



# Verbal versus physical aggression in Intermittent Explosive Disorder



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## ABSTRACT

Intermittent Explosive Disorder (IED) is the only adult psychiatric diagnosis for which pathological aggression is primary. DSM-IV criteria focused on physical aggression, but *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) allows for an IED diagnosis in the presence of frequent verbal aggression with or without concurrent physical aggression. It remains unclear how individuals with verbal aggression differ from those with physical aggression with respect to cognitive-affective deficits and psychosocial functioning. The current study compared individuals who met IED criteria with either frequent verbal aggression without physical aggression (IED-V), physical aggression without frequent verbal aggression (IED-P), or both frequent verbal aggression and physical aggression (IED-B) as well as a non-aggressive personality-disordered (PD) comparison group using behavioral and self-report measures of aggression, anger, impulsivity, and affective lability, and psychosocial impairment. Results indicate all IED groups showed increased anger/aggression, psychosocial impairment, and affective lability relative to the PD group. The IED-B group showed greater trait anger, anger dyscontrol, and aggression compared to the IED-V and IED-P groups. Overall, the IED-V and IED-P groups reported comparable deficits and impairment. These results support the inclusion of verbal aggression within the IED criteria and suggest a more severe profile for individuals who engage in both frequent verbal arguments and repeated physical aggression.

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## 1. Introduction

Although aggression is a recognized global health concern (Krug et al., 2002), and most aggression is affective in nature (Averill, 1983), there exists only one psychiatric diagnosis for which affective aggression is the core symptom: Intermittent Explosive Disorder (IED). According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), IED is defined as the failure to resist aggressive impulses that result in repeated acts of verbal and/or physical aggression (American Psychiatric Association, 2013). The inclusion of verbal aggression represents a major change over previous iterations of IED in the DSM.

IED is both common, with lifetime prevalence rates of 5.4–7.3% (Kessler et al., 2005, 2006; Coccaro et al., 2005; Ortega et al., 2008), and highly impairing. IED is associated with substantial distress, health problems, troubled relationships, occupational difficulty, and legal or financial problems (McElroy et al., 1998; McCloskey et al., 2010). Individuals with IED are rated as lower in overall psychosocial functioning than healthy volunteers or psychiatric

controls (McCloskey et al., 2006, 2008a). In addition, IED has been associated with several cognitive-affective deficits, including poor impulse control and affect dysregulation.

Individuals with IED report increased impulsivity on self-report measures, but do not appear more impulsive on validated laboratory tasks of impulsivity (Coccaro et al., 1998; Best et al., 2002). An argument could be made that the heterogeneity of “impulsivity” across measures (Evenden, 1999; Whiteside and Lynam, 2003) is likely to be responsible for this inconsistency. However, the relationship between IED and general impulsivity has been ephemeral even within the same measure (e.g., Barratt Impulsivity Scale (BIS)) (Coccaro et al., 1998; Best et al., 2002). This suggests that IED may not be wholly characterized as a problem of impulse control and that the aggressive outbursts may be more related to other constructs, such as emotion regulation. Individuals with IED have difficulty regulating their behavior under periods of extreme stress or intense emotion, particularly anger (Davidson et al., 2000; Siever, 2008). This difficulty regulating emotion does not appear to be limited to anger; IED is significantly associated with deficits in overall affect regulation relative to both healthy volunteers and other psychiatric populations (Coccaro et al., 1998; McCloskey et al., 2006, 2008b).

Despite marked cognitive-affective deficits and psychosocial impairment, empirical research on IED has been limited. This is

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partially due to a lack of congruence in defining the disorder. Prior to DSM-5, an IED diagnosis was limited to individuals who reported physical aggression. This may be related to the fact that physical aggression is often considered more severe than verbal aggression (e.g., [Salari and Baldwin, 2002](#)). However, studies showed that individuals with frequent verbal aggression (i.e., two or more times a week for a month or more) reported similar levels of anger, aggression, and impairment comparable to their IED counterparts, most of whom had high levels of both verbal and physical aggression ([McCloskey et al., 2006](#); [Coccaro, 2011, 2012](#)). These findings have, in part, led to the inclusion of verbal aggression in DSM-5 IED. However, there has been limited research comparing “pure” verbal and physical sub-types of IED. [McCloskey et al. \(2008a\)](#) found no differences between an IED group with both physical and verbal aggression and a verbally aggressive group on measures of trait aggression, trait anger, and clinical impairment, with both groups showing more aggression, anger, and impairment than a psychiatric control group. However, no study to date has directly compared individuals with pathological physical (but not verbal) aggression to those with pathological levels of verbal (but not physical) aggression. Understanding how these aggressive groups differ in terms of cognitive-affective functioning and psychosocial impairment will provide important insight into the homogeneity of the IED diagnosis ([Coccaro and Kavoussi, 1997](#); [Coccaro et al., 1998](#)).

The current study examined areas of increased cognitive-affective deficits and psychosocial impairment in three distinct groups of individuals with IED: (1) individuals meeting for IED verbal aggression (i.e., verbal outbursts, such as heated arguments, yelling and cursing, occurring on average at least twice a week for 3 months or more; IED based on only verbal aggression (IED-V group), (2) individuals meeting IED physical aggression criteria (i.e. either three assaults on people, animals, or property with damage/injury over a 12 month period or an average of two assaults on people, animals or property without injury/damage a week for 3 months; IED based on only physical aggression (IED-P group), (3) individuals met both physical and verbal IED criteria; IED based on both verbal and physical aggression (IED-B group). The three IED variants were compared to each other as well as to a psychiatric control group consisting of individuals diagnosed with a personality disorder, including personality disorder not otherwise specified, who did not meet any of the DSM-5 IED aggression criteria (personality-disordered (PD) group). All participants were assessed for the severity of deficits in anger, anger dyscontrol, and aggression using a multi-method approach that included behavioral, questionnaire, and clinical interview measures. Putative associated constructs of affective lability, impulsivity, and psychosocial functioning were also assessed.

