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Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

The experience of aggressive outbursts in Intermittent Explosive Disorder



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ARTICLE INFO

Article history:

Received 14 March 2014

Received in revised form

20 August 2014

Accepted 3 November 2014

Available online 11 November 2014

Keywords:

Intermittent Explosive Disorder

Aggression

Emotion

ABSTRACT

Conceptualizations of Intermittent Explosive Disorder (IED) have suffered from a scarcity of research investigating the subjective experience and phenomenology of the aggressive outbursts among those with IED relative to those who partake in more normative forms of aggression. Furthermore, though some studies have shown that individuals with IED are more impaired and have a poorer quality of life, few studies looked at negative outcomes specific to an individual with IED's aggressive behavior. The purpose of this study was to examine the subjective experience and social, occupational, and legal consequences of aggressive outbursts in IED. We assessed individuals with IED ($n=410$), psychiatric controls ($n=133$), and healthy controls (HC) ($n=154$) in the experiential correlates present before, during, and after an aggressive outburst as well as the consequences of aggressive outbursts. Results indicated that before and during aggressive outbursts, individuals with IED experienced more intense anger, physiological reactivity, and feelings of dyscontrol as well as more remorse after an aggressive outburst. Furthermore, individuals with IED report more negative consequences of their aggressive outbursts. These results provide an account of how the subjective experience and consequences of aggressive outbursts in IED differ from those with more normative forms of aggression.

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1. Introduction

Aggression, defined as behavior directed toward an individual with the intent to harm (Geen and Donnerstein, 1998) is a common occurrence, with over 80% of individuals engaging in some form of aggression in their lifetime (Newton et al., 2001). Homicide, aggression's most extreme point, is the second leading cause of death among individuals aged 15–24 (Xu et al., 2010) and lesser acts of violence are even more ubiquitous (Barratt et al., 1999). Thus, aggression is both ever-present and dangerous. Moreover, billions of dollars in productivity are lost yearly due to aggression and its consequences, so much so that the World Health Organization (2002) has identified aggression as a major public health concern. Despite this, the phenomenology and consequences of aggression are not well understood.

Aggression can vary in both form and function. With respect to form, aggression can be verbal (e.g., yelling, heated arguments) or physical (e.g., assaults against people or property), with the verbal more common and the physical typically more severe in its

consequences (Baron and Neuman, 1996). The function of aggression can also vary as aggressive acts can be predominately instrumental, in which aggression is a tool to achieve a goal not directly connected to anger (e.g., knocking someone down to rob them) or affective (i.e., reactive) where aggression is used express anger and/or retaliate (Anderson and Bushman, 2002). Though some have argued that a strict dichotomy based on these functions is not valid as most acts of aggression have both instrumental and affective aspects (Feshbach, 1964), research suggests the large majority of aggressive acts or predominately affective (Anderson et al., 1995; Bushman and Anderson, 2001). As such, aggression is linked to the activation of the sympathetic nervous system, often producing the subjective experiences indicative of a “fight or flight” response such as racing heart, trembling, fear and/or rage, and feeling out of control (Böddeker and Stemmler, 2000). These emotional and physiological responses may be enhanced among more aggressive individuals, such as those with an aggressive disorder.

Though several psychiatric disorders include aggression as a criterion, Intermittent Explosive Disorder (IED) is the sole psychological disorder defined by recurrent acts of affective aggression (DSM-5; American Psychiatric Association, 2013). Research on IED demonstrates that the frequency of the aggressive outbursts among individuals with IED is much higher than the general population with these individuals

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engaging in, on average, approximately 65–70 acts of assault and/or property destruction, causing over \$1000 in damage and leading to multiple hospitalizations in their lifetime (Coccaro, 2003; Kessler et al., 2006, 2011). Although the frequency of aggressive acts clearly differentiates individuals with and without IED, no study has assessed the extent to which the physiological and emotional experiences associated with an aggressive outburst differ among those with IED relative to other less aggressive clinical and non-clinical populations.

Aggression can be harmful to the aggressor as well as the victim. Highly aggressive individuals tend to experience interpersonal difficulties such as damaged friendships (Deffenbacher et al., 1996), workplace difficulties (Bedi et al., 2013) and negative health consequences such as high blood pressure, heart disease, and stroke (McCloskey et al., 2010). Individuals with IED are more likely to engage in aggression in romantic relationships (O'Leary et al., 2014), develop ulcers (Scott et al., 2013) and other more serious health problems (McCloskey et al., 2010), and show greater overall functional impairment relative to other psychiatric and non-psychiatric comparison groups (McCloskey et al., 2006). However individual with IED also tend to have global problems with emotion regulation (McCloskey et al., 2008a) and no published studies to date have examined the extent to which impaired psychosocial functioning (e.g., family problems, relationship problems, legal problems) in IED is specifically related to their aggressive behavior.

