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“MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS”

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“MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS”

3 CEU Credit Hours

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Course Description:

This course provides an intensive overview of the multiple Impulse Control disorders as outlined in the DSM, and discusses assessment and diagnosis methods, psychotherapeutic treatment approaches, pharmacological treatment options, epidemiology, etiology, and legal perspectives.

Course Objectives:

- 1.) Identify impulse disorders as specified in the DSM.
- 2.) Understand the pharmaceutical options available in the treatment of impulse disorders.
- 3.) Describe the role of psychotherapy and social supports with the impulse control disordered clients.
- 4.) Choose appropriate standardized assessments for evaluating clients.

Purpose of this course:

The purpose of this CEU course is to provide discussion relevant to the mental health counselor on assessment treatment issues concerning impulse disorders.

Course Outline:

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Administration and Completion of the Evaluation of Learning Quiz

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3 Clock Hours / CE Credits



Your instructor is **Richard K. Nongard**, a Licensed Marriage and Family Therapist, Certified Clinical Hypnotherapist and a Certified Personal Fitness Trainer.

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MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS

Course Outline:

- a- Introduction
- b- What are impulse control disorders?
- c- Assessment and evaluation of impulse control disorders
- d- Epidemiology
- e- Intermittent explosive disorders
- f- Kleptomania
- g- Pyromania
- h- Trichotillomania
- i- Pathological gambling
- j- Impulse control disorders not elsewhere specified
- k- Problematic Internet use
- l- The role of psychotherapy in ICD
- m- The legal perspective of impulse control disorders:

Introduction:

Throughout the past few years, impulsive control disorders (ICDs) have attracted the attention of clinicians and psychiatrists due to their impact on the society. Interestingly enough, the rapid advancement of technology and its effects on the society is incriminated to be the cause for the rise in the prevalence of ICDs. The advent of the Internet has created unlimited access to gambling, shopping, porn and stock trading; thus, the incidence of impulsive behavior patterns has risen sharply. Even more, new forms of impulsive disorders have emerged such as Internet addiction. With the increasing number of states which have legalized gambling (48 states now) and the rising popularity of online gambling, the incidence of pathological gambling in the United States has risen rather sharply. Furthermore, retail goods lost to shoplifting totaled more than 10 billion dollars in 2002 (Hollinger and Davis, 2003).

20 years ago, some psychiatrists suggested categorizing impulsive disorders as a part of obsessive/compulsive disorders due to the similarity between them regarding genetic predisposition and responsiveness to both psychosocial and pharmacological interventions.

However, after a decade of research, the fourth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) placed impulse control disorders in a separate category and defined them as disorders with inability to resist an impulse, temptation or a drive to do an action that can harm the person or others around him/her. According to this definition, an impulsive act is not thought of or premeditated and the patient has minimal or no control.

The DSM-IV-TR classifies impulsive disorders as follows:

1- Impulse control disorders not elsewhere classified:

- a- Intermittent explosive disorders
- b- Pyromania
- c- Kleptomania
- d- Pathological gambling
- d- Trichotillomania

2- Impulse control disorders not otherwise specified:

- a- Impulsive compulsive self injurious disorders
- b- Impulsive compulsive sexual disorders
- c- Impulsive compulsive buying disorders
- d- Impulsive compulsive Internet usage disorders

3- Other disorders marked by impulsivity:

- a- Binge eating disorders
- b- Bulimia nervosa
- c- Childhood conduct disorders
- d- Paraphilias: exhibitionism, fetishism, frotteurism, pedophilia, sexual masochism, sexual sadism, transvestic fetichism, voyeurism and paraphilia not otherwise specified.

4- Bipolar disorders

5- Attention deficit hyperactivity disorders

6- Substance abuse disorders

7- Cluster B personality disorders

8- Neurological disorders with disinhibition.

The DSM-V is expected to be published in May 2013. The preliminary drafts of the diagnostic criteria of the DSM-V are available for public review. The categorization of some impulse control disorders is expected to be modified. Pathological gambling is proposed for possible reclassification. Trichotillomania is proposed for possible placement in another diagnostic group of disorders.

Even though impulsivity can sometimes be a clinical problem, it is a main characteristic of the normal human behavior. Impulsivity is reflected in the behavior of an individual through carelessness, a sense of underestimation of harm, impatience, extroversion, tendency to take risks and failure to accept delay of rewards and gratifications. An impulse is considered pathological when the individual fails to resist it and/or its expression. Impulses as core symptoms of impulse control disorders should be distinguished as either mere symptoms or manifestations of a distinct disorder.

What are impulse control disorders?

An impulse, as defined by Oxford's dictionary, is a strong and unjustified urge or desire to do a certain act. Almost every normal individual acts on impulses at a point or another in his/her life. Nevertheless, individuals, who have developed a pattern of acting on impulses, usually experience problems with impulsivity. Impulsivity is defined as tendency to perform actions with less consideration, of the benefits and consequences of the act, than do individuals with similar abilities and/or knowledge.

Impulsivity is also defined as tendency to perform rapid unplanned responses to provoking external and internal stimuli regardless of the undesirable consequences of these responses. By definition, both impulse control disorders and impulsivity are closely interrelated, as they involve a behavioral pattern in which one often acts on impulses that may yield negative consequences.

Impulsivity is controlled by three major cognitive components which are all stressful for an individual who suffers from an impulse control disorder. These factors are as follows:

- 1- *Failure to delay gratifications.* An individual with an impulse control disorder often takes decisions that are aimed at seizing an immediate gain without considering the long term unfavorable consequences of his/her decisions and regardless of how trivial this gain might be.
- 2- *Distractibility:* failure to maintain continuous attention on a certain task.
- 3- *Disinhibition:* the inability to suppress behavior in a way that is expected to be appropriate in view of social norms and constraints.

Patients who suffer from impulse control disorders often experience a heightened sense of tension or arousal before performing the act. Furthermore, these patients report feeling happy, satisfied or released when performing the act. However, sometimes the patient feels guilty after the performing the act.

Assessment and Diagnosis of Impulse Control Disorders:

Many individuals exhibit impulsive symptoms such as self injurious behavior or gambling; hence, it is pivotal to carefully assess if these symptoms are manifestations of another psychological disorder or a particular impulse control disorder. For instance, not all forms of gambling behavior are pathological and it is crucial to differentiate pathological gambling from recreational or professional gambling. Professional and/or recreational gamblers are capable of estimation of the odds or risks, are successful in controlling the impulse to gamble and exhibit not functional impairment due to their gambling behavior. On the contrary, pathological gamblers are not able to control their behavior which interferes with their lives. They may lose their jobs, spouses and savings.

