Intermittent Explosive Disorder

Code: 312.34 (F63.81)

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Diagnostic Criteria 312.34 (F63.81)

A. Recurrent behavioral outbursts representing a failure to control aggressive impulses as manifested by either of the following:
1. Verbal aggression (e.g., temper tantrums, tirades, verbal arguments or fights) or physical aggression toward property, animals, or other individuals, occurring twice weekly, on average, for a period of 3 months. The physical aggression does not result in damage or destruction of property and does not result in physical injury to animals or other individuals.
2. Three behavioral outbursts involving damage or destruction of property and/or physical assault involving physical injury against animals or other individuals occurring within a 12-month period.
B. The magnitude of aggressiveness expressed during the recurrent outbursts is grossly out of proportion to the provocation or to any precipitating psychosocial stressors.
C. The recurrent aggressive outbursts are not premeditated (i.e., they are impulsive and/or anger-based) and are not committed to achieve some tangible objective (e.g., money, power, intimidation).
D. The recurrent aggressive outbursts cause either marked distress in the individual or impairment in occupational or interpersonal functioning, or are associated with financial or legal consequences.
E. Chronological age is at least 6 years (or equivalent developmental level).
F. The recurrent aggressive outbursts are not better explained by another mental disorder (e.g., major depressive disorder, bipolar disorder, disruptive mood dysregulation disorder, a psychotic disorder, antisocial personality disorder, borderline personality disorder) and are not attributable to another medical condition (e.g., head trauma, Alzheimer's disease) or to the physiological effects of a substance (e.g., a drug of abuse, a medication). For children ages 6–18 years, aggressive behavior that occurs as part of an adjustment disorder should not be considered for this diagnosis.
Note: This diagnosis can be made in addition to the diagnosis of attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder when recurrent impulsive aggressive outbursts are in excess of those usually seen in these disorders and warrant independent clinical attention.

Diagnostic Features

The impulsive (or anger-based) aggressive outbursts in intermittent explosive disorder have a rapid onset and, typically, little or no prodromal period. Outbursts typically last for less
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than 30 minutes and commonly occur in response to a minor provocation by a close intimate or associate. Individuals with intermittent explosive disorder often have less severe episodes of verbal and/or nondamaging, nondestructive, or noninjurious physical assault (Criterion A1) in between more severe destructive/assaultive episodes (Criterion A2). Criterion A1 defines frequent (i.e., twice weekly, on average, for a period of 3 months) aggressive outbursts characterized by temper tantrums, tirades, verbal arguments or fights, or assault without damage to objects or without injury to animals or other individuals. Criterion A2 defines infrequent (i.e., three in a 1-year period) impulsive aggressive outbursts characterized by damaging or destroying an object, regardless of its tangible value, or by assaulting/striking or otherwise causing physical injury to an animal or to another individual. Regardless of the nature of the impulsive aggressive outburst, the core feature of intermittent explosive disorder is failure to control impulsive aggressive behavior in response to subjectively experienced provocation (i.e., psychosocial stressor) that would not typically result in an aggressive outburst (Criterion B). The aggressive outbursts are generally impulsive and/or anger-based, rather than premeditated or instrumental (Criterion C) and are associated with significant distress or impairment in psychosocial function (Criterion D). A diagnosis of intermittent explosive disorder should not be given to individuals younger than 6 years, or the equivalent developmental level (Criterion E), or to individuals whose aggressive outbursts are better explained by another mental disorder (Criterion F). A diagnosis of intermittent explosive disorder should not be given to individuals with disruptive mood dysregulation disorder or to individuals whose impulsive aggressive outbursts are attributable to another medical condition or to the physiological effects of a substance (Criterion F). In addition, children ages 6–18 years should not receive this diagnosis when impulsive aggressive outbursts occur in the context of an adjustment disorder (Criterion F).

Associated Features Supporting Diagnosis

Mood disorders (unipolar), anxiety disorders, and substance use disorders are associated with intermittent explosive disorder, although onset of these disorders is typically later than that of intermittent explosive disorder.

Prevalence

One-year prevalence data for intermittent explosive disorder in the United States is about 2.7% (narrow definition). Intermittent explosive disorder is more prevalent among younger individuals (e.g., younger than 35–40 years), compared with older individuals (older than 50 years), and in individuals with a high school education or less.

Development and Course

The onset of recurrent, problematic, impulsive aggressive behavior is most common in late childhood or adolescence and rarely begins for the first time after age 40 years. The core features of intermittent explosive disorder, typically, are persistent and continue for many years.
The course of the disorder may be episodic, with recurrent periods of impulsive aggressive outbursts. Intermittent explosive disorder appears to follow a chronic and persistent course over many years. It also appears to be quite common regardless of the presence or absence of attention-deficit/hyperactivity disorder (ADHD) or disruptive, impulse-control, and conduct disorders (e.g., conduct disorder, oppositional defiant disorder).

Risk and Prognostic Factors

Environmental. Individuals with a history of physical and emotional trauma during the first two decades of life are at increased risk for intermittent explosive disorder.
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Genetic and physiological. First-degree relatives of individuals with intermittent explosive disorder are at increased risk for intermittent explosive disorder, and twin studies have demonstrated a substantial genetic influence for impulsive aggression.
Research provides neurobiological support for the presence of serotonergic abnormalities, globally and in the brain, specifically in areas of the limbic system (anterior cingulate) and orbitofrontal cortex in individuals with intermittent explosive disorder. *Amygdala* responses to anger stimuli, during functional magnetic resonance imaging scanning, are greater in individuals with intermittent explosive disorder compared with healthy individuals.

Culture-Related Diagnostic Issues

The lower prevalence of intermittent explosive disorder in some regions (Asia, Middle East) or countries (Romania, Nigeria), compared with the United States, suggests that information about recurrent, problematic, impulsive aggressive behaviors either is not elicited on questioning or is less likely to be present, because of cultural factors.

Gender-Related Diagnostic Issues

In some studies the prevalence of intermittent explosive disorder is greater in males than in females (odds ratio = 1.4–2.3); other studies have found no gender difference.

Functional Consequences of

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Social (e.g., loss of friends, relatives, marital instability), occupational (e.g., demotion, loss of employment), financial (e.g., due to value of objects destroyed), and legal (e.g., civil suits as a result of aggressive behavior against person or property; criminal charges for assault) problems often develop as a result of intermittent explosive disorder.

Differential Diagnosis

A diagnosis of intermittent explosive disorder should not be made when Criteria A1 and/or A2 are only met during an episode of another mental disorder (e.g., major depressive disorder, bipolar disorder, psychotic disorder), or when impulsive aggressive outbursts are attributable to another medical condition or to the physiological effects of a substance or medication. This diagnosis also should not be made, particularly in children and adolescents ages 6–18 years, when the impulsive aggressive outbursts occur in the context of an adjustment disorder. Other examples in which recurrent, problematic, impulsive aggressive outbursts may, or may not, be diagnosed as intermittent explosive disorder include the following.
Disruptive mood dysregulation disorder. In contrast to intermittent explosive disorder, disruptive mood dysregulation disorder is characterized by a persistently negative mood state (i.e., irritability, anger) most of the day, nearly every day, between impulsive aggressive outbursts. A diagnosis of disruptive mood dysregulation disorder can only be given when the onset of recurrent, problematic, impulsive aggressive outbursts is before age 10 years. Finally, a diagnosis of disruptive mood dysregulation disorder should not be made for the first time after age 18 years. Otherwise, these diagnoses are mutually exclusive.
Antisocial personality disorder or borderline personality disorder. Individuals with antisocial personality disorder or borderline personality disorder often display recurrent, problematic impulsive aggressive outbursts. However, the level of impulsive aggression in individuals with antisocial personality disorder or borderline personality disorder is lower than that in individuals with intermittent explosive disorder.
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Delirium, major neurocognitive disorder, and personality change due to another medical condition, aggressive type. A diagnosis of intermittent explosive disorder should not be made when aggressive outbursts are judged to result from the physiological effects of another diagnosable medical condition (e.g., brain injury associated with a change in personality characterized by aggressive outbursts; complex partial epilepsy). Nonspecific abnormalities on neurological examination (e.g., "soft signs") and nonspecific electroencephalographic changes are compatible with a diagnosis of intermittent explosive disorder unless there is a diagnosable medical condition that better explains the impulsive aggressive outbursts.
Substance intoxication or substance withdrawal. A diagnosis of intermittent explosive disorder should not be made when impulsive aggressive outbursts are nearly always associated with intoxication with or withdrawal from substances (e.g., alcohol, phencyclidine, cocaine and other stimulants, barbiturates, inhalants). However, when a sufficient number of impulsive aggressive outbursts also occur in the absence of substance intoxication or withdrawal, and these warrant independent clinical attention, a diagnosis of intermittent explosive disorder may be given.
Attention-deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, or autism spectrum disorder. Individuals with any of these childhood-onset disorders may exhibit impulsive aggressive outbursts. Individuals with ADHD are typically impulsive and, as a result, may also exhibit impulsive aggressive outbursts. While individuals with conduct disorder can exhibit impulsive aggressive outbursts, the form of aggression characterized by the diagnostic criteria is proactive and predatory. Aggression in oppositional defiant disorder is typically characterized by temper tantrums and verbal arguments with authority figures, whereas impulsive aggressive outbursts in intermittent explosive disorder are in response to a broader array of provocation and include physical assault. The level of impulsive aggression in individuals with a history of one or more of these disorders has been reported as lower than that in comparable individuals whose symptoms also meet intermittent explosive disorder Criteria A through E. Accordingly, if Criteria A through E are also met, and the impulsive aggressive outbursts warrant independent clinical attention, a diagnosis of intermittent explosive disorder may be given.

Comorbidity

Depressive disorders, anxiety disorders, and substance use disorders are most commonly comorbid with intermittent explosive disorder. In addition, individuals with antisocial personality disorder or borderline personality disorder, and individuals with a history of disorders with disruptive behaviors (e.g., ADHD, conduct disorder, oppositional defiant disorder), are at greater risk for comorbid intermittent explosive disorder.

Conduct Disorder

Diagnostic Criteria

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria in the past 12 months from any of the categories below, with at least one criterion present in the past 6 months:
Aggression to People and Animals
1. Often bullies, threatens, or intimidates others.
2. Often initiates physical fights.
3. Has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun).
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4. Has been physically cruel to people.
5. Has been physically cruel to animals.
6. Has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery).
7. Has forced someone into sexual activity.
Destruction of Property
8. Has deliberately engaged in fire setting with the intention of causing serious damage.
9. Has deliberately destroyed others' property (other than by fire setting).
Deceitfulness or Theft
10. Has broken into someone else's house, building, or car.
11. Often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others).
12. Has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery).
Serious Violations of Rules
13. Often stays out at night despite parental prohibitions, beginning before age 13 years.
14. Has run away from home overnight at least twice while living in the parental or parental surrogate home, or once without returning for a lengthy period.
15. Is often truant from school, beginning before age 13 years.
B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.
C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.
Specify whether:
312.81 (F91.1) Childhood-onset type: Individuals show at least one symptom characteristic of conduct disorder prior to age 10 years.
312.82 (F91.2) Adolescent-onset type: Individuals show no symptom characteristic of conduct disorder prior to age 10 years.
312.89 (F91.9) Unspecified onset: Criteria for a diagnosis of conduct disorder are met, but there is not enough information available to determine whether the onset of the first symptom was before or after age 10 years.
Specify if:
With limited prosocial emotions: To qualify for this specifier, an individual must have displayed at least two of the following characteristics persistently over at least 12 months and in multiple relationships and settings. These characteristics reflect the individual's typical pattern of interpersonal and emotional functioning over this period and not just occasional occurrences in some situations. Thus, to assess the criteria for the specifier, multiple information sources are necessary. In addition to the individual's self-report, it is necessary to consider reports by others who have known the individual for extended periods of time (e.g., parents, teachers, co-workers, extended family members, peers).
Lack of remorse or guilt: Does not feel bad or guilty when he or she does something wrong (exclude remorse when expressed only when caught and/or facing punishment). The individual shows a general lack of concern about the negative consequences of his or her actions. For example, the individual is not remorseful after hurting someone or does not care about the consequences of breaking rules.
Callous—lack of empathy: Disregards and is unconcerned about the feelings of others. The individual is described as cold and uncaring. The person appears more concerned about the effects of his or her actions on himself or herself, rather than their effects on others, even when they result in substantial harm to others.
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Unconcerned about performance: Does not show concern about poor/problematic performance at school, at work, or in other important activities. The individual does not put forth the effort necessary to perform well, even when expectations are clear, and typically blames others for his or her poor performance.
Shallow or deficient affect: Does not express feelings or show emotions to others, except in ways that seem shallow, insincere, or superficial (e.g., actions contradict the emotion displayed; can turn emotions "on" or "off" quickly) or when emotional expressions are used for gain (e.g., emotions displayed to manipulate or intimidate others).
Specify current severity:
Mild: Few if any conduct problems in excess of those required to make the diagnosis are present, and conduct problems cause *relatively minor* harm to others (e.g., lying,