It was predicted that IED-V participants would report less physical aggression than the other IED groups, whereas IED-P participants would report less verbal aggression than the other IED groups. No other differences were expected among IED groups on measures of anger, anger dyscontrol, and aggression. Further, it was expected that all IED groups would show higher levels of anger, anger dyscontrol, and aggression relative to the PD control group. Lastly, it was predicted that all IED groups would show decreased psychosocial functioning and increased levels of affect lability and impulsivity compared to the PD control group, but not differ from each other on these constructs.

## 2. Methods

### 2.1. Participants

Participants were 134 men and 168 women between the ages of 18 and 65 ( $M=37.27$ ,  $S.D.=9.80$ ) recruited from the community via advertisements for healthy volunteers and individuals with emotional or anger problems as a part of

larger ongoing studies of aggression, anger, and personality at the University of Chicago. Participants were excluded if they reported (a) current psychopharmacological treatment or substance dependence, (b) lifetime bipolar or psychotic disorder, (c) a traumatic head injury with loss of consciousness greater than 1 h, or (d) current major depression. This study was approved by the University of Chicago Institutional Review Board. Participants were predominately Caucasian (62.3%) or African-American (27.2%). Diagnostic groups consisted of: (a) IED-V ( $n=41$ ), (b) IED-P ( $n=60$ ), (c) IED-B ( $n=111$ ), and (d) PD ( $n=90$ ).

### 2.2. Psychiatric Interview Measures

The Intermittent Explosive Disorder Interview (IED-I; [Coccaro, 2005](#)) was used to assess DSM-5 IED. Structured Clinical Interview for the DSM-IV (SCID; [First et al., 1996](#)) to diagnose non-IED Axis I disorders, and Structured Interview for DSM-IV Personality (SID-P; [Pfohl et al., 1995](#)) to diagnose personality disorders. In addition, the Aggression scale of the Life History of Aggression (LHA-A; [Coccaro et al., 1997](#)) was administered to assess lifetime (since age 13) frequency of aggressive acts (i.e., temper tantrums, physical fights, verbal aggression, physical assaults on other people [or animals], and assaults on property), and a Global Assessment of Functioning (GAF) score was assigned after the interview.

### 2.3. Self-ratings of aggression and associated constructs

*Buss-Perry Aggression Questionnaire (BPAQ; Buss and Perry, 1992)* is 29 items self-report measure of trait aggressiveness that includes of four scales: physical aggression, verbal aggression, anger, and hostility.

*State-Trait Anger Expression Inventory-2 (STAXI-2; Spielberger, 1999)* is a 57-item self-report measure of anger and anger expression/control. Four STAXI-2 scales were used in the current study: Anger Expression-Out (AX-O) and Anger Expression-In (AX-I) which measure how often angry feelings result in aggression and anger suppression, respectively. Anger Control-Out (AC-O) and Anger Control-In (AC-I) scales assess how often individuals attempt to reduce anger and express it constructively.

*Barratt Impulsivity Scale 11 (BIS-11; Patton et al., 1995)* is an internally consistent ( $\alpha=0.79-0.83$ ) 34-item questionnaire of impulsive personality traits in the areas of motoric, attentional, and non-planning impulsiveness.

*Affective Lability Scale (ALS; Harvey et al., 1989)* is a 54-item questionnaire that assesses propensity to change affective state (higher scores indicate greater affective lability). The ALS contains six scales, four scales that assess lability from euthymia to anger, anxiety, hypomania, and depressed mood and two scales measure vacillation between depression and hypomania (biphasic) and anxiety and depression (anxiety/depression).

*Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q; Endicott et al., 1993)* is a self-report quality of life measure. For this study, the 15-item Summary scale of the Q-LES-Q was used.

### 2.4. Behavioral measures

*Taylor Aggression Paradigm (TAP; Taylor, 1967)* is a well-validated ([McCloskey and Berman, 2003b](#)) laboratory measure of retaliatory aggression. In this task, the participant competes against a fictitious opponent in a reaction-time game during which electric shock is administered and received. Before each trial, the participant selects a shock level for the opponent to receive should the participant have a faster reaction-time on that trial. Aggression is defined as the intensity of the shock selected. In the current study, the dependent variables were defined as both the mean shock selection and the number of extreme (20) shock selections across four provocation blocks.

*Immediate Memory Task (IMT; Dougherty and Marsh, 2003)* is a behavioral measure of motor impulsivity that consists of a series of briefly presented five-digit numbers on a computer monitor. Subjects are instructed to respond when the five-digit number they see is identical to the one that preceded it. On a third of the trials, the stimulus is a number that differs from the preceding number by only one digit (its position and value determined randomly). Responses to catch stimuli are recorded as commission errors, which are believed to reflect motor impulsivity in this task. The proportion of commission errors to correct detections, known as the IMT ratio, is the primary dependent measure of impulsivity for this task ([Dougherty et al., 2008](#)).

### 2.5. Procedure

On visit 1, participants completed a 3–4 h diagnostic interview that included the IED interview, SID-P, SCID, and LHA-A. Diagnosticians also assigned a GAF score after the interview. All interviews were conducted by trained graduate-level diagnosticians who were not informed about the study hypotheses. Diagnosticians underwent a rigorous training program, which resulted in good to excellent inter-rater reliabilities ( $K=0.84 \pm 0.05$ ) across Axis I and Axis II disorders. Final diagnoses were assigned by team best-estimate consensus procedures ([Klein et al., 1994](#)).

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