Presently, few measures are available to carefully assess impulse control disorders. The majority of the used measures, such as the Overt Aggression Scale Modified (OAS-M) and the Barratt Impulsiveness Scale Version 11 (BIS-11) are directed to evaluation of symptoms of impulsivity and/or aggression. Other assessment scales, such as the Psychiatric Institute Trichotillomania Scale and the South Oaks Gambling Screen are utilized for screening of gambling and trichotillomania. Self report scales of assessment such as the Hostility and Direction of Hostility Questionnaire (HDHQ), the Buss-Durkee Hostility Inventory (BDHI) and the Spielberger State Trait Anger Expression Inventory (STAEI) primarily evaluate symptoms of impulsive aggression.

Furthermore, some of the scales that were initially developed to evaluate obsessive compulsive disorders (OCD), e.g. the Yale Brown Obsessive Compulsive Scale (Y-BOCS), have been partially modified and used to evaluate the severity of some impulse control disorders (Y-BOCS) such as pathological gambling, kleptomania and sexual compulsions.

The BIS-11 evaluates impulsivity on 3 scales; non-planning impulsiveness, motor impulsiveness and attention impulsiveness. Through evaluation of the patient's symptoms in terms of the aforementioned scales, the BIS-11 is effective in providing a description of impulse control symptoms in otherwise normal individuals. The BIS-11 is a form of clinician rated scale which is usually completed in approximately 10 to 15 minutes. When performed on undergraduates, the BIS-11 score averaged 46, while male prisoners averaged 76 (Patton et al., 1995). The BIS-11 is one of the most commonly used scales to evaluate impulsivity because it is a simple scale to use; nonetheless, in severe cases its sensitivity is quite low. Moreover, the test is more directed towards population of the middle class.

The OAS-M is a form of an interview which is designed to evaluate the frequency and severity of aggressive behavior. The OAS-M evaluates levels of aggression in terms of four subscales; assault against self, verbal assault, assault against others and assault against objects. This test is usually used to evaluate the severity of impulsive aggression (Endicott et al., 2002).

Self report assessment scales include the HDHQ, the BDHI and the STAEI. Just as their names denote, all three scales are used to evaluate impulsive aggressive behavior by means of questions and items. The BDHI comprises 75 true or false questions which are categorized into eight subscales that are directed to evaluate aggression, hostility and danger. The main goal of the scale is to delineate the different components of hostility in terms of overall characteristics and its correlation with psychological disorders.

Despite the fact that BDHI is the oldest and best known hostility scale, it has no well-established norms; hence, interpretation of individual results is somehow difficult. The scale was criticized for focusing on inner feelings of aggression, which aggressive patients often misrepresent, and overlooks, to some extent, severe aggressive forms of behavior. On the contrary, the BDHI has a relatively high test-retest reliability which qualifies it to be an effective tool in psychological research.

The Anger, Irritability and Assault Questionnaire (AIAQ) is a rather long scale that is utilized for evaluation of aggression. Similarly to the BDHI, it is a self report form of scale. The AIAQ consists of 210 items that are weighed on a scale of one to four and every question item is rated in correlation to three time frames (last week, last month and throughout adulthood). The scale still doesn't have universal norms and in most cases, takes about 50 minutes to be completed. Many researches have proven that the AIAQ is a useful tool in the evaluation of impulsive aggressive behavior and it is appropriate for use in both research and clinical settings.

Many psychiatrists agree that careful measurement of impulsivity is somehow difficult, specifically because large discrepancy exists between an observer's report and a self report. Due to the fact that impulsivity is socially unacceptable, some patients are likely to answer scale questions untruthfully. Moreover, a patient may not seem or act as impulsively in an interview, as he/she would do in public or at home. Even more, a patient might act even more antagonistically during an interview as a consequence to the inherent stresses that are related to the interview. Accordingly, it is strongly advised to evaluate impulsivity using both types of scales; self report and observer's report.

Epidemiology:

The prevalence of impulse control disorders varies significantly with the subtype of the disorder. For instance, the incidence of intermittent explosive disorders varies according to age. Recent studies have shown that the prevalence was approximately 7.4% for individuals between 30 and 44 years of age, while it was only 5.7% for those between 30 and 44 years and dropped to 4.9% for those between 45 and 59 years (McCloskey et al., 2010).

It is rather hard to determine the prevalence of almost all other impulse control disorders because individuals who suffer from these disorders often attempt to conceal their behavior from others to prevent the "shame" of being detected. However, pathological gambling has been extensively studied and its prevalence is estimated to range between 1% and 3% among American adults. Pathological gambling often starts in adolescence when the prevalence is even higher ranging between 4% and 7%.

Although research data indicate that most individuals with kleptomania are identified, small percentages are never identified and even when they are caught, they may not be punished; hence, most of the data available is derived from studies performed on individuals who seek treatment and/or admit they have a problem.

A few surveys have estimated the prevalence of trichotillomania to be approximately 3.4% among adult women and 1.5% among adult men, but only 1% of those exhibit the criteria of a psychiatric disorder. Almost all surveys and studies which investigated pyromania were performed on children and adolescents. Data imply that the incidence of pyromania is approximately 3% among children and adolescents. However, recent studies have proven that some individuals with pyromania set fires in private places such backyards and vacation lots where they perform the compulsive act privately. Such individuals are only identified when they admit of having a problem. Generally speaking, the prevalence of pyromania is highly underestimated.

Intermittent Explosive Disorders:

Three key elements are needed for the diagnosis of intermittent explosive disorders. These are:

- 1- Repeated violent or aggressive acts that lead to assault of another person or sabotaging of property.
- 2- Disproportion of the aggressive response to the triggering stimulus that preceded the act.
- 3- Absence of another DSM-IV-TR disorder or a medical disease that could precipitate attacks of aggression.

The consequences of anger in patients with intermittent explosive disorders are often prominent on the patient themselves and the people around them. In many instances, patients end up in jail, unless they admit they have a serious problem, get professional help and work hard to learn how to control their "inappropriate" rage.

Example:

Kevin is diagnosed with an intermittent explosive behavior. He was raged with anger when a friend of him, Mike, mocked the way his hair looks. He suddenly punched Mike hard in the face breaking the poor guy's nose. This is just one of many examples of Kevin's unnecessary aggressive responses. When he is really angry, his temper builds up so fast and bursts with aggressive actions that usually harm people around him. His rage usually cools down in around 30 minutes after which he sometimes even forgets that he has harmed any one.

