



Social desirability, deceptive reporting, and awareness of problematic aggression in intermittent explosive disorder compared with non-aggressive healthy and psychiatric controls

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ABSTRACT

Individuals with DSM-5 Intermittent Explosive Disorder (IED) are often suspected of minimizing the nature of their recurrent, problematic, impulsive aggressive behavior due to the social undesirability of these behaviors. Our first study involved 400 study participants categorized as Healthy Controls (HC), Psychiatric Controls (PC) and as having IED and included the Crowne-Marlowe Social Desirability Scale (SDS), the Lie Scale from the Eysenck Personality Questionnaire-Revised (EPQ-R Lie), and the Readiness to Change (Anger) Questionnaire (RTC). IED study participants had lower SDS and lower EPQ-R Lie scores, while having higher RTC scores, compared with both HC and PC study participants. Thus, when studied in a clinical research setting, IED study participants do not provide socially desirable answers to questions and do not engaging in deceptive reporting; likely because they have recognized their need/interest in reducing their own impulsive aggressive behavior. The second study, part of a family study of 70 probands and their first-degree relatives revealed a very high positive (96.3%), but substantially lower negative (55.8%), predictive power for IED based on informant report. This suggests that, while interview of close informants can confirm the diagnosis of IED, informant interviews cannot rule out IED when such informants provide a negative report.

1. Introduction

The DSM-5 characterizes Intermittent Explosive Disorder (IED) as the presence of recurrent impulsive aggressive outbursts associated with distress and psychosocial dysfunction not better explained by other disorders or conditions (Coccaro, 2012; American Psychiatric Association, 2013). The body of evidence for the validity of IED as a diagnostic representation of problematic impulsive/affective aggression has grown over the last two decades (Coccaro et al., 2017) and the management and intervention of impulsive aggression remains of significant clinical and social relevance (Heise et al., 1994; Olson 2004; Olvera 2002). Despite this, the low incidence of IED presenting for treatment in clinical settings (Coccaro et al., 2005; Hawkins and Cogle, 2011; Kessler et al., 2006) in conjunction with the social undesirability of impulsive aggression have led some to question, among other issues (Zapata and Palacio, 2016), whether the information individuals with IED provide during evaluation and treatment underestimates their degree of impulsive aggression. This is critical because, apart from the associated experiences of interpersonal guilt, impulsive aggressive behaviors are socially undesirable in and of themselves

(Olson 2004; Piquero et al., 2014). Accordingly, extant investigations of IED have sometimes been critiqued for using data that comes only from the individual with IED, who may minimize aspects of their behavior, or who may fail to disclose relevant diagnostic information. While some investigations have explored the dispensability of self- or clinician-reports altogether, these studies, at the same time, provide evidence that both sources provide clinically useful information in generating a diagnosis (e.g., Uher et al., 2012). Another potential method is archival records of violence (e.g. arrests for violent behavior). However, even among individuals with clinically pathologic aggression, most report little formal history of legal issues (Kulper et al., 2015), highlighting the lack of sensitivity of archival records.

A further methodological consideration is that subjects choosing to participate in research on aggression, as for any topic, may do so for interests beyond scientific inquiry. Motivations for research participation can vary widely (Nappo et al., 2013). Initially, curiosity motivates many subjects to participate in clinical research (Castillo et al., 2012), though motivations often shift to those of altruism and/or personal gain. That said, most investigations of social-behavioral phenomena require interview and/or questionnaire based data collection to varying

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degrees. Such methods rely on the willingness and ability of respondents to answer honestly. This limitation is of particular relevance to those who may display otherwise socially undesirable behavior (Levine et al., 2003; Piquero et al., 2014). However, while some areas of investigation are adopting new technologies (e.g., Newman et al., 2002) and assessment tools (e.g., Sandvik et al., 1993) to strengthen, and in some cases, bypass (e.g., Nock et al., 2010), the use of such data, self-report interviews and questionnaires remain among the primary methods of inquiry in social and biomedical research. Thus, the accuracy of patient responses can be appropriately questioned in the empirical study of symptoms that are typically considered socially undesirable and it behooves researchers to evaluate the veracity and reliability of information collected in the context of studying socially undesirable behaviors.

The present paper explores response biases on assessments involving self-disclosure among participants with and without DSM-5 IED. In Study 1, we assessed the tendency of study participants to show an explicit (i.e. social desirability) and/or more implicit / subtle (i.e. deception) positive response biases. In addition, we assessed “readiness to change” one’s own problematic anger in order to gauge whether such impulsive aggressive behavior was viewed as ego-syntonic or ego-dys-tonic. We hypothesized that study participants with DSM-5 IED, recruited from the community, would display equal (or lower) scores on measures of social desirability, deceptive reporting, and higher scores regarding readiness to change in terms of problematic anger, compared with healthy and psychiatric controls. In Study 2, as a complementary approach to the question of behavioral minimalization among those with IED, we examined the level of agreement between study participants (probands) and corroborating sources (informants) regarding the specificity and sensitivity of the subject’s symptom reports and diagnosis specifically for IED and for other DSM-5 disorders for comparison purposes. We hypothesized that the diagnosis of IED based on our direct interviews would display high specificity with IED diagnoses based on interviews with first-degree family informants.

2. Study 1

2.1. Methods

2.1.1. Study participants

Four-hundred adult individuals participated in Study 1. All participants were physically healthy and were systematically evaluated in regard to aggressive and other behaviors as part of a larger program designed to study correlates of impulsive aggressive, and other personality-related, behaviors in human participants. Participants were recruited through public service announcements, newspaper, and other media, advertisements seeking out individuals who: a) reported psychosocial difficulty related to anger or, b) had little evidence of

psychopathology. Participants were recruited until we had 100 healthy control, 100 psychiatric control, and 200 DSM-5 IED study participants; a sample size designed to have 80% power to detect a small-sized effect (e.g., $f \leq 0.15$) between IED and control study participants at an alpha level of 0.05. All study participants gave informed consent and signed the informed consent document approved by our Institutional Review Board.

2.1.2. Diagnostic assessment

Psychiatric diagnoses were made according to DSM-5 criteria (American Psychiatric Association, 2013). Diagnoses were made using information from: (a) the Structured Clinical Interview for DSM Diagnoses (SCID-I; First et al., 1995) for syndromal (formally Axis I) disorders and the Structured Interview for the Diagnosis of Personality Disorder (Pfohl et al., 1997) for personality (formally Axis II) disorders; (b) clinical interview by a research psychiatrist; and, (c) review of all other available clinical data. Research diagnostic interviews were conducted by individuals with a masters, or doctorate, degree in Clinical Psychology. All diagnostic raters went through a rigorous training program that included lectures on DSM diagnoses and rating systems, videos of expert raters conducting SCID/SIDP interviews, and practice interviews and ratings until the rater were deemed reliable with the trainer. This process resulted in good to excellent inter-rater reliabilities (mean kappa of 0.84 ± 0.05 ; range: 0.79–0.93) across anxiety, mood, substance use, impulse control, and personality disorders. Final diagnoses were assigned by team best-estimate consensus procedures involving research psychiatrists and clinical psychologists (Coccaro et al., 2012). While information for assigning syndromal diagnoses were collected through the use of the SCID-1, more than sufficient information from was available to update syndromal diagnoses from DSM-IV to those of DSM-5; DSM-5 diagnoses for personality disorder, based on the SIDP, are the same for DSM-IV. Finally, participants with a current history of a substance use disorder or a life history of bipolar disorder, schizophrenia (or other psychotic disorder), or mental retardation were excluded from study, because, by definition, IED participants cannot have such comorbidity.

One-hundred participants had no evidence of any psychiatric diagnosis (Healthy Controls: HC); one-hundred participants met criteria for a lifetime diagnosis of a syndromal psychiatric disorder or personality disorder other than IED (Psychiatric Controls: PC), and two-hundred participants met criteria for a current DSM-5 diagnosis of intermittent explosive disorder. Of the three hundred participants with a psychiatric history, most ($n = 220$, 73.3%), subjects reported a history of behavioral disturbance during which the subject, or others, thought they should have sought mental health services but did not, and 59% subjects reported a history of formal psychiatric evaluation and/or treatment. Prevalence of syndromal and personality disorder diagnoses are listed in Table 1.

Table 1

Demographic, functional, and psychometric characteristics of Study 1 participants.

	HC (N = 100)	PC (N = 100)	IED (N = 200)	P*	Group Differences
<i>Demographic variables</i>					
Age	31.3 ± 8.8	34.4 ± 10.0	37.7 ± 9.7	< 0.001	HC < PC < IED ^a
Gender (% Male)	50.0%	51.0%	52.5%	= 0.914	HC = PC = IED ^b
Race (% White)	62.0%	62.0%	54.0%	= 0.173	HC = PC = IED ^b
SES score	44.5 ± 12.8	37.4 ± 15.7	38.6 ± 13.0	< 0.001	HC > PC > IED ^a
<i>Psychosocial function</i>					
GAF score	83.1 ± 5.0	68.2 ± 12.0	55.9 ± 9.0	< 0.001	HC > PC > IED ^a
<i>Psychometric variables</i>					
Aggression: LHA	5.0 ± 3.5	8.4 ± 4.9	18.4 ± 4.2	< 0.001	IED > PC > HC ^a
Aggression: BPA	29.6 ± 10.7	32.8 ± 10.7	44.9 ± 12.7	< 0.001	IED > PC > HC ^a
Impulsivity: LHIB	23.9 ± 16.9	37.2 ± 19.6	54.3 ± 18.8	< 0.001	IED > PC > HC ^a
Impulsivity: BIS-11	55.0 ± 16.9	62.5 ± 10.6	68.6 ± 11.3	< 0.001	IED > PC > HC ^a

^a By Chi-Square.

^b by ANCOVA with demographic variables as covariates.

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