



Intermittent explosive disorder and eating disorders: Analysis of national comorbidity and research samples

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Abstract

Objective: Clinical studies suggest comorbidity between eating disorders and aggressive behaviors. This study examined the pattern of comorbidity between intermittent explosive disorder (IED) and eating disorders (ED).

Methods: Data were analyzed from both the adult and adolescent samples of the National Comorbidity Survey-Replication ($n = 19,430$) and a clinical research sample ($n = 1,642$).

Results: Lifetime prevalence of Any ED was elevated in IED vs. non-IED for both the community and clinical research samples. Though anorexia nervosa displayed no relationship with IED in either sample, bulimia nervosa was associated with IED in the community sample and binge eating disorder was associated with IED in both the community and clinical research samples. Onset of IED preceded onset of Any ED in at least 70% of comorbid IED/ED cases in both community and clinical research samples. Associations of IED with Any ED and bulimia nervosa in the community sample, and associations of IED with binge eating disorder in the clinical research sample, remained significant after controlling for other psychiatric disorders.

Conclusions: Individuals with IED are more likely to report lifetime prevalence of ED, particularly bulimic spectrum disorders. This finding, and the observation that the onset of IED occurs prior to the onset of ED in the majority of individuals, suggests that longitudinal studies are needed to clarify this relationship and determine whether IED is a risk factor for the development of ED. Early identification of individuals with IED or impulsive aggression may provide clinically useful information to determine most effective treatment interventions.

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1. Introduction

Clinical presentations of eating disorders (ED) are complex and diverse, and psychiatric comorbidities are commonplace among this population. Empirical evidence suggests that aggression and anger (the emotion corresponding to aggression) [1] are associated with ED [2,3], severity of ED symptoms [4], and poorer treatment outcomes [5]. Research also suggests that individuals with EDs have increased aggressive behaviors against others and a higher risk of self-directed anger and aggression (e.g., suicidality, self-injurious behaviors) compared to the general population [1,6]. Studies have revealed that individuals with ED have higher prevalence of anger attacks [3] and higher scores on measures assessing aggressiveness [7] compared to healthy controls. Furthermore, studies in community samples have reported that adolescents with eating disturbances are more

likely to report aggressive and disruptive behaviors [8–10], and have higher propensity to display aggressive behavior against others [11].

Aggressive behavior against others and self-directed anger and aggression increase the complexity of clinical presentations, and can significantly influence prognosis and treatment [1]. Additionally, anger and aggression may play a role in the onset and maintenance of ED [1,2,12], and are associated with the co-occurrence of other psychiatric disorders. Indeed, epidemiologic studies report that intermittent explosive disorder (IED) is present in individuals with ED, particularly bulimic spectrum disorders [13–16]. IED is characterized by recurrent, problematic, impulsive aggressive behavior [17]. Aggression in IED may be displayed as non-destructive or non-injurious, or as destructive and/or injurious [18]. However manifested, aggression in IED is impulsive and/or anger-based.

Although epidemiologic studies have suggested comorbidity of IED among individuals with ED [14–16], only one study has examined the prevalence of ED among adults with

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IED [19]. Findings from this study suggested that 1.7% and 2.5% of cases had comorbidity of IED and lifetime BN or BED, respectively. Moreover, approximately 50% of individuals with comorbid IED and ED reported that IED onset preceded onset of BN or BED.

Further examination of the relationship between ED and IED may provide a better understanding of underlying mechanisms contributing to the development and maintenance of ED. Thus, the current study aimed to extend previous research by examining categorical IED and ED, and continuous measures of aggression, in two U.S. community samples of adults and adolescents, as well as a clinical research sample of adults. Based on theoretical and empirical data, we hypothesized that: 1) individuals with IED would be more likely to report Any ED compared to individuals without IED; 2) in cases of current IED/ED comorbidity, age of onset of IED would precede that for ED; 3) associations between IED and ED would remain after accounting for other psychiatric disorders; and 4) participants with ED would have greater aggression scores compared to healthy controls or individuals with non-IED/non-ED psychiatric disorders but lower scores than participants with IED or IED/ED.