Etiology:

Some researchers have spotted a correlation between aggressive behavior and disorders of the frontal lobe, especially with focal orbito-frontal injury; however, in such case, according to the DSM-IV-TR criteria, the diagnosis of intermittent explosive disorders cannot be made. Nonetheless, a high percentage of patients with violent behavioral patterns report history of head trauma, mostly due to the nature of their actions, which doesn't coincide with the onset of their aggressive actions.

Although the effect of trauma on the development of intermittent explosive disorders is still not fully investigated, evidence exists that supports the correlation between lesions in the prefrontal cortex and impulsive patterns of aggressive behavior. Some evidence support the role of the reduced function of serotonin pathways in the pathogenesis of impulsive patterns of

aggressive behavior. Moreover, some authors have reported the increased incidence of impulsive disorders amongst children with serotonin gene polymorphism patterns who experienced abuse, neglect or violence.

Pharmacotherapy:

In the past, pharmacotherapy was the mainstay of treatment for patients with aggressive behavior. However, intermittent explosive disorders involve a long term aggressive behavioral patterns which shouldn't be treated pharmacologically through sedating the patient to reduce his/her aggressiveness.

Early studies showed some benefits from administering lithium to patients with impulsive aggression; however, it is not practical as it has a low therapeutic index.

Several anticonvulsants were proven to ameliorate impulsive aggression in patients who were meticulously investigated to rule out the coexistence of epilepsy. Some studies have detected the benefits of phenytoin in reduction of violent behavior in patients with impulsive aggression. Valproic acid was also successfully used to reduce violent behavior in patients with impulsive aggression.

The evidence that supports the correlation between intermittent explosive disorders and serotonin neurological pathways has urged researchers to investigate the role of selective serotonin reuptake inhibitors (SSRIs) in controlling the aggressive behavior of patients with intermittent explosive disorders. In 2002, Coccaro et al., managed to use fluoxetine (Prozac) to reduce aggression and irritability in patients with intermittent explosive disorders after 2-3 months of treatment; however, many studies failed to find any benefits from using SSRIs in management of impulsive aggression.

Antipsychotic agents shouldn't be used as sedatives in the treatment of intermittent explosive disorders. Nevertheless, low doses of new generations of antipsychotic agents have yielded some anti-aggressive effects that aren't related to the sedative and/or antipsychotic effects of the drugs. Despite the fact that there is no sufficient research data to support the role of new generations of anti-psychotics in the treatment of intermittent explosive disorders, several studies have proven their efficacy in controlling aggression in children and adolescents suffering from disruptive behavioral disorders or autism.

Psychotherapy:

When treating a patient with intermittent explosive disorders, family and group therapies are usually used. This is because the patient's violent behavior is often triggered when other people are present; hence, managing the patient in an isolated environment is illogic and ineffective. Adolescents who direct their violent behavior towards members of their families largely benefit from family therapies. Moreover, within the group, violent patients usually have more courage to discuss issues they don't feel comfortable to disclose during a one-on-one treatment session. Group therapy allows the patient to interact with others who also suffer from anger outbursts. In most cases, patients don't see their problems and hence, must be confronted. Confrontation is easier and less dangerous when done during a group therapy session.

The psychotherapist should carefully evaluate the motivations of the patient and why they decided to seek treatment. The presence of a true motivation to be better is a good sign that predicts success of therapy. For instance, a patient seeking therapy, just because his wife is pressuring him to do so, will usually not benefit from the therapy. During psychotherapy, the therapist should help the patient facilitate verbal expression of his/her problems and/or conflicts in a manner that is merely nonjudgmental. The therapist should never criticize or negatively react to the patient's violent behavior. A patient with intermittent explosive disorders often can't express himself/herself, or previous attempts to express his/her feelings were met with unsupportive responses by close relatives and/or friends.

Psychotherapy should be directed to help the patient develop firm self control. At the beginning of psychotherapy, gaining control is not difficult and many patients experience a "honeymoon" period throughout which the aggressive behavior seems to have stopped; hence, greater focus should be exploited to the development of self control at more advanced stages of the therapeutic plan. Development of affective awareness is one of the most vital goals of psychotherapy in patients with intermittent explosive disorders as prediction of the consequences of violence is a mighty tool that can help patients cease to act violently.

The role of psychotherapy extends to involve helping in restructuring the patient's environment in a manner that would prevent violence. Different aspects of the patient's life should be considered thoroughly to aid in understanding of the mechanisms leading to violence and to act to hinder them. Most commonly, a patient with poor scholastic achievement lacks nonviolent ways of achievement; hence, the therapist should work on

solutions that would help the patient improve educationally. If the patient's job is threatened, the therapist must work to help him/her keep it.

Kleptomania

It is crucial to differentiate kleptomania from common theft. In kleptomania, the patient steals items that aren't needed in terms of use and/or their financial value. The shoplifting behavior is neither a response to anger or revenge nor triggered by hallucinations or delusions. Similarly to other forms of impulse control disorders, patients with kleptomania feel tensioned prior to performing the act of and relieved afterwards. Patients with kleptomania exhibit heightened impulsivity as shown through the higher scores on the (BIS-11) as compared to psychiatric comparison controls groups.

Etiology:

Little is known about the etiology of kleptomania; however, some researchers found an association between kleptomania and head trauma, cortical atrophy and frontal lobe lesions. Patients with kleptomania may exhibit low fractional anisotropy levels on diffusion tensor images which points to subtle pathological changes in the white matter. A few studies have proven that kleptomania is usually associated with abnormal executive functioning rather than abnormal neuropsychological testing results.

Epidemiology:

Kleptomania is considered the least researched of all the impulse control disorders. DSM-IV-TR described the prevalence of kleptomania as "unknown". Nonetheless, some studies have shown that the prevalence of kleptomania amongst psychiatric inpatients approaches 8%.

Similarly to intermittent explosive disorders, the age of onset of kleptomania lies between late adolescence and early years of adulthood. Kleptomania is more common in women as compared to men. Some surveys have shown that about two thirds of all kleptomania patients are women. The morbidity of kleptomania is worse in the coexistence of other psychological disorders such as personality disorders, mood disorders and/or chronic substance abuse.

Treatment

There are no established guidelines for the treatment of kleptomania. SSRIs have been used in view of the opinion that states that kleptomania is connected to obsessive compulsive disorders. Some case reports have shown improvement of kleptomania in response to prescription of SSRIs; however, some case reports failed to prove any benefits from the prescription of SSRIs to patients with kleptomania. Moreover, some reports have shown the beneficial effects of drugs such as naltrexone and topiramate in the treatment of kleptomania.

Little body of evidence exists in literature regarding the role of psychotherapy in the treatment of kleptomania. Some researches have shown the beneficial effects of cognitive behavioral therapy in the management of some patients with kleptomania.

