Intermittent explosive disorder in adults: Treatment and prognosis

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INTRODUCTION

Patients with intermittent explosive disorder are periodically unable to restrain impulses that result in verbal or physical aggression [1-4]. The aggressive behaviors are unplanned, out of proportion to the provocation, and cause subjective distress or psychosocial impairment.

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

DEFINITION OF THE DISORDER

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 [1-4].

Intermittent explosive disorder is diagnosed 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 leads 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

Additional information about the diagnostic criteria for intermittent explosive disorder and its clinical features are discussed separately. (See "Intermittent explosive disorder in adults: Clinical features, assessment, and diagnosis".)

TREATMENT

General principles — Intermittent explosive disorder can be treated by a variety of clinicians. The disorder is usually treated with pharmacotherapy by a psychiatrist, internist, or nurse practitioner. If cognitive-behavioral therapy (CBT) is used in addition to or instead of pharmacotherapy, a psychologist generally provides the psychotherapy. However, psychiatrists, internists, and nurse practitioners can provide all of the treatment if they are trained to administer CBT; treatment by a single clinician is often preferable because it allows for a better understanding of the patient and more consistent care. Patients whose disorder is either resistant or refractory to treatment are typically referred to a psychiatrist.

The goal of treatment for intermittent explosive disorder is remission, which is defined as resolution of symptoms or improvement to the point that only one or two symptoms of mild intensity persist. For patients who do not achieve remission, a reasonable goal is response, ie, stabilizing the safety of the patient and others, as well as substantial improvement in the number, intensity, and frequency of symptoms. Response can be quantified (eg, improvement

from baseline ≥50 percent) with standardized rating scales such as the clinician administered Overt Aggression Scale-Modified [5,6], but this is not standard clinical practice.

Patients with intermittent explosive disorder should be advised to avoid intoxication with alcohol and other substances. Epidemiologic studies suggest that substance use disorders significantly increase the risk of violent behavior in schizophrenia, bipolar disorder, and major depressive disorder [7]. In addition, a laboratory study with 56 healthy men found that alcohol intoxication significantly increased aggressive behavior, especially at lower levels of provocation, when most individuals are inclined to behave nonaggressively [8].

Acute treatment — We suggest that clinicians treat intermittent explosive disorder with pharmacotherapy plus CBT, based upon randomized clinical trials that have demonstrated the limited benefit of each treatment alone [9-11]. However, no head-to-head trials have compared CBT plus pharmacotherapy with pharmacotherapy alone or CBT alone. In addition, no trials have compared pharmacotherapy alone with CBT alone. Thus, it is reasonable to use either treatment alone based upon treatment availability, patient preference, prior response, and cost.

CBT teaches patients to anticipate and better manage aversive environmental stimuli and may thus prevent aggressive impulses. Medications may increase the threshold at which an aggressive impulse triggers an explosive outburst.

Monitoring outcome — Assessment of treatment outcome in patients with intermittent explosive disorder generally ranges from daily to monthly, depending upon the severity of persistent symptoms. Hospitalized patients are monitored daily. Outpatients are commonly seen on a weekly basis until their disorder has responded (ie, the safety of the patient and others has stabilized and the number, intensity, and frequency of symptoms has improved substantially) for two to four weeks. At that point the patient can be seen every two to four weeks until remission. Patients who subsequently deteriorate may need to resume a more frequent schedule of visits.

Pharmacotherapy — Several medications have demonstrated efficacy for treating impulsive aggressive behavior in patients with intermittent explosive disorder or other psychiatric disorders (eg, borderline personality disorder).

First-line — We suggest a selective serotonin reuptake inhibitor (SSRI) as first-line pharmacotherapy for intermittent explosive disorder based upon demonstrated efficacy, tolerability, and ease of use. Fluoxetine has been studied most often and is thus preferred. However, other SSRIs are reasonable alternatives. Based upon the duration of treatment in most randomized trials, we suggest 6 to 12 weeks of treatment (beginning from day one)

before determining whether the drug is beneficial [9,10,12]. Clinicians can expect that approximately 66 percent of patients will respond [9,12].

