While not all individuals with substance abuse problems exhibit or develop impulse control problems, research has noted a strong correlation between the two. Moreover, researchers have observed that individuals who abuse multiple substances show greater impulsive behavior than those who abuse single substances.[4]

Impulse control disorders are often present in a number of specific personality disorders, primarily borderline, antisocial, narcissistic and histrionic. Impulsivity presents in the form of risk-tasking behaviors, sexual promiscuity, gestures and threats of self-harm and other attention-seeking behaviors. By their very nature, some impulse control disorders can result in illegal or criminal behavior. The presence of concurrent comorbidities (e.g., psychosis, major mental illness, some personality disorders, substance abuse) increases the potential for dangerous, unpredictable and/or criminal behavior.[5,6] This is particularly the case with intermittent explosive disorder.

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CASE REPORT

A 31-year-old male presented with features of remaining aloof, sad, having prominent guilt ideas and entertaining thoughts of causing self-harm. The symptoms had developed insidiously when his wife learnt about his extramarital affair with a known relative. After his wife left him, the feelings of low mood became more intense and he started to entertain suicidal thoughts. While driving his motorcycle in the night, he met with an accident and started to bleed profusely. He tasted his own blood and liked the smell and taste of it. Thus, the frequent incidences of wrist cutting started so that he could suck his own blood. The act would be preceded by a mounting tension and arousal and subsequent relief would be noted later. He would break bottles and, with the glass pieces, would slash his palm, wrist and feet to see and feel the blood. He would also chew the glass pieces and the hurt caused by the glass pieces to his cheek and lips would actually be enjoyed by the individual. He even resorted to head banging so that the injuries caused to the scalp would produce more blood. As his unusual behavior was noted, he was admitted to the psychiatric center. While he was admitted to the hospital, he remained symptomatic. He was noted to remain quiet and aloof only to be shattered with episodic outbursts of intense anger and aggression. He assaulted other inpatients and derived pleasure from this fact. The episode lasted from 15 to 30 min and subsided on its own. The individual would remember the incident, but would give no reasonable explanation for his acts of violence.

He even consumed dettol solution with the intent to taste it after there was insurmountable anxiety before the act. He denied history of seizures, head injury or amnesia. There was no history suggestive of psychoses. He denied having any guilt ideas for his acts of aggression and denied a past history of similar episodes. He accepted consuming alcohol on several occasions but denied the relation of carrying out his episodic outbursts of violence to alcohol intake. Detailed premorbid history revealed him to be a rebellious student who had made violent protests during student election campaigning and even stabbed an opponent leader. He was also rusticated from school for several months. He had one broken love affair in college.[7]

A detailed medical evaluation and central nervous system evaluation were not significant. All hematological and biochemical parameters were within normal limits. Computed tomography (CT) scan and electroencephalogram (EEG) were normal. Mental state e xamination revealed him to be a depressed individual who had passive suicidal ideations with deranged biodrives. No thought disorder or perceptual anomalies were noted. Psychometric tests were carried out, which revealed the following:

- Rorschach test revealed impulsivity, poor ego strength, no paranoid traits but low productivity.
- Personality inventory showed him to be irritable, with impulsive traits, and a cyclothymic mood.
- Bender Gestalt test : Organizational disturbances and poor visuomotor sequencing were noted.
- BDRS score of 16, which showed mild to moderate depression.

He was managed with behavioral therapy, individual therapy, selective serotonin reuptake inhibitors that included Cap. Fluoxetine 20 mg OD and mood stabilizers that included Tab. Divalproex 1 g BD and Tab. Lamotrigine 50 mg BD. A typical antipsychotic that included Tab. Largectil 1800 mg/day was added along with Tab. Propanolol 40 mg BD. Gradually, his spouse also agreed and was initiated in the therapy, which proved beneficial.[8] After 6 months of follow-up, the individual remained asymptomatic and there were no incidents of episodic outbursts or undirected aggression. There was no evidence of prominent depressive cognitions.

DISCUSSION

As seen in this case, the symptoms were markedly present on the background of a presumptive stress. The case was all the more interesting for the rarity of the condition, even rarer being the mode of presentation of this individual. The diagnosis is always determined after ruling out organic components[9] or other psychogenic diagnosis.[2] Thus, the diagnostic process consisted of precise medical history, thorough physical examination and serial mental state examinations. It is also noteworthy to reveal that not all cases of intermittent explosive disorder have a favorable prognosis. Most of the times, the patient would be having a secondary psychiatric condition or would be receiving treatment in a nonpsychiatric set-up, leading to chronicity in these cases. Such patients, at times, land up in the hands of the law and the illness goes undiagnosed and untreated.[10]

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