Pyromania:

The diagnosis of pyromania necessitates the occurrence of more than one occasion during which the patient attempts deliberately setting fire. Moreover, the patient usually feels stressed before setting the fire and relieved after performing the act. Pyromania should be well differentiated from the act of arson which involves performing the act for financial gains or as a reaction of psychosis or impaired judgement due to substance abuse, mental retardation or dementia. Pyromania is extremely rare and literature data is rather scarce.

Etiology:

The exact cause for pyromania is still unclear. Evidence suggests a multi-factorial pathogenesis which involves environmental factors, temperamental factors and parental psychiatric disorders. Some psychiatrists have suggested that the cause for pyromania and most other impulse control disorders is linked neuro-biologically, at least in part, to substance abuse.

Treatment:

Very few studies have been conducted to investigate the role of pharmacotherapy in the management of kleptomania. Trial of SSRIs emerged from the hypothesis that kleptomania is some form of an obsessive compulsive disorder. Some studies reported some reduction of impulsivity, while others failed to show any benefits. Topiramate and naltrexone have also been tried.

There is little data in literature regarding the role of psychotherapy in kleptomania; however, evidence exists that cognitive behavioral therapeutic strategies can be helpful.

Pathological Gambling:

Apart from other forms of impulse control disorders, pathological gambling is somehow correlated to substance abuse disorders as the behavior is often associated with an urge to increase the amount of risked money or assets to feel satisfied which is similar to tolerance to drugs of abuse. Pathological gambling is usually associated with irritability and restlessness when trying to stop gambling which is similar to withdrawal symptoms that occur when the abused drug is abruptly stopped. Furthermore, individuals with a substance use disorder are at higher risk for development of pathological gambling. Some studies have shown that nearly 73.2% of individuals with pathological gambling have associated alcohol abuse disorders, while 38.2% of pathological gamblers suffer from other substance abuse disorders.

There is evidence that substance abuse and pathological gambling are related to environmental associations as well as genetic factors. In a study of 8,169 individuals from Vietnam's Era twin Registry, co-twins of individuals with pathological gambling had higher prevalence of alcohol dependence as compared with co-twins of individuals who don't suffer from pathological gambling. Analysis of the data of this study concluded that genetic factors rather than environmental influences are responsible of the familial co-occurrence of alcohol dependence and pathological gambling.

Epidemiology:

A survey of 2,638 American adults concluded that the prevalence of pathological gambling ranges between 1.3% and 1.9%. On the other hand, some surveys have shown that the prevalence of pathological gambling amongst patients with substance abuse disorders is somehow higher ranging between 10% and 18%.

Etiology:

Some researches have proven that there is correlation between altered brain functions and pathological gambling. Bechara and colleagues developed the Iowa Gambling Task to study a group of individuals who have normal IQ, yet in the real world, they continuously make wrong decisions that lead to negative impact on their lives. The Iowa Gambling Task was constructed to

evaluate impaired decision making behavior in those individuals. The individual taking the task is asked to choose among four card decks. Two decks are arranged so that choosing cards from them would lead to short term monetary gains, but eventually would lead to loss over the 100 trials that the task involves. Choosing cards from the other two decks would lead to trivial immediate gains, but would eventually increase the overall gain over the 100 trials that the task involves. 20 pathological gamblers were compared to 40 healthy individuals using the Iowa Gambling Task. The results showed scores of pathological gamblers that were similar to patients with injury of the prefrontal cerebral cortex.

Some case reports have proven that patients with Parkinson's disease have a heightened prevalence of pathological gambling behavior. Evidence exists that this is due to the dopamine agonists which are usually prescribed to patients with Parkinsonism. A recent study was conducted to address the prevalence of pathological gambling among patients with Parkinsonism who are on dopamine agonists. The study showed a higher rate of pathological gambling behavior among patients with Parkinsonism (2%) as compared to healthy individuals (0.2%). Another study predicted that early age of onset of Parkinsonism, positive family history of alcoholism and the use of dopamine agonists is associated with a higher incidence of pathological gambling amongst patients with Parkinsonism. Furthermore, some studies have shown that patients with Parkinsonism who are treated with dopamine agonists exhibit higher levels of behavioral patterns that are possibly due to poor impulse control such as compulsive shopping, hypersexuality and compulsive use of medications.

Functional magnetic resonance imaging (fMRI) and brain spectroscopy have shown that the ventromedial prefrontal cerebral cortex, striatum and dopaminergic neurons within the midbrain comprise the higher centers for perception and anticipation of monetary loss. Using the Stroop task, which is a scale of behavioral inhibition, Potenza et al. concluded that pathological gamblers exhibit decreased activity of the neuronal pathways in the left ventromedial portions of the prefrontal cortex. Collectively, a considerable body of evidence exists supporting the role of the ventromedial portions of the prefrontal cortex in the control of pathological gambling and other behavioral patterns that are associated with poor impulse control.

Pharmacologic Treatment

Unlike kleptomania, various pharmaceutical agents have proven to be beneficial in the control of pathological gambling. Most clinical trials have

been centered on the use of medications that are effective in the treatment of obsessive compulsive disorders and substance abuse.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Placebo controlled trials have shown controversial outcomes to the use of SSRIs in patients with pathological gambling. In 2007, Hollander et al. compared the effects of fluvoxamine therapy to placebo in 15 patients who were diagnosed with pathological gambling and reported reduction in the urge to gamble with the use of fluvoxamine. On the other hand, another placebo controlled clinical trial of fluvoxamine therapy in a group of 32 individuals with pathological gambling failed to find any benefits of fluvoxamine over placebo.

A placebo controlled clinical trial studied the effects of paroxetine on 45 patients who were previously diagnosed with pathological gambling and reported significant reduction in the urge to gamble in the group of patients who used paroxetine as compared to the placebo group. On the other hand, sertraline failed to be beneficial in the control of pathological gambling.

Opiate Antagonists

Due to the prominent correlation between pathological gambling and alcohol dependence, opiate antagonists, which had been proven effective in the management of alcohol dependence, were tried in the management of pathological gambling. In 2001, Kim and Grant studied the use of naltrexone in 83 patients with pathological gambling. Naltrexone treated patients showed significant improvement in their gambling behavior as compared to placebo treated patients.

A multi-center placebo controlled trial investigated the effects of nalmefene in 207 individuals with pathological gambling. The results of the study showed a significant reduction in the urge to gamble with the use of nalmefene.

In conclusion, opiate antagonists show great promise as treatment options for patients with pathological gambling, even in the absence of coexisting substance abuse.