The usual starting dose of fluoxetine is 20 mg taken once daily. For patients who do not respond within two to four weeks, the dose is increased by 10 to 20 mg per day, depending on how well the medication is tolerated. Patients who remain unresponsive to treatment should receive additional increases of 10 to 20 mg per day every two to four weeks as tolerated, to an effective dose. The maximum dose is 60 mg per day. The dose schedule for other SSRIs and the adverse side effects of SSRIs are discussed separately. (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects".)

Support for treating intermittent explosive disorder with fluoxetine includes a 12-week randomized trial that compared fluoxetine with placebo in 100 patients with intermittent explosive disorder plus a personality disorder (primarily obsessive-compulsive, paranoid, or borderline) [9,12]. Moderate to large improvement occurred in significantly more patients who received fluoxetine than placebo (66 versus 29 percent). Side effects that occurred significantly more often with fluoxetine included sexual dysfunction, sleep disturbance, nausea, vomiting, and restlessness.

Other studies indirectly support using fluoxetine to treat intermittent explosive disorder. A meta-analysis of randomized trials (3992 patients treated for a variety of psychiatric disorders) found that impulsive aggressive behavior occurred in significantly fewer patients who received fluoxetine than placebo (0.2 versus 0.7 percent) [13]. In addition, other randomized trials have found that fluoxetine reduces impulsive aggressive behavior in patients with borderline personality disorder [14] and those with an alcohol use disorder who perpetrate domestic violence [15].

Resistant disease — Intermittent explosive disorder often does not respond to an SSRI within 6 to 12 weeks of starting the drug. (Response is defined as stabilizing the safety of the patient and others, as well as substantial improvement in the number, intensity, and frequency of symptoms.) For these treatment-resistant patients, we suggest tapering and discontinuing the SSRI over one to two weeks at the same time that another medication is started and titrated up. The SSRI is generally tapered by the same amount for each dose decrease. As an example, fluoxetine 40 mg per day is decreased by 10 mg per day, every one to two days.

We suggest using the following drugs in sequence for resistant intermittent explosive disorder rather than trying a second SSRI, because of the demonstrated efficacy of the drugs listed below and the lack of evidence that a second SSRI is effective in patients whose disorder is resistant to an initial SSRI. The following drugs are listed in order of preference, based upon

how often each drug has been studied and how well it worked [16]. Following onset of treatment, we suggest 6 to 12 weeks of treatment before determining whether the drug is beneficial [9,10,12]. The proportion of patients who respond to any specific drug may be as high as approximately 60 percent [17].

- **Phenytoin** – The initial dose of phenytoin is 100 mg three times per day or 200 mg in the morning and 100 mg in the evening [18,19], depending upon tolerability and adherence. A 12-hour serum trough level should be checked two weeks after the first dose, and one week after any dose change. Although there are no data correlating serum levels with efficacy in reducing impulsive aggression, toxicity can be prevented by maintaining the serum concentration ≤20 mcg/mL. Most studies have maintained the drug at 300 mg per day, but patients who do not respond after two to three weeks may benefit from increasing the dose by 30 mg per day each week to 400 mg per day. The pharmacology of phenytoin (including adverse side effects) is discussed separately. (See "Antiseizure medications: Mechanism of action, pharmacology, and adverse effects", section on 'Phenytoin and fosphenytoin'.)

  Evidence of efficacy for treating impulsive aggressive behavior with phenytoin includes a systematic review of seven randomized trials [20] and a pooled analysis of three trials [10], which both found that symptoms decreased significantly more with phenytoin than placebo. As an example, a six-week trial compared phenytoin with placebo in 29 patients with intermittent explosive disorder, and found that the mean number of explosive outbursts per week was significantly fewer with phenytoin (0.6 versus 1.0) [18].

- **Oxcarbazepine (or carbamazepine)** – Oxcarbazepine and carbamazepine have a similar chemical structure, probably have a similar mechanism of action, and are generally regarded as comparable in efficacy for treating impulsive aggressive behavior [10]. Oxcarbazepine is generally preferred because it usually causes fewer side effects and drug-drug interactions [17]. However, carbamazepine may be less expensive and is a reasonable alternative.

