Case Report:

Intermittent Explosive Disorder

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Abstract

An interesting and rare case of intermittent explosive disorder (Impulse control disorder), was diagnosed and managed. In this case, the housewife, married two years back in a middle class family was brought to OPD by her husband, presented with explosive outbursts of violence and anger, which was not clearly directed. Following the act of aggression she always experienced a sense of gratification and relief. The episodes were recurrent and resulted in assaults, disturbances in interpersonal and family relationships. The aggression shown by the patient was out of proportion to any provocation and the patient experienced increasing tension and arousal before committing the act. The attack was often accompanied by irritability, rage, mood elevation, increased energy, and racing thoughts.

Keywords: Intermittent explosive disorder, gratification, racing thoughts

Introduction:

Intermittent explosive disorder comes under the impulse disorder as per the DSM-IV TR classification. This diagnosis has gone through many changes in all these years. In DSM-I (1952), would have been diagnosed as a passive aggressive personality, aggressive type. In 1968, DSM-II replaced the later with explosive personality, which, in turn, was eliminated by DSM-III (1980), in favor of intermittent explosive disorder. During the fashioning of DSM-III-R (1987), intermittent explosive disorder was, at first, deleted & then restored. The restored DSM-III-R diagnosis reflected the final conclusion of evaluators that psychosocial & environmental factors played a conclusive role in some cases of intermittent violent behavior. DSM-IV (1994) & DSM-IV-TR retain the DSM-III-R`s intermittent disorder; eliminate organic personality syndrome, explosive type; & redefine the exclusionary criteria (1). In 1938, Jean Etienne Esquirol proposed the term "Monomanies instinctive" to describe behaviors characterized by irresistible urges & without an apparent motive (2).

The disorder is characterized by 3 essential features: The failure to resist aggressive impulses that result in serious assaultive acts or destruction of property. The degree of aggressiveness expressed during the episodes is grossly out of proportion to any precipitating psychosocial stressor. The aggressive episodes are not better accounted by any other mental

disorder or under the effect of any substance or general medical condition. These individuals do not take the responsibility for their loss of control, but instead blame the victim. Patients work histories are poor; they report job losses, marital difficulties and trouble with the law. Lack of control is a central part of the problem, and inability to accept responsibility for the aggression helps to alleviate guilt. Anxiety, guilt, and depression usually follow an outburst, but this is not a constant finding (3). Impulsive behavior seems to have an underlying predisposition, which may or may not be related to existing mental health or medical conditions, but research over the past decade has stressed on the substantial co-morbidity of impulse control disorders with mood disorders, anxiety disorders, eating disorders, substance abuse, and personality disorders and with other specific impulse control disorders (4). It can be clinically difficult to differentiate them from other disorder that results in impulsivity. Traumatic brain injuries have resulted in some patients developing impulsive behaviors or impulse control disorders. This is true when the damage has been limited to the area of frontal cortex. Impulsivity is also commonly associated with substance abuse, but this is not included among the specific disorders of impulse control as defined in the DSM-IV-TR criteria. Moreover, researchers have observed that individuals who abuse multiple substances show greater impulsive behavior than those who abuse single substances (5). Impulse control disorders are often present in a number of specific personality disorders, primarily borderline, antisocial, substance intoxication, epilepsy, brain tumors, degenerative disorders and endocrine disorders. Impulsivity presents in the form of risk-tasking behaviors, sexual promiscuity, gestures and threats of self-harm, attention-seeking behaviors and can result in illegal or criminal behavior. The presence of concurrent co morbidities (e.g., psychosis, major mental illness, some personality disorders, substance abuse) increases the potentiality for dangerous, unpredictable and criminal behavior. This is particularly the case with intermittent explosive disorder (3, 4).

Case history:

A 26-year-old female was brought by her husband who presented with features of remaining upset, feeling down, having expressed guilt and entertaining thoughts of causing self-harm. Patient reports of intermittent explosive episodes associated with destruction of household property and injuries to self and others. Episodes occur very frequently once or twice every 2-3 days. She is having history of 8-10 episodes of self injury, two times she had cut on her breasts with blade, 2-3 times she bang her head in the wall, another times she took pills and cuts her wrist. She never reports her faults for any of the episodes and blames her in-laws for all that. She was fired from teaching job from school on grounds of beating children and explosive behavior for small issues in the class. On repetitive counseling's by the family members she never accepts her faults and blames on them for every episode. She never reported features of psychosis, manic episode, substance abuse, antisocial and borderline personality disorder, attention deficit hyperactivity disorder, obsessive compulsive disorder or general medical condition. Thorough general and systemic evaluations were non-significant. Routine hematological and other parameters were within normal limits. Computed tomography (CT) scans and electroencephalogram (EEG) reports turned out normal. Mental status examination revealed her to be a depressed individual

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who had passive suicidal ideations. No thought or perceptual disorders were reported. Psychometric tests revealed the following:

- Rorschach test revealed impulsivity, poor ego strength, and low productivity.
- Personality inventory revealed her to be irritable, with impulsive traits, and a sad mood.
- BDRS score of 10, which showed mild depression.
- Bender Gestalt test:Organizational disturbances and poor visuomotor sequencing.

She was managed with pharmacotherapy and psychotherapy. Started with risperidone 2 mg, fluoxetine 20 mg and oxcarbamezapine 300 mg/day and gradually tapered to 2 mg of risperidone, 60 mg of fluoxetine and 1200 mg of oxcarbamezapine. Simultaneously she was prepared for psychotherapy and started with behavioral therapy in the form of relaxation technique, anger management, delay in action and improving coping skills. Gradually, her spouse was also introduced in the therapy, which was beneficial. After 8 months of follow-up, the patient gained good control over her impulses and reported only few episodic anger outbursts. There was out of depression and suicidal ideas. She is maintained on same regime and doing well.

Discussion:

As seen in this case, the symptoms were markedly present on the background of a presumptive stress. The case was more interesting for its rarity of the condition. The diagnosis is always determined after ruling out organic components and other psychogenic diagnosis (4, 6). The diagnostic process consisted of thorough medical history, physical examination and full mental status examinations. It is noteworthy that not all cases of intermittent explosive disorder have a favorable prognosis. Most of the patient would be having a co morbid psychiatric disorder or would be receiving treatment in a non-psychiatric set-up, leading to chronicity. Many patients, at times, caught by the hands of the law and the illness goes undiagnosed and untreated (7).

References:

1. Comprehensive Textbook of Psychiatry by Kaplan & Sadocks 9th edition , 2009 , 32-56
2. Esquirol, E. (1938) Des Maldies Mentables, Paris, France, Baillier , 2007,65-90
3. Kaplans and Sadocks: Synopsis of psychiatry, tenth edition. www.synopsisof psychiatry.com
4. Case report on intermittent explosive disorder by Amitabh Saha Ind PJ.2010; 19(1): 55-57.
5. Schmidt CA, Fallon AE, Coccaro EF. Assessment of behavioral and cognitive impulsivity: Development and validation of the lifetime history of impulsive behaviors interview. Psychiatr Res.2004; 126:107–21.
6. McElroy SL, Pope HG, Jr, Keck PE, Jr, Hudson JI, Philips KA, Strakowski SM. Are impulse-control disorders related to bipolar disorder? Compr Psychiatry. 1996; 37:229.
7. Leong GB. A psychiatric study of persons charged with arson. J Forensic Sci. 1992; 37:1319–26.

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