Other medications:

Due to its effectiveness in cessation of smoking, bupropion was tried in the management of pathological gambling. A clinical trial compared the effects

of naltrexone and bupropion in the management of pathological gambling and showed a similar percentage of response in both medication groups.

Collectively, a group of pharmaceutical agents have been tried in the management of pathological gambling. Considerable body of evidence supports the beneficial effects of some agents in pathological gambling namely opiate antagonists.

Non-pharmacologic treatments:

Gambler's Anonymous:

The first meeting of Gamblers Anonymous was held in 1957. Nowadays, Gambler's Anonymous holds meetings throughout America and more than 47 countries worldwide have Gambler's Anonymous groups. The Gambler's Anonymous model is formatted to help patients accept that they are, by themselves powerless to stop gambling and to persuade them that they should rely on professionals to overcome their problem.

The following are the twelve steps of the Gambler's Anonymous model:

- 1- We admit that we are totally powerless over gambling; hence, our lives had become unmanageable.
- 2- We believe that we need a power that is stronger than ours to help us restore our lives and thinking to normal patterns.
- 3- We made a clear decision to turn our lives and wills over to the care of the power that we understand can help us.
- 4- We made fearless and searching moral and financial inventories of ourselves.
- 5- We admit to ourselves and to others the exact nature of our wrongs.
- 6- We are totally ready to be helped to get rid of these defects of character.
- 7- We humbly ask God (of our deep understanding) to excise our shortcomings.
- 8- We listed all people whom we had previously harmed and are willing to amend them all.
- 9- We will work hard to directly amend such people, unless doing so, would harm them or others.
- 10- We will continue to resort to personal inventory whenever we are wrong, promptly admitting it.
- 11- We seek by means of our meditation and prayers our vital connection with God as we have clearly understood Him. We pray only

for the knowledge of His good will for us and the internal power to carry that out.

- 12- We made every effort to exercise all of these principles throughout all of our affairs and we will continue to spread this message to all other compulsive gamblers.

The effectiveness of the Gambler's Anonymous 12 step model has been investigated over several studies which utilized this model in an elective psychotherapeutic program for individuals with pathological gambling. Meta-analysis of these studies showed a favorable outcome.

Cognitive Behavioral Therapy

Several clinical trials have utilized cognitive behavioral therapy in the management of pathological gambling. According to a study that used cognitive behavioral therapy in patients with pathological gambling, reductions of the urge to gamble were maintained for periods ranging between 6 and 12 months as shown during follow up sessions. Other studies proved the beneficial effects of group and individual therapy in the management of pathological gambling.

In conclusion, a wide array of psychotherapeutic strategies has been used in the management of pathological gambling. In view of the recent studies, present data highly supports the role of cognitive behavioral therapy and the 12 step Gambler Anonymous model in the management of pathological gambling.

Trichotillomania:

The criteria for the diagnosis of trichotillomania are generally similar to obsessive compulsive disorders, with an associated heightened tension immediately before doing the act and a sense of gratification and/or relief of tension after committing the act. It has been proposed that trichotillomania should be categorized under the new group of disorders; the obsessive compulsive related disorders for DSM-V. Nevertheless, some evidence denotes that trichotillomania is not simply a form of an obsessive compulsive disorder.

A study, which examined the first degree relatives of 80 patients with obsessive compulsive disorders and 73 controls, found no statistically significant difference in the prevalence of trichotillomania in the first degree

relatives of patients with obsessive compulsive disorders as compared to its prevalence in the control group. The prevalence of trichotillomania was 1% in the control group and 4% in the group of relatives of patients with obsessive compulsive disorders. These prevalence rates are somehow similar those of significant hair pulling behavior among college students which approaches 1.5% for men and 3.4% for women; however, only about 0.6% of those students met the DSM criteria for diagnosis of trichotillomania.

Etiology:

Little is known about the etiology of trichotillomania. It usually presents itself in late childhood and adolescence. Trichotillomania is more prevalent among women as compared to men. Several studies that investigated the neurobiological mechanisms behind trichotillomania examined the volumes of the putamen and caudate using MRI. These regions were selected because of evidence that they are affected in patients with obsessive compulsive disorders and Tourette's syndrome. Results showed attenuation of the volumes of the left lenticulate and left putamen in patients with trichotillomania as compared to normal controls.

Another study examined the levels of metabolites of the monoamine neurotransmitters in the cerebrospinal fluid of patients with trichotillomania. The results showed no significant difference between controls and patients as regards the cerebrospinal fluid levels of homovanilic acid (HVA), 5-HIAA and 3 methoxy 4 hydroxylphenylglycol. However, higher levels of cerebrospinal 5-HIAA were directly related to good response to SSRIs.

Recently, genetic research revealed a correlation between trichotillomania and serotonin 2A receptor gene polymorphism (T102C). Nonetheless, these genetic studies examined a relatively small sample of patients; hence, these researches should be replicated using larger samples to accurately determine the exact role of basal ganglia pathology and disturbances of the serotonin neuronal pathways in the pathogenesis of trichotillomania.

Treatment

One of the important features that delineate trichotillomania from obsessive compulsive disorders is the therapeutic response to SSRIs. Early case reports pointed to the beneficial effects of SSRIs on the manifestations of trichotillomania; however, placebo controlled trials failed to detect a significant differences between the responses to SSRIs and placebos. These results are highly contradictory to those of many placebo controlled trials

which proven efficacy of SSRIs in the management of obsessive compulsive disorders. A recent study concluded that the combination of the SSRI sertraline with a special form of cognitive behavioral therapy has a greater efficacy in the management of trichotillomania than either line alone; however, the results of this study cannot be generalized because the studied sample was rather small. Citalopram, naltrexone, lithium, venlafaxine and fluvoxamine have all been reported to ameliorate the manifestations of trichotillomania; nevertheless, with absence of placebo controlled trials, the use of these medications in the treatment of trichotillomania isn't established.

Psychotherapy:

Similar to other impulse control disorders, the cognitive behavioral therapeutic model has been shown to be effective in the management of trichotillomania. Due to the fact that trichotillomania usually starts during childhood, it has a relatively prolonged course; hence, behavioral treatment strategies seem to be useful. These strategies include covert desensitization, self monitoring and habit reversal. Another useful technique involves proposing to the patient practicing alternative motor responses such as clenching or grasping the hands for 2-4 minutes when feeling the urge to pull one's hair. The behavioral strategies are centered on identification of the situations that are usually accompanied by the hair pulling habit, most commonly during watching television or reading, and implementation of response prevention is tried in such situations. Positive attention or overcorrection is another important element of the behavioral therapeutic strategy and it involves asking the patient to comb or brush his/her hair after each paroxysm of hair pulling.