To address these gaps in the literature, the current study investigated the phenomenology of aggressive outbursts in individuals with IED, as compared to individuals with other psychiatric disorders and healthy volunteers. Specifically, we looked at (1) subjective emotional and physical reactions before, during, and after an aggressive outburst and (2) the reported interpersonal and occupational consequences of aggressive outbursts. We hypothesized that individuals with IED will report higher levels of negative emotions, physical symptoms, and feelings of dyscontrol before and during the aggressive outburst, as well as more negative emotionality following the aggressive outburst than participants in the control groups. We also predicted that aggressive outbursts in IED will be associated with more negative interpersonal, occupational, and legal consequences than in the comparison groups.

2. Method

2.1. Participants

Participants were 697 adults (53.7% female) recruited through public service announcements and advertisements for healthy volunteers and individuals with emotional/anger problems through the Clinical Neuroscience and Psychopharmacology Research Unit (CNPRU) at the University of Chicago. The participants completing the study ranged in age from 18 to 65 years ($M = 34.47$, $S.D. = 9.82$) and were predominately Caucasian (52%) or African-American (34%) and relatively well-educated (86% had at least some college education).

Informed consent was obtained for all participants. Participants were excluded from all CNPRU studies if they reported (a) current drug or alcohol dependence, (b) current (past month) psychopharmacotherapy, (c) a history of bipolar or psychotic disorder, or (d) a traumatic head injury with a loss of consciousness greater than 60 min. For this study, participants were divided into the following three diagnostic groups based on their responses to a clinical interview

Healthy controls (HC) had no history of psychiatric disorders ($n = 154$).

Psychopathology Controls (PC) had a history of psychiatric disorders without any lifetime IED ($n = 133$). See Table 2 for a breakdown of the diagnoses.

Intermittent Explosive Disorder (IED) met DSM-5 IED criteria (American Psychiatric Association, 2013).

2.2. Measures

2.2.1. Structured clinical interview for the DSM-IV (SCID; First et al., 1996)

The SCID was used to diagnose DSM-IV non-IED Axis-I disorders. The SCID is a semi-structured clinical interview used to assign diagnoses for mood disorders, schizophrenia and other psychotic disorders, alcohol and other substance abuse and dependence, anxiety disorders, somatoform disorders, eating disorders, and adjustment disorders. The SCID has adequate inter-rater reliability with kappa values for modules reported to be between 0.70 and 1.00 (First et al., 1996).

2.2.2. Structured interview for DSM-IV personality (SIDP-IV; Pfohl et al., 1995)

The SIDP-IV was employed to assess personality disorders (i.e., DSM-IV Axis II disorders). Estimates of inter-rater reliability for the SIDP-IV are reported to be adequate (Pfohl et al., 1995).

2.2.3. Intermittent explosive disorder interview (IED-I; Coccaro, unpublished instrument)

The IED-I, a structured clinical interview used to assess and diagnose DSM-5 IED, was the primary outcome measure. The IED-I obtains quantitative (e.g., frequency) and qualitative (e.g., description of most severe events) data for verbal aggression, aggression against property, and aggression against others, as well as the level of distress and negative consequences resulting from these behaviors. The IED-I also contains questions aimed at assessing the qualitative experience of aggression including the presence/absence of several emotions (e.g., feeling angry, enraged, detached/unreal) or physical symptoms (e.g., racing heart, shortness of breath, tingling sensations) before, during, or after a typical aggressive outburst. Preliminary data show the IED-I to have good predictive validity and inter-rater reliability (Coccaro and McCloskey, 2004).

2.3. Procedure

All participants completed an hour long diagnostic interview conducted by trained graduate-level diagnosticians who were not informed about the study hypotheses. All diagnosticians were graduate students in clinical psychology that had in-depth training in the interviews. All interviews were video recorded and a licensed clinical psychologist or psychiatrist supervised all interviews. IED diagnoses were made using the IED-I. Personality disorders were assessed using the SIDP-IV. Non-IED Axis-I diagnoses were assigned using the SCID. All diagnosticians went through a rigorous training program that included lectures on DSM diagnoses and rating systems, videos of expert raters conducting IED-I/SCID/SIDP-IV interviews, and practice interviews and ratings until the raters were deemed reliable by the trainer. This process resulted in good to excellent inter-rater reliabilities (mean kappa of 0.84 $S.D. = 0.05$; range: 0.79–0.93) across psychiatric disorders. Final diagnoses were assigned by team best-estimate consensus procedures (Leckman et al., 1982) in which the diagnostic report was reviewed and agreed upon by a committee of research psychiatrists and clinical psychologists. This methodology has previously been shown to enhance the accuracy of diagnosis over direct interview alone (Kosten and Rounsaville, 1992).

2.4. Data analysis

We conducted preliminary analyses using ANOVAs, *t*-tests, and chi-square tests to compare the three diagnostic groups on the demographic variables and prevalence of psychopathology. Any

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