Intermittent explosive disorder in adults: Clinical features, assessment, and diagnosis

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INTRODUCTION

Patients with intermittent explosive disorder are periodically unable to restrain impulses that result in verbal or physical aggression [1-3]. The aggressive behaviors are unplanned, out of proportion to the provocation, and cause subjective distress or psychosocial impairment.

This topic reviews the clinical features, assessment, and diagnosis of intermittent explosive disorder. The epidemiology, pathogenesis, treatment, and prognosis are discussed separately. (See "Intermittent explosive disorder in adults: Epidemiology and pathogenesis" and "Intermittent explosive disorder in adults: Treatment and prognosis".)

AGGRESSION

Aggression is defined as goal-directed behavior that is intended to harm or injure another person or object [4]. Aggressive behavior can be classified by the [5]:

- Target – Others, self, or property
- Mode – Physical or verbal
- Degree of planning – Impulsive (unplanned) or premeditated (predatory)

Impulsive aggression and premeditated aggression are both commonly pathologic, whereas defensive aggression, provoked by an immediate threat, is normal. Impulsive, aggressive

behavior is the core feature of intermittent explosive disorder, but can also occur in psychotic disorders, mood disorders, personality disorders, and general medical disorders [1,3]. The differential diagnosis of impulsive aggression is discussed separately. (See 'Differential diagnosis' below.)

Predicting future aggressive behavior is difficult; the best predictor may be past violence [6]. Assessing prior aggressive behavior is discussed separately. (See 'Assessment' below.)

EPIDEMIOLOGY

The prevalence of intermittent explosive disorder in the general population and in clinical settings is discussed separately. (See "Intermittent explosive disorder in adults: Epidemiology and pathogenesis", section on 'Epidemiology'.)

PATHOGENESIS

The pathogenesis of intermittent explosive disorder is discussed separately. (See "Intermittent explosive disorder in adults: Epidemiology and pathogenesis", section on 'Epidemiology'.)

CLINICAL FEATURES

Intermittent explosive disorder is one of several impulse control disorders that are marked by problems controlling emotions and behaviors, and result in behaviors that violate social norms and the rights of others [3]. Patients with intermittent explosive disorder are periodically unable to restrain impulses that result in verbal or physical aggression [1-3]. The aggressive behaviors are unplanned, out of proportion to the provocation, and cause distress or psychosocial impairment in patients. In addition, cognitive impairment and self-harm (eg, suicide attempts) can occur.

Psychotic experiences (delusions and hallucinations) are observed in many psychiatric disorders, including intermittent explosive disorder [7]. A cross-national study of community surveys from 18 countries identified individuals with a lifetime diagnosis of intermittent explosive disorder (n >1000) and found that psychotic experiences had occurred in 15 percent [8]. The psychotic experiences typically occurred after onset of intermittent explosive disorder, rather than prior to or concurrent with onset.

Aggressive behavior — The violent impulsive outbursts that characterize intermittent explosive disorder are generally preceded by a brief prodrome. The initial impulse to strike out typically occurs in response to a minor provocation, but may occur spontaneously [9]. The impulse is usually accompanied by an increasing sense of tension or arousal that progresses quickly [3,9,10]. Irritability, rage, increased energy, racing thoughts, poor communication, and inefficient information processing can occur, along with somatic symptoms such as paresthesias, tremor, palpitations, and chest tightness [11]. Little or no thought is given to the consequences of the violent behavior, which occurs with rapid onset ("all of a sudden").

The impulsive aggressive behavior consists of one or more of the following [1,12,13]:

- Physically striking other people or animals – Ranges from shoving or slapping to fistfights, using a weapon against someone, hurting someone badly enough to require medical attention, or even murder.
- Verbal outbursts, arguments, and threats to physically assault others – Generally occurs during temper tantrums or heated arguments that are marked by shouting and loss of control.
- Physical aggression to objects – Ranges from throwing things, slamming doors, or kicking objects to breaking objects or injuring an animal.

The explosive outbursts typically last less than 30 minutes, and, immediately afterwards, patients may feel a sense of relief [3]. Ensuing feelings commonly include fatigue, dysphoria, regret, and embarrassment.

The intensity and frequency of aggressive behavior in intermittent explosive disorder are for the most part inversely related [2,3,12]:

- Low intensity (nondestructive and noninjurious) aggression is relatively frequent
- High intensity (destructive and/or injurious) aggression occurs infrequently

A retrospective study of individuals with intermittent explosive disorder (n = 380) found that both forms of aggression, low intensity/high frequency and high intensity/low frequency, occurred in approximately 70 percent of the individuals [13]. Approximately 20 percent displayed only low intensity/high frequency impulsive aggression, and 10 percent manifested only high intensity/low frequency aggression.

High intensity aggressive behavior in patients with intermittent explosive behavior that consists of physically assaulting and injuring other individuals or animals, and/or damaging or

destroying property may occur as few as three times per year [1,3,14]. By contrast, verbal aggression and threats, or physical aggression directed towards property, animals, or other individuals that does not result in physical damage or injury (ie, low intensity aggression), occurs twice weekly on average for at least three months [3]. A nationally representative survey in the United States found that among 463 individuals with a lifetime history of intermittent explosive disorder, the mean number of physical (high plus low intensity) and verbal outbursts at the height of the illness was 28 per year [14].

Signs of generalized aggressiveness may occur in between explosive episodes [10,14]. Patients with intermittent explosive disorder may experience chronic anger, as well as subthreshold incidents in which aggressive impulses are resisted.

Cognitive impairment — Cognitive deficits can occur in intermittent explosive disorder. One study found that impulsive, aggressive male prisoners scored significantly lower on tests of attention, concentration, memory, and intelligence, compared with nonaggressive, noninmate controls matched for age, race, and education [15].

Intermittent explosive disorder is also associated with aberrant processing of social and emotional information. Multiple studies from the same research group presented vignettes of ambiguous, nonthreatening social interactions to individuals with intermittent explosive disorder, individuals with other psychiatric disorders (eg, depressive disorders or substance use disorders), and healthy controls, and found that those with intermittent explosive disorder were less able to absorb (encode) socially relevant information, compared with each control group [16-18]. Those with intermittent explosive disorder were also more likely to misinterpret others' behavior and make hostile attributions about the intentions of others, compared with each control group, and were more likely to respond with negative emotions and to take a more favorable view of aggressive behavior. In addition, strategic emotional intelligence (the ability to understand what one is feeling and to use that information for self-management) is lower in individuals with intermittent explosive disorder, compared with healthy controls and psychiatric controls [19]; this deficit is likely related to abnormalities in social-emotional information processing.

Psychosocial impairment — Intermittent explosive disorder is usually associated with psychosocial impairment, including interpersonal difficulties, divorce, job loss, school suspension, and financial problems [14,20,21]. Other adverse consequences include hospitalization because of injuries suffered in fights, legal charges, and incarceration. In a cross-national study of community surveys from 16 countries that identified approximately 350 individuals with a diagnosis of intermittent explosive disorder in the past 12 months, severe impairment in at least one domain of functioning was reported by nearly 40 percent [12]. The

prevalence of severe impairment was nearly three times greater among individuals with intermittent explosive disorder plus comorbid mental disorders, compared with intermittent explosive disorder alone (44 versus 15 percent).

Course of illness — Retrospective studies suggest that intermittent explosive disorder is persistent and chronic. A review found that the average duration of the illness ranged from approximately 12 years to nearly the entire lifetime [2].

Self-harm — Self-harm (self-directed aggression) such as suicide attempts and nonsuicidal self-injurious behavior (eg, superficial cutting with razor blades or burning with cigarettes without suicide intent) can occur in individuals with intermittent explosive disorder. In retrospective studies [22-25]:

- **Suicide attempts** – A history of attempted suicide is reported by 8 to 26 percent
- **Nonsuicidal self-injury** – A history of nonsuicidal self-injury is reported by 7 to 31 percent

The prevalence of suicide attempts and nonsuicidal self-injury are each greater in patients with intermittent explosive disorders than controls without the disorder [24,25]. As an example, one retrospective study found that the lifetime prevalence of self-harm was greater in individuals with intermittent explosive disorder alone (n = 74) than controls without mental disorders (n = 355; 18 versus 4 percent) [22].

Risk factors for self-harm include female sex [23,24] and a lifetime history of comorbid psychopathology, including unipolar major depression [23,24], posttraumatic stress disorder [24], and personality disorders [22,24]. As an example:

- Suicide attempts were observed in more than twice as many individuals with intermittent explosive disorder plus posttraumatic stress disorder (n = 111) than individuals with intermittent explosive disorder alone (n = 683; 41 versus 16 percent) [24].
- Self-harm was greater in individuals with intermittent explosive disorder plus a personality disorder (n = 452) than patients with intermittent explosive disorder alone (42 versus 18 percent) [22].

COMORBIDITY

Comorbidity is generally present in intermittent explosive disorder. Although intermittent explosive disorder is not diagnosed if the impulsive, aggressive behavior occurs only in the context of a different, active psychiatric disorder or an active general medical disorder, several

exceptions exist such that recurrent, severe aggressive behavior that requires independent clinical attention can be diagnosed as intermittent explosive disorder in the context of disruptive mood dysregulation disorder, antisocial personality disorder, borderline personality disorder, substance intoxication or withdrawal, attention deficit hyperactivity disorder, conduct disorder, or autism spectrum disorder [3]. (See 'Diagnosis' below.)

Psychiatric disorders — Among clinical patients and individuals in the community who have intermittent explosive disorder, the large majority have a history of other psychiatric disorders [12,25-27]. As an example, community surveys in the United States and other countries indicate that in individuals with a lifetime diagnosis of intermittent explosive disorder, at least one other psychiatric disorder had occurred in more than 80 percent [12,14], and that three or more other lifetime psychiatric disorders had occurred in nearly 50 percent [14]. Comorbidities included [12,14]:

- Unipolar major depression – 35 to 37 percent of patients with intermittent explosive disorder
- Alcohol abuse – 33 to 37 percent
- Drug abuse – 22 percent
- Social anxiety disorder – 23 to 28 percent
- Specific phobia – 22 to 24 percent
- Generalized anxiety disorder – 19 to 21 percent
- Oppositional defiant disorder – 25 percent
- Conduct disorder – 24 percent
- Attention deficit hyperactivity disorder – 20 percent
- Posttraumatic stress disorder – 15 percent
- Bipolar disorder – 15 percent

Other studies indicate that among individuals with intermittent explosive disorder, comorbid personality disorders are common, especially cluster B disorders (eg, borderline personality disorder) [22,25,27].

The prevalence of psychiatric comorbidity among individuals in the United States with intermittent explosive disorder is comparable to that in individuals with unipolar depression or substance use disorders [28]. However, the prevalence of a comorbidity in intermittent explosive disorder is greater than the rate in the general population [14]. As an example, the estimated lifetime prevalence of unipolar major depression in the general population is 23 percent [29], compared with 35 to 37 percent of patients with intermittent explosive disorder [12,14].

Patients with intermittent explosive disorder who are treated in clinical settings may have higher rates of comorbid psychopathology than individuals with intermittent explosive disorder who are identified in the general population. An observational study of 82 clinic patients with a lifetime diagnosis of intermittent explosive disorder found that a lifetime comorbid substance use disorder had occurred in 60 percent [26]. By contrast, an epidemiologic study in the United States identified 162 individuals with a lifetime diagnosis of intermittent explosive disorder and found that a lifetime comorbid substance use disorder had occurred in 35 percent [14].

Onset of intermittent explosive disorder usually precedes onset of its psychiatric comorbidities, including unipolar depression, generalized anxiety disorder, substance use disorders, posttraumatic stress disorder, and bipolar disorder [12,14,26-28,30].

General medical disorders — Multiple studies indicate that intermittent explosive disorder is associated with several chronic general medical disorders, but the observed effect generally appears to be small [31]. As an example, a cross-national study of community surveys from 17 countries identified individuals with a lifetime diagnosis of intermittent explosive disorder and looked for physical health problems that developed after onset of intermittent explosive disorder. In analyses that controlled for potential confounding factors (eg, age, sex, and smoking), the investigators found that the following disorders occurred more often among individuals with intermittent explosive disorder than the general population [12]:

- Arthritis
- Chronic lung disease
- Chronic pain
- Diabetes mellitus
- Heart disease
- Hypertension
- Peptic ulcer
- Stroke

After further adjusting for other mental disorders, the magnitude of the association between intermittent explosive disorder and subsequent onset of the general medical conditions was generally small.

A prior study based upon epidemiologic studies in the United States also found that intermittent explosive disorder was associated with an increased risk for the same set of chronic general medical disorders, and that the observed effect was typically modest [32].

SCREENING

For clinicians who want to screen patients for intermittent explosive disorder, we suggest the 10-item, self-report Intermittent Explosive Disorder Screening Questionnaire (table 1) [33]. However, screening is typically not part of routine clinical care.

The psychometric properties of the Intermittent Explosive Disorder Screening Questionnaire are good to excellent: sensitivity is 82 percent, specificity 97 percent, and positive predictive value 96 percent [33]. In addition, testing in university undergraduates (n = 740) in the United States found that the instrument identified intermittent explosive disorder in approximately 4 percent, comparable to what was observed in a nationally representative sample.

ASSESSMENT

The initial assessment for intermittent explosive disorder includes a psychiatric history and mental status examination, with emphasis upon aggressive impulses and behavior. In addition, the evaluation includes a general medical history, physical examination, and focused laboratory tests [34,35]. The clinician should be alert for psychiatric and general medical disorders that may entirely account for any impulsive, aggressive behavior and thus exclude the diagnosis of intermittent explosive disorder, as well as disorders that are often comorbid with intermittent explosive disorder. The differential diagnosis and comorbidity of intermittent explosive disorder are discussed separately. (See 'Differential diagnosis' below and 'Comorbidity' above.)

The psychiatric history taken from the patient and available informants (especially family members) should address the following [1,36,37]:

- Episodes of aggressive behavior, including the specific behavior and its frequency and severity
  - Physically assaulting other people or animals (eg, threatening gestures or striking someone)
  - Verbal aggression (verbal outbursts, arguments, and threatens to physically assault others)
  - Physical aggression to objects, including damaging property (breaking objects or injuring an animal)
- Antecedents to aggressive behavior

- Situations, behaviors, emotions, and cognitions that triggered the aggressive behavior
- Whether the provocation justifies the impulsive aggression (ie, was the explosive outburst grossly out of proportion to the precipitant)

- Planning for behavior
  - Whether the aggression was impulsive (unplanned and without regard to consequences) or premeditated
  - Whether the aggression was intended to achieve an objective (eg, sex, money, or power)
- Consequences of aggressive behavior, including job loss, disruption of interpersonal relationships, hospitalization for injuries, legal charges, and incarceration
- Lifetime chronology of impulsive aggressive behavior
  - Age of onset
  - Periods of remission
  - Prior efforts to control aggression
- Intensity and duration of generalized aggressiveness (eg, externally directed anger) between explosive outbursts
- Subjective distress
- Psychosocial impairment (eg, occupational and interpersonal functioning)
- Suicidal thoughts, suicide attempts, and nonsuicidal, self-injurious behavior such as head banging, superficial cutting, or burning

Although there are two clinician-administered instruments (The Module for the Diagnosis of Intermittent Explosive Disorder and a module of the Minnesota Impulse Disorders Interview) that can be used to assess patients for a possible diagnosis of intermittent explosive disorder, these are typically used in research settings rather than routine clinical practice [36,38,39].

DIAGNOSIS

We recommend that clinicians diagnose intermittent explosive disorder according to the American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5), which requires each of the following [3]:

- Failure to control aggressive impulses that lead to behavioral outbursts as manifested by either of the following:
  - Verbal aggression (eg, temper tantrums, tirades, arguments, or fights) or physical aggression directed towards property, animals, or other individuals that does not result in physical damage or injury; these outbursts occur on average at least twice weekly for three months.
  - Physical assaults that damage property or injure animals or other people, occurring at least three times in a 12-month period.
- Aggressive behavior is grossly out of proportion to the provocation or any precipitating psychosocial stressor
- Behavioral outbursts are impulsive, unplanned, and/or a response to anger
- Marked subjective distress or psychosocial impairment
- Aggression is not accounted for by another disorder

Intermittent explosive disorder is not diagnosed if the impulsive, aggressive behavior occurs only in the context of a different, active psychiatric disorder (eg, schizophrenia, schizoaffective disorder, unipolar major depression, or bipolar disorder) or a general medical disorder (eg, dementia, delirium, or temporal lobe epilepsy) [1,3]. However, if the aggressive behavior is severe and requires independent clinical attention, intermittent explosive disorder may be diagnosed in the context of (may be comorbid with):

- Disruptive mood dysregulation disorder
- Antisocial personality disorder
- Borderline personality disorder
- Substance intoxication or withdrawal
- Attention deficit hyperactivity disorder
- Conduct disorder
- Autism spectrum disorder

The World Health Organization's International Classification of Diseases – 10th Revision (ICD-10) does not specify diagnostic criteria for intermittent explosive disorder [40]. Rather, ICD-10

simply mentions the disorder as an example of "Other Habit and Impulse Disorders"; these are marked by repeated failure to resist impulses to carry out maladaptive behavior that is not secondary to another psychiatric syndrome, as well as a prodromal period of tension and a feeling of release at the time of the behavior.

The psychopathology encompassed by intermittent explosive disorder has previously been labelled episodic dyscontrol [41], explosive personality [42], and passive-aggressive personality, aggressive type [43].

Differential diagnosis — Recurrent, impulsive aggressive behavior can occur in psychiatric disorders other than intermittent explosive disorder and can also occur in general medical disorders. Other disorders that can give rise to aggressive behavior are differentiated from intermittent explosive disorder as follows [1,3]:

- **Schizophrenia and schizoaffective disorder** – Schizophrenia and schizoaffective disorder may cause paranoid delusions and command auditory hallucinations that can lead to aggressive behavior. By contrast, intermittent explosive disorder typically does not present with delusions and hallucinations, and is not characterized by other signs of psychosis (eg, disorganized speech and behavior and affective flattening). (See "Schizophrenia in adults: Clinical features, assessment, and diagnosis", section on 'Diagnosis'.)

- **Unipolar major depressive disorder** – Unipolar major depressive disorder and intermittent explosive disorder may both present with dysphoria (including irritability), guilt, and suicidal ideation and behavior. However, major depression usually includes anergia, anhedonia, sleep disturbance, and psychomotor retardation, which are generally not observed in intermittent explosive disorder. (See "Unipolar depression in adults: Assessment and diagnosis".)

- **Bipolar disorder** – Irritability, increased energy, and racing thoughts may be seen in both bipolar disorder and intermittent explosive disorder; in particular, the rage episodes of intermittent explosive disorder often resemble hypomania. However, mania and hypomania can be distinguished from intermittent explosive disorder by the presence of increased goal-directed activity, euphoria, inflated self-esteem, decreased need for sleep, and pressured speech, which are generally not observed in intermittent explosive disorder. In addition, the aggressive episodes of intermittent explosive disorder generally last minutes to hours, whereas hypomanic and manic episodes generally last days to months. Bipolar major depression is distinguished by anergia, anhedonia, sleep disturbance, and psychomotor retardation; these symptoms usually do not occur in intermittent explosive disorder. (See "Bipolar disorder in adults: Clinical features", section

on 'Clinical presentation' and "Bipolar disorder in adults: Assessment and diagnosis", section on 'Mood episodes'.)

- **Substance intoxication** – Alcohol and phencyclidine intoxication can present with nystagmus and amphetamine and cocaine intoxication can present with pupillary dilation; these ocular signs are not generally seen in intermittent explosive disorder. More so, drug tests can detect each of these substances. (See "Substance use disorders: Clinical assessment".)

- **Attention deficit hyperactivity disorder** – Attention deficit hyperactivity disorder in adults is characterized by the presence of hyperactivity, poor attention, inability to complete tasks, and disorganization, which are generally not observed in intermittent explosive disorder. (See "Attention deficit hyperactivity disorder in adults: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical manifestations'.)

- **Autistic disorder** – Autistic disorder is characterized by impairments in social interaction (eg, failure to develop peer relationships and lack of social or emotional reciprocity), communication (eg, stereotyped or idiosyncratic language), and behavior (eg, stereotyped and repetitive motor mannerisms), which are generally not observed in intermittent explosive disorder. (See "Autism spectrum disorder in children and adolescents: Evaluation and diagnosis", section on 'Diagnostic criteria'.)

- **Antisocial personality disorder** – Intermittent explosive disorder and antisocial personality disorder are both more prevalent in males than females. However, antisocial personality disorder is distinguished by the presence of a pervasive pattern of breaking laws (eg, stealing), deceiving others (lying, using aliases, or conning others for profit), chronic irresponsibility (eg, not honoring financial obligations), and lack of remorse; these traits are not characteristic of intermittent explosive disorder. In addition, the aggressive behavior in antisocial personality disorder is often premeditated and instrumental in the sense that the aggressive behavior is part of a plan to gain an advantage (eg, power or money) and intimidate others; this is not the case in intermittent explosive disorder. (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)

- **Borderline personality disorder** – Suicide attempts and nonsuicidal self-injurious behavior can occur in both borderline personality disorder and intermittent explosive disorder. However, borderline personality disorder is more prevalent in females in clinical settings, whereas intermittent explosive disorder is more prevalent in males. In addition, borderline personality disorder is marked by a pervasive pattern of chronic feelings of

emptiness, frantic efforts to avoid abandonment, and unstable interpersonal relationships that alternate between extremes of idealization and devaluation; these features are not characteristic of intermittent explosive disorder. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis", section on 'Diagnosis'.)

- **General medical disorders** – Aggressive behavior can occur in general medical disorders, which are differentiated from intermittent explosive disorder as follows:

  - **Dementia** impairs memory and other cognitive functions, and interferes with occupational and social functioning to a degree that generally exceeds what is found in patients with intermittent explosive disorder. (See "Evaluation of cognitive impairment and dementia", section on 'Criteria for dementia'.)

  - **Delirium** is characterized by a disturbance of consciousness and attention that usually develops over hours to days and tends to fluctuate during the course of the day; a change in cognition or the development of a perceptual disturbance that is not better accounted for by dementia; and evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a general medical condition, substance intoxication, or medication side effect. These features are not characteristic of intermittent explosive disorder. (See "Diagnosis of delirium and confusional states".)

  - **Temporal lobe epilepsy** is marked by a seizure aura or a simple partial seizure with sensory symptoms, behavioral arrest and staring, automatisms (ie, repetitive, stereotyped, and purposeless movements), and temporal sharp waves on the electroencephalogram; these findings are not characteristic of intermittent explosive disorder. (See "Focal epilepsy: Causes and clinical features", section on 'Mesial temporal lobe epilepsy'.)

In addition, intermittent explosive disorder is distinguished from purposeful, premeditated aggressive behavior that is intended to achieve an objective (eg, sex, money, or power) [1,3].

SYNDROMAL VALIDITY

Although criticisms have been raised that the diagnostic criteria for intermittent explosive disorder are arbitrary and that the disorder lacks validity [44], the DSM-5 [3] and the ICD-10 [45,46] both recognize intermittent explosive disorder as a valid mental disorder. Methods that have been used to establish its validity include studies that [47-49]:

- Describe the clinical features (see 'Clinical features' above)
- Specify exclusion criteria to delimit the disorder from other disorders (see 'Diagnosis' above)
- Follow patients over time to determine diagnostic stability and whether the diagnosis predicts level of functioning and quality of life, and response to treatment (see 'Clinical features' above and "Intermittent explosive disorder in adults: Treatment and prognosis")
- Examine the pathogenesis (see 'Pathogenesis' above)
- Assess families to determine whether the prevalence of the disorder is increased in family members (see "Intermittent explosive disorder in adults: Epidemiology and pathogenesis", section on 'Genetics')

The validity of intermittent explosive disorder appears to be comparable to that of other mental disorders, based upon its face validity (extent to which experts think the concept is distinct), descriptive validity (extent to which the defining characteristics of the illness are unique to the disease), predictive validity (extent to which one can predict the course of illness and response to treatment), and construct validity (extent to which the defining characteristics, boundaries, and pathophysiology of a disorder are known).

SUMMARY

- Intermittent explosive disorder is characterized by recurrent, impulsive aggressive behavior that is distinguished from both premeditated aggression as well as defensive aggression provoked by an immediate threat. (See 'Aggression' above.)
- Patients with intermittent explosive disorder are periodically unable to restrain impulses that result in verbal and physical aggression. The explosive outbursts are unplanned, have a rapid onset, grossly exceed the response that is justified by the precipitant, and cause marked subjective distress or psychosocial impairment. The intensity and frequency of the aggressive behavior are for the most part inversely related, such that low intensity (nondestructive and noninjurious) aggression is relatively frequent and high intensity (destructive and/or injurious) aggression occurs infrequently. Most patients manifest both forms of aggressive behavior. (See 'Aggressive behavior' above.)
- The large majority of patients with intermittent explosive disorder have a lifetime history of other psychiatric disorders; the most common comorbidities include alcohol abuse,

unipolar major depressive disorder, social anxiety disorder, specific phobia, and generalized anxiety disorder. (See 'Psychiatric disorders' above.)

- Intermittent explosive disorder is associated with general medical disorders, including arthritis, chronic lung disease, chronic pain, diabetes mellitus, heart disease, hypertension, peptic ulcer, and stroke. (See 'General medical disorders' above.)

- The evaluation for intermittent explosive disorder includes a psychiatric and general medical history, mental status and physical examination, and focused laboratory tests. The assessment should address episodes of impulsive aggressive behavior, whether the aggression was unplanned and grossly out of proportion to the provocation, consequences of aggressive behavior, signs of generalized aggressiveness between explosive episodes, psychosocial functioning, and suicidal thoughts and history of suicide attempts. (See 'Assessment' above.)

- The diagnosis of intermittent explosive disorder requires each of the following:

  - Failure to control aggressive impulses that leads to behavioral outbursts as manifested by either of the following:

    - Verbal aggression or physical aggression directed towards property, animals, or other individuals that does not result in physical damage or injury; these outbursts occur on average at least twice weekly for three months.

    - Physical assaults that damage property or injure animals or other people, occurring at least three times in a 12-month period.

  - Aggressive behavior is grossly out of proportion to the provocation or any precipitating psychosocial stressor

  - Behavioral outbursts are impulsive, unplanned, and/or a response to anger

  - Marked subjective distress or psychosocial impairment

  - Aggression is not accounted for by another disorder

  (See 'Diagnosis' above.)

- Recurrent impulsive, aggressive behavior can occur in many disorders. The differential diagnosis of intermittent explosive disorder includes schizophrenia, schizoaffective disorder, unipolar major depressive disorder, bipolar disorder, substance intoxication, attention deficit hyperactivity disorder, autistic disorder, antisocial personality disorder,

borderline personality disorder, and general medical disorders such as dementia, delirium, and temporal lobe epilepsy. (See 'Differential diagnosis' above.)

- Several treatments are available for intermittent explosive disorder. (See "Intermittent explosive disorder in adults: Treatment and prognosis".)

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