A small study was conducted to compare the effects of cognitive behavioral therapy to those of clomipramine and placebo in the management of trichotillomania. The responses to cognitive behavioral therapy were higher than those of other treatment groups. Another study of 25 patients with trichotillomania concluded that a combination of habit reversal training with acceptance and commitment therapy markedly improved the severity of hair pulling behavior as compared to a wait list group of controls. As aforementioned, evidence supports the beneficial effects of a combination of SSRIs and cognitive behavioral therapy.

Hypnotherapy has been used successfully in the treatment of individual cases of trichotillomania.

Impulse Control Disorders not Elsewhere Specified

Disorders that are associated with poor impulse control and do not fit under the criteria of diagnosis of any of the specific impulse control disorders or any of the mental disorders that exhibit poor impulse control behavior are collectively known as impulse control disorders not elsewhere specified. Skin picking is the most prominent member of this category. Other disorders that are listed under this category and meet the diagnostic criteria for obsessive compulsive disorders in the DSM-V include compulsive impulsive shopping, compulsive internet use disorders and compulsive impulsive sexual behavior.

The prevalence rates of compulsive impulsive shopping and sexual behavior are estimated to range between 2% and 8% among adults. Reports denote that 2% of patients who are referred to dermatologists suffer from skin picking. The incidence of pathological skin picking in individuals suffering from obsessive compulsive disorders is higher as compared to normal individuals.

Problematic Internet Use:

In the mid 1990s, several attempts were made to formulate diagnostic criteria for problematic Internet use. In 1996, Young used the DSM-IV criteria for substance dependence to describe individuals who suffer from "Internet addiction". Young considered an individual an "Internet addict", when he/she had 3 or more of the seven modified criteria. Young emphasized that individuals who suffer from Internet addiction are most likely to exhibit symptoms are identical to those addicted to substance of abuse, gambling or alcohol.

In 1997, Brenner formulated the Internet Related Addictive Behavior Inventory to detect Internet addiction. The Internet Addictive Behavior Inventory's criteria were adapted from the DSM-IV criteria for diagnosis of substance abuse. Brenner detected that there is a group of heavy Internet users who suffered from a wide array of problems that are highly caused by their Internet use.

In the year 2000, Armstrong and colleagues formulate the Internet Related Problem Scale which included 20 questions that were derived from the DSM-IV criteria for diagnosis of substance dependence. The authors found a direct relations between the numbers of hours spent online and the high scores which were also directly related to the scores of a scale which had been previously formulated for addiction; the Minnesota Multiphasic

Personality Inventory-2 Addiction Potential Scale. The authors concluded that Internet addiction is an entity that shouldn't be overlooked. On the contrary, in 1993, Satel proposed that expansion of addiction related disorders to include the so-called compulsive self destructive behaviors can somehow weaken the fact that addiction is a clinical disorder and would leverage treating all such behavioral patterns with 12 step therapeutic programs overlooking whether or not other treatment strategies would yield more favorable outcomes.

In 1998, Young conceptualized problematic Internet use as a form of impulse control disorders that is somehow similar to pathological gambling and formulated novel criteria that are based on those of pathological gambling. Young's criteria were centered on the individuals pattern of Internet usage, types of online activities that he/she participates in and the negative consequences that Internet usage has on his/her aspects of life. Young's Internet Addiction Diagnostic Questionnaire (IADQ) was the first screening tool developed to diagnose problematic Internet use.

The IADQ included the following 8 criteria:

- 1- Do you have a sense of preoccupation with the Internet (constantly think about activities you previously engaged in online or anticipate your next Internet use sessions)?
- 2- Do you get the feeling that you have to increase the amount of time spent online to achieve satisfaction?
- 3- Did you previously make unsuccessful attempts to quit, control or cut back your Internet usage patterns?
- 4- Do you feel depressed, restless, irritable or moody when trying to stop or even cut down Internet usage?
- 5- Do you often spend time online that is longer than you originally intended?
- 6- Have you risked the loss of a serious relationship, job or career or educational opportunities because of your Internet use patterns?
- 7- Did you ever lie to your spouse, family members or therapists to conceal your true involvement with online activities?
- 8- Do you use the cyber-world as a means of sanctuary from problems or as a way of relief of unpleasant moods such as feelings of guilt, anxiety, helplessness or depression?

The results of the questionnaire evaluated casual Internet usage which wasn't academically or business related. Individuals were considered having an Internet use problems if they positively endorsed 5 or more of the questionnaire's inquiries for a period that is more than 6 months. Excessive Internet usage, social isolation, neglect of life responsibilities and continuous

desire to conceal online activities are highly suggestive of presence of an Internet use problem. Although the IADQ has provided a scale for detection of addictive or pathological Internet usage patterns, the results are sometimes concealed by social norms that usually encourage Internet usage.

In the year 1999, Paterelli and colleagues surveyed college students using a 94 item questionnaire and concluded that individuals who suffer from problematic Internet use exhibit some psychiatric obsessive traits that are possibly the cause of their problems. In 2001, Beard and Wolf reformulated the criteria that were first developed by Young to diagnose problematic Internet addiction. They were concerned that many behavioral patterns that were included by Young could be manifestations to disorders other than addiction.

In 2000, Shapira and colleagues defined Internet usage as a problem when it is highly distressing, uncontrollable and/or markedly time consuming leading to occupational, social or financial problems. In their interviews with 20 patients with Internet usage problems, Shapira and colleagues concluded that all 20 of these patients have an impulse control disorder not otherwise specified according to the DSM-IV criteria, while only 3 of those patients match the criteria for diagnosis of obsessive compulsive disorders.

In the year 2001, Treur and colleagues found a high prevalence of manifestations of impulse control disorders amongst 86 random Internet users whom completed the questionnaire published on the authors' website. In 2003, Shapira and colleagues emphasized the importance of formulating provisional criteria for the diagnosis of problematic Internet usage as this would help in the estimation of the true size of the problem and planning of future research strategies. Similarly to other forms of impulse control disorders, individuals with problematic Internet use usually experience a feeling of tension before engaging in Internet usage and a sense of relief after completion of the act.

The American Psychiatric Association considered inclusion of diagnosis of problematic Internet use in the new version of the DSM-V. The diagnosis is a form of an impulsive compulsive disorder that should include both online and offline computer activities and comprises 3 subtypes; excessive gaming, email/text messaging and sexual preoccupation. All of the proposed variants share the following criteria:

- 1- Excessive use that is often accompanied by disorientation to time and neglect of basic responsibilities.

- 2- Manifestations of withdrawal which include feelings of tension, anger and/or depression when computer usage is not possible.
- 3- Tolerance which involves an increasing demand for more computer usage hours, better hardware, more advanced software...etc.
- 4- Negative repercussions such as lying, arguments, social isolation, poor achievements and fatigue.