2. Methods

2.1. Sample

This study used cross-sectional data from two community samples (NCS-R and the National Comorbidity Survey – Adolescent Supplement [NCS-R-AS] Studies: $n = 19,430$) and a clinical research sample ($n = 1642$). For all samples, onset and course of IED and ED were based on self-reported data including retrospective assessments of age at onset and number of IED outbursts per year. Table 1 provides characteristics of the samples. There was a significant group difference in age, in that the community sample was significantly younger compared to the clinical research sample, $t(df = 21,070) = 8.39$, $p < 0.001$. This study was approved by the University of Chicago Institutional Review Board.

Table 1
Demographic characteristics of the samples ($N = 21,072$).

	Community sample ($n = 19,430$)	Clinical research sample ($n = 1642$)
Age (mean \pm SD)	29.3 \pm 19.1 years (range: 13–99)	33.3 \pm 9.9 years (range: 18–70)
Sex	46.9% Male	56.4% Male
Race/Ethnicity	63.5% White	54.3% White
	16.4% African-American	33.7% African-American
	14.4% Hispanic	5.7% Hispanic
	5.6% Other	6.4% Other
Education	15.8% < HS degree	25.2% < HS degree
	30.3% HS degree	13.5% HS degree
	24.3% Some college	28.6% Some college
	29.6% \geq College degree	32.7% \geq College degree

2.1.1. Community samples

The NCS-R and NCS-R-AS are nationally representative surveys of the prevalence and correlates of mental disorders in the United States (US). Fully structured and laptop computer-assisted interviews were administered face-to-face to a sample adults (ages 18 or older) and adolescents (ages 13–17) who were English-speaking and living in the non-institutionalized civilian household population of the coterminous US (excluding Alaska and Hawaii) between 2001 and 2004. Details regarding the design and acquisition of the two NCS-R samples have been published [20,21]. Participants in the current study ($n = 19,430$) were predominantly White (63.5%) and female (53.1%), with a mean age of 29.3 years ($SD = 19.1$; range = 13–99).

The NCS-R and the NCS-R-AS studies were designed to assign DSM-IV diagnoses [22]. However, raw data enabled an updating of DSM-IV to DSM-5 diagnoses. For the diagnosis of IED, participants reported at least three “anger attacks” in any given year with at least one in the past year (criteria A₂). In addition, “anger attacks” were out of proportion to the circumstances in which they occurred (criteria B); impulsive in nature (criteria C); associated with functional impairment and/or distress (criteria D); and occurred in the absence of other psychiatric disorders (criteria F). Finally, all participants were at least six years of age (criterion E).

2.1.2. Clinical research sample

The majority of participants ($n = 1642$) were White (56.4%) and male (56.4%), with a mean age of 33.3 years ($SD = 9.9$; range = 18–70). Details regarding the clinical research sample have been published [23]. Psychiatric and personality disorder diagnoses were made using DSM-5 criteria [17]. DSM-5 diagnoses were based on information obtained from: (a) the Structured Clinical Interview for DSM Diagnoses (SCID-I) [24] and the Structured Interview for the Diagnosis of DSM Personality Disorder (SIDP) [25]; (b) clinical interview by a research psychiatrist; and, (c) review of all other available clinical data. The research diagnostic interviews were conducted by individuals with a master’s or doctorate degree in clinical psychology after a rigorous training program including lectures on DSM diagnoses and rating systems, videos of expert raters conducting SCID/SIDP interviews, and practice interviews/ratings until the raters were deemed reliable with the trainer. This process resulted in good to excellent inter-rater reliabilities (mean kappa = $0.84 \pm .05$; range: 0.79–0.93) across anxiety, mood, substance use, impulse control, and personality disorders. Final DSM-5 diagnoses were assigned by team best-estimate consensus procedures involving research psychiatrists and clinical psychologists as previously described [18]. For participants with any psychiatric diagnosis ($n = 1189$), 58% ($n = 690$) reported a history of formal psychiatric evaluation and/or treatment, and 14% ($n = 166$) reported a history of behavioral disturbance during which the subject or others thought they should have sought mental health services but did not.

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