  The initial dose of oxcarbazepine is 150 or 300 mg per day. The dose is increased every two to four days by 150 to 300 mg per day, taken in two divided doses, to a target dose of 1200 to 2400 mg per day as tolerated [17]. The pharmacology of oxcarbazepine (including adverse side effects) is discussed separately. (See "Antiseizure medications: Mechanism of action, pharmacology, and adverse effects", section on 'Oxcarbazepine'.)

  Carbamazepine is usually started at a dose of 200 mg per day in two divided doses. The dose is increased every five days by 200 mg per day to a target dose of 800 to 1800 mg per

day as tolerated. Although there are no data correlating serum levels with efficacy in reducing impulsive aggression, toxicity may be prevented by maintaining the serum concentration ≤10 to 12 mcg/mL; extended release formulations can provide more stable serum levels.

Carbamazepine often induces hepatic enzymes and the metabolism of concomitant drugs. Specific interactions of carbamazepine with other medications may be determined using the Lexicomp drug interactions tool (Lexi-Interact Online) included in UpToDate. The pharmacology of carbamazepine (including adverse side effects) is discussed separately. (See "Antiseizure medications: Mechanism of action, pharmacology, and adverse effects", section on 'Carbamazepine'.)

Evidence of efficacy for treating impulsive aggressive behavior with oxcarbazepine or carbamazepine includes a systematic review of four randomized trials [20] and a pooled analysis of two trials [10], which both found that symptoms decreased significantly more with either drug than placebo. As an example, a 10-week randomized trial that compared oxcarbazepine with placebo in 45 patients with intermittent explosive disorder found that response occurred in significantly more patients who received oxcarbazepine (62 versus 25 percent) [17].

For resistant patients with intermittent explosive disorder who do not respond to phenytoin within 6 to 12 weeks of starting the drug, or do not tolerate the drug, we suggest tapering and discontinuing it over one to two weeks at the same time that oxcarbazepine (or carbamazepine) is started and titrated up. Phenytoin is generally tapered by 50 to 100 mg per day, every two to three days.

Refractory disease — After not responding to an SSRI and to phenytoin, patients with intermittent explosive disorder often do not respond to oxcarbazepine within 6 to 12 weeks of starting the drug. (Response is defined as stabilizing the safety of the patient and others, as well as substantial improvement in the number, intensity, and frequency of symptoms.) For these treatment-refractory patients, we suggest tapering and discontinuing oxcarbazepine over one to two weeks, and at the same time, starting and titrating up another medication. Oxcarbazepine is generally tapered by 300 to 600 mg per day, every two to three days.

We suggest using the following drugs in sequence for refractory intermittent explosive disorder; the drugs are listed in order of preference, based upon how often each drug has been studied and how well it worked [16]. We suggest 6 to 12 weeks of treatment (beginning from day one) before determining whether the drug is beneficial [9,10,12]. In our clinical experience,

approximately 25 to 50 percent of refractory patients respond to one of these third-line medications.

- **Lamotrigine** – The initial dose of lamotrigine is 25 mg per day for weeks 1 and 2. For weeks 3 and 4, the dose is increased to 50 mg per day, taken in two divided doses (an extended release formulation is available for once a day dosing). The dose can then be titrated up by 25 to 50 mg per day, one week at a time for each increase. This slow titration reduces the risk of life-threatening skin rash. The target dose ranges from 50 to 200 mg per day [21]. The pharmacology of lamotrigine (including adverse side effects) is discussed separately. (See "Antiseizure medications: Mechanism of action, pharmacology, and adverse effects", section on 'Lamotrigine'.)

  Evidence of efficacy includes an eight-week randomized trial that compared lamotrigine and placebo in 27 patients with borderline personality disorder, and found that impulsive aggression improved significantly more with lamotrigine [21].

- **Topiramate** – The initial dose of topiramate is 50 mg per day, taken in two divided doses. The dose is increased by 50 mg per day every week, to a target dose of 200 to 300 mg per day as tolerated [22,23]. The pharmacology of topiramate (including adverse side effects) is discussed separately. (See "Antiseizure medications: Mechanism of action, pharmacology, and adverse effects", section on 'Topiramate'.)

  Evidence for the efficacy of treating impulsive aggressive includes two randomized trials that compared topiramate with placebo for eight weeks in patients with borderline personality disorder (n = 42 and 29) [22,23]. Both trials found that impulsive aggression decreased significantly more with topiramate.

- **Valproate (divalproex)** – The initial dose of valproate is 250 mg twice daily, which is increased by 250 mg per day every 3 to 7 days as tolerated, to an effective dose [24]. The maximum dose is 30 mg/kg/day. Although there are no data correlating serum levels with efficacy in reducing impulsive aggression, some authorities aim for a 12-hour serum trough level of 80 to 120 mcg/mL to maximize efficacy and minimize toxicity. The pharmacology of valproate (including adverse side effects) is discussed separately. (See "Antiseizure medications: Mechanism of action, pharmacology, and adverse effects", section on 'Valproate'.)

  Evidence for the efficacy of treating impulsive aggression with valproate is mixed. The largest randomized trial compared valproate with placebo for 12 weeks in 116 patients with intermittent explosive disorder and found no benefit for valproate [24]. However, other trials suggest that valproate may reduce impulsive aggressive behavior [16,20].

- **Lithium** – The starting dose of lithium is usually 300 mg two or three times daily. The dose should be increased by 300 to 600 mg every one to five days as tolerated. The goal is to reach a therapeutic serum level, which generally occurs with a dose of 900 mg to 1800 mg per day. The target serum level is between 0.8 and 1.2 mEq/L, and levels should usually not exceed 1.2 mEq/L. Patients who cannot tolerate a level of 0.8 mEq/L may respond to a level of 0.6 mEq/L. The pharmacology of lithium (including adverse side effects) is discussed separately. (See "Bipolar disorder in adults and lithium: Pharmacology, administration, and management of adverse effects", section on 'Prescribing lithium'.)

  Evidence of efficacy includes a 12-week randomized trial that compared lithium with placebo in 59 prisoners with chronic impulsive aggressive behavior, and found that aggression decreased significantly more with lithium [25].

For patients with refractory intermittent explosive disorder that does not respond to one third-line drug within 6 to 12 weeks of starting the drug, or do not tolerate the drug, we suggest tapering and discontinuing the failed medication over one to two weeks at the same time that another third-line medication is started and titrated up. The failed medication is generally tapered by the same amount for each dose decrease. As an example, lamotrigine 200 mg per day is decreased by 50 mg per day, every two to three days.

The efficacy and tolerability of antipsychotics has not been established for intermittent explosive disorder, and we generally do not use these drugs unless they are indicated for a comorbid disorder (eg, bipolar disorder) that may respond to antipsychotics. Although case reports describe positive results with antipsychotics for intermittent explosive disorder [26], other case reports describe negative results [27].

Cognitive-behavioral therapy — Impulsive aggressive behavior can be reduced with CBT [11]. CBT teaches patients how to manage aversive stimuli in the day-to-day environment, and may thus prevent aggressive impulses that can trigger explosive outbursts. Efficacious anger management interventions for patients with disorders other than intermittent explosive disorder typically make use of CBT [28].

Specific techniques used in CBT include:

- Cognitive restructuring (ie, modifying faulty assumptions and dysfunctional thoughts about frustrating situations and perceived threats; the patient is encouraged to examine the validity of the assumptions and thoughts in light of all the available evidence)

- Relaxation training (eg, deep breathing as well as progressive muscle relaxation that consists of tensing and relaxing different muscle groups while imagining situations that

provoke anger)

- Coping skills training (eg, role playing potentially provocative situations and rehearsing responses such as walking away)

- Relapse prevention (educating patients that recurrence of impulsive aggressive behavior is common and should be viewed as a lapse or "slip" rather than failure)

CBT works best for highly motivated patients who value a problem-solving approach to their illness. Conversely, CBT is contraindicated for patients who cannot learn the specific techniques that are taught (eg, patients with moderate to severe cognitive deficits) [11].

CBT can be administered in either a group or individual format. Patients typically receive 8 to 16 sessions of therapy, but some treatment plans may call for 20; each session lasts approximately 60 minutes. The skills taught in therapy are practiced in between sessions.

Evidence of efficacy includes a 12-week randomized trial that compared group CBT, individual CBT, and a waitlist control condition in 45 patients with intermittent explosive disorder who were not receiving pharmacotherapy [29]. A clinically large and statistically significant reduction of impulsive aggressive behavior occurred in patients who received CBT compared with the control group; only minor differences were observed between group and individual CBT. In addition, treatment effects persisted at the three-month follow-up.

Nonresponse — Our clinical experience is that CBT should be reconsidered for patients who make little progress after four to eight sessions, depending upon the total number of sessions called for in the initial treatment plan. Motivation should be reassessed and the use of pharmacotherapy discussed if a medication has not been prescribed. CBT should be terminated for patients who do not engage in treatment (eg, skip appointments without calling ahead or make no effort to complete homework) despite repeated efforts upon the part of the clinician. Patients who terminate treatment should be allowed to return when they are ready to actively participate.

Maintenance pharmacotherapy — We suggest maintenance pharmacotherapy for intermittent explosive disorder using the same medication and dose that induced remission. Based upon our clinical experience, the risk for recurrence of impulsive aggressive outbursts generally persists for months to years. However, there is little high-quality evidence to guide decisions about maintenance treatment.

Adverse side effects — Maintenance pharmacotherapy for intermittent explosive disorder may cause side effects (eg, sexual dysfunction due to fluoxetine) that necessitate lowering drug

doses within the target dose range. Side effects and target dose ranges are discussed separately. (See 'Pharmacotherapy' above.)

For patients with intermittent explosive disorder who cannot tolerate maintenance pharmacotherapy with the minimum target dose of the drug that induced remission, we suggest switching to another drug. The failed medication is tapered and discontinued over one to two weeks by the same amount for each dose decrease. (As an example, fluoxetine 40 mg per day is decreased by 10 mg per day, every one to two days.) At the same time, the new drug is started and titrated up. The choice of the new drug depends upon which medications, if any, were unsuccessful during acute treatment. Medication options, doses, and side effects are discussed elsewhere in the topic. (See 'Resistant disease' above and 'Refractory disease' above.)

Monitoring the patient — Patients who remit from intermittent explosive disorder should be interviewed regularly and monitored for recurrence of symptoms as well as medication side effects. Particular attention is given to explosive outbursts, including physical assaults, verbal threats of interpersonal violence, and destruction of property. Symptoms of intermittent explosive disorder are discussed separately. (See "Intermittent explosive disorder in adults: Clinical features, assessment, and diagnosis", section on 'Clinical features'.)

Monitoring can be tapered for patients who remit and remain stable, with progressively longer intervals between assessments. As an example, a patient who is seen every two weeks at the time of remission can be seen every two weeks for one or two more visits, then every month for one to three visits, and then every two months for one to three visits. Continuously stable patients can ultimately be seen every three to six months. More frequent visits should be scheduled for patients who develop symptoms or side effects; monitoring acutely ill patients is discussed elsewhere in the topic. (See 'Monitoring outcome' above.)

Duration and discontinuation — For patients who remit from intermittent explosive disorder, we suggest maintenance pharmacotherapy for at least two years, based upon clinical experience. However, the duration is not established, and some patients require treatment for many years. The duration depends upon clinical factors and is generally longer in patients with:

- Residual symptoms, particularly aggressive impulses and chronic anger
- Ongoing comorbid psychopathology
- Psychosocial impairment or stressors
- A history of suicide attempts or nonsuicidal self-injurious behavior
- A greater number of prior explosive outbursts (eg, ≥30 physical or verbal outbursts)
- Duration of illness for several years (eg, ≥5 years)

- A history of more severe impulsive aggressive behavior (eg, physical assaults that lead to hospitalization)

If the decision is made to discontinue maintenance pharmacotherapy for intermittent explosive disorder, we suggest slowly tapering the medication over one month to increase the probability of detecting incipient symptoms (eg, subthreshold incidents in which patients briefly scream) before full-blown explosive outbursts recur. Based upon clinical experience, we decrease the dose each week by approximately 25 percent of the dose used during maintenance treatment. As an example, fluoxetine 40 mg per day is reduced by 10 mg per day each week until it is discontinued.

If symptoms recur during the taper, the dose should be titrated back up to the full dose used initially to achieve remission. If full-blown explosive outbursts develop despite increasing the dose; the safety of the patient and others does not stabilize; and the number, intensity, and frequency of symptoms do not substantially improve within 6 to 12 weeks of increasing the dose; the recurrence is treated as a new acute episode. Acute treatment is discussed above. (See 'Acute treatment' above.)

Recurrence — Recurrent symptoms during maintenance pharmacotherapy for intermittent explosive disorder are initially treated by optimizing medication doses. For medications that do not have a suggested therapeutic serum concentration, such as SSRIs, phenytoin, oxcarbazepine, lamotrigine, or topiramate, the dose should be increased within the target dose range as tolerated. For medications that have a suggested therapeutic serum concentration, such as valproate or lithium, clinicians should ensure serum concentrations are in the therapeutic range, and increase the dose to achieve a higher serum level within the therapeutic range, provided that side effects do not intervene.

If impulsive aggressive behavior recurs during maintenance pharmacotherapy and optimizing the dose does not control symptoms within 6 to 12 weeks, the recurrence is treated as a new acute episode. (See 'Acute treatment' above.)

For patients with intermittent explosive disorder who decide to stop maintenance pharmacotherapy and successfully taper and discontinue their medication, but subsequently relapse, we suggest restarting the same medication that was discontinued. The relapse is treated as a new acute episode. (See 'Acute treatment' above.)

PROGNOSIS

Prospective follow-up studies of intermittent explosive disorder have not been conducted. However, a retrospective study of 463 patients found that the mean duration of the disorder was 12 years and the mean number of lifetime impulsive aggressive outbursts was 56 [30]. Other retrospective studies suggest that the mean duration of the disorder may be as long as 20 years [27,31]. A review of 16 studies of aggressive behavior in males found that the number of aggressive outbursts may decrease as patients get older, while aggressiveness as a trait (eg, chronic anger or confrontational behavior with others) may persist throughout adult life [32].

SUMMARY AND RECOMMENDATIONS

- **Clinical features and diagnosis** – 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. (See 'Definition of the disorder' above and "Intermittent explosive disorder in adults: Clinical features, assessment, and diagnosis".)

- **Acute treatment** – For acute treatment of patients with intermittent explosive disorder, we suggest pharmacotherapy plus cognitive-behavioral therapy (CBT) rather than pharmacotherapy alone or CBT alone (**Grade 2C**). However, monotherapy with either treatment modality is a reasonable alternative. (See 'Acute treatment' above.)

  - **Pharmacotherapy**

    - **First-line** – For patients with intermittent explosive disorder who receive acute pharmacotherapy, we suggest a selective serotonin reuptake inhibitor (SSRI) as first-line treatment rather than other medications (**Grade 2B**). Fluoxetine has been studied most often and is thus preferred. However, other SSRIs are reasonable alternatives. (See 'First-line' above.)

    - **Resistant disease** – For patients with intermittent explosive disorder who do not respond to or tolerate acute treatment with an SSRI, we suggest switching to phenytoin rather than other drugs (**Grade 2C**).

      For patients with intermittent explosive disorder who do not respond to or tolerate acute treatment with an SSRI, and subsequently do not respond to or tolerate phenytoin, we suggest switching to oxcarbazepine rather than other drugs (**Grade 2C**). However, carbamazepine is a reasonable alternative.

(See 'Resistant disease' above.)

- **CBT** – CBT works best for highly motivated patients. Conversely, CBT is contraindicated for patients who cannot learn the skills that are taught (eg, patients with moderate to severe cognitive deficits). Specific techniques used in CBT include cognitive restructuring, relaxation training, coping skills training, and relapse prevention. (See 'Cognitive-behavioral therapy' above.)

- **Maintenance treatment** – For patients with intermittent explosive disorder who remit, we suggest maintenance pharmacotherapy (**Grade 2C**). We use the same drug and dose that induced remission. (See 'Maintenance pharmacotherapy' above.)

- **Prognosis** – Retrospective studies suggest that the mean duration of intermittent explosive disorder is approximately 12 to 20 years. (See 'Prognosis' above.)

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