Treatment

There are no meta-analyses that have established the best lines of treatment for problematic internet use. Presently, cognitive behavioral therapeutic models are the primarily proposed treatment strategies to manage problematic internet use and replace it with other forms of activities. Family and group therapy formats are often encouraged to aid in the refurbishment of social relationships and to allow family and friends engage in the treatment plan.

Psychotherapy in the management of impulse control disorders:

Establishment of a working alliance is the initial pivotal step in the management of impulse control disorders. Despite the fact that this might be rather easy in some disorders such as trichotillomania, in other impulse control disorders establishment of a working alliance can be somehow challenging. Initially, determination of the therapist's and patient's responsibilities and outlining the exact relationship between them is crucial. Occasionally, it is essential to preserve external structure whether or not this is achieved by means of a period of hospitalization or through support of family and near people. Alternatively, the 12 step programs are sometimes indispensable. In patients who exhibit antisocial personality traits, it is better to resort to a limit setting. Impulsive symptoms are occasionally subjected to positive reinforcement; hence, limit setting should be viewed in a cognitive behavioral context.

Counter-transference is another crucial element to be considered in this context. During treatment of individuals with impulse control disorders, sometimes a range of intense reactions arise. Clinicians are sometimes deceived by the pleasure or excitement caused by their impulses; thus, leading to underestimation of their dangers. On the contrary, therapists sometimes perceive the patients' impulses as scary and are reluctant to participate in treatment.

The psychodynamic principles that govern the identification and understanding of an individual's feeling during facing an impulsive patient are pivotal. Cognitive behavioral constructs including schemas can be utilized in the conceptualization of these phenomena. Accurate structure, limit setting and boundaries are pivotal in containing feelings in the counter-transference and transference and avoiding acting them out.

Previous traumas impose an essential role in the psychodynamic mechanisms of patients with impulse control disorders. The consequences of past adverse environments can be formulated by means of their influence on maladaptive schemas or their neurobiological sequelae on the long run. During psychotherapy, it is crucial to create an environment throughout which the patient is allowed to experience a nurturing relationship that can help address and articulate the patient's transference and/or maladaptive schemas.

For some patients, heightened levels of negative affect are the most important factor underlying their disorders, while for others, mobilization of affect is indispensable to clearly identify and work with maladaptive schemas. Coexistent stressors are likely to catalyze patient's impulsivity particularly in patients with past history of trauma; hence, stress management techniques should be relevant to psychotherapeutic techniques.

Psychotherapy usually acts synergistically with pharmacotherapy in the management of impulse control disorders. The relatively high placebo response rate of patients with impulse control disorders to pharmacotherapy and the considerable rates of relapse during periods of maintenance of pharmacologic treatment illustrate that the relationship between the patient and the therapist is critical in determination of the patient's response to treatment. Patients who exhibit manifestations of severe negative transference are usually more susceptible to experiencing the adverse effects of pharmacologic agents.

Psychotherapeutic management is pivotal to prevent demonization or over-idealization of pharmacotherapy. Psychotherapy is a key factor in observation of the change in the patient's symptoms in response to the modifications of the patient's environment; thus, serving as a valuable tool in the determination of the efficacy of used medications.

Manual psychotherapeutic models have been developed for the treatment of patients with impulse control disorders providing a standard method for tackling most of the aforementioned issues. For instance, dialectical

behavioral therapy (DBT) has been utilized in the treatment of impulsive individuals and has proven to be effective in group and individual formats. Moreover, cognitive behavioral therapeutic strategies have been effectively used in the treatment of impulsive disorders in children.

The legal perspective of impulse control disorders:

The terms "impulse", "impulsivity" and "impulsive" don't have particular meanings within the law; however, the law exhibits many examples of how impulsivity is utilized in developing legal principles, increasing the degree of punishment and carving out exceptional legal rules.

An example that illustrates the reliance of the law upon impulsivity is "impulsive statements," which is considered one of the exceptions to the so-called hearsay rule. "Hearsay" refers to the situation when a witness's testimony is totally based on what another individual has told him/her, rather than on what he/she has observed firsthand. This rule has been established because if a statement, which was made by a third party, is presented as evidence in a trial, questioning the third party is crucial to determine whether or not the statement was accurate, yet it is not always possible.

Accordingly, there are many examples of complicated exceptions to the hearsay rule. One of the most common exceptions is the "res gestae" exception. The res gestae exception was developed to admit statements that are possible to be otherwise hearsay in the situation when the statements are excited utterances or spontaneous declarations. The philosophy underlying the res gestae exception is that if a statement is declared in haste, without careful thought, it is mostly truthful and hence, needn't be subjected to scrutiny.

Apart from the evidentiary rules, impulsivity arises in many situations that are repeatedly encountered in the legal system. In a tragic and weird case, Regina Evans was convicted in 1991 of brutally executing two women. Evans had an accident which caused some damage to his brain at the age of 9 years. After being charged with murder, Evans was examined by a psychiatrist and a psychologist who found that his IQ was that of a mentally retarded individual. Initially, Evans wasn't the main suspect. Alternatively, the police thought his brother was responsible for the crime. Evans was arrested for possessing marijuana and was pressured to present evidence against his brother. Although Evans was initially informed of his right

counsel, he reported that he didn't understand his rights. Moreover, when the police started to suspect Evans was responsible for the murders, he was neither formally advised that he was detained for suspicion of committing homicide nor was he readdressed of his right to council.

Throughout long interrogation sessions, Evans' statements unfolded a confession to killing both women. At trial, the jury's verdict found Evans guilty of first degree murders. The evidence was the confession he made to the police. Evan's lawyers appealed the verdict, claiming that his right to counsel and liberty had been clearly violated as the police didn't inform him during re-interrogation that he was considered then a prime suspect. Despite the fact that there had been a clear violation of Evan's civil rights, the British Columbia Court of Appeal held that evidence was compelling and freeing Evans would be harming to others' rights.

This famous example clearly illustrates how halls of justice are concerned with individuals whose patterns of behavior are impulsive or uncontrollable. Accordingly, in similar situations, impulsivity can serve as a determining element in identification of guilt and sentencing. Interestingly enough, the British Columbia Court of Appeal was intentionally overlooking infractions of constitutional rights aiming at protection of the society from Evan's destructive impulsive behavior.

Just like Evan's example illustrates, impulsivity is encountered in a considerable number of situations in the legal system. Generally speaking, *res gestae* statements, which are impulsively made, are usually considered reliable. The decision of the British Columbia Court of Appeal in the case of Evans clearly illustrates how impulsive patterns of behavior must be highly concerned, due to the striking fact that people are unable to control their impulses. Impulsivity yields behavioral patterns and statement that are somehow not under the control of an individual; hence, impulsive behavior are, in most cases, truthful and impulsive behavior is usually met with great concern.

One of the most interesting legal considerations of impulsivity is utilizing it in the strategies of criminal defense. Impulsive defendants may heighten the court's scrutiny of their behavior, instead of exculpating him/her. In other words, courts of justice are somehow sensitive to defendants, who exhibit impulsive behavior, because they are usually unable to control their behavior and hence, can impose a great risk to the society. On the other hand, when impulsive patterns of behavior are associated with mental illness, it is often used as a strategy of the criminal defense.

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On the page that opens, enter your information and take the T/F Quiz. When you click SUBMIT, the program will instantly grade your quiz, and provided you pass by at least 80%, it will then charge your credit or debit card.

Immediately, a new web page will open containing your Receipt and Certificate info, and a Link will be provided to access a fancy Certificate for you to Print and/or Save to your computer.

You will also receive an Email containing this same information and the link. *You will **NOT** receive a paper certificate in the mail - This electronic system provides numerous options for you to print and save your CEUs.*

FOR FAX OR MAIL SUBMISSION:

Print the Quiz and Payment forms on the next few pages of this document, and complete the requested information.

Our 24-hour secure Fax number is **(888)-877-6020**.

If you fax your quiz and payment to us, please do NOT also mail it.

We process faxes within approximately 4 business hours after receiving them. Faxes submitted late in the day or after hours will be processed the next business morning. However, all certificates are dated the date we receive your course quiz and payment.

*You will **NOT** receive a paper copy of your Certificate in the mail.*

Enter either your fax number or an Email address and we will send your CEU Certificate to the contact info you provide.

If you prefer to use a check or money order, please Mail the quiz and payment to:

PeachTree Professional Education, Inc.
15560 N. Frank L. Wright Blvd, #B4-118
Scottsdale, AZ 85260

EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

**** OR ****

You may complete and submit this information **ONLINE** by going back to www.FastCEUs.com and clicking the Quiz & Pay link for this course.

PLEASE NEATLY PRINT THE FOLLOWING INFORMATION:

NAME as you want it on your CEU Certificate: _____

Your professional cert/license with numbers: _____

ADDRESS for record keeping: Street: _____

City: _____

State: _____ Zip: _____

DAYTIME TELEPHONE Number: (_____)_____

We will FAX or EMAIL your CEU Certificate (no copy will be mailed).

— **CLEARLY PRINT** YOUR FAX # or EMAIL ADDRESS:

(IF you FAX us your Evaluations do NOT mail them. Please WRITE NEATLY so you get your CEUs.)

MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS

This **3** Hour CEU Course is **\$49.00**

CIRCLE: Master Card Visa Discover Card AmExpress Check Enclosed

Card Number: _____

Card Expiration Date: _____ Security Code: _____

(Security Code = last 3 digits on back of card for MC, Visa, Discover - or 4 digits on front for Amex)

Signature: _____

Mail: PeachTree Professional Education, Inc.

15560 N. Frank L. Wright Blvd, #B4-118

Scottsdale, AZ 85260

Phone: (800) 390-9536 **Fax:** (888) 877-6020

EVALUATION OF LEARNING QUIZ - PAGE 2 of 4

"MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS"

3 Hours of Approved Continuing Education Credit

The purpose of the following Evaluation of Learning questions is to:

- A.) Verify that you have read the required course materials
- B.) Demonstrate an understanding of the practical application of the course materials
- C.) Officially document your participation and completion of this course

☞ PLEASE ANSWER THE 15 T/F EVALUATION OF LEARNING QUESTIONS

- T F** 1. I have read all of the required reading material for this course.
- T F** 2. Even though impulsivity can sometimes be a clinical problem, it is a main characteristic of the normal human behavior.
- T F** 3. An impulse, as defined by Oxford's dictionary, is a strong and unjustified urge or desire to do a certain act.
- T F** 4. Patients who suffer from impulse control disorders often experience a heightened sense of relaxation and serenity before performing the act.
- T F** 5. The BIS-11 evaluates impulsivity on 3 scales; Speed, craftiness and impact.
- T F** 6. The OAS-M is a form of an interview which is designed to evaluate the frequency and severity of aggressive behavior.
- T F** 7. Typically, antipsychotic agents shouldn't be used as sedatives in the treatment of intermittent explosive disorders.
- T F** 8. In kleptomania, the patient steals items that needed that they otherwise cannot afford or obtain.
- T F** 9. Kleptomania is considered the most researched of all the impulse control disorders, a lot of data is available and its prevalence is well known.
- T F** 10. The diagnosis of pyromania necessitates the occurrence of more than one occasion during which the patient attempts deliberately setting fire.
- T F** 11. Individuals with a substance use disorder are at higher risk for development of pathological gambling.

CONTINUED →

EVALUATION OF LEARNING QUIZ - PAGE 3 of 4

"MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS"

- T F** 12. A clinical trial compared the effects of naltrexone and bupropion in the management of pathological gambling and showed a similar percentage of response in both medication groups.
- T F** 13. The criteria for the diagnosis of trichotillomania are generally similar to obsessive compulsive disorders, with an associated heightened tension immediately before doing the act and a sense of gratification and/or relief of tension after committing the act.
- T F** 14. Psychotherapy usually acts totally independent and non-synergistically with pharmacotherapy in the management of impulse control disorders.
- T F** 15. The terms "impulse", "impulsivity" and "impulsive" don't have particular meanings within the law.

GRADE THIS ONLINE COURSE! – Page 4

It is helpful to us if you return this form via snail mail or fax, along with your Quiz and Payment, if you are not completing the form online. Thank-you!

Participant Assessment of Home Study CEU Course

“MEDICAL AND PSYCHIATRIC TREATMENT OF IMPULSE DISORDERS”

3 Credit Hours

Please Rate the Following Statements from 1-5

(1 being the Lowest, 5 being the Highest.)

- _____ 1. I found the PeachTree Online Home Study Course Instructions simple to follow.
- _____ 2. I found the PeachTree Online Home Study Course materials to be of professional quality, and easy to read.
- _____ 3. I found the PeachTree Online Home Study Course materials to be of educational value, relative, and useful to my counseling practice.
- _____ 4. I completed the 3 Hour PeachTree Online Home Study Course in approximately 3 hours.
- _____ 5. I would take another PeachTree Online Home Study Course, and/or recommend them to a co-worker.

ADDITIONAL COMMENTS: